

THE POLITICAL ECONOMIES OF AIDS

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Introduction

Between 30 August and 7 September 1854, 500 people died of cholera in the Golden Square area of London. A local doctor, John Snow, had already developed and published views five years earlier on the transmission of cholera. Armed with his hypothesis, Snow sought to help his patients. He could do nothing for the stricken individuals: he had no curatives; they died. But he interviewed their families and soon discovered, by plotting the answers that he was given, that the victims had overwhelmingly drunk water taken from a pump in Broad Street. He also found a control group. None of the 70 employees of a brewery in Broad Street fell ill. The brewery had its own well from which they drank; or they drank beer. Reporting his intervention in the *Medical Times and Gazette* of 23 September 1854, Snow wrote that he discovered that the pump in Broad Street drew water within feet of the Marshall Street sewer. On 7 September he applied to the Board of Guardians for permission to remove the handle of the pump in Broad Street. The epidemic abated and Karl Marx, among others, was saved for posterity (for he was living near Golden Square at that time). Snow's researches continued. He concluded that people who drank water supplied by the Lambeth Water company from its new upstream abstraction point at Thames Ditton were ten times less likely to die of cholera than those drinking impure river water abstracted at Battersea by the Southwark & Vauxhall Water Company.

The celebrated story of John Snow and the Broad Street pump is usually regarded as the moment when public health – as distinct from somatic or individual treatment – began. From its birth, as the Golden Square story illustrates, the practice of public health has shown its two perverse, troubling defining characteristics.

The first is that the doctor treats the individual patient's illness *not* by direct medical intervention, but by an action unrelated to any single patient: a preventative action – since direct treatment may not be available anyway, as it was not in Snow's case.

The second characteristic is that the medical intervention of prevention is *inevitably a challenge to power*. In this case, it is the political economy of the private supply of water to the poor of London that is under scrutiny and challenge. In other cases, as in the one to which we will now turn, it is other things.

The road that brings me to this lecture today began at the Eloff Street depot of what was then called WENELA (the Witwatersrand Native Labour Association) in 1980. At that time, I was investigating the epidemiology of tuberculosis in Western Zambia, which by the 1970s had produced a classic plateau infection across all age groups in villages that I surveyed. These are signs of a previously unexposed, then infected, population. It was consistent with the readmission of WENELA north of the Zambezi after the Second World War. On that trip, my first after involuntary absence from South Africa for many years, I found the 1950s' recruitment registers heaped under a table at the depot (which, with the assistance of a helpful Lozi administrator who I met, we abstracted and which were then copied for me illicitly at the Chamber of Mines). The records greatly facilitated my work. I also discovered an elderly doctor there. 'What did you do', I asked, 'when you found active TB cases before you had any means to treat them effectively?' 'Well' – his words ring in my ears still – 'we fed the patients a high protein diet to build them up and to suppress the symptoms and then we sent them home' – where those vectors soon became again active with the results that I had seen in the field. In short, it was a pathological political economy of public health, the reverse of what one would hope to achieve: the spreading of illness not of health.

However, my researches 30 years ago were conducted against the background of cautious optimism. Accelerated treatment regimens with Isoniazid gave hope of real reductions in pervasive TB. It was actually working in rural Zambia in TB sanatoria where it was possible to keep the patients under close observation and management during administration of the course of the drugs. But what none of us knew was that something else was lurking.

One final anecdote completes the context. After the great transformation of 1994, I returned to South Africa as the envoy of the University of Cambridge to reopen full relations after the end of apartheid. In one of his many acts of creative political genius, which rescued this country at this

time, President Mandela convened a standing private seminar of all the talents. I was privileged to attend one session five months after the elections, when an eminent epidemiologist presented four viewgraphs to the group. They were his predictions of the course of AIDS in South Africa under different assumptions of intervention. The first was of full-scale national emergency action taken now; the second was the provision of palliative care only from now onwards; the third was of delayed interventions for a period of some years, perhaps a decade; and the fourth was nothing.

