

## Article

# AIDS Discourses and the South African State: Government denialism and post-apartheid AIDS policy-making<sup>1</sup>

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Post-apartheid AIDS policy-making in South Africa has been characterised by conflict between the government, civil society and the medical profession (Schneider 2001). At the heart of this conflict has been the controversy over South African President Thabo Mbeki's denial of the causal link between the HIV and AIDS, and claims that anti-retroviral drugs are ineffective and lethally toxic in the face of scientific evidence to the contrary. Against the backdrop of policy conflicts, which stem from government AIDS denialism,<sup>2</sup> the question has often been asked: what drives this denialism? It is this central, yet largely unresolved, question that this article will attempt to answer. The central claim of this paper is that government AIDS denialism is a response to a history of racist understandings of African sexuality as inherently pathological in AIDS science and linked discriminatory public health policy responses to the epidemic by the last apartheid government and internationally. As will be demonstrated later in this article, unlike AIDS dissidence internationally, the South African version of denialism espoused by Mbeki and other high profile government officials has been obsessed with colonial and late apartheid discourses of race, sexuality and disease in Africa.

This paper argues that AIDS denialism can be understood as driven by five main factors:

- The medical findings of certain dissident scientists, which have been appropriated by government officials in South Africa;
- The extent of the crisis brought about by the epidemic, which has prompted denialism because government cannot deal with it;

- As a strategy to avoid conflict over intellectual property rights of essential medicines;
- The impact of poverty on the course of the epidemic, which has led to government denialists positing poverty as a counter explanation to the virological cause of AIDS. Simultaneously, denialism may be a smokescreen for the government's adoption of poverty sustaining neoliberal economic policies, which may be blocking further public spending on AIDS; and
- The history of constructions of 'the African' as the inherently diseased racial and sexual other in both colonial and post-colonial times.

I will deal briefly with the first four, before turning my attention to the main core of this article – the exploration of the last and, I will argue, most important driver of denialism.

### **Science and denialism**

Early into Mbeki's presidency, in 2000, it became obvious that he and some key ministers had adopted denialist views that were referred to in the media as 'dissident/unorthodox' views on AIDS. In May of that year, the President (with the full support of the Health Minister) convened a Presidential Advisory Panel on AIDS including both AIDS dissident scientists such as Peter Duesburg and David Rasmussen (from the USA) and medical and scientific researchers holding orthodox views on AIDS to debate the basic mainstream science of AIDS. The advisory panel was briefed to debate both the accuracy of HIV tests and the causal link between HIV and AIDS. Little came of the Presidential Panel process as, in 2001, the panel released an interim report, which mostly highlighted the differences between the mainstream and denialist scientists. More research was agreed to by participants, but certain members of government claimed that they based their programmes on the 'premise' that HIV causes AIDS (Tshabalala Msimang 2001), a claim that was belied by the continuation of denialist utterances by other members of the government, as shall be shown.

International scandal over the President's denialist views grew after a speech he delivered at the opening ceremony of the 2000 International AIDS Conference, which was hosted in Durban. Whereas he was expected to repudiate his denialist views in the speech, he merely restated them by arguing that not everything could be "blamed on a single virus" and that poverty kills more people around the world than AIDS (Mbeki 2000:4). The link between poverty and inequality and AIDS was not new and in

itself would not have attracted widespread criticism had it not been for the president's simultaneous questioning of 'the reliability of and the information communicated by our current HIV tests' (Mbeki 2000:5). In 2000 and 2001 the causal link between HIV and AIDS was questioned several times by Mbeki. In both a *Time* magazine interview and during parliamentary question time he claimed that HIV could not cause AIDS because a virus could not cause an immune deficiency syndrome (Karon 2000; Schüklenk 2004).

