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The World Health Organization, HIV/AIDS and South Africa

Problems, Programs and Possible Solutions

South Africa has one of the highest HIV/AIDS infection rates in the world. As the host to the 2010 World Cup soccer tournament, South Africa became the focus of world attention, both for the sport and for its HIV/AIDS programs. As people flocked to South Africa, the government requested that more condoms be shipped into the country to help offset the influx of people. The Guardian.co.uk reported that Britain sent over forty-two million condoms (Guardian.co.uk 9 March 2010). Yet controversy broke out over FIFA's decision to bar condom distribution at venues (Guardia.co.uk 4 June 2010). A group of AIDS organizations at the World Cup wrote to Guardian.co.uk saying, "To date FIFA has not permitted any civil society organization to distribute HIV- or health-related information and FIFA has not provided any written confirmation that condoms may be distributed at stadia and within the fan-fests... This is despite the fact that commercial sponsors selling alcohol will have dedicated spaces available" (Guardian.co.uk 4 June 2010). While reports indicate that FIFA was the responsible party in making the decision to ban condom distribution, I can't help but wonder (given the racist and homophobic history of the crisis and the stigma around promiscuity and HIV/AIDS) if government officials informed the decision in some way.

I bring up the World Cup condom controversy in South Africa as a starting point for thinking about health organizations and their effectiveness in South Africa. Despite popular donations of condoms and funding from around the world - like that of the British government donating condoms

- actual health conditions as well as access to health information in South Africa is shaped and informed by myriad intersecting factors. Race, nationality, poverty and class, sexuality and gender all intersect in this geographical region in polyvalent ways. The World Cup incident, when examined outside of context, seems little more than a squabble over condoms. Yet when positioned within the historical context of the HIV/AIDS crisis in South Africa, and the continent of Africa more generally, the obstacles international aid groups must overcome become clearer.

In this paper I focus on the work of the World Health Organization and its strategic plan for HIV/AIDS treatment and prevention in South Africa. In order to better understand the obstacles the WHO faces, I first provide a general history of HIV/AIDS on the continent more generally, and then more specifically in South Africa. The more specific history of South Africa and HIV/AIDS will allow and examination of issues pertaining to HIV/AIDS, such as poverty, access to health care, sexuality and motherhood. Examining these issues brings the obstacles to the fore of my discussion. Next I examine the WHO's strategic plan in light of these issues, and critique their method of aid in South Africa. The WHO is dedicated to working with the South African government to implement HIV/AIDS treatment and prevention. Yet it seems that the government, in addition to issues on the ground, affect the WHO's ability to accomplish its goal.

The WHO, while providing invaluable statistics about health in South Africa, could better implement its policies and goals if it were to take a multi-pronged approach that would consider the history of racism and poverty in South Africa. Rather than focusing on treatment and prevention as large monolithic ideas, the WHO should allow specific issues of race and ethnicity, poverty and class, gender and sexuality inform how they go about providing funds (and to whom) for treatment and prevention. I end by outlining these critiques of the WHO, and suggest that perhaps it is time for the WHO to stop playing international politics and start pressuring the South African government to make a more direct response to the crisis by partnering with local pressure groups.

History of HIV/AIDS in Africa in General and South Africa

Sub-Saharan Africa has been ravaged by the HIV/AIDS crisis. Susan Craddock notes that the words "plague," "horror," "calamity" among others "are ... becoming more predictable" (Craddock 1). Since the beginning of the crisis in the 1980s, "with only a few exceptions such as Uganda and Senegal, the epidemic in sub-Saharan African continues to get worse" (Craddock 1). Peter Aggleton wrote in 2000 "Africa is facing a devastating crisis at the dawn of the twenty-first century, with over 70 per cent of the world's HIV-positive people" (Aggleton xi). He goes to note that after decolonization many of the new African states started frameworks for social welfare systems. State officials didn't know then that just a few decades later, an epidemic would challenge the capacity of the welfare "system" to provide services for each country's people.

For South Africa, like most other locales, the HIV/AIDS crisis started in the 1980s. Like the US and Europe, South Africa first believed the HIV/AIDS outbreak to be contained within the male homosexual community, and therefore less of a threat to the general populace. Yet while other countries learned that the virus was not contained within the homosexual community and was actually spreading rapidly through the heterosexual community and among drug users, South Africa entered a period that historians call AIDS denialism. Even before the end of apartheid and the subsequent rise of the African National Congress (ANC), the standing South African government's initial response to the HIV/AIDS crisis was as best "lukewarm" (Nattrass 45), and the new democratic government established in 1994, openly denied the link between HIV and AIDS and was vehemently critical of Western Drug companies and their marketing of antiretroviral medication.

