

## CHAPTER 4

### THE BURDENS OF THE HISTORICAL PAST

#### 4.1 Background: fundamental antagonisms in the story of AIDS

This Chapter aims to indicate how AIDS filtered through the narratives of apartheid orthodoxy. As shown in the previous Chapter, AIDS not only illuminates the possibilities and limits of representing disease within the framework of the received narrative (as the reader knows, the “received narrative” conceives of AIDS as a biological or pathological condition), but AIDS also offers us the possibilities for understanding the limits and consequences of living outside the social moralities of society. Like film genres,<sup>1</sup> the AIDS story is inclined towards framing societal issues in conservative terms: it singles out ethical or moral behaviour both as a condition for social order and for combating the AIDS scourge itself. Essentially, the AIDS story in the media was structured by two fundamental sets of oppositions. On the one hand, there was an opposition between morality and individual freedom. Here the story of AIDS fastened on the notion of individual voluntarism. Human actors contracted AIDS because they were left free to exercise their agency, so the argument ran. They were moved to violate the moral order of society, because they were left to their own devices – to exercise free will; owing to the fallibility of the human condition, they were urged towards some tragic destiny. In other words, their tragedy (contamination

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<sup>1</sup> See for instance masterpiece texts by Nick Browne and Glenn Man. Browne and Man fasten upon the idea that the three epic films of the Godfather (*Godfather I, II, and III*) embody classic examples of conservatism. See N Browne 2000, ‘Violence as history in the Godfather films’, in *Francis Ford Coppola’s the Godfather trilogy*, in N Browne (ed) *Francis Ford Coppola’s The Godfather trilogy* (United Kingdom: Cambridge University Press),

by AIDS) stemmed from the distortion of their character. They yielded themselves up to the most perverted of behaviour: sexual infidelity or promiscuity. Thus, from the early 1980s to the mid-1990s some researchers, including the media, invested themselves with the idea that the human catastrophe bequeathed by AIDS was primarily a consequence of humankind's personal limitation.

On the other hand, there was a fundamental opposition between morality and the social ills of our age: poverty, malnutrition, unemployment, crime, and lack of shelter, means of transportation, clean water, education, etc. This crisis of consumption bequeathed a historical limitation. Here AIDS was understood in relation to a constellation of sociological conditions in which the individual lived. According to this logic, AIDS flourishes in the context of institutional constraints. The moral decadence of the individual was absolved. And history was indicted for his or her abandoned behaviour. Because history violated the human character, it staged the groundwork for the spread of AIDS. This idea of 'historical limitation' echoed the most dominant tendency in the media from the mid-1990s.

From this perspective, therefore, the infection of the body frame by a microbe called human immunodeficiency virus (HIV) was said to be a consequence of both human free will and history (the social arrangements of society). The AIDS story in the media, *depending on variabilities over time and space*, indicted the individual and his or her own society. AIDS was said to be a metaphor for either the evil of the individual or the evil of society. What is also important is that in both instances –

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1 22; and G Man 2000, 'Ideology and genre in The Godfather films', in N Browne (ed) *Francis Ford Coppola's The Godfather trilogy*, 109–131.

tragedy as a personal limitation and as a historical limitation – there was a progressive violation of the society’s ‘moral reality’. When human actors choose to exercise their own free will, they all too often end up plunging themselves into the realm of immorality; they step into ‘otherness’, they gravitate towards homosexuality and promiscuity. And depending also on historical variabilities over time and space, their sociological conditions violate their moral character. Poverty, malnutrition, unemployment and lack of shelter become the major risk factors for infection by HIV and immune suppression – which is the hallmark of AIDS. Here it is not the individual who is evil in his or her overreach, but rather his or her own society.

This thesis therefore uses historical knowledge to provide significant information for an understanding of an abundance of meanings underlying AIDS as well as some of its recurrent themes, the sources they drew on, and the sorts of narrative that influenced them. In addition, it seeks to provide a much deeper access to an understanding of the journalist’s place in the history and representation of the AIDS disorder. Our concern with the historical perspective or historical consciousness also justifies looking at the place of the apartheid state in the story of AIDS.

#### **4.2 The “narrative of moral protest” and apartheid orthodoxy**

The apartheid state’s policy regarding AIDS can be understood in relation to the “narrative of moral protest” discussed previously (see Chapters 1 and 2). From the very beginning, the apartheid state evinced that the cause of AIDS was not only biological, but also moral. Furthermore, the cause of AIDS was not economic, but ethical. As will be seen later, the immediate effect of this train of thought was the

depoliticization of the disease. The larger issues of history, power, control and social deprivation were simply erased or effaced to deflect our collective attention from the incorrigible system of apartheid itself. From this standpoint, the apartheid state's manner of proceeding was overwhelmingly supportive of the status quo. It refused to consider how moral values associated with the institutions of the family, church and education, etc, were progressively broken down by its own corrosive ideology, that is, the ideology of racial domination.

Hence, although the apartheid state supported changes in social or sexual lifestyle (see below), one can clearly see conflicting moral and racial elements in its manner of thought. On the one hand, the apartheid state committed itself to building a completely 'moral society'. On the other hand, it was supportive of a racially based superstructure; it maintained a supportive stance towards an ideology based on racial separation. What is more important, it deflected attention from the larger political and economic issues by blaming the *individual* for AIDS.

I refer to this system of representation embedded in the apartheid state's thinking as behaviourism. I argue that behaviourism embodied the dominant motif of health policy under apartheid. I also evince that behaviourism can be located within an understanding of the political economy of South African society. Racial domination, political disaffection, political unrest, trade unionism, large-scale urbanization, increasing poverty, unemployment, squatting, economic recession and international economic sanctions: all these have had a close bearing on South Africa's health care structure.

### 4.3 The health bureaucracy: a brief historical overview

The leading causes of death in the Third World today are infectious diseases rather than the so-called degenerative diseases, namely heart disease, cancer, diabetes and strokes, etc.<sup>2</sup> The Industrial Revolution, which swept throughout Europe in the 19th century, improved the general living standards of people and also rehabilitated the health care structure on a grand scale. This, coupled with the creative geniuses of men such as Edward Jenner, Louis Pasteur, Robert Koch, Alexander Fleming and Joseph Lister (for a more detailed discussion see Chapter 6), heralded an epidemiological transition of major proportions. Contagious diseases ceased to be the major killer diseases confronting the advanced societies; infectious microbes ceased to be the No 1 killer diseases in Western Europe. However, in the Third World infectious diseases (notably polio, malaria, tuberculosis, syphilis, pneumonia, herpes, etc) continued to plague a large number of people.<sup>3</sup> For these diseases broke out in clusters within regions (cities and towns) and within families.<sup>4</sup> They exploded rapidly in a population (in other words, they rose in a compounded fashion) and were distributed equally between men and women. In keeping with Farr's law<sup>5</sup> (see chapter 7) the rate of infection increased within a limited period of time. Partly, this was because many Third World societies were incapable of immunizing large numbers of people against disease.

