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DISCOURSE AND DISEASE:
AN ANALYSIS OF THABO MBEKI'S POSITION ON AIDS
2000-2004

by

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A thesis submitted to the Faculty of Humanities, University of the Witwatersrand, Johannesburg, in fulfilment of the requirements for the degree of Master of Sociology

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ABSTRACT

This study focuses on President Thabo Mbeki's rhetoric on the HIV/Aids epidemic from 2000 to 2004 in South Africa. By analysing the changes and implementations of the cabinet statement on HIV/Aids, and Mbeki's speeches, interviews and public interventions, this study traces his counter-scientific line of argument and its influence on the policy process.

This research provides a historical unfolding of HIV/Aids in South Africa, stressing its social, economic, political and cultural impact. It critically examines Mbeki's scepticism over the provision of treatment. In doing so, two lines of arguments are outlined: Mbeki's counter-scientific statements; and his consciousness of the African past in the present.

This study argues that Mbeki is ambiguous in talking about Aids and when referring to the link between race and disease in terms of power and knowledge. He criticises the conventional view of Aids by questioning who has the right to speak and by supporting dissident arguments. Nevertheless, dissidents do not provide a local explanation to Aids patterns in Africa; therefore, Mbeki does not challenge the knowledge that others have about the epidemic in Africa but the authority of those who talk about it. The study shows that in referring to the role of the past in the present, however, he opposes the knowledge that the West had of Africa in the past, hence, his second line of argument differs from the first one.

DECLARATION

I declare that this research report is my own unaided work. It is submitted for the degree of Masters of Arts in Sociology at the University of the Witwatersrand, Johannesburg. It has not been submitted before for any other degree or examination in any other university.

…… …….day of …….. 2004

Marcela Ospina Salcedo

To all the women in my life who made possible for me to be here

Thanks to my mom, Clara my dearest aunt

And Olga

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LIST OF ABBREVIATIONS

AIDS	Acquired human immunodeficiency Syndrome
ACT	Aids Communication Team
ANC	African National Congress
ARVs	Antiretrovirals
NEC	National Executive committee
CASE	Community Agency for Social Enquire
COSATU	Congress of South African Trade Unions
DP	Democratic Party
HIV	Human Immunodeficiency Virus
HSRC	Human Sciences Research Council
MTCT	Mother to Child Transmission
MTCTP	Mother to Child Treatment Programme
MRC	Medical Research Council
NACOSA	National AIDS Committee of South Africa
NEDLAC	National Economic Development and Labour Council
NAPWA	National Association of People Living with Aids
NEPAD	New partnership for Africa's Development
NGOs	Non-governmental Organisations
SAIRR	South African Institute of Race Relations
SANAC	South African Aids Council
STATS SA	Statistics South Africa
STDs	Sexually Transmitted Diseases
TB	Tuberculosis
TAC	Treatment Action Campaign
USA	United States of America

PREFACE

With 4.8 million people infected, South Africa has the highest number of HIV-infected people in the world (*Nelson Mandela and HSRC study of HIV/Aids* 2002). According to the Medical Research Council (MRC) statistics, Aids accounts for 25% of deaths in South Africa and, given current trends, the number will continue to increase, reaching 7 million by 2010.

South Africa's economic, social and cultural inequalities are the main causes of the development of the epidemic, since lack of access to resources and health services makes people vulnerable to HIV, the virus that causes Aids (Gilbert & Walker 2002; Pelser 2002). In this respect, chapter 1 explains that categories of social inequality such as poverty and unemployment are linked to people's health status, because lack of access to resources also limits their access to health facilities and services. People who live in these conditions are vulnerable to sexually transmitted diseases, since poverty makes them engage in unsafe activities for surviving (Pelser 2002). Considering that inequalities in the country are remarkable, with a poverty rate of 67.8% among black people compared to 8.4% in the white population, migration of labour and prostitution are two of these high-risk activities (*Measuring Poverty in South Africa* 2000).

