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The politicisation of HIV/AIDS in South Africa: Responses of the Treatment Action Campaign and South African government, 1994-2004 – A literature review

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Abstract

The HIV/AIDS epidemic became a deeply political and politicised issue throughout South African society from the 1990s. The ANC government and the country's most prominent HIV/AIDS movement, the Treatment Action Campaign, engaged one another in a political battle over HIV/AIDS policy and specifically ARVs. Highlighting a number of key international, continental and domestic factors that contributed to the politicisation of HIV/AIDS in South Africa, this review analyses the responses of government and the TAC to this highly charged environment. The literature reveals that the TAC saw HIV/AIDS primarily as a health crisis, appealing to medical science and a campaign to secure free ARV treatment for all South Africans, while the government understood the HIV/AIDS disaster through the prism of race and racism, poverty and South African public health history. Authors have also highlighted the importance of accounting for Mbeki's views and their impact on government HIV/AIDS policy. Four different paradigms are outlined through which the literature can be understood: 'biomedical-mobilisation', 'public policy', 'historical-sociological' and the 'Marxist critique'. There are no 'schools' or 'categories' associated with the TAC's response to politicisation due to their open and non-contradictory actions and therefore no 'problem' to explain. Hence this review will look at two specific TAC responses to what it perceived as government denialism; a grassroots treatment literacy campaign and the establishment of an epistemic community capable of engaging in an intensive media-based 'intellectual campaign'. Finally, this review will suggest that the initial manner in which a social issue is politicised impacts heavily on its outcomes.

"… the imagery of sex as freedom, as the symbol of a virile new lease on life, jostles with that of sex as menace, sex as death."

Deborah Posel (2005:139)

"We have learned very little that is new about the disease, but much that is old about ourselves.' A doctor wrote of the polio epidemic in NY in 1916. Much the same may be said about AIDS in Johannesburg in 2000."

Dieder Fassin (2007:32)

"It has long been recognised in the international AIDS community that successful AIDS policy requires government and civil society to work together, and in this respect South Africa was a worrying exception"

Nicoli Nattrass (2007:178)

"Any disease that is treated as a mystery and acutely feared will be felt to be morally, if not literally, contagious."

Susan Sontag (1991:5-6)

1. Introduction

In 1990, South Africa had an HIV/AIDS infection rate of approximately 1%. Yet by 2005, the pandemic had spread to 18.1% (UNAIDS, 2006) of the population (over 5.7 million people), resulting in HIV/AIDS becoming a significant cause of social mobilisation. However the ANC government and the country's most prominent HIV/AIDS movement, the Treatment Action Campaign (founded in 1998), engaged one another in a political battle over HIV/AIDS policy and specifically ARVs, which severely impacted on the state's and civil society's response to the epidemic.

This review is an attempt to identify key themes, authors, areas of debate and consensus and seek to understand the strengths and weaknesses of the literature that deals with the 'state of knowledge' of the responses of the government and TAC to the politicisation of HIV/AIDS in South Africa.

First, however, four categories can be established through which the literature (mainly on the government and Mbeki) will be analysed: 'biomedical mobilisation', 'historical-sociological', 'public policy' and the 'Marxist critique'. This review will then conceptualise two terms, 'politicisation' and 'denialism', that will be used throughout this paper and highlight the key role

that they play in understanding the subsequent debates as well as expressing some of the caveats and assumptions that this paper utilises. While this literature review focuses on the period from 1994 until 2004, it first highlights a number of historical events and key international, continental and domestic factors that contributed to the politicisation of HIV/AIDS in South Africa. Thereafter, it analyses the responses of the ANC administration[1] and TAC to this politicised environment by pointing towards the different manner in which each understood the AIDS epidemic and their role in relation to it. The literature contends that TAC saw HIV/AIDS primarily as a health crisis, appealing to medical science and a program of mobilisation to secure free ARV treatment for all South Africans. On the other hand, various authors suggest that the government understood the HIV/AIDS disaster through the prism of race and racism, poverty and South African public health history. In order to better account for the government's stance on HIV/AIDS, it is also necessary to look at the different ways in which the writers have understood President Mbeki's views and their impact on government policy. The literature does not suggest any 'schools' or 'categories' associated with TAC's response to politicisation and due to the organisation's open and non-contradictory actions there has been no 'problem' that academics have had to explain. Hence, this review will look at two specific TAC responses, the grass-roots treatment literacy program and its institutional-level 'intellectual campaign' against denialism (Ashforth & Nattrass, 2005: 296-297). These are two examples mentioned in the literature highlighting the multi-level response that TAC embarked upon to counter what it termed 'denialism'. Finally, this review will recommend areas for future research and suggest that the initial manner in which a social issue is politicised impacts heavily on its outcomes.

2. Categories and Concepts

2.1. Categorising the Literature

Academic contributions to the issue of HIV/AIDS, the South African government and TAC cover a broad range disciplines, including history (Iliffe and Fourie), politics (Friedman, Sparks, de Waal, Schneider, Mbali, Geffen and Suresh Roberts), sociology (Fassin, Youde, Steinberg, Neocosmos, Posel), public policy (Butler), public health (Phillips) and economics (Whiteside, Nattrass). Each of these fields has a specific approach to the politicisation of

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[1] Note that the terms 'government' and 'ANC administration' will be used interchangeably.

HIV/AIDS in South Africa and contributes a different perspective on the way that the actions of government and TAC should be understood.

Attempting to group the literature around the politicisation of HIV/AIDS and the response of government and the TAC is challenging since there are no defined fields that each of the abovementioned authors subscribe to. For the purpose of this paper, however, there are five broad categories of literature that can be created, utilising the fields from which the authors in question originate. The easiest to define, but weakest to explore, are the group of self-proclaimed AIDS dissidents who refuse to see any benefit in medical science whatsoever and claim that all ARVs are toxic and simply a racist plot. The most vociferous voice of this group is Anthony Brink.[2] Brink and his group see government's provision of ARVs as genocidal and a result of the pressure placed on it by groups like TAC and international pharmaceutical companies, who are driven by racist indifference to black people. Since his perspectives, and the other people within his TIG (Treatment Information Group), are seen as being marginal in the literature, this paper will not consider Brink, or his group, in any further detail.

The remaining categories can be roughly divided into four perspectives: 'biomedical-mobilisation', 'historical/sociological', 'public-policy' and a broad, if crude, 'Marxist critique'. The 'biomedical-mobilisation' group consists of academics like Nattrass (2007) and activists like Heywood (2004) and Geffen (2006)[3], who see the origins of the pandemic through the eyes of medical science (and the way that it characterises the epidemiology of HIV/AIDS) and who subscribe to "the best practices and advice of multi-lateral institutions such as the World Health Organisation and UNAIDS would be accepted and acted upon" (Heywood, 2004: 21). This group sees the Mbeki and his Health Minister, Manto Tshabalala-Msimang, as motivated by a denialism that has seeped throughout South Africa's HIV/AIDS policy from 1999 up to and including 2004.[4]

The 'historical-sociological' group consists of academics like Fassin (2007), Schneider (2003) Posel (2005 and 2008), Youde (2007),

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[2] Brink has recently tried to take Zackie Achmat, the former chairperson of the TAC, to the International Court in the Hague on charges of genocide for his role in pushing government to provide free ARVs to all South Africans including Nevaripine and AZT to prevent mother to child transmission of HIV during childbirth (Brink, 2007: 96).

[3] Heywood works for the AIDS Law Project, a key TAC ally, and Geffen worked, until recently, for the TAC. This may serve to bias their perspectives and should be noted by the reader.

[4] Although all three argue that this denialism has deeply affected AIDS policy up until the present.

and Steinberg (2008) who understand the epidemic through historical/gendered/sociological studies lenses, taking a 'wide and long' view and focusing on the impact of South Africa's racist public health history, the role of sexuality/sexual politics and the influence of international pharmaceutical companies through the eyes of South Africans (so-called 'Western science').[5] They identify these as key factors in explaining government policy and Mbeki's views of the HIV/AIDS pandemic and, while they all agree that Mbeki is an AIDS dissident or denialist, they attempt to give a deep contextualisation of his perspective. Finally, the 'public policy' perspective looks at the constraints and opportunities that the ANC government faced at various moments since 1994. On the one hand it includes Suresh Roberts (2007), who is more of a Mbeki supporter than he is a 'public health' political scientist and on the other Butler (2005), who sees Mbeki's actions as the rational outcome of the set of circumstances that he faced at the time –cautiously desiring to increase ARV treatment, while at the same time providing additional ways of promoting healthy living to those who have AIDS but are out of reach of treatment.

The 'Marxist critique' is captured in the writing of Neocosmos (2007) who focuses on the exploitative nature of pharmaceutical companies, the dominant 'biomedical paradigm', the hidden racism of AIDS institutions, the influence of conspiracies on South African political discourse and what Neocosmos terms the de-politicising nature of TAC itself. While Neocosmos does agree that Mbeki is an AIDS dissident, Butler is cautious about attributing the term to him and Suresh Roberts flatly denies the claim. While the subsequent authors will be placed in categories, it must be stated up front that many of their arguments cross over into other groupings.

2.2. 'Politicisation' and public policy

Public policy making goes through various stages (Fourie, 2006: 10), which are all constantly affected by the policy environment.[6] When designing public policy in response to a specific social problem, Heineman *et al* highlight that a government/society may face a 'wicked problem' if there is no consensus about

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[5] It is important to note that Youde, Posel and Fassin all support a nation-wide rollout of ARVs, and appeared sympathetic to the cause of the Treatment Action Campaign, yet they have analysed the politicisation and impact of the HIV/AIDS pandemic in South Africa using a different prism than the economists, lawyers and activists in the previous group.

[6] Which includes factors, according to Anderson, such as natural resources, population size, race and age distribution, class systems, cultural norms and regime type (Anderson, 2001: 44).

whether a problem exists in the first place (Heineman, Bluhm, Peterson & Kearny, 2002: 48). Fourie points out that the initial stage of policy-making is that of 'problem identification', which "occurs in response to a societal ill" (Fourie, 2006: 11). Hence, the correct diagnosis of the problem is fundamental to establishing the appropriate policy response. Significantly, merely the formulation of public problems is in itself a political act. The second stage that Fourie identifies is that of agenda-setting, which is when a problem is "converted into an issue that the government actually responds to" (ibid.: 12) while concurrently being "continually sifted and sorted according to the importance attached" (Bealy, 1999: 15-16) to it. Anderson contends that when there is a "denial of the problem or certain causal links" (Fourie, 2006: 13) it may be used as a tool (which some authors claim was the South African government policy). Only once a problem has been correctly identified and it has made it onto the agenda, can public policy be formulated, adopted and implemented (ibid.: 13-15). If, however, there is debate about what the problem actually is, as in the case of South Africa's HIV/AIDS epidemic, where there was consensus that AIDS was a major crisis facing the country, but debate over whether poverty or the HI Virus was its cause, then public policy can become immobilised. This could be used as a tactic so that an issue "might then lose its agenda status" (ibid.: 13).

Parsons suggests that building an agenda is facilitated through the "conscientisation of large sections of the population about a specific issue" (Fourie, 2006: 12) which could force a problem previously deemed marginal into the centre of the public policy agenda (Parsons, 1996: 128-129). Hence, one of the routes of placing an issue on the agenda is to 'politicise' it, which can be defined as "to render political in tone, interest or awareness" (Collins Concise English Dictionary, 1993: 1034). Posel furthers this definition by stating that politicisation is when an issue becomes "the site of heated public argument, mobilisation and conflict" (Posel, 2005: 127) By extension, 'politicisation' is therefore defined as 'the state of being politicised'. The nature and style of 'politicisation' is a reflection of the power dynamics in a society, and in the case of public policy, different actors engage one another in an each attempt to secure their respective interests. The final public policy outcome will reflect the relative balance of forces in that society at a specific time. Reflecting on the term 'politicisation', Director of the Institute of War and Peace Studies at Columbia University, Richard Betts, says that we normally think of politicisation in a negative sense and hence it "is nearly always applied to actions of which one disapproves" (Baldwin, 1985: 209). Yet, Betts argues, it is often necessary to bring issues within the realm of politics to affect public policy. 'Illegitimate politicisation' is a reflection of what is thought of as normal controversy and occurs when the beholder of a specific "political frame of reference differs from

the implications of the analysis beheld" (Betts, 2002: 3). Betts continues by suggesting that governments engage in blatant forms of politicisation when there are direct attempts to suppress information that may undermine a government policy in order to try to change it (ibid.: 19).

In South Africa, public debates involving government surrounding the issues of HIV/AIDS were not merely intellectual discussions, but rather political acts concerning a specific set of responses to a particular health crisis; an expansion of Clifford Geertz's conception that the public activities of a regime are the 'state in action' (Krasner, 1984: 232). Posel differentiates between the *politics of sexuality* (which she says is always a part of modern society) and the *politicisation of sexuality* (which Posel argues is the result of particular historical circumstances) (2005: 127). In effect, the same logic may be applied to HIV/AIDS in South Africa: as a health issue it could have been *political* in the same way as TB in terms of unequal access to quality health care, yet, it was *politicised* due to a number of societal factors and most often played out concerning the medium of public policy around HIV/AIDS. During the 1990's the government had been involved in a number of controversial events that placed HIV/AIDS on the public agenda, yet once TAC was formed in 1998, it set the course for an increasingly politicised environment where the abovementioned protagonists reacted to one another, further raising the "level of inflammatory rhetoric and moral outrage" (van Niekerk, 2001: 151).

As a brief but illuminating tangent to highlight the fact that 'politicisation matters', a comparison may be made with Brazil to demonstrate the manner in which HIV/AIDS was politicised and the response of government and the AIDS NGO's in that country. Both Brazil and South Africa are 'third wave' democracies, both have progressive constitutions, are seen as regional leaders and there are a number of economic similarities including severely unequal income distributions and their relatively similar GDP per capita (see Appendix 1). By 2003 Brazil's HIV infection rate, despite being similar to South Africa in 1990 at approximately 1% of the population, had decreased to less than 0.7%, (Gauri & Lieberman, 2004: 2) while South Africa's had soared to 18.1% (UNAIDS, 2006). In both societies, HIV/AIDS was a major challenge and a cause of social mobilisation, demonstrated through the social movements that existed within each country. Yet, although there was a period of political conflict in Brazil between the administration and the 'AIDS NGOs', they established an alliance[7] that resulted in Joao Biehl's label of 'the activist state'

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[7] The literature suggests many reasons for the success of the alliance, ranging from a lack of resource constraints due to a large World Bank loan, to connections built between activists and government officials in their past struggles for democracy in the 1980's and a country less

being given to the efforts of the Brazilian government (Biehl, 2004). The Brazilian state lobbied in the international arena (beyond the scope of most NGOs) to be able to produce generic drugs legally[8], while the NGOs campaigned and built support for the free national ARV rollout, and simultaneously accessed areas throughout Brazil that the state could not. Hence, although HIV/AIDS was politicised in Brazil, it resulted in an alliance of NGOs broadly committed to similar goals. While it would be simplistic to attribute the decrease in HIV prevalence and AIDS-related mortality in Brazil to the NGO-state partnership, the effect of this alliance has also been widely acknowledged to be a major factor in what appears to be a successful state response to HIV/AIDS (Parker, 2003: 143-183).

2.3. Denialism

'Denialism' is a widely used term of reference used by many of the activists[9] and authors[10] who have been participants and/or actors who have been critical of government HIV/AIDS policy, specifically around the issue of ARV treatment. An understanding of some of the meanings of this term is necessary before continuing.

Stanley Cohen, in his book *States of Denial* (2001), argues that denial is a common thread running through "people, organisations, governments or whole societies" when they "are presented with information that is too disturbing, threatening or anomalous to be fully absorbed or openly acknowledged. The information is therefore somehow repressed, disavowed, pushed aside or reinterpreted" (Cohen, 2001: 1). Denial is hence often used as a coping mechanism to assist in dealing with disturbing emotions like guilt and anxiety that are unthinkable or unbearable. He characterises denial as "assertions that something did not happen, does not exist, is not true or is not known about" (ibid.: 3).

