

Conflict, Contradiction and Crisis:

An analysis of the politics of AIDS policy
in post-Apartheid South Africa

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ABSTRACT

Despite the profound impacts of HIV and AIDS on all sectors of South African society, governmental responses to the AIDS epidemic have been inundated with contradiction, conflict and contestation. Though governmental leaders have justified not funding HIV treatment programs because they believe that poverty needs to be dealt with first, social spending has been slashed as part of an adherence to a neo-liberal economic model. Though it would seem that the government would seem to have everything to gain by establishing a cooperative relationship with non-governmental actors regarding the epidemic, the relationship between the government and non-governmental actors has instead been described as nothing short of hostile. Though the government enthusiastically backed Virodene, a supposed treatment for AIDS that turned out to be no more than an industrial solvent, other ‘scientifically backed’ AIDS treatments have been treated with caution and skepticism – to the point where the government even refused to provide funding for programs to prevent mother to child transmission of the virus. And perhaps the most perplexing is that although widely respected for his intellect and cool demeanor, former President Mbeki chose to risk his political career on the AIDS issue by shunning away from the mainstream consensus on the biomedical causes of the epidemic and instead surrounded himself and sought advice from AIDS ‘dissidents’

This thesis will seek explanations for these apparent contradictions. Using Bourdieu’s (1986) typology of capitals, it will build on an argument put forward by Helen Schneider (2002): from the South African government’s perspective, the contestation regarding HIV and AIDS policy and implementation is over symbolic capital, or the right to legitimately hold and exercise political power regarding the epidemic. Though this argument helps explain the conflictual relationship between the government and non-governmental actors regarding the AIDS crisis, in order to understand the perplexing contradictions within the governmental policy response, the political context of policy formation must first be taken into consideration.

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Preface

Acknowledgements

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Dedication

This thesis is dedicated to the little girl who drew the stars with me at the ARV clinic, and the 40 million like her around the world who are HIV positive. It is my hope that someday politics will no longer get in the way of finding a way to rid you of the burden of HIV and AIDS.

Chapter 1 – Introduction

The South African AIDS Epidemic

The scale of South Africa's HIV AND AIDS pandemic would be overwhelming to any government. The first HIV case in South Africa was identified in 1982. By 1990, the first annual national survey in antenatal clinics found an HIV prevalence rate of 0.8% among pregnant women. The next year, that figure had doubled to 1.5%, and it was clear that South Africa was in the early stages of a serious AIDS epidemic¹. The World Health Organization (WHO) 2003 estimate for adult prevalence of AIDS in South Africa was between 17.8-24.3%², with among the highest number of infected people in the world. The enormous impact of the spread of HIV and AIDS across sub-Saharan Africa has been said to be one of the greatest humanitarian crises of our time, and South Africa is home to over 5 million of the estimated 40 million people in the world who are infected with HIV³. The immensity of the situation has forced its way to the forefront of attention of national governments, international organisations and civil society across the globe.

South Africa contributes almost half of the total economic output of Sub-Saharan Africa, and in theory has the financial resources to provide universal accessibility to HIV prevention, care and support⁴. Its tertiary health system is renowned for such achievements as pioneering the world's first heart transplant and contributing significant knowledge to the understanding of severe child malnutrition⁵. However, its health and other social indicators are discrepantly poor compared to other middle income countries (see

¹ Schneider, Helen, and Joanne Stein. "Implementing AIDS policy in post-Apartheid South Africa." *Social Science and Medicine* 52 (2001): 723-731.

² WHO. "Summary Country Profile for HIV/AIDS Treatment Scale-up: South Africa." *World Health Organization*. June 2005. http://www.who.int/3by5/support/june2005_zaf.pdf.

³ Benatar, Solomon. "Health Care Reform and the Crisis of HIV and AIDS in South Africa." *The New England Journal of Medicine*, 2004: 81-92.

⁴ Johnson, Krista. "The Politics of AIDS Policy Development and Implementation in Post-Apartheid South Africa." *Africa Today* 51, no. 2 (2004): 107-128.

⁵ Sanders, David, and Mickey Chopra. "Key Challenges to Achieving Health for All in an Inequitable Society." *American Journal of Public Health* 90, no. 1 (2006): 73-78.

Table 1 'Comparison of Five Middle Income Countries'). Although it has some of the top medical facilities in the entire world, 80% of its population has limited access to health care. Though it is often touted as the “leader of Africa” and is often one of the first nations to respond to disasters and troubles (political and otherwise) that arise within the African continent, arguably the most significant problem facing its own population – the HIV and AIDS epidemic – has gone essentially unchecked. It is estimated that between 40 and 50 percent of the South African workforce could die within the next decade as a result of AIDS⁶.

Given the rather desperate situation in South Africa, it is incredibly perplexing that the state’s AIDS policies⁷ have been described at best as schizophrenic⁸. The South African government has been widely criticised both domestically and internationally for the approach it has taken in addressing HIV and AIDS. President Mbeki’s questioning of the biomedical causes of AIDS has in large part baffled both national and international audiences inside and outside of the medical fields, and governmental decisions to deny funding for treatment programmes such as the Mother to Child Treatment Prevention programme have drawn wide criticism from non-governmental organisations committed to human rights. The HIV and AIDS policies put forward by both the presidential office and the Department of Health have been shrouded in scandal and criticised widely for prevarication and overall confusion⁹. In short, the overall governmental response to HIV and AIDS in South Africa has been widely characterised as delayed and insufficient. Even the policies that have been drafted meticulously have been derailed and generally implemented poorly, with the result that the South African government has been unable to realise any sort of strategic plan that would substantially reduce the risk of transmitting HIV or dying from AIDS-related illnesses¹⁰.

⁶ Benatar, “Health Care Reform”.

⁷ Though ‘AIDS policy’ will often be referred to, it is with the understanding that HIV is the virus that causes AIDS, and that unless otherwise stated, AIDS Policy is seeking to address those who are at risk of contracting HIV, have already contracted HIV, and those who have reached the immunodeficiency level low enough to be categorized as having ‘AIDS’.

⁸ Youde, Jeremy R. *AIDS, South Africa, and the Politics of Knowledge*. Hampshire: Ashgate Publishing Limited, 2007: 2.

⁹ Butler, Anthony. "South Africa's HIV/AIDS Policy, 1994-2004: How can it be explained?" *African Affairs* 104, no. 417 (2005): 591-614.

¹⁰ *Ibid.*

Within the South African context, there is general consensus that there has been a ‘crisis of implementation’ surrounding AIDS policies since the epidemic was first identified. The reasons for the failure of these policies, however, have far less of a consensus, and there is wide variation in the reasons put forward within the literature. For example, among literature in the field, there is fairly wide disagreement among over how much the role of the political elite has played into the perpetuation of AIDS prevalence. Authors such as Robins (2004) place heavy emphasis on the importance of cultural politics issues such as President Mbeki’s pro-dissident stance on HIV. According to Robins and like-minded authors, President Mbeki and his “inner circle” have directly undermined public health institutions and contributed to the deaths of tens of thousands of people. However, authors like Hunter (2007) argue that although President Mbeki has been widely criticised for his stance on AIDS, his politics have actually played a minimal role in exacerbating the scale of the AIDS epidemic, and that the leader’s role in implementing (or not implementing) AIDS policy has actually been minimal. Other examples of reasons put forward for the failure of policy implementation within South Africa are outlined by Schneider and Stein (2001), Schneider (2004), Johnson (2004), and van Niekerk (2003). These reasons include: the continual restructuring of the government on all levels caused by the transition to democracy, institutional constraints due to the legacy of Apartheid that have limited access and funding for health care within the country, adherence to neoliberal economic policies which has resulted in increased social and economic inequalities, and an ideological stalemate between prevention and treatment campaigns.

Why Policy is Important: Historical Context and Lessons Apartheid

It is estimated by the World Health Organization that between one out of every 4 or 5 South Africans is HIV positive¹¹. The resulting social and economic burdens of this type of statistic would be colossally difficult for any state to deal with, regardless of political stability. Compound all of this with the fact that South Africa is still in the midst of a massive upheaval from the dissolution of the Apartheid state and transition into democracy, and it is not hard to see that the challenge presented to the government by the epidemic is tremendous.

¹¹ WHO, “Country Profile for HIV/AIDS”.

The most significant factor that distinguishes South Africa from other African nations¹² is its unique experience of Apartheid¹³. The policies associated with the Apartheid-era have been particularly relevant to facilitating the spread of HIV and AIDS in contemporary South Africa¹⁴. Not the least of these was the vast displacement of people from urban to rural areas. The political domination and racial segregation of the indigenous people of South Africa began shortly after the colonization of the Cape of Good Hope in 1652, but became formally entrenched in 1948, when the white minority Nationalist Party gained full political control, despite the fact that over 80% of the population of South Africa consisted of black indigenous Africans. The Nationalist Party implemented the policies of Apartheid – or racial separateness – that lasted until South Africa’s first democratic elections in 1994¹⁵. During the era of Apartheid, over four million Black, Coloured and Indian people were removed from their homes in urban areas and moved into rural areas designated as “homelands” Additionally, there were forced removals within the urban areas – in the major metropolitan areas, hundreds of thousands of people were displaced from the centers of towns to the peripheries. The result of this was the creation of a huge population of people who lived in barren rural areas or in overcrowded areas outside of cities. The conditions in these places were often not even conducive to a subsistence existence. Additionally, in line with Apartheid policy, these areas were often devoid of health and education services¹⁶.

In addition to the forced displacement of the majority of the population, the negative effects of Apartheid policies were intensified by the effects of a migratory work system that was created to serve the mining industry. With the discovery of mineral wealth, international proprietors and foreign capital poured into South Africa to exploit the mineral resources. This greatly disrupted the pastoral societies of both the indigenous Africans and Afrikaner farmers.

¹² Other than Namibia.

¹³ Aliber, Michael. "Chronic Poverty in South Africa: Incidence, Causes and Policy." *World Development*, 2003: 473-490.

¹⁴ Sachs, Jonny. "South Africa as the Epicenter of HIV/AIDS: Vital Political Legacies and Current Debates." *Current Issues in Comparative Education* 3, no. 1 (2002): 52-56.

¹⁵ Van Niekerk, Robert. "The Evolution of Health and Welfare Policies in South Africa: Inherited Institutions, Fiscal Restraint, and the Deracialization of Social Policy in the Post-Apartheid Era." *The Journal of African American History* 88, no. 4 (2003): 361-376.

¹⁶ Sachs, South Africa as Epicenter”.

The mining industry demanded a workforce, and in addition to luring Europeans to the area, mining tycoons needed to transform the indigenous men, most of whom were previously subsistence farmers, into labourers. The tycoons used strategies such as imposing hut and poll taxes and introducing the desire for manufactured products in order to persuade and coerce the indigenous population to enter into a monetary economy. Additionally, male black workers were brought in from the homelands to work in the mines. Once pulled into the system, the new underground mine labourers were induced to live for year-long stints in male-only compounds¹⁷. The need for labour, compounded with the displacement of large populations of people into 'homelands' created a system of migrant labour which was a defining element of the Apartheid system.

The system of migrant labor set the scene for the rampant spread of sexually transmitted diseases and infections in South Africa. Black mine workers were required to work under the terms of the pass laws, and were only allowed to visit, and not live, with their families. Very few black women were able to find work, but those who did usually served in the homes of white families, and a few subsisted by becoming sex workers in the mine compounds. The migrant patterns of the men led to large amounts of prostitution and men having multiple sexual partners¹⁸. In a much quoted paper on the social pathology of syphilis, Sidney Kark (1949) first put forward the dismaying data that showed how epidemic sexual disease was spread along the routes of migrant labor – from the cities back to the rural reserve areas.

The spread of sexually transmitted diseases was not the only detrimental effect of Apartheid policies on health, however. Another way to view the effects of the policies is to look at the outcomes on the health indicators of the population. During the 1970s, 1980s and early 1990s, while South Africa's system was legally segregated, the health and development of the 'black', 'coloured' and Indian citizens were completely different experiences than the health and development for the 'white' populations. There were intense contrasts in the health of the different populations. As Leonard Thompson indicates in his book about the history of South Africa, white South Africans, much like Western Europeans or North Americans, experienced both a long life expectancy and a low infant mortality rate (64.5 years for males and 72.3 years

¹⁷ Abdool Karim, Quarraisha, and Salim S. Abdool Karim. "The evolving HIV epidemic in South Africa." *International Journal of Epidemiology* 31 (2002): 37-40.

¹⁸ Ibid.

for females in 1969-71, and 14.0 per thousand live births in 1978 respectively). The most commonly occurring diseases were in sync with those of industrialised nations, and they had access to some of the highest standards in health care around the world¹⁹.

Meanwhile, the experience for black South Africans was entirely different. During the 1970s, the unemployment rates for black South Africans increased dramatically, almost doubling from ½ million to 2.3 million between 1960 and 1977²⁰. Consequently, black South Africans experienced high levels of poverty, under-nutrition, and disease. Though the government did not keep reliable medical statistics for black South Africans during Apartheid, the estimates are alarming. Official estimates for life expectancy were 51.2 for males and 58.9 for females in 1965-1970, and these are most certainly overestimates. Child mortality rates for both black and coloured 1-4 year olds were thirteen times as high as for whites, and the main cause of such drastic child mortality rates was inadequate nutrition. Also notable, the primary diseases that led to death for black South Africans were pneumonia, gastroenteritis, and tuberculosis, the same diseases that are most common in the 'third world'²¹. Essentially, within the same nation, different populations were experiencing different stages of the epidemiological transition²² from 'third world' to 'first world'.

More current statistics are perhaps even more depressing. Consistent with the understanding that the affluent sections of the population of South Africa have completed the epidemiological transition, while economically disadvantaged sections of the population continue to suffer under the burden of pre-transitional pathologies, the poor of South Africa are

¹⁹ Thompson, Leonard. *A History of South Africa: Third Edition*. NewHaven and London: Yale Universtiy, 2001. Statistics quoted by Thompson are taken from the *South African Survey 1999-2000*.

²⁰ As estimated by South African economist Charles Simkins in Thompson, *A History of Africa*.

²¹ Thompson, *A History of Africa*.

²² Omran, Abdel. "The Epidemiologic Transition: A Theory of the Epidemiology of Population Change." *The Milbank Memorial Fund Quarterly* 49, no. 4 (1971): 509-538. Originally proposed by Omran (1971), "epidemiological transition" refers to a shift in the pattern of the causes of mortality within a particular society or country to shift from infectious diseases toward more degenerative diseases. Normally, the epidemiological transition occurs during the process of economic modernization or development within a country, as advances are made in the health care system. In today's world, less developed countries are assumed to have higher rates of mortality due to infectious diseases (usually due to a lower level of available health care). In turn, there is an assumption that in more developed countries, more people die from degenerative diseases (such as heart disease or cancer) since infectious diseases (malaria, cholera, typhoid, and so on) are easily treated within the context of their more developed health care systems. In South Africa, because of the high levels of socio-economic inequality, different populations have different access to health care, education and resources, causing the population to be at different levels of the epidemiological transition.

disproportionately affected by infectious and sexually-transmitted disease, most namely HIV and AIDS. The patterns of morbidity and mortality are shaped by persistent and severe inequalities in the major risk factors such as rates of malnutrition (stunting rates are six times higher in those within the poorest quintile compared with those in the richest quintile)²³.

The health outcomes shaped by Apartheid policies have led authors such as Marks (2002) to claim that the AIDS epidemic was ‘waiting to happen’ in South Africa. This argument is based on the idea that prior to the onset of the AIDS pandemic, the social and political environment of South Africa was set up in such a way that it only took a small spark to ignite the outbreak of the epidemic. This type of environment has been called a ‘high risk situation’ which is defined by such indicators as “impoverishment and disenfranchisement, rapid urbanization, the anonymity of urban life, labour migration, widespread population movements and displacements, social disruption and wars, especially counter-insurgency wars²⁴”. In ‘high risk situations’ such as these, where the focus is on daily survival (or daily survival is dangerous) and social bonds are low or broken, risk taking (especially sexually) is much more likely and gender relations are usually highly unequal. Additionally, in situations such as these, it is more likely that transactional sex, drug use, alcohol misuse and other high risk behavior will take place, which sets up the probability that if a sexually transmittable disease is introduced, it will spread rapidly and widely.

This is seemingly exactly what happened in South Africa. When HIV was first discovered in South Africa in 1982, the scene was set – in addition to the sweeping political changes and enormous, accumulated wealth existing side by side with abject poverty, the conflict and ‘low-intensity’ warfare taking place within its borders added to a very unstable social situation. The black population was experiencing essentially every one of the ‘high risk’ indicators listed above. It would be nearly impossible to understand the implications and progression of the AIDS epidemic in South Africa without giving attention to the very specific historical context in which it occurred. The lessons from Apartheid are important reminders that governmental policies and priorities can directly affect the health outcomes of its populations.

²³ Sanders and Chopra, “Key Challenges”.

²⁴ Marks, Shula. "An Epidemic Waiting to Happen? The Spread of HIV/AIDS in South Africa in Social and Historical Perspective." *African Studies* 61, no. 1 (2002): 13-26.

Why Policies Matter: Post-Apartheid Policy-making

The racist policies of Apartheid set the scene perfectly for a ‘high risk situation.’ Until the late 1980s, Apartheid policies institutionalised inequalities through labour laws and highly unequal investment in social services for different racial groups. Because of this, the current health situation within South Africa is often directly linked to Apartheid-era policies. However, upon closer examination, it becomes apparent that the ‘blame’ for the scale of the epidemic cannot end there. Simply pointing fingers towards the past does not explain why, fifteen years later, the socio-economic patterns institutionalised under Apartheid are worsening. Other issues must be taken into account. For example, recent neoliberal policies (which will be examined in greater depth in chapter 3) enacted by the post-Apartheid government have perpetuated and even increased inequalities between the rich and poor within the country²⁵. Additionally, rapid trade liberalization, which increased wage competition, put the manufacturing sector under enormous financial pressure. The result was an increase in unemployment to levels over 40% of the population²⁶. As rural areas suffered from decreased wages, many women as well as men²⁷ began migrating into informal urban areas. These changes also impacted the structure of households, and percentage of marriages declined²⁸. The mushrooming of informal settlements, which is in many cases attributed to the end of influx controls as the Apartheid policies were negated, was perpetuated by the reorganisation of rural households which was a by-product of increased social inequalities created by the current government’s neoliberal economic policies²⁹. All of these factors have perpetuated the ‘high risk situation’ described by Marks. The key point is that this high risk situation is not something that ended with Apartheid, but instead, is being perpetuated by current governmental policies.