Despite the abatement of this most weird and malevolent disease in Brazil, in Thailand, in Uganda or indeed in Senegal, it is not only South Africa that has done effectively nothing. Last year, at a closed seminar held under the Chatham House Rule, I heard one of the most central figures in the global fight against AIDS observe that, if Martians were to look at humanity's record in dealing with this epidemic since 1980, they would conclude that a conscious decision had been taken at that time to let the epidemic run as a sort of grand macabre experiment, since that has been the nett effect of interventions in the first 25 years.

But now it looks as if this may change for the first time. In the State of the Union speech of 2003, as well as preparing world opinion for the coming liberation of Iraq from Saddam Hussein, President Bush astonished everyone by announcing a new \$ 15 billion American anti-AIDS fund to be administered through the State Department. Why? In the most recent issue of *Foreign Affairs*, Holly Burkhalter documents the critical role of the entry of conservative religious evangelicals into the AIDS issue. The February 2002 Christian Conference on HIV/AIDS was convened by Franklin Graham, son of the evangelical superstar, Billy Graham, and administrator of the important evangelical charity, The Samaritan's Purse. This, she suggests, was key in political mobilisation for the prevention of mother-to-child transmission. And, as Burkhalter points out, that decision was crucial not only for the provision of funding: even moreso it was significant for the tacit recognition that AIDS was a heterosexually transmitted disease, not only God's vengeance on homosexuals and other perverts, as it was seen in the eyes of President Bush's core constituency.

So now we shall see the experiment of the introduction of both prevention and treatment regimes beginning, just as the first wave – the southern Africa wave – enters the death phase, and as the second waves – in Nigeria, Angola and Ethiopia – are committed and as other waves – in Russia, Ukraine, East Central Europe and then India and China – come into political view. For an overview of the world experience with AIDS, I commend the January issue

of the *Index on Censorship*, which puts together essays on all the known waves between one set of covers.

This is a grave, but appropriate moment, therefore, to wonder *why* the Martians would think that we had done so little so late and so inappropriately, not only, but sadly especially, in South Africa, when we knew, in time, were warned, and did not act.

I would single out the degree to which, to date, AIDS has been addressed as overwhelmingly a medical – or, more strictly, as a medicalised – issue. This may sound strange, even impudent, from a non-medic such as myself. We know huge amounts more about this cunningly mutating virus than most others. But in the terms of the story with which I began, we have done Dr John Snow's 1849 report on the aetiology of cholera; but we have not yet done the 1854 study of the water companies. We know, in short, spectacularly little compared to need about the *political economies* of AIDS. Not economy singular, please note: political economies, plural. In the rest of this lecture, I want to sketch two rather different political economies. Political economy is a term which I take in this context to describe the place where suffering and its alleviation collide with power.

I

In her brilliant and tragic book last year, *Letting them die: why HIV prevention programmes fail*, my LSE colleague, Cathy Campbell, uses South African data, principally from Kyalitsha, near Cape Town, to ask a key psychological and political question. Why is it, she asks, that knowing the risks, people still engage in unprotected sex? Her reply is that the psychological part is linked with denial. We see this in especially clearly in data from the South African armed forces in an essay published by Dr Lindy Heinecken, of the South African Military Academy, in the journal *Armed Forces and Society*. We also see this in data from mining companies, where those who are best able to know of the risks nonetheless endure above average infection rates. But a much larger part is linked to power, or, in this case, to powerlessness. The powerlessness in question is that of young women who are unable to negotiate or to control their sexual début or their subsequent sexual encounters. It is the repeated theme of studies from the place and moment of the first African episode in Rakai district of Tanzania – onwards.

There, Alan Whiteside and Tony Barnett, his colleague (now also a welcome new arrival in the growing LSE AIDS research community), detail the workings of the *magendo* economy. This is the structural dysfunction of the micro-economy of poor societies in the Great Lakes region in the 1970s. Fassin and Schneider in the *British Medical Journal* last year make the same

point more widely for South Africa that Whiteside, Barnett and Campbell document: young women engage in ‘... survival sex – whereby young women in the townships, often migrants from impoverished rural areas, use their bodies as an ordinary economic resource outside the culture of prostitution but within the culture of male violence.’

