

IMAGINING AIDS—SOUTH AFRICA'S VIRAL POLITICS

MBEKI'S 'DENIALISM'—ITS ROOTS AND BRANCHES

The roots of what has come to be called President Mbeki's 'denialism' are undeniably rooted deeply in South African soil. Its branches are discernable in many aspects of health beliefs and medical practice in South Africa. It is far too simple to call it a 'denial'. It points to a world of meanings—a worldview—that link almost every aspect of health and illness to the social. It is not a denial of knowledge, or a denial of science and medicine. It is a refusal to bring into the mind's eye, the imagination, a vision of the community of sufferers and the cause of their suffering.

President Thabo Mbeki has been in the forefront of efforts to reduce violent conflict in Africa, and to reform governments across the continent. He has led the continent in formation of the African Union (AU), a new continent-wide organisation that has replaced the old, corrupt and somnolent OAU. A programme of 'peer review' of African governments by other Africans has been put in place in order to lead the continent toward good government and economic development. In the eyes of many South Africans, Mbeki is more concerned with the rest of Africa than he is with his own country. In most areas of government, Mbeki's leadership has been excellent, and he has earned high approval ratings across the South African political and racial spectrum. Early in his presidency he announced the coming of the African Renaissance. While it was not entirely clear what this might mean, it has been taken to be a call for African pride, African sovereignty, and 're-birth' of African self reliance. Mbeki has helped to negotiate peaceful settlements of several violent conflicts in Africa, set up the New Economic Programme for African Development (NEPAD), was instrumental in development of the AU constitution and its institutions, and has campaigned strongly at world forums for reduction of debt and increased aid from African development.

As admirable as these efforts have been, they have had negative impacts too. The premise of solidarity between African governments has led him to ignore the steady decline into chaos, poverty and starvation in Zimbabwe, South Africa's neighbour, for instance. With respect to AIDS, it has led him to recruit other African countries into his contrarian positions on HIV, use of ARV drugs, condoms, and educational interventions. The successes and the failures are part of a package of pluses and minuses that are intricately bound up with a commitment to 'Africanism'—which implies finding a distinctive 'African way' to solve problems of society and governance—and a politicisation of most issues that might have simpler, more technical solutions.

Between May 31 and 5 June, 2006 delegates from around the world met in New York for the United Nations General Assembly Special Session on HIV/AIDS (UNGASS). The meeting was meant to review progress towards goals set in 2001 for dealing with AIDS. There, a consortium of countries led by Gabon (as the current president of the AU) and South Africa sought to undermine previous agreements made in Abuja, Nigeria, in 2001 (The Abuja Declaration). This initiative by the UN offered progressive evidence-based methods and commitments for fighting AIDS. Gabon represented the concerns of African states with Islamic majorities. With

the support of the South African government delegation, it sought to exclude reference to homosexuality (or men having sex with men), sex workers, and women and young girls, all of whom are especially vulnerable to HIV infection. The South African delegation has also sought to exclude mention of specific targets for provision of antiretroviral drug therapy, suggesting that they did not want the government to be held accountable for the chronically slow provision of ARVs across South Africa.

Before the meeting, however, the Ministry of Health had already moved to exclude the AIDS Law Project and TAC from accreditation at UNGASS 2006. A number of civil organisations had also prepared a memorandum to Kofi Anan, Secretary General of the UN in order to point out the inadequacies of the South African Department of Health's own report. Apart from its exclusion of key stake holders, the report failed to include or misrepresented statistics on HIV mortality, HIV prevalence, TB and HIV incidence, and the total number of patients receiving ARV treatment. In keeping with their desire not to be held to promises, the DoH report to the UNGASS also omitted ARV treatment target.¹ A representative from Open Society South Africa, Sisonke Msimang, commented that 'Our [African] states have behaved in the most shocking fashion. ... Our missions have been complacent and disorganised at best, and in the case of Gabon and South Africa, obstructionist.'²

The organisation of African states that Mbeki had worked hard to create was now supporting him in his campaign to undermine AIDS prevention. Just two weeks before, Nozipho Bhengu, the daughter of a South African member of parliament, had died on May 19th as the result of AIDS and of following the advice of the Minister of Health Manto Tshabalala Msimang. Nozipho's mother, Ruth Bhengu, had made headlines in 2001 by announcing in Parliament that her daughter was suffering from AIDS related illnesses. They announced that she was doing well, however, because she was following the nutritional advice of the Minister of Health, and eating a diet rich in garlic, ginger, olive oil, lemon juice, beetroot, and vitamins provided by Matthias Rath³, yet another charlatan offering an 'AIDS cure', like Virodene, with the imprimatur of the South African Government. The peculiar diet had been devised by Tine van der Maas, a former nurse and self-taught nutritionist. She had managed to convince the health minister that her diet was an effective cure for AIDS. In 2005, an apparently healthy Nozipho had declared the diet effective after having been on it for 3 years. 'It works. I am the scientific proof', she claimed.⁴ Early in 2006 Nozipho had said that she was writing a book, 'From

¹ Letter to Kofi Anan, Secretary General, United Nations; from Joint Civil Society Monitoring Forum (JCSMF), founded by the AIDS Law Project, Health Systems Trust, Centre for Health Policy, Institute for Democracy in SA, Open Democracy Advice Centre, Treatment Action campaign, UCT School of Public Health & Family Medicine, Public Service Accountability Monitor & *Médecins Sans Frontières*, Re: United Nations General Assembly Special Session on HIV/AIDS (UNGASS)- South Africa's Progress Report, dated 6 April 2006. Electronic Document on TAC website, accessed 25 June 2006.

² 'PanAfrica: Politics Override the Needs of Vulnerable People At UNGASS UN Integrated Regional Information Networks'. June 1, 2006; Posted to the web June 1, 2006. <http://allafrica.com/stories/200606010192.html>. Palitza Kristin. 'South Africa: AIDS gathering highlights tensions between government, NGOs. Inter Press Service News Agency, Friday, June 16, 2006, 13:45 GMT. <http://www.ipsnews.net/africa/nota.asp?idnews=33502>.

³ Rath describes his product as 'micronutrients' that are 'key factors to fight immune deficiencies.' Pharmaceutical companies providing ARVs are described as engaged in 'pharmaceutical colonialism.' See <http://www4.dr-rath-foundation.org>.

⁴ 'Aids patient backs Manto [Tshabalala-Msimang, SA Minister of Health]', News24.com. 06/05/2005 08:51 - (SA). http://www.news24.com/News24/South_Africa/Aids_Focus/0,,2-7-659_1700611,00.html.

Victim to Victor', about the success of her diet. She died of AIDS before the book was completed.⁵

The vitamin salesman Matthias Rath has contributed to the deaths of many other AIDS victims. The Treatment Action Campaign has documented a number of these.⁶ Seriously ill people have been recruited by Rath and his team at the Rath Foundation in Cape Town to participate in drug trials that are conducted illegally and without scientific protocols. These are apparently protected by the Minister of Health who refuses to prosecute and continues to promote their products.

