

## AIDS IN AFRICA

There is an excellent book on the subject of AIDS and the HIV virus by the geographer Peter Gould which was first published in 1993. It is remarkable not only for its clarity and the quality of its research but also for its passionate nature. Its title is *The Slow Plague*. One might well startle at such a title in view of the speed with which the devastation of AIDS has swept through the world and throughout the continent of Africa in particular.

When I visited Zimbabwe in 1982, there was still no hint of the impending disaster. In fact, it was in that year that the discovery of the first type of human immunodeficiency virus, HIV-1, was made public. Three years later, in 1985, French virologists identified a second virus, HIV-2.

It has taken only fifteen years to reach a stage where, in many parts of central and southern Africa, the proportion of the sexually active population which is infected by the virus equals or exceeds 30 percent over wide geographic areas. In the continent at large, there may be as many as 40 million infected people. The number of deaths to date probably exceeds 8 million. There is little sign of any abatement.

In 1982, one of the striking features of many of the central African counties was the youthfulness of their populations. Over 50 percent of the Zimbabwean population was said to be under the age of 15. One could see evidence of this in crowded places. Nowadays there may be fewer young people. The so-called demographic reaction of family limitation, which is a universal but a highly variable response to the survival of increasing numbers of children, was already well underway in Zimbabwe by the 1980's.

Since then, the fertility rate has dropped by a third from 6.5 children per adult woman to 4.3. It takes some time before such changes are fully reflected in the age structure of the population; and so this is not the feature which struck the members of my family who visited the country recently. What stuck them most forcibly was the number of orphans and the children in care of relatives and older family members. The parents of the children, both of them, would have fallen victims to AIDS.

If this is a slow plague, then by what standards is its speed being judged? The answer must be by the standards of other pandemics which have hit the human race in recent years. We are inclined to think of the influenza pandemic of 1918–1919. It is estimated that some 30 million people died in this short period as a result of the flu. (The eventual mortality from AIDS will greatly exceed this figure.) The epidemic was highly contagious. There were no vaccines to combat it, nor any other human recourse. However, the worldwide plague was brief.

One or two years were all that were necessary for the human population to produce an immunological response.

The influenza epidemic is at one end of a spectrum of epidemic diseases which is bounded at the other by the slow plague. Elsewhere in the spectrum there are such diseases as cholera which swept through Latin America as an epidemic in 1991. This is less contagious than influenza, the human immunological response is weaker, and the scope for action to defeat it is far greater. It can be combated by a range of familiar public health policies.

The HIV virus is only weakly infective. It can be passed from one person to another only by the interchange of bodily fluids, by blood or by semen or by vaginal secretions. It is even doubtful whether it is transmissible via saliva. However, once the disease has been contracted, there is no immunological response which will save the victim from an eventual death. At most, the victim has 10 years to survive before dying of AIDS. In conditions of poverty, such as characterise much of the African continent, they are more likely to be granted only six or eight years.

There are only expensive palliatives. There is no medical cure for AIDS; and it is the opinion of most experts that there is unlikely to be one in the foreseeable future; and certainly not one which will be affordable on a large scale. In the absence of an immunological response to HIV, the only thing which can defeat it is a sociological or a behaviour response in the populations which are at risk.

That response, which can be measured on the same time scale as the demographic response, is already underway in many African countries. Indeed, we are witnessing a remarkable instance of human adaptability, but we know, that, measured against the speed of the slow plague, the response is too slow to avert widespread suffering and disaster.

It is not entirely idle to wonder why Africa is so greatly afflicted by the disease nor to ask why the response appears to be markedly less rapid than in other parts of the world. It helps in combating the disease to know the answers in detail. We might ask, for example, whether there is something in the cultures of Africa or in the sexual mores of its populations which is conducive to sexually transmitted disease.

I raise these cultural allusions only to dispose of them. I do not believe that one needs to give a detailed exposition in order to do so. It is perhaps enough to remind ourselves that, in the absence of penicillin, the war-ravaged Europe of the late 1940's would have been devastated by epidemics of Syphilis and Gonorrhoea. That threat was the natural outcome of the concomitance of men without social constraint and women without any means of support for themselves or their families except prostitution or something close to it. Rape would have played a part as well.