There are three ways to understand denial, says Cohen. First, it is a statement that is said in good faith based on facts that can be debated ('no, that did not happen, look at the following facts'), which he later refers to as 'literal denial'.

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fractured by racial divisions which made partnerships across the class and racial lines less controversial. Most authors point to a common desire to roll back the potential of a wide-spread epidemic. See Gauri & Lieberman, 2004; Serra, 2004; and Darrah, 2005.

[8] Deemed controversial due to international trade law and patent protection.

[9] Activists from the TAC like Nathan Geffen (2006) and Zackie Achmat (2008) and Mark Heywood of the AIDS Law Project (2004).

[10] Nicoli Nattrass (2007), Mbali (2003)

Second, 'denial' is a deliberate attempt to lie where the truth is known, but, for a multitude of reasons, it is concealed (Cohen, 2001: 3-4). The final option that he puts forward is where people are not fully aware that they are blocking out information in part because the "statement is not wholly deliberate, and the status of 'knowledge' about the truth not wholly clear."[11]

Cohen goes on to make two further salient points. He notes a distinction between 'literal denial' (when a fact is being denied due to ignorance) and 'interpretive denial' where "the raw facts (something happened) are not being denied. Rather, they are given a different meaning from what seems apparent to others" (ibid.: 7). Cohen applies this to the government level by arguing that "Officials do not claim that 'nothing happened', but what happened is not what you think it is, not what it looks like, not what you would call it" (ibid.: 7). Cohen introduces one final distinction in the category he names 'implicatory denial', where there is no effort to deny the facts or their interpretation, but rather an attempt on behalf of governments to deny the political or moral implications that would normally follow. When denials of implications appear to be completely inappropriate (like 'government does not care if poor people are dying'), "we reach out for explanations: He obviously doesn't seem to grasp what's going on' (he needs more information); 'she can't really mean that' (she is being disingenuous … deep down she really cares)" (ibid.: 8).

Cohen says that 'official denial' (i.e. the 'denial' by governments) and 'cultural' denial, in which societies create unwritten agreements about what is remembered and acknowledged, exist in a state of "mutual dependency" (ibid.: 10-11). Hence, a statement of 'official denial' needs to latch on to cultural 'hooks' within a society to resonate with the population.

Finally, Cohen relates 'denial' to the issue of HIV/AIDS[12,] and claims that "acknowledgement is difficult – the syndrome's menacing and mysterious emergence, the finality of the diagnosis, the association with stigmatised groups and sexual practices, the potent metaphor of depravity" (Cohen, 2001: 56). This is a particularly powerful observation that is picked up upon by numerous authors in their understanding of the politicisation of HIV/AIDS in South Africa.

Didier Fassin, argues that 'denial', in the South African context was utilised in a prescriptive (falsehood vs. truth) and polemic (good vs. evil) sense. He cautions the 'slip' from "'denial' (empirical observation that reality and truth are being

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[11] These are "states of mind … in which we know and don't know at the same time." (Ibid.: 4)

[12] Ashmore, quoting Ainsworth and Teokul, says that, "every country has engaged in denial" when HIV/AIDS is initially discovered in a specific society. (Ashmore, 2008.)

denied) to 'denialism' (an ideological position whereby one systematically reacts by refusing to reality and truth)" (Fassin, 2007: 115). In South Africa, the accusation of 'denialism' was applied to all those who expressed doubts about the aetiology of AIDS, which linked 'denialism' to the accusation of 'genocide' in reference to the delays in implementing the government's national rollout of ARVs. In other words, 'denialism' was a political tool utilised against government policies and those who supported them.

Fassin dismisses the application of Sartre's bad faith hypothesis[13] to the South African government, because he cannot consider that it is "refusing to tell the truth in the name of a political project" (Fassin, 2007: 119) and hence wilfully allow South African's to die without providing ARVs which they know to be effective (hence the intentional self-deception). He argues that this is the understanding of 'denial' that has been used in the 'polemics' (a euphemism for the activist movements, like TAC). Instead, Fassin prefers to use Freud's hypothesis of 'unconscious denial' where "'I know, but I can't accept I know'" (ibid.: 119). Hence, Fassin claims, the government, and indeed portions of South African society may push away intolerable facts like "sexuality which has been the object of so many racist representations and so much discrimination" is "responsible for the transmission of the illness that is decimating the nation at the very moment it finally achieved democracy and a deracialised identity" (ibid.: 119).

Finally, Butler argues how difficult it is to try to claim that 'denial' occurs at the societal/cultural level and that the term is so difficult to pin down as its meaning is constantly evolving. The key use of the term in South Africa refers to 'biomedical denialism', which may include questioning the link between HIV and AIDS and citing poverty as the cause of AIDS (not HIV).[14]

Hence, there are three main ways that 'denial' can be used: as an analytical category (Butler), a psychological term (Cohen) or an ideological expression (Heywood or Achmat). This paper will follow a simplistic version of the definition of denial in order to avoid becoming overly embroiled in the definitional issues highlighted above. Ashmore proposes that denial can be defined as "cynicism regarding the mainstream scientific consensus" (Ashmore, 2008) that HIV causes AIDS. This literature review will be based on the

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[13] Which is very similar to Cohen's second form of denial where statements of subject/government/organisation are deliberate lies.

[14] In addition the term may refer to those who argue that AIDS may actually be the result of ARVs themselves or claiming that scientists are merely stooges of international pharmaceutical companies involved in a racist plot against Africans. (Butler, 2005: 603)

abovementioned definition of denial but will interrogate other uses of the term by the various authors whose work constitutes 'the literature'.

2.4. Parameters and Caveats

Before continuing with the rest of this literature review, a number of caveats need to be made. Firstly, for the sake of simplicity, the Treatment Action Campaign and the South African government are being utilised as the two key protagonists in the politicisation of HIV/AIDS in South Africa, embodying different understandings of the nature of HIV/AIDS in South Africa and how best to respond to it. While this over-simplification leaves this paper with many avenues open for criticism, because not only is TAC not the largest component of 'AIDS civil society' in South Africa,[15] but there are also many other 'sites' where the politicisation of HIV/AIDS played out in South African society. Nonetheless, the literature[16] has portrayed TAC as the most influential AIDS organisation in South Africa and Gumede characterises it as "the country's most vocal and visible AIDS activist group" (Gumede, 2007: 188). Second, it is not possible, within the limits of this paper to explore in depth the nature of TAC, and will assume that it can be considered a social movement.[17] Third, this literature review will be focusing on the period from 1994, when the ANC stepped into power and began policy implementation surrounding HIV/AIDS, until 2004, when the Department of Health's Operational Plan (focusing on ARV distribution) began to be implemented, corresponding to the relative easing of tensions between TAC and government.[18] Finally, while this paper focuses on the responses of TAC and the government to the politicisation of HIV/AIDS in South Africa, it may appear to imply that they were not major agents of this politicisation in the first place. Hence, 'responses' in this case implies how TAC and government constituted the politicisation of HIV/AIDS,

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[15] That title belongs to NAPWA – National Association of People Living with AIDS

[16] The public quality of the tension between the TAC and the South African government has led to a greater quantity of literature on this topic, with many authors identifying these two players as key conflicting parties in the politicisation of HIV/AIDS in South Africa including: Suresh Roberts, R. 2007, Posel, D. 2005, Nattrass, N. 2007, Gevisser, M. 2007, Mbali, M. 2003, Vandormael, A. 2007 and Neocosmos, 2007.

[17] For an in-depth discussion of how literature on the TAC sees the organisation, its strategies and tactics, see Oshry, 2007: 7-24.

[18] While the creation of this plan and its implementation since 2004 has certainly not seen the end to the politicisation of HIV/AIDS in South Africa (due to the subsequent controversies like the slow rollout of ARVs , issues like Dr Matthias Rath and his sale of micro-nutrients and local cures like 'Ubejane'), the Operational Plan has seen the increased strengthening, within government, of those who support immediate, national rollout of ARVs (Nattrass, 2007: 128-168).

being simultaneous agents of, and respondents to the increasingly political nature of HIV/AIDS in South African society as a whole, although they occupied different places on the spectrum at different times.

3. Historical Context: From Racist Public Health to the 'Operational Plan'

The narrative of HIV/AIDS in South Africa is a crucial part of understanding how an issue, that of HIV/AIDS became one that almost defined the near decade long Presidency of Mbeki from 1999. The HIV/AIDS crisis struck at the heart of post-apartheid South Africa, forcing even hardened nationalists to question their values and support for the ruling party. The unintended consequences of the pandemic will reverberate in South African society for many years to come.

The choice of where one begins in defining the origins of a particular event is in and of itself, a decision that colours the analysis (as does the choice of which events to include). It is not possible to do justice to the events that would give a full historical context for the politicisation of HIV/AIDS in South Africa in such a short literature review, since a number of writers have highlighted the key role of racist health policy since the 1800s (Fassin, 2007 and Youde, 2007) as important historical background to understanding the development of AIDS policy. Nonetheless, this paper will focus on the incidents that have occurred since the ANC won the first democratic elections in 1994, up until the implementation of the 'Operational Plan' (which included ARV distribution) by government in 2004. The events highlighted will be those that the literature identifies as increasing the political temperature around HIV/AIDS in South Africa, but will exclude many dates and actions that critics may deem to be vital to the overall analysis.

While the first case of HIV was diagnosed locally in 1982, South Africa's "environment of risk"[19] provided a "rich Petri dish" (Fourie, 2006: 51) in which the HIV/AIDS epidemic was incubated and could flourish. Yet, the identification of HIV in the context of Apartheid and its racist public health legacy was not simply interpreted as a medical issue, but brought with it the public health disasters that Youde identifies as having scarred South African history (Youde, 2007: 67-69). A brief example could be the discovery of the

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[19] Including an grossly skewed racist public health system, widespread poverty, political instability, gender inequality and the migrant labour system, confirming Louis Pasteur's quip that "[t]he microbe is nothing; the terrain everything" quoted in Fourie, 2006: 51.

bubonic plague in Cape Town in 1900, which led to the first forced removals of black people and the creation of "native locations"[20] and the calls for increased racial segregation in the light of the tuberculosis epidemic that swept through the country in the 1900's[21]. Steinberg, while conducting research into South African public health for *The Three Letter Plague* (Steinberg, 2008: 149), found records of hostility by residents of the Transkei and Ciskei towards public health officials who were travelling the country with Spanish flu inoculation kits, citing "the 'long needle' of the White man [had come] to inject more harm" (Carton, 2003: 204). Apartheid health policy for black people was described by Andersson and Marks as "hidden violence" (Anderson & Marks, 1987: 177) because the government failed to create an efficacious public health system that ended up turning "diseases into epidemics."[22]

In Soweto in 1992, after a number of consultative meetings between ANC-aligned health professionals and the incoming ANC government, the National AIDS Convention of South Africa (NACOSA) was formed.[23] NACOSA's National AIDS Plan, which was created in conjunction with the WHO,[24] was adopted by the new Government of National Unity (GNU) in 1994. The plan included provisions for prevention, the treatment of opportunistic infections and care for those who were already sick[25.] Yet, this Plan, which created with the input of many different sectors, was not implemented, even though it was designated a Presidential Lead Project (which had privileged access to government funds). The reality, as Fourie suggests in the title of his book, was that AIDS was simply 'one burden too many' (Fourie, 2006) for the new government as it chose to focus its attention on the task of restructuring the

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[20] Hence, the first time that separate living areas were created in South Africa by law was on the pretext of public health. (Swanson, 1977: 392-393)

[21] Phillips argues that the AIDS pandemic be understood in the light of the previous public health crises that have decimated South African, including the Spanish flu, which killed 300 000 people in six weeks between October and November 1918. He contends that one of the factors that had made AIDS different to the epidemics that preceded it was the increasing penetration and acceptance of biomedicine into the lives of all South Africans (Phillips, 2004:38).

[22] Some of the most grotesque results included life expectancy rates for whites which could compare to the rest of the Western world, in comparison to black life expectancies, which ran 15 years below. An astounding statistic the Youde points towards is that the annual health budget for KwaZulu in the 1970's and 1980's was comparable to the per annum spending of one of the main white hospitals in Johannesburg, except when it came to the well resourced family planning campaign which the government started in the mid-1970's (Youde, 2007: 70)

[23]"together with hundreds of other activists, experts, policy-makers, scientists, doctors and lawyers, we drafted South Africa's first National AIDS Plan" (Achmat, 2008).

[24] World Health Organisation

[25] "the importance of the AIDS Plan lay firstly in the participatory manner in which it was developed, involving large numbers of people over several years" (Schneider, 2002: 146).

health care system (Illife, 2006: 142-143). Mandela himself, later acknowledging his mistake, took three years before he spoke publicly against AIDS, and only while he was overseas in Davos. Nattrass contends that during the first few years of the GNU, the Health Minister, Dlamini-Zuma, did not consult with civil society (as envisioned by the National AIDS Plan), one of the causes of the bitter criticism that she, and her department, received during the *Sarafina II* scandal of 1996 (Nattrass, 2007: 41).

Fourie asserts that government HIV/AIDS policy since 1994 has been "defined by public scandal."[26] The *Sarafina II* controversy erupted when media reports claimed that the Health Minister had allocated over R14 million to an AIDS awareness play which was criticised by civil society as being ineffective and exorbitantly expensive. The resulting "storm of protest" (Nattrass, 2007: 41) from newspaper editors, civil society and medical professionals felt to government like a betrayal of trust, in which the "most serious consequence is that yesterday's allies lost faith in each other" (Fassin, 2007: 40). The key consequence was, according to Gary Adler, the Executive Director of the AIDS Foundation, "the demise of a shared vision for AIDS in this country" (ibid.: 40). Fourie contends that the South African government responded by creating an 'AIDS orthodoxy' within government in which any criticism outside of that 'orthodoxy' was seen as counter-transformationalist or racist (what Fassin calls the "besieged fortress syndrome"[27]). The increasingly political nature of HIV/AIDS had begun with many actors vying with one another for the 'right' to comment authoritatively on the epidemic (Fourie, 2006: 124).

Following on the heels of *Sarafina II*, 1997 HIV/AIDS policy[28] was marked by what Mbali calls government's 'championing' of a new experimental drug, Virodene, which was created by Olga and Ziggy Visser, from the University of Pretoria (Mbali, 2003: 314). Myburgh argues that the Vissers, who had told the Health Ministry of their encouraging clinical trials, said that the 'AIDS establishment' was interfering in their research because it posed a financial risk to pharmaceutical company profits (Myburgh, 2005: 42). Dlamini-Zuma then

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[26] He identifies four key policy scandals: Sarafina II (1996), Virodene (1997), the decision to suspend AZT MTCTP pilot projects (1998) and what he terms a movement away of "entrenchment of the human-rights centred HIV confidentiality principle, to making AIDS notifiable" (Fourie, 2006: 122).

[27] "… the department felt misunderstood, if not betrayed, since only the drawbacks and never the successes of their actions, however spectacular, were pointed out" (Fassin, 2007: 40).

[28] Butler refers to Mbeki's hailing of a new HIV/AIDS plan to increase awareness of HIV and also attempted to target sexually transmitted infections (STI's), while the government attempted to avoid talking about ARV provision, mainly on the basis of cost (Butler, 2005:594)

invited the Vissers to present their results to cabinet, after which all of the ministers gave the local scientists a standing ovation[29] and pledged to assist them in furthering Virodene research up until the medicine was registered by the Medicines Control Council (MCC). However, due to a number of efficacy and safety concerns, the MCC banned any further clinical trials (it was later found that Virodene consisted mainly of an industrial solvent), which angered Mbeki and the Health Minister.[30] The main results of this event were to set a 'precedent' of "high profile South African government figures taking on medical authorities in the AIDS policy arena," (Mbali, 2003: 315) reinvigorate conflict between civil society and the government[31], begin what Posel calls Mbeki's "distaste for the power of the scientific establishment in respect of AIDS" (Posel, 2008: 15) and mark the beginning of Mbeki's personal forays into the world of AIDS medicine. The idea, argues Hodes, that Virodene was a 'home-grown' answer to the HIV pandemic was sufficiently appealing to encourage a political attempt to circumnavigate biomedical protocols (Hodes, 2008: 10). In addition, in the context of HIV/AIDS, government complaints of the underlying racism of health critics and harsh civil society reaction became established as a pattern. Gevisser argues that while *Sarafina II* and the Virodene saga were rash and ill-informed policies, they both arose from a government that was desperate to control an epidemic that it appeared relatively powerless to halt (Gevisser, 2007: 732).