In spite of all this, in a letter to the *Mail & Guardian* newspaper on June 9th, 2006, the Minister of Health, Manto Tshabalala-Msimang, declared triumphantly 'We were right all along', referring to the views she and the president had expressed. She declared that her report to UNGASS had been an outstanding success. 'Returning to New York last week for the review of the Declaration of Commitment on HIV/AIDS was gratifying', she began. She said the meeting showed 'how far the world has come to accept what President Thabo Mbeki sought to highlight as early as 2000.' She ignored the issue of treatment entirely in saying that 'Secretary General Kofi Anan ... recognised that poverty, underdevelopment and gender inequality are among the principal contributing factors to the spread of HIV and AIDS.' This, she said, had been 'the basis of the South African government response all along. She also emphasised that 'promoting a healthy lifestyle ... traditional medicine and other therapies' were prioritised by her department.⁷ At the International HIV/AIDS Conference in Toronto, Canada, in August, the Minister further embarrassed South Africa by setting up an amateur-looking stand with bowls of beetroot, garlic and lemons. The UN's Special Envoy for HIV/AIDS in Africa, Stephen Lewis, condemned Tshabalala Msimang and President Thabo Mbeki, saying their 'theories [were] more worthy of a lunatic fringe than of a concerned and compassionate state.' He added that, in his opinion, 'they can never achieve redemption' and that they know 'what they are doing is wrong.'⁸ Even Tshabalala-Msimang's deputy in the Ministry of Health, Nosiviwe Madlala-Routledge, said that the stand was an 'embarrassment'.⁹

By the end of September, 2006, there were movements to put South Africa on a better course. The powerful Congress of South African Trade Unions (COSATU), a partner of the ANC in the Tri-partite Alliance with the miniscule South African Communist Party, voted at their meeting on 19 September to adopt a resolution that said 'the time for conflicting and confusing messages about HIV/AIDS is over.'¹⁰ The Deputy President, Phumzile Mlambo-Ngcuka, attempted to address the meeting to explain the new government position, but was shouted down, as other members of government had been before. They blamed her husband, Charles Ngcuka, for the prosecution and removal of the former Deputy President, Jacob Zuma.

⁵ 'Nozipho Bhengu' [Obituary] *The Economist*, Jun 8th 2006.

http://www.economist.com/obituary/displaystory.cfm?story_id=7033269. 'TAC [Treatment Action Campaign] statement on the death of Nozipho Bhengu'. TAC Electronic Newsletter 24 May 2006. <http://www.tac.org.za/nl20060524a.html>.

⁶ 'Analysis of deaths on Matthias Rath illegal clinical trial', 2 November 2005. Electronic document: Treatment Action Campaign newsletter, ns02_11_2005.html.

⁷ Letter to the Editor, 'We were right all along', from Ms Manto Tshabalala-Msimang, Minister of Health, to the *Mail & Guardian* (Comment and Analysis page), June 9-15 2006, p. 23.

⁸ Westhead, Carter and Momberg 2006.

⁹ Cullinan 2006.

¹⁰ Monare & Daniels 2006.

By the middle of October, the Minister of Health was taken to hospital with what was described as an 'acute respiratory illness'. No further information was made available about her illness until March 2007, but in her absence, the Deputy President, Phumzile Mlambo-Ngcuka, moved to take over the government's AIDS programmes. At a meeting of the South African National AIDS Council, in later October, Mlambo-Ngcuka announced that a new five-year National Strategic Plan on HIV and AIDS would be announced on 1 December, World AIDS Day. The old plan had expired in 2005, without action from Minister Tshabalala-Msimang. At the end of October, the Deputy Minister of Health, Nosiviwe Mdlala-Routledge, appeared to have take charge of the ministry's AIDS programme. She said that she and the Deputy President had been in consultation with TAC for the past three months, and had obtained agreement from cabinet that 'foods like garlic and beetroot, while good for health, are not alternatives to anti-retrovirals. They announced new targets for action, to be achieved by 2011, including treating 650,000 people with ARVs (currently 175,000 were being treated), distributing 500 million condoms annually (currently 340 million are distributed), promoting 'mutual faithfulness', and reducing by a modest 10% the number of children under 14 who engage in sex.¹¹ Nevertheless, a few days later, the Office of the President responded to say that Manto Tshabalala-Msimang was 'still in charge' of the AIDS programmes but by the 10th of December recanted, saying that Mdlala-Routledge would maintain control even after the Minister returned to work briefly from her extended stay in hospital.¹² Speculation had it that her husband, Mendi Msimang, the Treasurer-General of the ruling African National Congress, had intervened to prevent her being sacked or boarded.¹³ Apparently, the 'time for conflicting and confusing messages' was still not over, and a TAC spokesperson said they were 'not popping Champagne corks yet.'

Tshabalala-Msimang did not return to her ministry until June 2007. She was clearly still ill and was gravely thin, the nature of her illness still undisclosed. Although back at work, she refused to attend the 3rd South African AIDS Conference in Durban, convened 4–8 June, because she felt that the organisers had snubbed her by not giving her a major speaking role.¹⁴ Her deputy, Madlala-Routledge also withdrew in sympathy.

It is difficult to understand these tragedies and travesties, but the roots of Mbeki's denialism, and that of the two Ministers of Health in the New South Africa, can be traced to two things. First, there is a determination to find an 'African solution to African problems.' This is an oft repeated slogan, but one to which President Mbeki and his government are deeply committed. On the positive side, this commitment has led to the founding of the new African Union and unprecedented economic and political development in South Africa. But, this commitment also helps to explain the Sarafina II and the Virodene scandals and the government's 'denialism.' This idea has close parallels with the thinking of South African traditional healers who say that if

¹¹ Cullinan 2006; Adams 2006; Monare & Daniels 2006; Westhead, Carter and Momberg 2006.

¹² 'Manto still in charge of AIDS programme,' November 06 2006 at 09:15PM; Online: http://www.iol.co.za/index.php?set_id=1&click_id=125&art_id=qw1162827362448B243; 'New plan for AIDS in South Africa.' Online: Africa News Dimensions, November 5, 2006, <http://southafrica.andnetwork.com/index.jsessionid=6E76B05C195EA6A211EE520578B2B488?service=direct/1/Home/older.fullStory&sp=155345>; 'Manto's deputy will be her voice on Aids', www. iol.co.za, November 10 2006 at 04:11AM, http://www.iol.co.za/index.php?from=rss_South%20Africa&set_id=1&click_id=&art_id=vn20061110011955724C801675; Manto's absence a boon for TAC, November 09 2006 at 02:08PM; Online: http://www.iol.co.za/index.php?set_id=1&click_id=125&art_id=vn20061109134229846C354511

¹³ Zukile Majova, 'How Manto dodged axing', The Mail & Guardian May 18-24, 2007, page 2.

