South African Politics, Inequalities, and HIV/AIDS: Applications for Public Health Education

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South Africa is home to 5 million of the total 45 million people living with HIV and AIDS. The enormity of the South African AIDS crisis is almost too great to imagine; except, the immense suffering demands that we pay attention.

We may consider the South African AIDS epidemic from a host of disciplines ranging from sociology to political science and, indeed, we would do well to discuss the problem in such an interdisciplinary manner. As a public health educator, I have begun a journey into various fields of study to improve upon and broaden my own approach to HIV/AIDS prevention.

The purpose of this paper is to discuss global capitalism’s influence on the politics of nations and, ultimately, the health of individuals. To accomplish this goal, I will describe the influence of neo-liberal policy on the economic and social structure of post-apartheid South Africa and examine how these structural conditions have lead to increased levels of poverty, social inequalities, and HIV/AIDS. Understanding these connections, I will provide recommendations for public health researchers and educators who continue often ignore established links between politics, inequalities, and health.

Global Influence on South Africa

It has been eleven years since the end of racial apartheid, a system marked by the brutal repression of black Africans by a white minority. Apartheid rulers dictated where blacks lived, worked, who they could marry, and how they could move about. Today’s South Africa is often celebrated as a miraculous example of a nation who has reversed racist and isolationist policies. However, it is important to consider the national decisions and global alliances made since Nelson Mandela’s election. How well has the democracy under the African National Congress (ANC) worked for those who were able to vote for the first time in the 1994 elections?

Early in his Presidency, Nelson Mandela unveiled a plan which he hoped would meet the basic needs for the poor South African majority. The Reconstruction and Development Program (RDP) aimed to 1) redistribute wealth and 2) overcome the structural legacy of apartheid (Magubane, 2002). However, when capitalists looking to invest in a new South African market found out that RDP measures did not provide ample opportunity for profit, they pressured the ANC to come up with a new plan (Magubane, 2002). The most important thing to note about the Research and Development Program is that its ideas were progressive, but it wasn’t around long enough to benefit anyone. What came next was a policy more in step with the game of global capitalism. GEAR—or the Growth Employment and Redistribution strategy—stressed growth before the redistribution of wealth. But in actuality, GEAR delivered neither growth nor redistribution. What it did deliver was an explosion in joblessness: from 16% in 1995 to 30% by 2003. Especially interesting is that the average income for black households dropped 19% while the average income for white households rose 15% between 1995 and 2000 (Bond, 2004). These disturbing results were probably not the outcome Mandela and his predecessor, Thebo Mbeki, had in mind when they first brought forward the new reform package; but the results can be understood better when we unmask it for what it truly is: a program not unlike the neo-liberalist structural adjustment programs, or SAPs.

During the 80s and 90s, poor nations around the globe were bullied by the World Bank and the
International Monetary Fund (IMF) to adapt structural adjustment programs. These programs gave
loans to nations who would agree to large-scale adjustments that promised “development” (that is-
economic development, not social development). Though the World Bank and the IMF did not hide the
fact that their programs were good news for the wealthy, it took years for at least one of these
international agencies, the World Bank, to admit that their programs were also bad news for the poor.
The programs were in fact so devastating that the overwhelming majority of nations who followed
through with the required privatization, trade liberalization, and social spending reductions, found
themselves with crushing debts and increased levels of social and economic inequalities (Kolko, 2002;
Weisbrot et al., 2001). The impact of SAPs in other poor nations is, in fact, exactly what South Africa
experienced after the implementation of the Growth, Employment and Redistribution strategy.

Did the South African revolutionary leaders “sell out” to global capitalism? Or was the threat of
transnational corporations’ disinvestments from the South African economy too powerful for a newly
free nation struggling to ‘develop?’ Because the answers to these questions are outside of the scope of
this paper, I would like to offer the relevant words shared by writer and activist Arundhati Roy during
the 2004 World Social Forum in Mumbai:

No individual nation can stand up to the project of Corporate Globalisation on its own. Time and again
we have seen that when it comes to the neo-liberal project, the heroes of our times are suddenly
diminished. Extraordinary, charismatic men, giants in Opposition, when they seize power and become
Heads of State, they become powerless on the global stage. I’m thinking here of President Lula of
Brazil…I’m thinking also of ex-President of South Africa, Nelson Mandela…

Why does this happen? There’s little point in beating our breasts and feeling betrayed. Lula and
Mandela are, by any reckoning, magnificent men. But the moment they cross the floor from the
Opposition into Government they become hostage to a spectrum of threats — most malevolent among
them the threat of capital flight, which can destroy any government overnight. To imagine that a
leader’s personal charisma and a c.v. of struggle will dent the Corporate Cartel is to have no
understanding of how Capitalism works, or for that matter, how power works. Radical change will not
be negotiated by governments; it can only be enforced by people.