This structural powerlessness of women is reflected in their risk factors. The key demographic statistic is of a rise of young adult, especially female deaths. In the South African case, which is the best documented from the work of the Actuarial Society of South Africa (ASSA), we see from an analysis of death certificates that taking a base line of 1985, the risk of death for the age cohort of young women aged 25 to 29 has increased by a ratio of 3.5. AIDS is the only feasible explanation for this dismal finding.

Unfortunately, the meaning of these baleful figures is currently obscured in the national debate. A journalist called Rian Malan who, on the evidence of his published writings, does not understand the elementary principles of medical statistics and epidemiology, has sought to suggest that there has been an exaggeration of the epidemic. He has furthermore suggested that there may be conspiratorial motives in something called the “AIDS industry” which promote this. Since Mr Malan has demonstrated in his articles that he is not technically competent to review these delicate matters, I have no intention of engaging his arguments: he has not paid the entry price to the arena. However, his views are clearly attractive to those such as the President who would prefer to deny the whole problem, and so it is important that people know that until Mr Malan has done his training, he has no substantive contribution to make to this debate. I do not presume to think that with no proper training I can take the controls of a jet-liner; and many more lives are at stake in this journey. I am sure that there are suitable courses for Mr Malan at the medical school in this university.

Returning to where we now are, we face the equivalent task to removing the handle of the Broad Street pump on 7 September 1854. That task is to get a handle on the culture of male sexual violence now made even more aggressive by the phenomenon of inter-generational sex as older men prey on very young girls often in the mistaken belief that intercourse with a virgin may cure them of their affliction. But to grapple with this phenomenon involves facing some unpleasant aspects of African male sexuality, which, tragically, in his Fort Hare speech of 12 October 2001, President Thabo Mbeki candidly explained that he did not wish – perhaps understandably, but in my opinion unforgivably - could not bear, to do.

Re-engaging this first type of political economic dimension, I must now sketch out a tragic but at the same time heroic paradox. It should be some

comfort to realise that part of the tragedy lies in it being an adaptive response to adversity. The self-injuring effects are also evidence of African strategies *not* to be passive victims. Let me explain.

When the newly-independent government of Zambia decided, overnight, to suspend recruitment by WENELA of Zambians to go and work on contracts in mines of the Witwatersrand, the justification by the Minister, Arthur Wina (himself a Mulozi and son of one of the Litunga's chief ministers), was that it was no longer right to allow 'our people to be taken down to slavery'. But the difficulty was that whatever view one might take of the activity of long-distance labour migration, it had become an integral part of the political economy of how Buluzi ran during the middle of the 20th century, and was highly popular among many of those who engaged in it. (I have interviewed scores in Buluzi, to underpin that statement.) It was certainly a rite of passage for young men; but I would not place too much weight upon the mystical. More, it was an immensely practical moment for capital accumulation. Young men would, through their contracts on the mines, obtain capital enough to begin to purchase cattle and would also bring back from South Africa, often on their shoulders, ploughs, cooking pots and other desirable consumer goods. The cutting off of migration meant that, at a stroke, these many portals through which small amounts of money trickled into the domestic economy were shut off; yet the need for that lubrication of the domestic economy remained. How was it now to be achieved?