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<sup>2</sup> G E du Plessis 2000, *The sociology of population, Only study guide for SOC204-5* (Pretoria: University of South Africa), 53.

<sup>3</sup> J R Weeks 1999, *Population: an introduction to concepts and issues* (Belmont: Wadsworth), 115–117.

<sup>4</sup> Duesberg, *Inventing the AIDS virus*, 255–298.

<sup>5</sup> D J Bergman and A D Langmuir 'Farr's law applied to AIDS projections', *Journal of the American Medical Association* 263:50–57.

In South Africa, public health programmes were underpinned by institutional – and legislative – means. In 1833 the first Public Health Act was promulgated, in the wake of the outbreak of the smallpox epidemic in Kimberley.<sup>6</sup> Following the United States’ experience, the national state invested local authorities with the power to deal with matters pertaining to public health emergency; occasionally local public health officials entered into affected premises either to enforce quarantine regulations or to maintain environmental hygiene.<sup>7</sup> Furthermore, more money was made available to local authorities to fight disease. Private corporations participated in health care too. For example, in terms of the Native Labour Regulation Act of 1911, the gold mining sector became responsible for providing housing, adequate diet and hospital care for native labourers under its employ.<sup>8</sup>

However, for the majority of the population (most of whom were unemployed) health care became an individual responsibility.<sup>9</sup> Health care was by no means administered according to need – health care was administered according to the ability to pay.<sup>10</sup> Actually, this was one of the major findings of the National Health Services Commission (the so-called Gluckman Commission). Established in 1944 as part of “a wave of reform-minded thinking of two decades”, the Gluckman Commission was propelled by the desire to reform health care “in many respects and in many ways”.<sup>11</sup> Among other things, the commission found that health care services were not available and accessible to all sectors of the population. To lend force to this point of view, the commission cited the unequal provision of hospital accommodation. Shortages were

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<sup>6</sup> F Ginwala, 1981, *Health status report: South African health system (a review)*, (Pretoria: Department of Health), 7.

<sup>7</sup> Ibid, 7.

<sup>8</sup> Ibid, 9.

<sup>9</sup> Ibid, 8.

<sup>10</sup> H C J Van Rensburg. 1995 *Health care in South Africa: structure and dynamics* (Pretoria: Academia), 60.

found to be more acute in the black areas, where there was a bed-population ratio of 1:1198 patients.<sup>12</sup> The commission argued that these problems arose from private practice: health care services were located where wealthy people lived and not where the poor lived.<sup>13</sup> To remedy the situation, the commission recommended, *inter alia*, that the national state assume full responsibility for the provision of health care, take control over hospitals under provincial authorities, render personal health services free of charge, form a network of regionalized community services clustered around community health centres, phase out private practice, and deploy doctors, irrespective of race, gender and class, across the country according to need.<sup>14</sup>

Just the same, none of these recommendations were singled out for implementation, partly because of the unwillingness of some provinces to delegate their jurisdiction over hospitals, partly because of opposition from the medical professionals, who were afraid of losing their sense of independence, and of course, partly because of the coming to power of the Nationalist Party government in 1948, which from the outset was directly opposed to the recommendations of the Gluckman Commission.<sup>15</sup> Meanwhile, a protracted struggle ensued between the national government and provincial authorities. Parliament's response to this conflict found expression in the promulgation of the Public Health Amendment Act of 1946. Significantly, the Act vested more power in the hands of the provinces. Provincial authorities became solely responsible for general hospital and outpatient services, whereas the national government undertook to provide the so-called extra institutional services.<sup>16</sup> However,

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<sup>11</sup> Ibid, 60.

<sup>12</sup> Ibid, 62.

<sup>13</sup> Ibid, 62.

<sup>14</sup> Ibid, 62

<sup>15</sup> Ibid, 63.

<sup>16</sup> Ibid, 23.

this provincialist attitude bequeathed the problem of fragmentation: there was considerable lack of coordination at the centre. The health care system remained “disjointed”, “haphazard” and “parochial”.<sup>17</sup> A motley of institutions became responsible for health care: local authorities, provincial authorities, the Department of Health, the mines, missionary societies, charitable organizations and private hospitals.<sup>18</sup>

Another major difficulty facing the health care system during this period was the lack of funding. Problems of affordability made impossible the establishment of a new system of health care centres envisioned by the 1946 Amendment Act. Also, health policy was increasingly determined by political criteria rather than universalistic criteria. For the dominant impulse of health policy was the provision of health care for the white population.<sup>19</sup> Clear evidence of this particularistic attitude can be seen in the Tomlinson Report’s recommendation for a *separate* Bantu Health Service.<sup>20</sup>

#### **4.4 Public health policy and the reformation of apartheid**

With the implementation of the Bantustan programme (the homeland system) in the 1960s, the health bureaucracy became even more fragmented. Provincial administrations were broken up into a number of departments (seventeen to be precise), many of which lacked political legitimacy.<sup>21</sup> The immediate effect of this was the misallocation of resources, the duplication of services, as well as poor

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<sup>17</sup> Ibid, 61.

<sup>18</sup> Ibid, 61.

<sup>19</sup> Ginwala, *Health status report*, 9.

<sup>20</sup> Van Rensburg, *Health care in South Africa*, 57.

<sup>21</sup> Ginwala, *Health status report*, 10.



communication between various health care structures.<sup>22</sup> What is more, the homelands created an “intermediate level of responsibility and administration”.<sup>23</sup> In addition, the homelands became reservoirs of cheap labour, low wages, housing shortages, illiteracy, famine and overpopulation; the Bantustans also became a haven for many diseases of poverty, particularly diphtheria, measles, respiratory ailments, malaria, tuberculosis, bilharzia, cholera, trachoma, kwashiorkor, marasmus, typhoid, and gastro-enteritis.<sup>24</sup> Lack of coordination at the centre, coupled with the particularistic attitudes of the apartheid state, hamstrung the apartheid state in its endeavour to countervail the ravaging effects of contagious epidemics.