Denialist views would be repeated numerous times by Mbeki until he finally, decisively and formally 'withdrew' from the public debate about AIDS denialism in April 2002. From this point onward, however, his Health Minister, Manto Tshabalala-Msimang, would take up the mantle of repeating AIDS denialist views in public.<sup>3</sup>

Because of the adoption of denialist views by high profile government figures such as President Thabo Mbeki and his Health Minister Manto Tshabalala-Msimang, denialism prevailed and informed and influenced government policy. This was the case despite the medico-scientific literature (Pallela et al 1998; UNAIDS 2003; NIH 2003) demonstrating the following: that HIV causes AIDS; that HIV tests are highly effective in diagnosing HIV infection; and that anti-retroviral drugs, correctly prescribed as triple therapy or to prevent mother-to child transmission, can both prevent HIV infection and treat HIV.

This paper posits that Mbeki's position can be seen discursively as part of a wider belief that several key tenets of science around AIDS are racist, with denialism being a defence of Africans against racism and neo-imperialism, a belief well-established within certain circles in the African National Congress (ANC).

Instead of merely pointing to and condemning very real examples of racism in the history of AIDS, government's denialism appears to have attempted to throw out altogether the Western biomedical/scientific paradigm relating to AIDS. As will be argued below the specific history of discriminatory discourses around AIDS, may be driving the government's denialism.

### **Denialism as a response to the sheer extent of the crisis**

Denialism could also be explained as a way to avoid addressing severe policy challenges posed by the sheer scale of the epidemic. By any measure, AIDS represents a huge crisis, which presents daunting policy

and planning challenges for the government. Recent AIDS research has shown that the epidemic is a human catastrophe for South Africa in terms of prevalence, economic impacts and social impacts, such as the orphan crisis generated by the epidemic (Sishana et al 2002; Department of Health 2001; Dorrington and Johnson 2002:38; Barnett and Whiteside 2002).

Faced with the cruel reality of five million HIV infected citizens and the highest HIV infection rates in the world (UNAIDS 2000), it is conceivable that officials of a government in such a predicament would sometimes hope that the epidemic would somehow disappear, or at the very least diminish in its seriousness or intractability. AIDS denialism offers to fulfil this potential hope on the part of a government faced with such a crisis. According to the unscientific and illogical tenets of AIDS denialism: AIDS is no longer sexually transmitted and will therefore spread much less easily; therefore there is no requirement for complicated and controversial HIV prevention campaigns; there is no requirement to spend on anti-retrovirals, as they are seen as ‘poison’; and there is no requirement to take the epidemic as seriously because it is ‘exaggerated’.

### **Denialism as avoiding conflict over intellectual property rights**

The adoption of AIDS denialism by key government officials and representatives may also in some cases have afforded the government the comfort of avoiding further major confrontation with the multinational pharmaceutical companies, in the wake of the 2001 Medicines Act case, over their exclusive intellectual property rights for essential medicines. Multinational pharmaceutical companies use exclusive intellectual property rights, in the form of patent monopolies, to inflate excessively the price of antiretroviral drugs (TAC 2002). Civil society groupings, and at times the government, have challenged these exclusive intellectual property rights by calling for generic or parallel imported cheaper essential medicines.

In 2001, the government faced off the Pharmaceutical Manufacturers’ Association (PMA) in their challenge to strike down sections of the Medicines Act. The Medicines Act allowed for the government to authorise the production of generic drugs and for parallel importation of drugs, and would have forced the industry to be more transparent about their pricing mechanisms. Policies such as those allowed for in the Act have dramatically reduced the price of essential medicines in other developing countries such as India and Brazil. The PMA, an organisation representing 39 multinational pharmaceutical companies, fearing their intellectual property rights and

profits to be in jeopardy, took the government to court to try to remove the price reducing sections of this act. In the event, the PMA withdrew the case.<sup>4</sup> This was partly because it generated prominent negative media publicity for the pharmaceutical industry, as civil society groups in South Africa and around the world held co-ordinated protests against the PMA's court action. It was also because of the judge's ruling that the drug companies must produce their detailed accounts to show exactly how much they had actually spent on research to develop the drugs (Baskaran and Boden forthcoming).