If we are to begin a discussion about how to make an impact on the growing South African HIV/AIDS
epidemic, it is essential to understand that global capitalism and South African politics are intimately
entwined. Key issues effected by global capitalist power include: the level of support provided by
international agencies, NGOs, and rich nations in the cause of HIV prevention (Parker, 2002); debt
repayment that moves funding away from health services (Basu, Mate, & Farmer, 2000); the
availability of AIDS drug treatments to those living with HIV and AIDS (Mokhiber & Weissman, 2003;
Cornwell, 2004); and the cost/accessibility of health services to poor given privatization and decreased
spending on social services (Wildt, Rowson, Stoffers, & MKoivusalo, 2001).

Arundhati Roy’s statement, that radical change must come from the people rather than from
government, is particularly compelling when one considers President Mbeki’s unpopular statements
regarding the connection between poverty and HIV/AIDS. In June of 2000, at the 13th International
AIDS Conference in Durban, South African President Thebo Mbeki was a keynote speaker. His
message, as later noted by Paul Farmer, was that “poverty and social inequality serve as HIV’s most
potent co-factors, and any effort to address this disease in Africa must embrace a broader conception of
disease causation” (Farmer, 2001). Mbeki’s speech was a bold attempt to begin a dialog about the
economic and social forces which increase individuals’ vulnerability to infection. But, as the media,
leading researchers, and many AIDS activists quickly and harshly noted, entertaining such ideas would
dramatically shift the focus of HIV/AIDS prevention away from scientifically accepted “risk
behaviors” (a term that places the blame for ill-health squarely on the individual, rather than on society)
(Swarns, 2000).
Why would the South African President call for such a radial change in the way HIV/AIDS is addressed? Maybe more importantly, why was his stance so politically unpopular? Before answering these questions, let us take a closer look at the AIDS epidemic in South Africa and how we might frame a critical approach to the situation.

The South African HIV/AIDS Epidemic

With 5 million infected, South Africa leads the world in the number of people with HIV/AIDS. Approximately 21.5% of adult (15-49 years) South Africans are infected with HIV or AIDS (UNAIDS/WHO, 2004) while life expectancy is quickly receding to 30 years of age for females and 34 years of age for males (Williams & Gouws, 2001). Poor Africans, who are disproportionately black, present a high rate of HIV infection (Fassin & Schneider, 2003). Also, throughout Sub-Saharan Africa, females are at higher risk for HIV infection than males (Mukherjee, 2004) due to a mix of biology and gender-based power structures that may, for example, render condom negotiation with a partner difficult or impossible.

To prevent new HIV infections in South Africa and throughout developing nations, public health programs have focused on decreasing risk behaviors (Basu, 2004; Irwin, 2003). International health agencies and NGOs most often approach risk reduction by way of the “health belief model.” This model is rooted in psychology and works under the premise that if a person simply understands which decisions are unhealthy, they will be able to avoid risky behavior. However, as Senhay Basu (2004) explains:

> [g]iven that the top epidemiological predictor for HIV infection around the world is not a “risk behavior” but rather a low income level, those most vulnerable to HIV infection will not significantly benefit from a model focused exclusively on education—a model that assumes people in poverty have sufficient agency to control the circumstances of their lives.

An individual’s capacity to choose healthy behaviors can be compromised by a multitude of situations; I will explore the major factors here.

A Question of Agency. Scientists from a range of disciplines have established important connections between social inequalities and health (Wilkinson, 1996; Kawachi, Wilkinson, & Kennedy, 1999; Muntaner, Lynch, & Oates, 2002; Wakefield & Poland, 2005). The HIV/AIDS epidemic has presented a new challenge for researchers interested in understanding how certain segments of a population pose an increased risk for infection.

In 2000, Parker, Easton, and Klein reviewed ten years of literature pertaining to the structural factors or ‘social determinants’ that shape the HIV/AIDS epidemic in developing nations. The social determinants were first identified and then organized into the following three major categories: 1) economic (under)development and poverty, 2) mobility and 3) gender inequalities. In 2003, Fassin and Schneider identified the same three categories, but their short review was specific to South Africa. It is important to note that, although the above mentioned determinants may affect persons independently, each may also act in synergy with the others.