Another immediate consequence of the implementation of the Bantustan system concerns the active involvement of the apartheid state in its grandiose plans of social engineering. This interventionist approach was given major impetus by the economic boom of the 1960s. In good measure, the expansion of the economic sector was owing to the increasing demand for consumer goods and massive inflows of foreign capital.<sup>25</sup> The country achieved an annual growth rate of 5,6 per cent.<sup>26</sup> The mining sector earned foreign exchange and managers and technicians “provided the basis for technological knowledge”.<sup>27</sup> Locally produced goods also increased as a result of the competitive advantages offered by the import-substitution strategy.<sup>28</sup> These processes

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<sup>22</sup> Ibid, 10.

<sup>23</sup> Ibid, 10.

<sup>24</sup> Van Rensburg, *Health care in South Africa*, 66.

<sup>25</sup> T Moll 1999, *Macro-economic redistributive packages and growth in developing countries* (Bellville: University of the Western Cape), 279.

<sup>26</sup> Ibid, 279.

<sup>27</sup> Ibid, 279.

<sup>28</sup> Ibid, 279.

were underpinned by structures of collective bargaining on the shop floor as well as favourable credit and subsidy arrangements.<sup>29</sup>

But while profit rates were enough to finance the economic boom, “the growth/accumulation path was clearly unsustainable”.<sup>30</sup> As Legassick states, the pursuit of growth through continued capital intensification and the furtherance of separate development policies reinforced economic development in the white areas on the one hand and black political and economic impotence on the other.<sup>31</sup> As a direct consequence, by the early 1970s crisis tendencies began to emerge within the South African economy. There was a massive decline in foreign exchange reserves and labour costs; the increasing rate of foreign investment exacerbated capital intensity.<sup>32</sup> Added to this was the massive increase in the price of primary commodities, the consequence of which was the oil crisis of 1973.<sup>33</sup> This increase bequeathed the apartheid state a massive problem of rising domestic inflation.<sup>34</sup>

Understandably, the black population were the hardest hit by the economic recession. By the mid-1970s the black townships, as a result of declining economic returns, faced up to “a crisis of reproduction: overcrowding, inadequate urban services, rising unemployment, and declining real wage levels as inflation rose”.<sup>35</sup> Amidst this emerged a new generation of youth enraptured or inspired by the Black Consciousness

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<sup>29</sup> S Gelb 1987, *The economic crisis in South Africa: 1974–1986* (Johannesburg: University of the Witwatersrand Press), 40.

<sup>30</sup> N Nattrass 1990, *The political economy of South Africa* (Cape Town: Oxford University Press), 275.

<sup>31</sup> M Legassick 1974, *Foreign investment and the reproduction of racial capitalism in South Africa* (London: Anti-Apartheid Movement), 29.

<sup>32</sup> *Ibid.*, 29.

<sup>33</sup> *Ibid.*, 29.

<sup>34</sup> *Ibid.*, 29.

<sup>35</sup> M Swilling 1987, *State, resistance and change in South Africa* (Johannesburg: Southern), 4.

Movement (BCM) and the revolutionary struggles that reverberated throughout Angola, Mozambique and Zimbabwe.

In 1976 the new youth movement took to the streets in righteous protest against the introduction of Afrikaans as a medium of instruction and the injustices of apartheid rule. The South African state faced up to popular resistance on other fronts too. By the beginning of the 1970s both English and Afrikaans-speaking businessmen, represented by the Urban Foundation and the Afrikaanse Instituut (AHI) respectively, came to grips with “the visible entanglement of politics and economics”.<sup>36</sup> They questioned the ideological orthodoxy of apartheid and wanted to fashion an inclusive ideology, an ideology that would give greater prominence to the role of free or unfettered markets in the constitution of the economy and society.<sup>37</sup>

Confronted by the crisis of legitimacy on these fronts, the South African state embarked on reform. The reformation of apartheid orthodoxy was cast as the new “language of legitimacy”<sup>38</sup> within Afrikanerdom. And ‘total strategy’ became the dominant motif of this reformist initiative – led at the time by the so-called *verligtes* (moderates). ‘Total strategy’ was built on a combination of military planning and political policy making based on reform.<sup>39</sup> The new “language of legitimation” aimed to ensure the steady accumulation of capital and to ward off mass protest from below. However, its key rationale was to regulate the relationship between the apartheid state and the black segment of the population within what Lemon would call a “modified

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<sup>36</sup> S Greenberg 1987, ‘Ideological struggles within the South African state’, in S Trapido and S Marks (eds), *The politics of race, class, and nationalism in 20th century South Africa* (New York: Longman), 393.

<sup>37</sup> *Ibid*, 393.

<sup>38</sup> D Posel 1987, ‘The language of legitimation’, in S Trapido and S Marks (eds), *The politics of race, class, and nationalism in 20th century South Africa* (Essex: Longman), 425.

<sup>39</sup> Swilling, *State, resistance and change in South Africa*.

apartheid framework”.<sup>40</sup> (The reader should bear in mind that at the time the apartheid state saw itself as a vehicle for the social cohesion and integration so essential to the society at the heart of a political crisis – as a legitimate and efficient organizing political power in society.)

But although the apartheid state undertook to manage *political* relations, by no means did it undertake to regulate the *economic* system as a whole. The ideologues of apartheid figured out that political relations were not related to those of economics. Accordingly, the free market system was heralded as a panacea for South Africa’s political conundrums – quite evidently, South Africa’s troubles were of considerable magnitude! In the view of Van Rensburg *et al*, the free market ideology was closely linked to certain economic considerations, economic demands and economic problems: escalating public sector expenditure, unfavourable exchange rates for importing equipment, consumer goods and medicines, rising costs, the high inflation rate, and the increasing costs of medical technology.<sup>41</sup> Against this backdrop one can understand why the apartheid state framed the question of what was wrong with this society in monetarist terms. The idea of non-intervention in the economy dictated the road that the apartheid state followed – it became biased towards neo-liberal principles. De Beer and Price summarize this free market approach in this manner:

The monetarist solution ... lay in cutting back state intervention in the economy, reducing taxes and, accordingly, state spending on welfare and privatizing numerous state-owned

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<sup>40</sup> A Lemon 1991, *Homes apart* (Cape Town: David Phillip), 16.

<sup>41</sup> Van Rensburg, *Health care in South Africa*, 80.

enterprises. *Linked to this strategy is an ideological offensive about the responsibility of the individual for his or her welfare*<sup>42</sup> (my emphasis).

To take an excellent example, in the housing sector “the state made an attempt to depoliticize the government’s role, particularly in the black townships”.<sup>43</sup> And the extent of state involvement in housing was diversified away from a housing programme administered by the state.<sup>44</sup> Public officials “publicly encouraged individual and corporate responsibility for shelter ... arguing that home ownership provides a highly desirable social objective, whilst for the private sector the privatization of construction presented a substantial business opportunity”.<sup>45</sup> Thus, private ownership and *limited* social provisioning became the end-goals of apartheid orthodoxy. Limited social provisioning was geared towards winning the hearts and minds of the downtrodden.

