Underreaction to AIDS in Sub-Saharan Africa

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Although the AIDS epidemic in sub-Saharan Africa is still in its early stages, it is already clear that it will be regarded in retrospect as the major health crisis of our time and one of the terrible epidemics of history. It is likely to prove to be different in the region from the epidemic in the world as a whole. While just over 9 percent of the world's population is in sub-Saharan Africa, around 55 percent of persons infected with the HIV virus are there. The proportion is probably 83 percent for seropositive women and possibly higher still for children.

The high numbers of infected women are the product of predominantly heterosexual transmission in the region which means that approximately equal numbers of the sexes have the disease. In some ways this renders the situation more difficult than in the gay communities of the West. First, there is poorer communication across the African gender divide than there is within the one-sex, relatively well educated gay community, and this is one reason - although only one - why defensive behavioral change is likely to be slower in Africa. Second, heterosexual transmission means that the disease has ramifying implications for almost every aspect of the family and society.

Those presenting 'worst case scenarios' have argued that the impact of the disease is unlikely to be Malthusian and that population projections for East, Middle and Southern Africa show natural increase falling no further than from the previously predicted 3.5 percent per annum to 1.5 percent (Feldman, 1989:3). However, even for this restricted region and with such levels being reached gradually, a decline in growth of this magnitude would imply over 100 million excess deaths in the region in a generation and over 150 million if AIDS spreads with equal ferocity to West Africa.

These are not scare-mongering figures. The data for Uganda are sufficiently secure, and the HIV latency period sufficiently long, for there to be little doubt that the death rate in that country a decade from now will not be the 11 per thousand which could otherwise have been achieved but close to 20 per thousand. Even if such margins are not reached in the whole of East, Middle and Southern Africa for a further 5 years, this implies by the middle of the first decade of the next century excess annual mortality of close to 5 million persons, and possibly 7 million if the disease spreads rapidly in West Africa. The full shorter-term disaster is unlikely to be avoided. The longer-term one may be modified in three ways. First, there may be a biomedical breakthrough producing effective vaccines in sufficient quantities and cheaply enough to cover the whole region, but few anticipate such discoveries taking place and allowing programs of this magnitude to be fully in place in less than 10-15 years, after which it would take another decade before the number of AIDS deaths began to decline. Second, there may be a massive behavioral change, but, except among small minority groups, this may be slow in coming, partly for reasons addressed in this article. Third, the epidemic may burn itself out (van de Walle and Palloni, 1987), but projections indicating this likelihood are not fully convincing - no more so than others that argue for oscillations in intensity.

Given this situation, the reaction to it is less than might be anticipated. This is true at the governmental and international levels but this is explicable and will be addressed briefly below. What is more complex, and more basic, is the subdued population response, which will be the focus of this article. Throughout much of the region observers have been surprised, and even impressed, at the way individuals, families and communities have accepted this new scourge without hysteria.

There are many worrying reactions. Outside the elite the disease is little discussed. The victims refuse to put into words what has afflicted them and family members refuse to say, or apparently to admit to themselves, what is wrong with their relatives. There is an acceptance of the disease, even of death from it, which has surprised many foreigners.

Uganda's most famous contemporary popular musician made a final tour on a visit from his home in Sweden while dying of AIDS, in order to tell people that he had the disease and to encourage others with it to speak up. Although he finally received permission to say so publicly in Kampala's Anglican cathedral, his model was not followed. Nyamwaya (1988:8) has written of Kenya: 'Usually any major, serious or just threatening occurrence is discussed freely in matatus (mini-bus type public service vehicles). Not so with AIDS. Discussion of the subject is minimal even among health personnel ... Discussion of AIDS is limited to researches and planners, administrators and politicians.' Schoepf (1988:631) reported of Zaire: 'The most common reaction to AIDS in Kinshasa appears to be a denial of risk ... They react casually, as though antibiotic injections could provide a cure, even though on another level they state that neither biomedicine nor folk healers can cure AIDS.' Hooper (1987) appeared to find a similar situation in a village on Lake Victoria in Uganda which he identified as having suffered more from AIDS than any other community on earth.

There is a problem here that almost certainly goes deeper than the largely oral discussion of it. The problem is likely to prove central to the battle against AIDS and must be identified and analyzed. This article is an attempt to begin that process.

More obvious reasons for the silence about AIDS

Before discussing more fundamental societal reactions to AIDS, there are good reasons for dealing with the more obvious ones. We do not wish to imply they are unreal or superficial, for some are important. Nevertheless, they are mostly fairly easily susceptible to change.

Governments, in a difficult situation, are sensitive to discussions which might imply that they have not done enough. On the other hand, 'It is not politically useful for a government to acknowledge the presence of a disease for which it can provide no useful treatment, much less a cure' (Fredland, 1988:3). Some, as in Kenya, fear the loss of tourist revenue if there is too much publicity. It could be said that many other governments, being unelected, are failing to respond to pressures from those they rule. The truth seems to be that they accurately reflect the lack of pressure from the ruled, and fear the charge that they have overreacted to AIDS and are intervening too forcibly in private and very personal matters. This is probably why so much of the interventional campaigns is aimed at captive school children and why the adult campaigns are media and poster events often with little impact. The sensitivity of African governments leads to foreign governments and international organizations being wary of offering too much assistance too soon.

The fragile data base leads to different estimates although it is not so deficient as to excuse some of the political claims that the danger is not really proven. African mortality estimates do not come from death registration systems but are derived from the employment of sophisticated analytical techniques, which are not understood in

government beyond a few professionals in the statistical office, on retrospective information about the survival of children gathered by sample surveys. (Even these methods are now being rendered inappropriate by AIDS because of an increasingly strong association between the deaths of children and their mothers in circumstances where surviving respondents are usually mothers or parents). The result is that there is no ongoing measure of the number of deaths occurring. Nor is there any national measure of the changing cause of death, for, in the whole region, only a very small percentage of deaths occurs in hospitals or under the care of a doctor while fewer still are subject to postmortem. In many countries the estimates of HIV levels come from relatively few sources and only a small fraction of those who die of AIDS are ever proven to have been seropositive. These sources often are atypical, such as STD clinic patients and blood donors, or they may come from two or three small and remote mission hospitals.