If one were to accept the AIDS denialist claim that AIDS drugs are 'poison', there would be no need for the government to (continue to) confront the powerful multinational pharmaceutical industry to obtain them at cheaper prices. This is a move likely to be necessary in the light of US President Bush's unyielding support for the pharmaceuticals and their increasing strength in relation to the US government and WTO (Boseley and Denny 2003). The South African government may be aiming to shy away from such confrontation with the industry and their globally powerful political supporters, through its denialism.

### **Poverty, inequality and the economic rationale behind denialism**

Whilst the main argument of this paper is that government denialism is driven by the history of racist representations of Africans in relation to AIDS, there are also powerful counter-arguments that it is socio-economically driven. On the one hand, Mbeki has argued, not entirely falsely, that AIDS is 'caused' by poverty, whilst on the other denialism may mask a reluctance to increase public spending due a desire to adhere to the neoliberal ideal of 'fiscal discipline'.

#### ***Readings of AIDS as a 'disease of poverty'***

Mbeki and Tshabalala-Msimang have presented AIDS as fundamentally a problem of poverty and poor nutrition. A strong case can be made that poverty and inequality are significant factors that have shaped the AIDS epidemic in South Africa; however, this case cannot be made, in a denialist way, to the exclusion of mainstream scientific explanations of the viral cause of AIDS in the body of HIV-infected individuals.

Mainstream scientists and public health experts, have also shown the links between poverty, nutrition and AIDS. However, unlike government denialists, such AIDS researchers believe that AIDS is virologically caused by HIV, and also hold that at a socio-economic level the epidemic can be

understood as influenced by poverty and inequality. Paul Farmer, for instance, has understood AIDS as a disease of poverty and inequality (2001) because in an unequal world AIDS disproportionately affects the poor.

South Africa has one of the highest levels of inequality in the world (May, Woolard and Klasen 2000:26-28). Whilst research into the effect of poverty and inequality on South Africa's AIDS epidemic is often contradictory and inconclusive, there are a few things that can be said. First, the relationship between poverty and inequality and risk of infection with HIV seems to be less than clear-cut in South Africa. The *Nelson Mandela /HSRC Study on HIV/AIDS* indicated that whilst poorer persons from race groups other than African were more at risk of HIV infection, amongst Africans, the poorer and the richer seemed to have similar risks of infection (Shisana et al 2002:9). On the other hand, qualitative studies have shown that poverty and at times gender inequality drive women into commodified and at times commercialised relationships, which may have led to higher rates of infection amongst women (Hunter 2002; Campbell 2000; Leclerc-Madlala 2001).

One area where poverty has a clearer impact on the shape of the epidemic in South Africa is in terms of disease progression. In general, internationally, it can be said that relative wealth or poverty affects the vulnerability of individuals, households and societies to the impact of the epidemic (Barnett and Whiteside 2002:276). Whereas wealthier patients often have access to private health care and even combination anti-retroviral therapy in the private sector, poorer patients often lack access to these drugs, and only have access to overstretched public facilities. In addition, they will often have a lower level of nutrition and their immunity is likely to be compromised by this as well as by HIV.

Therefore, it can be said that there is a case for causally linking poverty and inequality and AIDS, if analysed at a socio-economic level, but not in such a way as to exclude medical understandings of HIV as the cause of AIDS.