²⁵ Hunter, Mark. "The changing political economy of sex in South Africa: The significance of unemployment and inequalities to the scale of the AIDS pandemic." *Social Science & Medicine* 64 (2007): 689-700.

²⁶ Kenny and Webster 1998, as cited in Hunter, "The changing political economy of sex".

²⁷ Men’s migration has long been attributed to the spread of sexually transmitted diseases within South Africa. See Hunter, "The changing political economy of sex" for a review of literature in this area.

²⁸ For a more in depth examination of women’s migration and decline of marriage, see Hunter, "The changing political economy of sex".

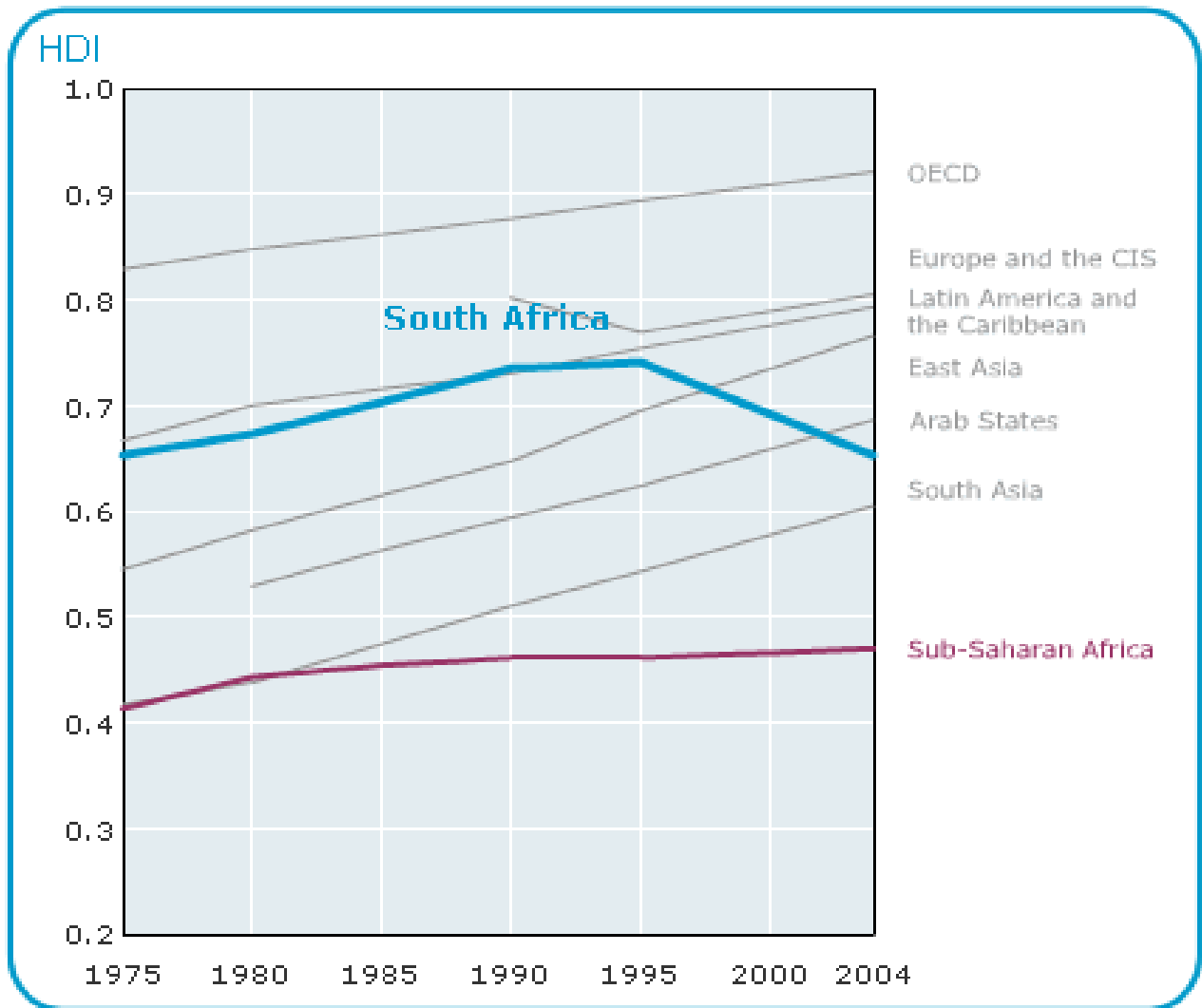
²⁹ Ibid.

When Nelson Mandela, as the head of the ANC, was elected president of the new democratic South Africa in 1994, there was wide celebration among democratic nations across the globe. At last, the era of racialised Apartheid had officially ended, and though it was already clear that AIDS was beginning to gain a hold on the South African population, there was no apparent reason that the new government would not be able to adequately address the issue and implement policy to block the progress of the disease. However, South Africa was struggling to gain control of its most pressing health issues while at the same time creating a political structure that would represent its people. A quick look at current statistics shows that the struggle did not attain total success. Though South Africa has one of the highest per-capita GDP (PPP adjusted) among similar middle-income countries, its social indicators are significantly lower (See

Table 1 'Comparison of Five Middle Income Countries'). According to the UNDP's 2006 Human Development Report, the Human Development Index for South Africa was at a .653 in 1975, raising slowly until hitting a peak in 1995 at .741, and then, despite the end of the Apartheid era, declining to a .653 by 2004 (See Figure 1 'Human Development Index Trends '). From the same report we see that the percent of population that had access to clean water had fallen from 69 in 1990 to 65 in 2004, and the overall per capita growth rate from 1975 until 2004 was -0.5³⁰.

³⁰ Statistics taken from UNDP. "Human Development Report 2006:South Africa." *United Nations Development Programme*. http://hdrstats.undp.org/countries/country_fact_sheets/cty_fs_ZAF.html (accessed October 2007).

Figure 1 'Human Development Index Trends'³¹,



³¹ Though Human Development Index Data before 1991 is largely estimated, and most likely inflated, social indicator trends since the end of Apartheid show that social indicators continue to fall, suggesting that the graph, while representing estimated data before 1991, does accurately portray the decline of social indicators after 1991. Source: UNDP, "HDR 2006: South Africa".

Table 1 'Comparison of Five Middle Income Countries'³²,

		Comparison of five middle-income countries					
HDI Rank	COUNTRY	GDP per capita (PPP US\$) (HDI) 2004	Children under height for age (% under age) 1996-2004	HIV prevalence (% ages 15-49) 2005	Life expectancy at birth (years) 1970-75	Life expectancy at birth (years) 2000	Gini Index
	Average Middle Income Country	6,756	..	0.6 [0.5 - 0.8]	62	70	..
50	Cuba	..	5	0.1 [<0.2]	70.7	77.2	..
61	Malaysia	10,276	16	0.5 [0.2 – 1.5]	63	73	49.2
69	Brazil	8,195	11	0.5 [0.3 – 1.6]	59.5	70.3	58
74	Thailand	8,090	13	1.4 [0.7 – 2.1]	61	69.7	42
81	China	5,896	14	0.1 [<0.2]	63.2	71.5	44.7
121	South Africa	11,192	25	18.8 [16.8 – 20.7]	53.7	49	57.8

This overall decline in development indicators for South Africa over the last thirty years can be contextualised by taking a deeper look into the causes and perpetuation of the inequalities that exist today in South Africa. After Apartheid, no quick fix was available to the government to ‘undo’ consequences of the prolonged segregation of South Africa’s people. For nearly half of a century, inequity had been legalised, and though the ANC government worked hard to change policy, economic decline prevailed. The government did attempt to provide health care to thousands of people who had never before had access, but because changes in budgets shifted money away from urban hospitals into rural clinics, there was a severe decline in health care provided in the public hospitals³³.

³² Ibid.

³³ Thompson, “A History of South Africa”.

The Politics of AIDS Policy in South Africa

Policies can be made and implemented by a great variety of different actors, including (but not limited to) non-governmental organisations (NGOs), international multilateral organisations such as the United Nations (UN), universities or governments³⁴. Even within these categories, policy can be created and implemented on a variety of levels – for example, in the case of South Africa, government policy creation and implementation it can take place on the local, provincial or national levels. This thesis will concentrate almost exclusively on policy created and implemented at the level of the national government.

From the perspective of the national government, all things being equal, AIDS policy is similar to other types of governmental policy that demands citizens to do something that the government wants them to do, and it normally is comprised of two different parts: inducements, which are meant to convince people that said actions and habits are in their own best interest, and constraints, which put in place sanctions for not conforming to the actions or habits³⁵. AIDS is not *caused* by socio-economic conditions, but socio-economic conditions can certainly exacerbate the conditions under which people are more likely to make behavior choices that can spread the HI virus. The purpose of AIDS policy is to attempt to establish new patterns of behavior and new habits among citizens - getting individuals to do something that they may not normally do or want to do. Examples include: getting citizens to wear condoms, use clean needles, get tested for HIV or abstain from sexual relations.

However, because of the nature of the behaviours associated with the spread of HIV (see section above), the government may not always be the most effective actor to address the epidemic. Non-governmental actors such as non-governmental organisations (NGOs) may actually be better suited to respond effectively to the epidemic. As defined by Broadhead and O'Malley, 'non-governmental organisations' (NGOs) are diverse organisations that "work together outside of government to address a need, advance a cause or defend an interest³⁶." The

³⁴ Fourie, Pieter. *The political management of HIV and AIDS in South Africa: one burden too many?* New York: Palgrave Macmillan, 2006: 8.

³⁵ Garui, Varun, and Evan Lieberman. "AIDS and the State: the Politics of Government Responses to the Epidemic in Brazil and South Africa." *Annual Meeting of the American Political Science Association*, 2004: 1-50.

³⁶ Broadhead and O'Malley, 1989, as quoted in Seta, Hormazd. "The Role of Non-governmental Organizations (NGOs) in HIV/AIDS prevention and care." *Case Western Reserve University*. 2003. www.cwru.edu/med/epidbio/mph439/GNOs&AIDS.htm.

World Bank builds upon that definition, stating that NGOs are ‘private organisations that pursue activities to relieve suffering, promote the interest of the poor, protect the environment or undertake community development³⁷.’ NGOs have a unique role in providing services to citizens. Though every NGO has different strengths, a common characteristic of NGOs is that they are normally much smaller and have more flexible administrative systems as well as more manageable bureaucracies than do governmental organisations. Because of this, NGOs are typically more capable of dealing on the grassroots level with sensitive issues (such as sexuality or condom use). They are also usually staffed by community members, which gives them credibility within the communities in which they serve, and makes it more likely that they will attract community participation in their campaigns³⁸.

Because of the relative strengths of non-governmental actors like NGOs, it would seem logical that the South African government would seek to cooperate and collaborate in the formation and implementation of AIDS policy. However, this has not been the case. Quite on the contrary, relations between the state and non-state actors in South Africa have been characterised as nothing less than ‘hostile³⁹.’

This leaves us with the question: Why has the South Africa state been unwilling to cooperate with non-state actors in order to best address the AIDS epidemic? Chapter 3 will venture to address this question, building on an argument put forward by Helen Schneider (2002) that uses Bourdieu’s (1986) typology of capitals in order to explain the contestation regarding AIDS policy and implementation between state and non-state actors. Though this argument goes a long way in offering an explanation for conflict that has taken place in regards to AIDS policy, it does not explain why members of the South African government, particularly former President Mbeki and his Health Minister, went to the extreme of adopting dissident or denialist views on the very biomedical causes of AIDS. The manner in which they conceptualise the problem at hand will very much affect the way in which they draft and implement policies in which to address that problem. In the case of AIDS in South Africa, the policy arena has become

³⁷ World Bank 1988, as quoted in Sethna and Hormazd “The role of NGOs”.

³⁸ Sethna and Hormazd “The role of NGOs”.

³⁹ Friedman, 2000 as quoted by Boone, Catherine, and Jake Batsell. "Politics and AIDS in Africa: Research Agendas in Political Science and International Relations." *Africa Today* 48, no. 2 (2001): 3-33.

inundated with what Helen Schneider has referred to as ‘high politics.’⁴⁰ This has deeply affected the way in which AIDS policies have been created and implemented.

AIDS Science vs. AIDS Denialism

AIDS Science

Before continuing, it is important to establish a framework through which to view the AIDS problem in South Africa, especially considering that the science regarding HIV and AIDS has been questioned by the President himself. This thesis is working within scientific understanding that HIV is the causal link to AIDS.

The science of HIV and AIDS has been well established within the international scientific community, and has been accepted for years by multilateral and international organisations such as the United Nations and the World Health Organization. The scientific explanation goes something like this: HIV is the abbreviation for the ‘human immunodeficiency virus’. HIV primarily infects white blood cells known as CD4 positive T-cells, though it can also infect other cells such as macrophages. Both T cells and macrophages are key components of the cellular immune system, and HIV essentially destroys these cells or damages their function⁴¹. AIDS stands for ‘acquired immunodeficiency syndrome’ and is a “surveillance definition based on signs, systems, infections, and cancers associated with the deficiency of the immune system that stems from infection with HIV⁴².” Unless treated, AIDS leads rapidly to death.

HIV is found in bodily fluids such as blood, semen, vaginal fluids and breast milk, and is spread through the transmission of these fluids (though activities such as unprotected penetrative (vaginal or anal) and oral sex with an infected person; blood transfusion or the use of contaminated syringes, needles, or other sharp objects; or from an infected mother to her child

⁴⁰ Schneider, Helen. "On the fault-line: the politics of AIDS policy in contemporary South Africa." *African Studies* 61, no. 1 (2002): 145-167.

⁴¹ UNAIDS. "Fast Facts about HIV." *UNAIDS: Joint United Nations Programme on AIDS*. May 2008. http://data.unaids.org/pub/FactSheet/2008/20080519_fastfacts_hiv_en.pdf.

⁴² Ibid.

during pregnancy and breastfeeding⁴³). Once inside an infected cell, HIV multiplies and makes copies of itself, which are able to go on and infect healthy cells within the body. The more healthy cells that are infected, the more deficient the immune system becomes (hence the term immunodeficiency). Though there is no cure for HIV, there is treatment available that greatly reduces the virus' ability to replicate within the body, and therefore drastically slows down the progression towards AIDS. HIV treatment, called antiretrovirals (ARVs), interfere with the manner in which HIV produces copies of itself and the way that it spreads from cell to cell⁴⁴. There are several different classes of ARVs; brief descriptions of three of the main classes follow:

- Nucleoside Reverse Transcriptase Inhibitors (NRTIs): HIV is a retrovirus. This means that instead of its genetic information being located in its deoxyribonucleic acid (DNA), it is located in its ribonucleic acid (RNA). All retroviruses use a substance known as reverse transcriptase to synthesise RNA into DNA⁴⁵. HIV therefore needs reverse transcriptase to make new copies of itself. NRTIs block the reverse transcriptase by “fooling” the reverse transcriptase into using them rather than DNA, and therefore block the creation of new HI virions⁴⁶.
- Non-Nucleoside Reverse Transcriptase Inhibitors (NNRTIs): like the last group, this group also blocks the reverse transcriptase, but by binding directly to it and thereby disabling it⁴⁷.
- Protease Inhibitors: Once inside the nucleus of a cell, HIV DNA essentially plants itself into the host-cell chromosome, and begins creating viral RNA, which ‘buds’ out of the

⁴³UNAIDS. "Fast Facts about HIV Prevention." *UNAIDS: Joint United Nations Programme on AIDS*. April 2008. http://data.unaids.org/pub/BaseDocument/2008/20080501_fastfacts_prevention_en.pdf.

⁴⁴ UNAIDS. "Fast Facts about HIV Treatment." *UNAIDS: Joint United Nations Programme on AIDS*. June 2008. http://data.unaids.org/pub/FactSheet/2008/20080903_fastfacts_treatment_en.pdf.

⁴⁵ Natrass, Nicoli. *Mortal Combat: AIDS denialism and the struggle for antiretrovirals in South Africa*. University of KwaZulu-Natal Press, 2007: 18.

⁴⁶UNAIDS, “HIV Treatment”, Natrass “Mortal Combat”, 20.

⁴⁷ Natrass “Mortal Combat”, 20.

cell. To do this process, HIV needs a substance called Protease, and PIs block the creation of new virions by blocking this substance⁴⁸.

The first ARV drug was an NRTI named Azidothymidine, or AZT. If taken by an HIV-positive mother shortly before giving birth, and then given to the at-risk infant shortly after birth, it was shown to be extremely effective in drastically reducing the chance of HIV infection from mother to child. Though AZT was initially effective in stopping viral replication, as the virus evolved and subsequently developed drug resistance, the effectiveness of AZT was undermined. Today, the standard treatment for people living with HIV is a drug ‘cocktail’ of three or more ARVs⁴⁹. This combination of drug targets different components of the HIV replication cycle highly active antiretroviral therapy (HAART).

AIDS Denialism

Though the biomedical conceptualisation of HIV and AIDS as described above is widely accepted as unquestionable, there is a small but vociferous ‘denialist’ camp that refutes the scientific evidence regarding HIV and AIDS. Though personal denial regarding HIV and AIDS is quite common, meaning that it is common that individuals refuse to acknowledge that they or their partners have or at risk of contracting HIV in the face of all reason, very few people deny the evidence about the HIV/AIDS pandemic in general. As De Waal states:

Across the continent, there are billboards and radio messages, statements from politicians and church leaders, news stories and NGO programmes, all hammering home the message that HIV/AIDS is a risk. In the 2003 round of the Afrobarometer survey, more than half of respondents in Kenya, Malawi, Namibia, Tanzania, Uganda and Zambia reported that they had lost at least one close friend or relative to AIDS. In Uganda it was 85 per cent and the median number of friends or relatives said to have died of AIDS was five. What these figures tell us is that most people readily accept that HIV/AIDS exists, even

⁴⁸ UNAIDS, “HIV Treatment”.

⁴⁹ Ibid.

though many refuse to accept the possibility that they might have contracted the virus⁵⁰.

South Africa, however, is a special case. In the same Afrobarometer survey that de Waal described, only 18 percent of South Africans reported a personal loss due to AIDS. Among those who refused to acknowledge a personal loss was former President Thabo Mbeki⁵¹. Many people believe that Mbeki ascribes to AIDS denialism or dissidence. De Waal describes denialist or dissident views as “including the scientific or epidemiological denialism propounded by a small number of ‘dissident’ academics, who claim that HIV does not cause AIDS, that AIDS does not exist, or that the statistics of HIV prevalence are erroneous or fraudulent⁵².”