Furthermore, social consciousness is most affected by sickness and death. Because of a long latency period (typically 10 years) compared with that of sickness (typically less than one year), at least ten times as great, most infected persons are not sick. Added to this situation is the fact that the disease is still spreading, so that the ratio of asymptomatic persons to those with symptoms can be 40 or 50. So far, the AIDS deaths have been such a small part of all deaths that African leaders are prone to suspect the foreign expert of being an alarmist. In any case much of Africa has suffered and emotionally survived many disasters, warfare, drought-induced famine and other epidemics. In the age range most affected by AIDS, 20-40 years, death rates are 6-7 times the level found in industrialized countries, and many of those deaths have symptoms not easily distinguished from those of AIDS especially in communities where there is little exact knowledge about AIDS: it is, in fact, difficult to describe and the symptoms vary, and some illnesses with comparable symptoms are treatable. This is compounded by the fact that rural populations have low levels of education and usually regard AIDS as a disease of urban promiscuity. (Its levels are higher in urban areas but the much larger rural populations probably include the majority of infected persons). People feel, with some degree of logic, that there is no point in knowing that one has AIDS and no charity in telling others that they have it. Governments are tempted to adopt similar attitudes because economic difficulties have led to the health care systems being strained to breaking point without the potentially immense burden that AIDS could place on them.

Many members of the African elite believe that foreigners brought the disease to the country and that foreigners are now exaggerating the danger in the region, both because of a proneness to intellectual hysteria, arising from an overdeveloped academic and research sector, and because of a desire to put Africans down. Many prostitutes believe they are safe if they refuse European customers and that they are already cared for by arrangements with traditional healers which cover all occupational diseases and sometimes pregnancies as well (Orubuloye, Caldwell and Caldwell, 1990:18). Some men believe that AIDS can be contained by campaigns against women who might be likely to spread it. Many feel that the costs of avoiding the disease are too high. Wives do not like to suggest the use of condoms even to husbands with many outside sexual contacts, because it will imply that they themselves have other partners. 'Outside wives' (semi-permanent mistresses, usually of the urban elite) are in an even more difficult position in this regard. Poor prostitutes cannot afford to alienate customers (Schoepf, 1988:631). There is a belief in Middle Africa that semen gives a woman and her fetus strength (Taylor:1990), and, in any case, there remains a

strong suspicion against wives and daughters knowing of contraceptives or using them because the resulting feeling of safety from pregnancy may induce them to stray sexually (Caldwell, Caldwell and Quiggin, 1989:209).

Many ordinary people, especially men, have another reason for being suspicious of the motives behind, and hence the arguments for, campaigns against venereal diseases and AIDS. They believe that such campaigns are directed at destroying the pleasures of sex itself and arise from the puritanism of preachers, governments and foreigners, all obsessed by specific aspects of the Christian and Islamic messages. In addition there is a deep suspicion that foreigners are irritated that Africans are not like themselves, and they seize any opportunity to make Africans conform to Western norms (*cf.* Grmek, 1990, Ch. 15). The coalition of preachers, governments and foreigners is suspected of seizing on any rumor to further its cause. This was a major reason why in the 1990 Ekiti study so much persistent effort had to go into convincing individuals and communities that the investigators had no ulterior motives, that they were not officials but rather university researchers, and that the information would not be released to others to assist their campaign against sexual activity and attempts to identify miscreants. The problem was that some respondents already felt that religious, community and political leaders might wish to take legislative or other measures to change sexual behaviour and that their responses would be used to further a purpose with which they did not fully agree' (Orubuloye, Caldwell and Caldwell, 1990:2). It is true that evangelical preachers, who often draw thousands of listeners, are already employing the threat of AIDS to demonstrate that God has sent the disease to condemn sexual license. It is also true that the government's family planning advocacy can be interpreted as disapproval of excessive sexual activity.

A search for an underlying societal explanation for underreaction

The aim of this article is, then, the search for an explanation lying more deeply in African society for the relatively calm acceptance of the disease. Because the explanation is concerned with the nature of the society itself, the argument will often include references to the people with whom we have the most recent research experience, the Yoruba of Nigeria, especially the Ekiti District, even though the impact of AIDS there is as yet relatively slight.

The discussion will examine aspects of premodern society which is in many ways almost synonymous with traditional religion and its concepts of the causes of illness and their cure. Much has now changed. Christianity and Islam have continued their penetration of the region and have now enrolled around 90 percent of its inhabitants. Nevertheless, much of the old religion retains force, not because the conversions have been superficial but because each culture interprets the world religions in its own way, eclectically infusing them with preexisting values and interpretations. Indeed, the point that needs most emphasis is that these are very religious societies (*cf.* Omoyajawo, 1973:5; Kuukure, 1985:57), and religions, old and new, have played an important role in attitudes to illness and its cure. The high Gods often had a leader in the pantheon, easily identified with the Christian or Moslem God; ancestral spirits could easily be seen as operating from Heaven; the cosmic forces for good and evil manipulated by ancestral and other spirits, as well as sorcerers and witches, manipulated could as easily be interpreted as operating from God or the Devil as from their previously somewhat obscurer origins. Furthermore, a crisis was likely to sharpen the concept of evil forces. Maclean (1978:154) concluded from her study of illness and its treatment in Nigeria: 'Yorubas form over 90 percent of the Ibadan population and, although 65 percent would proclaim that they were Moslem while the remainder would profess

Christianity, traces of paganism still persist, with its connotations of Orisha [the minor Gods, often associated with individual lineages, that can protect individuals from misfortune, especially illness] worship, faith in divination [the identification of the source of misfortune, often sickness, usually with the aid of a specialist, the diviner], and a belief in witchcraft. The advent of serious illness or misfortune is especially liable to encourage a return to the traditional specialists and remedies which sustained generation of their forefathers'. In Ghana, Twumasi (1979:349) found continuing support in rural areas for much of the traditional explanation for illness and its prevention, but that the older system was being eroded in the towns. There is a question with regard to the rate of that erosion. Sargent (1989:42), working in 1976 in both a rural area and a provincial town in a predominantly Christian part of central Benin, found that while the entire rural population still believed in witches and *abiku* (spirit babies born to die), 80 percent of the urban population believed in the former and 91 percent in the latter.

In West Africa the adoption of a new religion was not a one-way process with missionaries casting out the old and replacing it with European Christianity. There are continuing changes with important implications for illness and its treatment. Syncretic African Christian millenarian and Pentecostal churches have grown in importance to a point where perhaps one-quarter of all Nigerians, and one half of the country's Christians, have at least some contact with them. Most of these churches teach faith-healing with the centrality of prayer in treatment, a message which is financially attractive during economic hard times when structural adjustment policies have often meant charging for treatment and medicines in government health facilities.