### ***Denialism and Neoliberal Economic Policies***

The epidemic patterns of AIDS demonstrate the influence of poverty and inequality. There is a further development of arguments linking AIDS and poverty that denialism neatly complements the government's adoption of poverty-entrenching neoliberal economic policies. It can, therefore, be

seen as, in some senses, a position produced by government economic policy. According to such a position government denialism can be said to be a convenient clause to avoid the drastic increases in public spending that would be required to roll out combination HIV treatment. The government's adoption of policies of 'fiscal discipline' and neoliberal macro-economics, evinced in the Growth Employment and Redistribution strategy (GEAR) (Bond 2001) also indirectly affects the formulation of AIDS policy in the following ways: privatising essential basic and social services; reducing social spending (including spending on health); and liberalising trade relations, thus making developing countries' economies attractive to foreign investment. These policies have hindered the formulation of macro-economic policy more favourable to addressing poverty and inequality in the country (Bond 2001; Habib and Padayachee 2000:3). This means that they can be said to have affected the shape of the impact of the AIDS epidemic in ways suggested by the links between poverty and the epidemic suggested above.

Whilst government opponents have argued that government has miscalculated the costs and benefits of spending on an HIV treatment roll out (Nattrass cited in HEARD 2001; TAC 2003), the government's reluctance to spend on a roll out of combination anti-retroviral drug therapy can be seen within the rubric of its adoption of neoliberal economic policies. On the other hand, it could be argued that government is merely operating as best as it can within the constraints of a globalised economy (Turok 2002), and that there would be real consequences to the social democratic policies of defying the drug companies on intellectual property rights (such as trade sanctions), and increasing taxes (thereby discouraging investment) or going into a deficit to spend more on health.

However, in some senses it can be argued that AIDS denialism, has afforded government officials and representatives the opportunity to avoid public participation in these serious debates about the economic consequences of rolling out treatment. Comments at the height of the mother to child transmission debate by the late Presidential spokesperson Parks Mankahlana that it would use less state resources to let HIV infected children die, than to have them dependent on the state as orphans (*Independent Online*, July 15, 2000), gives credence to the explanation of AIDS denialism as masking neo-conservative economic rationale.

On the other hand, at this stage, the direct evidence supporting the thesis that the imperative to the denialism of some government officials is

fundamentally economic in nature is rather scant and, therefore, it rests more at the level of speculation. Alternatively, if the discourse of AIDS denialist utterances and writings of government officials and representatives themselves are taken on their own terms, the thesis of this article, that AIDS denialism is driven by older discourses of race and disease seems equally, if not more persuasive.

### **In defence of African sexuality: racism and African denialist resistance**

Whatever the contribution of other factors/discourses to denialism, in the rest of this article I will argue that the type of denialism the ANC government officials have espoused has been framed by its adherents as a response to the history of racist colonial and apartheid discourses concerning African sexuality. However, by the time that Mbeki and other government leaders were making denialist arguments to counter racism in AIDS research, non-discriminatory human rights based approaches to AIDS had become the dominant paradigm as shall be demonstrated. Denialism has been rendered out of date by a local and global shift towards the discursive framing of AIDS policy in ways which do not discriminate against HIV positive people and members of groups vulnerable to infection. The following passage reveals the obsession of government denialism with the legacy of racism in AIDS science and racist responses to the epidemic:

Thus does it happen that others who consider themselves to be our leaders take to the streets carrying their placards to demand that because we [black people] are germ carriers, and human beings of a lower order that cannot subject its [sic] passion to reason we must perforce adopt strange opinions, to save a depraved and diseased people from perishing from self-inflicted disease...convinced that we are but natural-born promiscuous carriers of germs...they proclaim that our continent is doomed to an inevitable mortal end because of our devotion to the sin of lust. (Mbeki, *Mail & Guardian*, October 26, 2001)

As the above quotation shows Mbeki has explicitly objected to the racist notion that Africans are ‘promiscuous germ carriers devoted to the sin of lust’, which he sees his opponents, the ‘placard carrying’ AIDS activists associated with TAC, as arguing.