Because AIDS denialism has become so relevant to the South African policy-making environment, understanding the denialists claims are important. Edwin Cameron explains their positions further:

“Denialists assert that the "hypothesis" that Aids is caused by a sexually transmitted virus is unproven and irresponsible. Aids in North America and Western European they attribute to "the long-term consumption of recreational drugs" and to the widespread use of drugs as sexual stimulants by homosexual men and, more recently, to the administration of anti-retroviral drugs that doctors wrongly prescribe for Aids.

They refute the "impression" that there is a microbial epidemic in Africa, ascribing it instead to "non-contagious risk factors that are limited to certain sub-sets of the African population". The millions of deaths attributed to Aids they characterise as "a minor fraction of conventional mortality under a new name⁵³".

⁵⁰ De Waal, Alex. *AIDS and Power: Why there is no political crisis - yet*. London: Zed Books, 2006:11-12.

⁵¹ Ibid.

⁵² Ibid.

⁵³ Mail and Guardian. "The Dead Hand of Denialism." *Mail and Guardian*, April 17, 2003.

Nattrass also explains:

“...a group of AIDS denialists in Australia (the so-called Perth Group) insists that HIV does not exist – recently testifying to this effect in an Australian court... Other AIDS denialists accept the existence of HIV but, following Peter Duesberg (a molecular biologist at the University of California), believe it to be harmless. What unites them all is the unshakable belief that the existing canon of AIDS science is wrong and that AIDS deaths are caused by malnutrition, narcotics, and ARV drugs themselves....⁵⁴”

This is not to say that questioning mainstream science is always a bad thing. On the contrary, both dissent and critique are *central* to science⁵⁵. However, the current day AIDS ‘dissidents’ have gone beyond scientific reason in their questioning:

In the 1980s, it was understandable that AIDS dissidents were uneasy about the claim that one virus could cause so many different diseases. But, once it was shown that HIV worked by undermining the immune system, thereby rendering the body vulnerable to a host of opportunistic infections, their concerns should have been put to rest. Similarly, the wealth of data on the successes of ARV treatment should have alleviated their initial worries about its overall therapeutic benefit. Thus one of the early AIDS dissident doctors, Joseph Sonnabend, had, by 2000, welcomed the life-saving capacity of ARVs, describing them as a “wonderful bless”. However, this did not deter today’s AIDS denialists, who continue to cite his dated views on their Web sites in support of their unchanged views.

The highly controversial nature of AIDS denialists’ views makes Mbeki’s attraction to them perplexing. Why is it that a man of his stature and intellect would be willing to make the

⁵⁴Nattrass, Nicoli. "AIDS: Denialism vs. Science." *Skeptical Enquirer*, 2007: 31-37.

⁵⁵ *Ibid.*

political risk in exploring and adopting such views? This question will be examined in much more depth in Chapter 4.

In order to understand the controversial stances that these governmental leaders took, Chapter 4 will examine the very framework in which policy-making takes place. Importantly, government policy-makers are forming policy within a specific political context, and Chapter 4 will analyze the role of identity and the production of knowledge within the specific context of post-Apartheid South Africa in an attempt to elucidate Mbeki's particular conceptualisation of AIDS.

This thesis' attempts to explain the policy contradiction and contestation in South Africa are no more than they claim to be. No one will ever know for sure exactly why particular policy-makers and implementers have responded the way that they have. However, two resounding facts emerge: first, the HIV and AIDS problem in South Africa is both massive and devastating; second, the government has failed to adequately respond to the epidemic despite the transition to democracy in 1994. Irrespective of any governmental policies or actions, the exponential rise in HIV statistics prove that this policy either has not worked or has not been implemented at all. This thesis is concerned with why South Africa's government has failed so drastically in adequately addressing the AIDS pandemic.

Chapter 2 – AIDS Policy and Conflict in post-Apartheid South Africa

An important component of many state strategies for influencing patterns of behavior that are connected with the spread of disease is a partnership between the state and non-governmental actors and organisations. This may take the form of consultancies, provision of monetary resources, or even symbolic encouragement⁵⁶. However, the overall response to HIV and AIDS in South Africa has been widely characterised by a “vicious cycle of growing alienation between key members of the state and non-governmental AIDS actors⁵⁷.” Even carefully drafted AIDS policies have been derailed and generally implemented poorly, resulting in the South African government’s inability to realise any sort of strategic plan substantially reducing the risk of HIV transmission or AIDS-related deaths⁵⁸. Much of this may be due to the fact that relations between the national government of South Africa and non-governmental actors (both local and international) have been riddled with conflict instead of cooperation. South Africa’s mineral wealth has allowed it to remain generally non-dependent on foreign aid, unlike its less resource-rich counterparts in the rest of Africa⁵⁹. This distant relationship with international organisations was compounded during the Apartheid era, when the South African government was considered an international pariah, greatly limiting relationships with international organisation and donor funding. At the domestic level, however, an active civil society grew out of resistance to Apartheid. Within the context of this massive civil society mobilization against the Apartheid state, local NGOs proliferated.

Before the transition to democracy, then, it is possible to characterise the relationship between international organisations and the South African state as distant and non-collaborative, and the relationship between the state and domestic civil society/NGOs as hostile. However, with the end of Apartheid, there were high hopes that civil society would become a partner to the

⁵⁶ Garui and Lieberman, “AIDS and the State”.

⁵⁷ Schneider, “On the fault-line”, 150.

⁵⁸ Ibid.

⁵⁹ Parkhurst, Justin, and Louisiana Lush. “The political environment of HIV: lessons from a comparison of Uganda and South Africa.” *Social Science & Medicine* 59, no. 9 (2004): 1919.

state in order to re-enfranchise the majority of the citizens and provide a better life for all, including an aggressive and adequate response to the burgeoning AIDS epidemic.

This chapter will discuss a number of the contestations that have taken place around HIV and AIDS policy in South Africa, with a focus on the growing rift between the state and non-governmental actors.

The National AIDS Plan

In the phase of transition to democracy, a cooperative partnership between the state and civil society regarding formulation of AIDS policy seemed highly possible. During the run-up to democracy before 1994, a large number of actors, both state and non-state, were involved in debating both the content and the principles of an appropriate response to AIDS⁶⁰, and representatives of numerous NGOs provided vocal input into the development of HIV and AIDS policy⁶¹. In October of 1992, a year and a half before the first democratic elections, the National AIDS Convention of South Africa (NACOSA), an umbrella organisation that included governmental and civil society actors, was born out of a series of consultative meetings that were held between the incumbent government and a range of ANC-aligned health practitioners⁶². The purpose of NACOSA was to coordinate the policy development process and to write a comprehensive National AIDS Plan so that the new democratically elected government could begin implementing the policy immediately after taking office. Despite the historically hands-off approach of international NGOs in South Africa, the WHO, United States Agency for International Development (USAID), Department for International Development (DFID), the European Community and the government of Belgium all provided technical assistance in drafting the specifics of the National AIDS Plan, which included the procurement and distribution of condoms and education materials⁶³.

⁶⁰ Schneider, "On the fault-line".

⁶¹ Parkhurst and Lush, "The political environment of HIV", 1919.

⁶² Natrass, "Mortal Combat", 39., Schneider and Stein "Implementing AIDS Policy", and Van der Vliet, Virginia. "South Africa divided against AIDS: a crisis of leadership." In *AIDS and South Africa: The social expression of a pandemic*, edited by K. Kauffman and D. and Lindauer. New York: Palgrave Macmillan, 2004.

⁶³ Ibid.

The National AIDS Plan outlined a framework for an integrated and collaborative response to HIV and AIDS, including six different areas through which to address the epidemic: prevention (with a focus on education); counseling (for those infected); health care; upholding human rights and law reform; overall welfare; and research⁶⁴. The key goals and objectives of the Plan were to: prevent the transmission of HIV, provide care for those infected and affected by HIV and AIDS, alleviate the impact of the AIDS epidemic on communities, support those not infected by HIV in remaining uninfected, provide a medium for South Africans to become involved in efforts to prevent the further spread of HIV and AIDS, identify resources that could be used to combat AIDS, and ensure community involvement in all levels of the development and implementation of the National AIDS Plan⁶⁵. The Plan couched the AIDS epidemic within a broad social framework that included education, prevention and care, and emphasised the importance of both prevention and care strategies. This is significant: in later years, treatment and prevention strategies were largely polarised and treated as mutually exclusive in governmental policy-making⁶⁶, creating conflict between various actors who believed that one or the other should be emphasised. Also significant is that in the National AIDS Plan, there was a strong emphasis on unifying and mobilising resources among the local, provincial, national and international levels⁶⁷, and a call for cooperation and collaboration between state and non-state actors.

The formulation of the National AIDS Plan was considered an important step forward in addressing the escalating AIDS epidemic, and many believed that it was only the beginning of an organised, progressive and deliberate response. Several of the members of the eight-member drafting team went on to hold high positions within the ANC-led government, including Nkosazana Dlamini-Zuma and Manto Tshabalala-Msimang, who went on to become the first two Health Ministers (under President Mandela and President Mbeki, respectively) for post-Apartheid South Africa⁶⁸. The importance of the plan lay especially in the manner in which it

⁶⁴ Fourie, “One burden too many?”, 111.

⁶⁵ Ibid.

⁶⁶ Ibid.

⁶⁷ Ibid, 112.

⁶⁸ Natrass “Mortal Combat”, 39.

couched a response to the epidemic as the protection of basic human rights, as well as in the participatory manner in which it was crafted. This established an expectation of future collaborative, human-rights based participation in AIDS policy⁶⁹ by both state and non-state actors. In short, the new government of South Africa entered office with a promising arrangement for a uniquely effective attack on the AIDS epidemic. There were a number of consultative structures in place, a progressive and lauded AIDS policy framework was laid out, and supportive relations with health professions had been established⁷⁰.

However, despite the idea that the National AIDS Plan was an ‘ideal’ policy that incorporated all of the right ideas about collaboration and a human rights-based approach, empirical data showed that it was not effective in achieving the plan’s primary goal: over time to lower HIV prevalence and AIDS morbidity/mortality within the population⁷¹. Among women attending antenatal clinics in 1994, the figure for HIV prevalence was an unsettling 7.6%. Moreover, in spite of the implementation of the National AIDS Plan, this figure not only failed to stabilise, but *increased* during the tenure of the Mandela government, and tripled to over 24% by the year 2000 (see Table 2 'HIV seroprevalence in South Africa')⁷². Though analysts are largely in agreement that the contents of the National AIDS Plan are not to be faulted, it is clear that something went terribly wrong.

Table 2 'HIV seroprevalence in South Africa'⁷³,

Year	Women attending antenatal clinics %	Total population
1990	0.8	0.1
1991	1.4	0.3
1992	2.4	0.6
1993	4.3	1.1
1994	7.6	1.8
1995	10.4	2.9
1996	14.2	4.5
1997	17.0	6.3
1998	22.8	8.2
1999	22.4	10.1
2000	24.5	11.7

⁶⁹ Schneider “On the fault-line.”, 146.

⁷⁰ Natrass “Mortal Combat”, 40.

⁷¹ Fourie, “One burden too many?”, 108.

⁷² Ibid.

⁷³ Table adapted from Fourie, “One burden too many?”, 109; data compiled from Dorrington and Johnson, “The Politics of AIDS Policy”.

Policy Contradictions: Macroeconomic Shifts

Significantly, democracy in South Africa came at a time when the dominant global opinion about development focused on neoliberal ideology of fiscal restraint and liberalization of markets. The introduction of neo-liberal macroeconomic reforms within South Africa, designed to attract foreign investment and corroborate with the prescriptions of capitalist globalization, had a devastating effect on employment and income levels for the poor⁷⁴ as well as for policies such as the National AIDS Plan that relied on a development-based approach for successful implementation.

For the first half of the 1990s, the post-Apartheid government's strategy was guided by the Reconstruction and Development Programme (RDP), which included a strong role for a "neo-Keynesian" state whose role would facilitate social transformation and which emphasised the need for people-driven development⁷⁵. The RDP was designed to break down the negative relationship between the state and society and intended to bind the state to economically redistributive policies which were aimed to meeting the basic needs of the majority of the population of South Africa⁷⁶. The RDP embraced the normative model of the National AIDS Plan, even elevating the plan to one of its five central elements⁷⁷. Both RDP and the National AIDS Plan included similar values: "policy-making would be inclusive, conciliatory, stable and consensual, focusing on bottom-up, populist measure mechanisms to ensure that all the appropriate policy stakeholders take ownership of the policies⁷⁸." These 'pro-poor' policies were slanted strongly toward development, with such priorities as "social spending for the sake of alleviating the plight of the indigent⁷⁹." It was believed that this type of development model would address the societal issues that exacerbated the conditions in which HIV was spread:

Johnson, "The Politics of AIDS Policy", Sanders and Chopra, "Key Challenges".

⁷⁵ Johnson, "The Politics of AIDS Policy".

⁷⁶ Ibid.

⁷⁷ Fourie, "One burden too many?", 111., "One burden too many?", 109.

⁷⁸ Ibid, 109-110.

⁷⁹ Ibid, 110.

The rational and logical way properly to manage [AIDS] is to contextualise it within the [RDP] paradigm, and to approach the problem with the principles and concepts embodied in the RDP. The RDP concept itself will in the long run do the most to minimize the impact of the epidemic...⁸⁰

However, in April of 1996, amid a broad shift in the policy-making environment, the RDP was discarded. Though the government promised not to abandon the developmental focus of its key policies, in June, the ANC announced the adoption of the Growth, Employment and Redistribution Strategy (GEAR). The intention of GEAR was to spur economic growth by reducing state expenditure and promoting fiscal responsibility⁸¹. GEAR set into policy the prioritization of a neo-liberal ideology, which significantly impacted AIDS policy implementation. The adoption of GEAR therefore essentially revealed an overall governmental shift from a pro-poor policy-making stance to a pro-growth macroeconomic policy stance. As a part of the neo-liberal project, which by nature cuts back on state spending, GEAR arguably had the most impact on the health sector, which depended heavily on social spending. GEAR and other like policies resulted in a 14.1% decline in per capita investment in social welfare programmes between 1995 and 2002⁸². In addition, although there has been some improvement in health spending among the most disadvantaged provinces, real per capita health expenditure has only increased at an annual rate of 0.3% since 1998⁸³. This slowed the health care sector transformation, which in turn perpetuated Apartheid institutions and economic legacies. For example, in 1994, the Mandela administration set out to shift large amounts of resources away from the tertiary care system into a clinic-based primary care system. Because of fiscal restraints, however, this shift was not fully implemented⁸⁴, thus allowing the Apartheid-era inequitable health financing to continue. The neoliberal push also impacted AIDS policy

⁸⁰ Eveian, "AIDS, Reconstruction and Development, and Corporate Response," *AIDS Analysis Africa* 5 no. 6 (1995): 3 as quoted in Fourie, "One burden too many?", 110.

⁸¹ Johnson, "The Politics of AIDS Policy".

⁸² Sanders and Chopra, "Key Challenges".

⁸³ Ibid.

⁸⁴ Van Niekerk, "The Evolution of Policies".

implementation by escalating the bureaucracy's inability to implement AIDS policies in the face of restrictions of government expenditures⁸⁵. Like many of the social policies put forward at this time, the National AIDS Plan greatly overestimated the new government's capacity to implement the suggested policies⁸⁶, especially in a context of fiscal restraint, and the plan essentially drowned among an environment of governmental restructuring and institutional roadblocks⁸⁷. Despite the fact that the National AIDS Plan was entitled to preferential access to funding because of its special status of a Presidential Lead Project, the new government instead concentrated funds on restructuring the health system and improving basic health care⁸⁸. The result was very little implementation⁸⁹ of the policies put forward⁹⁰. Neoliberal ideals encouraged the ANC toward a more closed and centralised political leadership and policy processes. This ran contrary to the expectations of most South Africans as to the manner in which a participatory democracy should function.

In the context of the massive policy shift, it was decided that the governance of AIDS policy would be situated in the National Department of Health rather than the Presidency. This undermined the ideal of the National AIDS Plan to keep the AIDS policy problem couched as a human rights issue. This also meant that it would be the Health Minister, not the President, who would be the main policy actor with regards to addressing the epidemic⁹¹.

[T]his undermined the relationship between South Africa's HIV and AIDS civil society and the government, and counteracted the spirit underpinning the [National AIDS Plan]'s mission to facilitate inter-and cross-sectoral co-operation. Instead of taking on the AIDS issue at a macro yet powerful

⁸⁵ Johnson, "The Politics of AIDS Policy".

⁸⁶ Schneider and Stein "Implementing AIDS Policy".

⁸⁷ Schneider, "On the fault-line", 146.

⁸⁸ Natrass "Mortal Combat", 40

⁸⁹ For a comprehensive and in-depth analysis of why the National AIDS Plan was not able to be implemented, see Fourie, "One burden too many?", 112-120.

⁹⁰ Garui and Lieberman, "AIDS and the State".

⁹¹ Fourie, "One burden too many?", 118.

presidential level, it was left to the Health Ministry and other individual government departments to co-ordinate activities. The distance that had opened between the government and civil society on this issue was later played out in the discursive environment and AIDS actors willingness and ability to redefine the AIDS policy problem...the schism between civil society and the state presaged a battle between the government's increasingly obdurate position on the importance of prevention, versus civil society's insistence on access to treatment for people who were already living with the virus⁹².

During this same time there was a great shift in the relations between the government and non-governmental organisations. Firstly, the NGO community was weakened by the transition to democracy, as many senior staff from NGOs transitioned into governmental positions⁹³. And secondly, unlike the period of time leading to the transition to democracy, there was little contact between the governmental offices and NGO AIDS actors. Reflective of this change in governance lack of consultation, the then Health Minister, Nkosazana Dlamini-Zuma, was quoted in the Mail and Guardian as saying "AIDS does not consult, it infects people⁹⁴."

Scandal: Sarafina II and Virodene

Implementation issues surrounding AIDS policy were further complicated by a series of scandals regarding governmental policy decisions. In 1995, the Health Ministry decided to commission a musical, *Sarafina II*, which was designed to educate the masses about AIDS⁹⁵. The budget for the production was huge, with a governmental contract of more than R14 million, and there was a massive outcry from a wide variety of non-governmental actors when news was released about the governmental contract for the musical. Complaints about the musical included both the content of the production and the manner in which the Health Minister had gone about funding it. The content of the play and its messages were criticised for not reaching their intended market and for including controversial messages about HIV and AIDS, which

⁹² Fourie, "One burden too many?", 118.

⁹³ Parkhurst and Lush, "The political environment of HIV", 1919.

⁹⁴ Schneider "On the fault-line", 147.

⁹⁵ Van der Vliet, "A Crisis of Leadership".

undercut the value in the production⁹⁶. The Health Ministry was criticised for the secrecy of the process, the unauthorised expenditure of the money used for the production (improperly allocated European Union funding), and the large amount of money that was involved⁹⁷ that should have gone to other AIDS prevention and education programmes.