¹⁴ 'Manto snubs AIDS conference'. The Star (Johannesburg) 6 June 2007.

the ancestors (*madloti*) knew about AIDS, then surely they must know how to cure it from the resources of the African bush. In her defence of her 'HIV salad' display at the Toronto International AIDS convention, Tshabalala-Msimang argued that 'more than 80 percent of people on the [African] continent use traditional medicine', merging her own advocacy of an idiosyncratic diet with so-called 'traditional medicine'.¹⁵ It is also similar to the go-it-alone attitude during Apartheid of the previous ruling party, the white Afrikaans-dominated National Party, which is now, in any case, merged with the ruling party, the black African-dominated African National Congress.

The era of government-approved efforts to create such an 'African solution', like Virodene, is by no means over. In July, the University of Cape Town suspended Girish Kotwal, an chief of medical virology at the Institute of Infectious Diseases and Principal Investigator in the university's medical biotechnology programme; he subsequently resigned. He and his laboratory staff had conducted unauthorised clinical test of their herbal remedy called 'Secomet V'—a plant extract—on HIV-positive people.¹⁶ Kotwal had organised a conference on 'natural products and molecular therapy' in South Africa in January 2005 which Tshabalala-Msimang attended. She claimed that such research on 'natural' remedies such as this 'provide an opportunity to reclaim our [African] scientific and socio-cultural heritage, which was stigmatised and discredited as primitive rituals and witchcraft during many years of colonialism and apartheid.' She claimed that a 'false division' between African traditional medicine and bio-medicine had been created 'by the need to make money from patented drugs through discrediting the use of natural products.'¹⁷

Second, there is a belief that AIDS is some sort of trick foist on Africa by major Western pharmaceutical companies. Many believe that, at best, this is rooted in racist myths, or, at worst, in actual racist agendas pursued by shadowy forces of multi-national corporations. Many are suspicious of the methods used to combat AIDS, such as promotion of condoms that some fear are dangerous, or through denigration of sex through promotion of abstinence, and an apparent focus on black sexuality in particular. This is again similar to the discourse of the traditional healers who say that if AIDS is, in fact, incurable, then the African spirits and ancestors that guide African healing cannot know about it, and therefore it must come from outside. Far from being a wild and unmotivated invention of the political elite, then, Mbeki's denialism is consistent with at least some popular beliefs of the ordinary South African.

However, there has also been intervention from a number of Western scientists, led by Peter Duesberg and David Rasnick who until February 2003, had been associated with the Department of Molecular and Cell Biology of the University of California, Berkeley. Their papers and research in the late 1990s and early 2000s evidently convinced the President that HIV did not cause AIDS and that AIDS was a 'lifestyle disease' caused by recreational drug use, and by misguided use of AZT and other antiretroviral medication that had been used to treat the so-called AIDS-related diseases. Duesberg and Rasnick denied that there was any connection between HIV and AIDS and that, in the words that President Mbeki used to paraphrase their findings, 'a single virus cannot cause a syndrome [AIDS]'. (In her June 9th 2006 letter of the Mail & Guardian, Tshabalala-Msimang reaffirmed this view saying, 'we could

¹⁵ Westhead, Carter and Momberg 2006.

¹⁶ See <http://www.secomet.com/pages/science.php>. Secomet V is an 'acidic plant extract from the *trifolium* species' (Kotwal, Kaczmarek, Leivers et al. 2005)

¹⁷ 'UCT acts against academic associated with AIDS tonic,' *Mail & Guardian* Online, 3 July 2006; http://www.mg.co.za/articlePage.aspx?articleid=276134&area=/breaking_news/breaking_news__national/; 'UCT prof resigns over HIV 'concoction'', *Cape Times* (Cape Town) October 26, 2006, p. 5.

not blame the challenge of HIV/AIDS only on the virus.¹⁸) Given his 'Africanist' ideology, Mbeki's reliance on Duesberg and Rasnick, and the faith placed in Matthias Rath's vitamin cocktails and Tine van der Maas's diets may seem surprising since none are South African. Duesberg is a German-born American and Rasnick is American, while Rath is German, and van der Maas is Dutch. Nevertheless, their message is consistent with Mbeki's beliefs and commitments. With much of the rest of South Africa, Mbeki appears to accept the view that disease and death is caused by social forces, including other people, 'lifestyle', witches, bad attitudes, and food. These beliefs are largely unchallenged by the high degree of medical pluralism that exists in South Africa: there is always another therapy. No system of healing or medical treatment appears to have hegemonic status in South Africa. Bio-medical (allopathic) medicine competes with homeopathic, chiropractic, osteopathic, New Age, traditional African, Christian faith healing, Chinese, Islamic and Hindu healing practices, use of patent medicine, 'food supplements' and herbs (African, Asian, European), among many others. In this context, bio-medical explanations, preventive strategies and approaches are taken as one option among others by the South African public.

Duesberg's and Rasnick's 'denialism' was based on their observations about the course of the HIV epidemic, especially in the US and Europe in the last two decades of the twentieth century (see Chapter 2, this volume). They listed 10 'facts' about the epidemic, including that it was not infectious since health workers in contact with AIDS patients had not been infected, that there was no one *defining* illness but rather a 'syndrome' while other viruses caused a discrete disease such as chicken pox or poliomyelitis; and that the epidemic progressed 'non-exponentially, just like a lifestyle disease (such as lung cancer due to smoking, or obesity and diabetes).¹⁹ They believed that they could show that 'Recreational drug use is a common denominator for over 95% of all American and European AIDS patients' and that, therefore, 'HIV proves to be an ideal surrogate marker for recreational and anti-HIV drug [ARV] use.'²⁰ Their 'denialism' was based on their misinterpretation of the HIV prevalence trends in the US and Europe, but was wholly accepted by President Mbeki. He included Duesberg and Rasnick in his 'Presidential International Panel of Scientists on HIV/AIDS in Africa' that was meant to advise him on AIDS policy. Despite the presence of other scientists who comprehensively disproved the denialist position, Mbeki has clung to his beliefs.

In a number of speeches between 1999 and 2001, Mbeki presented the denialist position to South Africa. It stopped just short of implementation in policy. In fact, the Ministry of Health, led by factions who disagreed strongly with the President and the Minister of Health struggled to develop a rational AIDS policy in spite of their leadership. Mbeki was persuaded to keep his ideas to himself. Almost. In April 2002, Mbeki announced that the government would proceed with treatment based 'on the premise that HIV causes AIDS.'²¹ Stopping just short of acknowledging that HIV causes AIDS *as fact*, the government agreed to proceed *as if* HIV caused AIDS.

¹⁸ Letter to the Editor, 'We were right all along', from Ms Manto Tshabalala-Msimang, Minister of Health, to the Mail & Guardian (Comment and Analysis page), June 9-15 2006, p. 23.

¹⁹ Duesberg and Rasnick 1998; Duesberg 2000.

²⁰ Duesberg and Rasnick 1998:85.

²¹ African National Congress, Mbeki's Statement of cabinet on HIV/AIDS, 6th May. *ANC Today*, the organisation's publication (African National Congress 2002b) states 'government's starting point is based on the premise that HIV causes AIDS.'