The answer was through an ingenious indigenous economic adaption. By the time that I was conducting my fieldwork, during the ten years after the ending of labour migration to South Africa, a new form of domestic redistribution mechanism had arisen. It was based on the brewing and selling of beer. The way that the system worked was that in a group of villages, female brewers would collaborate informally in a brewing cycle. Thus, in village A woman X would brew on the first day of the week, woman Y in village B on the second and so on. This type of *bucwala* – maize beer – was actually called 'Seven Days' because that was how long it took to become properly fermented. Those with money were now the new labour aristocracy. They were men working for the Public Works Department of the Republic of Zambia or others in receipt of government salaries, as well as those who obtained money from the sale of cattle. These were the drinkers. And their money thus recycled back into the micro-economy where the brewing women were able to use it principally for children's expenses (uniforms, school fees etc). But there was a catch. As the group of drinkers moved day by day from village to village, thus spreading their wealth around, the system was policed by sex. The women brewers were coerced into sex by their customers under the threat that, if they did not

submit, then they would be denounced as brewers of bad beer, which had given people stomach aches and thus they would be cut out of the cycle. You can see, therefore, that when such a society falls victim to a sexually-transmitted epidemic such as AIDS, it is structurally vulnerable to the spread of infection. This is what is meant by asymmetric sexual power.

My Lozi example shows that, while the causes of such behaviour are in part the ghastly result of having to fight back against structural adversity, which has been the overriding experience in southern Africa over the last generations, in its very refusal to accept victim status but instead to find creative ways of making the circumstance work to one's advantage, there can be seen an energy which was once tapped and which, therefore, lies available to be tapped again.

As this political economy of AIDS becomes understood and acted upon, I see several dangers. Let me signal them.

The first is an over-emphasis on treatment of the wrong sort at the wrong time. There is no technical fix to the problem of asymmetric sexual power. Thus, the effects of Nevirapine therapy to prevent mother-to-child transmission is a medical intervention that is entirely different in its impact at this point in the southern Africa epidemic to the widespread use of ARVs for HIV positive patients regardless of sex – the core issue in the recent passionate struggles here that Zackie Achmat described in his contribution to the *Index on Censorship* collection. This is an example of the profound ethical challenges that this approach to public health therapy *unavoidably* brings.

The balance sheet on the use of ARVs seems to me to stand like this. In its favour is that their use will save children from orphanhood for a little longer. Or rather, to put the point more brutally and precisely, ARVs can be used to keep mothers alive so that their children can at least reach the early stages of adolescence before they are alone. The scale of this problem for South Africa is mind-boggling. From a situation where there were no AIDS orphans in prospect in 1995, by 2020 South Africa must be preparing for two million. Also on the positive side is the testimony of Jim Kim of the World Health Organisation to the effect that treatment can aid prevention programmes and he cites for this Ugandan evidence. But I am one of those who is still agnostic about what it is that has produced the reduction in prevalence rates in Uganda. Has it been the effect of the social interventions or has it been simply a natural demographic progression in the career of the episode? I really am not sure. And counter to Jim Kim's testimony stands the evidence of Cathy Campbell from Kyalitsha.

Against the use of ARVs stand two charges. The first that there will likely be an accelerated loss in the effectiveness of these drugs, as happened with Isoniazid and TB. This is through no fault or inadequacy of the patients. It is a product of the circumstance. South Africa is simply structurally not equipped in its medical services to be able to support the increased need for the monitoring of viral loads etc that goes with the administration of ARV therapies. Without these, the shift from the first, to the second, to the third cocktail, as progressively they lose their efficacy for the patient, cannot be sufficiently carefully controlled.

Secondly, the accelerated use of ARVs across the population is an opportunity/cost choice on efforts. My Columbia colleague, Jeffrey Sachs, has called for massive increases in external aid funding as the primary driver for a world effort to combat the pandemic. The Sachs experiment is now, in fact, being conducted and the problem is that it may well exceed the capacity of the administrative and governmental structures of many countries – structures which many frequently have frail legitimacy in any case - to absorb it. There is some evidence that this is already the case in Tanzania.

Furthermore, the move to large-scale externally-funded ARV therapies effectively makes whole populations dependent on foreign aid. There is another vulnerability also. We should recollect the awful historical example of what happened in the Belgian Congo. During the late 1950s, the Belgian authorities chose to combat trypanosomiasis (sleeping sickness) by attacking the vector in the human hosts through a programme of mass inoculation. Quite astonishing levels, above 95% of the population, were being annually inoculated by 1959–60. But with the opening of the civil war over Katanga and the eventual and precipitate collapse of the Belgian Congo into anarchy the suspension of the colonial medical services led to a raging outbreak of human trypanosomiasis as a consequence.