The scandal surrounding *Sarafina II* was a watershed event regarding relations between the Health Department and civil society⁹⁸. As a NACOSA briefing states: “*Sarafina II* has done immense damage to the individuals and organisations active in the AIDS field. The process was not transparent and this has resulted in a rift between the Department of Health, NACOSA and the NGOs, as well as public derision about and hostility to HIV/AIDS work and programmes⁹⁹.” The scandal was the new government’s first real experience with widespread opposition from its constituency, and this rift did not go unnoticed by governmental leaders. President Mandela later described the *Sarafina II* debacle as one of the three mistakes of the ANC in 1996¹⁰⁰. However, even while the matter was still being investigated, the government found itself tied up in yet another AIDS policy-related scandal.

The outrage over *Sarafina II* was shadowed the next year by the Virodene scandal. This scandal was significant not only in the fact that it fomented the conflict between the government and civil society over the best way in which to address the AIDS epidemic, but it also was an indicator of the beginning of Mbeki questioning the authority of AIDS science¹⁰¹.

In 1996, President Mandela’s Health Minister, Nkosazana Dlamini-Zuma, was contacted by Olga Visser, a medical technician from Pretoria, who claimed to have discovered a treatment for AIDS¹⁰². Visser reported to Dlamini-Zuma that she had given a treatment of what she called

⁹⁶ Fourie, “One burden too many?”, 125.

⁹⁷ Schneider “On the fault-line”, 147.

⁹⁸ Van der Vliet, “A Crisis of Leadership”, 55.

⁹⁹ NACOSA briefing to the Parliamentary Portfolio Committee on Health (3 September 1996) as quoted in Van der Vliet, “A Crisis of Leadership”, 55.

¹⁰⁰ Natrass “Mortal Combat”, 41.

¹⁰¹ Ibid.

¹⁰² The Virodene section pulls heavily from Epstein, Helen. *The Invisible Cure: Africa, the West, and the Fight Against AIDS*. New York: Farrar, Straus & Giroux, Inc., 2007, 119 – 122.

‘Virodene’ (which consisted of a substance known as dimethylformamide or DMF) to several South African AIDS patients and had achieved excellent results. Minister Dlamini-Zuma quickly approved further human trials of the treatment. Mbeki, who was then the deputy president under Mandela, became intrigued when the results of the further trials delivered purportedly promising results. Mbeki invited Visser and her colleagues to present the findings from their trials at a cabinet meeting. Their presentation reportedly received enthusiastic applause.

However, the excitement soon hit a roadblock. When the South African Medicines Control Council (MCC) found out about Visser’s trials, they immediately sought to halt them, citing that there was no evidence that DMF was anything more than a toxic chemical. The MCC, which oversees the clinical trials of any pharmaceuticals in South Africa, deemed the Virodene trials unscientific and stated that although DMF was useful for a variety of industrial uses (including dry cleaning), there was a lack of evidence showing that it could be used in any way as medicine. Additionally, DMF was known to cause a variety of side effects such as liver damage and skin rashes. Despite the condemnation from the MCC, the Virodene researchers continued their research, supposedly with Mbeki’s blessing. When in 1998 the MCC again attempted to stop the trials, the chairman and two other top officials from the council were fired. This event like the *Sarafina II* debacle, greatly undermined the relationship between the state and NGOs as NGO groups vociferously criticised the actions of the government, and the government responded defensively: “The Virodene saga is significant in that it opened up the government to a new line of criticism regarding its handling of HIV and AIDS as a public policy issue, namely, that the government was interfering in science and not focusing on what they were supposed to be doing: governing the country and implementing policies¹⁰³.” The Virodene saga is also significant in that when compared to the government’s later responses to HIV treatment options, it highlights a stark contradiction. Mbeki and his followers within the government later rejected the use of ARVs as an option for the treatment and prevention of HIV and AIDS just as zealously as they embraced Virodene.

Following the *Sarafina II* and Virodene debacles, power surrounding issues of AIDS policy creation and implementation became increasingly concentrated, and the presidency began

¹⁰³ Fourie, “One burden too many?”, 125.

to be less willing to elicit outside sources of expert advice. The interactions between state and NGOs began to be characterised in large part by growing suspicion¹⁰⁴. Although the government and NGO actors had again attempted to coordinate a national vision for AIDS policy in another national conference in 1997, the distance between governmental and non-governmental actors grew as it became clear that the implementation of transformative policies remained low on the list of the national government's priorities¹⁰⁵.

In terms of HIV and AIDS policy-making, Peter Fourie argues that the adoption of GEAR, the failure to implement the National AIDS Plan and the scandals led to a fundamental redefinition of the AIDS policy problem in South Africa:

“The first phase of public policy-making on HIV and AIDS under the Mandela government effectively came to an end in 1996. Indicators of the shift to a second phase of AIDS public policy-making include: the demonstrable failure to implement the [National AIDS Plan] of 1994 effectively; the move from the RDP (abandoned in April 1996) to GEAR (announced in June 1996); and the emergence of an AIDS policy environment defined by public scandal¹⁰⁶.”

In the latter half of the 1990s, the relationship between the states and non-governmental actors further deteriorated with the unequivocal contestation between key members of the South African state and major advocacy groups over access to treatment¹⁰⁷.

Organizing Civil Society: the TAC

In 1998, a Thai medical trial released results showing that if HIV positive pregnant women took a short course of AZT, maternal transmission of the virus to the child dropped from 18.9 to 9.4 percent¹⁰⁸. The Gauteng provincial Health Department responded quickly to the findings by

¹⁰⁴ Butler, "South Africa's HIV/AIDS Policy".

¹⁰⁵ Garui and Lieberman, "AIDS and the State".

¹⁰⁶ Fourie, "One burden too many?", 125.

¹⁰⁷ Schneider "On the fault-line", 147.

¹⁰⁸ Natrass "Mortal Combat", 45.

setting up five pilot sites to test the Mother to Child Transmission Prevention (MTCTP) programme, and after the price of AZT was cut by two-thirds, several more MTCTP programme sites were introduced in various clinics around the country¹⁰⁹. However, in October, Health Minister Dlamini-Zuma announced the suspension of the MTCTP programmes, first claiming that the reason was so that the Department of Health could focus on 'prevention,' but when challenged that MTCTP programmes *were* a form of prevention, she stated that MTCTP programmes were simply 'unaffordable'¹¹⁰.

For many activists, this move went too far. On Human Rights Day in December of 1998, about fifteen AIDS activists gathered on the steps of St George's Cathedral in Cape Town and demanded that medical treatment be administered to people living with HIV and AIDS¹¹¹. Their protests were in direct response to the government's decision to halt MTCTP programmes and to deny funding for treatment in general. Out of this gathering, the Treatment Action Campaign (TAC) was born. One of the founders of the TAC, Mark Heywood, explained the reason for its formation: "It was clear by late 1998 that nobody was doing or saying anything about treatment and that we needed to create a movement led primarily by people affected by HIV directly¹¹²."

The TAC's objectives are described in the organisation's Constitution as follows:

- Campaign for equitable access to affordable treatment for all people with HIV/AIDS.
- Campaign for and support the prevention and elimination of all new HIV infections.
- Promote and sponsor legislation to ensure equal access to social services for and equal treatment of all people with HIV/AIDS.

¹⁰⁹ Natrass "Mortal Combat", 45.

¹¹⁰ Ibid.

¹¹¹ Robins, Steven. "'Long Live Zackie, Long Live': AIDS Activism, Science and Citizenship after Apartheid." *Journal of Southern African Studies* 30, no. 3 (2004): 12.

¹¹² News24. "How the TAC Began." November 29, 2005.
http://www.news24.com/News24/South_Africa/Aids_Focus/0,,2-7-659_1842267,00.html.

- Challenge by means of litigation, lobbying, advocacy and all forms of legitimate social mobilisation, any barrier or obstacle, including unfair discrimination, that limits access to treatment for HIV/AIDS in the private and public sector.
- Educate, promote and develop an understanding and commitment within all communities of developments in HIV/AIDS treatment.
- Campaign for access to affordable and quality health care for all people in South Africa.
- Train and develop a representative and effective leadership of people living with HIV/AIDS on the basis of equality and non-discrimination irrespective of race, gender, sexual orientation, disability, religion, sex, socio-economic status, nationality, marital status or any other ground.
- Campaign for an effective regional and global network comprising of organisations with similar aims and objectives¹¹³

The movement quickly grew; by 2004, it was reported to have 150 different chapters around the country and over 8,300 active members¹¹⁴. It is currently the most high-profile AIDS social movement in South Africa¹¹⁵. Over the years, TAC has linked themselves with a variety of global campaigns for drug access. They have formed a strong alliance with international NGOs such as Medicins Sans Frontieres (MSF)¹¹⁶. Domestically, TAC mobilised within working-class black communities and used the trade union movement to garner support. At its forefront is Zackie Achmat, a Muslim law graduate, former anti-Apartheid and gay activist, and openly HIV-positive person¹¹⁷. The formation of the TAC was a defining moment in what became a battle to hold the government responsible for providing treatment to its HIV positive citizens.

¹¹³ TAC. "About the Treatment Action Campaign." *Treatment Action Campaign*. <http://tac.org.za/community/about> (accessed November 2008).

¹¹⁴ Smith, R., and P. Siplon. *Drugs Into Bodies: Global AIDS Treatment Activism*. Westport, CT: Praeger Publishers, 2006: 85.

¹¹⁵ Schneider "On the fault-line", 158.

¹¹⁶ Ibid.

¹¹⁷ Robins, Steven. "Long Live Zackie".

The government did not respond entirely positively to the momentum that the TAC and other non-governmental and civil society groups were gaining. Despite a brief but successful partnership with the TAC over the battle against international pharmaceutical companies over the importation of cheap generic ARVs (see Chapter 3), the government refused to build on that collaboration. This was epitomised in 2000, when the South African national AIDS Council (SANAC) was formed under the leadership of Deputy President Jacob Zuma. Significantly, representation was not offered to the Treatment Action Campaign or to other high-profile NGOs such as the AIDS Law project. This suggested the “government’s increasing desire to pursue an approach autonomous from the most recognizable non-government AIDS organisations¹¹⁸.”

Questioning AIDS Science

Health Minister Dlamini-Zuma’s response to MTCTP programmes, which spurred the creation of the TAC, was actually only the first of a great wave of controversial governmental stances regarding AIDS treatment. In 1999, Deputy President Thabo Mbeki became the second president of the new South Africa, and added a new Health Minister to his cabinet, Manto Tshabalala-Msimang. Any anticipation that the new administration would bring a positive change with regards to AIDS policy was quickly squelched in 1999, when both President Mbeki and his new Health Minister began to openly question the connection between HIV and AIDS, as well as continue to challenge the use of the antiretroviral drug AZT for use in MTCTP, claim that it was toxic, and like the last administration, continued to refuse to make AZT available for the prevention of mother-to-child transmission widely available at public health institutions¹¹⁹. This same year, Mbeki began his highly publicised solicitation of AIDS dissident opinion¹²⁰, convening a panel of these dissidents in addition to other scientists to reexamine core assumptions by the scientific community about HIV and AIDS.

From the period 1999 through 2003, President Mbeki questioned the international scientific consensus that HIV was the causal link to AIDS, and multinational pharmaceutical companies, in conspiracy with Western scientists, were purposely exaggerating the claims about

¹¹⁸ Wang, Joy. "AIDS denialism and 'The humanisation of the African'." *Race & Class* 49, no. 3 (2008): 6.

¹¹⁹ Smith and Siplon, “Drugs into Bodies”, 86.

¹²⁰ See chapter 1 for an outline of the AIDS dissident view.

the incidence and prevalence rates of HIV and AIDS in order to sell overpriced and unaffordable drugs. At the beginning of 2000, President Mbeki sent a letter to several world leaders expressing the fact that he doubted that HIV was the sole determinant of AIDS and that other socioeconomic factors should be considered more thoroughly. Shortly afterward, he convened a panel discussion between orthodox and heterodox AIDS experts. The purpose of this presidential panel was to advise him on the appropriate responses to the South African AIDS epidemic¹²¹. He also suggested that ARVs were toxic to South African patients, and that instead of using Western medicine, that the AIDS issue should be considered part of the 'African renaissance', where African people may discover an African cure for an African problem¹²².

Reactions to Mbeki's controversial stance reached a fever pitch at the Durban AIDS Conference in 2000. The Durban conference was highly significant in a number of ways as it was the very first international AIDS conference to be held in the developing world, and was key in drawing attention to the specific nature of AIDS epidemics playing themselves out in the developing world. It was a moment of high tension surrounding international agenda-setting around MTCTP, vaccines, and the dire need to address the global inequalities in AIDS treatment.¹²³ However, the events at the Durban conference, which included a vociferous march by the TAC and a speech by HIV-positive Justice Edwin Cameron,¹²⁴ were very much overshadowed by the growing resistance to the statements that had been made by Mbeki and other governmental officials regarding HIV as causative of AIDS and skepticism about the toxicity and cost of ARVs. Everyone knew that Mbeki had been consulting with AIDS dissidents, and the Durban conference was a chance for him to 'clear his name' of these 'denialist' stances. Mbeki gave the opening speech to the conference, and in the speech, claimed that "The world's biggest killer and the greatest cause of ill health and suffering across the globe, including South Africa is extreme poverty"¹²⁵, which was met with wide-spread disapproval.

¹²¹ Fassin, Didier, and Helen Schneider. "The politics of AIDS in South Africa: beyond the controversies." *BMJ* 326 (2003): 495.

¹²² Wang, Joy. "AIDS denialism", 2.

¹²³ Schneider, "On the fault-line", 160.

¹²⁴ Ibid.

¹²⁵ Wang, "AIDS denialism", 6.

Hundreds of conference participants walked out, citing the fact that Mbeki did not say that HIV causes AIDS.¹²⁶

In April of 2000, the MEC for Health, Zweli Mkize, who was the deputy leader of the ANC in KwaZulu-Natal, published a statement that directly attacked the stances of the dissident scientists on Mbeki's Presidential Panel. Shortly thereafter the TAC launched a series of law suits designed to force national authorities to prescribe Nevirapine to HIV positive pregnant women. The result was a constitutional court victory for the TAC, and amid this setting, a tacit rebellion against governmental HIV policy began to acquire support within the ANC¹²⁷. It was at this point in September of 2000 that Mbeki was called upon by the SACP and COSATU to stop raising questions about the causes of AIDS in public. Shortly thereafter concerned commentary at an ANC National Executive Committee meeting led to the assurance that the president would 'definitely try to be quiet about the issue'¹²⁸.

Continued Conflict

Although Mbeki certainly had a cohort of supporters around him, including the Health Minister, there was also a strong insurgency of loyal ANC followers who deeply disagreed with his controversial stance. Though in the AIDS denialist community AZT was questioned over its toxicity and effectiveness, the use of AZT for use in the prevention of MTCTP grew a strong base of support from many ANC members, including public expressions of support by Nelson Mandela, Winnie Mdikizelea-Mandela and MP Pregs Govender¹²⁹. In October of 2000, Health Minister Manto Tshabalala-Msimang, a loyal follower of Mbeki, was pressured to authorise the limited trial of prescriptions of AZT in hospitals in eight of the nine South African provinces. However, when early the next year the premier of Gauteng extended this programme to twelve hospitals in his province, he drew a sharp admonition from the minister¹³⁰.

¹²⁶ Ibid.

¹²⁷ Lodge, Tom. "The ANC and the development of party politics in modern South Africa." *Journal of Modern African Studies* 42, no. 2 (2004): 206.

¹²⁸ As quoted in Lodge "The ANC and Party Politics", 206.

¹²⁹ Ibid.

¹³⁰ Ibid.

Despite a number of outspoken and high profile critics, Mbeki's views certainly had a number of supporters within the ANC, and even became orthodoxy to several health MEC's, especially in the province of Mpumalanga. Peter Mokaba was one of Mbeki's more vociferous disciples, and was said to have been involved in the writing of the document called 'Castro Hlongwane, Caravans, Cats, Geese, Foot and Mouth Statistics: HIV-AIDS and the Struggle for Humanity in South Africa.' The paper asserted that AIDS was nothing more than a mythical illness that was used by those who wished to further exploit prejudices about African sexuality¹³¹. The document was distributed widely in March of 2002, only shortly after Nelson Mandela had made a public plea that AZT be provided to the masses free of cost. The Castro Hlongwane document claimed that anti-retroviral medication was responsible for the death of many supposed AIDS victims. Mokaba died shortly after, most likely of AIDS.

At this point, the camp of Mbeki supporters on the AIDS issue was drawing enormous domestic and international condemnation. The director general of the Department of Health, Ayanda Ntysabula, threatened resignation, and the Castro Hlongwane paper drew severe criticism from within the ANC. Additionally, Nelson Mandela continued in his public support of the TAC, making appearances at key TAC demonstrations. He also publicly expressed his unhappiness with the cabinet ministers who failed to oppose Mbeki's views, and met personally with Mbeki in an attempt to reconcile differences.

In December of 2001, six months after the Durban AIDS Conference, legal representatives of TAC argued in the High Court of South Africa that the South African state was constitutionally-bound to promote access to health care to its citizens. They argued that this was extended to providing AIDS drug treatment¹³². TAC won their case. After a good deal of struggle, the government eventually announced plans to begin public treatment in 2003. At this point, Zackie Achmat, the chairman of TAC, finally abandoned his pledge to refuse access to ARVs until they were distributed by the South African government to all people living with AIDS¹³³.

¹³¹ Lodge "The ANC and Party Politics", 206.

¹³² Robins, Steven. "Long Live Zackie, 14.

¹³³ Smith and Siplon, "Drugs into Bodies", 87.

Mandela's support, combined with the Constitutional Court's ruling in favour of the TAC, and pro-AZT lobbying efforts of several figures from directly within Mbeki's entourage all set the stage for a National Executive Council meeting and cabinet decision to expand the provision of Nevirapine¹³⁴. This decision was reached in mid-April of 2002, with a goal to make Nevirapine widely available by the beginning of 2003.

After years of international and civil society pressure, the South African public rejoiced in October of 2003 when the South African cabinet made a historic decision to roll out HAART. One month later, the Department of Health published what appeared to be an optimistic plan to have a million people on treatment by the year 2008, and it seemed as if South Africa's controversial stance on providing ARV treatments to persons living with HIV AND AIDS was finally changing for the better. However, the then Health Minister, Dr. Manto Tshabalala-Msimang, was far from on board with the HAART rollout plan. From the time of the cabinet decision, it took nearly a year – until September of 2004 – for the Department of Health to release even the treatment guidelines surrounding ARVs, greatly slowing the process, with the result that the pace of the rollout was incredibly sluggish and inefficient¹³⁵. The HAART roll-out only truly gained momentum in the immediate lead-up to the 2004 elections, causing many to speculate that the only real reason for the long-delayed roll-out was because of fear of political backlash. Activist organisations such as the TAC saw the pace of the rollout as unacceptable, and responded with a series of marches and demonstrations. Tension grew between governmental actors and the civil society organisations. In July of 2005, police fired rubber bullets at 700 TAC protestors in the Eastern Cape, causing an international uproar¹³⁶.