Two significant events occurred in 1998. First was Dlamini-Zuma's decision, despite the Health Ministry's establishment of PMTCT pilot sites using the antiretroviral drug AZT, to suspend the projects because she saw the expansion of this program to national level as unaffordable. Second was the founding of the Treatment Action Campaign on 10 December 1998, which aimed to "campaign for equitable access to affordable treatment for all people with HIV/AIDS"[32]. TAC was created to use all legal means necessary to challenge the obstacles that limited access to treatment for HIV/AIDS by creating a form of "grassroots and racially representative AIDS activism."[33] TAC would now form the focal point for tension between civil society and government around ARV provision, and indeed the entire gamut of the increasingly political

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[29] Which was later compared to a 'church confessional' by Jakes Gerwel, Mandela's cabinet secretary (Achmat, 2008).

[30] For further details see Mbali, 2003: 314-316 and Nattrass, 2007: 42-44.

[31] Achmat reflects that he sees the Virodene incident as "influential in forming the nature of the AIDS debate going forwards" (Achmat, 2008).

[32] TAC Constitution on its website: http://www.tac.org.za/community/about (accessed 22 October 2008)

[33] Some of the method used by the TAC included litigation, lobbying, protests, education and all forms of social mobilisation. (Friedman & Mottair, 2005: 512-513)

HIV/AIDS pressure-cooker. While the withdrawal of the PMTCT sites was of concern to Zackie Achmat, who, since TAC's inception has been the international face of the organisation (Robins, 2004: 663), he initially thought that the ANC-administration and TAC would support one another to decrease the price of drugs like AZT and hence make the PMTCT program affordable for government (Achmat, 2008). Hence, when the government entered into a court battle with the Pharmaceutical Manufacturers Association (PMA) over the former's creation of the 1997 Medicine's Act (which provided for the generic production of ARVs, hence breaking patent laws), TAC lobbied locally and internationally against the drug companies and supported the government's case by becoming an *amicus curiae*. The PMA backed down and withdrew the case.[34]

Yet, it was at this moment that Mbeki is meant to have had contact (1999) with a range of AIDS denialists[35] including Anthony Brink, who wrote an article in the *Citizen* claiming that AZT was a toxic drug (Nattrass, 2007: 47). Mbeki then started to publicly question the safety of AZT[36]. Questions over the toxicity of ARVs[37] led Mbeki to create the highly controversial 'Presidential AIDS Advisory Panel,' which included a number of 'denialist' scientists[38] and was tasked with not only establishing an answer as to whether there was sufficient evidence for the "viral aetiology of HIV"[39] but also what an appropriate

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[34] Judge Edwin Cameron, who was the first high-profile figure to disclose his HIV positive status, credits the TAC's intervention in the PMA case as critical because it was able to expose, and publicise, the massive profits that the pharmaceutical companies were making at the expense of massive death (Cameron, 2005: 165-167).

[35] Jeremy Youde gives a detailed account of the various self-proclaimed AIDS denialists, and their attempt to organize themselves into a 'group' or school of thought so as to be taken more seriously by the medical establishment. See Chapter 3 and Chapter 6 of Youde, 2007.

[36] In an address to the National Council of Provinces in 1999, Mbeki said that: "There also exists a large volume of scientific literature alleging that, among other things, the toxicity of this drug is such that it is in fact a danger to health" (Mbeki, 1999).

[37] Fassin notes how important it is to take note of this explanatory shift (and it is worth quoting him at length): "As long as it was the cost of the drugs that was put forth as an argument, it was possible to take issue with the government in an equal footing, either to dispute their cost-benefit analysis, or conversely, to say they had made the right choices when deciding on public health priorities or eve, as most activists would do, to attack their decisions at home but at the same time support them in their international efforts against the pharmaceutical companies. But when the president and his health minister changed the argument to one of toxicity, the polemic entered a dangerous zone." He continues "more than simply a change in scientific paradigm, we find ourselves in a territory that lies beyond normal science" (Fassin, 2007: 54-55)

[38] Moore is quoted as saying that the panel was comprise of "pretty well everyone on it who believes that HIV is not the cause of AIDS, and about 0.0001 per cent of those who oppose this view" (Cherry, 2000: 105-106)

[39] 'Invitation', March 2000, www.virusmyth.net

response to the local pandemic would be for the South African government. Nattrass says that the results of the panel were predictable, as the denialists and orthodox scientists had two completely different sets of understandings about the nature of HIV and divergent sets of policy recommendations (Nattrass, 2007: 60). There were many reasons attributed to Mbeki's convening this panel in the first place; Suresh Roberts says that he approached the issue with an inquiring mind because he was puzzled and wanted to understand how best to respond to HIV/AIDS in South Africa (Suresh Roberts, 2007: 190-193) while Nattrass argues that Mbeki and the new Health Minister (since 1999), Dr Manto Tshabalala Msimang, could then "portray AIDS science and policy formation as deeply contested" (Nattrass, 2007: 61).

In addition, a number of other high-profile events are mentioned in the literature. On the side of government and Mbeki, these include: the creation of the South African National Aids Council – SANAC - without representatives of TAC (January 2000), Mbeki's letter to world leaders in which he questioned orthodox AIDS science (April 2000) and the Durban AIDS Conference (July 2000) in which Mbeki spoke about poverty being the biggest killer and the subsequent response. Some of the actions by civil society during this time included a direct response to Mbeki's address to the AIDS Conference, which became known as the 'Durban Declaration' as it was signed by over five thousand scientists and reaffirmed orthodox scientific thinking on HIV/AIDS (Gevisser, 2007: 737-745; Nattrass, 2007: 55-74 and Gumede, 2007: 197-200) and Achmat's visit to Thailand where he purchased three thousand capsules of the generic medicine Biozole[40], in an effort to protest against the high price of ARVs in South Africa (Cameron, 2005: 163-164). Lastly, after a controversial interview with *Time* magazine[41], Mbeki withdrew from the public debate over the science of HIV/AIDS. Each of these controversies helped to further increase the politicisation of HIV/AIDS in South Africa, entrenching the positions of civil society and government and making co-operation between them increasingly difficult.

In August 2001, TAC and various other NGOs filed a case against the government stating that it was a constitutional obligation to create free PMTCT programs at all public hospitals and recommending the use of a cost effective

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[40] Biozole treats oesophageal thrush (deadly to many AIDS sufferers) and is the generic version of Pfizer's drug Fluconazole produced and sold at a fortieth of the price being charged in South Africa (Cameron, 2005: 163-164).

[41] In which Mbeki responded to a question asking whether he was prepared to acknowledge a link between HIV and AIDS by saying that "you cannot attribute immune deficiency solely and exclusively to a virus (Mbeki, T. quoted in *Time*, 2000).

ARV called Nevaripine[42]. The case made it all the way through to the Constitutional Court, which ruled in favour of TAC in March 2002.[43] The public and political battle between TAC and the government was at its most intense. At this point, Nelson Mandela decided to enter the fray on the side of TAC, meeting Achmat, who despite being HIV positive refused to take ARVs until they were freely available to all, at his home and trying to encourage him to take ARVs. While TAC saw Mandela's input as an immense boost to its campaign, Mbeki was incensed as he saw the icon of South African democracy (and his former boss) supporting one of his most bitter social critics.

After Nevaripine had been secured, TAC moved to try to place a full national treatment plan, including ARVs for all who need them. TAC, together with its ally COSATU, decide to try to use the National Economic Development and Labour Council (NEDLAC), which brings business, government and labour together to reach a consensus on political and economic issues, to resolve to establish a special HIV/AIDS task team to create a national treatment plan by December 2002 (Achmat, 2008). However, when the Health Ministry refused to endorse the treatment plan, TAC turned to civil disobedience as a means of pressurising the government into action[44]. Ultimately, after months of protests, the Cabinet announced in August 2003 that it would roll out HAART in the public sector, but it was not until mid-2004 that the 'Operational Plan' became functional throughout the country (Nattrass, 2007: 128). While there have been numerous claims and counter-claims by activists and academics about the pace of the rollout, where the Health Minister is accused of dragging her feet and promoting 'alternative' therapy instead of HAART (Geffen, 2006: 2-4), the commitment of government to the 'policy logic' (Mauchline, 2008: 3) of a national ARV treatment plan meant that the program just needed to be scaled up.

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[42] Based on the efficacious results of a Nevaripine trial in Uganda (deemed to be a 'low resource setting') investigating its use in MTCTP. The trial showed a decrease in transmission of HIV from mother to child in 47% of cases (Guay, et al, 1999: 795–802).

[43] The Constitutional Court recommended the immediate (with sufficient time to draw up a plan) implementation of the MTCTP program in those hospitals that had sufficient capacity, while places a responsibility on government to establish the MTCTP program throughout South Africa (Gumede, 2007: 210).

[44] "We intended the protests to be the biggest in South Africa since the days of Apartheid" says Achmat and included demonstrations, invasions of police stations and government buildings, disruptions of speeches by politicians and laying charges against the Ministers of Health and Trade and Industry respectively (Achmat, 2008 and Oshry, 2007: 7)

4. Why did HIV/AIDS become so politicised in South Africa (1994-2004)?

> "South Africa is unique in having generated heated argument about what AIDS is (and isn't) which emanated from the highest echelons of power – in the Office of the President – catapulting the idea of AIDS and its contested meanings to the very forefront of the political agenda"
>
> Deborah Posel, 2008: 14

Before attempting to explore the answers the main question of this literature review, that of the 'responses of TAC and South African government to the politicisation of HIV/AIDS', it is first necessary to lay out the themes that the authors utilise in their explanations. While none of the writers tries to deal systematically with all of the factors expanded upon below, they are utilised in various combinations. When these factors are combined with specific understandings of the events highlighted previously, they lay the foundations that the literature uses to construct its comprehension of the responses.

So, why did a potentially technocratic-medical issue, suddenly become one of the most fiery and political features of post-1994 South African society? It is essential to look at the 'HIV/AIDS politicisation factors' below in the light of three different levels of analysis[45].

4.1. International Factors

The unequal power between developing and developed countries in the international system played an important role in the politicisation of HIV/AIDS in South Africa. This 'first world/third world' power differential is refracted through the unequal distribution of pharmaceutical companies located in the West[46] the capacity of the international system of patents to stop life-saving

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[45] In an alternative version of Kenneth Waltz's 'three levels of analysis' when he was trying to understand what the causes of war between states are by dividing the explanations into three fields: "within man, within the structure of the separate states, within the state system" (Waltz, 1959: 12)

[46] "contrary to what is suggested by the way the debate has been personalised around the figures of South Africa's President Thabo Mbeki and, to a lesser extent, former Vice President Jacob Zuma and two successive health ministers, Nkosazana Zuma and Manto Tshabalala-Msimang, politicians have not been the only ones to contest the authority of biomedical discourse, nor are they the only ones to express thereby their distrust of Western

ARVs reaching poor people the power and the influence of world health institutions (like UNAIDS or the WHO) who many still suspect of being fronts for the profiteering of 'Big Pharma'. Before 2000, the international price of ARVs made them unacceptably expensive for many developing countries to consider national treatment plans, yet, as cheaper generics became more widely available, so did the cost-effectiveness of nationwide rollouts (Geffen & Nattrass: 2003). Other international factors which increased the political tension around HIV/AIDS included the support that TAC received from global organisations like Medecins Sans Frontieres (MSF – 'Doctors without Borders') and New York-based ACT-UP (Friedman & Mattair, 2005), which actively campaigned throughout the world on its behalf to pressurise the South African government to implement ARV programmes and to place pharmaceutical companies in the court of public opinion for high drug prices.

4.2. African Continental Factors

South Africa is also a part of the African continent, which is often suspicious of the West's intentions in relation to poor countries. In addition, African discourse and its perspective on the post-colonial legacy of the continent (Ake, 1991) view the actions of Western companies or organisations as influenced by racism. Many authors point to the orthodox scientific aetiology of HIV/AIDS as having originated in Africa as an example of the racist nature of the international medical establishment (Chirimuuta & Chirimuuta, 1989). Hence, concepts like 'the African Renaissance' are intellectual paradigms attempting to instil a sense of African nationalism by advocating 'African solutions for African problems', rather than relying on the altruism of the West to hand-out of ARVs. The HIV/AIDS pandemic played into these themes of self-determination, exploitation and Western racism.

4.3. Internal South African Factors

Ten features related to South African society in particular[47] can be identified as causes of HIV/AIDS becoming so uniquely politicised in South Africa.

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hegemony. That the government's statements on this matter have had great resonance in South African society is not, contrary to what has often been said, because they turned highly malleable public opinion away from the truth but because there were favourable conditions for accepting their assertions" (Fassin, 2007: 13).

[47] Fassin notes three factors specifically: controversy over national identity (who is and who is not an Africa), race (was used as a mobilising issue in all of the battles between government

First, the most obvious factor are the high numbers of deaths that the pandemic has caused throughout the country, where nine hundred and fifty people die every day as a result of AIDS-related illnesses (ASSA, 2006), and which has come to the fore post-1994 as a mainly post-democracy health crisis (Marks, 2002: 16). More than that, while it was initially thought that AIDS would affect mainly white homosexuals, it has caused deaths from across the racial and socio-economic divide (Nattrass, 2007: 38). Families have been destroyed, children are dying before their parents and AIDS has become a visible part of South African life. The ANC government, democratically assuming office after an eighty-year struggle against white racism, arrived to find that it was relatively powerless to stop a large part its population from dying[48]. The injustice of a newly free, democratic country that would be hollowed out by a virus is a theme that many authors utilise in their explanations of the responses of TAC and government (Posel, 2005).

Second, Posel has pointed out that since the advent of democracy, sex and sexuality have become major parts of South African life, moving out of the shadows and 'exploding' onto local newspapers, TV shows and culture events[49]. Sex (Posel, 2005: 128-132), she argues, has been identified with liberation as more people engage in sexual contact across the colour lines, which used to be considered illegal by the Apartheid regime. Yet, it is exactly this sexual liberation that has wrought such death through HIV/AIDS.

Third and closely linked to the issue of sex, is that of race and racism in South Africa specifically. HIV/AIDS has exposed a number of the racial fractures of South African society. On the one hand, on a cultural level, it surfaces issues around stereotypes of African promiscuity (to which Mbeki often referred) and on an institutional level, racism was said to pervade both the history of public health responses and the culture of the public health institutions in South Africa (alluded to in Section 3).

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and the TAC) and conspiracy theory (which he says South Africa had been full of before 1994 – either ANC or Apartheid plots against one another – but resurfaced through the HIV/AIDS discussion) (Fassin, 2007: 71-73)

[48] "only a few years after the advent of democracy in South Africa, Aids has become the main political question, not so much because of its incredibly rapid spread or even its incalculable human and economic costs, as for the violent way it confronts the facility of political power and rends people's lives and relations" (Lodge, 2002: 4).

[49] "Indeed, the anxieties, denials and stigmas which persist in the midst of new and unprecedented declarations of sexuality - often provoked directly by them - contribute directly to the new sites and intensities of the politicisation of sexuality" (Posel, 2005: 129).

Fourth, as within all societies, but especially developing countries like South Africa, the HIV/AIDS situation has been seen as exemplifying the cultural clash between the 'traditional' and 'modern'[50]. The purported clash, between 'modern' and 'Western' biomedical science and 'traditional' African medicine was hence a microcosm of a broader cultural struggle that is going on throughout South African society. Some authors have pointed towards this conflict as a source of the 'popular denial' of medical science that would serve as cultural fertiliser for Mbeki's purported HIV/AIDS denialism. Once the battle lines were drawn around HIV/AIDS, the conflict between the 'modern' and 'traditional' flared up and served to further politicise the pandemic[51].