And with good reason. Virgina van der Vilet argues that much of the discussion of HIV/AIDS in the late 1980s and '90 carried over racial overtones (Vilet 50-1). In May of 1990 the racialized rhetoric of HIV/AIDS made its way into the South African Parliament as Conservative Party member Dr. F. H. Pauw "was accused of reassuring it's white members that black majority rule posed no threat because AIDS would ensure that black became a minority within five years" (*Debates of Parliament,* 18 May 1990, col. 9761, as quoted by Vilet, 51). This is just one example of the racism implied in the debate over HIV/AIDS, and this kind of thinking, the racial divisions of apartheid, characterize much of the history of HIV/AIDS in South Africa. Further, the homophobia and stigma surrounding HIV/AIDS compounded the race issue, thereby making one racist remark doubly demeaning. Not only was Dr. Pauw blaming Black men for HIV/AIDS, but also insinuating that Blacks men were participating in gay sexual activity.

Nelson Mandela came to power in South Africa in 1994, and as Amy S. Patterson notes, "the government faces pressing demands to create jobs, encourage foreign investment, and provide services to millions of poor South Africans" (Patterson 34). The HIV/AIDS issue was just one among myriad problems facing the Mandela administration. While there were few advances on HIV/AIDS specifically under Mandela, Patterson acknowledges that the government did increase its funding for condom distribution, education, and primary care centers (Patterson 35).

During the transition of government with Mandela, leaving apartheid behind, the government created the Networking HIV/AIDS Community of South Africa (NACOSA). NACOSA was supposed to be a comprehensive response to the AIDS crisis from the ANC, on that was "suppose to 'astonish the world' as much as [South Africa's] transition to democracy had done" (Vilet 53). Yet after just a few years it was clear that the initiative was failing. From 1994 to 1996 the number of South Africans living with HIV had doubled from 7.6 percent to 14.2 percent (Vilet 54). Further, the government and NACOSA were involved with two scandals concerning HIV/AIDS, the *Sarqfina II*

(a large budget, all-star production meant to "take AIDS education to the masses" (Vilet 54)) debacle and the drug trials for Virodine.

Virodine was originally a drug tested as a part of cancer therapy, but was later rejected because it was found to be toxic and ineffective (Vilet 56). Thabo Mbeki, then Deputy President, endorsed the drug for treatment of HIV/AIDS. Patterson locates the support of Mbeki and the health minister of Virodine as part of how the "president... defined the renaissance [of Africa] as finding African solutions to African problems" (Patterson 40). Mbeki supported Virodine in 1997 because it was developed in South Africa despite the Medical Research Council's warnings of the drugs toxicity (Patterson 40). Though Mandela did not seem to focus on HIV/AIDS, it appears that most historians locate the beginnings of AIDS denialism in 1999 with the rise of the ANC and the election of Thabo Mbeki as president.

While the elections of 1994, the switch to a democratic state and the end of apartheid promised a better future for South Africa, it seems that Mbeki's government spread mass confusion about HIV/AIDS and "the regime's actions on AIDS also reflects a growing distance between the ruling elite and the poor" (Patterson 41). When Mbeki came to power in 1999, he denied the link between HIV and AIDS. He believed that there were several reasons that one's immune system could shut down, such as poverty and malnutrition (Furlong 141). Furlong and Bell believe that Mbeki's stance on HIV/AIDS was motivated for political reasons, namely his distrust for Western drug companies. Mbeki "concluded that South Africa could become fertile ground for the 'pseudoscience often embraced by politicians'" (Makgoba as quoted by Furlong, 141). Thus Mbeki's distrust of Western drug companies trying to make huge bucks off of poor black people in South Africa led to him denying even the FDA approved drug AZT to pregnant women. AZT has been shown in test to cut the rate of transmission of HIV from mother to child, and as Sonia Saha writes, in 1999 "about one-quarter of all pregnant women in South Africa appeared to be carrying the virus, according to annual antenatal surveys, but the government refused to pick up the tab for

any antiretroviral drugs to treat the women or prevent the virus from infecting their infants" (Saha 104).