Since categories of inequality in South Africa vary according to social class, gender, race and geographical location, this study presents the factors that affect the development of the epidemic according to province and shows how these are related to economic, gender and racial differences (Pelser 2002). In general terms, Gauteng, Free State, Mpumalanga and KwaZulu-Natal have the highest percentages of HIV-infected people and present remarkable inequalities. Gauteng, despite being the country's richest province, presents high levels of gender inequalities and rape, following a pattern of mobility produced by mining work, and Free State is one of poorest provinces in the country. KwaZulu-Natal and Mpumalanga have high levels of poverty and unemployment, combined with mobility patterns related to sugar transportation. In sum, the prevalence of inequalities at different levels in these provinces is correlated to a higher prevalence of the virus.

Nevertheless, social inequalities and their consequences on people's health are not the only factors that affect the epidemic's scale in the country. "The government's inability to respond", paraphrasing Barnett and Whiteside (2002), has been indicated as the biggest obstacle in

combating the HIV/Aids epidemic in South Africa. Taking this into account, this study critically analyses Mbeki's position on Aids throughout the treatment policy process from 2000 to 2004.

The fight against the spread of HIV/Aids before 1994 emerged as an initiative by Non-Governmental Organisations (NGOs), researchers and health workers that created a network that focused on counselling and information (Schneider & Stein 2000). In 1994 the 'The Soul City Institute for Health and Development' was created in order to educate people and modify health behaviours related to HIV/Aids transmission. In addition, in the period between 1994 and 2004 educational campaigns such as 'Lovelife' have made great effort to communicate messages about sexual health among the youth, who happen to be at high risk of contracting the virus.

The NACOSA HIV/Aids plan (1992) was the first official attempt at combating the development of the epidemic. The National Aids Committee of South Africa proposed a multi-sectoral structure that included the implementation of units in the Ministries of Health, Welfare, Education and Defence to combat the spread of the epidemic (Nattrass 2004:43). Nevertheless, this did not succeed, since it was formulated during a period of political changes and government had other priorities.

In this context, after some provincial attempts at providing treatment to prevent mother-to-child transmission (MTCT) of HIV, the HIV/Aids strategic plan for South Africa 2000–2005 was formulated. The plan was promoted by government actors at national, provincial and local levels, by all the country's sectors and by HIV stakeholders (Ngwena & Rensburg 2002:65). This aimed at attacking the spread and development of the epidemic from three different fronts: prevention through information and communication; treatment through the provision of anti-retroviral drugs (ARVs) to prevent MTCT of the virus; and care through monitoring delivery of treatment.

Although the plan provided hope for HIV-infected people in the form of a national strategy against the epidemic, the process of treatment provision has been delayed by Mbeki's position on Aids from early 2000 to this day. Since he had contact with dissident ideas, the use and provision of ARVs were questioned. Hence, arguing that ARVs were toxic caused the implementation of treatment to be postponed. Nevertheless, this implementation has been promoted and supported by the Treatment Action Campaign (TAC), which emerged in 1998 with the purpose of confronting the HIV epidemic and fighting for treatment to prevent MTCT. This group has led a

vigorous civil campaign to guarantee the provision of ARV therapy, playing a central role in the implementation of the policy process.

In following the progress of the treatment policy, chapter 1 presents Mbeki's reasons for not making implementation of the treatment programme effective. These arguments belong to his counter-scientific line of reasoning, this is, the group of statements that supports Aids dissidence.

Mbeki's connection with dissident ideas became very obvious in 2000 when he and Minister of Health Tshabalala-Msimang argued that provision of ARVs was irresponsible because the effects of the medication were unknown. At this stage, they said that ARV drugs were harmful to HIV-infected people. In the same year Mbeki organised an international panel of scientists to learn more about the virus in Africa. Some of its members were recognised dissidents, that is, a group of people who deny the causal link between HIV and Aids and, hence, the existence of the disease. To justify their dissidence, this group of scientists, politics and intellectuals argue that the disease known as Aids is produced by poverty, unhealthier behaviours and lifestyle choices. In addition, according to them, the use of ARVs is dangerous as their effects can damage the organism without curing the disease.