There are elements here which must be explored much further, but, in the effort to clear the ground first of other factors contributing to the silence over AIDS, there is one further matter that must be dealt with now that religious transition has been discussed.

Sex, shame and AIDS silence

There has long been nonmarital male sexual activity on a considerable scale in sub-Saharan Africa because of the problems of late male first marriage, necessary to make polygyny possible, and of lack of access to wives, because of long postpartum sexual abstinence (Caldwell, Caldwell and Orubuloye, 1990:4). This has also necessitated significant female nonmarital sexual activity. There has often been a rather pragmatic attitude toward sex which has enabled migrant Africans to fit more easily into modern industrialized societies than, for instance, South Asians. Sexual networking has made the society susceptible to AIDS.

It might, then, seem surprising to suggest that the region might be one of shame and silence with regard to sexual matters. Yet this is suggested. Nyamwaya (1988:8) has written: 'matters related to sexual behavior are rarely discussed in public in Kenya because sex is a taboo subject for most Kenyan cultures. In my view, this is the major reason why AIDS is not discussed openly.' Kisekka (1973:149) maintained that his own ethnic group, the Baganda, had always been secretive about sex, although he admittedly contrasted this with much of the rest of Africa. Beidelman (1968:117) reported of the Sudanese Nuer that there was no discussion of sexuality between kin because it was thought improper and hence was prohibited.

What seems to be true is that the discussion of sex is widely regarded as indecent between parents and children. Traditionally there has also been very little discussion between husband and wife and between kin. Both these conditions probably hold, together

with considerable male extramarital sexual activity and boasting among peers, in the real shame and honor cultures of the Mediterranean. Traditionally in Africa there seems to have been little male boasting, only the satisfaction of felt needs. In some societies, mothers knew of their daughters' activities, partly to protect them by admitting the names of their suitors if a birth proved difficult (Douglas, 1963:126). However, daughters are not told of their mothers' activities. The lack of communication on sexuality between spouses has created problems for family planning programs, and the ignorance of children about their forebears' sexual activities has rendered oral history on the subject impossible.

Silence was reinforced in other ways. Husbands were supposed to inflict physical punishment on straying wives, and sometimes on their lovers, and many preferred not to know what was going on. Wives knew that their husbands sought solace elsewhere during postpartum abstinence periods but preferred not to know about it, and certainly not to discuss it with husbands or their kin. Indeed there were strong social sanctions against the wife complaining, including the possibility that her jealousy could lead to her unconsciously performing acts of witchcraft.

In some ethnic groups, especially the strong patrilineal and patriarchal societies that Gluckman (1955) labelled 'father right' societies, such as the Zulu or Luo, there were very strong male attitudes against wives or daughters sexually straying and such acts were certainly regarded as immoral.

Islam reinforced such attitudes in a wide range of African societies. With the impact of Christianity, especially in much of Southern Africa and parts of East Africa where European types of church were less modified and absorbed into the preexisting cultures than was the case in West Africa, the situation was more complex. The silence about nonmarital sexual relations was often transformed into shame, usually without modifying sexual patterns except among small groups of great piety, sometimes, but not always, found among the elites.

The shame could be reinforced by speaking it. Bleek (1976) studied a rural town in the matrilineal area of Ghana and paid particular attention to one lineage some of whose members provided him with accommodation. Some of its girls practiced prostitution in the larger towns and in Accra and flaunted the wealth that they had gained in this way. Yet they misstated their relationships and their sexual activity. Bleek (1987) was later to conclude that what he now termed 'lies' were told by his respondents in order to save themselves from embarrassment and to gain respect. When they had to reply to the social scientist, they lied; in many other circumstances they would just have avoided the subject. In Ekiti and throughout the region, prostitutes hide their work and preserve their chances of marriage or remarriage in their home areas by working elsewhere, often among another ethnic group. They imply to their families and neighbors that they have an office or domestic job but very little discussion on this point ever takes place.

Much of AIDS-affected Africa is now convinced that there is a relationship between AIDS and illicit sex. Often women who have been infected by their husbands may be blamed, and may be thrown out in a moralistic way by their husbands if they are unfortunate enough to develop the symptoms first. Announcing AIDS victims in the family is like shouting their illicit sexuality to the world. Traditional and imported religions have combined to render this improper and indecent. There are some parallels, especially in parts of Southern and East Africa, to the situation described by Shorter (1990:4) in Western Europe during the late 18th and 19th century epidemic of gonorrhea and syphilis: 'Both men

and women seem to have reacted with an overwhelming sense of shame. For them, a venereally-transmitted infection was evidence of sin, and their main response was denial, in the form of not seeking treatment'.

Nevertheless, the very quotation from Shorter shows that we have not reached the heart of the explanation for the silence about AIDS in Africa. Gonorrhea and syphilis are discussed; men may boast that they have symptomatic discharges which prove their manhood (Bakare, 1990). AIDS strikes in some a chord of fear which is very different, while in others, or even the same people, it fails to produce those behavioral changes which might be anticipated. The basic explanations lie in interpretations of illness and predictions of life's end.

Is AIDS or is any illness necessarily predictable or mortal?¹

African society is changing rapidly, but, like all societies, it is an uneasy amalgam of its past and what it is becoming. In the area of health and reactions to AIDS it is important that the past should be understood. Traditional African religion and philosophies that explained the way the world worked were almost indistinguishable from their disease etiologies (Foster, 1976:773). There is no real distinction between good fortune and good health or between misfortune and illness. Both the latter are usually caused by gods, ancestral spirits, sorcerers, witches, magic, other spirits (mostly malevolent), curses or breaking oaths. This number of causative agents is not as confusing as might appear, for there is usually thought to be but one supranatural force, originating with the gods or ancestors or witches, which the various agents focus or block. The gods and ancestors cause illness to show disapproval or as a corrective chiding, while sorcerers or witches usually intend harm. It is to Evans-Pritchard (1931, 1937) that we owe the distinction between sorcerers, who are almost any men who can manipulate harmful forces, and witches, who are usually women with an innate and often unconscious power to convert bitter thoughts and malevolent wishes to destruction. Evans-Pritchard later, wrote of the Azande: 'The concept of witchcraft ... provides them with a natural philosophy by which the relations between men and unfortunate events are explained and a ready and stereotyped means of reacting to such events. Witchcraft beliefs also embrace a system of values which regulate human values' (Evans-Pritchard, 1937:63). In most African societies, and perhaps the Azande too, this description should be transposed to the whole traditional belief system, of which witchcraft was a part. The major elements of this system were found across the continent with the qualification that witchcraft emanating from a specific class of persons is not universal (Murdock, Wilson and Frederick, 1978:468-9) - but, in any case, its effects are indistinguishable from sorcery.