I do not think it is possible to stress enough the distrust of the Mbeki government of antiretroviral drugs and clinical tests modeled after Western positivist science. For instance, Saha shows that the trials of Emtriva, a new antiretroviral drug made by Gilead, produced mistrust in patients. Patients began to complain that some of their entrance exams and informed consent procedures "consisted of a few minutes' long conversation and an instruction to 'sign on the line to get a drug that will cure them'" (Saha 107). Patients later started dying and "mistrust between the test subjects and investigators surged" (Saha 107). Given the ethical errors of the study directors, the culture of mistrust of the West bred by African neonationalism, and the association of HIV/AIDS with promiscuity and homosexuality, it's not surprising that Mbeki, some health officials and those promised a cure would view Western drug companies trying to sell antiretroviral drugs with a large amount of suspicion.

It seemed that the issues of denialism and antiretroviral drugs were going to come to a head at the AIDS 2000 Conference. Vilet notes that just before the opening of the conference, 5000 medical professionals, some of them Nobel Peace Prize winners, signed the Durban Declaration, clarifying the scientific position on HIV/AIDS (Vilet 60). Mbeki opened the conference, and while many expected this to be his moment to get on board with the mainstream, he decided to talk about the WHO 1995 report that stated that he number one killer world-wide is poverty (Vilet 60). While Mbeki was a let down, former president Mandela closed the conference with all call to a "South Africa united against AIDS" and specifically called for "large scale interventions to prevent MTCT [mother to child transmission]" and education on safer sex (Vilet 61).

But Mandela's call to action failed (Vilet 61). While it seemed that some drug manufactures, the government and some NGOs were all on board for antiretroviral treatment, the ANC pulled its support after one week. The ANC published to its website "a detailed report, drawing selectively on

US guidelines, pointing to the immense difficulties and dangers involved in antiretroviral (ARV) treatment, a situation with it said 'does not admit of inhuman games and clever intellectual point scoring. It does not allow for the propagation of unscientific slogans that "the time for scientific enquiry is over"'" (Vilet 63). Later that year (2001) Mbeki refused to take an HIV test, saying that doing so would show him buying into the scientific view point: "I go and do a test -I am confirming a particular paradigm" (Vilet 63). Mbeki's decision to refuse the test was a political one. Through the denial he at once denied the validity of medicalized tests and symbolized South Africa's refusal to submit to the West and all the racist and homophobic stigma that is associated with the disease.

Despite the denialism of Mbeki, the government and judicial systems could not ignore the growing call for antiretroviral drugs from HIV/AIDS patients, NGOs and doctors. The Treatment Action Campaign (TAC) led the fight against the government. After a four-year battle with the government, trying to persuade the implementation for a MCTC program, TAC "finally made good on its threat to take the government to court on the issue" (Vilet 69). Judge Chris Botha, a member of the Constitutional Court found in favor of TAC. The government argued that the court forcing the implementation of such a program overstepped the separation of powers written into the South Africa Constitution. Judge Botha addressed this issue directly, "When the court, being part of the judicial arm of the government, sits in judgement [sic] on the reasonableness of steps taken by the executive arm in the fulfillment of its constitutional obligations it is exactly a perfect example of how the separation of powers should work" (Judge Botha as quoted in Vilet, 70).

While Judge Botha was clear in saying, "About one thing there must be no misunderstanding: a countrywide MTCT prevention program is an ineluctable obligation of the state," (Vilet 70) the 2001 decision was not the end of AIDS issues. Mbeki and the country's image suffered after the court ruling and after several well-publicized events once again thrust South Africa into the media over HIV/AIDS. One such event was the 2002 denial of a nine-month-old child ARV's after she had been raped and sodomized because the government's

health policy stated that ARVs "should not be issued to the victims of rape or sexual assault" (Vilet 70).

The turnaround on ARV's through the 2001 court decision has since been fraught with confusion. Patterson notes that, in 2003, the MCC withdrew its approval for nevirapine (AZT) and that "a national treatment plan would be threatened" (Furlong 144). Mbeki continued to avoid the topic of HIV/AIDS, while the ANC in general said, "it [HIV/AIDS] must also put the campaign against it at the top of our agenda" (**News24.com**, 19 December 2002, as quoted in Vilet, 77). But to add to the confusion, the administering of antiretroviral drugs and the cost effectiveness of the program seemed to be slowing the process. The **Estimates of National Expenditure,** produced in 2003, merely indicated that, "Investigations on the introduction of a national antiretroviral program are far advanced, and recommendations are close to finalization" **(Estimates of National Expenditure,** as quoted in Vilet, 78).