The mounting tension between non-governmental actors and the state also played itself out in the distribution of public finances. Although governmental budgets have been allocated specifically towards the purpose of encouraging partnerships with NGOs and people who are living with HIV AND AIDS,¹³⁷ the amounts have been discouragingly low. Even in 2004, after the South African HIV AND AIDS budget had grown quite large, the amount of money that was

¹³⁴ Ibid.

¹³⁵ Natrass "Mortal Combat", 129.

¹³⁶ Ibid.

¹³⁷ Parkhurst and Lush, "The political environment of HIV", 1920.

earmarked to transfer to NGOs was only R54 million. Additionally, like many policies in the post-transition era, these too have been wracked with issues surrounding implementation.

Since then, relations between civil society, the TAC and the government have been rocky, with a number of highly public battles between them, each criticizing the other. In a statement on May 5, 2005 by Sibani Mngadi, the spokesperson for the Health Minister, the Ministry of Health did not even attempt to conceal the hostility towards TAC:

“During the closing session of the international conference on microbicide held in Cape Town last week, Achmat went on to revive his old populist grand standing style, criticizing almost everything that government has done to address the challenge of HIV and AIDS in the country. The first opportunity to have a TAC representative in the country delegation to an international forum has been squandered. Zackie Achmat and his government-bashing lobby are back in action¹³⁸,”

Fortunately, relations seemed to have turned for the better in 2007, when the government of South Africa announced the new National Strategic Plan (NSP) for addressing HIV and AIDS, and TAC praised governmental efforts: “The TAC NEC believes that the NSP marks a genuine commitment by government to ambitious but achievable targets for the treatment and prevention of HIV, to monitor the epidemic appropriately and to ensure the rights of people affected by HIV are protected...TAC believes the NSP is a decisive break with AIDS denialism¹³⁹.” In the same report, the moderator commented on improved relations with the government: “TAC also noted its much closer relationship with government. In particular, the election of Mark Heywood as the Deputy Chair of SANAC, and better working relationships with a range of government departments at national, provincial and local levels...¹⁴⁰,”

¹³⁸ Department of Health (South Africa). "Relationship between the Department of Health and Treatment Action Campaign." *Department of Health*. May 5, 2005. <http://www.doh.gov.za/docs/news/2006/nz0504.html>.

¹³⁹ TAC. "TAC Electronic Newsletter: TAC NEC commends progress in national response to AIDS - Now for implementation." *Treatment Action Campaign*. May 24, 2007. <http://www.tac.org.za/community/node/2156>.

¹⁴⁰ *Ibid.*

Conclusion

These are only a few in a long series of dramatic and conflict-ridden episodes in the story of AIDS policy and policy implementation in South Africa. During the era of high-cost antiretroviral treatment, when pharmaceutical companies were still refusing to allow the manufacturing of cheap or generic forms of the medicines, governmental resistance to implementing treatment programmes was understandable even if it was not seen as ethical¹⁴¹. However, local production of generic drugs and substantial reduction in ARV prices have greatly changed the situation and many have found it is nothing less than bewildering as to why the Health Minister worked to delay or sabotage the implementation of policy that is coming from her own department, let alone why education or prevention campaigns are often met with hostility or resentment.

What is certain is that contestation over health policy prescriptions is nothing new in the Department of Health, or in the post-Apartheid South African government in general. While the President, the Health Minister and others in the government have long questioned the biomedical causes and treatment of HIV and AIDS, other members of the cabinet and the Ministry of Health have quietly defied them by formulating a national strategic plan that comprises elements such as the treatment of opportunistic infections, sexual behaviour modification programmes and education. However, with such high level discordance, it is no surprise that even the most cogent of policies addressing AIDS have not been implemented successfully. A huge number of infrastructural and institutional constraints have frustrated attempts to implement any sort of a comprehensive prevention and treatment programme¹⁴² and have been compounded by manoeuvrings by leadership.

In short, there is a high amount of contestation surrounding the formulation and implementation of AIDS policy in South Africa, and in order to be adequately understood, it is necessary to analyze possible explanations as to why this contestation is taking place.

¹⁴¹ Benatar “Health Care Reform”, 88.

¹⁴² Schneider and Stein “Implementing AIDS Policy”.

Chapter 3 – AIDS Policy, Conflict and Power

The massive impact of the spread of HIV AND AIDS across Africa has been said to be one of the greatest humanitarian crises of our time, and has forced its way to the forefront of attention of national governments, international organisations and civil society across the globe. It has been increasingly clear that the AIDS epidemic is one that needs a colossal response from each of the economic, social, medical and political sectors. Because of this, the epidemic is one that is demanding cooperation between the domestic and the international, and the governmental and non-governmental. Since the 1980s, international organisations have been promoting technical guidelines for national governmental HIV and AIDS prevention and treatment programmes. However, the transfer of policy between the international and domestic levels and between non-governmental organisations to government policy-makers is a highly complex process¹⁴³, which challenges the very core of the communication and power dynamics within the territory of nations affected by the AIDS epidemic.

Explaining the Conflict

It would seem that the government would have everything to gain by maintaining a cooperative relationship with non-state actors who hold a stake in the AIDS crisis, many of whom have powerful connections to international organizations and foreign governments and have large amounts of resources waiting to be directed toward addressing the AIDS epidemic in South Africa¹⁴⁴. The conflicted nature of the relationship between government and civil society regarding AIDS policies in South Africa (as discussed in the last chapter) is extremely difficult to comprehend. The actions and stance of governmental leaders, especially those of former President Mbeki and his Health Minister Manto Tshabalala-Msimang, have been analysed by many authors, and a great deal of explanations have been put forward in an attempt to understand an apparently irrational approach to AIDS policy and uncooperative relationship with non-

¹⁴³ Parkhurst and Lush, “The political environment of HIV”,

¹⁴⁴ For example, the World Bank Multisector HIV/AIDS Project, the Global Fund to Fight AIDS, Tuberculosis, and Malaria, and the Clinton Presidential Foundation all have budgets allocated for fighting HIV/AIDS in South Africa.

governmental actors regarding AIDS. Their positions could easily be interpreted as an effort by the government to obfuscate the huge scale of the epidemic in the country, as well as conceal the massive challenges the epidemic creates for the project of nation building, the allocating of resources, and the urgent need to address poverty and inequality¹⁴⁵. This approach assumes that the former President, as well as other key policy-influencing members of his cabinet, are in ‘denial’ about the very nature of HIV and AIDS and the government’s role in addressing the epidemic (either unintentionally because they have believed misinformation about the epidemic, or deliberately because they do not think it is possible to adequately address it or do not have a desire to do so). One of the most prominent promoters of this ‘denialist’ explanation is Edwin Cameron, an HIV positive South African Supreme Court Judge and outspoken critic of President Mbeki’s stance on HIV and AIDS. In a speech at Harvard Law School’s Human Rights Programme, Cameron lashed out at Mbeki, comparing the President’s stances on AIDS to that of a Holocaust denialist. The speech ran on the front page of the *Mail and Guardian* on Easter day of 2003, titled “The Dead Hand of Denialism¹⁴⁶.” The denialist explanation has also been put forward and popularised by William Gumede¹⁴⁷ and Allister Sparks¹⁴⁸, both of whom highlighted Mbeki’s denialism as a key characteristic of the current state of affairs in South Africa. Gumede, in particular, portrays Mbeki as having become a true AIDS dissident after being swayed heavily by AIDS denialist arguments through Internet research: “He stoically believes that he is a modern-day Copernicus who will ultimately be vindicated, even if posthumously¹⁴⁹.”

However, not everyone is prepared to accept that the high levels of contestation and conflict within the AIDS policy-making environment in South Africa are due primarily to the controversial views of a small political elite. Alternative reasons for the lack of successful policy

¹⁴⁵ Schneider, “On the fault-line”.

¹⁴⁶ Mail and Guardian. "The Dead Hand of Denialism." *Mail and Guardian*, April 17, 2003.

¹⁴⁷ Gumede, William. *Thabo Mbeki and the Battle for the Soul of the ANC*. Cape Town: Zebra Press, 2005.

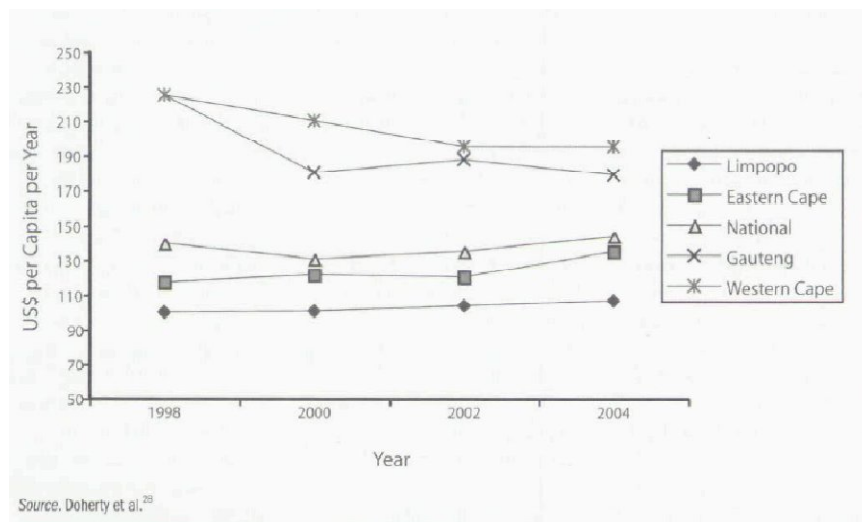
¹⁴⁸ Sparks, Allister. *Beyond the Miracle: Inside the New South Africa*. Chicago: University of Chicago Press, 2003.

¹⁴⁹ Gumede “Thabo Mbeki”, as quoted in Natrass “Mortal Combat”, 80.

responses have therefore been put forward. One of the most touted of these explanations is explaining policy failure in terms of the institutional constraints of the post-Apartheid state.

The new government inherited a health care system which was designed during the Apartheid era to attend to an intentionally fragmented society. The central government was in charge of policy implementation, coordination and funding, but health care delivery was restricted to the provincial level¹⁵⁰. When the new government was negotiating with the Apartheid regime before the transition to democracy, it was decided that power would be divided between the national, provincial and local governments to ensure that centralization and single-party control could be avoided. Though this decision was made with the best of intentions, it left open the possibility of re-fragmentation and confusion over which level of government should be responsible for health care policy and service delivery¹⁵¹. It also left responsibility of health care funding largely to the provincial level, which meant that richer, majority white provinces (whose health indicators resemble those of a developed country) were able to invest much more in their health care industry than the poorer provinces (whose health indicators resemble that of a least developed country – see Figure 2)¹⁵².

Figure 2 'Per capita health expenditures in South Africa, by province¹⁵³



¹⁵⁰ Van Niekerk, “The Evolution of Policies”.

¹⁵¹ Ibid.

¹⁵² Sanders and Chopra, “Key Challenges”.

¹⁵³ As used in Sanders and Chopra, “Key Challenges”.

The result has been a continuation of the racial dualism that limited access to health and welfare under Apartheid¹⁵⁴. Funding for health care has continued to be monopolised by tertiary academic institutions in the richest provinces, much because the private health care sector was left virtually untouched by the restructuring of national budgets that took place under GEAR¹⁵⁵. Though it seems the only solution to eliminate these inequities across the provincial level would be a state led regulation of health care delivery and redistribution of wealth¹⁵⁶, this is complicated by the legacy of autocracy that took place under the Apartheid regime. Because of this legacy, the government is bound by the commitment to allow the nine nation provinces to retain their own administrations and responsibility to deliver social services¹⁵⁷.

This institutional context could perhaps provide a compelling argument. Fourie (2006) used the context of institutional restraints as his primary explanation for the policy confusion in post-Apartheid South Africa, arguing that AIDS was simply ‘one burden too many’¹⁵⁸. In addition, to explain the failure of AIDS policy in South Africa, Schneider and Stein¹⁵⁹, Schneider¹⁶⁰, Johnson¹⁶¹, and van Niekerk¹⁶² all use reasons such as the continual restructuring of the government on all levels caused by transition to democracy, institutional constraints due to the legacy of Apartheid that have limited access and funding for health care within the country, and adherence to neoliberal economic policies that have resulted in increased unemployment, migration of women in addition to men, declining marital rates and growth of informal urban areas, and overall increased social and economic inequalities.

¹⁵⁴ Van Niekerk, “The Evolution of Policies”.

¹⁵⁵ Sanders and Chopra, “Key Challenges”, Van Niekerk, “The Evolution of Policies”.

¹⁵⁶ Ironically, the ‘R’ in GEAR stands for “redistribution”.

¹⁵⁷ Van Niekerk, “The Evolution of Policies”.

¹⁵⁸ Fourie, “One burden too many?”, also argued in Natrass “Mortal Combat”.

¹⁵⁹ Schneider and Stein “Implementing AIDS Policy”.

¹⁶⁰ Schneider, “On the fault-line”,

¹⁶¹ Johnson, “The Politics of AIDS Policy”.

¹⁶² Van Niekerk, “The Evolution of Policies”.

However, the problem with this kind of argument is that it does not take into account the fact that many of the policy issues over which the government obfuscated the most could have actually helped relieve pressure from the institutional constraints: As Nattrass points out:

Certainly with regard to MTCTP the institutional... constraints were negligible because it could have been provided using existing networks of clinics and hospitals. Furthermore, it would have reduced the number of AIDS-sick children (thereby reducing pressure on hospital staff) and improved the morale of doctors and patients alike. As an affidavit (for the TAC MTCTP case) from the acting medical superintendent of a rural hospital in KwaZulu-Natal noted, many doctors, when faced with the unbearable plight of HIV-positive pregnant women, opted to purchase Nevirapine for MTCTP out of their own pockets and the only 'side effect' has been 'extreme gratefulness'¹⁶³.

Additionally, arguments that justify the failure of South Africa's AIDS policy by pointing to the structural and institutional constraints faced by the country fail to view South Africa's situation comparatively with other developing nations. 'Institutional' arguments "implicitly assume that South Africa's challenges in the post-Apartheid period were unique in their difficulty, when in fact developing countries the world over are constantly battling with the challenge of building appropriate developmental infrastructure and policies in the face of scarce resources"¹⁶⁴.

To illustrate this argument, Nattrass provides a comparative analysis which suggests that greater HAART coverage should have been possible, given South Africa's level of development and institutional characteristics. She concludes: "This suggests that a lack of political will to utilise ARVs was a key part of the South Africa story and not just cover for a deeper, underlying structural problem"¹⁶⁵.

¹⁶³ Nattrass "Mortal Combat", 82.

¹⁶⁴ Ibid.

¹⁶⁵ Ibid.

Also important to take into account is that no matter what the inherited institutional constraints were upon the new government of South Africa, governmental leaders *chose* to adopt a neo-liberal macroeconomic model which has been perhaps one of the most daunting of the contextual constraints for AIDS policy in the post-Apartheid period. As was discussed in Chapter 2, shifting away from RDP and toward the neo-liberal approach of GEAR greatly affected social spending and governmental capacity, and subsequently, affected the ability to implement social policies such as the National AIDS Plan. Explaining policy conflict and failure within this economic context is appealing – as Nicoli Natrass explains (who was an avid supporter of an ‘economic’ explanation for the confused AIDS policy environment in her 2004 book):

After all, it was on economic grounds that the government resisted legal challenges to provide ARVs in the public sector for either HIV prevention or AIDS treatment. But this argument cannot explain why the Health Minister turned down the offer from Boehringer Ingelheim to provide Nevarapine free to government clinics. It also cannot explain why the government disregarded studies – including its own – showing that it was cost-effective for government to provide MTCTP¹⁶⁶.

Neoliberal economic policies, however, were not the only contextual constraint that AIDS policy implementation faced.

There is no doubt that there is enormous incentive, and enormous pressure within the globalised world economy, for a state to transform itself to fit into the neo-liberal economic paradigm. It would seem ‘rational’ that states would abandon development-centred policies in order to maintain themselves in a changing economy. This was largely the argument the South African government used when they chose to abandon RDP and shift to GEAR as a macroeconomic strategy¹⁶⁷. However, research has shown that if a state committed to

¹⁶⁶ Ibid, 80-81.

¹⁶⁷ However, the social democracies of northern Europe, China, India, and Cuba have all adhered to protectionistic policies that in some sense have defied the neoliberal project. The results are notable. For example, considering the severe economic crisis that rocked Cuba after the dissolution of the Soviet Union in the early 1990s, it is a remarkable fact, when compared to the 125 developing countries, Cuba consistently ranks in the top five percent on

development-focused social policy (such as the ‘pro-poor’ policies of the RDP) maintains productivity through an investment in its local labour force, higher state spending on social programmes can be maintained, despite competitive pressures in the global context¹⁶⁸. In relation to South African AIDS Policy, this argument is incredibly relevant. First of all, it shows that the South African government *has options* in maintaining social spending, despite how ‘unaffordable’ it may be. This makes it all the more perplexing as to why Mbeki and his government, despite repeatedly citing poverty as a determinant for the spread of HIV and AIDS and unaffordability as a key reason as to why MCTCP programmes could not be implemented and HAART could not be rolled out earlier, adhered steadfastly to macroeconomic policies that undercut social spending. Perhaps this contradiction could be explained by a fundamental paradox within the neo-liberal project itself:

“We find that there is a central paradox in the neo-liberal understanding of politics and the neo-liberal model of the state. On the one hand, the latter is oriented towards an ideal image of the *minimalist* state whose functions and autonomy are supposed to be tailored towards enforcing global business norms. A state that accepts and conforms to the rules of the world market needs to be readily replaceable and completely interchangeable; it must exist in a relation of competition with as many states of the same ilk as possible and it must have

social development indicators such as life expectancy, infant and maternal mortalities, adult literacy, and primary and secondary school enrolment. In fact, in 1996 Cuba was ranked in the top 20 percent of all countries, including those countries considered the most highly developed. Additionally, other than the social indicators that are associated most closely with food shortages or lack of imported medicine, most social indicators have consistently improved since the early 1990s, though at a less rapid pace than during the previous four decades¹⁶⁷.