This study observes that the participation of dissidents in the advisory panel showed Mbeki's questioning of the conventional scientific view on Aids, since he emphasised that there is not a sole scientific truth. This fact and his doubts about the reliability of ARVs revealed his sympathy with dissident arguments, despite these being discredited by the conventional scientific community. In addition, at the opening session at the *Conference on Aids in Durban 2000*, Mbeki said that poverty was the major cause of ill health in the world; thereby suggesting that HIV was not the only cause of the immune deficiency of the body. His counter-scientific arguments go along with his understanding of the African past of oppression. This second line of argumentation refers to his rejection of the link between race and disease and is intertwined with the first one.

In understanding Mbeki's position on Aids, chapter 2 presents the policy process as an interaction between power and knowledge. In this sense, Foucault's views are related to his scepticism about absolute truths and, therefore, to his question about who has the authority to talk about HIV/Aids. Taking this as the point of departure, Mbeki's views on the past and disease in the present are seen from Said's understanding of the colonial experience in post-colonial territories. The concept of alternative modernities is useful to understand the interaction between the colonial

past and present that Said underlines, thus, this chapter will integrate this idea to the analysis of Mbeki's language usages in chapter 3. Lastly, because Mbeki's references to race and disease point to issues of identity that his African Renaissance (AR) deals with, chapter 2 considers development as an important element in defining the African identity in the present. In this respect, Escobar's criticism of the development discourse is used as a guideline to complete the theoretical framework.

Continuing with the briefing of the policy process, in 2000 Mbeki's scepticism influenced the Cabinet's decision to provide ARVs in public hospitals. In 2001 the TAC took the Minister of Health and provincial health functionaries to court, demanding that the government cease its delay in providing treatment to prevent MTCT of the virus. In December 2001 the applicant's petition was favoured and Cabinet announced its statement in April 2002. At first, the statement announced the provision of treatment at pilot sites, so the roll-out of the ARV drugs was only partial. Since then, the TAC has put pressure on the government to implement the programme, but despite the reform of the statement in October 2002 and 8 August 2003, the roll-out of treatment is still reduced in some provinces. Mbeki's arguments to justify this situation involve the costs of the drugs and the treatment, and the lack of trained personnel to supply them. His scepticism about a scientific view on Aids still influences the development of the process. In this respect, chapter 3 follows his statements on Aids until 2004, including his speeches, letters and interviews.

By analysing Mbeki's speeches, interviews and public interventions, chapter 3 focuses on the relationship between Mbeki's counter-scientific line of reasoning and his rejection of the representation of Africans as diseased people in the context of power and knowledge.

This chapter presents and interprets his understanding of the past in the present regarding his definition of African identity. Mbeki's extreme preoccupation with the African past varies when he talks about Aids and development. He rejects any connection between race and disease and, in this sense, any colonial image that represents Africans as human beings of a lower order. In the same plane, he questions the conventional scientific view on Aids, as he queries the power and authority of the West in talking about an African epidemic. In other words, he challenges the power of the West by criticising the conventional scientific view on Aids in Africa. This criticism is contradictory and does not succeed, as he does not propose an alternative view on Aids.

On the other hand, he defends a principle of self-defined identity by which African people decide their own future without letting others intervene in the process. He stresses these ideas in *I'm an African* and the *African Renaissance*. Nevertheless, this principle of self-definition becomes different when he talks about development for Africa. In this respect, he supports policies that promote African economic growth and the opening of the continent to the world economic system. From this perspective, the study observes, he defends his authority in controlling the process of guiding Africa towards the Renaissance, but he does not challenge the Western system of knowledge that represents the continent as amodern and underdeveloped in the present. Why then does he adopt different stances regarding representations of Africans as diseased and amodern?

In answering this question, chapter 3 presents an alternative explanation concerning the role of the sexuality discourse in Mbeki's position on Aids. Based on Posel's explanation, the analysis shows that the representation of African people as inherently diseased jeopardises Mbeki's nation-building project. Posel develops her argument by explaining that Aids is a sexually transmitted disease and, therefore, following Foucault's views on power, the state must control and invigilate the health of the nation. In this sense, saying that Africans are 'natural-born carriers of germs', in the context of Aids, is the equivalent of saying that they are 'devoted to the sin of lust'. This study argues that the principle of self-defined identity that Mbeki defends cannot succeed if this link between African people and an uncontrollable sexuality prevails. This, by implication, means that the representation of Africans as underdeveloped and amodern does not represent the same threat to the nation-building project. This, however, must not be confused with Mbeki's conformism with these images. On the contrary, the study stresses his ambiguity, since he shows a remarkable interest in taking Africa onto the path of development that the Western system of knowledge traces.