In early 2002, the document entitled ‘Castro Hlongwane, Caravans, Cats, Geese, Foot & Mouth and Statistics: HIV/AIDS and the Struggle for the Humanisation of the African’²² began to circulate with the ANC ranks. Though the 40,000 word text does not identify its author, the document was traced to Thabo Mbeki’s computer by means of the ‘properties’ that are embedded in every Microsoft Word document. A co-author was also identified, Peter Mokaba, who died, probably of AIDS, the following year. The document has not been repudiated by the ANC or withdrawn from circulation.²³

The effect of the document was dire. Edwin Cameron, now the Supreme Court of Appeal Justice and founder of the AIDS Law Project, wrote,

The distribution of the ANC document—and suggestions that its provenance commanded high approval—cast a sombre shadow over the AIDS debate in South Africa. Within influential government circles, for agonising months, eventually years, public debate about AIDS, its treatment and its causes seemed to come to a virtual dead stop. Support for the facts about HIV transmission and AIDS treatment seemed a heresy to which no government minister would adhere.²⁴

The document begins with a number of quotes, including one from the author’s preface to the novel *The Constant Gardener* by John Le Carré.

As my journey through the pharmaceutical jungle progressed, (in which a number of people were murdered, others killed with experimental drugs, and governments and universities corrupted), I came to realise that, by comparison with the reality, my story was as tame as a holiday postcard.²⁵

‘Castro Hlongwane’ takes this as its theme, and accuses the pharmaceutical industry of having ‘manufactured’ the AIDS epidemic in order to sell highly expensive and ultimately toxic drugs to unsuspecting Africans. The document is a jeremiad couched in the legalistic style of a formal petition for redress. The authors declare that the ‘monograph discusses the vexed question of HIV/AIDS ... based on the assumption that to understand this matter, it is necessary to study it.’ Fifty-three ‘theses’ are then proposed in the manner of a constitutional preamble or of Martin Luther’s ninety-five theses posted on the door of the Wittenberg Cathedral at the start of the Protestant Reformation in Europe. Each one begins with one or other of the phrases ‘It [the document] accepts ...’, or ‘It rejects ...’ or ‘It recognises ...’. The leading thesis declares that the author(s) ‘does not accept the assertion that only scientists and medical doctors are capable of understanding this medical condition’ and that ‘there are many unanswered scientific questions about the HIV/AIDS thesis and many hypotheses about this matter that are falsely presented as facts.’

Among these theses are the following that effectively summarise the thrust and intention of the document.

²² African National Congress

²³ Cameron 2005: 98.

²⁴ Cameron 2005:99.

²⁵ Le Carré 2001. See also Celia Farber (2006) for a later version of the Duesberg/Rasnick ‘denialist’ position and Le Carré’s worries about the corruption of medicine by drug-industry money. Gallo, Geffen, Gonsalves et al. (2006) present a refutation of Farber’s claims.

It recognises the reality that there are many people and institutions across the world that have a vested interest in the propagation of the HIV/AIDS thesis, because they have too much to lose if any important element of this thesis is proved to be false.

It accepts that these include the pharmaceutical companies, which are marketing anti-retroviral drugs that can only be sold, and therefore generate profits, on the basis of the universal acceptance of the assertion that "HIV causes AIDS".

It also accepts that the HIV/AIDS thesis as it has affected and affects Africans and black people in general, is also informed by deeply entrenched and centuries-old white racist beliefs and concepts about Africans and black people. At the same time as this thesis is based on these racist beliefs and concepts, it makes a powerful contribution to the further entrenchment and popularisation of racism.

It rejects as baseless and self-serving the assertion that millions of our people are HIV positive.

It rejects as fundamentally incorrect and anti-democratic the attempt to transfer the responsibility to look after oneself to the state, which seeks to turn the state into an omnipotent apparatus that must even police the sexual activities of every individual South African.

It argues for loyalty to the truth and a refusal on the part of the government and the people to succumb to pressures that are directed at serving particular commercial and political interests at the expense of the health of our people.

It rejects the assertion that, as Africans, we are prone to rape and abuse of women and that we uphold a value system that belongs to the world of wild animals, and that this accounts for the alleged "high incidence" of "HIV infection" in our country.

It enjoins all our people to think for themselves, refusing to be intimidated or terrorised by those who have powerful voices and the backing of the fabulous wealth we do not have, because we are poor.

‘Castro Hlongwane’, then, declares in the most forceful language possible Thabo Mbeki’s commitment to an ‘own way’ of his own devising, one that is based in an overwhelming fear of conspiracy by the pharmaceutical industries to sell drugs at any cost, and a deep loathing of what he sees as a racist agenda behind it. There can be no doubt that in some cases, international pharmaceutical industries have tested, marketed and even ‘dumped’ drugs on poor populations in the third world, and that there is more than a suspicion of blame. The movie version of John Le Carré’s novel is based on this premise. Both the movie and the novel have sold exceptionally well, demonstrating that Mbeki is not the only one to fear and loathe this fact. But there is no evidence that this has actually happened in the case of AIDS and ARVs in Africa. In fact, the South African government had already negotiated highly favourable price reductions for all AIDS medications. Boehringer Ingelheim had offered the drug Nevirapine at no charge to government clinics for use in MTCT prophylaxis, but the government had rejected its offer in the belief that it was ‘toxic’²⁶ It is used for MTCT prophylaxis in all other countries, however.

The document also displays the personal pain of those who have watched their colleagues and friends die of AIDS. It tells in heroic terms the story of Parks Mankahlana, one of Mbeki’s closest friends and advisors at the time, who, like Peter Mokaba, probably died of AIDS²⁷

²⁶ Deane 2005: 543.

²⁷ Cameron 2005: 106, 114.

(though this was denied). He is portrayed as a loyal defender of the faith who sacrifices his life for truth.

Parks Mankahlana rose from his deathbed to oppose this campaign against the President and the truth. He spoke in words that polite society, the friends of the Africans, considered unacceptable because they were not pretty.

And then he died, vanquished by the anti-retroviral drugs he was wrongly persuaded to consume. He suffered from anaemia and received dedicated attention from his doctor. Nevertheless he died prematurely, because some, **other than his doctor** [emphasis in original], advised him to take anti-retroviral drugs.

The document concludes in the manner of the Communist Manifesto, rejecting the idea that Africans were, in the wording of the document 'sex crazy ... and diseased', prone to 'abuse women and the girl-child with gay abandon!' because Africans were a people among whom 'rape is endemic because of our culture!'

No longer will the Africans accept as the unalterable truth that they are a dependent people that emanates from and inhabits a continent shrouded in a terrible darkness of destructive superstition, driven and sustained by ignorance, hunger and underdevelopment, and that is victim to a self-inflicted "disease" called HIV/AIDS.