For example, in the 1980s the state sold 500 000 houses to urban blacks (recall the so-called Great Sale). The state introduced, for the very first time in apartheid history, a housing subsidy and site-and-service schemes; the state also invested more money on township infrastructure.<sup>46</sup> From this non-interventionist approach the apartheid state derived this key benefit: housing became *depoliticized*. For the government’s neo-liberal ways of thinking inculcated the spirit of conservatism or elitism among some blacks. (As you know, home-ownership encourages a diffidence toward the politics of collectivism, such as strikes; homeowners all too often shy away from solidarity

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<sup>42</sup> M Price and C De Beer 1988, *Can privatisation solve the problems in the health care sector* (Johannesburg: Centre For The Study Of Health Policy), 59–88.

<sup>43</sup> S Parnell 1995, *Perspectives from the ivory tower of urban studies* (Johannesburg: University of the Witwatersrand), 59.

<sup>44</sup> *Ibid*, 59.

<sup>45</sup> *Ibid*, 59.

<sup>46</sup> *Ibid*, 59.

relations, for fear of losing their employment and/or mortgages.<sup>47)</sup> There was also a clear bias toward the black middle class who reaped many economic benefits from the new policies, the workers being expected “to bear the costs for township upgrading”.<sup>48</sup> Therefore, on the one hand, the apartheid state gravitated towards the market mechanism (it was supportive of a distinctly economic approach, namely monetarism). On the other hand, it inclined towards a pragmatic method; it supported limited welfare for the black majority. The major difficulty, though, was that the state’s welfare programme was also implanted with certain racial connotations. It was intimately tied to its overarching goals of racial separation, racial discrimination, and racial domination. Nonetheless, the apartheid state denied that the government’s policy was embedded in the issues of skin colour. It evinced that the public service was an expression of economic rationality, that it served the ‘general’ interest rather than the racial interest. It conveyed the sense in which the government’s policy was completely neutral or colour-blind.

Against this economic viewpoint one can understand the apartheid state’s handling of AIDS. Before the mid-1990s the government’s free market ideology and the idea of individual responsibility for welfare shaped its overarching policy towards AIDS. The apartheid state chose to operate within the general framework of the free market system, not only to create favourable conditions for economic growth, but also to strip public policy of its racial overtones, to convey the sense of egalitarianism or universalism.

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<sup>47</sup> Ibid, 60.

<sup>48</sup> Ibid, 59.

#### 4.5 Bearing the economic costs of an “immunodeficiency disease”

When AIDS was discovered in the early 1980s and declared by the Centres for Disease Control (CDC) a major health emergency facing the human world, a dualistic structure was embedded in South Africa’s health care system. On the one hand, there was a health care structure for the white population: well resourced and endowed with an abundance of highly trained personnel. On the other hand, there was a non-white health care structure: understaffed, underfunded and invested with a poorly trained personnel.<sup>49</sup> What is more, no unified structure of health care existed for the whole of the country. There were three so-called own affairs departments of health – for whites, for Indians and for coloureds – all established in 1983 through a constitutional dispensation called the Tricameral Parliament, ten other “own affairs” departments in the homelands, and a single department of health at national level.<sup>50</sup>

More importantly, as in the past, health care policy was dictated more by private needs than public needs. Health care was deemed a personal responsibility; the state subsidized the individual rather than the institution, namely the hospital; it encouraged “responsible self-medication”<sup>51</sup> and effective competition in the free market context. To this effect, medical schemes were restructured to stimulate private competition – the government also announced that individuals “bear the costs of disease”.<sup>52</sup> Seen in this light, the government’s health care programme encouraged the “sustainability and efficient use of resources”.<sup>53</sup>

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<sup>49</sup> Van Rensburg, *Health care in South Africa*, 70.

<sup>50</sup> *Ibid*, 71.

<sup>51</sup> *Ibid*, 82.

<sup>52</sup> Department of National Health and Population Development April 1991, *Background to and strategy for AIDS prevention* (Pretoria: Government Printer), 6.

<sup>53</sup> *Ibid*, 4.

At the time the apartheid state conceived of AIDS as a “rare immunodeficiency disease”,<sup>54</sup> a mysterious human disease. The disease had first been identified in the United States, where it struck about 750 male patients, “mainly in the New York and San Francisco areas”.<sup>55</sup> As a result, the government made a connection between AIDS and homosexuality; gay men were encouraged to go to health care centres for tests to detect changes in their immune status. The idea that AIDS was a homosexual disease was given strength by the death of two stewards working for the South African Airways (SAA) in 1983, namely Ralph Kretzen and Pieter Steyn (see also Chapter 5 for a more detailed discussion). According to *The Star*, the death certificate of one of the victims provided as clear a proof as one could get that he had died of pneumonia and that he “exhibited all the symptoms of AIDS disease”.<sup>56</sup> Reportedly, the first victim, Ralph Kretzen, “was a self-confessed homosexual”.<sup>57</sup> According to his mother, Mrs Harrie Kretzen, her son went back and forth to many doctors and hospitals because of ill health:

His last flight was to London and when he returned home he became very ill and was admitted to hospital. Doctors did not know what was wrong with him until the day before he died. Then it was too late.<sup>58</sup>

Commenting on her son’s passing, Mrs Kretzen said that “she knew that her son Ralph had been gay” and that “I have always known that he is gay”.<sup>59</sup> Following the death of

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<sup>54</sup> *The Rand Daily Mail*, 5 January 1983.

<sup>55</sup> *Ibid.*

<sup>56</sup> *The Star*, 5 January 1983.

<sup>57</sup> *Sunday Times*, 9 January 1983.

<sup>58</sup> *The Star*, 5 January 1983.

<sup>59</sup> *Rand Daily Mail*, 6 January 1983.



Ralph Kretzen and Pieter Steyn, the government pleaded with gay men who had visited the US – and had more than one sex partner – to seek medical attention if they experienced weight loss, fever, loss of appetite, inexplicable lesions or sores on the skin, tongue or mouth, and enlarged glands in the neck, groin or armpits.<sup>60</sup> The government also undertook to carry out screening tests on homosexual men to identify other possible sufferers.<sup>61</sup>

But because AIDS was seen as a rare condition, homosexual men living with the disease were regarded as isolated cases. In fact, according to the government, “the danger to the general public should not be exaggerated”.<sup>62</sup> In the view of the Department of National Health and Population Development, AIDS was a “rare US disease”,<sup>63</sup> a disease confined to high-risk groups (homosexuals) and was “not infectious like colds or flu”.<sup>64</sup> Professor Jack Metz, a spokesman for the State Advisory Group on AIDS (set up to advise the Department of National Health and Population) said at the time that “AIDS is not a serious health problem here” and that there was no evidence that “a sufferer is of any danger to the community or that AIDS can be spread through contact other than sexual”.<sup>65</sup> Professor Metz also stated that homosexuals must refrain from donating blood because of their capability to spread the disease and that “adequate containment depends on their willingness to change their lifestyle”, in other words, to avoid promiscuity. “With the full co-operation of the high-risk groups we have every reason to believe that the disease will remain of minor

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<sup>60</sup> *The Citizen*, 11 January 1983.