Fifth, the pervasive nature of poverty and inequality in South African society has seen the issue become a major site of political contestation, and became the core thrust of Mbeki's understanding of how best to respond to the HIV/AIDS epidemic[52]. The reality that the wealthy could afford ARV treatment, while the poor died, influenced the responses of the protagonists to declare poverty either as a 'co-factor' in spreading the disease (TAC) or as one of its causes (government). Patterson, a government critic, even goes as far as to argue that the state's actions on AIDS reflected a growing distance between the 'ruling elite' and the poor, because government officials could afford access to ARVs and private hospitals, beyond the reach of the majority of South Africans (Patterson, 2006: 41).

A sixth and poverty-related cause is the relative resource-constraints of the South African government as a middle-income country. The Apartheid-

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[50] While this dichotomy is a Western attempt to establish a juxtaposition between Western and non-Western countries (and also explain how societies change as they move through the industrialisation process), it may give some insight into the South African case. Some of the categories that these political thinkers created to highlight the polarities of 'traditional' and 'modern' included 'rural and urban', 'agricultural and industrial', 'sacred and secular' and 'traditional and rational' (Bill & Hardgrave, 1981: 51).

[51] However, these categories were seen to be limiting and incorrect, not only due to Lloyd and Susanne Rudolph's argument that most societies are a mixed form of both 'modern' and 'traditional', but because "qualities often attributed to traditional societies may bear little relationship to the actual nature of a given traditional society". The Rudolph's challenge the notion that social change happens in the Third World only due to its confrontation with modernity encapsulated in the West, because they claim that the 'modern' and 'traditional' change each other. This point, about the false dichotomy between 'Western' and 'African' remedies is picked up on by subsequent authors. (Bill & Hardgrave, 1981: 54)

[52] This is hardly surprising in a country that has over 57% of people in South Africa living below the poverty line in 2001 (in which household of 4 persons was defined as being in poverty if their combined income was R1 290 per month or less) and a GINI coefficient (in 2001) of 0.77, making it one of the most unequal societies in the world (Schwabe, 2004).

constructed inequality in the health system, with its emphasis on serving white areas, left poor, mainly black people with severely under-resourced health facilities that were overly reliant on regional hospitals, not local clinics (Steinberg, 2008: 84-88). This led to a debate about the capacity to fund, manufacture and effectively distribute a national treatment plan (Butler, 2005: 592).

The seventh politicising factor can be seen as the structure of the political system and ANC party dominance. The fact that Mbeki, as state president, became so intimately involved in the debates around HIV/AIDS science is attributed to the dominance of the ANC, the centralisation of Mbeki's decision-making power in the Presidency (see Chothia & Jacobs, 2002: 145-162) and the ANC's relative immunity from serious political challenge by other parties (Gauri & Lieberman, 2004: 17-20). More than that, the nature of the party list system (rather than a constituency-based one) meant that criticism from within the ANC was stifled because Ministers of Parliament knew that they would fall out of favour with the President, and not be re-elected. In addition, the ANC, during the period from 1999-2004, saw some of the cracks in its outward unity come to the fore, especially around the issue of HIV/AIDS. Four brief examples of this include the 'cabinet revolt' when Cabinet members forced a shift towards the HAART rollout (Nattrass, 2007: 118-119), the provincial rebellions which began MTCTP when national government had banned it, the alliance of TAC, the South African Communist Party and the largest trade union – COSATU (traditionally in an alliance with the ANC) (ibid.: 74) and the contradictory policy between the ANC's national and international views on HIV/AIDS[53]. A factor that straddles both the nature of the ANC and the soft nationalism of the 'African Renaissance' is the ANC's desire to show the world that they could rule South Africa in a much more competent manner than the white Apartheid government. Hence, it took the full burden of the AIDS epidemic onto its shoulders, and once under criticism, the ANC government reacted by accusing its critics of being racially motivated (Fourie, 2006: 136-139).

Eighth, and related to the previous cause, authors have suggested that the political battle around ARVs was really about a conflict between the state and civil society (Habib & Southall, 2003: 227-240) around who could talk authoritatively on AIDS and subsequently on a wide range of social issues (Schneider, 2002: 152). Schneider utilises Bourdieu's typology of 'capitals'[54]

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[53] Internationally the ANC supported mainstream approaches to HIV, like supporting policies that called for national expenditure on ARVs, while arguing at the domestic level arguing about their toxicity (Schneider, 2002: 152).

[54] "Capitals" are resources that yield power and include economic (material resources), cultural (educational credentials) and social (durable networks of relationships of mutual

and argues that the politicisation of AIDS was a result of a battle over 'symbolic capital': the "legitimate right to hold and exercise power." Schneider also argues that all societies go through a degree of mobilisation and politicisation around AIDS as a means of compelling government to implement treatment, and in this regard, the civil society actors (primarily TAC) saw how 'raising the political temperature' had worked in other countries.

Ninth, authors like Fassin, have suggested that TAC and government merely found themselves bound up in a vicious cycle of criticism and contestation, which neither wanted and from which neither could escape (Fassin, 2007: 70). Yet, as the political climate intensified, these two protagonists could not disentangle themselves from their entrenched positions, creating an ever increasing, and unstoppable momentum of HIV/AIDS politicisation.

Finally, South Africa's history of protest against injustice, represented most strongly through the Defiance Campaign of the 1950s and the mass protests of the 1980s against Apartheid, was the legitimising cultural capital that allowed Ms Graca Machel to say, "TAC's struggle grows out of the best traditions of the anti-apartheid movement."[55]

5. Accounting for the Responses to Politicisation of HIV/AIDS of the South African Government

5.1. Understanding South African Government Responses

There is a significant amount of literature around the politicisation of HIV/AIDS in South Africa and the conflict between TAC and government. Much of this focuses on the South African government by looking at Thabo Mbeki himself and the question of whether he is or is not an AIDS 'denialist' (Suresh Roberts 2007, Gumede 2007, Nattrass 2007, Gevisser, 2007). The four main schools identified initially ('biomedical-mobilisation', 'historical-sociological', 'public-policy', and the 'Marxist critique') are useful paradigms through which to

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acquaintance and recognition) capital. Symbolic capital is the form taken by all capitals when their possession is perceived to be legitimate" (Ibid.: 153)

[55] During the address in which Machel awarded the TAC the Nelson Mandela Health and Human Rights Award (Achmat, 2008).

analyse this government response. In addition, as a combination of the 'historical-sociological' and 'Marxist critique', a number of authors have identified the influence of African traditional medicine on the politicisation of the discourse of 'African' vs. 'Western' science[56].

While the literature does not mention many instances when the different components of TAC were inconsistent with one another (due in part to its relatively small size), the same cannot be said for the South African government (see examples in Section 4). This presents a theoretical problem of how authors seek to understand 'the state' and hence its action and policy.

While the literature on the state[57] is vast,[58] Stephen Krasner distils two of the main schools, which he calls the state-centric and pluralist approaches. Of the many differences between them, he firstly says that 'statist' literature treats the state as an actor in its own right, in comparison to the pluralist school that sees different parts of the state in constant conflict with each other (Krasner, 1984: 224-225). Second, Krasner argues that the 'statist' literature sees the institutional constraints on individual behaviour within the state, in comparison to pluralists who argue that civil servants follow their own interests, but within the limits of the state itself. Both of these insights are helpful in alluding to the oversimplification that is involved when some authors try, for instance, to characterise South African policy on HIV/AIDS as 'denialist' in its entirety[59]. Vandoermael, argues that Mbeki's position was so strong "that it became

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[56] While this literature review will highlight some of the factors that set these authors apart, it does not mean that they would necessarily disagree with academics in another category (for instance writer in 'biomedical-mobilisation' category may agree with an argument of someone in the 'historical-cultural' category'). It is not possible to build or display all of the links, merely pick up on some of the core arguments. A good example is Jeremy Youde, who agrees with Nattrass that the South African government's AIDS policies can best be explained by denialism and the influence of dissidents (Youde, 2007: 97).

[57] Note that this literature review will often utilise the term 'government' and 'state' interchangeably, even though it is acknowledged that the 'state' is a much broader concept than 'government'.

[58] For further reading see: Bilgin, P & Morton, A. 2002, Chilcote, R. 1981, Dowding, K. 2004, Geertz, C. 1980, Migdal, J. Skowronek, S. Skocpol, T.

[59] A number of authors have utilised Mary Douglas' book 'How Institutions Think' as a theoretical tool to disentangle the web of the state and its internal actors and have simply argued, as does Youde, that the "state speaks with 1 voice." The same sentiment is echoed by Gauri and Lieberman, who suggest the following: "It is useful to make certain simplifying assumptions about how policy gets made. We are concerned with national policies, which are ultimately decided by top government leaders, especially the minister of health and the chief executive. While there may be intra-cabinet disagreements about policy, we consider this executive to be a unitary decision-maker who responds to political incentives and disincentives" (Douglas, 1986; Youde, 2007: 5; and Gauri & Lieberman, 2004: 9).

difficult to distinguish it from the official position of the government and hence the state" (Vandormael, 2007: 221). Yet, while some authors have assumed this theoretical difficulty away, it does not detract from the pluralist critique of the state in which different actors pull in different directions. In fact, the example of the South African state and HIV/AIDS may serve as an excellent case study to highlight the pluralist case. While many writers have attempted to ignore this problem by amalgamating their explanations of Mbeki and government, how academics have attempted to answer this theoretical problem of differentiation is one of the markers of their contribution's academic merit. Note that at the end of every section, the literature will be summarised on a table.

5.1.1. Public Policy and politicisation: Government HIV/AIDS policy – creating a 'meaningful' explanation

A number of authors have attempted to go beyond the 'polemics,' which ascribe ineffective HIV/AIDS governance in terms of 'ir/rationality'[60] and seek to understand the South African government response through the set of institutional, economic, ideological and cultural factors in existence during its decision-making process. There are important differences in their approaches. Ashmore (2008)[61], Butler (2005), Suresh Roberts (2007) and Fourie (2007) seek to understand government policy on its own terms and while they may not agree on its outcomes, they do contend that South African HIV/AIDS policy can be "meaningfully explained" (Ashmore, 2008).

Butler divides TAC and the South African government responses into two paradigms. First, he terms the TAC, medical professional and activist communities' response the 'mobilisation/biomedical paradigm,' which focuses on "society-wide mobilisation, political will and antiretroviral treatments." Second, Butler creates the 'nationalist/ameliorative paradigm' of government and its supporters that "focuses on poverty, individual responsibility, palliative care, traditional medicine and appropriate nutrition" (Butler, 2005: 592). He says that each paradigm appealed to a different set of shared ideals and collective memories and made its own set of assumptions about the 'nature of society' and the role of public policy within that framework (ibid.: 602). He attempts to show why the 'ameliorative' gained ascendancy due to a host of

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[60] Butler contends that 'irrationality' is not an adequate explanation for collective human behaviour. (Butler, 2005: 498)

[61] Since Ashmore's is a Master's Thesis, and unpublished as yet, it will not be explored in depth, as it is not yet a part of the major components of 'the literature'.

internal ANC factors mentioned in Section 4 (like the centralisation of decision-making power) and severe capacity constraints in South Africa's health sector.

Butler is also theoretically conscious of the oversimplification in trying to characterise the totality of ANC-administration AIDS policy due to the contradictory responses of different sections of the government, and hence he alludes to a lack of "consensus on the issues raised" (ibid.: 595-596). He contends that the 'ameliorative model' cohered with the overall government drive to alleviate extreme poverty in South Africa which Mbeki saw as the key to tackling the South African AIDS epidemic (see Pauw & Mncube, 2007). At one stage, while ARV prices were extremely high, the ANC government did not consider them to be a realistic option because they did not want to implement an inequitable and unsustainable antiretroviral program. Yet, Butler suggests, once ARV prices started their dramatic decline, the government responded by drawing up a national treatment plan, which revealed the rational, economic considerations of their previous decisions to halt a rollout (Butler, 2005: 610). The politicisation of HIV/AIDS was therefore caused by the 'ameliorative' and 'biomedical' paradigms talking past, rather than to, one another due to their different understandings of the nature and appropriate response to HIV/AIDS. Butler also points out that the executive, under Mbeki's Presidency, became a key part of the politicisation of HIV/AIDS. Mbeki's administration centralised power, attributed racist motives to those who criticised it, was generally defensive in outlook and refused to collaborate with civil society unless on government's terms (ibid.: 599-602). Butler's analysis does not seem to attribute an important role to the 'cycle' of criticism and political tension that TAC and government found themselves in and does not take into account the politicising effect that the HIV/AIDS crisis had on the South African body politic. Even more so, Butler does not give sufficient weight to the impact of TAC and its allies in pushing government to change its AIDS policy, nor in helping to bring down the prices of ARVs in the first place.

In *Fit to Govern: The Native Intelligence of Thabo Mbeki*, Ronald Suresh Roberts argues, even more forcefully than Butler does, that government policy was rational and coherent. Suresh also points out that it was based on the premise that "HIV causes AIDS," (Suresh Roberts, 2007: 180) with an AIDS budget that gradually increased as the state could afford spend more on ARVs. The government had acted cautiously, not immediately rolling out a mass ARV program before AIDS science had been settled on how best to administer triple therapy.[62] Suresh Roberts then argues that the rules of ARVs treatment were

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[62] Triple therapy, a combination of three different ARVs, was found to be the most effective way of treating HIV, effectively making it a chronic, rather than a life threatening, illness.

only finalised in and around 2001, when government started to create their MTCTP program in the first place; a responsible policy choice on government's behalf. In each of the two chapters that he dedicates to the subject in his book, Suresh Roberts frames the HIV/AIDS debate as a conflict between 'fundamentalists', who, like their religious cousins, are so utterly convinced by their version of the truth that real discussion is impossible[63]. He lays the blame for the increasing politicisation of HIV/AIDS at the feet of a conflict between Anthony Brink's Treatment Information Group (TIG) and NAPWA on the one side, and TAC on the other, which required Mbeki's calming intervention.[64] Suresh Roberts also characterises the majority of government policy critics as racist, from the "colonial press" (Suresh Roberts, 2007: 204) to Mark Heywood (ibid.: 198) and Zackie Achmat.[65] Suresh Roberts then attempts to contextualise the AIDS epidemic in South Africa along racial lines and refers to John Iliffe's book, *The African AIDS Epidemic: A History*, to argue that the AIDS epidemic was inevitable in South Africa (Suresh Roberts, 2007: 213) and hence, when criticism and the subsequent politicisation arose, "it was easier and more politically convenient for the illiberal establishment to blame black incompetence and even callousness for the AIDS epidemic."[66] The last relevant point that Suresh Roberts makes is his focus on the importance of highlighting poverty as a major component of the South African AIDS crisis. He quotes from Emily Oster, a Harvard economist, who said that "any attack on AIDS should therefore include an attack on poverty,"[67] in what appears to be an attempt to showcase the lack of understanding of NGO's like TAC in their insistence of ARVs.[68]

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[63] Terms like 'fundamentalist', 'zealot' and 'redemption' pepper the text itself. (Suresh Roberts, 2007: 190-203)

[64] Suresh Roberts' conception of Mbeki's role will be dealt with subsequently.

[65] Suresh Roberts charges that Achmat is a racist because he attacks African nationalism only and not all forms of nationalism (Ibid.: 296)

[66] Suresh Roberts also points out what he sees as the racialised nature of HIV/AIDS science by looking at one example of an AIDS vaccine in the USA that he claims was discontinued when it was found not to have an impact on whites. He then goes on to point out the racist manner in which Tony Leon, the leader of the opposition party, the Democratic Alliance, chose to characterise Mbeki's responses to HIV as based on 'snake oil cures and quackery'. The thrust of his argument draws heavily on Chapter 4's 'race factor', contending that racism is so embedded in this debate that it is almost impossible to have in an intellectually honest way (Ibid.: 214).