Although the South Africa government has made significant changes under the direction of President Jacob Zuma, it seems that the cultural vestiges of racism and homophobia are still lingering. Further, a recent book edited by Jean Baxen and Anders Breidlid shows promising results of studies that are beginning to account for social and cultural practices and how they impact the HIV/AIDS epidemic. By accounting for social factors and behaviors, these researchers are adding to the understanding of the epidemic in
ways that previous studies were unable to do. Yet despite the welcomed change, some of the studies are still conducted in a manner that couches the findings in terms of epidemiology using technical language. Such rhetoric, while sometimes helpful, still serves to distance the researcher from the problem while talking about the HIV/AIDS epidemic that is inaccessible to the people of South Africa. Thus these researchers, while important in scholarly work, do little to ease the public confusion about FflV/AIDS today (See Baxen and Breidlid).

The confusion over condom distribution at the World Cup in 2010 is just another event in a long line of the confusing politics of HIV/AIDS in South Africa. While the government asked for forty-two million condoms for the World Cup this year, due to FIFA's regulations (and the government's silence) it is unclear if condoms were actually donated to the country, and if so, if those condoms made it into the hands of the people at World Cup events. Yet this historical analysis shows many of the difficulties the WHO and other NGOs face when trying to implement HIV/AIDS policy. First and foremost, there is the issue of access to health care and poverty. Many South Africans live well below the poverty line and have little to no access to health care.

Secondly, there is the issue of MTCT. Poor mothers are more likely to not have access to education about safe sex, and less if any access to health care that could -possibly - provide them with antiretroviral drugs. Mother to child transmission seems to be one of the largest issues in the academic literature, yet is seems that the confusion surrounding the cost effectiveness debate is affecting positive pregnant mothers the most Nattrass notes that the rhetoric of cost effectiveness creates a distancing effect that silences voices who do not have the economic and scientific authority to speak. Because mothers, especially those living with HIV/AIDS, are more likely to be of the poor and working classes, few if any have the educational background to speak in such a language. Further, the distancing effect of the technical rhetoric removes the human emotional element from the debate, causing the mothers living with HIV/AIDS to be forgotten (See Nattrass 17 and Fassin 31-2). And lastly, the implications of treating mothers for MTCT seem - at least in rhetoric - to put a burden on the government. Mother to Child Treatment treats the spread of the disease to the child, but not necessarily the mother. Thus it seems that the country could be overrun with orphans whose mothers died from HIV/AIDS while they were successfully treated at birth (See Phillips, H. 40-1).

Lastly, there is the issue of sexuality in general: gay, straight or otherwise. Few academic authors mention homosexuality in their work, and when they do, it is often to cite the thought in the 1980s that HIV/AIDS was contained within the homosexual community. None of the authors

mention homosexuality as part of the government's current analysis of the HIV/AIDS crisis. The only shining moment for gays and lesbians in South Africa is the overturning of sodomy laws in 1999, yet another liberal move by the courts that echoes to decision of Justice Botha.

The World Health Organization

History, Issues and Programs in South Africa

The World Health Organization officially admitted South Africa in 1947. Yet it was not until the end of apartheid and the beginning of the democratic government in 1994 that WHO had an actual presence in the country. Their liaison office was established in Johannesburg in 1996 and later moved to Pretoria. The WHO has been working with the government of South Africa and its over twenty-five partners to improve South Africa's

health infrastructure and collect substantive data on health in the country. As the WHO's ***WHO Country Cooperation Strategy 2008-2013: South Africa*** demonstrates, South Africa has made some improvements from 2003 to 2008, citing larger numbers of people receiving ARV's.

Despite the improvements, the report does acknowledge that some of the same problems historians identified in the previous section still exist. The issue of mother to child transmission is still a priority issue for the WHO and its partners. In addition, the WHO is currently studying and recording behavior data to better understand at-risk populations and to devise ways of targeting those populations for prevention and treatment programs. Since 2003, the WHO has collected data on at risk populations, most of which focus on women and children, those effected by geographic location, and age range. Yet even in collecting data, the report shows some significant gaps in data

gathering. Reliable numbers for the younger population are missing. Rates of infection for pregnant women and the number of people receiving prevention/treatment are estimated, with the government's estimates being higher and lower respectively. Further, the entire spreadsheet for the demographic "men who have sex with men" is empty for all years.