<sup>61</sup> *Ibid.*

<sup>62</sup> *Ibid.*

<sup>63</sup> *The Citizen*, 5 January 1983.

<sup>64</sup> *The Star*, 26 February 1985.

<sup>65</sup> *The Star*, 13 March 1985.

importance,”<sup>66</sup> he added. To lend further strength to the story of a rare disease, Professor Metz told *The Argus* newspaper the following:

... so far the incidence of AIDS in South Africa had been extremely low compared to North America, Europe and Central America ... 21 cases of AIDS had been reported in South Africa of which 14, all males, had died. Three cases were recorded in 1982, one in 1983, eight in 1984, and nine this year.<sup>67</sup>

From this perspective, until the mid-1980s AIDS was seen by the government as a rare disease affecting generally homosexual men. The disease was said be showing particularly low incidence in all population groups. It was also deemed to be amenable to prevention. Thus, sustaining public awareness and keeping homosexuals informed about the dangers of sexual promiscuity became the key to keeping the disease “under close surveillance”.<sup>68</sup> The discovery of the human immunodeficiency virus in the mid-1980s by no means heralded major shifts in the government’s approach; for the government’s surveillance strategy continued to dictate public health policy towards AIDS. The government set up a top-level committee of medical experts to probe the extent of the spread of AIDS and to recommend methods of diagnosis so to identify victims of the “killer virus before they begin to show symptoms”.<sup>69</sup> The government understood the HIV “killer virus” along these lines:

HIV is a sexually transmitted retrovirus ... The Human Immunodeficiency Virus ... is able to incorporate itself into the genetic material of a number of human cells. In time, the virus can damage the infected cells in a variety of different ways, causing severe illness and

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<sup>66</sup> *The Sunday Star*, 8 September 1985.

<sup>67</sup> *The Argus*, 14 August 1985.

<sup>68</sup> *The Citizen*, 6 March 1985.

death. HIV is passed from person to person primarily during penetrative sexual intercourse. Unlike most other sexually transmitted infections, there are no symptoms to make a recently infected person suspect him- or herself of being infected. Some time later, usually a matter of weeks, the body responds to this viral infection by producing antibodies. These antibodies provide indirect but strong evidence of HIV infection. However, the antibodies do not confer any protection on infected individuals.<sup>70</sup>

Regarding the transmission of HIV to susceptible heterosexual men and women, the government stated:

A great deal of epidemiological data has been collected in South Africa. From this it is possible to conclude that heterosexual transmission from man to woman and from woman to man is by far the commonest mode of transmission. A direct consequence of this is that there has been a rapid rise in the number of HIV infected women of childbearing years. It is likely that many of them, when they become pregnant, will pass on HIV to some of their children, and this mode of transmission shortly becomes the second commonest mode of HIV transmission. Although anal intercourse was responsible for the earliest recorded cases of AIDS in the country, efforts by the gay community have reduced the incidence of this mode of transmission.<sup>71</sup>

One of the significant consequences of the discovery of HIV in the mid-1980s was its heralding of the narrative of heterosexual plague in South Africa. Soon after the announcement (by Margaret Heckler, former US Secretary of Health and Human Sciences) that “today we add another miracle to the long honour roll of American

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<sup>69</sup> *The Citizen*, 27 February 1985.

<sup>70</sup> Department of National Health and Population Development, *Background to and strategy for AIDS prevention*, 1–2.

<sup>71</sup> *Ibid.*, 3.

medicine and science”, and that “today’s discovery represents the triumph of science over a dreaded disease”<sup>72</sup>, and soon after the development of a test kit to detect HIV in the serum (blood or plasma), the South African government reported that the disease was spreading faster, that it was on an exponential rise. For example, in 1986 the State Advisory Group on AIDS stated that the disease was likely to double in 12 months and that there “was no room for complacency”.<sup>73</sup> The government’s Medical Research Council agreed:

AIDS is spreading faster in South Africa than doctors anticipated and normal heterosexuals could soon be endangered ... Generally we are not doing enough research on AIDS in South Africa, nor are we doing enough to persuade members of the public most at risk to take precautions ...<sup>74</sup>

In 1988 the Department of National Health and Population Development reported that 120 AIDS sufferers had died and that one in every 540 people was infected. This finding, which indicated a rapid growth of the threat of AIDS among heterosexuals, was seen by the department as a shock increase, “very disturbing news”.<sup>75</sup> The department added:

Taken as a whole, the horrible reality comes through clearly. We must now act concertedly to reach all groups. The potential implications on health, social and economic levels are fearsome. We cannot afford not to act immediately.<sup>76</sup>

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<sup>72</sup> J Crewdson 2000, *Scientific fictions* (California: Macmillan), 22.

<sup>73</sup> *The Argus*, 28 October 1986.

<sup>74</sup> *The Argus*, 14 January 1986.

<sup>75</sup> *The Citizen*, 4 November 1988.

<sup>76</sup> *Ibid.*

As in the past, this shock AIDS increase was traceable to loose morals; loose morals were singled out as the reason for the spread of AIDS, and sexual fidelity and abstinence were marked out as preventive checks against mortality from the disease. Individuals were put in a position where they had to take not only moral responsibility for their own welfare (to stop sleeping around!), but also personal responsibility. Problems of health were wrenched free of their historical and social understandings. In other words, health problems were completely decontextualized. AIDS was regarded as solely an aspect of biology; its social dimensions were rendered invisible. The primary duty of the public health official was to gather vast amounts of *quantitative* data (statistics), to monitor the incidence and prevalence rates of the disease “in the representative samples of the population”,<sup>77</sup> and to “evaluate and review the effectiveness of the national strategy regularly in to order to reprogramme when necessary”.<sup>78</sup> These tasks completed, it behoved the public health official to pose these perennial questions: ‘Which province is disproportionately affected by AIDS?’ Or, ‘Which sociological category (defined by age, race, gender or socio-economic status) is more at risk of infection by HIV?’ The data gathered and quantified was made available to members of the public through the prism of media reports. From this perspective, the government’s strategy against heterosexual AIDS hinged on a preventive approach: to change or modify individual lifestyle. Although the apartheid state advanced the understanding that South Africa’s problems were attributable to individual characteristics, it still evinced that “behavioural change was inevitable”.<sup>79</sup> In 1991 the government announced that its preventive strategy was underpinned by the following objectives:

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<sup>77</sup> Department of National Health and Population Development, *Background to and strategy for AIDS prevention*, 7.