[67] One suspicious component about Suresh Robert's book is that he says that his footnotes are all online, yet, when trying to look them up 'www.ste.co.za/Mbeki/footnotes.pdf' and 'www.ste.co.za/Mbeki/index.pdf', they were not available (25 October 2008).

[68] Conveniently ignoring that organisations like the TAC have also campaigned for the implementation of the Basic Income Grant as poverty-reducing mechanism.

Fourie points out that "HIV and AIDS have become probably the most politicised issue in South African society" (Fourie, 2006: 177). He takes an in-depth look at the policy history of the South African government on the issue of HIV/AIDS from 1982 until 2004. He traces the HIV/AIDS policy environment from a moral-based discourse in the early 1980's to a biomedical response in the late 1980's and finally a rights-based approach with the establishment of democracy in 1994 (Ibid.: 176). Utilising a quotation from Professor Malegapuru Makgoba, who was the head of the Medical Research Council, that when the ANC looked at the array of issues that it faced after coming into power in 1994, the problems of the HIV epidemic became "one challenge too many" (Sparks, 2003: 285). Thus, says Fourie, when the ANC was criticised for not being able to face up to the realities of AIDS, it immediately became defensive, establishing the 'fortress mindset' referred to in Section 3 and beginning the chain of 'scandals' which Fourie argues built up its own momentum, rapidly politicising the HIV/AIDS story in South Africa.

In accounting for the racialised aspects of the epidemic, Fourie looks back at Apartheid government policy, in which HIV/AIDS were seen as a moral issue, leading "to an unwritten policy response steeped in a moralist discourse: in this discourse the real problem that needed to be addressed was not so much a biomedical response combating a virus as the immoral acts of homosexuals, IDUs [intravenous drug user], commercial sex workers and black migrant workers" (Fourie, 2006: 175). However, as AIDS started to make its way out of smaller groups and into what Fourie calls 'normal' society, more people started to die and the epidemic became identified with black people, which "served to *racialise* and *politicise* the epidemic" (Ibid.: 175). The Apartheid government also used AIDS as an pretext to exclude foreign mineworkers and blame liberation organisations like the ANC for trying to infect South African society through the 'AIDS weapon'. After coming into power, the ANC government was desperate to find a swift and effective response to an epidemic that it did not seem able to control, which helps to explain its initial overwhelming support of Virodene.

Schneider picks up on some of the themes put forward by Fourie and foregrounds the importance of the cycle of criticism "dominated by a series of responses and counter-responses in which actors have competed to set the agenda for AIDS in South Africa" (Schneider, 2002: 145). She claims, as has already been shown in Section 4 and by other authors, that there was no specific, overarching, coherent response from the state itself because it was not unified behind Mbeki's position on AIDS, with different elements of the state defying national policy on ARVs (before the announcement of the Operational Plan in 2004). Schneider says that a key reason for the conflict around AIDS was the

emerging battle between the state and non-state actors about "who has the right to speak about AIDS, to determine the response to AIDS, and even to define the problem itself" (Ibid.: 153).

Table 1. 'Public policy' reasons for the politicisation of HIV/AIDS

Suggested reasons	Butler	Suresh Roberts	Fourie	Schneider
Models/paradigms talking past one another ('biomedical-mobilisation' or 'clash of fundamentalisms')	X	X		
Government defensiveness as a result of criticism leading to a cycle of politicisation			X	X
Race as a key factor	X	X	X	
Battle for the 'right to speak' on AIDS as a fight between the state and civil society	X			X

Table 2. 'Public policy' understandings of government policy

Suggested reasons	Butler	Suresh Roberts	Fourie	Schneider
Rational policy decisions due to capacity/financial/resource constraints	X	X	X	
Based on the best science available		X		
Lack of clear state response: confused and contradictory	X		X	X

5.1.2. 'Biomedical-mobilisation': The power of Mbeki's denialism and state support of pseudo-science

Nattrass (2007) and Geffen (2003), criticise the emphasis on ARV expense and the lack of health care capacity suggested by Butler and Suresh Roberts. They debunk the economic argument of a financially untenable ARV rollout after the decrease in ARV prices 2001 and highlight Mbeki's key role in guiding government actions (Geffen & Nattrass, 2003). Feinstein, who was an ANC Minister of Parliament in 2000, takes a look at Mbeki's role in government HIV/AIDS policy in his book *After the Party*. He argues that Mbeki's intervention not only changed Dr Tshabala-Msimang's views on HIV/AIDS, but also health strategy due to his "active involvement in and often domination of every area of policy making" (Feinstein, 2007: 133). Regarding treatment,

Feinstein points to ANC MP Barbara Hogan, who in 2003 initiated hearings in the Finance Committee on the cost effectiveness of an ARV rollout, in an attempt to counter 'cost myths' (Ibid.: 138).

Through attempting an understanding of how government HIV/AIDS policy evolved, and its subsequent clash with civil society, Nattrass "highlights the power of ideas rather than economic interests" (Nattrass, 2007: 12). When trying to comprehend how the government tried to deal initially with HIV/AIDS (rather than its politicisation), Nattrass is mystified by what she sees as government's overall lack of response. As an economist, she tries to analyse the costs of implementing MTCTP and HAART, finding them to be cost neutral, if not cost saving (due to savings made in hospitalisations) (Ibid.: 4-6). After looking at a number of other factors, she concurs with Geffen (2006: 2), that the defining characteristic of South African government policy concerning HIV/AIDS was a lack of 'political will' (especially in comparative perspective with other countries facing similar resource constraints to South Africa) (Nattrass, 2007: 7-8). Using a scientific, comparative method, Nattrass deduces that the key element making South Africa stand out was a lack of decisive political leadership, which she accounts for through denialism on behalf of a number of ANC national executive committee members (Ibid.: 64). Heywood (2003: 282) analyses what he terms government denialism on the PMTCT program and the obstacles that government tried to place in the way of a national initiative. Cameron (2005: 116), a High Court judge who has long been a supporter of TAC, contends that the Constitutional Court, in awarding the PMTCT case to TAC brushed aside the government's argument of ARV toxicity and expense, which he says are characteristic of the 'denialist thesis'. Geffen seeks to augment this by referring to instances in which the state acted to support what he terms 'pseudo-science'[69]. He says that the government acted promoted pseudo-science directly, like including AIDS dissidents on the Presidential AIDS Panel, and indirectly like failing to act against "against pseudo-scientists promoting alternative remedies to HAART."[70] Mbeki's role is highlighted as the key factor in steering government's response to HIV/AIDS, a theme that will be explored subsequently.

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[69] This is supported by Nattrass, Heywood and Cameron.

[70] While some of these instances fall outside of the frame of reference of this paper (from 2004 onwards), there are a number of stances that Geffen refers to before 2004, like Virodene, the Presidential Panel and the dissemination of dissident material at clinics, in full knowledge of the Health Department (Geffen, 2006: 2).

Table 3. Reasons for politicisation

Suggested reasons	Nattrass	Geffen	Feinstein	Heywood	Cameron
Mbeki's direct influence on AIDS policy (who is labelled as a denialist)	X	X	X	X	X

Table 4. Accounting for government's response

Suggested reasons	Nattrass	Geffen	Feinstein	Heywood	Cameron
Disagree with the argument that national ARV program is too expensive	X	X	X	X	X
Lack of response/lack of political will	X	X	X	X	X
Denialism	X	X	X	X	X
Battle for the 'right to speak' on AIDS as a fight between the state and civil society	X			X	

5.1.3. 'Sociological-Historical': A long and wide lens

Trying to deal with the symbolic and historical components of race and public health policy in understanding the government response to HIV/AIDS have been taken forward by a range of different authors. Four writers will be explored: Mandisa Mbali, Jeremy Youde, Didier Fassin, and Helen Schneider.

AIDS discourses have changed as the epidemic has evolved. Mbali argues that the South African government response to HIV/AIDS has been 'haunted' by the 'ghosts of colonial and apartheid medical discourse', especially in the realm of public health, and hence has been framed mainly by an attempt to reply to racist conceptions of African sexuality in AIDS research, which led to government denialism (Mbali, 2004: 117). Hence, the government chose to disregard Western science and adopt a discourse of 'poverty as cause', which allowed them to further scale up poverty alleviation mechanisms, without necessarily providing ARVs, and yet still claim that they are responding to the HIV/AIDS epidemic. Drawing on Patrick Bond's writing, Mbali explores government's denialism (although the concept is not fully fleshed out) as a component of its poverty entrenching neoliberal economic policies, which attempted to avoid the purported increases in public spending associated with a comprehensive ARV

program (Bond, 2001 in Mbali, 2004: 109-110). Yet, Mbali argues, when the government started to advocate its denialist stance, the international discourse around HIV/AIDS had changed from one which only highlighted a biomedical response to a non-discriminatory human rights based approach (Ibid.: 111). The rights-based discourse allows space for both the biomedical and social conditions that have facilitated the spread of the epidemic, but rather than acknowledge this shift, Mbali argues that government's AIDS denialism reflects an "obsess[ion] with colonial and late apartheid discourses of race, sexuality, and disease in Africa" (Ibid.: 104). Hence, the *contemporary* response is appropriate for a past *conceptualisation* of the disease (Youde, 2007: 95).

Didier Fassin, a French sociologist, argues that since the beginning of the pandemic the discourse and its surrounding policies have focused merely on the medical components of the illness while, in South Africa, the issue has been mainly around ARVs making "the social issues (both carried and revealed by AIDS) practically inexpressible" (Fassin, 2007: 189). Fassin contextualises the story of the AIDS controversy, its heightened political nature and massive spread of death, in counterpoint to South Africa's inspiring narrative of national reconstruction (Ibid.: xvi). He argues that the struggle over AIDS "appears more a discussion about the legacy of the past and the re-actualisation of political commitments than a battle merely between ideas and programs" (Ibid.: xvii). Building on Mbali, Fassin contends that the best way to understand the politicisation of HIV/AIDS in South Africa is in light of its history of public health, which he says has been used to justify racial segregation and labour exploitation. This was achieved through theories of black inferiority and African sexual promiscuity and deviance (Ibid.: xix). With a sense of dramatic tragedy, he notes, "the dream of a democratic renaissance had become the nightmare of a catastrophe foretold" (Ibid.: 3).

"The political history of AIDS in South Africa since 1996," says Fassin, "is a chain of disputes rather than the endless solitary controversy that has so often been described" (Fassin, 2007: 70). He credits a number of instances where the simmering battle between civil society and government over HIV/AIDS started to spill over[71], and then highlights the snowballing effect of the cycle of political tension that TAC and government found themselves embroiled in.

Fassin argues that while the 'poverty causes AIDS thesis' is inexact (if it excludes HIV as *the* cause with poverty as a co-factor), "there is a profound

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[71] Fassin points towards the 1998 NGO budget from government, which cut government support for NGO's from R19 million to R2 million, indicating that the government was going to create policy that they might disagree with (Ibid.: 40)

truth behind the factual error."[72] Epstein elaborates on this theme, recalling Mbeki's angry questioning of the value in giving sophisticated drugs to people who did not have enough to eat (Epstein, 2007). This provides some justification to Mbeki's argument that there is an African dimension to the AIDS epidemic, even if his science was incorrect. Fassin's thrust, to protest against racialised views of African promiscuity as the key factor in the rapid spread of HIV, is then also justified (Fassin in Mantel, 2007).

Fassin and Schneider (2002: 46) claim that denial is normally displayed when a person or a collective is not able to face an intolerable reality and prefers to pretend that it does not exist. Hence, in the South African context, two denials arose; one of reality (simply the magnitude of death) and the other of justice (that AIDS arrived as South Africa entered a new era of freedom and democracy). Yet, they argue, simply to say that the "essential character of the state's positions on AIDS is one of denial is not an adequate explanation" (Ibid.: 46) in the light of Mbeki's high intellectual reputation and the increasing allocations of resources to public policy on AIDS which reflect orthodox science (Ibid.: 46). Fassin and Schneider attribute the politicisation of HIV/AIDS to the events of the 1990's (from *Sarafina II* to the disagreements on AZT), but say that the key point of contention was the symbolic fight over the MTCTP program, which activists saw as the first step towards a comprehensive treatment plan because it represented hope through the capacity to save the life of a child. The government, again through it schizophrenic AIDS policy, only established pilot sites nine months after it first indicated its intention to do so. Fassin and Schneider (2002: 47) characterise this as a government response to politicisation: they would implement an MTCTP program, but at their pace, controlling the direction and scale of HIV/AIDS policy.

Jeremy Youde, from Grinnell College in the USA, also argues that racist public health history and identity are key elements in comprehending the government's response to HIV/AIDS. Yet, he adds a further component, positing that the government had to translate this state emphasis into policy, creating a 'counter-epistemic' community[73] of scientists and AIDS dissidents[74] to provide

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[72] Fassin says that Mbeki's point is all the more important if some of the latest theory on the epidemic, which has highlighted the role of long term concurrent relationships of people in different areas (Fassin in Mantel, 2007).

[73] "An epistemic community is a network of scientists and experts to whom policymakers turn for guidance and unbiased information when a new issue emerges" (Peter Haas quoted in Youde, 2007: 3).

[74] Through the Presidents AIDS Advisory Panel, state consultation of people like Roberto Giraldo, who addressed a meeting of the Health Ministers of the South African Development Community (SADC) in 2002 (Nattrass, 2007: 107).

intellectual gravitas and buttress government's policies and statements on HIV/AIDS, the role of ARVs and alternative medicines (Youde, 2007). Government's 'counter-epistemic community' attempted to gather all of those scientists who believed in the dissident AIDS thesis to act as an intellectual counterweight to 'orthodox' science. The government also sought, as mentioned in Section 3, to argue that there were deep disagreements amongst AIDS scientists about the nature and aetiology of the pandemic, which would strengthen the case for the 'poverty' thesis and its appropriate policy response (i.e. not ARVs)[75].

Extending this idea, Nattrass attempts to show how the government supported links that dissident scientists were attempting to build in South Africa to give their science local resonance (Nattrass, 2007). The ANC-administration also sought to find holes in the current HIV orthodoxy, demonstrated by its response to news reports in December 2004 that HIVNET012, the key Ugandan study demonstrating the effective use of Nevaripine in short courses as a means to prevent MTCT of HIV, contravened international patient safety standards. Some South African government officials claimed that this example justified their slow implementation of the MTCTP program and demonstrated the continued racist nature of AIDS science in its abuse of Africans (Youde, 2007: 83). Heywood refers to government's response to TAC in the constitutional court case around Nevaripine, arguing that it wanted to actively "undermine established science and scientific institutions" (Heywood, 2003: 298). In part, it was the establishment of this 'counter-epistemic' community as a response to the increasingly political nature of HIV/AIDS in South Africa that ironically served to heighten tensions as civil society's concerns deepened over the willingness of the state to provide ARVs to people with AIDS.

Fassin also seeks to explore the deeper cultural consequences of AIDS on South African society, because he argues that they are not simply pathological in nature, but also "reveal historical truths about the social body" (Fassin, 2003: 35). Fassin and Schneider identify two common themes in the South African government's response to AIDS. Firstly, the government tended to racialise issues, a brush with which all critics were painted.[76] Secondly, they pick up on the theme of conspiracy against Africans, "either from the country's white

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[75] In Chapter 5 and 6, Youde extrapolates how the government's counter epistemic community was constructed (Youde, 2007).

[76] Just as Suresh Roberts attempts to do referring to the public debate between Tony Leon and Thabo Mbeki. In addition, Youde points to the anger that Mbeki felt when the MCC refused to certify Virodene "a product of African science, which he claimed had been suppressed and denigrated for far too long" (Youde, 2007: 81-82).

conservatives or from the pharmaceutical industry" (Fassin & Schneider, 2003: 497).