This means that Africa has always been mainly concerned with the antecedents of misfortune and how the disaster could have been avoided and might now be reduced (Gluckman, 1955:84). Those who can shed light on the matter and suggest a new course of

1 This section has drawn especially on Arhem, 1989; Bascom, 1969; Bauer and Hinnant, 1987; Dawson, 1979; Evans-Pritchard, 1931, 1937; Fortes, 1949; Fortes and Dieterlen, 1965; Foster, 1976; Gluckman, 1955; Goody, 1962; Harwood, 1970; Idowu, 1962; Janzen and Feierman, 1979; Kokot, 1981, 1982; Leeson and Frankenberg, 1977; Maclean, 1976, 1978; Marwick, 1970; Mbiti, 1989; Middleton, 1967; Mitchell, 1965; Morton-Williams, 1960; Murdock, Wilson and Frederick, 1978; Nadel, 1952; Opoku, 1987; Prince, 1964; Quinn, 1968; Sindzingre, 1985; Sodipo, 1973; Vecsey, 1983; Westerlund, 1989; Wyllie, 1983.

action are the diviners. Horton (1967:53) wrote that diviners both identify the causes of disease and then put it into its worldly context: 'it is usual for him to add something about the human hatreds, jealousies and misdeeds that have brought such [supernatural] agencies into play ... Through the length and breadth of the African continent, sick or afflicted persons go to consult diviners as to the cause of their troubles'. Diviners may play a role in healing or this may be largely up to the individual and his kin. When healers struggle with witchcraft and other occult forces, they too may be harmed (Sindzingre, 1985:47). Nevertheless, some illnesses have always been so trivial as to be accidental or largely natural in the sense that the causative agent is unlikely to intervene again if an appropriately skilled person cures the symptoms.

The Yoruba have always taken protection from death very seriously (*cf.* Morton-Williams, 1960; Idowu, 1962:78; Prince, 1964; Bascom, 1969:70-1) Maclean, 1978; Buckley, 1985. They employ a class of diviners, Ifa diviners or *babalawos*, who pick up and throw palm nuts or other appropriate objects for guidance in selecting appropriate mystical verses for identifying the true nature of a disorder and its causes. The diviners practice herbalism but there is also a separate herbalist profession or *oniseguns*. There are also minor deities, or *orisas*, usually specifically associated with lineages and whose cults can give added protection. Sodipo (1973:16-19) argues that the Yoruba attitude to health cannot be understood except as part of a broader philosophy of events largely outside human control: 'when I questioned ten people whose views I believe still reflect the Yoruba traditional outlook how they would explain a situation in which of two competitors one won a house or a chest of gold through the toss of a coin, nine answered that the Gods or God must have ruled in his favour. The tenth said, "it was just luck";' Accordingly, 'the lorry driver knows he will have an accident if his brakes fail while he is driving at high speed, but his question is why did his brakes fail just at that time.'

This system is in disarray as the imported religions mold yet another African world view. Yet it has important elements which continue to play a role in the new belief systems, and almost entirely explain some of the reactions to AIDS.

It offered explanations at several levels. People did die because of accidents, snake bites or yellow fever, but the cause and timing of their deaths were also due to some activities in the other world or the actions of persons in this world who could employ these forces. Only the very young and the very old die of natural causes alone; all other deaths are engineered. Thus herbalists can employ worldly medicines and there has been little religious or philosophic conflict in expanding the pharmacopeia to include modern medicine. Where that treatment was effective, it proved that these were largely 'natural' disorders and preexisting classificatory borders moved under the influence both of this proof and of an increasingly more educated and urbanized population (*cf.* Janzen and Feierman, 1979 on Africa's pluralistic attitude to medicine). Wyllie (1983:49-51) reports that in the Ghanaian coastal town of Winneba, spiritual and traditional 'healers ... did not view most illnesses as being exclusively spiritual or exclusively natural in causation', although nearly half believed that malaria and gonhorrea were naturally caused, probably because they are demonstrably curable by modern medicine.

Yet, it is precisely this pluralism which is of relevance to the discussion of the reaction to AIDS for two related reasons.

The first is that it argues that nothing is strictly incurable. Even if traditional or modern medicines are ineffective, there is still hope for there is no need to cure the disease if the

ultimate agents causing it to manifest itself in the first place can be appeased. Conversely, no one need fear the disease if he or she has not provoked or unconsciously disturbed such forces.

The second reason is that it is precisely the overwhelming nastiness of AIDS, its reputed incurability and its mysterious way of announcing itself that are likely to identify it as something more than natural even among those who retain little belief in traditional religion. Ayode (1979:49) wrote that the very fact that healers of this world had pronounced a medical condition incurable was, among the Yoruba, but another way of identifying it as being of divine origin. Horton (1970:142-3) noted the contemporary social scientist is dealing with people for whom 'commonsense is the handier and more economical tool for coping with a wide range of circumstances in everyday life. Nevertheless, there are certain circumstances that can only be coped with in terms of a wider causal vision than commonsense provides. And in these circumstances there is a jump to theoretical thinking [i.e. to either the traditional religious explanations or these fused with Christianity]'. Significantly, his example of such a jump (in a discussion not of illness but of thought), drawn from research in the Niger delta, was when sickness is incurable, unusual or frightening. Maclean (1978:154) reported of Ibadan that it was the serious or incurable illnesses that caused people there to return to older beliefs. Schoepf (1988:631) wrote of contemporary Kinshasa, 'That ultimate causes are occult does not mean that people reject biological causality ... However, when biomedicine fails, people want to know why a specific person was attacked by the ... [AIDS] virus.'

Nyamwaya (1988:8) has written of AIDS in Kenya that 'the lay view is that it is a mystical infliction brought about by God or some other mystical force as a punishment for moral degradation especially among the so-called "modern" people living in the towns. This view seems to have pervaded the whole of Kenyan society'. One of the problems with AIDS is that it has no obvious specific symptoms except an ominous and mysterious wasting and weakening. Nadel (1952:19), reporting the beliefs of the Nupe and Gwari of Nigeria half a century ago, described witchcraft 'as destroying life, mainly through mysterious wasting diseases ... implying the power of witches to "eat" the "life-soul" of the victim.' Indeed, the Lugbara of the Uganda-Zaire border, an area now badly affected by AIDS, believe that not only the bewitched but the witches themselves are identifiable by symptoms hardly separable from AIDS (Middleton, 1967:65). In East Africa the disease is identified with wasting and is widely called 'slim'. In Ekiti, and throughout West Africa, unusual thinness is associated with not only the victims of witchcraft but also the witches themselves. The Yoruba have long seen a direct relation between witchcraft and carnality, sexuality and prostitution, the common link being, of course, females (Hoch-Smith, 1978).