The WHO cites a "remarkable reconstruction and transformation of facilities and service infrastructure in the health sector in the last decade" *(WHO Country Cooperation Strategy,* s2.6, 10). And while improvements have been made, the WHO report acknowledges that the "Government continues to have a strong stewardship role in mobilizing resources and developing effective policies and programs coordination mechanisms for attaining health targets and goals" *(WHO Country Cooperation Strategy,* s2.6, 10). This means that, despite large amounts of funding and the assistance of NGO's,

the South African government still has control over how funds are dispersed, to whom, at what rate, and for how long.

Specifically, the WHO report calls notes:

"With respect to priority health programmes [sic], the implementation of the policy interventions that have been introduced needs to be accelerated specially in districts which have higher than average disease burdens. Specific areas such as tuberculosis, HIV and AIDS, malaria, infant, child and adolescent health, noncommunicable chronic diseases, and injuries and trauma need to be scaled up. This will be necessary to accelerate progress towards achievement of the Millennium Development Goals" *(WHO Country Cooperation Strategy, s2.6,* 10).

Thus the programs that are currently in place, such as MTCT prevention and distribution of ARV's, while better, are not moving rapidly enough to serve the need of the HIV positive population. The WHO is committed to working with the government to improve in these areas, yet there are some problems in cooperation among the WHO's NGO partners and the government of South Africa. The report notes:

"A recent evaluation of the Paris Declaration [23] in the country shows that there is still increasing misalignment and lack of harmonization between partner programmes [sic] with that of government. In the health sector, the weaknesses are reflected in patterns of health

financing which turn to be oriented towards funding few preferred programmes [sic]. For instance, there is a disproportionate allocation of resources towards HIV and AIDS issues with very little directed at maternal and child health. In the compilation of pledges by partners to support the health sector as a whole, allocations to HIV and AIDS accounted for 26.4 %of the total pledges; health infrastructures (4.4%); capacity building and training (4.0%); reproductive/maternal health (1.2%); nutrition (0.3%); health information (0.07%)" *(WHO Country Cooperation Strategy,* s3.5, 13).

While it could seem that the WHO is advocating for less funding for HIV/AIDS programs, the above

actually shows that more funding needs to be funneled to health infrastructure for South Africa. The

WHO essentially argues that no amount of money for HIV/AIDS programs will be effective if there is

no functioning infrastructure through which to deliver

prevention and treatment programs. Although their argument may have some merit, it seems that

the HIV/AIDS epidemic is so large that pulling funding from existing programs would do more harm

than good.

HIV prevalence among young people, 2007 *Source: UNAIDS/WHO, 2008*	Male	Female
Prevalence among 15-24 year olds	4.0	12.7
Low estimate	1.7	9.1
High estimate	6.0	17.0

The prevalence of HIV/AIDS in young women, even in 2008 as the chart at left from

Epidemiological Fact Sheet on HIV and AIDS Core Data on Epidemiology and Response

shows, is still more than three times that of young men. In fact, as some historians have noted,

women have, in general less access to health care (See Baylies, Nattrass, Itano). While the *WHO*

Country Cooperation Report acknowledges problems for pregnant women and MTCT, there is

not direct examination of why women have less access to health care. Presumably the gender

variance is addressed through the WHO promotion of gender equality and the betterment of healthcare infrastructure.

Additionally, the *Epidemiological Fact Sheet* from 2008 notes that, in general, more females than males are having sex before the age of fifteen. For people age fifteen to twenty-four, it appears that five percent of men had sex before the age of fifteen, while twelve percent of women had intercourse before the age of fifteen *(Epidemiological Fact Sheet 2008,* 14). This kind of behavior study, focusing on young men and women, shows that the age of first intercourse is relatively young. While it is nice to have rough estimates on the age range of first intercourse, other behavior factors should be accounted for in reporting the sexual behaviors of all people, regardless of age. For instance, how often do

young people use condoms or other methods of birth control? Is there an awareness of how condoms can help in reducing one's chance of contracting HIV? Why are young women contracting HIV faster than young men? One possibility is that women contract HIV faster because of the amount of mucous membranes exposed during intercourse and the number of vaginal microtears. Nattrass writes, "In Southern Africa, socio-cultural norms of gender inequality, sexual violence, a preference for dry sex [without lubrication], fatalistic attitudes and pressures to prove fertility contribute to a high-risk environment" (Nattrass 26-7). Further, it seems that women are having sex with older men, and churches in South African communities - committed to abstinence only sexual education -discourage condom use (See Hattas for a broader discussion on churches and sexuality in South Africa). Condom usage and other behavioral factors should be studied to give a better indication of how the WHO can better target this age range of men and women, and perhaps find out why it seems that women are at a higher risk for HIV infection.