The underlying problem is that these approaches really employ the wrong medical model of analysis. What we are seeing here are actions driven by the standard somatic treatment model: individual patients are suffering and individual patients are to be the recipients of the best medical intervention that science can at that moment provide. That it will have a marginal social benefit (for example in putting off orphanhood for some children for some time) is an accepted and welcome gain, but it is not the driving motivation.

In contrast, a public health approach would address a *larger unit* of treatment, where the somatic – the treatment of the sick individual – could actually undermine the effectiveness of the overall strategy. This may well be the case with the failure to produce sufficiently powerful and sufficient early public health interventions in the case of the South African epidemic.

Thirdly, that being the case (as I fear that it may be), in South Africa today, the correct model for medical analysis comes from battlefield medicine.

In battlefield medicine, there is always a shortage of resources, of time and of opportunity. Triage is practised under those constraints. Triage means that patients are assessed at the casualty clearing station and categorised into those groups whose condition is hopeless, those who will recover anyway and those who, through immediate intervention, might be helped to make the difference between life and death. For the first group, the treatment is only palliative. For the third group, the prescription is immediate evacuation to a rear area. Only the second group is treated in the MASH unit on the front line. It is only here, in my view, that the war analogy, which has become popular in describing AIDS, is actually precise. What it means, in blunt terms, is that among the global population of those who could be provided with ARV only a specific target population (logically of mothers with pre-pubescent children) are given priority and they are given the full support of the limited resources for medical monitoring, viral load measurement etc that are necessary to maximise the effectiveness of the use of ARV for them.

The horrendous ethical dilemmas that such a situation creates are described best by Professor Onora O'Neill in 'Public health and clinical ethics: thinking beyond borders', published in the journal *Ethics and International Affairs* in 2002.

Baroness O'Neill starts from the premise that 'contemporary medical ethics has been preoccupied – in my view damagingly preoccupied – with the autonomy of individual patients.' Such an approach implies the dominance of a rights-based approach (prominent in the ARV campaign) and the view that '... all compulsion for the sake of health is wrong'. It quickly brings memories of quarantine camps, of lazarettos and of the stigmatisation and isolation of victims from the pre-scientific era of the management of infectious disease. But is it? O'Neill advocates starting from 'a systematic account of obligations rather than rights'. Obligations fall on all agents: 'obligations to reject coercion and deception, victimisation and oppression, and to assist in permissible forms of action specifically to support the health of others'. For those of a philosophical turn of mind, this is a minimalist Kantian prescription combined with an operational definition of Common Good.

Thus, the greatest security threat in countries with above 20% adult prevalence (and South Africa has an adult prevalence rate of 19.94%) is the reduction in life expectancy. These are among the most tragic figures that one can read. In South Africa, average life expectancy at birth has fallen

from 63 in 1990 to 47 today; in Zimbabwe from 59 to 43; in Botswana from 63 to 36; in East/Central Africa overall, from 55 in 1990 to 42. In Zambia, average life expectancy at birth is 33 years: an expectation level on a par with that which we believe to have been the case in Europe at the time of the Black Death.

These are personal disasters. They are also social disasters. The problem for the reproduction of society is that adults with less than 30 to 40 years of mature life in expectation are unable to effect intergenerational transmission of culture. After all, if you live your conscious life in the expectation of early death there is little motivation to learn, to act or to transmit. This means that, for example, democracy may simply not be possible because democracy depends on a concept of deferred benefit: that you give up something that you would like for yourself immediately in the expectation of a greater benefit for yourself or for those who you care about at some point in the future. Those with no expectation of adulthood are unlikely to see the point. It is a useful optic through which to look at the socially suicidal behaviour of the Zimbabwean elite associated with Robert Mugabe, an elite which, we know from such blood samples as it has been possible to analyse from identifiable groups, is highly infected – well above the 20% mark. However, with the changes that have occurred in Libya, which give the international community for the first time a lever to eject Mugabe and his clique from control of the country to your north, we may - for the first time - realistically look forward to their imminent departure.