The fear that AIDS might be caused by witchcraft or sorcery may easily lead people in affected areas not merely to ignore and fail to discuss it but to censor it in their own minds. These are dangerous forces wielded by dangerous people, and any sensible person avoids such things. Schoepf (1988:631) again reported of Kinshasa: 'Since incurable diseases ultimately tend to be categorized as socially or supernaturally caused, people have an added incentive to push the fatal outcome of AIDS from their minds. The process of finding a sorcerer is well-known, unpleasant and threatening to many'. These are very real problems as was shown by two related studies carried out in Nigeria's Ondo State in 1990 (Orubuloye, 1991:24-25). When questioned about the classic venereal diseases, which the respondents knew well, 16 percent of persons in the Ekiti study and 46 percent in the Owo

study reported that the primary cause was divine or supernatural. With regard to AIDS, still known only from newspaper reports, the levels fell to 8 and 26 percent respectively, but will almost certainly rise when the first victims are encountered.

Shorter (1990) identified neurosyphilis in Europe at the turn of the present century as perhaps the nearest parallel to AIDS in that it inexorably killed within two to three years of symptoms appearing, was at first of unknown origin, and disproportionately killed the elites. Yet its scale was small, contact with the sufferers did not frighten people and people were not silent. The fourteenth century Black Death might have been a closer European parallel. Almost certainly the best recent parallel in Africa is smallpox.

Maclean (1976:304-5), writing of Ibadan in the mid-1960s, and describing the major 1957 smallpox epidemic, reported: 'smallpox ... is preeminently the disease which arouses most alarm in the majority of the Yoruba... It is still widely believed to be brought upon the community by the God Shopanna [Soponna], who is also the source of madness, and many people were most reluctant to discuss in detail such a dangerous subject for fear of attracting the unwelcome attention of the deity'. Later, she wrote (1978:157): 'Many refused to use the Yoruba name, Shopanna or Sakpata, of the awesome god of smallpox.' Idowu (1962:95ff) said that, when a Yoruba has smallpox, 'he is under bondage to the king [Soponna]'. He emphasized that the disease was as likely to be a scourging of the community as a specific attack on the individual. There are, of course, defenses. 'At the prospect of warfare or during pestilence ... men perform a rite (Oro) from which women are strictly excluded, summoning the ancestors collectively to drive witchcraft from their town' (Morton-Williams, 1960:37-38). Transitional society also had other, possibly parallel, reactions. Maclean (1978:305) reported that one-third of the sufferers in the 1957 Ibadan epidemic sought modern medical help. However, Morgan (1969) cross-questioned those being vaccinated in the highly successful campaign against the disease in Lagos in the 1960s, and concluded that nearly all regarded smallpox as having divine origins but believed that the treatment, especially its scar, might prove helpful as a supplication or a shield.

Maclean (1978:158) also added that half the population turned to traditional methods, including offerings (particularly of cooked beans and corn), meanwhile hiding the ill from authorities in compounds and even churches in case they were forced to adopt alternative courses. Quinn (1968) has provided a very similar picture, in nearly all its details, of smallpox in Dahomey (now Benin). Imperato and Traore (1968:227), studying smallpox in rural Mali, reported: 'Obvious objective evidence of the contagious nature of the disease is not attributed to an infectious agent. The contact who falls ill with smallpox does so in the eyes of his fellow villagers, not because of association with a known case, but because of the ever-present remote supernatural cause. At the same time, the contact who, by chance, does not fall ill with smallpox, even after sufficient association with an infectious individual, is strong living evidence supporting belief in a spiritual cause'.

The parallels between smallpox and AIDS are quite striking. Both are deadly and affect whole communities convincing even those who are largely separated from traditional society that forces beyond those of this world might be operating, even if worldly defenses are also adopted. In both cases this possibility - or likelihood - renders much of the population silent. It also causes many to turn to traditional health or religious persons of power or authority.

There is among the Yoruba an important related concept, which has easily been absorbed into Christianity and even given a greater precision (*cf* Akiwowo, 1988). There is a

belief in the struggle between good (*Ire*) and evil (*Ibi*) forces which have coexisted at all times. Death is evil and so is smallpox, while AIDS will inevitably be defined that way. Because of the strength of the evil forces, people are reluctant either to speak the names of death and smallpox or to talk about their occurrence. The same attitude will be taken to AIDS. The ignoring of smallpox was facilitated by removing sufferers to distant lonely farms.

Fertility is so central to traditional African religion and thought that diseases that threatened it or were associated with the reproductive organs belonged to a special category. Westerlund (1989:197) concluded from his survey of African culture and health that witches were feared because they caused misfortune and illness, and specifically reproductive complaints. Certainly, evidence is very strong that even in contemporary Africa these are the diseases that are most likely to be regarded as the province of traditional rather than modern medicine. Maclean (1978:158) noted of the Yoruba in Ibadan: 'Among the other conditions [in addition to conditions which were obviously due to witchcraft, presumably because of such symptoms as wasting] quoted as being unsuitable for hospital treatment were impotence, barrenness, swollen testicles, gonorrhoea and disorders of menstruation - all of them related to the reproductive system whose correct functioning was the centre of universal concern.' In a study of patients in Lusaka, Zambia, Leeson and Frankenberg (1977) found that, although two-thirds of ill persons now go first to modern doctors, certain complaints, described as genito-urinary diseases and especially infertility, are still predominantly the province of traditional healers.

This association of sexually transmitted diseases with indigenous medicine has two implications with regard to AIDS. First, such venereal diseases as gonorrhea, syphilis, chancroid, chlamydia and herpes, which may cause lesions or ulcers and so facilitate HIV transmission, may remain longer uncured. It is quite possible that Christianity and Islam have reinforced the tendency to employ traditional practitioners for sexually transmitted diseases in that those affected may feel that there is greater secrecy in going to them than to health centers, hospitals or doctors. These practitioners may also feel a greater empathy for their patients' sexual activities. Secondly, government publicity is convincing people that HIV infection is itself a sexual disease. This fact was at first no more obvious to African villagers than neurosyphilis was to Europeans (Shorter, 1990), but in each case the message was ultimately convincing. Thus the tendency to believe that indigenous medicine may have a solution to a problem even when modern medicine denies any solution, or especially when there is such a denial, is reinforced.