Chapter 4 concludes the previous analysis by criticizing and questioning Mbeki's uses of a language that still conceives reality in terms of oppositions and irreconcilable polarities.

Lastly, I would like to thank my supervisor, Ran Greenstein, as the completion of this study would not have been possible without his support. Special thanks to him and to all the people who supported me in Colombia.

METHODOLOGY

1. AIM

The aim of this research is to analyse Thabo Mbeki's discourse on science and disease, and examine how this has affected the formulation and development of the HIV/Aids treatment policy process in South Africa from 2000 until 2004. I argue that in order to make sense of Mbeki's statements on HIV/Aids, they must be seen in the context of the main elements of the ANC's nation-building project. These are African identity, development, and the relationship between Africa and the West.

2. RESEARCH QUESTIONS

- What is Mbeki's position on HIV/Aids?
- What are the consequences of Mbeki's position on Aids for the HIV/Aids treatment policy process?
- What wider world-view or ideology is behind this position?
- How is Mbeki's position on HIV/Aids related to other central ANC concerns such as African identity and development?
- How does Mbeki define African identity in the African Renaissance?
- What is the role of development in the ANC's nation-building project?
- What is Mbeki's view of the relationship between Africa and the West in the context of HIV/Aids and in terms of African identity and development?
- What are the possible explanations to Mbeki's position on Aids?

3. DATA SOURCES

3.1 Primary Sources

The main source of information for this research is Thabo Mbeki's speeches, letters and public interventions since 2000 until 2004. Most of the selected material refers to his position on HIV/Aids and his views on science. In addition, speeches on national identity previous to 2000, are analysed because they point out Mbeki's understanding of African identity and the historical relationship between Africa and the West, which frame his approach to HIV/Aids. Some of his

speeches as a chairperson of the African Union are analysed, in order to grasp his views on development and the role it plays in the Nation-building project.

Since the treatment policy process involves different actors, such as the government, journalists, academics and NGOs amongst others, the study selected a variety of texts in order to highlight positions that differ from Mbeki's. In addition, empirical data such as statistics was collected, analysed and compared. The texts are classified as follows:

- **Empirical data:** statistics on HIV/Aids prevalence and poverty in South Africa, and global studies on HIV/Aids incidence, prevention and treatment. This information allows us to determine the status of the epidemic in South Africa, and elsewhere, and to evaluate arguments regarding the epidemic, such as those presented by Mbeki.
- **Cabinet Statements on HIV/Aids:** These documents are crucial to follow the course of the policy process and implementation.
- **TAC's documents on treatment campaigns:** these are useful to picture the contestation between a socio-political movement and the government's policies.

3.2 Secondary Sources

- **Academic analyses of Mbeki's position on HIV/Aids:** these analyses are important because they place Mbeki's statements within a broader ideological context.
- **Journalists' reports of Mbeki's public interventions on HIV/Aids:** journalists have dynamically participated in the debate around the policy process. They examine Mbeki's arguments on HIV/Aids as well as other perspectives, such as those advocated by the TAC. Their voice is important for this analysis because it points out a different perspective of the process.

3.4. Source's use

Empirical data such as local statistics on poverty, rape, HIV/Aids incidence and mortality, provides evidence to give an account of patterns of spread, levels of prevalence and demographical incidence of HIV/Aids in South Africa. This information is crucial to understand the status of the epidemic in the country. In addition, global studies on HIV/Aids incidence in the USA and Europe are compared to the local figures because the patterns of the epidemic in

Southern Africa differ from those in the mentioned regions. This comparison is important to understand Mbeki's views on HIV/Aids in Africa and the West..