For centuries we have carried the burden of the crimes and falsities of 'scientific' Eurocentrism, its dogmas imposed upon our being as the brands of a definitive, 'universal' truth. [emphasis in original]

While there may indeed be people who believe such things, they were scarcely evident anywhere in South Africa. For evidence of racism, Mbeki quotes W E B Dubois, the American writer and civil rights activist of the late nineteenth and early twentieth century, and Angela Davis, a radical activist of the 1960s USA. The Castro Hlongwane of the title was a black child who was excluded from a caravan camp (a holiday destination) on the South African coast where he had gone with his white school friends for an end of year party in December 2001. According to the Sunday Times newspaper, 'Schoolmate Ryan Templar, 18, said he was told by (Park owner) Theresa Smit that Hlongwane had AIDS and would rape other campers.'²⁸ While the document acknowledges that the proprietor of the holiday camp was 'unsophisticated', it attributes these beliefs to 'mature practitioners of the deceptions of the sophisticated' by which he apparently means his critics. These moral and ideological beliefs had little bearing on the public health crisis that AIDS presented. There is no evidence that South Africans, or black people in general, are 'sex crazy ... and diseased' as Mbeki asserted, and this document certainly does not present any convincing evidence. The source of Mbeki's fury expressed in the 'Castro Hlongwane' jeremiad can only lie in the models of struggle against and resistance to Apartheid. But that battle had already been won. Mbeki's own presidency was the proof of that.

The legacy of adversarial conflict between government and civil society, however, is deeply etched in South Africa's politics but Mbeki's document also strongly reflects his own educational background as a University of Sussex student and as political leader of the ANC's struggle against Apartheid. His inspiration lies as much in English Romantic and revolutionist rhetoric as they do in South Africa. A quote from the poet and Irish Republican, W B Yeats, is the source of the 'geese' in the title, while the American author and satirist Mark Twain is the source of the 'cats'. The Marxist humanist Herbert Marcuse is liberally quoted, too. The American anthropologist Paul Farmer's book 'AIDS and Accusation', published in 1992, is

²⁸ The 'Castro Hlongwane' document cites *The Sunday Times* of January 6, 2002 as the source of this remark.

given credit for showing that AIDS is a disease of poverty, a 'misery seeking missile'. The document states that 'the South African Government has nevertheless put in place 'an anti-AIDS programme as good as any other anywhere in the world,'²⁹ a view that Mbeki and his Minister of Health have restated many times since then. Their 'denialism' or 'dissent', however groundless, cannot be attributed to anything but their best intentions for the country.

The 'denialist' response to AIDS that Mbeki and those around him espouse repeats the pattern of political struggle rather than active engagement with good governance. Its effect has been to allow the needless deaths of many people, in fact, far more than died during the violent period of armed resistance against Apartheid, and far more than ever die of poverty in South Africa.³⁰ This claim was made by Costa Gazi, a medical doctor who worked in a government hospital and Health Secretary for the Pan African Congress (PAC). In April 1999 Dr Gazi had said that Health Minister Nkosazana Zuma was guilty of manslaughter as a result of her refusal to use AZT to prevent mother-to-child transmission of HIV. Dr Gazi was sacked by the enraged Minister of Health. After lengthy court proceedings, it was not until 24 March 2006 that a full bench of the Transvaal Provincial Division of the High Court handed down judgment in an appeal by Dr Gazi against the Minister of Public Services and Administration and others.³¹ The judgement concurred with Dr Gazi's statements, noting that the Minister of Health's decision

amounted to a conscious, deliberate and informed policy to sacrifice the life of babies that would contract HIV/AIDS because their mothers were not treated with AZT, in order to save the expense It is hardly surprising that some members of the medical profession and of the public at large would describe this policy as a murderous one.³²

TAC had also laid formal charges of culpable homicide in March 2003 against the Ministers of Health (Tshabalala-Msimang), and Trade and Industry (Alec Erwin), but these were eventually dismissed by the court.

Mamphela Ramphela, former colleague of the Black Consciousness leader Steve Biko (and mother of his two children), former head of The University of Cape Town, and World Bank vice-president, has also called this 'irresponsibility that borders on criminality.'³³ The title of Campbell's 2003 book, 'Letting them Die', echoes the words of the South African satirist and actor, Pieter-Dirk Uys: 'In the old South Africa we killed people. Now we're just letting them die'.³⁴ Catherine Campbell's major study exposes the reasons for the failure of many AIDS programmes in South Africa. She places great emphasis on the failure of government to build 'bridging capital' consisting of 'state-society synergy.' Such synergies were vastly important in Uganda's reduction of HIV prevalence. She points to 'national government disunity and vacillation over the existence and causes of AIDS' as a major factor in the failure of the project aimed at sex workers around a mine complex.

²⁹ 'Castro Hlongwane', Chapter 13, (pagination varies in the electronic versions).

³⁰ See Posel 2003b, n. 96, which cites Costa Gazi, 'Aids far deadlier than Apartheid', *Mail and Guardian*, 22 March 2001.

³¹ Court case: Costa Gazi versus the Minister of Public Services and Administration; the Director-General: Provincial Administration, Eastern Cape Province and Magistrate Maqubela; judgement of 24 March 2006. See TAC Electronic Newsletter, 30 March 2006.

³² Judgment of Judge J Bertelsman, paragraphs 44 and 45 in Costa Gazi versus the Minister of Public Services and others, 24 March 2006. See TAC Electronic Newsletter, 30 March 2006.

³³ Cameron 2005: 113

³⁴ Campbell 2003. The title of the book is 'Letting Them Die: Why HIV/AIDS intervention programmes fail.'

With more and more people suffering from AIDS or living with HIV, Mbeki and the Minister of Health sought to preserve the illusion of a well-mannered debate. They blamed ‘scientific Eurocentrism’ and toxic ARVs, while their critics decried this as a ‘murderous’, and blamed government intransigence. Where government failed, the NGOs and organisations of civil society stepped in.

TREATMENT ACTION CAMPAIGN: CIVIL SOCIETY’S RESPONSE

Despite the failure of the government five year plan of action for 2000 to 2005, most important steps against AIDS would not have been taken without strong pressure from outside of government, and outside of the ruling party. Foremost among these pressure groups has been the Treatment Action Campaign (TAC). The TAC first appeared on the scene on Human Rights Day, December 10 1998, with a manifesto to government to end ‘unnecessary suffering and AIDS-related deaths of thousands of people in Africa’ that was caused, they said, by ‘poverty and the unaffordability of HIV/AIDS treatment’.³⁵ TAC was, like the AIDS Consortium, a spin off of the AIDS Law Project and initiated by the National Association of People Living with AIDS/HIV (NAPWA). It was led by Zackie Achmat who was himself living with HIV. The organisation was launched on the steps of St. George Cathedral in Cape Town, the site from which some of the most important social movements and civil disobedience campaigns against Apartheid were also launched. As in the struggle against Apartheid, the country’s independent judiciary soon became one of the most important means for seeking redress.

In its initial statement, addressed to then Minister of Health Nkosazana Zuma and the Minister of Finance, Trevor Manuel, the statement demanded treatment, but not prevention. It held much common cause with what then Deputy President Thabo Mbeki would later emphasise as his chief concerns: poverty and the power of the pharmaceutical industries. Despite this, the movement became deeply embroiled in constant protests, petitions to government, court action and marches to protest government action or inaction, and to seek redress.