What puts AIDS into a special category is its variable and not easily defined nature and its characteristic wasting. This is in some ways reinforced by scientific and governmental advice as to how long and secretly it works its harm. Africa has long described such ailments and they are the most likely of all to be regarded as not being of completely natural or biological origin. AIDS's most recent Western historian Grmek (1990:x) describes it in a way that would certainly strike a chord across Africa: 'a disorder without its own specific symptoms; marked only by invisible, subcellular lesions; and induced by an agent undetectable before the most recent analytical methods.' Morton-Williams (1960:36) wrote of the Yoruba, 'A victim may succumb to more slowly acting forms of death through witchcraft or sorcery; but the fear aroused by a sign of the attack may be enough to prompt the victim ... to perform placatory acts - perhaps ritual, perhaps giving gifts to those whose hostility he thinks he has aroused.'

This association of AIDS or 'slim' with wasting has other implications. There is a widespread belief that people who have not lost weight cannot be infectious (Nyamwaya, 1988:8) and, among men, that plump women are safe (Schoepf, 1988:633). On the other hand, as the symptoms are stressed, some persons with persistent diarrhea and others with the older venereal diseases, become convinced that they are HIV-infected (Hooper, 1987:472).

The belief that modern medicine does not know everything and that indigenous medicine may at any time produce a solution, either because it is an alternative medical system or because it is in addition tapped into other and more powerful forces, is strongly reinforced by the media. Nigerian newspapers report every few days that somewhere in the continent a herbalist has made a decisive breakthrough in the cure of AIDS, and quite commonly that, somewhere in the region's laboratories, modern science has done so. No reader is left with the impression that a person catching a disease with an average latent period extending beyond a decade would be left without hope. A Ghana Ministry of Health (1986) film, with various excellent features, nevertheless carries the message that indigenous medical cures may already exist.

What of destiny?

The issues we have already discussed explain much of the silence with regard to AIDS. There may well be another issue, however, certainly in West Africa and probably beyond, that is at least as important in explaining the apparent acceptance of AIDS and a certain disregard or even recklessness in attitude to it. This is predestination, but it is a complex area which requires some explanation.

Bascom (1951), although addressing principally the question of social status and wealth among the Yoruba, held that they believed that not only these achievements but most other aspects of life were outside the control of individuals.

A person's luck and his success in economic and other affairs is ... a matter of destiny (ayanmope, ayanmo) or fate (iwa) [better translated as 'character'], which is also known as 'to kneel and choose' (akunleyan). Before a child is born its soul is said to kneel (kunle) before the deity Olodumare and choose (yan) its fate on earth. Those who humbly make reasonable requests for food, money or children receive what they ask during their life on earth. However those who make their requests as if they had the right to expect what they wanted, do not receive them. Thus those who say indifferently or in an independent manner, 'You may give me money', or 'You may give me food', receive neither. A person whose destiny on earth is poverty may be able to acquire some money by working hard, but he will never have very much. Diviners of various kinds, especially the babalawo or priests of Ifa, are consulted to find out what is in store for the future and what can be done to avert evil or insure a favorable outcome. An individual may go to such a diviner as an adult to find out how his life will be or what kind of career he should follow in order to prosper; but while the diviners may be able to recommend sacrifices (ebo) which will influence events in the immediate future, they cannot alter the course of one's life or change his destiny (Bascom, 1951:492).

This passage makes no specific reference to the span of life, but later Bascom (1969:72) wrote that mortality was the most immutable of all: 'The day of one's death can never be postponed, but other aspects of one's destiny can be modified by human acts and by

superhuman beings and forces.' Maclean (1978:158) found this in her study of illness and its treatment in Ibadan city: 'In the course of answering, many people expressed the sentiment that, if it was one's fate to die, no treatment would avail.'

This belief in destiny, especially with regard to death, was held by Fortes (1983) to be general in West Africa. It meant that an individual's behavior could do little to endanger or protect him: 'the notion of Prenatal Destiny serves as a legitimate alibi. It relieves the sufferer's kin, and therefore society at large, of responsibility and guilt for his troubles and, indeed, exonerates him in his own eyes ... he is not [even] aware that he is the victim of his Prenatal Destiny until this is revealed by a Diviner.' Opoku (1978:100) reported that 'There is a general belief among West African peoples that man has a destiny which he receives from God which is largely unchangeable'. He also reported many Akan (the Ashanti and related peoples of Ghana) proverbs of which the following is typical: 'If God does not decree your death, you do not die.' He added that the usual Akan view is that the whole of life and manner of death are fixed before birth. A very similar picture emerges from Herskovits's study of religion and fate in Dahomey (1938:vol. 2, 101-308). Fortes (1983) reported of the Tallensi of northern Ghana that the baby before birth, or possibly before conception, makes its desires concrete as its Spoken Destiny. It might declare its will to die and get away from the earth, or a woman might choose an evil Spoken Destiny and decide to be barren. It is striking how close these beliefs are to those of the Yoruba who traditionally held the concept of the *abiku* or baby who did not intend to remain in this world (cf Soyinka's poem (1967:28-30), and of the sinfulness of the barren woman who had made a compact before her birth with evil spirits that she would bear no children in this world, or kill them in her womb.

Given the present geographical spread of AIDS, an important question is whether this strong concept of the preordained timing of disease and death extends also to the other regions of sub-Saharan Africa. Fortes (1983:7) believed that it was predominantly West African. However, Westerlund (1989:197) appears to conclude that it was more general. Moore (1968:57) concluded from his study of 'the imagery of death in African poetry' that a message found everywhere is that 'Death is not an arbitrary event. It comes only at its proper time, whether it strikes young or old'.

Moving first east and then south, we might note that in Zaire, a plumber explained of AIDS to Schoepf (1988:633) that one was either fated to get it and die or not. Among the Lugbara on the Zaire-Uganda border, Middleton (1967:63) reported: 'An unexpected sickness is usually due to the action of poison; but, if it leads to death, people say, "if God did not want him to die, why should a man offer him poison and why should he accept it?".' Okot (1971:159) noted specifically that the Luo of Kenya had a concept of predestination but that it was weaker than that held by the Yoruba. Among the Maasai of Tanzania and Kenya, 'Disease ... is beyond comprehension, since no man can predict the action of God' (Arhem, 1989:80). Finally, the Tswana of Botswana believe that sickness and death may be destiny or the will of God (Instad, 1989:252-3). It appears likely that the concept of a preordained time of death is weaker outside West Africa and is more closely related to divine decisions arising from the continual monitoring of behavior.