The last issue address concerning women in the *Epidemiological Fact Sheet 2008* is the issue of mother to child transmission. The report notes that, in general, the number of women receiving ARV treatment to prevent transmission to the child has grown dramatically since 2004: 32 541 in 2004 to 127,164 in 2007. While the number has increased, the number of mother receiving

ARV's is still only marginally more than half of the actual number of mothers needed ARV's, which the *Epidemiological Report* believes to be around 220, 000 mothers *(Epidemiological Fact Sheet 2008,* 15).

Some historians, like Nicoli Nattrass, believe that this incongruence is due to the debate over the cost of treatment versus the cost of prevention. As noted earlier, the South African government was, at first, negative about what Nattrass calls "highly active antiretroviral therapy" or HAART (Nattrass 13). She notes that in 2003, the rhetoric surrounding HAART changed from one of denial to one that focused on the sustainability of HAART programs. While a sustainable program would be ideal, Nattrass writes, "By locating the AIDS policy discussion in a seemingly technical discourse of affordability and sustainability, the space for public deliberation over the appropriate size of a national treatment program has been sharply curtailed" (Nattrass 17). Couching the epidemic in technical discourse removes the ability of the people to express their opinion about treatment and prevention programs because such language requires the proper education and institutional standing in order for the rhetoric to have merit.

While the debate over cost-effectiveness of ARVs continues, there is still complete silence on behavior patterns and homosexuality in South Africa. Robert Lorway notes that gay and lesbian groups have little chance of breaking into the public health sector in sub-Saharan Africa "due to the illegal status of homosexuality, defined as sodomy in criminal codes, in most African countries" (Lorway 145). Yet in 1999, South Africa overturned its sodomy laws, making homosexuality legal in *National Coalition of Gay & Lesbian Equality* v. *Minister of Justice,* with Justice Ackerman writing the decision (Franke 1404). What more, the South African case is founded on terms of public liberty (the ability to be visibly gay, such as two men kissing), whereas the US case overturning sodomy laws, *Lawrence* v. *Texas,* is founded on a much smaller notion of privatized liberty - as in free to do what you wish, so long as it is behind closed doors (Franke 1405-6).

So if the court is open to homosexuality, why are there no statistics on gays and lesbian and HIV/AIDS in South Africa? One could guess and offer a few reasons. First, it could be that the WHO just recently started taking stats on men who have sex with men

and therefore do not have any available data yet. Secondly, while changing laws help, if the cultural feelings about homosexual do not change, gays and lesbians will continue to be an invisible part of society. Oliver Philips notes that many of the sub-Saharan leaders pride themselves on having a nation free of homosexuals, invoking **ubuntu** (or **munhu)** which "invoke an Africanist conception of humanity and society" that frames homosexuality as "a 'white man's disease' alien to 'African tradition'" (Philips 157-8).

Critique of WHO Work in South Africa

While I do not want to diminish the amount of work the WHO has done in South Africa, it seems that the WHO reports do not demonstrate a concrete way to change the condition of South Africa's poor health infrastructure. Moreover, the report does not mention the lasting vestiges of apartheid in the country today, nor does it acknowledge the damage a slow governmental response and outright political games played out in HIV/AIDS denialism. The **WHO Country Cooperation Strategy** emphasizes their work in bringing "scientific knowledge, advocacy and adherence to global initiatives" **(WHO Country Cooperation Strategy,** s4.2, 16), which can be read as an allusion to the "unscientific" past of AIDS denialism. While these effects cannot be quantified - as the WHO so likes to do - they effects of apartheid and HIV/AIDS denialism are still a part of the cultural memory of South Africa.

Didier Fassin's book *When Bodies Remember: Experiences and Politics of AIDS in South Africa* looks at the cultural memory of South Africa and how "the inscribing of historical time onto flesh, the social determinations of individuals' biological fate, and the remembering through which they seek to give meaning to their present" can help us rethink the history of South Africa and the effects of politics on the bodies of South Africans (Fassin XV). The cultural memory of apartheid is linked to the issue of poverty in South Africa. Recent historical studies of South Africa note that poverty is perhaps the largest issue facing HIV positive people. Poor people, the large majority of them Black, have little or no access to health care and live in areas where health infrastructure is poor. While, as shown above, there has been an increase in facilities providing ARVs, those facilities have been largely concentrated in urban areas. Rural areas of the country thus have disproportionately high rates of infection and little access to treatment. Mbeki was perhaps right when he linked the issue of poverty to immune deficiency, though not in the causal way he meant.