In May 2000 the five pharmaceutical companies that produced the major AIDS drugs—Glaxo Wellcome, Bristol Meyers Squibb, Roche, Merck and Boehringer Ingelheim—together with the World Bank and UNAIDS began negotiations to radically reduce the price of these drugs to South Africa among other needy countries. Access to the antiretroviral drugs—AZT, 3TC, DDI and D4T—was TAC’s primary goal, but provision of Diflucan (fluconazole), produced by Pfizer was also essential for treating thrush and other fungal and yeast-type secondary infections. Early in the next year, TAC staged mass demonstrations against the price of AIDS drugs. Led by Mark Haywood of the AIDS Law Project, a TAC team began negotiations with Pfizer to reduce the price. When negotiations proved unsatisfactory, Zackie Achmat, the director of TAC, flew to Thailand in October where locally produced generic fluconazole was sold for 2 rand a capsule, one-fortieth of the cost in South Africa. On his return, he brought 3000 capsules back with him in an act of civil disobedience since generic fluconazole was not registered in South Africa, and therefore illegal.³⁶ Courts declined to prosecute Achmat, however, and Pfizer agreed to donate fluconazole to 400 of South Africa’s three thousand public health facilities. A compromise was reached that did not flout patents protecting Pfizer’s rights to Diflucan/fluconazole, but did make it available to many of those who needed it. Supplies fell far short of total demand, however.

³⁵ Treatment Action Campaign. Press Statement. 10 DECEMBER 1998 -- Day of action, International Human Rights Day www.tac.org.za/treat.html

³⁶ Cameron 2005:162-166; Sidley 2000.

In August 2000, TAC took the Minister of Health to court to force government to provide Nevirapine for mother-to-child transmission and won the case. The government initially consented, then appealed the decision, and referred the matter back to the Cabinet. After more than a year's delay, on December 14, 2001, TAC won the appeal against the Minister of Health and nine Provincial MECs for Health, forcing government to begin implementation of Nevirapine programmes in all public hospitals that were equipped to do so, then back-pedalled again. The case was eventually heard by the Constitutional Court, the highest in the land. The Constitutional Court issued an interim order and, in July 2002, issued a final order against the Minister of Health requiring government to protect newborns from congenital HIV infection by the best means possible, including (but not exclusively) the use of Nevirapine. The government was finally defeated in court, and effective drugs began to be used in government hospitals to this end.³⁷ Despite continuing resistance from the Ministry of Health, by the middle of 2006 Nevirapine was finally available in all government hospitals to treat mother to child transmission, but only with a single dose at time of birth, and a six-week follow-up which few poor women attended. As one of only seven countries worldwide in which child mortality was rising, and 90,000 children infected with HIV each year, it was clear that the intervention was either already too late or insufficient. Medical researchers recommended using AZT with Nevirapine over a longer treatment period, but government healthcare workers were too fearful of 'angering the health department' to implement the new program.³⁸



Figure 9.1. The Minister of Health, Manto Tshabalala-Msimang defies court order requiring state provision of Nevirapine in cases of potential Mother-to-Child transmission at birth

By 2005, TAC and other organisations were more concerned with treatment than with prevention. Suzanne Leclerc-Madlala, an anthropologist whose research on AIDS and public response has often been essential to support for public action, expressed the view that the technical language of prevention—terms such as ‘risk profile’, ‘awareness’ and ‘sexual negotiation’ for condom use and safer sex—‘seemed to be from an age of innocence’. With AIDS now infecting or affecting nearly everyone, the terrain had shifted from an emphasis on prevention to treatment as the only hope. Prevention seemed to be failing; treatment for those living with HIV and AIDS was now paramount.³⁹ Against this, the government continued to

³⁷ Deane 2005: 545; Cameron 2005: 116.

³⁸ Beresford 2006.

³⁹ Leclerc-Madlala 2002.

resist campaigns for treatment and continued to promote prevention with the bulk of the resources at its disposal. In this, the government was no doubt correct, but it seemed to flout the demands of 'the public', especially as represented by TAC, ALP, AIDS Consortium and other major non-government organisations.

As a result of pressure from the press, the TAC, other NGOs and professional organisations, on 8 August 2003, the South African Cabinet committed itself to the provision of antiretroviral treatment in public hospitals. Three months later, government published the 'Operational Plan for Comprehensive Care and Treatment for People Living with HIV and AIDS' that was meant to guide the process. The plan stated that at least one ARV treatment point would be available and stocked in each of the 53 administrative districts in the nine provinces. The roll out, however, was unconscionably slow. The first public ARV service point was established in Gauteng Province in March 2004, and it was not until the end of 2005 that all 53 districts were eventually served by at least one hospital. Still, it was not enough. Approximately 85,000 people were receiving treatment by the end of 2005 out of the 5.2 million who were infected. At least 520,000 of those infected required immediate ARV therapy at that time, while the model proposed in the Operational Plan suggested that 120,000 should be reached at that time.⁴⁰ The results of the roll out were well below the target specified in the Operational Plan.⁴¹ This failure was without doubt the primary reason that statistics were not reported to UNGASS in May 2006, and why all mention of specific targets was strenuously resisted by the South African delegation led by the Minister of Health.

TAC, often in association with other organisations, has continued to bring action against members of the government and others who refuse or appear unable to contribute to the roll-out of treatment. For instance, in association with the South African Medical Association (the largest and principal organisation of South African medical practitioners), TAC filed court papers against the Minister of Health, the Medicines Control Council (MCC), the Western Cape MEC for Health, the mega-vitamin promoter Matthias Rath and 'AIDS denialists' Dr. David Rasnick and Dr Sam Mhlongo, a Professor of Family Medicine at the Medical University of South Africa (MEDUNSA). They also assisted prisoners in the Westville Correctional Centre in Kwa-Zulu Natal Province to file papers with the court requesting immediate access to ARV for prisoners. The case was filed in early May, and by the end of June the court issued orders compelling the Provincial government to provide ARV therapy to prisoners. The Jali Commission found that up to 90% of prisoners in South African prisons were HIV-positive due in large part to gang rapes and overcrowding in prisons.⁴² These and other court actions have been exceptionally important in moving treatment ahead.

While resisting treatment with ARVs and promoting 'alternative' therapies, including traditional healing, special diets, vitamins and others, the government has invested heavily in prevention. The effectiveness of this has remained difficult to measure but the continuing rise in HIV prevalence and stable levels of incidence suggest that it may well be ineffective. Prevention messages have almost entirely been delivered by high-end media such as large billboards erected and maintained by Primemedia and other major players in the entertainment and media industry. Many members of the new black middle and upper classes are heavily

⁴⁰ According to the Actuarial Society of South Africa, 2005 ASSA model. Press release in TAC electronic newsletter, document ns29_11_2005.htm.