But is fate inexorable, even in West Africa - indeed, even among the Yoruba? Moore (1968:57), analyzing the common elements of poetry in the whole of sub-Saharan Africa, decided that the message was that death 'can also be divined, explained or even averted by those who know and follow the proper rituals for doing this'. Opoku (1978:102) reported that most West Africans believe that predestination can be modified: 'This paradox betrays the

West African's recognition of the limit of human understanding. For what happens to a man cannot be explained with any degree of finality; it may be his destiny; [but] it may be the working of evil forces, or what he has brought upon himself.' Among the Yoruba, Bascom (1969:72) reported that, although death could not be postponed it could come prematurely. Morton-Williams (1960:34) wrote that much of Yoruba activity was aimed at presenting that prematurity: 'In the Yoruba view, while the death of the aged is to be expected, the moment of death and its immediate cause are contrived. The death of the young is horrifying, an unnatural calamity, and always due to till will ... Early death so offends that it is hidden [by having no ceremonies] from society at large.'

Death, then, in West Africa is largely preordained. When it is premature, and most deaths before extreme old age are premature, it is not by the act of gods but because of human malevolence. It is murder. Goody (1962:208:9) wrote of the LoDagaa of northern Ghana, 'Most deaths ... are viewed as cases of homicide'. In Zaire, 'the vast majority of deaths among the Luba are said to be the result of witches, or by curses cast by those who might not be active sorcerers but who still possess maleficent powers' (Vecsey, 1983:28). In East and Southern Africa decisions on mortality are more likely to be made by God, increasingly the Christian God. What is clear is that biomedicine is not credited in either region with playing the sole, or even major role in postponing premature death.

There is another element which is glimpsed but not so often described. The fortunate person, the one predestined to flourish and not to die for a long while, unconsciously displays his or her good fortune in every action. Healthy persons with everything going for them are hardly likely to be infected with AIDS. But such persons will have an active, and probably varied, sex life, which will in turn both sustain and demonstrate that strong vital force (Caldwell, Caldwell and Quiggin, 1989:225). The person who falters and worries about infection and AIDS has already shown evidence of vulnerability to attack. Sodipo (1973:13) wrote of the Yoruba, 'If a man is destined to be lucky, his affairs usually prosper', and Schoepf (1988:631) of Kinshasa, 'Many find it difficult to imagine that healthy people who are now carrying occult HIV infection may die within the next ten years'.

Attitudes to death

One aspect of the whole reaction to AIDS, even in the areas most affected, has been not only an underreaction to danger but an extraordinary stoicism about death. This is not merely the effect of a belief in predestination or of Christianity, but, at least partly, something deeper. There is a strong belief in survival after death in one form or another.

One form is that of ancestral spirits, who are held to be as much a social as a theological fact and whose survival has proved to be compatible with holding Christian or Moslem beliefs. Opoku (1987:11) wrote of the whole region, 'The survival of a part of man after death is a certainty that is not doubted, and is a stark reality', and, again (p.13), 'Because the dead continue to live, communication with them is possible; and there are culturally accepted ways of maintaining the relationship between the living and the dead'. Vecsey (1983:37) reported of the Luba of Zaire, 'the ancestors reconcile the immortality humans once had with the mortality which is their present condition. In effect, the ancestors are immortal mortals ... the existence of a persisting vital force after death'. Talbot (1926:298) has written of the Yoruba and closely related people in southern Nigeria, 'to him the dead are not dead but living'.

The survival of ancestral spirits and the nature of that survival is extraordinarily uniform in the belief systems across the region (Fortes and Dieterlen, 1965:16-20; Opoku, 1987:10-13;

Mbiti, 1989:151-152). The dead survive but it is a difficult journey and the living must play a role in terms of the necessary rituals if the transition is to be successfully completed (Kuukure, 1985:128-129). Indeed, among the Yoruba, if one spouse causes the other's death, the result will be a restless spirit seeking revenge (Ward, 1938:91). These spirits, at least in a conscious state, are not immortal, but fade after several generations when the living can no longer remember them (*cf* on the Kikuyu and Meru of Kenya, Kihara, 1985:9). Ancestors remember their descendants and intervene in their lives; They do not retain their specific personalities but gravitate toward a general ancestral personality, so that even the most amiable and helpful will become judgemental and punitive (Fortes and Dieterlen, 1965:134-135). Ancestors may even become a kind of 'group mind'.

Death, then, in the words of Mbiti (1989:152) is a departure but not an annihilation. Africans, whether still adherents of traditional religions or followers of the new religions, probably believe more strongly than any other society in personal survival after death. That security almost certainly makes it easier to face death. Nevertheless, that ease is qualified by the fact that death, even immediately, involves some transformation and in the end forgetfulness and forgottenness. It seems likely Christianity has absorbed the ancestors and rendered them more enduring in both personality and survival. The Yoruba have a solution to this problem, as summarized by Morton-Williams (1960:36):

They ... know they will become grouped with the ancestral spirits of lineage and town, whose intervention will be invited from time to time by their survivors. But one of the spurs to success ... is the desire to be commemorated as an individual. This is achieved through an egungun. The egungun rite is a masquerade performed by male members of the egungun cult in order to make visible the ancestral spirits and to command their power. A prominent man, provided he has lineal descendants, may hope to have an egungun mask bearing his name, and to have songs sung in his praise while the egungun parades the town.

There is, however, a more concrete form of survival in the form of reincarnation which might seem somewhat at odds with spirit survival, although, at least among the Yoruba, the ancestral spirit can retain that status even though a form of it is also reincarnated (*cf* Awolalu, 1979:60). Opoku (1987:15) claims that, from West Africa to Zululand, there is a belief in reincarnation. One of the six common themes on mortality found by Moore (1968:57) in African poetry was that 'The dead can be reborn among us. Such rebirth is often recognized in the naming of a child'. Indeed the Yoruba bear many names to attest this: *Iyabo*: mother returns; *Yetunde*: mother comes back a second time; *Babatunde*: father has come again; *Omotunde*: the child has come back again; *Omodeinde*: the child has turned back and is here; *Babajide*: father wakes up and is here; *Babatunji*: father wakes up again. Similar lists can be compiled for the Ewe (Opoku, 1987:15) and many other groups. Morton-Williams (1960:36) reported that the belief in reincarnation brought reassurance to the aged, and perhaps a greater degree of certainty about the course of life to the younger. The rebirth is often within the same family and almost always within the same patrilineal clan. In Zambia, divination is employed to identify the ancestor who is being reborn so that the child can be given an appropriate name (Stefaniszy, 1954:131-132). This underscores the point that reincarnation involves a greater transformation than even survival as an ancestral spirit, for the ancestors' memory does not survive into the child.