The African National Congress (ANC) is by its nature, an anti-racist and anti-colonialist, African Nationalist party. Mbeki has often explicitly located himself within this ANC tradition, especially in his calls for an ‘African

Renaissance' or African Renewal. His calls for an 'African Renaissance' stem from his arguments of the need for socio-economic and political renewal and development of Africa, which are yoked with arguments about the need for a revival and celebration of African cultural and intellectual achievements (Mbeki 2001). Significantly for the main argument of this article that government denialism rests on the historical legacy of racist discourses of Africans as being in possession of a diseased sexuality he has argued that his calls for an African Renaissance operate self-consciously in relation to a history that has

created an image of our Continent [Africa] as one that is naturally prone to...an AIDS epidemic caused by rampant promiscuity and endemic amorality. (Mbeki 2001:7)

Furthermore, the influence of the history of racism in public health and medical discourse around AIDS and reproductive public health on government denialism is evident in a denialist document written by Peter Mokaba, which was circulated to the ANC's National Executive Committee in 2002. As the following quotation shows, the view that the mainstream science of AIDS discredits African sexuality in a racist manner has been very much evident in the denialism espoused by government leaders:

Yes we are sex crazy! Yes we are diseased! Yes we spread the deadly HI Virus through our uncontrolled heterosexual sex... Yes among us rape is endemic in our culture!... Yes, what we need and cannot afford because we are poor, are condoms and anti-retroviral drugs! (Mokaba 2002:88)

The idea that African sexuality is inherently diseased was widespread historically in colonial and apartheid medicine and there is evidence of a very real contemporary legacy of such ideas, as Africanist colonial medical historians have shown. Megan Vaughan shows how some Africans have argued AIDS is a Western health problem skilfully blamed on Africa and Africans, when it is really, according to such a view, seen as being due to Western degeneracy and homosexuality (Vaughan 1991:205).<sup>5</sup>

Historically, AIDS denialism of this type is not a new position amongst African leaders and intellectuals. Richard Chirimuuta and Rosalind Chirimuuta, two Zimbabwean Tropical Medicine experts, who espoused ideas on racism and AIDS in their book *AIDS African and Racism* (1989) have heavily influenced government AIDS denialism. They have been cited extensively by government denialists such as Mokaba (2002). The Chirimuutas questioned HIV as the cause of AIDS, the African origin of

AIDS and the safety of anti-retroviral drugs (1989:2-47). Like Mbeki, they also claimed that HIV prevalence and AIDS deaths in Africa were dramatically exaggerated as part of a racist plot to discredit African culture and sexuality (Chirimuuta and Chirimuuta 1989:80-81). Laurie Garrett has shown that in the 1980s, African health ministers and leaders also refused to accept HIV prevalence statistics as presented by the WHO and medical researchers from the US and Europe (1995: 353-362). Moreover, they saw the need to defend Africans against racist accusations that their sexuality was inherently pathological (Garrett 1995:353).

Chirimuuta and Chirimuuta's book was not entirely without merit. In particular, it seems that some early arguments made about the origins of AIDS in Africa did rely on fairly flimsy evidence, and made insulting and culturally inaccurate speculations about African sexuality, which led in some cases to discrimination in the West against Africans and people of African descent. Some researchers apparently tried to claim that HIV passed from monkeys to Africans in Central Africa due to bizarre sexual practices like Africans injecting monkey blood into their anuses and vaginas and claims that Africans had more anal intercourse, had intercourse during menstruation and were excessively promiscuous.<sup>6</sup> This had more to do with racist beliefs that Africans were evolutionarily inferior to white people, and anxieties about Africans as hypersexualised and having animalistic sexuality (Chirimuuta and Chirimuuta 1989:73-134). However, in the South African history of the epidemic, crude racist and sexist explanations for the spread of AIDS which appeared in public health literature were challenged soon after they appeared. Notions of the 'diseased' African prostitute as responsible for the spread of AIDS, for example, emerged in *South African Medical Journal* articles in the mid-nineteen eighties (Mbali 2001:25). But also, in a broader sense, they were simultaneously refuted as apartheid health and socio-economic inequalities were shown by anti-apartheid and feminist academics to be the true engine for ill health and the spread of AIDS in South Africa (Mbali 2001:42-47). This shows that government denialists such as Mbeki have ignored a key historical shift in the late 1980s and early 1990s in discourse around AIDS policy towards rights-based discourse.