⁴¹ South African Government Information website (2005), 'Implementation of the Comprehensive Plan on Prevention Treatment and Care of HIV and AIDS: Fact sheet', 23rd November, <http://www.info.gov.za/issues/hiv/implementation2006.htm>

⁴² South African Institute of Race Relations 2004: 320.

invested in these companies. The costly prevention strategy fits nicely with ANC policy aimed at rapidly developing a black managerial and professional class. Though billboards developed by LoveLife are often obscure and overly clever, and often appear in inappropriate languages for their locations, South Africans are all highly mobile and this method does reach a large percentage of the public. The use of television is also justified by high levels of access across South Africa. Forty-four percent of black African households had television sets in 2001, and this percentage has certainly increased greatly in subsequent years.⁴³ While LoveLife addresses the outdoor advertising, print, and other awareness programmes targeted at schools and rural areas, Soul City produces and presents extremely popular TV programmes. Due to questions about the effectiveness of LoveLife's approach, the Global Fund for AIDS, TB and Malaria cut its funding to LoveLife at the end of 2005. Nevertheless, both programmes continue to dominate the prevention scene in South Africa.

Although late in developing, there has been a powerful and more positive response to AIDS mounted by many organisations, churches, NGOs and service organisations around South Africa. Their growth in numbers has been almost exponential (unlike the more linear progress of HIV prevalence), but not quite as rapid as the Ugandan response. For example, the following figure (Figure 9.2) shows that rapid increase in organisations dealing with children who are either infected or affected by HIV and AIDS.

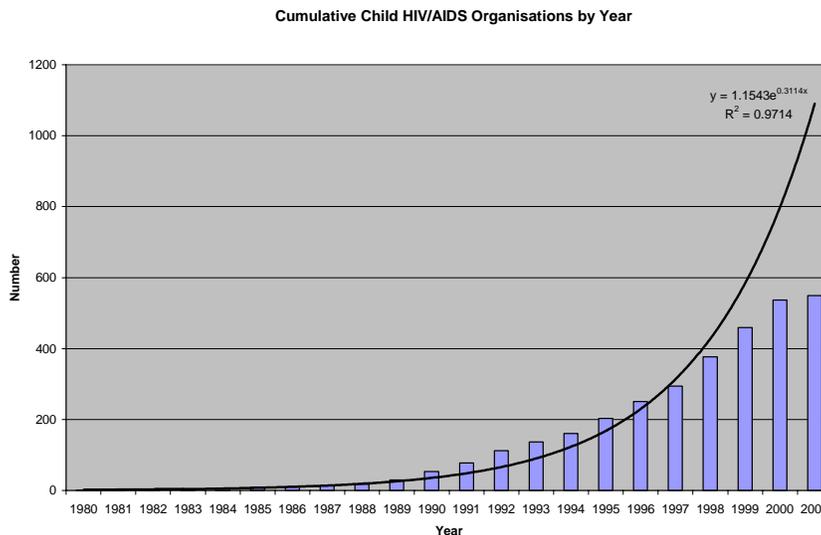


Figure 9.2. Exponential increase in number of NGOs and private organisations dealing with children and HIV/AIDS (data from The Children's Institute, University of Cape Town)

As the Lancet editorial suggests (see chapter epigram), something like a Truth and Reconciliation Commission is required not only to make AIDS appear as a clear and present danger to the fabric of South African life and livelihood, but to compel action. The South African judicial system has played a central role in the response to AIDS. Court action has been constantly required to force government to take responsibility. The courts have acted as the primary interface between civil society awareness and government action. The struggle against AIDS in South Africa, in other words, has taken on the dynamics of the struggle against

⁴³ South African Institute of Race Relations 2004: 368, 'Households with television sets by race, 2001', based on Statistics South Africa, Census 2001.

Apartheid in which broad based social movements, NGOs and external donors have had to struggle against an intransigent government. Despite the 'gulf of incomprehension that divides the African National Congress policy makers from their critics'⁴⁴, the struggle against AIDS in South Africa was also a struggle that engaged the modern institutions of a highly bureaucratic but democratic state. The sources of conflict lay in competing version of modernity,⁴⁵ especially in differing understandings of how 'the social' in its broadest sense generated the conditions and the causes of disease. The 'denialists' seem truly to believe that 'poverty' caused AIDS, especially poor nutrition, a heavier burden of other diseases among the poor, and their victimisation by powerful and wealthy multi-national pharmaceutical corporations. They believed their action was justified by an alternative science and by an astute political analysis of the effects of globalisation, especially the greater threat posed by unscrupulous capitalists.

AIDS in South Africa has been understood, too, in terms of competing concepts of human rights. President Thabo Mbeki has couched his approach to AIDS in a commitment to an ideology of Africanism that prioritises the right for an autonomous African identity that can create its own solutions for its own problems.⁴⁶ His Africanism, however, is predicated on a modernist discourse of development and self determination. This places Africa at odds with the developed West while, at the same time, seeks to achieve similar levels of social and economic development that will lead to full sovereignty, that is, the right to full power of self determination as an autonomous actor in world politics. This frequently places the government at odds with the TAC and other NGOs and social movements that are rooted in the discourse of human rights, specifically the rights to life, health and livelihood that are guaranteed by the South African constitution. The President and his Minister of Health are involved in a global politics, then, while their opponents from civil society are engaged in a national politics of and for human rights. Ironically, this dichotomy is not unlike the one that divided government and people during the struggle against Apartheid. These two differing visions of the political community and of South Africa's place in it have had profound implications for the way the struggle against AIDS has been fought.

The original Truth and Reconciliation Commission, however, was set up by Bishop Desmond Tutu and others in order to present the truth of what happened during the struggle against the previous government for universal democracy and human rights. It aimed to normalise relations between government and the South African people, on the one hand, and to seek reconciliation between groups of people who had formerly been in deep and violent conflict with each other. It also attempted to ensure justice, recommending punishment when this was appropriate and practical, and forgiveness wherever possible. But the Truth and Reconciliation Commission concerned itself with the past. AIDS is very much of the present, hidden or apparent.

IMAGINATION AND AIDS

Among other lessons, the South African experience of AIDS in the decade and a half of its ascendancy teaches us that alone among epidemics, AIDS requires a tremendous feat of imagination. Imagination is required because the infection is not immediately manifest in its host. It takes imagination to visualise the impact of the epidemic before anything much has happened, as does shaping an effective response. While the consequences of each infection are readily apparent to those who suffer it and eventually die, and for those around them who are

⁴⁴ Butler 2005: 591.

⁴⁵ Posel 2003b.

⁴⁶ Salcedo 2004.

either infected or affected as a result, it is nowhere obvious that a political response is the only effective response that can be made. To understand that AIDS—both a medical and a social condition—requires a political ‘solution’ takes a leap of imagination. The imagination must be shaped by its political and cultural context. Yet AIDS is not itself of political origin.