Table 5. Historical-Sociological: Reasons for Politicisation

Suggested reasons	Mbali	Fassin	Youde	Schneider
History of racist public health and racist stereotypes in South Africa	X	X	X	X
HIV/AIDS in South Africa as a chain of disputes/cycle of snowballing politicisation		X		X

Table 6. Historical/Sociological: Accounting for government policy

Suggested reasons	Mbali	Fassin	Youde	Schneider	Nattrass	Heywood
Poverty as cause and the link to other government social and economic programs	X	X				
Utilising an outdated discourse of race and sexuality rather than human rights	X		X			
Denial of justice		X		X		
Denial of reality		X		X		
Government wanting independence to create and implement its policy according to its own timeline		X		X		
Creation of an 'epistemic community' of denialists to defend the government perspective on HIV/AIDS			X		X	X
Government tendency to racialise issues to protect themselves from critics		X		X		
Government appeal to conspiracy theories to account for epidemic and ARV-pharmaceutical link		X		X		

5.1.4. Marxist conceptions and conspiracy theories

While it is intellectually dishonest and simplistic to link serious Marxist analyses of South African government policy with the conspiracy theories that still haunt the epidemic, they often share similar sorts of argument. This paper will attempt to distinguish between them in an effort to maintain the integrity of the Marxist critique.

Fassin argues that when all of the seemingly disconnected polemic episodes surrounding HIV/AIDS are placed together, they form a meaningful frame and reveal the "ideological structure of South African society" (Fassin, 2007: 71). He focuses on three elements: national identity (who and what constitutes the nation), race (along which, he says, all of South Africa's challenges lie) and conspiracy theory, to which we turn now.

Conspiracies, in the South African context, have a long history, well-rooted in Apartheid. Whites accused blacks of being communists who had come to destabilise the country and blacks accused whites of vicious forms of population control. After 1994, the need to utilise conspiracies in an explanatory fashion disappeared as the transparency of democracy made them redundant. Yet, the polemics around AIDS "have progressively rebuilt a double barrier of danger, internal and external" (Fassin, 2007: 73). As the AIDS dissidents entered the picture, so the plot became global connecting the West, science and capitalism through pharmaceutical companies who wanted to test their products on Africans for profit. However, the theme of conspiracy runs thick through the battles around HIV/AIDS in South Africa.

Treichler argues that while those in the West may attempt to disregard conspiracy theories as the results of ignorance and propaganda, the notion, throughout the developing world, that AIDS is an American invention is a recurring one (Treichler, 2004: 103-104). Western conspiracies through the medium of AIDS reveal a narrative that seeks to highlight neo-colonialism in a post-colonial world. Mantel observes that as the virus spreads throughout the world, so too do "multiple fables tyrannise the imagination. AIDS is caused by antiretrovirals, by witchcraft, by the CIA. It's the freemasons; it's extraterrestrials. If you hang up a certain brand of condom in the sun, you can see the HIV virus squirming around inside it. Rumours may be culturally intelligible, or they may take novel forms" (Fassin, in Mantel, 2007). Fassin points to some of the more strange conspiracy theories that he heard during his field work in South Africa including: a trip to Alexandra township where he was told that the virus was injected into oranges and informed that AIDS was a product of the biological warfare of the Apartheid government (Fassin, 2007: 165-166).

The ANC, in many instances, still speaks in quasi-Marxists terms[77] so laying the groundwork for AIDS to be framed as a capitalist plot to profiteer from the poor when the real causes of the crisis are inequality and poverty. Gevisser points out

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[77] Many of its leaders trained in Soviet Russia, and it has been in a strategic alliance with the South African Communist Party for decades (Butler, 2005: 606).

that this theme is strongly advanced in the infamous *Castro Hlongwane* document, believed to have been co-authored by ANC NEC member Peter Mokaba and Mbeki (Gevisser, 2007: 736), which focuses on how much money is to be made from the simple thesis that 'HIV causes AIDS' and how Africans are mere guinea pigs of international pharmaceutical companies. Heywood argues that many people suspected these pharmaceutical companies to be a part of a capitalist plot to undermine the ANC government (Heywood, 2004: 12). In addition, many in the ANC draw on the familiar language of the Dependency theorists who argue that Africa has been kept weak in order to preserve neo-colonial relations between it and the developed world,[78] which appears to be replayed through the AIDS crisis and the dependence on Western biomedicine. Combining both the conspiracy and racist elements of the explanations suggested above, Hodes says that the anti-scientific and anti-Western language of many politicians to ARV treatment "was a defensive reaction against some of the value-laden, racist claims made about Africans and the origin of HIV, particularly in the eighties but continuing to the present" (Hodes, 2008: 4)[79].

Neocosmos, who attempts to maintain an honest Marxist critique, argues that the South African state attempted to hide behind the constitution's guarantee of human rights instead of redistributing wealth. He supported the government's attempts to question and challenge the accepted biomedical standards of how to response to AIDS exclusively in terms of providing expensive ARV treatment (benefiting Western pharmaceuticals). However, Neocosmos says that the state was clumsy in its approach which, by alienating the local media and medical establishment (Neocosmos, 2007: 9) through the various scandals already mentioned, eventually forced it "into capitulation to existing bio-medical paradigms" (Ibid.: 48).

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[78] See Hirschmann (1961), Rosen and Jones (1979), Ake (1979 & 1991)

[79] Hodes's footnotes continue: "P. Farmer has termed these 'immodest claims of causality', and his AIDS and Accusation: Haiti and the Geography of Blame (Oxford, 1992), is an anthropological analysis of responses to HIV/AIDS as 'cultural artefacts'. See P. Rushton and A. Bogaert, 'Population differences in susceptibility to AIDS: an evolutionary analysis', Social Science and Medicine (Vol. 28, No. 12, 1989), pp. 1211 – 1220, for an example of the racialisation of 'sexual restraint' in which 'Negroids' were argued to be less in control of their sexual impulses than other races. For a more recent version of this argument, see UNFPA, AIDS Update 1999, particularly the Chapter on 'Promiscuity and the Primacy of Cultural Factors: A Lethal Mixture in Africa', p. 6, prepared by J. Sioncke. Available at www.unfpa.org. (Last accessed 19 August 2008). Also, R. Gronemeyer, Living and Dying with AIDS in Africa: New Perspectives on Modern Disease (Frankfurt, 2005), pp. 14, 18, 27."

Table 7. Marxist critique (and conspiracy theory): Accounting for politicisation of HIV/AIDS

Suggested reasons	Fassin	Treichler	Gevisser	Heywood	Neocosmos
History of conspiracy theories in South African society	X	X			
Contemporary conspiracy theories of HIV in South Africa	X				

Table 8. Marxist critique (and conspiracy theory): Accounting for government policy

Suggested reasons	Fassin	Gevisser	Heywood	Neocosmos
HIV causes AIDS as a profiteering opportunity for pharmaceutical companies	X*	X*		
Capitalist attempt to undermine the ANC government			X	
Questioning the dominance of the biomedical paradigm and the power structures that lie behind it				X

*Explains the argument, but does not support it

5.1.5. Socio-historical and Marxist critiques: 'Western' versus 'African' Science

A related theme to that of conspiracy theories as an explanation of government response to the politicisation of HIV/AIDS, is based on the clash between the 'traditional' and 'modern' through the medium of 'Western' and 'African' science. This clash, with much of it a result of the mistrust of Western biomedicine, was the cultural foundation that the denialist component of government's response built upon.

One of the recurring themes in this regard is that the symptoms of AIDS (coughing, diarrhoea, abdominal pains etc) are the result of witchcraft (Henderson, 2005), said to be the cause of death in one in four people from the Africa Centre's Demography Information System verbal autopsies (Ashforth & Nattrass, 2005: 289). Many of those who have AIDS would prefer to be 'cured' of witchcraft, than stick to a HAART regime for the rest of their lives,

subscribing to the "the 'African science' of witchcraft and healing" which "rests on a different set of propositions about illness and healing to conventional science" (Ashforth & Nattrass, 2005: 295).

Steinberg, in trying to gain a deeper understanding of the cultural factors that make people resistant to ARVs, spent a significant amount of time in the rural Eastern Cape. He argues that the 'shame' associated with AIDS is very similar to the 'shame' of witches, who are purported to have murderous sexual appetites and be active agents of spreading HIV (Steinberg, 2008: 133). Even as people are attempting to strip AIDS of evil through medical explanations of the syndrome, "it nonetheless remains lodged in an old and poisonous well of fear, of suspicion, and of misogyny" (Ibid.: 133). In Lusikisiki, where Steinberg was based, he found that many people thought that AIDS was caused by politics and white people.

On the other hand, the protagonist in Steinberg's book, Sizwe, did not buy the 'witches theory', rather subscribing to the suspicion that HIV was 'brewed' in the laboratories of the West (Ibid.: 146). While he refuses to acknowledge that he may have HIV, Sizwe's views showcase Steinberg's suggestion that contamination "elides the boundary between the physical and the moral" (Ibid.: 301) where a set of ARVs have the capacity to allow an HIV positive person to cleanse their body of internal dirt (i.e. HIV itself).

Achmat argues that African Traditional Medicine (ATM) has played an important role in the health of Africans for many years, but due to colonialism, it was criminalised 'fossilising' its practice, which did not allow it to develop and interact with Western science (Achmat, 2008). This left HIV positive people open to abuse by those ATM practitioners who claimed that they had magical, 'natural' cures. The government utilised traditional healers as one of the bastions of political support in its clash with TAC over the politicisation of HIV/AIDS, through the rhetorical use of 'African' medicine as the best answer to the pandemic.

Hodes argues that the distinction between Western and African science is not only 'not helpful' but also incorrect because there are an increasing number of African doctors who are practicing 'orthodox' medicine in South Africa. She argues that the core of the political controversies around HIV was the differing views of biomedicine and a "misplaced attempt to challenge the hegemony of Western pharmaceutical firms and biomedical strictures, and to resist notions of Africa's continued dependence on Western technology, including medicines" (Hodes, 2008: 2). Finally, Hodes refers to the irony that did not seem to bother

those politicians who lamented Western Science; the majority of the AIDS dissident scientists are from developed countries.[80]

Table 9. Account of politicisation of HIV/AIDS: Socio-historical and Marxist critiques: 'Western' vs. 'African' Science

Suggested reasons	Henderson	Ashforth & Nattrass	Steinberg
AIDS as a result of witchcraft	X	X	
Shame of AIDS is similar to the shame of witches			X
AIDS is caused by politics and white people			X
AIDS is brewed in the laboratories of the West			X

Table 10. Account of government policy: Socio-historical and Marxist critiques: 'Western' vs. 'African' Science

Suggested reasons	Achmat
Traditional healers a part of the ANC government's political support	X

A general criticism that can be directed towards the majority of the literature explored thus far is that authors did not attempt to theoretically account for a separation between Mbeki's perspectives from that of the state, preferring to simply 'collapse' his utterances into state policy. The reality was that Mbeki and Tshabalala-Msimang were involved in a complex struggle with different parts of the state and ANC-party apparatus over AIDS policy. There have been very limited attempts to categorise and organise the available literature into schools of thought thus far, which reflects that this area of debate is still in its early stages. More specifically, in the 'public policy' paradigm, Schneider's unwillingness to deal with race in South Africa as a politicising factor has to be viewed as a weakness, especially in an area like HIV/AIDS where not only was race a means of politicising the epidemic overall, but played a role in how the various actors chose to respond. Butler and Suresh Roberts, on the other hand, do not give a sufficient account of the impact of TAC on the politicisation of HIV/AIDS and how it influenced and pushed the ANC government to implement a national rollout that, from the rest of the literature, it appeared as if it wanted to ignore. The 'biomedical-mobilisation' group all identify the strong influence of Mbeki in the HIV/AIDS policy-making process (as does Suresh Roberts). In many ways, this category is much more unified in its approach, due

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[80] Like Giraldo, Duesberg, Rassnick (Hodes, 2008).

in part to their engagement/involvement with TAC over a number of years. While this does imply that the 'biomedical-mobilisation' contributions may be similar, it does not detract in any way from their validity. Overall, the Marxist and conspiracy theory accounts appear to be weak, not only because they are porous, but because there does not appear to be much support for these ideas elsewhere (i.e. the opinions do not appear to be widespread in the literature).

Finally, in trying to account for the government's response to the politicisation of HIV/AIDS, the literature runs into a moral problem, precisely because this was not merely an academic debate: government policy had a direct impact on the lives of over five and a half million South Africans. The challenge is this: how does one understand government policy in all of its depth, taking into account the full range of its causes, without falling into a moral relativism that justifies it. The 'biomedical-mobilisation' paradigm does not lend sufficient weight to the issues of racist public health in South Africa due in part perhaps, to their need to focus on the goal of ensuring that ARVs were provided on a national scale. Fassin, on the other hand, attempts a deep sociological understanding of South African society and government policy but does not articulate with sufficient clarity a moral objection against the government's exceptionally lethargic rollout that resulted in thousands of unnecessary deaths.

5.2. Understanding Mbeki and the question of denial: How does the literature account for Mbeki's response to the politicisation of HIV/AIDS?

> **TIME:** You've been criticized for playing down the link between HIV and AIDS. Where do you now stand on this very controversial issue?
> **Mbeki:** Clearly there is such a thing as acquired immune deficiency. The question you have to ask is what produces this deficiency. A whole variety of things can cause the immune system to collapse. Now it is perfectly possible that among those things is a particular virus. But the notion that immune deficiency is only acquired from a single virus cannot be sustained. Once you say immune deficiency is acquired from that virus your response will be antiviral drugs. But if you accept that there can be a variety of reasons, including poverty and the many diseases that afflict Africans, then you can have a more comprehensive treatment response.
>
> <div align="right">Mbeki (quoted in Time, 2000)</div>

Far too many simplistic understandings have joined the 'common sense' view of Mbeki's purported 'denialism'. Njabulo Ndebele, the former Vice-Chancellor of the University of Cape Town, has stated that he has never seen an unequivocal statement by Mbeki that HIV does not cause AIDS (Ndebele, 2004: 76), in other words, Mbeki has not been explicit on the issue. Yet Fassin argues that it is obvious that Mbeki was influenced by the dissident thesis[81] and a careful analysis of his statements on the matter is not needed in order to make this clear. Fassin suggests that the analyst has two options on how to respond; either they can dismiss Mbeki's ideas as irrational, in which case the debate becomes "radicalized but simple" or they can try to "grasp the particular rationality of Mbeki's thinking, suggesting a sociological interpretation of the epidemic" seeking "a means of making the biological and social theories compatible" (Fassin, 2007: 15). Hence, while there is a relative degree of consensus in the literature that Mbeki was skeptical about the scientific consensus (barring Suresh Roberts), there are many divergent perspectives on his motivations for holding a dissenting perspective. Whiteside argues that there are eight reasons normally given for Mbeki's response to HIV/AIDS in South Africa (Whiteside, 2008: 88):

1. Issues of sexuality and masculinity favoured by African men – AIDS threatens how men see themselves (and hence how African men were viewed)
2. Origin of AIDS as stigmatising brushed with depraved sexuality: "Africans have sex with monkey's"
3. Africans are over-sexed and can't control their sexuality
4. 'HIV spread as the country has been liberated': liberation as the bringer of death
5. AIDS used by opposition parties to attack the government, assisted by the many HIV/AIDS related scandals
6. The use of public health under racist government to justify health policy and early racist messages about HIV from the Apartheid government
7. Cost to the national treasury of an ARV rollout
8. Press painted Mbeki and Manto into a corner: hence their defensiveness, which they could not escape

Feinstein, in trying to establish the main reasons explaining Mbeki's position, argues that there are three main views. In addition to what he terms the

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[81] "AIDS denialism is an umbrella term that to me describes many different variants of common themes. However, what seems to unite all AIDS denialists is a belief that the science on HIV/AIDS that is generally agreed upon worldwide is wrong and that AIDS deaths are in fact attributable to malnutrition, narcotics and even ARVs themselves" (Achmat, 2008). In addition, see, amongst others: Feinstein, 2007: 124-126; Posel, 2005: 142-144; and Nattrass, 2007: 54-66.

'rationalist-economic' (similar to (7) above) and 'defensive Africanist' (similar to (1) and (2) above), he adds the 'psychotic denialist' which says that either Mbeki himself might by HIV-positive and is in an extreme form of denial, or, he is in denial due to the number of people around him who are HIV-positive (Feinstein, 2007: 147).