This brings us to the second type of political economy.

II

It is a truism of international politics that nothing happens in international politics for single reasons. Altruism when it occurs in international politics is usually altruism for selfish reasons. But selfish altruism is none the worse for that, if it is nonetheless altruistic in its effect! One should always remember the observation of Count Metternich upon receiving the news of the death of Talleyrand. Pensively, the great schemer asked himself, 'I wonder what he meant by that?' Look for multiple causes, some possibly surprising, of everything.

The second type of political economy of AIDS is larger in scale, but hitherto not much noticed since it relates to events in the coming years rather than events already on the ground, and it resides in topics that are seemingly unrelated to epidemic disease. For the plain fact is that Central, Southern and West Africa, in particular, should now start to live in the expectation of substantial increases in non aid real resources in the coming 15 years and,

with that, an associated increase in the strategic interest that the United States and its allies will show to that region. This may be a mixed blessing – and the nature of the mixture I will discuss shortly – but it is now unavoidable.

Although some people present it in a quasi-conspiratorial manner, the oil motivation, among the several which led to the actions to remove Saddam Hussein from power, is perfectly evident and, in terms of *Realpolitik*, perfectly proper. It was signalled first in the paper on United States energy futures, which was prepared early during the Bush Administration, under the chairmanship of Vice-President Cheney. The paper became notorious because of the high reliance placed upon their friends from the oil industry by this Administration of oil men and women. (Dr Rice, the National Security Adviser, former board member, had a Chevron oil tanker named after her, although I understand that the name has been changed, once someone in a newspaper mischievously drew attention to it.) But on the specific matter of oil supplies, the point at issue stands independently of source. What the Cheney paper argued for was the strategic importance for the United States of energy diversification. In the case of Iraq, it was plainly strategically intolerable for Saddam Hussein to control the world's largest known unexploited reserves of oil, whilst at the same time being in a position to threaten the world's largest current oil producer, namely the oilfields of Saudi Arabia. In the present mixture, the United States obtains about 30% of its oil from Mexico and Canada, about 27% from the Persian Gulf and between 12–14% from Africa, principally from oilfields in Nigeria and Angola. But under the strategy of diversification of supply, expectation is that by 2020 Africa will account for about one quarter of America's oil supplies. And that means that, for the first time since Angola was interesting to Henry Kissinger as a site for a proxy war with the Soviet Union, following the American withdrawal from Viet Nam, the sub-Saharan region begins to take on real strategic importance.

The process began under the Clinton Administration and was to be seen in its backing for stabilisation of Nigeria through support for the government of General Obasanjo. One desirable (from the American point-of-view) consequence of such stabilisation would be to permit safe increase in oil production in the Delta oilfields. But, unfortunately, to date it hasn't worked as planned. There is considerable continuing instability in the coastal belt and the Nigerian oilfields coincide geographically with the site of the main AIDS infections predicted in Nigeria.

As already mentioned, the effect of the removal of Saddam will be the stabilisation of both Saudi and Iraqi oil on the world markets and a second consequence, *via* the normalisation of relations with Libya, will be the return

of American oil companies to Libya and the re-entry of Libyan oil into the equation. But oil industry sources agree that in the next 15 years the big push will be in the considerable oil fields which lie offshore in the Bight of Benin. These West African oilfields belong legally to 'states' such as Angola, Chad, Sao Tomé and Equatorial Guinea. I use the inverted commas simply to signal the problematic nature of such a description for contexts some of which are remote from the assumption of a well-knitted civil and political society. Corrupt controlling elites are not the same as states, even if they hold the symbols of office. The conditionality of sovereignty which is expressed in the rising international responsibility to protect the human rights of peoples against pathological governments is a principal result of the shame and shock at the world's failure to intervene and stop the Rwandan genocide a decade ago. This emerging norm of customary international law puts eager elites, keen to be corrupt, on warning; and not before time.