AIDS requires a political response because it affects the foundations of social order at the level of the family whose members and labour are lost, and for individuals who feel the sting of prejudice, or ‘stigma’. Because it is a slow epidemic, developing over many years with an effect on population as a whole, it becomes a feature of daily life. Its impact on life style and life expectancy is like the impact of poverty, war, civil disorder, administrative collapse or other political catastrophes. The connection that Duesberg and Rasnick saw between lifestyle and AIDS exists, but the denialists had the direction of the causal arrow reversed. The overall ability of a society to care for its members affects the ability of those who are afflicted to survive or to maintain an acceptable quality of life for as long as possible. While South Africa’s failure to provide adequate care for people living with AIDS is not in itself the consequence of poverty or war, the effects on society are the same. Thabo Mbeki’s stated belief that AIDS is a disease of poverty, while not true in itself, has the same effect on HIV positive people as would pervasive poverty. AIDS *causes* poverty, and as much as denialism leads to further death and higher HIV prevalence, it causes greater poverty. This is a failure of imagination with powerful political consequences.

Any political order stands or falls on its ability to shape and change certain behaviours of its members who are the citizens or subjects of that order. We also expect a democratic state to provide security and to guarantee the human rights of its citizens. Another irony emerges. While Uganda is ruled by a sort of benevolent dictator who came to power through force of arms, it has provided significant civil benefits through an effective response to AIDS. It did this largely through popularly approved social mobilisation around the threat of AIDS which was presented as a political problem to be solved politically. South Africa, though triumphantly democratic after 1994, has often failed to provide the means for securing its citizens’ right to health, security and welfare by failing to mobilise society effectively. The effort to make democracy work in the New South Africa diverted attention from AIDS: during Nelson Mandela’s stewardship, AIDS simply fell off the political radar for all practical purposes. More than this, however, the patterns of South African politics that emerged over the last quarter of the twentieth century seem to have dictated a politics founded on adversarial relations—as if history was coming back to haunt those who did not understand it—rather than solidarity and common purpose.

Both Uganda and South Africa evolved political responses, but in entirely different ways. These differences reflect different histories, social organisations and cultures. Uganda moved in a way that allowed the struggle against AIDS to be incorporated into a general social movement of reconstruction and nation building in the aftermath of war and civil collapse. Levels of social integration were possible in Uganda because of its size and limited diversity, while South Africa’s response has been characterised by a culture of conflict between civil society and the state that has not been transcended despite the end of Apartheid as the manifest target of civil resistance. The ‘tradition’—or better, a pattern or ‘structure’ of conflict—has been a characteristic feature of South African politics from at least the beginning of the twentieth century.

This epidemic, unlike others, confuses categories of the personal and the public. HIV infects individuals, but is transmitted through social structures, that is, sexual networks. It infects us at our most intimate moment but changing the overall course of the epidemic is only possible through massive public effort. Its first and most obvious consequences are personal as an

affliction of the body, but its broader implications exist at the level of national economies that lose labour, productivity, commitment, and trust.

This opposition between the personal and public has to be resolved through a social imaginary that can unite the large scale of political order with the small scale personal experience of both sex and of illness and death. Conceptually, this book has sought to do this by showing how individuals are linked in larger networks. But practically, this must be done through political mobilisation and political vision. Ultimately it depends on the quality of political community and moral purpose.

South Africa has attempted this through an approach based in human rights (and 'cultural rights'), on the one hand, and one based in large scale public messages on the other. This has been far less effective, evidently, than Uganda's approach which has directed its messages at the most local level: the school classroom, the office and workplace, the church or mosque congregation. While not ignoring human rights issues entirely, Uganda set its anti-AIDS agenda in terms of achieving a collective objective of national survival and reconstruction by building its AIDS programmes into national reconstruction. During South Africa's reconstruction of national identity and social transformation, efforts to stem the tide of AIDS were perceived as an impediment and burden.

South Africa's responses to AIDS have been highly politicised. But because AIDS has been cast as a political cost, the political process became adversarial rather than cooperative. Its cost lay not only in the financial outlay that would be required to provide adequate means for testing, care, treatment, and social change, but in the leadership's perception of the burden of the past, of Apartheid, and its racialised discourse of sexual shame. First, the Office of the Public Protector's action in the Sarafina II scandal, then the action of the Medical Control Council in quashing plans for the 'development' of virodene as a miracle cure, and finally, in the TAC in opposing the Minister of Health's foot dragging in provision of ARV therapies, were perceived by the national leadership as threats to the political ascendancy of the ANC, and as virtually treasonous questioning of the legitimacy of the Minister of Health and the Deputy President, Thabo Mbeki. (For better or worse, Mandela remained aloof throughout, taking a critical stance only after the end of his presidency. He was the only one who could do so without being accused of obstructionism.) This perception created an adversarial relationship between national leadership and civil society. This in itself was all too familiar to all South Africans. When Mbeki then seized on the 'dissident' notion that HIV did not cause AIDS and that ARVs were too toxic to administer on a national scale, he seemed to take a position against normal science and common sense. His tirade in 'Castro Hlongwane' demonstrated that he had a deeper fear that South Africans, especially black South Africans, would be seen as savages with an unbridled sexuality. While there are those who might believe this, they are scarcely in a position to make their views known, still less to have a political effect. This fear seems to loom large in the political imagination of Mbeki and his group, and has thus had an ironic political effect: shame. Whether or not a robust belief in the value of sex and the participation of many South Africans in dense networks of sexual relations is anything to be ashamed of, shame has apparently led leadership to deny the very existence of AIDS. It is especially ironic since the Mbeki government represents the rationalist and moderate side of the ANC in most other issues, especially with respect to economic policy. Mbeki's position has deflected South Africa from effective political action, but is ultimately rooted in rational assessment of the costs, risks, and evidence, however misguided this now seems. The primary value appears to be a commitment to a romantic revolutionism that justifies an intransigent Africanism. Like the Apartheid government that he fought for so long, Mbeki has chosen a nationalist go-it-alone policy that neglects evidence in favour of ideology. He represents it as a 'renaissance' of African responsibility and action that grows out of an authentic African experience and knowledge.

Another faction in the ruling party led by the former Deputy President, Jacob Zuma, acts as a counterpoint to Mbeki's position. Despite allegation of rape and corruption, Jacob Zuma continues to occupy a populist position that calls for a return to African tradition and culture. In opposition to Mbeki's perceived 'Englishness', Zuma presents himself as a '100% Zulu boy.'⁴⁷ Despite his appeal to 'tradition', and his adherence to a strong ethnic and working class identity, Zuma led the Government's AIDS campaign before leaving the Deputy Presidency. He continues to support treatment and an aggressive AIDS policy as leader of the ANC, recognising the deep resonance this will have with many of South Africa's poor who support him. In the following chapter we will see how these contradictory positions are also rooted in South African tradition.

In attempting to explain South Africa's partial failure of social policy, political imagination and collective action against AIDS I tried to portray the contradictory meanings that lie behind the apparent surface of nearly incomprehensible complexity, folly and often futile conflict. This is not adequate to the task of achieving a more positive understanding of AIDS in South Africa, however. To do this, we must explore further the cultural meanings of sex in South African life and the nature of the sexual networks that provide the channels through which HIV moves. With this done, we shall finally be in a position to make some suggestions about how a new approach can be structured around this a new, deeper, culturally-informed and politically embedded understanding.

⁴⁷ Moya 2006.