Yet this array of answers is both repetitive, in that there are issues of depraved and rapacious stereotypes of African sexuality counted in three separate instances, and incomplete. A broader view of the literature suggests that there are seven main perspectives in the literature that seek to account for Mbeki's thinking (some of which overlap with ideas presented previously). First, that he was a cautious scientific thinker who never disagreed with the prevailing 'scientific orthodoxy' but merely wanted to create a sustainable program (Suresh Roberts 2007). Second, he was converted by the denialist thesis (Nattrass 2007). Third, it was a result of his personality's natural defensiveness to being criticised (Gevisser 2007 and Feinstein 2007). Fourth, it was a part of his political history as a left-winger with elements of conspiracy (Steinberg 2008). Fifth, it was a consequence of his fixation with race and identity (Fassin 2007, Mbali 2003 and Nattrass 2007). Sixth, his denial of sexual shame and sexual behaviour associated with HIV/AIDS and his attempt to replace them with poverty because they were uncomfortable to face (Posel 2005 & 2008). Seventh, it was a result of the "symbolic politics of the new South Africa" (Posel, 2008: 15) and Mbeki's dream of the African Renaissance (Youde 2007 & Posel 2005).

While it is possible to try and squeeze the literature into the four main paradigms outlined previously ('bio-medical-mobilisation', 'public policy', 'historical-sociological' and 'Marxist critique') this is perhaps a crude attempt because each author is trying to account for the thinking of a particular individual. Hence, it is more fruitful to discuss the perspectives that each writer posits, especially since many of them offer insights on different viewpoints. An attempt to categorise the answers is compiled at the end of this section.

Since the nature of this literature review is looking at the response of government, not necessarily Mbeki's, to the politicisation of HIV/AIDS, why is it important to interrogate the literature for an understanding of his opinions? There are two major reasons[82]. Firstly, as pointed out previously, the President,

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[82] A third reason for interrogating Mbeki's views comes through an anecdote told by Feinstein. While he was in a minibus taxi on his way from Soweto, he noticed three young people pointing and laughing at a poster of Mbeki emblazoned with a safe sex message. When he asked them what was funny, the reply was 'He doesn't believe in AIDS, why should we?' The point is that Mbeki's views permeated South African society to a significant depth, which

as the head of state, had a very influential role in shaping HIV/AIDS policy through both his public statements and the impact that he had through his close relationship with the Health Minister. Secondly, Mbeki's dissenting views on HIV/AIDS were a major politicizing/mobilizing factor themselves, with TAC and other NGO's/health professionals seeking to challenge Mbeki and the ANC administration utilising 'denialism' as a rallying call.

Suresh Roberts argues that Mbeki's critics were racially motivated in their attempt to brand him a denialist and de-legitimise him.[83] Suresh Roberts highlights the key role of Mbeki in South Africa's HIV/AIDS policy production acting as a mediator between the 'pro-drug' fundamentalists, represented by TAC, and the 'anti-drug' fundamentalists, represented by Brink's TIG (Suresh Roberts, 2007: 198-199). Suresh Roberts tries to set these two opponents up as equal in intellectual weight even though TAC's perspective was supported by international research on ARVs while Brink relied on a few, scattered denialist voices. In a self-defeating manner however, Suresh Roberts savages Brink as being not quite sane because not only does he think that ARVs are toxic, but he believes in the "wholescale rejection of condom use or [and] pap smears" (Ibid.: 199) (how then is Brink's TIG an intellectual equal to TAC?). He argues that Mbeki had to find a way to bring these two warring factions together and build a coherent and scientific ARV program, which is why he supported a slow, but steadily increasing, ARV rollout from 2002 starting with MTCTP. Suresh Roberts argues that Mbeki was never a 'denialist' nor a 'dissident'; rather, he refused "to play stenographer to the drug companies in the management of South Africa's major public health issue" (Ibid.: 186). Hence, argues Suresh Roberts, neither Ndebele nor Cameron could find an instance when Mbeki out rightly denied the causal chain of HIV leading to AIDS. All of Mbeki's actions, from the creation of the Presidential Panel (which he did because he was curious, confused and wanted to establish a professional debate on how best to move forward) to the final Operational Plan, which – due to Mbeki's flak-taking from TAC, "received a far more cautious and sensible rollout" (Ibid.: 205) – were based on the best scientific knowledge available. Yet, in a manner that would be very seriously questioned by the 'orthodox' bioscience that Mbeki supposedly supports, Suresh Roberts (quoting Mbeki) argues that "AIDS cannot be attributed 'solely and exclusively' to HIV" (Ibid.: 187). Suresh Roberts does not account for all of the instances where Mbeki's very strange HIV/AIDS opinions were aired and instead starts to attack the former President's critics, in

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may have been an influence on government's thinking from the 'bottom-up', rather than merely from the 'top-down' (Feinstein, 2007: 143).

[83] See previous Chapter on how Suresh Roberts utilizes race as a brush with which to paint all Mbeki critics.

an Mbeki-esque style, on the grounds of racism because they saw him as the 'stubborn native' who did not agree to the dominant biomedical perspective.

After coming into contact with AIDS denialists in 1999, Nattrass argues that Mbeki was convinced by their arguments. Sparks states that Anthony Brink introduced the President to websites run by AIDS dissidents who referred to themselves as 'The Group' (Sparks, 2003: 286) and thereafter had contact with Anita Allen, a journalist who is a 'passionate crusader' in "the cause that the HI virus and AIDS do not exist" (Ibid.: 186). Nattrass argues that Mbeki's denialism can be inferred from the his questioning of the link between HIV and AIDS and his 'paper trail' of questions about HIV and his sympathetic view of the denialists. Being convinced by the denialists' position meant that the argument over the cost-effectiveness of ARVs was not a factor in Mbeki's analysis as he did not think that they should be used a priori. Gevisser says that only after Mbeki had engaged with denialists like Rasnick, over an extended period of time, did he start to advance his 'poverty thesis' (Gevisser, 2007: 743). Yet, even after Mbeki withdrew from the debate itself, he continued to "haunt the policy environment through his silence… and through ongoing links between AIDS denialists and the government" (Nattrass, 2007: 35). Further, contends Nattrass, Mbeki 'championed' the denialists' cause by granting them respectability without which they would have been "consigned to obscurity long ago" (Ibid.: 33), a sentiment echoed by Mbali who says that before Mbeki adopted elements of the denialist thesis they were "virtual unknowns" in South Africa (Mbali, 2003: 318).

The third school of answers to understanding Mbeki's views try to delve into his personality by looking at, for instance, his "hypersensitivity to criticism, especially where he believes there is a racist dimension to the comment" (Van der Vliet, 2004: 88). Nattrass says that this is the de facto explanation of most journalists and commentators, identifying all criticism as a personal attack. Makhanya, the editor of the *Sunday Times*, said that the hallmark of Mbeki's presidency has been its "intellectual superiority complex" (quoted in Nattrass, 2007: 84). Gevisser, whose biography of Mbeki is considered to be authoritative, posits that Mbeki sees himself as a modern Galileo, a 'brash newcomer'[85] who would come in from outside the AIDS world to force it to see the key role that poverty plays in producing and perpetuating AIDS (Gevisser, 2007: 727-728). In

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[85] Gevisser points to a book that was very influential for Mbeki's thinking called Black Athena by Martin Bernal. In it, Bernal argues that European racism was to blame for the 'common knowledge' perspective that civilisation started in Greece "No, Bernal writes, the evidence is clear Greek civilisation was profoundly rooted in Egypt, in Africa, and the only reason why centuries of European classicists have been blind to this evidence is because of their own Eurocentric racism" (Gevisser, 2007: 728).

another Mbeki biography Gumede reaffirms Van der Vliet's criticism saying that Mbeki's Achilles heel is his 'you are with us or against' attitude. Feinstein argues that Mbeki is incredibly insecure, which is the key explanation for his belief that those who disagree with him "either hate him or want to topple him" (Feinstein, 2007: 150). Additionally, while other people may disregard his opinions on HIV presently, Mbeki believes "with absolute conviction" (Ibid.: 735) that he will be proven correct once again.

Mbeki's Marxist background, combined with his appeal to the conspiracy theories of capitalist pharmaceuticals, is the fourth suggested reason for his dissident/denialist opinions. Stanley Cohen, when commenting on the nature of denial by a government, claims that journalists and human rights observers are seen as selective and working from a hidden political agenda, or else as naïve and easily manipulated (Cohen, 2001: 105). Gevisser points out Mbeki's belief that AIDS was simply the latest form of Afropessism, which was being exploited by 'Big Pharma', using "AIDS activists as its stooges as it dumped expensive products on unsuspecting Africans" (Gevisser, 2007: 739). Steinberg agrees and suggests that Mbeki believed that the 'received wisdom' that HIV causes AIDS was "sustained by one of the most powerful commercial interests on the planet" (insinuating some form of capitalist plot against the continent) (Steinberg, 2008: 91). While taking notes during an ANC caucus meeting in 2000 Feinstein jotted down Mbeki's speech in which he stated that one problem with saying that HIV=AIDS is "the international political environment where the CIA has got involved. So, the US says we will give loans to Africa to pay for US drugs" (Feinstein, 2007: 124). Framing AIDS as a Western, capitalist plot, was also Mbeki's way of showing that he had not capitulated to an exploitative global capitalism.[86] Nattrass argues that Mbeki's intellectual background may have influenced his view that science was merely a "self-serving organ of capitalism" (Nattrass, 2007: 85) which suppresses views that threaten the dominance of its power relations.

Gevisser contends that Mbeki's Marxist conception of AIDS as a 'lifestyle' disease centred on income "constitutes a purely materialist reading of sexuality" (Gevisser, 2007: 763). Further, AIDS can then be conceived of as the result of rapid class change that has alienated a new elite from its worker/peasant history "to the point of morbid pathology" (Ibid.: 763). In other words, the entire epidemic becomes much easier to conceptualise and deal with; poor people get AIDS because they are poor, while the rich get AIDS due to their rapid

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[86] Despite Mbeki's championing of the neoliberal Growth, Employment and Redistribution (GEAR) economic policy in 1996, seen by many on the left as the ultimate sell-out of the ANC to capitalist forces (See Bond, in Calland & Jacobs, 2002: 53-82)

accumulation of wealth and its resulting decadence. Either way it is an issue of money, not one of sexuality and sexual behaviour.

Fifth, linked to the issue of racist views of black sexuality but distinct in that it highlights the role of sex and sexuality in South African society, Posel argues that by "refusing the connection between AIDS and sex, Mbeki (and those who share his arguments) rhetorically refuse[s] to engage in any public argument about sexuality – male sexuality in particular - and even more emphatically, in any public scrutiny of the sexual practices of black men" (Posel, 2005: 144). Posel claims that while much of the debate over Mbeki's opinions has focused on treatment and denial, the issues of sexuality and the centrality of sex as the key vector in the spread of HIV has largely been ignored by Mbeki's critique. He has preferred to claim that much of the debate around HIV/AIDS in South Africa is deeply rooted in stereotypes about "the rapacious and violent sexuality of black men" (Ibid.: 142). Gevisser says that Mbeki saw the controversy of HIV through the prism of sexual shame, and in the case that he might have to identify himself as HIV positive, it would imply that he had been sleeping with prostitutes (Gevisser, 2007: 761). To sideline issues around sexual behaviour and sexual shame, Mbeki preferred to focus on a discourse of poverty and hence he did not need to confront what happened in "the African bush" (Posel, 2008: 22).

While AIDS took centre stage in South African life as a 'national catastrophe', Mbeki refused to acknowledge it because he saw it as inappropriately alarmist. Yet, asserts Posel, it was precisely this refusal that caused the urgent need to communicate a sense of impending crisis (Posel, 2005: 145). It is at this point of 'national catastrophe' that the controversy went beyond issues of sexuality and deep into the politics of nation-building, where the discussion over HIV/AIDS "becomes a reflection on the identity and values of the national subject, along with the moral character of the nation" (Ibid.: 145). The building of a South African nation needed the creation of a 'new form of person' who would finally be able to throw off the burden of the colonial stereotypes of Africans. Yet, it is this 'new person' who may have been contaminated by HIV. If the body of the nation was contaminated then so too was its image infected[87] and sex, far from bringing life into the freedoms of a new democracy, became a "vector of death" (Ibid.: 147). In the 'symbolic politics' of the 'new' South Africa (Posel, 2008: 18), the nation itself had become vulnerable and hence Mbeki's nation-building

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[87] "Susan Sontag (1990) has underlined the profoundly metaphorical character of the AIDS epidemic in the West: what AIDS does to the individual body has widely been read as a reflection on what the epidemic does to the social body, punishing moral transgressions, subverting the project of modernity and reinstating racist invectives against the 'primitivism' of Africa" (Posel, 2005: 149)

project was threatened by the AIDS epidemic at the moment of its birth. Gevisser points out that Mbeki's biggest concern was to reaffirm the racist underpinnings of black sexuality, verbalising Mbeki's fears that "we are the Africans that our colonial oppressors said that we were, and we have not been able to liberate ourselves from their definition of us" (Gevisser, 2007: 763).

It is this set of symbolic politics that forms the basis of the sixth justification for Mbeki's perspective, that of the African Renaissance and the establishment of a just, equitable new South Africa. Gumede summarises the former president's version of the African Renaissance: "both intellectually and emotionally, Mbeki is intent on proving Afropessimists wrong" (quoted in Youde, 2007: 79). In order to move forward, Africans need to refuse to capitulate to its 'blighted past' and foster a desire to transcend a history of misery and reassert Africa's yearning to prosper (Posel, 2008). Gevisser points to Mbeki's response to Mandela's intervention into the AIDS debate. He says that Mbeki integrated his critique of orthodox AIDS science and its supporting institutions into the assertions of NEPAD[88] and the call for Africans to design solutions to the challenges that they face (Gevisser, 2007: 746). Gevisser tracks the development of Mbeki's thought over two years, arguing that what had begun as a scientific quest, out of a desire to design the best AIDS policy for his people, turned into "an impassioned cry for self-determination" (Ibid.: 750). In an analysis of the *Castro Hlongwane* document (which Gevisser says Mbeki agrees with), Gevisser says that paper itself comes very close to a form of essentialist racism that he characterises as "nativism at its crudest" (Ibid.: 752). Nattrass points out that Mbeki's support for Virodene, as a home-grown solution to HIV, is an example of his brand of African Renaissance nationalism. She then argues that this begs the question because it does not account for Mbeki's shift from 'scientific answers' (i.e. Virodene) to attacking science's authority itself (Nattrass, 2007: 89). It is possible that Mbeki's AIDS position changed over time but the African Renaissance appears to be a supporting, rather than the decisive factor.

Finally, interwoven throughout all of the abovementioned reasons is Mbeki's fixation on the issues of race and identity. Nattrass asserts that there is evidence to say that Mbeki viewed the scientific search for the origins of HIV through the contact between primates and humans in Africa as racist and an attempt to blame the continent for the epidemic (Gevisser, 2007: 87)[89]. Mbali posits that

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[88] New Partnership for Africa's Development, one of Mbeki's projects to promote good governance, economic development, democracy and accountability on the continent.
[89] Given further credence by Mbeki's Z.K Matthews memorial lecture at Fort Hare in 2001 in which he states, "we must perforce adopt strange opinions, to save a depraved and diseased people from perishing from self-inflicted disease." (Quoted in Gevisser, 2007: 749).

the key reason for Mbeki's strange AIDS discourse is best explained through the lens of race and identify, specifically in relation to the practice of colonial medicine and its portrayal of Africans as promiscuous (Mbali, 2002, in Vandormael, 2007:224). Fassin adds that the discovery of local, African remedies for HIV was seen as 'revenge' for centuries of colonial/post-colonial medicine that exploited African people. Lastly, in an article in the *British Medical Journal*, Fassin and Schneider remark that there were only biomedical and behavioural approaches to the HIV pandemic available when Mbeki was searching for a broader explanation for the pandemic in South Africa[90], rather than a coherent social epidemiology leading to the appeal of the dissident's theses (Fassin & Schneider, 2003: 496).