The general explanation for this seeming anomaly is that Cuba has continued to meet its population's most basic needs in spite of its economic woes. The Cuban Revolution prided itself most on improving education and health, and eliminating absolute poverty. During the economic crisis, public spending on social programmes was maintained despite a 15 percent cut of total state expenditures. To put this in perspective, in the late 1980s, social expenditures constituted about one third of Cuba's GDP. In the 1990s, social expenditures constituted about two fifths of the GDP.

This is not unique to Cuba. Gosta Esping-Andersen, in her book *Welfare States in Transition*, argues that of all the advanced welfare states, “only a few have undertaken radical steps to roll back or deregulate the existing system. All, however, have sought to trim benefits at the margin or to introduce cautious measures of flexibilization. As we have seen, those following a more radical liberalization strategy do better in terms of employment but suffer a high cost in terms of inequality and poverty. In contrast, those resilient to change pay the price of high unemployment” (Esping-Andersen, Gøsta. *Welfare States in Transition: National Adaptions in Global Economies*. London: Sage Publishing, 1996.)

¹⁶⁸ Castells, Manuel. *The Rise of the Network Society*. Oxford: Blackwell Publishing, 1996.

internalized the neo-liberal world market regime institutionally, as it were. On the other hand, though, market deregulation and the privatization of public services *cannot* be achieved by a weak state. What is called for, instead, is a *strong* state, as the legal systems that conform to the needs of global business have themselves to be sanctioned by states and established *in opposition to* resistance within society¹⁶⁹.”

Perhaps it is feasible, then, to posit Mbeki’s stance within this neo-liberal understanding of the model of the state. There is little doubt as to why a neo-liberal economic model was appealing to Mbeki – seeking rapid economic growth for South Africa (and subsequently recognition within the global economy) was most certainly a factor. However, though the economic reforms of GEAR drastically cut social spending, making it appear logical to seek out non-governmentally funded partners to step in and address social needs, Mbeki and his administration did just the opposite – on almost every level, they refused to consult or cooperate with non-governmental actors (see Chapter 1).

While the ‘denialistic’, ‘institutional’ and ‘economic’ explanations are all plausible and certainly help elucidate a portion of the confusing story as to why the government has failed to adequately address the AIDS epidemic, none of them sufficiently addresses the issue as to why the government has been so hostile toward non-governmental actors and non-governmental responses to the epidemic. In order to explain this, then, perhaps it is necessary to examine the issue within the broader arena of state-civil society relations¹⁷⁰. Helen Schneider (2002) argues, this, suggesting that within the context of a budding post-Apartheid South Africa, it is highly plausible that the conflict surrounding AIDS actually represents a significant yet tacit battle between governmental and non-governmental actors over the question of who has the right to speak about, define, and determine the response to AIDS¹⁷¹.

¹⁶⁹ Beck, Ulrich. *Power in the Global Age*. Cambridge: Polity Press, 2005: 85.

¹⁷⁰ Natrass “Mortal Combat”, 83.

¹⁷¹ Schneider, “On the fault-line”.

The struggle for legitimacy

State/non-state partnership

Amid a complex political environment, the AIDS epidemic has continued to be a devastating reality for the impacted individuals. Therefore, despite the fact that there has been a high level of political contestation involved in AIDS policy-making and implementation on the governmental level, non-governmental actors and civil society have continued pushing forward. In South Africa, both domestic and international non-governmental actors have in many ways been seeking to fill the void left by inadequate government response. Non-governmental actors have gone a long way in leading the fight to provide treatment for HIV to populations unreached or deliberately ignored by government policies. The South African civil society movement, which was born largely out of the civil society movement that successfully helped bring down the Apartheid government, and led by the internationally-connected TAC, has garnered a large amount of 'power' through building legitimacy with the public and utilising powerful domestic and international networks to bolster their positions. Rooted in a human-rights rhetoric the civil society movement has gone a long way to ensure that treatment is provided to persons living with HIV and AIDS. However, the role of civil society and non-governmental organisations and their perceived power have in many ways challenged governmental authority on matters regarding AIDS, and who has the right to define what is the best way to respond to the epidemic. Within this context, it is possible to explain the high levels of conflict and defensive manoeuvrings by the government with regard to non-governmental actors, which in turn could explain the perpetuation of the crisis of implementation that has clogged the path toward a more humane response to the epidemic.

South Africa should have an endless amount to gain by collaborating with the international AIDS regime and streamlining its approach to addressing the epidemic (especially if the reason that they have been unable or unwilling to provide treatment or fund large-scale prevention campaigns has been because of limited funding or resources). Collaboration between non-governmental organisations and the government would seem to be especially strategic:

NGOs possess many positive characteristics that complement the work of governments in AIDS care. While governments have largely focused on the public health/epidemiological approach, NGOs have put more emphasis on the

broader social approach to AIDS care, by “addressing the social processes and inequalities driving the epidemic and intensifying its effects.” NGOs have been able to inspire trust among their constituents, while also encouraging processes of participatory decision-making. NGOs are more willing and able to address sensitive issues such as how to negotiate sexual relations and how to eliminate sexual coercion which are both necessary to reduce vulnerability to HIV transmission. International NGOs also have an added strength of not only lobbying Northern governments, foundations, pharmaceutical companies, and the United Nations system, they are also able to collaborate with community based local organizations to put into effect bottom up strategies for community empowerment¹⁷².

There are in fact several examples of how a solid relationship between the government and civil society can lead to an effective response against the AIDS epidemic in Africa. Uganda’s government, under the leadership of Museveni, is the most often cited as being exemplary in drawing together coalitions of NGOs, civic associates and governmental programmes in an endeavor to redress the impact of the epidemic¹⁷³. Policy-makers in South Africa seemed intent to follow suit with the drafting of the 1997 White Paper for the Transformation of the Health System in South Africa¹⁷⁴:

It is recognised that HIV/AIDS cannot be prevented without addressing the socioeconomic factors which underlie its spread. The cause and impact of AIDS extends beyond the health sector, requiring the commitment of and intervention by a variety of sectors - the State, private sector, nongovernmental

¹⁷² Chikwendu, Eurdora. "AIDS/HIV--When the State Fails: NGOs in Grassroots AIDS Care." *Dialectical Anthropology* 28, no. 3-4 (2004): 246.

This would seemingly have been ESPECIALLY appealing to Mbeki and his followers, who repeatedly cited social issues as the cause of AIDS.

¹⁷³ Boone and Batsell, “Politics and AIDS in Africa”.

¹⁷⁴ Department of Health (South Africa). "White Paper for the Transformation of the Health System in South Africa." *Department of Health*. April 1997. <http://www.doh.gov.za/docs/policy-f.html>.

organisations (NGOs) and community-based organisations (CBOs)... The following [principle] will therefore be adopted for the control of HIV/AIDS in South Africa:

- *Civil society and the Government sector will be involved mutually in containing the spread and impact of HIV/AIDS¹⁷⁵.*”

Shortly after the formation of the TAC in 1998, it looked as though a healthy partnership was going to be established between civil society (led by the TAC) and the state. In the mid-1990s, the South African government passed the Medicines Act that allowed for parallel importing and compulsory licensing of medicines used to treat HIV. At this point, hopes rose that the government would be a source of leadership regarding the fight for access to affordable medications. The TAC and the government, temporarily putting their differences aside in a collaborative move, became involved in a drawn-out legal battle over AIDS drug patents and the importation of cheap generic ARVs with international pharmaceutical companies. Together, the South African government and the TAC executed a highly successful global media campaign, and were able to garner support from a wide international public. The result was a huge success - the Pharmaceutical Manufacturer’s Association was forced to bring down their prices and allow developing countries to manufacture generics¹⁷⁶.

However, the elation over the partnership was short-lived. Despite the assertions of the White Paper, and despite the fact that it was specifically listed in the National AIDS Plan as an important area of focus, cooperation and collaboration between governmental and non-governmental actors with regard to AIDS policy has been characterised much more by discord than harmony within South Africa. NGOs The AIDS policy arena has been littered with conflictual relations between governmental and non-governmental actors, as was discussed in Chapter 2. One policy analyst described the relationship between the two groups as “in a world, hostile¹⁷⁷.” To explain this phenomenon, Schneider’s (2002) asserted that the AIDS policy

¹⁷⁵ Italics added.

¹⁷⁶ Smith and Siplon, “Drugs into Bodies”, 86.

¹⁷⁷ Friedman, 2000 as quoted by Boone and Batsell “Politics and AIDS”.

process in South Africa can only be fully understood when seen as a part of a perpetual struggle between various power-wielders¹⁷⁸.

A struggle for capital

At the African Development Forum in 2000, it was put forward that there are three areas of power for political leaders in dealing with AIDS: by exerting influence through formal state systems, by creating and sharpening discourse, and by supplying moral authority about the epidemic¹⁷⁹. In South Africa, it is possible to argue that all three areas of state power have been undermined. First, the unique political environment of South Africa (such as the structural weaknesses of the state bureaucracy inherited from Apartheid and the unequal independence of the quasi-federal system) has weakened the ability of political leaders to ensure that policies are implemented¹⁸⁰. Second, attempts by the political leadership to shape discourse about AIDS in South Africa have been mired in controversy and resulted in a loss of credibility surrounding the issue, rather than a sharpening of the discourse. Issues such as the *Sarafina II* debacle and the Virodene scandal have undermined faith in the governmental response, and President Thabo Mbeki's policy of 'AIDS denialism' has been arguably the most significant controversy to burden the South African government during the post-Apartheid period. Instead of shaping the discourse surrounding the epidemic, however, Mbeki's questioning led instead to a backlash from the media and civil society groups. Instead of considering his message regarding the underlying socioeconomic issues that have to be addressed in order for AIDS to be comprehensively addressed in Africa (such as poverty, inequality and a high STI prevalence), domestic and international observers focused on the fact that Mbeki had solicited advice from widely discredited AIDS dissidents and refused to fund initiatives such as providing AZT to prevent mother-to-child HIV transmission. And Third, the moral authority of the government has been deeply weakened by the backlash surrounding controversial governmental choices surrounding AIDS policy, such as openly questioning the connection between HIV and AIDS, challenging the use of the antiretroviral drug AZT, soliciting advice from AIDS denialists, and

¹⁷⁸ Schneider, "On the fault-line", italics added.

¹⁷⁹ Ibid, 161.

¹⁸⁰ Ibid.

finally refusing to make AZT available for the prevention of mother-to-child transmission¹⁸¹ or HAART available to persons living with AIDS. Because of this, the state's ability to provide moral authority regarding the epidemic was deeply undermined.

Despite the lack of successful state response, the AIDS epidemic has engendered such strong responses from a wide variety of actors both locally and globally, and both domestic and international non-governmental actors have been seeking to fill the void left by inadequate government response. In contrast to the overall failure of the South African state in wielding political power with regards to the AIDS epidemic, non-state actors in South Africa have been quite successful in wielding significant power. This power has been acquired through building legitimacy with the public and utilizing powerful domestic and international networks to bolster their positions:

Underlying the power of non-governmental actors is their access to both cultural and social capital, generated by the linking of multiple social dimensions and spaces: marginalized gay men and township youth; middle class expertise and popular mobilization; individual and broader social and economic rights; activists and scientists; the North and the South; the national and the international. In the literature on social capital, 'bridging' networks such as those commonly found in the AIDs field, are considered to be particularly effective forms of resource mobilization. These social networks have been facilitated by physical networks of electronic communication and vastly increased access to informational through the internet.... Also important have been: alliance building with internationally 'credentialed' groups such as MSF, winners of the Nobel Peace Prize; active support from an independent local media, seeing in AIDS an opportunity to call the new state into account; and finding concrete targets for short term mobilization¹⁸².

¹⁸¹ Smith and Siplon, "Drugs into Bodies", 86.

¹⁸² Schneider, "On the fault-line", 162.

As mentioned previously, it would seem that the power wielded by non-state actors should be to the benefit of state – if non-state actors aid (or even replace) the state in responding to the epidemic, it would relieve at least a part of the burden of responding to a difficult and costly problem. However, if we view relative power of non-state actors with regard to having the ability and resources to address the AIDS epidemic within the larger context of state power, it becomes clear that the accumulated power of non-state actors poses a challenge to the South African government at its core.

In order to understand this power struggle, we can examine Pierre Bourdieu’s typology of capitals. Bourdieu places heavy emphasis within his works on the idea of capital, and extends the concept of capital to all forms of power, believing that individuals and groups both draw upon cultural, social and symbolic assets in order to uphold and enhance their relative positions within the social world¹⁸³. Bourdieu usually refers to four different generic ‘forms’ of capital: economic (monetary resources), cultural (institutionalised by educational qualifications), social (made up by social ‘connections’ and institutionalised by titles of nobility)¹⁸⁴, and symbolic (legitimation)¹⁸⁵. Within the modern world, economic capital, cultural capital (which usually manifests in the form of educational credentials) and social capital (which usually manifests in the form of networks) and symbolic capital have all become sources of power¹⁸⁶. In terms of the state, then, Bourdieu sees the accumulation of capital as a means of constructing a space in which its power can be utilised:

“The state is the *culmination of a process of concentration of different species of capital*: capital of physical force or instruments of coercion (army, police),

¹⁸³ Swartz, David. *Culture & Power: the Sociology of Pierre Bourdieu*. Chicago: University of Chicago Press, 1997: 73.

¹⁸⁴ Bourdieu, Pierre. "The Forms of Capital." In *The Sociology of Economic Life*, edited by Mark Granovetter and Richard Swedberg. Cambridge: Westview Press, 2001: 243

¹⁸⁵ Earle, William. "Bourdieu Nouveau." In *Bourdieu: a Critical Reader*, edited by Richard Shusterman. Oxford: Blackwell Publishers, 1999. Symbolic capital is not so much a ‘kind’ of capital, but instead is a way of “emphasizing certain relational features of capital in general” According to Bourdieu, “Symbolic capital is capital with a cognitive foundation, which rests upon knowledge and recognition - As quoted in Earle “Bourdieu Nouveau”, 183.

¹⁸⁶ Swartz, *Culture and Power*, 74.

economic capital, cultural or (better) informational capital, and symbolic capital. It is this concentration as such which constitutes the state as the holder of a sort of meta-capital granting power over other species of capital and over their holders. Concentration of the different species of capital... leads indeed to the *emergence* of a specific, properly *statist capital* which enables the state to exercise power over the different fields and over the different particular species of capital... It follows that the construction of the state proceeds apace with the construction of *a field of power*, defined as the space of play within which the holders of capital (of different species) struggle *in particular* for power over the state, i.e., over the statist capital granting power over the different species of capital and over their reproduction...¹⁸⁷.”

The link between the ideas of capital and the concept of policy-making is not hard to make. According to Bourdieu, resources become capital when they become objects of struggle as resources that are valued¹⁸⁸. Governments are the traditional providers of services to its citizens, and policy is a tool through which those services can be provided. In turn, these services become a form of ‘capital’ for the government. Bourdieu views one of the key areas of state power to be that of controlling the manner in which its citizens conceptualise and reproduce the world and the world’s problems: “One of the major powers of the state is to produce and impose (especially through the school system) categories of thought that we spontaneously apply to all things of the social world...¹⁸⁹” In the case of South African AIDS policy, then, the object of struggle would be the right to decide how to respond to the AIDS epidemic. If we agree with Bourdieu’s typology, the struggle over this legitimacy to respond to the epidemic is the struggle over symbolic capital. Essentially, in the presence of an active civil society that contains a number of educated citizens who are able to connect via networks with civil society and non-

¹⁸⁷ Bourdieu, Pierre. "Rethinking the State: Genesis and Structure of the Bureaucratic Field." In *State/Culture: State-Formation after the Cultural Turn*, edited by George Stein, translated by Loic Wacquant and Samar

Farage. Ithaca: Cornell University press, 1999: 57-58.

¹⁸⁸ Swartz, *Culture and Power*, 74.

¹⁸⁹ Bourdieu, “Rethinking the State”, 53.

governmental organisations all over the world, and who claim the authority of knowing the best manner of response to the AIDS epidemic, the government of South Africa finds itself vying for symbolic capital, or the legitimacy to decide what to do about the epidemic. The struggle over who gets to decide the response to AIDS is actually a fundamental struggle for power.

One commentator suggests: “The act of policy-making is a moment of social violence, because ‘to describe something as “policy” is to give it special significance¹⁹⁰. If we use Max Weber’s famous definition of the state as the, ‘monopoly of violence,’ this view of policy-making becomes even more poignant. Bourdieu concurred that the state claims the monopoly of the legitimate use of both physical and symbolic violence¹⁹¹, but viewed the state’s monopoly over violence as successful only if it effectively triumphed over its domestic competitors: “the state could not have succeeded in progressively establishing its monopoly over violence without dispossessing its domestic competitors of instruments of physical violence and of the right to use them...¹⁹²”. Though in this instance he was referring to the physical monopoly of violence, it is not difficult to expand the concept to include the dominance over the policy arena, thus conquering the legitimacy, or symbolic capital with regards to the problem. In the case of South African AIDS policy, the government’s ‘domestic partners’ would be the power-wielding non-governmental actors who hold the symbolic capital with regards to the AIDS epidemic.

With this understanding of the policy environment representing a much larger struggle for power, it is possible to explain the perplexing conflicts that have taken place between the state and non-governmental actors, which in turn could explain the perpetuation of the crisis of implementation that clogged the path toward a more humane response to the epidemic. The role of civil society and non-governmental organisations, and subsequent accumulation of power, have in many ways challenged governmental authority¹⁹³ on matters regarding AIDS by

¹⁹⁰ Matlosa, Chablee. *Challenges of Conflict, Democracy and Development in Africa*. Johannesburg: Elisa Publishers, 2007: 247-248.

¹⁹¹ “Symbolic violence is characterised as: *...the coercion which is set up only through the consent that the dominated cannot fail to give to the dominator...when their understanding of the situation and relation can only use instruments of knowledge that they have in common with the dominator, which, being merely an incorporated form of the structure of the relation of domination, make this relationship appear as natural*” - As cited by Wolfreys, Jim. "In perspective: Pierre Bourdieu." *International Socialism Journal*, no. 87 (2000).

¹⁹² Bourdieu, “Rethinking the State”.

¹⁹³ Ulrich Beck argues that the struggle between the state (especially those states that are seen as not adequately responding to societal needs) and civil society is a phenomenon that is present throughout the globalized world: “The autonomy of the nation-state is called into question... by the meta-power of global civil society. Its meta-

challenging who has the right to define the best way to respond to the epidemic. It is possible to argue that this is especially true within the unique situation of South Africa, where governmental authority to respond to the epidemic has been undermined on a variety of levels (see above). Schneider argues that it is this struggle in South Africa that has been responsible for the nearly complete non-accommodation and highly publicised disagreement between senior African national Congress (ANC) politicians and an entire range of non-governmental actors regarding the AIDS policy process¹⁹⁴. Because the public debate on AIDS in South Africa has been dominated by competition between state and non-state actors to set the agenda for AIDS in South Africa, Schneider argues that both Presidential and Ministerial state interventions on AIDS can be viewed as countering efforts by the scientific and activist communities to influence policy.