Real discrimination against Africans and those of African descent did arise in Europe and America in the 1980s out of the notion that Africans were 'AIDS carriers/victims'. Africans and those of African descent, especially Haitians were turned down for apartments, forced to have AIDS

tests before being accepted for certain academic scholarships and people with HIV or AIDS were not allowed entrance into America (Chirimuuta and Chirimuuta 1989:71-134). This formed part of a larger battery of proposed discriminatory measures in the West in the 1980s against gays, blacks, prostitutes, drug users (people deemed to be at 'high risk' of contracting HIV) and HIV positive people. In America, institutionalised and legal discrimination against HIV positive people on the basis of their HIV status, and 'high risk' groups became common in the 1980s (Brandt 1987:192). Prejudice and discrimination also informed early policy responses to AIDS in late apartheid South Africa in the 1980s. In South Africa regulations were proposed to force foreign mine workers to have HIV tests and deport them if they were found positive (Jochelson 2001). Government denialism can therefore be read as a local response to the history of local and international prejudice and racist discourses around AIDS policy-making. However, anti-discrimination has been an important principle in AIDS policy-making circles internationally for quite some time now. Jonathan Mann's assertion, as head of the World Health Organisation's Global Programme on AIDS, that AIDS policy internationally must protect rather than infringe the rights of HIV positive individuals, has meant that rights-based notions of AIDS policy have had international currency for quite some time (Schneider and Stein 2001:10; Garrett 1995: 67). Various agents in South Africa in the 1980s and early 1990s managed to force a shift in the way that AIDS and family planning policy would be framed: coercive practices outside a human rights framework ceased to form a legitimate part of discourse produced by government, medical and public health quite some time ago in the country (Mbali 2001), which renders denialism historically obsolete.

### **The ghosts of colonial and apartheid medical and public health discourse**

Government AIDS denialism can be powerfully explained in terms of its being haunted by the ghosts of colonial medicine and Western culture, and their characterisation of Africans as diseased. I will now turn to this largely extinct racist discourse itself, which has influenced government denialism.

Colonial medical discourse around Africans was highly sexualised, perhaps, nowhere more so than when it was attached to STD management programmes. African sexuality was constructed in colonial medical discourse as primitive, uncontrolled and excessive, and as representative of

the darkness of the continent itself (Vaughan 1991:129). On the other hand, other colonial actors saw colonisation's social and economic transformations as causing the 'degeneration' of an 'innocent' African sexuality (Vaughan 1991:129).

The influence of both of these views is traceable in government denialism. In so far as it posits that the Western biomedicine attached to AIDS aims to stigmatise African sexuality and in its frequent appeals to unspecified 'African' solutions to the problem, it relies on an imagined, pristine and essentialised notion of African culture. Controversially enough for African feminists, 'African' solutions to AIDS proposed by government officials have included virginity testing for adolescent girls, and in Swaziland the mandatory wearing of tassels by adolescents and teenagers to indicate virginity.<sup>7</sup> This tends to point to an ahistorical 'Merrie Africa' vision of Africa's past, where there were no 'promiscuous', corrupted, Westernised African women, and all African women avoided sex before marriage and did not 'spread' STDs and AIDS.

Sander Gilman has examined the history of the representations of black sexuality, as inherently diseased in Western scientific, artistic and intellectual discourse (1985). In terms of this history, the recurrent representation of blacks as inherently diseased, and disease-carrying, evident in mid-1980s South African public health discourse around AIDS (Mbali 2001:25-28), can be linked to a strong desire in post-Enlightenment Western culture to push its own fears and perceived negative qualities onto the Other (Gilman 1985).