A general criticism directed towards much of the literature outlined is the frivolous manner in which the term 'denial' was used, without taking into account its complexity, as outlined by Cohen. While Nattrass argues that we may never actually know the motivations for Mbeki's decisions, it is valuable to try to establish the strongest argument of those discussed above (Nattrass, 2007: 89). Suresh Roberts can be seen as an outlier, with whom very few agree and whose case, based on the evidence presented in the rest of the literature, appears to be weakest. Mbeki was at least a dissident (if not a denialist). There are two ways in which the literature outlined can be appraised. Firstly, by looking at the table on the subsequent page, the strongest case could be seen as that which is supported by the greatest number of academics, that is 'the symbolic politics of the new South Africa and the African Renaissance'. Yet, piling up facts, or in this case, academics, to support one view does not necessarily demonstrate its strength. Each of the suggested answers seems to highlight an important part of Mbeki's perspective, which seems to start with his obsession with racism and its corollary of the emancipatory nature of the African Renaissance. However, Mbeki does seem to have genuinely been converted to the denialist thesis. Yet this leaves a question unanswered (which is applicable to all of those who advocate a denialist stance). If Mbeki believes in science and was presented with comprehensive and vast ranges of literature on AIDS and ARV research, why is it that he refused to be convinced? This apparent unwillingness to come to terms with current scientific thinking is perhaps a factor that displays the importance of a more psychological and sociological approach, to which the whole issue of 'denial' is directed in the first place. While Gevisser delves furthest into Mbeki's psyche, Posel and Fassin appear to best highlight the denial that

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[90] It is interesting to note that, according to Gevisser, Mbeki has 'mellowed' on HIV/AIDS, because he thinks that his contribution concerning the central role of poverty, is now recognized by the major health institutions the world over (Gevisser, 2007: 758-759)

resulted from the complexity of building a nation in the context of a racist past and current mass death.

Why did Mbeki hold the views that he did on HIV/AIDS?

Suggested reasons	Suresh Roberts	Feinstein	Nattrass	Gevisser	Mbali	Gumede	Steinberg	Posel	Fassin* & Schneider
Mbeki was never a denialist	**X**								
Mbeki was convinced by denialist arguments after 1999			**X**	X	X				
Mbeki's personality and hypersensitivity to criticism			**X**	X	X		**X**		
Mbeki's Marxist background and pharmaceutical conspiracy				X	X		X		X
Sex, sexuality and sexual shame					X			X	
Symbolic politics of the new South Africa and the African Renaissance			X	X	X	X	X		X	X

Note: the perspectives that an author deals with in their analysis is marked. In the instance where an author has indicated their primary understanding, it is highlighted in **bold.**

* In addition, Fassin specifically looks, as analysed previously, at the role of racism and identity in the light of South Africa's racist public health.

6. Accounting for the responses to the Politicisation of HIV/AIDS of Treatment Action Campaign

The literature dealing with TAC itself is very limited, in both scope and depth. There has been some discussion surrounding the nature of the organisation itself and whether or not it is a 'single issue' organisation or a social movement,[91] which may play a role in the manner in which it operates and could be understood through the 'biomedical-mobilisation', 'historical-sociological', 'public policy' and 'Marxist critique' categories. Yet even though TAC has featured prominently in these paradigms, there has not been a need to try to

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[91] The discussions between Patrick Bond (2004 & 2006) and Vally (2003) on the strong left side of the spectrum and Friedman & Mottair (2005) and Mbali (2003) from the left-liberal flank, offer insight into this conceptualization framework.

account for the actions its actions as TAC has been explicit about its perspective, goals, membership and methods. The only real criticism of TAC comes from the 'Marxist critique', which is explored subsequently.

The consensus in the literature is that TAC, in contrast to government, followed the biomedical 'orthodox' position in its understanding of HIV/AIDS science[92]. More than that, its messages were not confused and obscure and hence its responses require much less explanation (which accounts for the relatively small amount of literature on the subject). TAC, described as "the most vibrant and powerful social movement of the post-apartheid era" (Posel, 2005: 140-141) was effectively a response to government's HIV/AIDS policy and positioned itself on the moral high ground while campaigning for equal, free access to ARVs for all South Africans. TAC's campaign of and for the poor, who are seen by the ANC to be its constituency, led to an immediate defensiveness on the part of government as TAC appeared to be appropriating its legacy of human rights (Friedman & Mottair: 2005). Achmat argues that the TAC has achieved its goals in a number of ways (some of its means were mentioned in section 3) but has always relied on "evidence, fact and reasonable argument" (Achmat, 2008) in its internal education on science, law, medicine and economics. As a social movement, TAC found itself in an unusual position: normally, social movements are societal responses attempting to get unconventional positions onto the public agenda yet, in South Africa, TAC was trying to defend the international orthodoxy on HIV/AIDS (Friedman, 2008).

Fassin says that TAC capitalised on the label of denial that it attributed to government, which made its public intervention all the more forceful (Fassin, 2007: 117). One of the challenges that TAC faced was simultaneously dividing its resources between pressurising pharmaceutical companies to lower their prices and pushing the government to create an effective and large-scale roll out of ARVs (Mauchline, 2008: 18). TAC's campaign was multi-dimensional and well beyond the limits of this paper to discuss in detail[93], yet there are two components, each on a different end of the spectrum that are interesting responses to what TAC saw as government's deadly denialism. On the 'grassroots level', TAC felt that it needed to respond to HIV/AIDS denialism in South African society (regardless of its origin as the result of a suspicion of Western science or the impact of Mbeki's views) through the creation of its mass-based Treatment Literacy program to educate people about HIV/AIDS

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[92] However, it was very critical of pharmaceutical company profiteering, often campaigning against them.
[93] For an in-depth analysis see Friedman, & Mottair, (2005), Mbali (2004), Robins (2004) and Jones (2005) and de Waal (2006)

science. On the other hand, at a societal level, TAC established an 'epistemic community' of well-educated activists who could counter denialist claims and represent the TAC bioscience message to government, the media and the international community. Despite the need to 'respond' to ANC policy, TAC always maintained that it was ready to work with government to ensure that it implemented good AIDS policies (Nattrass, 2007: 111).

6.1. Grassroots Response: The Treatment Literacy Program

Oshry (2007) points to Robins' (2004) claim that the one of TAC's key successes has been its grassroots mobilisation from throughout racial and class divisions, representing "globalisation from below" (Robins, 2004: 651). It is this spirit of the mass movement that encouraged TAC to establish a wide-spread HIV/AIDS education campaign with many people who never had formal schooling. The Treatment Literacy (TL) program, which was started in 2002, is a grass-roots cultural project in support of orthodox science. Participants are taught about the science of HIV and how ARVs work so that they can better engage with their doctors about regimens and potential side effects (Nattrass, 2007: 166). It is meant to empower people and allow them to feel confident with the language of medical science and all of its related terminology. To support the TL program TAC created a number of fact sheets, posters, songs, art and a booklet series called "In Our Lives" (Achmat, 2008) which were distributed at workshops, clinics and its offices. The information gathered from these discussions also helped TAC members counter the arguments advocated by denialists who they encountered in their communities. This grass-roots response to denialism was made even more difficult by what TAC calls the state's sponsorship of pseudo-science (Ashforth & Nattrass, 2005: 300). Friedman adds that the TL process is also a 'consciousness-raising' one (Friedman, 2007: 4-5), which effectively created additional supporters of orthodox science and potentially TAC's political campaign. Hence, the Treatment Literacy program can be seen as one of TAC's key responses to the politicisation of HIV/AIDS.

6.2. Institutional Level: TAC's Intellectual Campaign

Alain Vandormael argues that TAC created its own internal epistemic community, supported by outside scientists and institutions, in order to defend and consolidate biomedical science from institutionalized political attacks in South Africa. He describes this as TAC's 'intellectual campaign', which he

argues differs in conception and practice to TAC's other civil actions (like civil disobedience or marches). Vandormael contends that this campaign is distinct because it involved a select group of individuals who tasked themselves with providing a comprehensive response to the stance advanced by Mbeki's government, which they considered to be a challenge to orthodox AIDS science (Vandormael, 2007: 218). Vandormael contends that this intellectual campaign established an 'epistemic platform' upon which the rest of TAC's tactical program was built (Ibid.: 218). This internal epistemic community had to undergo 'expertification' on a range of topics surrounding HIV/AIDS and medical issues[94] so that it could talk confidently to government and other stakeholders (Ibid.: 223). TAC consistently called for the utilisation of 'good orthodox] science' rather than the 'pseudo-science' that Mbeki was accused of incubating within the Presidency. TAC claimed that Mbeki's perspectives on science fell into the realm of 'denial' and his continued relationship with 'dissident' scientists resulted in the sidelining of the "mainstream scientific community" (Ibid.: 223). While TAC valued scientific debate, it felt that the main scientific questions surrounding HIV/AIDS had already been established and hence saw no benefits for a non-specialist like Mbeki, to begin challenging them.

The major critic of this approach is Neocosmos, who argues that TAC merely re-enforces the bio-medical power system by encouraging people to see themselves as 'patients': "passive recipients of medical and state *delivery*, rather than as active agents in their own cure with the help of experts" (Neocosmos, 2007: 47-48)" Yet, this passivity was exactly what the Treatment Literacy project had been designed to counter, as reflected in the literature.[95] Neocosmos further contends that TAC's successful engagement with government in compelling it to supply ARVs was due to the fact that it did not fundamentally challenge any of the established positions of power in the bio-medical scientific block[96]. Perhaps unexpectedly, Neocosmos argues that TAC's engagement with government actually served to de-politicise AIDS by forcing it into the "hegemonic bio-medical paradigm of science which expects people to passively be the recipients of medical technology" (Neocosmos, 2007: 9).

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[94] Some of the areas that they needed to cover included: the long and short term side effects of ARVs, post-exposure prophylaxis, the treatment of opportunistic infections and the value of alternative medicines.

[95] See Nattrass (2007), Friedman & Mottair (2005), Friedman (2007)

[96] Despite his criticism of the TAC and his support of nutrition initiatives, Neocosmos does affirm his belief in the wide use of ARVs as the only way to treat people with full blown AIDS.

7. Conclusion

Since 2004, the approach of TAC and government has mellowed. TAC has incorporated a much stronger focus on poverty (de Waal, 2006: 38) while the government has, although relatively slowly, created and implemented the largest ARV program in the world (IRIN, 2008). Yet, while the politicisation of HIV/AIDS resulted in a long, drawn out and damaging conflict between TAC and government, it was an unnecessary process.[97]

The concepts dealt with in Section 2, 'politicisation' and 'denial', are both vital parts this review in helping to establish the theoretical basis on which much of the subsequent literature was analysed. One of the most critical weaknesses that many of the authors faced was the inexact manner in which they defined 'denial', preferring to use the term without trying to flesh out its complexity. While it was beyond the scope of this review to analyse how each author utilised 'denial' it is noted as a general weakness. Since history has played such an important role in the manner in which the politicisation of HIV/AIDS has played out, the key themes of a long-standing precedent of racist public health in South Africa and the series of escalating HIV/AIDS-disputes between civil society and government, were vital components in understanding the context of the politicisation of the pandemic (Section 3). Yet, before it was possible to account for the responses of TAC and government, the question of why HIV/AIDS itself had become so politicised needed to be addressed (Section 4).

The literature on the South African government seems to suggest a number of conclusions. First, on a more technical note authors used the term 'denial' too easily without trying to account for its complexity or defining it sufficiently clearly. Second, the literature too often collapsed what they saw as Mbeki's views, or those of Tshabalala-Msimang, with that of the state. Third, each of the paradigms outlined offers a very important perspective which, taken together, increase the depth of trying to understand the rationale behind the government's response to the politicisation of HIV/AIDS. It is clear that race, poverty, history and the politics of the new South Africa play a pivotal role in coming to grips with the stance taken by government. Yet TAC's role in forcing the government to change its policy is under-explored by some of the 'public policy' and 'historical-sociological' authors. The 'biomedical-mobilisation' paradigm does not give sufficient weight to the history of racist public health in South Africa while a sociologist like Fassin, who does attempt to delve into a more complex

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[97] There is ample evidence, as presented before, of the cost effectiveness and capacity of the South African health system to design and implement a national ARV rollout from 2002 onwards (Geffen & Nattrass, 2003).

understanding of South African society, steps too far onto the side of justifying ANC-government policy.

Clearly, President Mbeki loomed large in the analysis with each component of the literature being forced to choose a method of how to account for his thinking and behaviour especially since there is a consensus that he played an important role in the creation of AIDS policy. While Nattrass argues that Mbeki's motivations will never be understood, most authors agree that he was a dissident (while many would call him a denialist) thus strengthening the case of his genuine belief in dissident arguments. The impact of the African Renaissance and the 'symbolic politics' of the new South Africa were both seen as vital factors key to gaining access to Mbeki's worldview. Yet something does appear to be missing: Mbeki's apparent unwillingness to come to terms with the latest ARV and AIDS research (hence the claim of 'denialism') point to a psychological factor, which many suggest is a combination of insecurity, defensiveness and arrogance.

7.1. Gaps in the literature

While the literature on Mbeki's views on AIDS is vast, there has been very little writing trying to thrash out his complicated relationship with various parts of the state around the issue of HIV/AIDS. Even more so Mbeki's views on HIV/AIDS cannot be seen in a political vacuum as they served as one of the fault lines which deepened political divisions in the ruling party (resulting in the December 2007 Polokwane conference where Mbeki was removed as the President of the ANC).

TAC's response to the politicisation of HIV/AIDS is perhaps the most interesting and yet vastly under-explored in the literature. Despite attempts at a Marxist critique of TAC, which are of academic interest only and have almost no relevance in real world of politics where TAC has become one of the most powerful social movements in post-Apartheid South Africa, there are no 'schools of thought', trying to understand its response to politicisation.

Finally, in this area of debate, there have been very limited attempts to categorise and organise the available literature into schools of thought, which reflects it is still in its early stages.

7.2. Final conclusions and recommendations for future research

While Gevisser (2007) and Gumede (2007) have attempted to provide an integrated perspective of Mbeki, their books dedicated only one chapter each to his views on AIDS. What is needed is an attempt to see how political events, not only those that related directly to HIV/AIDS, influenced his thinking. More specifically additional research needs to be done in trying to account for exactly how his views filtered into the various components of the ANC and government overall and which factors facilitated this process.

TAC is very under-represented in the literature. There is currently no comprehensive history of the organisation, nor of the transformation that it has gone through since it was formed a decade ago. TAC needs to be grappled with by a variety of disciplines so that schools of thought emerge and the current shallow understandings are deepened.

Perhaps the most interesting area of future research that could be undertaken is to try to understand how a social issue (in this case HIV/AIDS) becomes politicised between civil society and government, and how that process of politicisation can have a determining impact on its outcome. Regarding AIDS specifically, the Brazilian case (Beyrer, Gauri & Vaillancourt, 2005) and other examples of middle-poor income countries where AIDS was politicised in a different manner resulting in a social alliance between civil society and government, would be of academic value.

Finally, there the issue of how social movements utilise discourse and what allows them to entrench their discourse as the dominant one in society is a fruitful area of research that arises from this literature review. Taking into account the long battles between TAC and the government, this can be demonstrated through a brief quote by then Secretary-General of the ANC, Kgalema Motlanthe who said, in 2004, 'We are in the same boat with TAC now' (Heywood, 2004: 22).

Appendix 1

(Mauchline, 2008: 4)

Table 1.   Key country indicators (2006)

	Brazil	Thailand	South Africa
Population	188.7 million	64.7 million	47.4 million
GNI per capita	$4,730	$2,990	$5,390
Gini coefficient	57.0 (rank: 70th)	42.0 (rank: 78th)	57.8 (rank: 121st)
HIV prevalence (adults aged 15-49)	0.5%	1.4%	18.8%
Total PLWHA	620 000	580 000	5.5 million
Pregnant HIV+ women receiving ARVs for MTCTP	57.6%	30.6%	14.6%
PLWHA receiving ARV therapy	N/A	60.0%	21.0%

(Source: UNAIDS, 2006; World Bank, 2006; UNDP, 2007)

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