While the WHO acknowledges the rampant poverty in South Africa, it appears from their reports that the WHO has had little success in alleviating poverty. The map below shows some population information with regard to HIV infection rates.
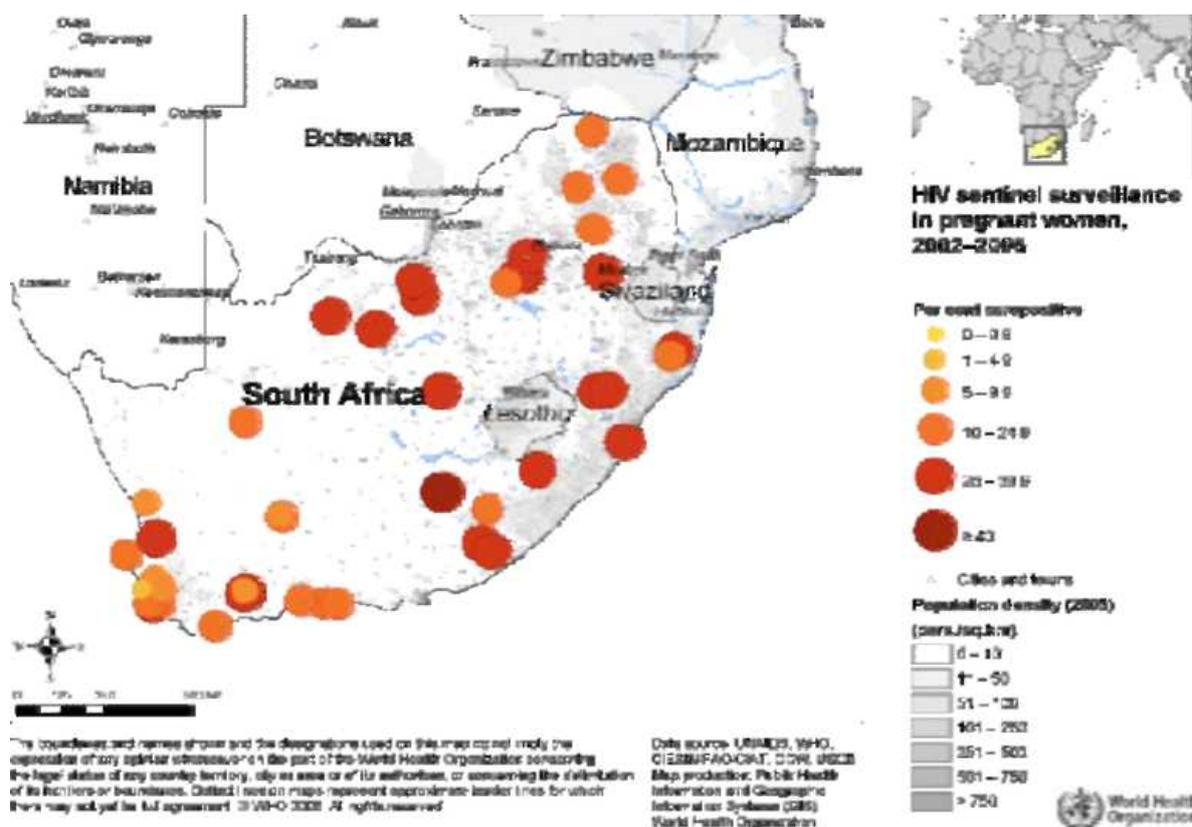
Darker shades of grey indicate a denser population, or urban areas, whereas lighter shades of grey indicate sparse density. Similarly, darker shades of red indicate high rates of infection, whereas shades of yellow indicate lower rates of infection. As the map shows, the less populated area of South Africa bordering

Botswana and to the west of Swaziland are less dense but have high rates of infection *(Epidemiological Fact Sheet 2008,* 9). As noted above, the primary partners of the WHO are other international organizations and NGOs that focus primarily on health initiatives. The WHO should expand its partnerships to include local anti-poverty groups, and thereby address this systemic issue that directly affects HIV/AIDS prevention and treatment rates.

Possible Ways to Move Forward

From 1994 to the present, the World Health Organization has helped South Africa make vast improvements to its health infrastructure while increasing the number of people receiving treatment and promoting prevention. Each of their reports show positive increases in the numbers of men and women served, as well as the number of pregnant women receiving MTCT treatment and prevention programs. Additionally, the WHO is beginning to conduct behavioral studies that attempt to understand how sexuality influences rates of infection differing ages groups and (to some extent) geographic location.