Africa continues to be ravaged by war, by drought and by the displacement of large numbers of people. Many parts of the continent have been afflicted recently by bands of marauding soldiers. For years, there have been congeries of migrant labour passing up and down the length of the the Rift valley. Throughout the century, there has been a rapid migration of displaced people into urban slums, seeking refuge from war or drought or simply leaving a countryside which can no longer contain them; and the rate of this migration has risen.

As befits the work of a geographer, the book by Gould gives a spatial as well as a temporal dimension to its account of the spread of the plague. In his own phrase, it spreads by hierarchical and contiguous diffusion. That is to say, it travels from node to node of the transport networks of African, and thence it is diffused into the hinterland. There are rural villages within reach of the network were sixty percent of women who have been tested in mobile ante natal clinics have proved to be seropositive. The principal axis of this process is a line which follows the Rift Valley stretching from Addis Abbaba or Djibouti at the mouth of the Red Sea all the way to the Cape. A secondary axis stretches from Dakar in the west to Mombassa and Dar es Salaam in the east.

Amongst the the principal vectors of the infection have been the migrant workers, the truckers and the prostitutes; but the disease knows no occupational or class boundaries. Particularly affected have been the African urban elites and the military personnel—those who have the disposable income to command the services of prostitutes. Untold harm is done to the economic prospects of Africa by the decimation of its urban elites; and, as Gould remarks, we know very well what tends to happen when armies, depleted of their leadership, are taken over by corporals.

The struggle against AIDS has been made all the harder by the attitudes of much of Africa's political leadership who have been wilfully negligent of the issue and who have often been affronted when it has been raised in international forums. These attitudes are now changing. No longer is the president of Kenya capable of ascribing reports of AIDS to a deliberate hate campaign against his country. The ban on all references to AIDS on death certificates in Zimbabwe has been lifted. One of the central African presidents was galvanised into action by the death of his own son from the disease.

Our principal alliances must be with the indigenous people who are struggling with the issue on the ground, and this can best achieved through the agency of non-governmental organisations strongly supported their governments. In the sixties and seventies, western governments failed to press the issue of family planing in the African continent. The notion that the west wished to exercise population control over Africa affronted many African leaders. The post-colonial diffidence of some of the western governments was such that the issue was allowed to go into abeyance, but the problem of the population explosion

did not disappear. We must be more robust in our approach to the problem of AIDS.

It is not upon exhortation and advice that we must rely primarily. The one device which can most effectively block the transmission of the HIV virus is the condom. The condom should be included in pay packets by every western firm operating in Africa. It should be freely available in bars and shabeens, in bus depots and railway stations, and in prostitute's parlours. It should even be made available via schools.

The solution to the problem of the AIDS epidemic and the solution to the problem of birth control are one and the same thing. There is a hopeful example which suggests that a country undergoing a rapid demographic transition can quickly and effectively counteract an AIDS epidemic. The country in question is Thailand, where it once seemed that the circumstances were optimised to assist the spread of the HIV virus. Now there is an expectation that it will be held in check.

It is exactly two hundred years since the Reverend Thomas Malthus published his dismal *Essay on the Principle of Population*. In it, he classified the checks to the growth of population as either preventive or positive. He would, not doubt, have classified the AIDS epidemic as a positive check in the company of the other checks of war, famine and pestilence. The deferment of marriage and the abstinence for sexual activity, or the resort to prostitutes, were described by him as the preventive checks; and, in his perception, these were the only available preventive checks. All possible outcomes were categorised by Malthus either as states of vice or as states of misery.

The pessimism of the Malthusian doctrine and its moralising tone invoke a strong aversion in many of us. We like to think that there is a far greater scope for human amelioration than Malthus allowed. Nevertheless, the Malthusian spectre is one which confronts us today in Africa no less that it confronted an English clergyman in his own country two hundred years ago. To people of goodwill and optimism, it is surely clear that there are immediate actions which demand to be taken if we are to help in defeating the spectre of AIDS in Africa.