Survival after death in the form of an ancestral spirit or a descendant's rebirth is problematic: it may involve change in personality and either diminution or destruction of

the individual memory. Nevertheless, it is so certain both in the traditional religion and in the new religions transfused with traditional certainties on this point, that death is not regarded as an end.

Pulling the themes together

The underreaction to AIDS in Africa is an extremely serious matter and will almost certainly delay an adequate response to the disaster. Underreaction among the population as a whole affects governments; it makes it less urgent for them to do things they are reluctant to do and that will call for greater resources than are readily available. Underreaction by governments means that ordinary people have their doubts reinforced about just how serious the situation is. Powerful and educated people clearly do not completely identify themselves with the official messages.

There is both skepticism and defensiveness at governmental levels and among the common people. These are not new reactions. Both occurred among the 'gay' community in the West (Grmek, 1990:40) in a rather similar way. They believed that the 'straight establishment' was once again trying to show that they and their way of life were inferior, and were attempting to employ half proven scientific mumbo jumbo to change that way of life. The problem was that, although the science was better than had been charged, its implications were that, at the existing level of medical capability, there was little alternative but to urge some change in lifestyle.

African society and its belief systems have probably been changing more rapidly than is the case for any other major society. However, those changes have not meant wholesale jettisoning of the past, for much was compatible with the new. Mbiti (1989:268), assessing the situation from the stance of an East African who has become both a Christian pastor and an academic theologian, has recently written, 'Beliefs connected with magic, witchcraft, the spirits and the living-dead are areas of traditional religions which are in no danger of an immediate abandonment'. In the meeting of traditional religion with Christianity, the survival of ancestral spirits could be translated into the passing into Heaven - indeed with a longer period of survival and the persistence of greater individuality; malevolent forces easily became evil and the work of the Devil; and preordained destiny fitted in well with the element of predestination in Protestantism.

What is even more pertinent is the fact that much of Africa is still in a theological and philosophic transitional state. People have not completely embraced modern science and hence are not absolutely convinced by the scientist's assurance that he knows that AIDS is certainly not curable. Most have not lost all faith in traditional medicine and rituals, and, when medicine cannot offer a cure for AIDS, few would willingly relinquish the hope that the indigenous system may come up with something. Most feel the presence of immanent evil more strongly than does the contemporary secularized West, and even the West has been shocked by AIDS to the point where there is a temptation to treat it as something qualitatively different from other deadly diseases.

African skepticism is partly driven by the enormous problems of doing anything about the disease at short notice. The health and other supporting governmental systems lack the strength. More seriously, its predominantly heterosexual transmission means that the culture as a whole is being asked to make fundamental changes. These are probably more difficult changes than were demanded of the Western gay communities where many probably had a strong temptation toward safer sex and even a greater degree of monogamy than was encouraged by the ideological stances of the 1970s. There is in much of sub-

Saharan Africa some gap between sex as it is practiced and sex as it is discussed. Islam and Christianity have compounded that problem and deepened the silence.

These qualifications are all true but are also in some ways superficial. The most fundamental reason why the great majority of Africans are more sanguine than might have been predicted with regard to the AIDS epidemic is that they are not fully convinced that biomedical determinism is the only force operating in the world. Western Christians might argue that their religion too offers multiple causation, but they do not act as if this were so. The more complex African attitude toward illness and death rests on two partly related complexes of belief. The first is that there are different levels of causation. One is certainly the 'natural' biomedical one, but this is triggered by other forces, chiding, punitive or malevolent. The natural cause can be checked and reversed if the underlying force can be identified and appeased. The other is the belief in destiny, stronger in West Africa than in the East and South but probably not nonexistent in the latter areas. This, in its most extreme form, holds that the date of death is written and changes in lifestyle will not put off that event. The situation, even in most of West Africa, is usually more complex than this because of the concept of the employment of evil forces to cause premature death and the consequent need to identify this danger and take remedial action. AIDS can, and almost always does, result in premature death in that it occurs before old age, but such deaths predating the prescribed time are never solely biomedical. The HIV virus is merely the instrument.

Finally, the question of silence. Some of it arises from the belief that the disease is sexual and sinful in origin, and some of it from the impossibility of making the family adjustments which would be necessary if its control were to be maximized. Nevertheless, the depth of the silence almost certainly is partly because the incurability of the disease and the prematurity of death show that evil forces are operating. Furthermore, the inevitability of death and the wasting and other distressing aspects of the final stages of the disease tend to demonstrate that these forces are malevolent rather than chiding and corrective. Clearly witchcraft and sorcery are overwhelmingly likely to be at work. People are frightened of the presence of such overt evil, and are likely both to keep their distance and to shrink from pronouncing its name.

Many Africans do not believe that the HIV virus is the sole cause of AIDS death and most are not completely convinced that no indigenous or biomedical cure exists or will soon be found. These facts, combined with a reluctance to discuss the disease, mean that little pressure is put on African governments to move faster to contain the epidemic. The governments in turn have their own reasons for not wishing to move faster. They fear provoking a crisis situation in their countries, and they know they have insufficient resources to meet such a crisis. They are far from convinced that anything they could do would change the situation. They believe that the West and international organizations are singling out Africa. Not all leaders and officials are convinced that AIDS is not, or will not soon be, curable.

The result is that, in their turn, most African governments are failing to put enough pressure on governments in industrialized countries or on international organizations to obtain the funds, the expertise or the changes in advocated policies that will be needed to avert a disaster of such magnitude that it will dominate the history of our era. Clearly the advocated policy that must go first is the linking of health services to economic structural adjustment policies. AIDS in Africa is already on such a scale that we must beg persons to

accept free health services and advice, not discourage them or turn them away. Not only will those services, both when they treat AIDS and other sexually transmitted diseases and also when they deal with health more generally, have to be vastly augmented but they will need a great deal of external aid toward this end (*cf* Caldwell, 1991). This will help convince African governments that help is needed, that the right kind will be given, and that African priorities, sensitivities and culture will be respected.

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