Government AIDS denialism can be read as a reaction to this deeply rooted Western Othering cultural belief that Africans have inherently diseased sexuality. In *Castro Hlongwane*, for example, Mokaba comments, '...we are African [sic] who have overcome centuries of treatment as the repulsive and unacceptable other' (2002:110). At an earlier phase in the epidemic some Africans may have been inverting the Western racialised process of Othering, by claiming that AIDS is a 'white man's disease' due to certain 'white' types of degeneracy, like 'homosexuality'. Certainly, this is a type of discourse that was attractive to some HIV positive patients at Baragwanath hospital in the early 1990s (Allwood et al 1992). Ann Laura Stoler has shown that Foucault's notion of biopower can be expanded to understand how 'normalising' society in the West simultaneously excluded and differentiated itself from those of other races (1995:134-135): the nation in the West was made by differentiating sexualised, racial Others

from 'white' Westerners; European power and prestige in colonies ideologically depended on controlling the way that Europeans had sex, and with whom, and defining heterosexual monogamous norms of Western sexuality as 'normal' and 'native' sexuality as diseased.

If Western nationhood in the late nineteenth and early twentieth century was defined in Europe, against the negative of 'native' sexuality and its diseased-ness, should we see Mbeki's misguided attempt to rehabilitate African sexuality as an attempt to redefine South Africa nationhood and the body politic, in terms of his misty concept of the 'African Renaissance'? Can government denialism's attempt to re-mould images of African sexuality, by denying the veracity of mainstream Western biomedicine's model of AIDS, be seen as a nationalistic one to defend the nation against ideas that it is degenerate? Certainly metaphors and technologies of power based around notions of contaminated/pure blood, protecting the health of the racially-defined 'nation's' children formed part of the legitimisation of institutionalised control of sexuality by the power/knowledge regime, both in colonies and the metropole and in late apartheid South Africa (Jochelson 2001). Government AIDS denialists have reverted to the past to argue against discourse, which for the most part had been massively surpassed in the 'AIDS world' by rights-based, anti-discrimination discourse and a shift to a medical, technical, non-'moralistic'/stigmatising approach. The key question is whether key governmental actors, who still appear influenced by AIDS denialism, such as the Health Minister will be able to get out of the constraints of discourse defined by the boundaries of nationalism and colonialism?

### **Better alternative responses: HIV treatment activism and rights based discourse**

Whilst denialism's harmful consequences have catalysed critiques of it by civil society and doctors, some of the most powerful critiques of government denialism have emerged from activists using rights based discourse. The policy gridlock partially created by AIDS denialism must end by appeals to both human rights discourse around access to treatment and the human dignity of South Africans infected with HIV, and the predictive and interpretative power of biomedicine.

The Treatment Action Campaign (TAC), one of the key civil society opponents of government denialists, has so far successfully adopted a strategy of using the courts to argue for expanded access to correctly

administered anti-retrovirals in the public sector on the basis of socio-economic rights in the South African Constitution. As Zackie Achmat the Chairperson of TAC recently said

For children, women and men with HIV/AIDS the rights to dignity, life and equality and their inter-connection with the right to health care access, particularly access to medicines including anti-retrovirals stands between us and death... These rights...are essential tools in our struggles to remove the barriers to HIV treatment and health care for all. (Achmat 2002)

At a microbiological level, Western biomedicine provides a powerful model for understanding the direct physical causes of disease and developing effective treatments, preventative methods and cures for them. Such rights-based and Western biomedical models will have to be used to devise rational government policies to alleviate the very real human suffering that the epidemic is causing. However, government AIDS denialism claims that all AIDS activists who believe in ‘AIDS orthodoxy’ and disagree with government AIDS policy are racist, in that they believe that Africans are ‘rampantly promiscuous’ and ‘endemically amoral’ (Mbeki 2001).<sup>8</sup>

## **Conclusion**

Government denialism has fundamentally been a response to beliefs that Western biomedical mainstream understandings of the causes and treatments of HIV and AIDS are part of a plot to discredit Africans, their culture and sexuality. As a discourse, government denialism wrestles with the ghosts of colonial medicine and old traditions in Western culture projecting ‘negative’ sexual practices and sexual traits onto the Other.