<sup>78</sup> *Ibid.*, 6.

<sup>79</sup> Van Rensburg, *AIDS in South Africa*, 82.

- To inform and educate the general public about the spread and prevention of HIV and AIDS
- To modify behaviour patterns and sexual practices and thereby reduce HIV transmission
- To educate young adults and adolescents about behaviour that promotes the health expression of sexual interests
- To undertake regular research projects to investigate priority areas in AIDS prevention to guide the National AIDS Strategy
- To educate the public, those at risk ... on sexually transmitted infections and their prevention and treatment
- To ensure modification of national policies by making available consensus statements, guidelines and other AIDS-related materials
- To make guidelines available for the clinical management of HIV-infected persons, persons with AIDS, HIV related and sexually transmitted infections and tuberculosis
- To work with AIDS support organizations and persons with AIDS in implementing appropriate care schemes.<sup>80</sup>

Also, the government aimed to influence patterns of sexual behaviour by doing the following:

- Informing the public, particularly those at risk, about AIDS
- Supporting changes in sexual behaviour aimed at preventing the spread of HIV
- Promoting social support for appropriate changes in established behaviours. This included support of the role of women in sexual decision-making and greater acceptance of condoms

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<sup>80</sup> Department of National Health and Population Development, *Background to and strategy for AIDS prevention*, 5–6.

- Promoting appropriate use of health and educational services
- Encouraging all persons who may have acquired a sexually transmitted disease to seek out appropriate treatment.<sup>81</sup>

To this effect, the government established a sub-directorate for AIDS within its Chief Directorate, namely Health Care, to provide the necessary expertise pertaining to AIDS prevention.<sup>82</sup> The spokesperson of the Department of National Health and Population Development, Natalie Stockton, captured other contours of the government's public health strategy in this manner:

What we have said is that ... as this pandemic increases, we are going to need a Primary Health Care infrastructure and we must get ourselves well planted within the Primary Health Care infrastructure ... I do support sex education in the schools. We have got to go to the headmasters of the schools. We have got to activate parents to say we want it in our schools and then it will happen ... We ... feel very strongly that we have to deal with sexuality ...<sup>83</sup>

Without sex education, Stockton continued, “we are not going to get anywhere as far as AIDS is concerned in South Africa”.<sup>84</sup> Sex education was singled out as a public health construct, a countervailing power against the AIDS scourge. Seen in this light, the government's policy was dependent upon the identification of specific risk situations, many of which were related to so-called sexual behaviours.<sup>85</sup> The rampant

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<sup>81</sup> Ibid, 25.

<sup>82</sup> Ibid, 7.

<sup>83</sup> Department of National Health and Population Development 11–14 November 1992, *AIDS and your response: Proceedings* (Pretoria: Government Printer), 5.

<sup>84</sup> Ibid, 5.

<sup>85</sup> Department of National Health and Population Development, *Background to and strategy for AIDS prevention*, 27.

spread of HIV was dependent on sexual behaviours or “patterns of sexual networking”.<sup>86</sup> Consequently, KAP (knowledge, attitudes, practices and behaviour) studies were carried out and their results “compared with other African countries”.<sup>87</sup> Note that one of the key reasons that the government decided to bring AIDS into the domain of public health was not so much to accentuate the social dimensions of the disease as to move away from what it deemed “a vertical or top-down programme”<sup>88</sup> – that is, a health care system managed from above by the national Department of Health in Pretoria. And to “bring services closer to the people”,<sup>89</sup> the government set up surveillance programmes; especially notable among these being the so-called AIDS Training and Information Centres (ATICs).

Therefore, in the absence of a cure for AIDS, the government found it necessary to convey an epidemiological message (for further reading see Chapter 5). The government studied a range of diseases in the population and located them within an understanding of people’s sexual lifestyle. In the view of the government, the solution hinged on personal and moral responsibility. However, the government’s policy ran into a series of contradictions; it encountered problems of considerable magnitude. For one thing, the government substituted the idea of social responsibility for health care for the idea of individual responsibility. It mainstreamed the idea that our society’s advance in the prevention of AIDS hinged on behavioural modification alone. Furthermore, the government’s approach wrongly implied that “the fewer sexual partners one has, the less the risk of infection”.<sup>90</sup> Apparently, the government

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<sup>86</sup> Ibid, 28.

<sup>87</sup> Ibid, 28.

<sup>88</sup> Ibid, 4.

<sup>89</sup> Ibid, 4.

<sup>90</sup> M Crewe 1992, *AIDS in South Africa* (London: Penguin), 56.



downplayed Mary Crewe's counsel at the time, which was that a single 'unsafe' sexual encounter with an infected person could be sufficient in itself to contract AIDS.<sup>91</sup>

Another weakness was that the government's response to AIDS was far too tedious, to say the least. The government's message was by far too rhetorical. For example, although the government acknowledged that many AIDS cases had been diagnosed, it delayed its decision to implement public health programmes regarding sex education.<sup>92</sup>

What is more, the government's public health campaign, which cost a meagre R4,5 million, was aimed only at the heterosexual community.<sup>93</sup> In addition, the AIDS Advisory Committee which counselled the Minister of Health and Social Welfare had no statutory powers. The committee acted only in an advisory capacity; it was not invested with the power to implement policy. Amid this obfuscation by the apartheid state, the rate of HIV infections reportedly increased. In the early 1990s a total of 969 people reportedly had full-blown AIDS, of whom 385 died.<sup>94</sup> And it was estimated that by the end of 1991 as many as 180 000 people would have been infected by HIV and that the number could reach 5,2 million by 2000.<sup>95</sup> Faced with widespread public criticism over its handling of AIDS, the government went on the defensive. The disease, the government argued, was being politicized.<sup>96</sup> The government set out its line of thought in this manner:

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<sup>91</sup> Ibid, 58.

<sup>92</sup> Ibid, 59.

<sup>93</sup> Ibid, 59.

<sup>94</sup> Ibid, 59

<sup>95</sup> Ibid, 63–64.

<sup>96</sup> Crewe, *AIDS in South Africa*, 62.