Conclusion

Within the South African context, the power of the governmental leaders has been challenged significantly. To complicate matters further, non-governmental actors have sidestepped infrastructural constraints by eliciting support from international donor agencies, wielded incredible power in shaping the discourse surrounding AIDS, and through organisations such as TAC, with its strong links to widely respected institutions such as MSF, have provided a sense of moral authority. In short, non-governmental actors are giving the government a ‘run for its money’ in regards to the power and legitimacy to deal with AIDS. However, like Helen Schneider argues, the state is not even necessarily united in its response, especially when considering President Mbeki’s positions. For example, the growing number of resources being allotted to HIV and AIDS and the decision by certain provincial-level governmental officials to defy national policies with regards to the use of ARVs are both signs that a degree of political and bureaucratic independence have been present. Consequently, contestation within the state has added significantly to the position (and power) of non-governmental actors¹⁹⁵.

Though Bourdieu’s typology of capitals may shed light on *what* it is that the state and non-state actors are struggling for in regards to AIDS Policy, it doesn’t address *why* some

power is based on establishing the validity of human rights in opposition to the nation-state-based apparent taken for grantedness according to which states can do whatever they please within their own sphere of domination. Beck, Ulrich. *Power in the Global Age*. Cambridge: Polity Press, 2005:64.

¹⁹⁴ Schneider, “On the fault-line”.

¹⁹⁵ Schneider, “On the fault-line”.

members of the government chose to question AIDS science and challenge the international consensus on the best ways in which to respond to the epidemic, while other members of the government chose to align themselves with a more mainstream view. Chapter 4 will discuss this ‘why’ in further detail, with reference to the context in which the members of the government in South Africa are seeking to respond to the epidemic in the first place.

Chapter 4 - Policy Contestation

To summarise the discussion so far, the government of South Africa has been unable to implement policy in such a way as to quell the growing AIDS epidemic within its borders. Chapter 2 provided a narrative of the conflict-ridden history of AIDS policy in post-Apartheid South Africa, and Chapter 3 sought to explain several of the key areas of policy confusion and conflict by framing it within the larger struggle for power between the government and non-governmental actors. While this political power struggle interpretation is useful in explaining the conflict within the AIDS policy environment in regards to the conflict between government and non-governmental actors, it does not explain contestation that has occurred within the government itself, or why the government has produced policy that it then has refused to implement. In other words, how did it get to the point where governmental and non-governmental actors were approaching the same problem with different solutions in the first place? Or, more specifically, why would Mbeki and his followers put themselves in the position where they had to struggle with scientists and AID activists in the first place?

There has been a great deal of discord within the government over the best way to respond to the epidemic. After all, the national government, though represented widely as a unitary actor, is comprised of individuals, and each of those individuals is working and creating policy within the context of his or her own particular identity and understanding of the world. For example, while President Mbeki and his Health Minister publicly questioned the very cause of AIDS and the efficacy and toxicity of AIDS treatment, other members of the government¹⁹⁶ and former President Mandela came out to publicly express support for the international biomedical consensus for addressing the disease. At the same time that the Health Minister has advocated nutrition as the best way to treat AIDS, other members of the Department of Health have continued to purchase and distribute millions of condoms and focus on the rollout of Highly Active Anti-retroviral Therapy (HAART) in state sponsored clinics¹⁹⁷. The national government

¹⁹⁶ Schneider, "On the fault-line", 165 n16 : "Individuals who have taken public positions against Mbeki's stance on AIDS include William Makgoba, President of the MRC, and Mamphela Ramphele, former Vice-Chancellor of the University of Cape Town."

¹⁹⁷ Youde, *Politics of Knowledge*, 2.

has been at odds with individual provincial-level governments about how best to address the AIDS epidemic a number of times. In short, it seems that there is no consistent message coming forward from the various sectors of South African government; even within various departments of the government, words and actions do not seem to match up. As was outlined in the Chapter 2, the result has been that huge amounts of jumbled and sometimes contradictory policies have been produced, some of which contradict the AIDS regime and instead reflect the influence of AIDS dissident advisors.¹⁹⁸

This chapter will attempt to make sense of this apparent policy-confusion among governmental policies and procedures and examine a possible explanation as to why there seems to be so little consensus within the government about how to best respond to the epidemic. While the last chapter focused upon the conflicts within the AIDS Policy arena with special attention to the divisions between civil society and the government, this chapter will focus more specifically upon the specific paradigms that different members of the government have ascribed to in order to both make sense of the epidemic and to choose the way in which they believe that the state should respond. Specifically, the debate between the mobilization/biomedical and nationalist/ameliorative policy paradigms will be referenced. The mobilization/biomedical paradigm emphasises societal mobilisation, political leadership, and anti-retroviral treatments, whereas the nationalist/ameliorative policy paradigm focuses on poverty, palliative care, traditional medicine and proper nutrition¹⁹⁹.

Competing Paradigms

Despite the fact that within the ANC there have been different opinions over a great number of issues related to HIV and AIDS such as condom marketing, notifiability, whether outreach programmes should focus on sex workers, and so on, two rather distinct competing policy models are possible to distinguish. The first will be referred to as the mobilization/biomedical paradigm, and the second will be referred to as the nationalist/ameliorative paradigm. Author Anthony Butler describes the distinction as follows:

¹⁹⁸ Ibid.

¹⁹⁹ Butler, "South Africa's HIV/AIDS Policy".

A social mobilization and biomedical paradigm, advanced by the medical establishment and campaign groups, argued for more declarative and clear national political leadership, the mobilization of all social resources to combat the epidemic, the introduction of publicly funded post-exposure prophylaxis for rape survivors and health professionals, and the use of ARVs to prevent mother-to-child-transmission as a centrepiece of prevention policy. Supporters of this paradigm were later at the forefront of demands for a drastically scaled-up public ARV treatment programme.

A second model, ascendant within government after 2000, focused on sexually transmitted infections (STI) treatment, behaviour change, condom marketing, a mass communications strategy, and life-skills education. The emphasis within this paradigm was on prevention and palliative care, with nutrition, traditional medicine, massive social grants provision, and anti-poverty programmes prioritized, while bolstered traditional leaders were given responsibility for reinforcing the cohesion of rural communities²⁰⁰.

Importantly, these two policy paradigms are not fundamentally inconsistent with one another. It is not difficult to imagine an adherence to both a commitment to provide ARVs to those who need it while concurrently focusing on prevention of further transmission by addressing such issues as poverty and the epidemic of sexually transmitted diseases. However, as Butler alludes, in South Africa, especially during the first half of the Mbeki administration, the nationalist/ameliorative paradigm, which largely discounts ARV treatments as an option for people living with AIDS in the country, was by and large the one adopted as policy. Concurrently, aspects of the first paradigm, such as a scaled-up ARV treatment programme (including providing AZT to HIV positive expectant mothers), were largely and often angrily disregarded. Though there is a good chance that leaders may have been concerned that an entirely biomedical approach to addressing HIV and AIDS would take attention away from vital issues that have been seen to be endemic in Africa such as “extreme poverty, poor sanitation and

²⁰⁰ Ibid.

nutrition, dysfunctional families, a lack of recreational facilities, sexual promiscuity, and high crime rates²⁰¹,” it just doesn’t seem likely that this concern would lead governmental leaders to go as far as to *completely* discount ARV treatments as an option for people living with AIDS. Moreover, a high amount of conflict has occurred between supporters of the two different policy paradigms, most likely because adherence to a specific paradigm is underpinned by different fundamental assumptions about the very nature of the HIV and AIDS challenge and the role of the government in addressing it²⁰².

In his book *AIDS, South Africa, and the Politics of Knowledge* (2007) Jeremy Youde posits that the divide in adherence to distinct policy prescriptions has arisen because different key governmental leaders have been influenced by different (and often contradictory) knowledge paradigms or epistemic communities. Youde defines an epistemic community as “a network of scientists and experts to whom policy makers turn for guidance and unbiased information when a new issue emerges²⁰³.” In turn, policymakers use this information in order to create appropriate governmental responses to the issue. This means that members of an epistemic community actually wield a considerable amount of power as they are the ones who are framing the entire issue at hand for not only the politicians, but in many cases, the public. According to Youde, the concept of an epistemic community was first introduced to international relations scholars by Peter Haas. Haas argues that power is granted to the epistemic community because the information they provide is supposedly impartial and objective. The scientists and experts that make up an epistemic community are supposedly apolitical, and therefore policymakers are more likely or willing to adhere to what the epistemic community says. There are a great number of examples of an epistemic framing a particular issue such as on global warming, pollution, and the regulation of space satellites²⁰⁴.

However, a limitation is that this concept of the epistemic community put forward by Haas assumes that there will only be *one* epistemic community that emerges on any one issue²⁰⁵.

²⁰¹ Benatar “Health Care Reform”, 88.

²⁰² Butler, "South Africa's HIV/AIDS Policy", 592.

²⁰³ Youde “The Politics of Knowledge”, 3.

²⁰⁴ Ibid.

²⁰⁵ Ibid, 4.

When examining the stances taken by many of the members of the South African government surrounding the issue of AIDS, it is clear that while some policymakers have gathered and adhered to advice from the epistemic community surrounding AIDS²⁰⁶, some also have sought advice from what Youde terms a ‘counter-epistemic community.’ In the case of AIDS in South Africa, the epistemic community has been that of the ‘mainstream’ international AIDS regime – highly respected scientists and academics from around the world who hold views that fall much in line with the mobilisation/biological model discussed above, or that of the ‘AIDS Science’ discussed in the introduction. It follows the basic scientific orthodoxy regarding HIV and AIDS:

The human immunodeficiency virus (HIV) infects individuals through the exchange of bodily fluids, generally transmitted through sharing needles for intravenous drug use, sexual intercourse, or breastfeeding. Once infected, the virus gradually weakens the person’s immune system by attacking the T-cells that fight infection. With HIV attacking the T-cells, those cells cannot then fend off other opportunistic infections. Once a person loses enough T-cells, they are clinically diagnosed with AIDS. Most scientists believe that HIV causes AIDS, that AIDS is incurable, and that the disease is ultimately fatal in all instances²⁰⁷.

The counter-epistemic community²⁰⁸, on the other hand, is also comprised of a number of scholars and scientists who – contrary to much popular opinion – are generally highly qualified in their field and many of whom hold prestigious positions in various academic and scientific institutions. However, members of the counter-epistemic community offer a fundamentally divergent or ‘dissident’ understanding of AIDS, and suggest an entirely different set of policy prescriptions than does the epistemic community:

²⁰⁶ In this case, the epistemic community would be the ‘mainstream’ view on AIDS: HIV causes AIDS, the best form of treatment for people living with AIDS is ARVs, etc.

²⁰⁷ Youde, *Politics of Knowledge*, 98.

²⁰⁸ In this case whose views would line up more with the nationalist/ameliorative policy model discussed above. Also, this group of scholars is highly suspicious of colonial-like tendencies of the West or pharmaceutical companies, questions HIV as the cause of AIDS, and in general, focuses more on poverty and finding an ‘African’ cure rather than abiding to the epistemic community’s treatment and prevention models.

“AIDS dissidents share their own causal beliefs, challenging the established orthodoxy at almost every turn....Members of the counter-epistemic community generally deny that HIV causes AIDS. ...They argue that not all who have AIDS are HIV-positive, and that some who are HIV-positive never develop AIDS...In essence, they disagree with all of the arguments made by mainstream AIDS epistemic community²⁰⁹.”

The counter-epistemic community therefore frames the AIDS issue in an entirely different manner, focusing within a socio-economic rather than biomedical paradigm, couching suggestions about AIDS policy in terms of a burgeoning democracy and struggles against oppression, appealing strongly to the identity of many South Africans, and identity that has been formed by decades of less than positive experiences with outside public health campaigns and a desire for a distinct voice on the international stage²¹⁰.

Putting it in perspective: Thabo Mbeki and AIDS “denialism”

Before moving forward, it is important to take a step back and examine more carefully how governmental leaders policy choices are drastically affected by the specific context of South African politics and identity. Or, more specifically, it is important to discover why some South African leaders would be drawn away from a more ‘mainstream’ biomedical view of AIDS and attracted to eliciting advice from a counter-epistemic community. Because of the huge publicity surrounding his views and the importance of his position as president of the nation from 1999-2008, Thabo Mbeki will be used as an example of a South African leader who became influenced by the counter-epistemic community.

President Thabo Mbeki’s policy of ‘AIDS denialism’ – which is a name associated with Mbeki’s choice of words and actions regarding the HIV epidemic - has been arguably the most significant controversy to burden the South African government during the post-Apartheid period. As was discussed in Chapter 2, from 1999 through 2003, Mbeki questioned the international scientific consensus that HIV was the casual link to AIDS, and voiced concern that

²⁰⁹ Youde, *Politics of Knowledge*, 98-99.

²¹⁰ Youde, “The Politics of Knowledge”, 3,97.

multinational pharmaceutical companies, in conspiracy with Western scientists, were purposely exaggerating the claims about the incidence and prevalence rates of HIV and AIDS in order to sell overpriced and unaffordable drugs. He also suggested that anti-retroviral (ARV) drugs were toxic to South African patients, and that instead of using Western medicine, that the AIDS issue should be considered part of the 'African renaissance', where African people may discover and African cure for an African problem.²¹¹

In large part due to the publicity of these controversies, Mbeki's views and the views of members of his cabinet (specifically his Health Minister), were widely criticised within South Africa and internationally notorious for the approach their views took in addressing HIV and AIDS. President Mbeki's questioning of the biomedical causes of AIDS in large part baffled both national and international audiences inside and outside of the medical fields, and governmental decisions to deny funding for treatment programmes such as the Mother to Child Treatment Prevention Programme drew wide criticism from non-governmental organisations committed to human rights. However, when put into the perspective of South Africa's problematic history with racialised health care, Mbeki's stance is - if not justifiable - much easier to understand.

Racism and conspiracy are nearly impossible to extract from South Africa's history, most especially in the realm of public health. As has been documented a number of times, colonial medical discourse about Africans was extremely sexualised, especially regarding the spread of STIs. In Colonial discourse, African sexuality was depicted as "primitive, uncontrolled and excessive, and as representative of the darkness of the continent itself."²¹² As early as 1900, the bubonic plague was used as an excuse to remove hundreds of black South Africans from their homes in Cape Town to the first of the 'native homelands' under a law that had been passed in 1883 called 'The Public Health Act.'²¹³ It should therefore be no surprise that when AIDS appeared in South Africa, it was interpreted from nearly all angles through a racialised lens. The disease has been described often by academics, politicians and civil society in terms of African sexuality and promiscuity²¹⁴. During the Apartheid era, some white leaders even went as far as

²¹¹Wang, Joy. "AIDS denialism", 2.

²¹² Ibid, 14.

²¹³ Fassin and Schneider, "The politics of AIDS", 496.

²¹⁴ Ibid.

to publicly rejoice over the fact that a disease could wipe out black people.²¹⁵ As has been shown through testimonials that were publicised during the Truth and Reconciliation Commission, during the last years of Apartheid, National Party leaders were developing chemical and biological weapons (such as anthrax) to assassinate black leaders, researching sterilization techniques to use on the black population in order to stymie population growth, and even attempting to purposely spread HIV through the black communities by strategically ‘planting’ HIV infected prostitutes²¹⁶.

This historical narrative is very evident in Mbeki’s statements about AIDS. One of the most upsetting examples of the dehumanising legacy of Western science in Africa was the fate of Sarah Baartmann, whose legacy Mbeki addressed in a speech given in 2002 on the occasion of the return of Sarah Baartmann’s remains to her home in South Africa.²¹⁷ In the 1800s, Baartmann, a Khosian woman, had been kidnapped from her home in Cape Town and was taken to England and France to be displayed with little clothing as a ‘freak.’ Scientists in Europe used her to affirm the grotesque stereotypes of African sexuality at the time.²¹⁸ The symbolism of her funeral in the current AIDS debate is highly important because it served as a poignant reminder of the monstrosities performed on African bodies in the name of Western science.²¹⁹ Speaking in the Eastern Cape to crowds between a reported 5000 - 7000 people, Mbeki said:

The story of Sarah Baartmann is the story of the African people of our country. It is a story of the loss of our ancient freedom...It is a story of our reduction to the status of object that could be owned, used and disposed by others.²²⁰

Though he never specifically referenced AIDS during his speech, the implications were clearly there. His rhetoric was a warning to any that were hoping to forget the past of racial oppression.

²¹⁵ See Fassin and Schneider, “The politics of AIDS”, 496.

²¹⁶ Ibid.

²¹⁷ Wang, “AIDS denialism”, 8.

²¹⁸ Ibid.

²¹⁹ Ibid.

²²⁰ As quoted in Wang, “AIDS denialism”, 9.

A racialised interpretation of public health in South Africa is not only understandable, but hard to avoid. It is imperative to therefore consider Mbeki's statements and actions, which show an Africanist, anti-colonial ideology, as well as a desire to ensure that Africa is not 'blamed' for a sexually driven epidemic²²¹ with this historical perspective in mind. Some authors, such as Raymond Downing, take this argument even further, saying that not only do we need to keep in mind South Africa's racialised past with health care, but we have not given Mbeki enough credit, and that the way he has been portrayed in the media, especially the Western Media, has been unfair and inaccurate. Downing recounts a May 22, 2000 interview on *The News Hour* (in the United States) with Jim Lehrer in which Mbeki defended what he believed about the HI virus:

The interviewer Gwen Ifill asked, "...You've said that you were mischaracterized in some of the comments you said about the relationship between HIV and AIDS...Exactly where do you stand with that now do you think?"

Mbeki responded, "Well, yes, I don't know where these reports came from, that we're taking a position saying there's no connection from HIV - between HIV and AIDS. I never said it..." She then asked about his opposition to AZT, and he told her his reasons: "Affordability, medical infrastructure in order to dispense these medicines, and potential toxicity." In the same interview he explained why he invited the dissident scientists, explained again the difference between the African and American epidemics, and explained his desire to confront AIDS together with all the other health problems facing South Africa.²²²

Downing uses examples such as these and many others to argue that Mbeki has been misrepresented in the media, and how his statements need to be contextualised within the specific rhetoric of African medicine. It has to be taken into consideration that Mbeki raised very valid points about the socioeconomic and political factors contributing to the scale of the South African AIDS epidemic, points that have been largely overshadowed by the perception

²²¹Nattrass, Nicoli. "AIDS and the Scientific Governance of Medicine in Post-Apartheid South Africa." *African Affairs* 107, no. 427 (2008), 163.