Although these are positive steps, there are several factors that prevent the WHO from actualizing their mission to its fullest extent. First and foremost, I believe the government's wish to maintain a positive international appearance prevents the WHO from accomplishing its initiatives, and the reports give hints that the WHO believes the same to be true. Funding is adversely directed at HIV/AIDS programs - so much so that it seems from the reports that the funds are held, never spent, or directed elsewhere because of the rhetoric of sustainability and affordability that Nattrass points out. Rather funding should be distributed not only to existing HIV/AIDS programs, but also to help further improve

rural health infrastructure so the HIV/AIDS programs can be delivered to underserved populations. The WHO should, in addition to working with its other international partners, work with local rural organizations to help better rural health infrastructure. Working on a grassroots level will help the WHO better understand the needs of those most affected, and perhaps allow the WHO to devise a better plan for curtailing the HIV/AIDS epidemic.

Further, the tone of the reports belies the WHO's wish to remain internationally neutral in politics. While there are hints to the country's past and to how the government continues to hold back HIV/AIDS programs, the WHO reports hedge on issues of racism, classism and national policy. I do not mean to say that the government is still in denial about the connection between HIV

and AIDS. Rather I am talking about the vestiges of the time period of denialism that is still in the cultural memory of the people of South Africa. This middle of the road approach that does not address the lasting effects of racism and homophobia, while allowing for some improvement, does little to change the cultural thinking of the country, nor does it account for the history of racism, sexism and AIDS denialism. I believe that the WHO should be more openly critical of the government of South Africa. I'm not saying that it should be antagonistic, but rather lobby around issues that the government seems to be willing to ignore. The WHO could support local groups (ones like TAC in the early 2000s) that lobby around HIV/AIDS issues and protect government inefficiency and negligence. Being an international health program, I can understand why the WHO wants to remain politically neutral. Yet I do not believe that a politics of respectability should be the dominant paradigm when lives are in the balance.

Lastly, the WHO and its partners serve as an epidemiological watch-group or surveillance group that examines bodies and collects epidemiological data on target populations. This "scientific" process, though important, is rather tedious and tends to dehumanize the issues surrounding HIV/AIDS and the target populations. A specifically historical approach, according to Fassin, allows "the work of historians, who, through their surveys of illnesses and the medical profession, often manage to bring the human social dimension to situations that medical language tends to disembody" (Fassin 31-2). Thus historical analysis puts a face and a humanity to the problem of HIV/AIDS and helps alleviate the impersonalization of dehumanizing effects of medical studies and "strictly the facts" reports, such as those produced by the World Health Organization and its partners. The WHO would do well to, in addition to surveillance, fund historians and anthropologists to help them better understand how their data is weighted by a history inscribed into flesh (Fassin XV). The distancing effect of technical and epidemiological rhetoric could be lessened through historical and feminist analysis of the lives of those *living* with HIV/AIDS, thereby putting a human face, body and personage back into how the epidemic is

examined. In all of the rhetoric surrounding the HIV/AIDS crisis, it is the **human** element that has been lost.

Examining and accounting for the human element would vastly improve the effectiveness of the WHO. Nattrass reminds us of some of the cultural implications of sex and sexuality, writing, ""In Southern Africa, socio-cultural norms of gender inequality, sexual violence, a preference for dry sex [without lubrication], fatalistic attitudes and pressures to prove fertility contribute to a high-risk environment" (26-7). Rather than examining and gathering data on purely epidemiological issues of HIV/AIDS, perhaps the WHO should find a way to look at gender inequality, sexual violence, homophobia and sexual practices that increase the risk of infection. This approach, in addition to the epidemiological approach, would help the WHO approach the issue of HIV/AIDS in a systemic way that not only addresses the epidemiology of HIV/AIDS, but the socio-cultural factors that are concurrent with the epidemic.

This method, working with local grassroots organizations who are better positioned to account for the human factor in the HIV/AIDS epidemic, would require that the WHO position itself differently as an international health surveillance group. Because the WHO is an international group, it has to walk a fine line to keep a positive international face. Explicitly talking about and examining issues of race, class, gender, sexuality (especially homophobia and transsexuality) will not win the WHO a positive international reaction. Yet so long as the human factor is unaccounted for, so long as issues of race, class, gender, and sexuality are swept under the rug, people will continue to die unnecessarily.

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