Unfortunately, the message of AIDS has been politicized ... Well-meant governmental programmes and efforts have been politically discredited ... This has a negative effect on the outcome of anti-AIDS programmes.<sup>97</sup>

And feeling embittered by the ‘politicization’ of AIDS, the government took refuge in the economic approach discussed earlier. Health care was deemed a private concern, an individual matter. AIDS was also said to be preventable through what Van Rensburg would call “responsible self-medication”.<sup>98</sup> Against this background one can understand why the government lamented the spiralling costs of AIDS in South Africa. In 1989 the government announced that projections on the incidence of AIDS indicated that treatment would cost the country R71 million at best in 1993, or R1,3 billion at worst.<sup>99</sup> In addition, the treatment of each patient, stated a spokesman for the Department of National Health and Population Development, could cost R30 000 to R80 000, plus disability allowances, coupled with indirect costs relating to manpower.<sup>100</sup> The department indicated that because there was no cure for AIDS, South Africa could foresee the possible death of more than 100 000 people by 1995, an increased need for treatment of AIDS patients, which could lead to a decline in many health services (including blood testing, surveys, health education, the distribution of condoms and the treatment of patients) and an economic disaster.<sup>101</sup> “The country can’t foot the bill,”<sup>102</sup> the department bemoaned. “And there is no way the medical services can cope”<sup>103</sup> with the rising number of AIDS patients.

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<sup>97</sup> J H Lombard 1995. *AIDS prevention strategies*. Unpublished paper, 6.

<sup>98</sup> Van Rensburg, *Health care in South Africa*, 70.

<sup>99</sup> *The Citizen*, 22 February 1989.

<sup>100</sup> *Ibid.*

<sup>101</sup> *The Sunday Star*, 5 March 1989.

<sup>102</sup> *Ibid.*

Therefore, AIDS was conceived of in narrow terms, in economic terms. Also, the disease was seen as an effect of the personality characteristics of the individual – AIDS was blamed on loose morals – rather than an effect of the social structure. The historical underpinnings of the disease were simply effaced. By my account, this narrow view of health care has its origins in the United States. For in the 1930s and 1940s medical historians in that part of the world – the so-called men of goodwill<sup>104</sup> – thought very differently about disease. According to Rosenberg, the “men of goodwill” (highly prominent among whom was the leading historian Henry Sigerist) made a concerted effort to depoliticize disease by erasing its social aspects.<sup>105</sup> Rather than regard disease as a reflection of arbitrary socio-economic inequalities or a power imbalance in society, the men of goodwill argued that disease is essentially a “real pathological phenomenon”, a biological process or a “sum total of the abnormal reactions of the organism or its parts to abnormal stimuli”.<sup>106</sup> Rosenberg adds that the “men of goodwill shared an optimistic faith in science and medicine”, and maintained a stance towards the belief that,

... superstition and social injustice had, and would, impede the accumulation and distribution of knowledge ...<sup>107</sup>

Also, the “men of goodwill” advanced the understanding that,

... the ultimate trend was toward a more humane, healthy, an enlightened society.<sup>108</sup>

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<sup>103</sup> Ibid.

<sup>104</sup> C E Rosenberg 1988, ‘Disease and social order in America: perceptions and expectations’, in E Fee and D M Fox, *AIDS: the burdens of history* (London: University of California Press), 14–17.

<sup>105</sup> Ibid, 14.

<sup>106</sup> Ibid, 14–15.

<sup>107</sup> Ibid, 14.

One can see some points of convergence in the apartheid state's view on AIDS and the manner of thinking of the men of goodwill. For the apartheid state maintained a positivist attitude (see Chapter 10) towards AIDS. It maintained the sense in which science alone was a pivotal force in the fight against AIDS, the sense in which laboratory principles were the necessary aspects of the solution to the problems bequeathed by AIDS.

#### **4.6 The social environment of AIDS under apartheid**

The idea I am developing here is that the apartheid state's monetaristic and individualistic approach reveals the reason that it did not see a complex interaction between biological and social factors in the development of AIDS. To borrow from Annandale's idea of "hospital medicine",<sup>109</sup> the apartheid state made judgements in terms of the physical attributes of the patient only. The patient was construed as a material object. AIDS was solely understood as a physio-chemical condition explicable in accordance with the laws of nature. AIDS was not understood in relation to what Parsons would call the "sick role".<sup>110</sup> (Note that Parsons's "sick role" locates disease in relation to an understanding of the general functioning of society as a whole; it seeks to "vivify the nascent social model".<sup>111</sup>) And because AIDS was viewed as a problem of the individual, as an outcome of personal limitation rather than an effect of the larger historical processes, the HIV-infected body was seen as some sort of machine or biological organism. The sick body, the body frame contaminated by

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<sup>108</sup> Ibid, 14.

<sup>109</sup> N Jewson 1976, 'The disappearance of the sick man from medical cosmology 1770–1870', *Sociology* 10:235.

<sup>110</sup> T Parsons 1951, *Essays in sociological theory* (New York: Free Press), 430.

AIDS, was treated as a passive target for medical intervention. It did not occur to the apartheid state that human disease flourishes under conditions overburdened by unemployment, poverty, homelessness, welfare dependency, crime and social unrest. The apartheid state's real weakness stemmed from completely ignoring Hermanus's counsel:

Once ... AIDS ... has entered a society, it tends towards the path of least resistance. Globally, that line runs directly through some of the world's least powerful communities; poorest, most disadvantaged and underdeveloped groups whose members constitute an increasingly disproportionate share of the world's total AIDS case ... The AIDS pandemic cannot be understood apart from this background, and it is arguable that AIDS will never be controlled, let alone eliminated, without a change in the combined conditions of underdevelopment, unbalanced development and political marginalization which provide it with fertile soil ...<sup>112</sup>

The idea advanced by Hermanus is simply this: AIDS, like any other type of disease, is underpinned by a wide range of social factors. As someone put it, AIDS has environmental and social causes; the disease is also "a focus of struggles for control over resource allocation".<sup>113</sup> For example, AIDS thrives in societies where levels of unemployment are very high. This point of view is even more important, considering that in the early 1990s about 5 million people were unemployed in South Africa.<sup>114</sup> (Compounding this was the acute shortage of shelter.<sup>115</sup>) Furthermore, AIDS thrives in

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<sup>111</sup> Jewson, 'The disappearance of the sick man', 235.

<sup>112</sup> M Hermanus 1990, *Occupational health and safety legislation in Southern Africa: a comparative analysis* (Rondebosch: University of Cape Town Press), 25.

<sup>113</sup> Crewe, *AIDS in South Africa*, 54.

<sup>114</sup> *Ibid*, 57.