The fact is, though, for the most part overwhelming consensus had already shifted by the late 1990s in the ‘AIDS world’ of doctors, medical researchers, NGOs, and most governments internationally, to more human rights based discourses around policy responses to AIDS.

There may be convincing alternative explanations for what drives the adoption of the AIDS denialism by individuals at the highest levels of government, more especially that denialism has the potential to provide a discursive escape hatch from a number of insuperable policy issues such as the scale of the problem and economic challenges posed by its links to poverty, the issue of generics and general failures of post-apartheid health delivery. However, analysed on its own, as a discourse, it becomes clear that government AIDS denialism is heavily affected by the legacy of racist public health discourse.

Seen in this light, government denialism has done nothing to address what is easily the biggest public health crisis South Africa has ever seen. It can only be hoped that the efforts by civil society and AIDS researchers to convince the government of the need for the rights-based policy response of providing HIV treatment for all who need it prevails over policies informed by AIDS denialism.

## Notes

1. This paper is based upon my 2001 BA Honours thesis entitled “‘A Long Illness’: towards a history of government, medical and NGO discourses around AIDS policy-making’. In 2002 I published an article in the *Mail and Guardian* which reiterated many of the arguments in this paper ‘Mbeki’s strange Aids discourse’ (March 22, 2002). It is also based on a paper I presented at the Nelson R Mandela Medical School’s Public Health Journal Club Seminar in May 2002.
2. The term ‘denialism’ is a neologism coined by AIDS activists in South Africa to describe the rejection by Mbeki and others of: the fact that HIV causes AIDS; the accuracy of HIV tests; and of the use of retrovirals as ‘safe’. I first heard TAC activists use this term in 2000, around the time of the AIDS 2000 conference in Durban.
3. It was claimed in October 2000 that Mbeki had withdrawn from the debate over AIDS denialism, a claim that Mbeki subsequently denied (Paton 2000; SAPA AFP 2000).
4. Despite the PMA’s 2001 climb down, the issue of the need for generic AIDS drugs remains. Illustrative of this is that whereas a month’s supply of generic WHO approved AZT would cost R232, a month’s supply of the patented version produced by multinational pharmaceutical company GlaxoSmithKline cost R811 (TAC 2002). In particular, provision of generics in South Africa will be vital to improving the feasibility of the implementation TAC’s proposed National Treatment Plan (TAC 2003).
5. Here she is citing authors like Richard and Rosalind Chirimuuta (extensively and favourably cited in the Mokaba piece), who argued for all the key pillars of South African President Thabo Mbeki’s current AIDS denialism.
6. Chirimuuta and Chirimuuta cite Noireau (1987) in order to make this argument.
7. Virginity testing, currently condoned by traditionalists in the KwaZulu-Natal provincial government, consists of inserting a reed into the girl or young woman’s vagina to ‘check’ if her hymen is ‘intact’. I heard Deputy President Jacob Zuma advocate it as an ‘African solution’ to the problem of AIDS at the National Beyond Awareness National Tertiary Education and AIDS conference at Kopanong Conference Centre in Gauteng in 1999. The South African Gender Commission, and prominent gender activists have been highly critical

of the practice, because it cannot definitely establish virginity, is deemed to undermine girls' dignity, and there is no equivalent practice for boys or men.

8. 'AIDS orthodoxy' is a term used to describe the generally accepted scientific view that HIV is the cause of AIDS, and that anti-retroviral therapy, if correctly medically administered, is both safe and effective.

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