Sometimes, all of the above mentioned social determinants of HIV risk combine, resulting in dangerous situations for certain segments of South African society. To illustrate this point, I will describe the practice of transactional sex, a tactic not uncommon among poor South African women. Transactional sex is described as sex by which women (it is recognized by the author that men may practice transactional sex with other men) use their bodies as an economic resource. This is not commercial sex work, but rather a relationship seen in terms of reciprocity. Examples include a woman receiving small gifts from a boyfriend or a woman receiving a gift as a “thank you” from a man she has had sex with only once. Gifts may be incentives for some women to forgo condom use. It is also important to note...
that some women use gifts from transactional sexual relationships in order to meet basic financial needs. (Dunkle et al., 2004)

Clearly, transactional sex is driven by economics, but it is also closely related to mobility, racial capitalism, and gender inequality. Poor women who migrate from rural areas to find work may rely on transactional sex to supplement low wages or the lack of employment common among seasonal workers (Fassin & Schneider, 2003). Related to mobility is racial capitalism which is the exploitation of black labor for the benefit of a mostly all-white elite class. This system materialized under rule of colonialism, was violently maintained during thirty years of apartheid, and has not faded under a system of guaranteed and extensive racial equality. Racial capitalism prevents millions of black South African women from building a safe and secure life, a life entirely possible for white South African women. Finally, gender inequality increases responsibilities for women in care-taking roles while decreasing opportunities for education and higher social status. Also, sexual violence is a real danger for women who participate in transactional sex; the greater a woman’s financial need, the higher her risk in encountering violence (Dunkle et al, 2004). Inconsistent condom use has also been associated with women’s limited sexual power (Pettifor, Measham, Rees, Padian, 2004).

Understanding the economic and social conditions that determine the day to day lives of so many South African people is essential for those who wish to make an impact on the HIV/AIDS epidemic. Failing to address major social determinants of HIV infection has leads to an ‘exaggeration of personal agency’ (Farmer, 1999) as researchers and practitioners, nations, and international agencies design programs that teach condom use rather than addressing the policies which determine economic and social structures. To describe exaggeration of personal agency another way, Brook Schoepf notes: “The structure of the wider political economy establishes the situations and restricts the options that people can choose as a means of survival. A focus on ‘sub-cultures,’ as on individual behaviors, tends to obscure the underlying causes of social interaction” (cited in Farmer, 1999, p.85).

New Directions for Public Health

Politics are conspicuously missing from the field of public health. This past April, I was able to attend the first annual Health Not War conference organized by students from Boston University’s School of Public Health. A central goal of the conference was to change the culture of public health from a study and practice rooted in silence to one rooted in advocacy. The day-long conference left me hungry for more dialog about the potential of public health workers to purge realpolitik and adopt bold activism.

This paper has explored the political economy of South Africa for the purpose of analyzing relationships between politics, inequalities, and health. Transactional sex, as used by poor African women, was detailed in order to give context to the social forces which render discussions of HIV ‘risk behavior’ irrelevant. The patterned HIV/AIDS pandemic offers scholars and activists unique opportunities to crystallize the links between global capitalism and health. Given this analysis, I believe that the challenge to public health workers lay in becoming effective critics of a system that exploits many for the gain of a few.

Recommendations for Public Health Educators. I believe that public health educators are uniquely positioned to mobilize communities and confront current power structures. For example, many educators understand that communities possess the strength and integrity required to create and sustain social change. Also, most of us thrive in practice-based work that requires skills in building authentic relationships. However, as a whole, our weakness is that we tend to lack a clear critique of dominant power systems. Despite this weakness and because of it, I will end with a short set of recommendations to public health educators and the researchers who seek to move the practice ever forward.

• Pursue Participatory Action Research
Participatory Action Research builds on the knowledge and strengths of a community as it depends on its members to engage in cycles of dialog and consciousness raising, planning, and action. The approach evolved from models of empowerment and popular education and aims to create change at the community-level rather than relying on traditional models which exaggerate personal agency.

- **Call for Macro-level Governments Changes**

  Patterns of economic and social determinants of health identified within certain South African communities are similar to the experiences of many communities around the world. This includes many poor nations as well as pockets of people living in rich nations. As social determinants of health are the result of policy, it is important that public health advocates push governments of every nation to embrace policies that are truly redistributive.

- **Challenge Current Systems of Power**

  The internationalization of capital, labor, and knowledge is controlled by the most wealthy in order to serve their interests. Powerful nations, transnational corporations, and a community of international agencies (including the World Health Organization, the World Bank, the World Trade Organization, and the United Nations) need to be sent a powerful message about the consequences of neo-liberal economic strategies: they are poor public health policy.

  Real change is possible only when communities collectively identify who is in power and are able to effectively organize to action. Public health workers have a key role to play in the struggle for the health and well-being of society, but they first need to find their way onto the field.

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**References**


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