²²²Downing, Raymond M.D. *As They See It: The Development of the African AIDS Discourse*. London: Adonis & Abbey Publishers Ltd, 2005: 68.

that he was an AIDS ‘denialist.’ Take for example, Mbeki’s remarks in July of 2000 at the Durban AIDS conference (see Chapter 2).

However, Mbeki also did not officially deny the link between HIV and AIDS, and the ruckus definitely detracted from the message that he was conveying: that underlying socioeconomic issues have to be addressed in order for AIDS to be addressed in Africa:

As I listened and heard the whole story told about our own country, it seemed to me that we could not blame everything on a single virus. It seemed to me also that every living African, whether in good or ill-health, is prey to many enemies of health that would interact one upon the other in many ways, within one human body. And thus I came to conclude that we have a desperate and pressing need to wage a war on all fronts to guarantee and realize the human right of all our people to good health. And so, being insufficiently educated, and therefore ill-prepared to answer this question, I started to ask the question, expecting an answer from others, what is to be done, particularly about HIV-AIDS! One of the questions I have asked is ‘are safe sex, condoms and anti-retroviral drugs a sufficient response to the health catastrophe we face?’²²³

Though Downing’s defense of Mbeki may be too forgiving, it is too simplistic to argue that Mbeki’s arguments are simply irrational. When put in the historical context of South Africa’s experience with racialised public health, as Didier Fassin argues, Mbeki’s views and statements clearly echo a narrative of political resistance to white domination and to the global order in general, as well as claim alternative treatments and interpretations of the disease based within the spirit of the African Renaissance²²⁴. The basis of Mbeki’s argument has been that instead of simply relying on the conventional Western biomedical discourse surrounding AIDS, we should instead work on a discourse that addresses the socioeconomic realities of South Africa. As mentioned previously, he has stated a number of times that AIDS is a disease of

²²³ As quoted in Downing, *As they See it*, 71.

²²⁴ Fassin, Didier. "Embodied history: Uniqueness and exemplarity of South African AIDS." *African Journal of AIDS Research* 1, no. 66 (2002): 66.

poverty, and that it is poverty, not AIDS, that is the world's biggest killer²²⁵. This argument focuses on the social conditions that make the spread of an epidemic likely, rather than on the behaviours that spread the disease. As Youde points out:

If Mbeki is approaching AIDS from a socioeconomic perspective rather than a biomedical one, then some of his positions make more sense. Addressing AIDS is less about providing ARVs and more about fundamentally restructuring the international economic order. It is a problem of poverty and underdevelopment, not just sick bodies, and needs to be holistically addressed from that perspective²²⁶.

This is a valid point. While proponents of a biomedical paradigm are correct in asserting that certain behaviours place people at high risk of contracting the disease, it is also irrefutable that certain economic and social conditions put people in a situation where they are more likely to choose those risky behaviours in the first place, as they lack the economic or social resources to make decisions that may keep them at lower risk of the disease²²⁷. This discourse, which is imperative to understanding and quelling the spread of HIV, is one that Mbeki perceived and took up. And it is arguable that the strong and vehement renunciation of his views limited the discourse on the other side to too narrow of a biomedical or behavioural approach. As Fassin and Schneider argue: "Had a social epidemiology of HIV been more prominent in the scientific arena, rather than the dominant biomedical and behavioural approach, Mbeki might have found an interesting alternative to the explanation of the epidemic given on the dissidents' websites²²⁸."

As it stood, however, Mbeki's views were harshly criticised by the medical epistemic community, sharp lines were drawn, and AIDS became a central part in the attempt to shape a distinctly South African identity. Mbeki's consideration of a dissident view of HIV AND AIDS

²²⁵ Youde "The Politics of Knowledge", 91.

²²⁶ Ibid.

²²⁷ Ibid, 92.

²²⁸ Fassin and Schneider, "The politics of AIDS", as quoted in Youde "The Politics of Knowledge", 92.

and the creation of a Presidential panel that was made up of nearly half dissident scientists would put him in the camp of being influenced by the ‘counter-epistemic community.’

If we take Youde’s theories on epistemic communities to be true, it becomes much easier to decipher the competing sets of policy prescriptions discussed above: In South Africa, a counter-epistemic community of experts has been allowed to gain influence within the governmental policy-making process because it offers a framing of AIDS that is in line with several policymakers’ nationalist desires and identities. This counter-epistemic community provides advice and recommendations about policy from a fundamentally different place than does the epistemic community. However, not all members of the government have fallen in line with this counter-epistemic community. On the contrary, many governmental players are quick to cooperate and seek advice from the epistemic community (see Chapter 2), and thus align themselves with the international AIDS regime, which also frames the AIDS issue through the epistemic community. Because of the existence of two strongly competing frameworks, the policy that has been created has come from two fundamentally different paradigms. When policy from one paradigm has been formulated, because it is not supported at even the most fundamental levels by key leaders of the government who frame the issue from the competing policy paradigm, it becomes hopelessly jumbled in a conflict-ridden policy environment.

Chapter 5 - Conclusion

The stance of former President Mbeki and his allies regarding HIV and AIDS has been widely condemned. Though it is too simplistic to simply argue that their views are irrational, it is also imperative to take into consideration the implications of their stances on policy-making and subsequently, on the lives of those affected by HIV and AIDS. It would be understandable if, as Fassin and Schneider (2003) argue, widespread distrust of Western medicine, science, and public health still remain deeply imbedded in the consciousnesses not just of the governmental leaders, but also a large percentage of the population. However, some authors, such as Mandisa Mbali (2002) suggest that most within South African society recognise that a racist discourse surrounding AIDS is increasingly in the past. A racialised interpretation of the current AIDS epidemic, at least in the way Mbeki has articulated it, is reacting to a largely extinct racist discourse, which saw Africans as inherently pathological²²⁹.

Mbali argues that when Mbeki contends that Western biomedicine regarding AIDS aims to stigmatise African sexuality and appeals to non-specific ‘African’ solutions to the epidemic, he is essentialising the notion of ‘African culture’ in the first place, and assuming that it has been completely and permanently altered by Western culture (through the means of colonisation). This, continues Mbali, is an archaic argument in today’s world and surrounding today’s epidemic. Mbali argues that Mbeki’s rhetoric about AIDS has gone back in time to argue against a discourse which in today’s world has been largely surpassed by “rights-based, anti-discrimination discourse and a shift to a medical, technical non-‘moralistic’/stigmatising approach.”²³⁰ In other words, Mbeki’s policies and arguments are challenging an anachronistic identity that the international community has already taken great strides to move beyond – “the *contemporary* response is appropriate for a *previous* conceptualisation of the disease²³¹”. While Mbali may be a little overly-optimistic about the philanthropic nature of all ‘Western’ medicine, she delivers a clear point when she says that regardless of the arguments against the racist nature

²²⁹ Mbali, Mandisa. "Mbeki's Denialism and the Ghosts of Apartheid and Colonialism for Post-Apartheid AIDS policy-making." *Public Health Journal Club Seminar Paper*. University of Natal, Durban, May 2, 2002.

²³⁰ Ibid: 18

²³¹ Youde “The Politics of Knowledge”, 95.

(past or present) of AIDS discourse, it is the job of the president to provide health services to the population of his country. This gridlock caused by questioning the science of AIDS is inexcusable as people need treatment.

This argument has been taken up and carried quite vociferously by the Treatment Action Campaign, as well as a large portion of civil society. As articulated in the *Mail and Guardian* in 2000:

Faced with this crisis, we can legitimately expect of our president that he ensure that state policy on the issue is coherent well-understood by the public at large, energetic and based on the best available scientific knowledge...Instead, he has at times behaved like someone trying to be the Boy's Own basement lab hero of Aids science. He has allowed his attention to be diverted by abstruse debates on immunology and related science...In the process, the nation's attempt to deal with this national health crisis has been plunged into confusion. And the four million-odd South African who have contracted the syndrome can be forgiven for feeling, if not exactly abused, certainly neglected.²³²

Perhaps this viewpoint is most graphically depicted by looking at the numbers. Nicoli Natrass takes a quantitative approach to exploring what 'could have been' if there had not been a 'stalemate' regarding AIDS policy, and the government's choices had been different. She uses the ASSA2003 demographic model in order to explore this question by modeling different policy scenarios. The baseline of the model looks at the "reality" – or the outcomes that occurred using the ARVs, prevention and treatment. The four other projections look at what could have happened if any one of the strategies had not been in place, one with no intervention at all. As is apparent by looking at Figure 3, interventions using ARVs for both prevention and treatment helped probably about a quarter of a million more people from becoming infected with HIV than if no interventions had been implemented.²³³

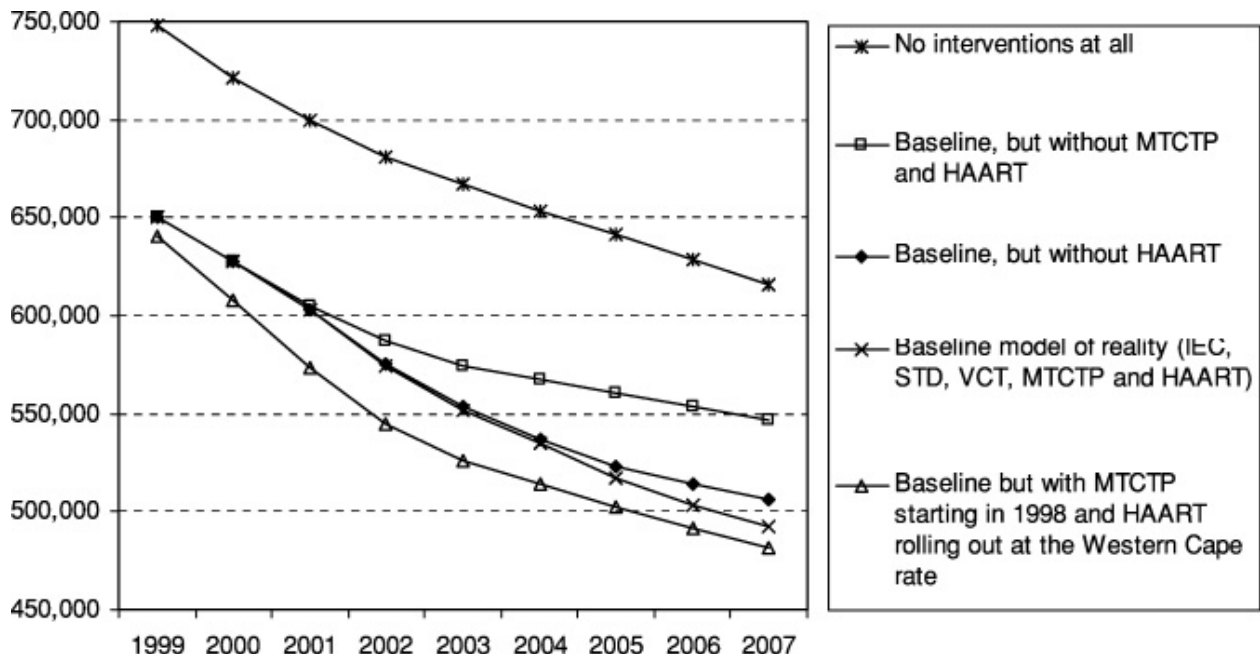
²³² Mail and Guardian. "What's behind Mbeki's crusade?" *Mail and Guardian*, March 31, 2000 - as quote in Mbali "Mbeki's Denialism": 19.

²³³ Natrass "AIDS and Scientific Governance", 173-174.

However, Nattrass' argument is that this achievement could have been much greater if national political will had been similar to the political will in the Western Province, which was the only province that has remained in control of the opposition in the post-Apartheid era, and has defied national policy by starting a HAART project in conjunction with *Medecins Sans Frontieras* (MSF) in 2000²³⁴. There is a fifth projection on Figure 3 that shows the estimate of the impact on new HIV infections if MTCTP had been rolled out in 1998 instead of in 2001, and if HAART had been rolled out throughout the country at the same time that the Western province rolled it out. This model indicates that more than 171,000 new HIV cases could have been prevented if this had been the case²³⁵.

Figure 4 repeats this same exercise, only with AIDS deaths, and the model estimated that an additional 343,000 AIDS deaths could have been prevented by implementing HAART and MTCTP at an early date. Figures such as these have lead Nattrass and other authors to accuse the South African government of 'genocide by sloth.'²³⁶

Figure 3 'New HIV infections: different scenarios (ASSA2003 demographic model)²³⁷,



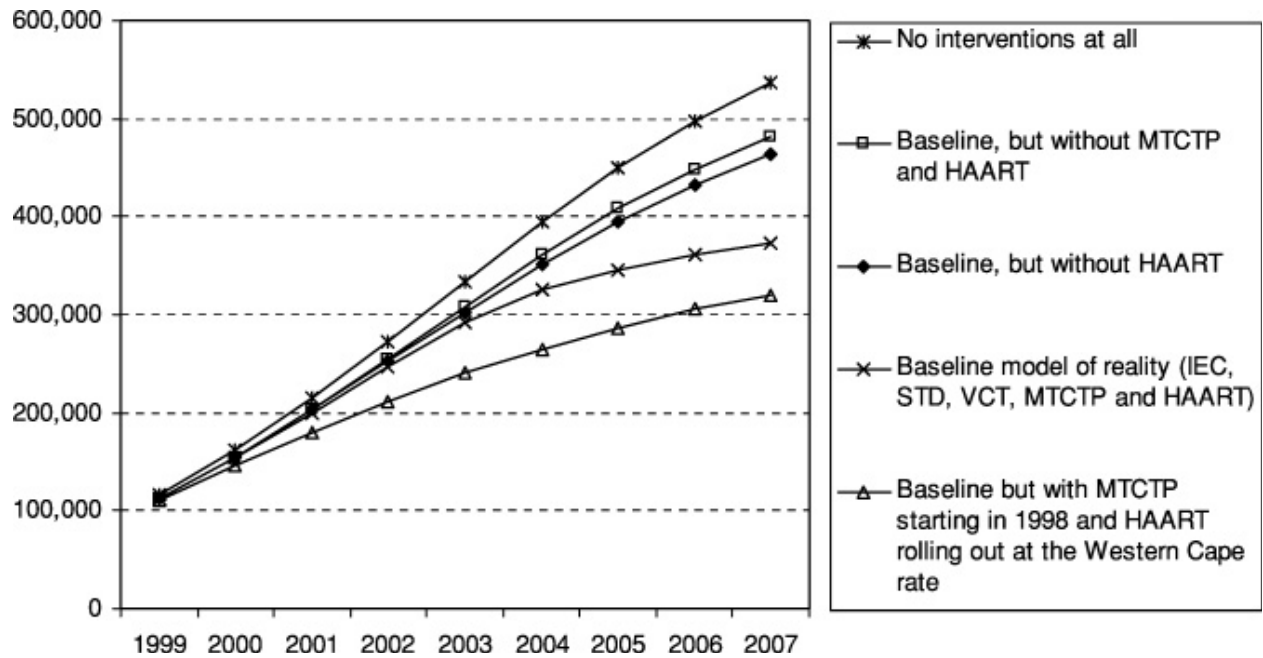
²³⁴ Ibid.

²³⁵ Ibid.

²³⁶ Ibid: 175.

²³⁷ Taken from Nattrass, "AIDS and Scientific Governance", 173.

Figure 4 'AIDS deaths: different scenarios (ASSA2003 demographic model)²³⁸



Natrass' argument illustrates the potentially devastating effect of a policy environment that is inundated in conflict and contradiction: Though the inequalities within South Africa were institutionalised by the Apartheid regime, which set the scene for the AIDS epidemic, the current scale of the AIDS situation cannot simply be contextualised in terms of the past. As was learned from Apartheid, policies matter. We already know that current social factors, which can be at least in part contributed to neoliberal policies such as increased unemployment, migration of women in addition to men, declining marital rates and growth of informal urban areas are perpetuating inequalities²³⁹. This 'high risk situation' in South Africa is compounded by a policy environment that has been mired by both conflict and contestation, and consequentially, even the most lauded of AIDS policies have not been properly implemented. The result has been that the AIDS epidemic in South Africa has not been in any substantial way quelled by the government.

This thesis sought to examine possible explanations for the high levels of conflict and contestation regarding AIDS policy in South Africa. Through an examination Bourdieu's typology of capitals and a reconceptualisation of AIDS policy within the framework of a larger

²³⁸ Ibid, 174.

²³⁹ Marks, "An Epidemic Waiting to Happen".

struggle for power and legitimacy within the specific context of post-Apartheid South Africa, a possible explanation was put forward for the high levels of conflict between government and non-governmental actors: the struggle over AIDS policy has actually become a struggle over symbolic capital, or legitimacy. However, in order to explain contradiction regarding AIDS policies that has occurred *within* the government (or why the government has produced policy that it then has refused to implement), the framework through which policy-makers are influenced was explored. The theories put forward by Anthony Butler and Jeremy Youde offer an explanation of competing policy paradigms and in turn, how those have been adopted by key governmental members and formulated into policy. With fundamentally different frameworks shaping the policy that is being put forward, it is of little surprise that there has been a great deal of confusion and prevarication taking place.

Perhaps what is most tragic about the counter-epistemic (or denialist) messages that were put forward and supported by the government during the early 2000s is not that it depicted a resistance to the racist and colonial histories of Western medicine, or that it critiqued neocolonialism, multinational companies and even NGOs. Instead, the tragedy lies in the fact that unlike figures such as Paul Farmer and Susan Sontag, both whom passionately used arguments about poverty and racism to amplify the dire need for AIDS treatment in the developing world, Mbeki's statements and like thoughts (as articulated in the 'Castro Hlongwe' document) used anti-colonial and anti-racist rhetoric to stall the application of ARVs.²⁴⁰ As Youde aptly points out:

While Mbeki may have this different interpretation [regarding the paradigm through which to view AIDS], there is no reason to assume that it is an either/or issue. A restructuring of the international economic order may indeed provide greater equity and justice, but that does not mean that those sick bodies here today should be sacrificed for a goal that is perhaps even more overwhelming than the AIDS epidemic²⁴¹.

²⁴⁰ Wang, "AIDS denialism", 7.

²⁴¹ Youde "The Politics of Knowledge".

What is clear is that the government certainly did not take as aggressive of a stance as it could have. This is understandable in light of the racist history through which South Africa has come. However, though it may be understandable, it is not excusable, and this must be kept in mind by the current and future governments. The tragedy of the past does not excuse inaction in the present.

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