

In 1982, in Oxford, Dr Harold Jaffe, a senior investigator from the Centers for Disease Control (CDC) in Atlanta presented a cluster of cases of homosexual men who were engaged in risky sexual behaviour, who had all the features of Acquired Immune Deficiency Syndrome (AIDS). At this stage the Human Immunodeficiency Virus (HIV) had not been isolated or identified yet but AIDS, as a syndrome, had been described a year earlier by the CDC. At this meeting I remarked that "This syndrome may be more common in Africa than it is appreciated". I made this premature, but predictive, remark for the following reasons: as a medical student at King Edward Hospital in the years 1973 to 1976 I had seen several young, male patients with Kaposi's Sarcoma and I knew homosexual behaviour was being practised within African communities but always denied or suppressed. In rural Sekhukhune, for example, we always heard of the practice of 'matanyola' (sexual practice between men) and we also heard of men who engaged in this practice, particularly in prisons. In KwaZulu-Natal I also came to know of 'isitabane', a Zulu word for homosexual practice.

However, when AIDS was first wrongly linked to homosexual practice many Africans promoted the notion that homosexual practices were 'unAfrican', thus sowing the seeds for denial to justify why AIDS would not be prevalent in their communities. This denial predictably became the first African public response to AIDS and swept across the continent as country after country became engulfed in the HIV/AIDS epidemic. Today, despite many documented cases of homosexual practice in Africa, this denial continues. The AIDS denial was later compounded by stigmatisation, chauvinism, the distortion of scientific information and ignorance.

In 1985, actor Rock Hudson died of AIDS. Much later Freddie Mercury of Queen and Rudolf Nureyev (the Russian ballet dancer) also died of AIDS. In the 1990s, tennis player, Arthur Ashe died of AIDS after a transfusion of HIV-infected blood. Noerine Kaleeba, Director of the AIDS Support Organisation in Uganda lost her husband Chris through AIDS; former Zambian President, Kenneth Kaunda lost his son through AIDS and Fela Kuti, world-renowned Nigerian musician and political activist died from AIDS. At the same time, many thousands of nameless people were dying from AIDS through heterosexual transmission. One name, Nkosi Johnson, became well known through his brave campaign after he became infected through mother-to-child transmission. I point out this history to illustrate that HIV/AIDS knows no boundaries of class, status, race or sexual preference. Both the powerful and powerless in every society are caught up in this vicious epidemic and it is now estimated that 36 million have been infected worldwide.

A virus named HIV has been identified and fully characterised by its unique sequence. HIV has fulfilled all of Koch's postulates as the sole cause of AIDS. It is vitally important to recognise that diagnosis and classification of a disease in medicine is based on the exponential summation of discriminating characteristics from four components: medical history, clinical signs, laboratory investigations and response to treatment. At each level there should be a discriminating feature that, when taken in context and in toto with the others, allows us to arrive at a probable diagnosis. This, too, is the case with AIDS. From this report, it has become clear that statistical modelling of epidemiological and mortality data adds a fifth component to the art of diagnosis.

Preface

The data presented in this report make the following salient points:

- i) the pattern of mortality from natural causes in South Africa has shifted from the old to the young over the last decade particularly for young women - this is a unique phenomenon in biology;
- ii) there is a differential mortality pattern between women and men;
- iii) this shift in mortality pattern fits several AIDS models;
- iv) the future burden and impact of the epidemic is broadly predictable from the models with reasonable confidence over the next decade;
- v) the differential patterns of mortality and prevalence will allow for differential intervention strategies in the different parts of the country.



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This report is a chilling reminder of how powerful stereotypes across society have colluded in creating the most explosive epidemic in the history of our country. Comprehensive, powerful and rigorous as these data are, they can be seized upon positively by individuals, government and society to intervene at many levels such that no South African person, family or community has to live under the cloud of this vicious and unrelenting epidemic.

I sincerely hope that information in this report will be used to promote the culture of 'Breaking the Silence' around this silent killer of our nation. As Africa faces the challenges of its renewal or renaissance, there is no greater potential barrier to the attainment of this vision than the spectre of the HIV/AIDS epidemic.