<sup>115</sup> *Ibid*, 56.

societies where hospitals and clinics are understaffed, underfunded and overwhelmed by the number of people needing assistance.<sup>116</sup> Against this backdrop one can understand why infectious diseases are very rare among whites. In the white areas access to better health care and improved standards of living mitigate against the spread of infectious disease; among blacks, however, infectious diseases run rampant.<sup>117</sup>

Also important for an understanding of the sociology of AIDS under apartheid is to recognize that the disease was a socially constructed phenomenon. AIDS under apartheid entered into the moral assumptions and stereotypical stories of South African society (see Chapters 7 and 8). Understanding AIDS under apartheid as both a disorder and a narrative means understanding this particular set of signifying practices (such as stereotyping). The apartheid state accepted these signifying practices as fixed essences; they permeated much of its thinking. As will be shown, AIDS under apartheid entered into popular images.

A sizeable literature in sociology deals with the social stereotyping of people afflicted by disease (see Chapter 2). Take for example Waldby's study. His work is a comprehensive inquiry into how the heterosexual male body is represented in some medical texts as being impermeable, that is, as being able to maintain "the necessary rigid boundary between the inside of the body and the outside world to avoid the transmission of disease".<sup>118</sup> By contrast, the female body and that of gay men, says Waldby, are always construed as being permeable in pregnancy, birth and in vaginal

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<sup>116</sup> Ibid, 57.

<sup>117</sup> Ibid, 57.

<sup>118</sup> C Waldby 1996, *AIDS and the body politic* (London: Routledge), 32.

sex for women and in anal sex for gay men. According to Waldby, this reveals the reason that women and gay men are unstable and vulnerable to viral transmissions.<sup>119</sup> This has justified their labelling as deviant.<sup>120</sup> Under apartheid, not only was AIDS represented in economic and individualistic terms; AIDS was also conceived of in stereotypical terms, as a phenomenon affecting the most sinful of members of society. AIDS under apartheid was linked to what Crewe calls “profligate” behaviour.<sup>121</sup> Moral rectitude was seen as a sign of fortitude. And profligate behaviour was a sign of major weakness. Promiscuous sexual behaviour became, so to speak, a ‘co-factor’ for AIDS!

#### **4.7 Conclusion: apartheid orthodoxy and the ‘pro-social’ ideology**

We have seen that individual and moral responsibility weighed more heavily in the thinking of the apartheid state. The regime of health care devolved to the individual rather than society at large. However, this approach bequeathed major difficulties on many fronts. For example, it engendered a crisis of authority at the level of the health bureaucracy. The health bureaucracy ran into a series of contradictions. The government’s public health programme proved very inadequate because it emphasized individual responsibility for health care in the context of a growing crisis of consumption. As in the US,<sup>122</sup> this threatened to disrupt public security against disease. What is also important is that by individualizing health care, the apartheid state succeeded in creating a sense of good and evil. The individual was represented as either good or evil. The individual was said to be ‘good’ if he or she assumed personal

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<sup>119</sup> E Annandale 1998, *The sociology of health and medicine* (London: Polity), 8.

<sup>120</sup> *Ibid*, 8.

<sup>121</sup> Crewe, *AIDS in South Africa*, 63.

<sup>122</sup> D M Fox 1988, ‘AIDS and the American health polity: the history and prospects of a crisis of authority’, in *AIDS: the burdens of history*.

responsibility for health care. Also, the individual was considered ‘good’ when he or she assumed moral responsibility, when he or she exercised moral restraint. Failure to assume both individual and moral responsibility bequeathed a personal tragedy: infection by HIV. In this context, the individual is no longer romanticized or idealized. Instead, the individual is indicted. Society exacts its revenge on him or her for failing to abide by its moral principles.

Not only does this pattern of thought echo some of the underlying assumptions of the narrative of moral protest, but the apartheid state’s thinking is consistent with some of the profounder concerns of the so-called pro-social ideology in film studies. Glenn Mann<sup>123</sup> states in another context that a pro-social ideology is wont to create conceptions of right and wrong. It embodies a conservative cast of mind, since it foregrounds or accentuates ethical behaviour above anything else. Moreover, a pro-social ideology is unequivocally supportive of the status quo,<sup>124</sup> since it romanticizes the social system of society and masks its fundamental contradictions and crises.

By my account, there is a fit between the apartheid state’s policy on AIDS and Glen Mann’s pro-social ideology. The government’s policy on AIDS was embedded with Mann’s pro-social connotations. For it concealed, camouflaged or covered-up the fundamental contradictions wrought by apartheid. What is more, it accentuated moral responsibility by conveying the sense of good and evil. The government argued that individuals who tend towards sexual promiscuity in their overreach or break the bounds of moral restraint are bound to carry themselves to their final doom, their

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<sup>123</sup> G Mann 2001, ‘Ideology and genre in the godfather films’, in N Browne: *Francis Ford Coppola’s The Godfather trilogy* (United Kingdom: Cambridge University Press), 109–131.

<sup>124</sup> *Ibid*, 109.



ultimate punishment – their death from AIDS! The individual affected by AIDS was represented as a tragic character lacking any redeemable qualities. His or her tragedy was said to be personally motivated, a tragedy that was an inevitable consequence of nefarious ways. Contamination by the disease embodied society's revenge for crimes of promiscuity, infidelity and homosexuality. Against this background, the devastation caused by AIDS was not political but moral (and of course biological too).

This subjectivization (individualization) of AIDS is a classic example of conservatism, which lies at the root of the free market ideology discussed previously. By framing health policy in political, biological, individual and moral terms, the apartheid state accomplished its overarching goal: it managed to disguise the socio-political problems at the heart of South African society. Rather than opt for a more comprehensive programme of treatment, it extended its gaze, it looked outside itself, at its individual subjects, the majority of whom had been severely ravaged by the corrosive images of unemployment and poverty. Also, it looked at their employers for support, who, unfortunately, construed AIDS only in terms of “investment of resources and productivity”.<sup>125</sup>

Therefore, the government's policy towards AIDS was weakened by its narrow-mindedness; the government's economistic approach limited its scrutiny. We have seen that under apartheid the health bureaucracy favoured not so much the accumulation of capital, as the maintenance of the racial system of social welfare. Health policy was oriented towards the overarching goal of managing the contradictions and crises bequeathed by the racial ideology of apartheid. Health policy

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<sup>125</sup> Crewe, *AIDS in South Africa*, 69.

was expressive of the society's system of racial order. For example, according to one writer, in the early 1990s hospitals were reluctant to become involved in caring for black people with AIDS.<sup>126</sup>

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<sup>126</sup> Ibid, 69.