Once oil begins to flow, those countries may expect to be the recipients of a deluge of royalty income. The West African oil fields will certainly be entirely protected from the sea by Western navies and the operation conducted from sea-based platforms. But some think that, given the instabilities and difficulties for foreign companies in running a large-scale off-shore operation from on-shore bases in such volatile areas, the whole will need to be controlled from some reliable base on land, of which the only likely candidate is South Africa. So, in a strange way, the coming oil bonanza off-shore West Africa may have many of the characteristics of early European trade with that part of the world, which was conducted by supercargoes on ships off-shore, trading with local agents into the interior.

Strategic interest in sub-Saharan Africa is, therefore, assured. Huge increases in non-aid funding look highly likely; a challenge is thereby posed.

The problem is that if the political economy of the first type, which I have described, is not successfully adapted and stabilised before the arrival of the oil royalty bonanza, there is a danger that funding and political interest risk being like petrol poured onto flames. More precisely, what that means is that robust civil society needs to be grounded and nurtured along the West African littoral and the last of the Big Men of the 'liberation generation' (the generation of Mbeki, Mugabe and Nujoma) need by then to have been successfully survived and superseded, for this to occur. Only then can the patrimonial post-colonial state be replaced by something with greater likelihood of endurance.

With that responsive sort of political economy, genuinely responsive to the needs of people and, in this case particularly the multiplying number of HIV and AIDS sufferers, then a public health ethic of obligation, as described by

Baroness O'Neill, can begin to be fashioned. And if that can be done in time, then the coming oil boom could be salvation rather than its opposite.

South Africa is, for better or worse, the essential, indispensable test bed for all these propositions. Currently, as the tragedy of Zimbabwe moves rapidly to its *dénouement*, signalled most recently by Mugabe's decision to confiscate Anglo-American's sugar estates at Hippo Valley, President Mbeki will be forced to make up his mind. Does he continue to stand with his comrade from the years of joint exile and, through his continuing gnomic silence, appear to give tacit support to the deliberate destruction of what was once the second most successful economy and society in the region? Or will he stand up for the rights of expropriated South Africans – in this case the largest and single most important company in the South African economy? We shall see and, in the next few months, I expect it to become plainer how South African society will survive the tenure in power of Thabo Mbeki's generation of exiles.

Although nothing is to be taken for granted, I think we have good reason to hope that South Africa can survive this lesser test and, through it, be strengthened to survive its involuntarily chosen role as the site of the even more awful test which AIDS now poses in the coming 20 years. This is because South Africa has a depth of talent – of shared human capital – and of nascent common purpose, which transcends the eccentricities of any particular group of politicians – here today, gone tomorrow – as they occupy high office. It is the emergent common purpose and the human capital, which, joined to the rich infrastructure and the autonomous wealth of the country, mean that, if that common purpose can prevail in the continuing battle for the soul of the country against those who would follow the Zimbabwean road, South Africa will not only save itself but will provide that essential example to be exported northwards across the Limpopo to countries where the AIDS statistics suggest that they face problems even graver than those which will be encountered here.

Why do I have this confidence? If we are honest, in the end, it always comes down to personal experience. During my 1994 visit to the country to reopen the links of Cambridge University with universities here, I found myself one week-end with time on my hands in Cape Town. I rented a car and drove to the Cape of Good Hope to watch the clouds being formed where the Indian Ocean meets the Atlantic.

On my way back, I came upon a lady beside the road in her best Sunday dress and wearing an enormous hat, looking for a lift to Llandudno. My rental car was very small and she was rather large, but we managed to settle ourselves and, as we drove off, I said in a light-hearted tone, which I

immediately regretted, ‘You are rather late coming from church to-day, aren’t you?’ Gravely, she turned to me and replied, ‘Oh no, you see we have been praying for our beautiful South Africa.’ And we both promptly burst into tears.

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