The Cabinet Statements on HIV/Aids and the TAC's documents are used to describe the formulation and development of a policy on HIV/Aids treatment in South Africa.

In order to answer to the formulated research questions, Mbeki's statements on HIV/Aids, African identity and development will be systematically analysed and discussed in chapter 3. His statements on HIV/Aids will be used to present his line of argument on science and disease from 2000-2004 in the context of the policy process. The journalists' criticism and interpretations of Mbeki's views, are simultaneously presented to give an account of the process of contestation that his position on Aids has produced. Subsequent to his views on HIV/Aids, Mbeki's statements on African identity and development will be compared, contrasted and analysed in connection with his arguments on the epidemic. Academic analyses on his position are presented in order to provide a possible explanation to his line of reasoning.

Lastly, I would like to clarify that although this research analyses Mbeki's statements on Aids, it does not use discourse analysis as a research method. Instead, this study is a non-conventional analysis of a controversial topic of discussion in South Africa's socio-political context.

CHAPTER 1
The HIV/AIDS EPIDEMIC IN SOUTH AFRICA: Historical unfolding

1.1 Introduction

South Africa's social, economic and political life has been affected extensively by the HIV/Aids epidemic. One in five adult South Africans are HIV-positive and Aids deaths are expected to rise sharply until 2010 (Nattrass 2003:13). With 4.8 million HIV-infected people, some analyses confirm that the epidemic will be the most important phenomenon in shaping future demographic, health and development trends in South Africa (Pelser 2002:19). This is why a complete understanding of HIV/Aids requires a careful overview of the developing epidemic and its economic and social implications.

This chapter will look at the conditions that facilitated the spread of HIV in South Africa, and the political debate that emerged around the HIV treatment policy process.

1.2 The relationship between social and health inequalities: Who is vulnerable to HIV/Aids in South Africa?

The unequal distribution of resources is the main legacy of the apartheid era in South Africa. Poverty and unemployment levels reflect disparities that vary, primarily, according to gender and race. According to Statistics South Africa, the poverty rate among black people was 67.8% compared to 35.3% among coloureds and 8.4% among whites in 1995 (*Measuring Poverty in South Africa* 2000). Simultaneously, the unemployment percentage was higher among blacks, especially among black women. The figures show that in 1998, 25% of black men and 35% of black women were unemployed, compared to 14% of coloured men and 19% of coloured women. In sharp contrast, the proportion of white unemployed people was much lower, and there was also a difference between men's and women's percentages with 3.3% of men and 6.2% of women being unemployed (*Labour force survey* 2000).

The proportion of poverty levels between genders is that one in two female-headed households (52%) are regarded as poor or very poor, compared with one in three (35%) male-headed households (*Measuring Poverty in South Africa* 2000). Following this information, inequality levels are shaped by factors such as poverty and unemployment that vary according to race and gender.

According to Pelser there is an inescapable link between morbidity, mortality and poverty. Lack of access to basic services such as electricity and potable water is related to the prevalence of preventable diseases (for example diarrhoea and Tuberculosis (TB)). Furthermore, poverty affects access to education and health services, causes dislocation owing to inter-country or internal migration in pursuit of employment opportunities, and increases engagement in high-risk activities for economic survival reasons (Pelser 2002:37).

Drawing on this information, there is a tight relationship between social categories of inequality - for example poverty and unemployment - and health status. In the context of the HIV/Aids epidemic, Gilbert and Walker observe, a "more in-depth look at inequality is necessary owing to the differential growth patterns of the epidemic in developing and developed countries, as well as within countries on racial, gender and class bases" (2002:7). The authors seek to understand the impact of social inequality on patterns of HIV/Aids, and how this is specifically related to women's vulnerability to the epidemic. Put differently, this analysis underline the link between vulnerability, social inequalities and HIV/Aids.

For Gilbert and Walker the various dimensions of social inequalities put people in vulnerable positions, such as lack of access to resources as well as lack of entitlement, political and economic power, and social and cultural capital, among others. These vary according to race and gender, as stated earlier, as well as geographical location and age, as the section will present in relation to HIV-positive prevalence.

TABLE 1

Indicators associated with HIV/Aids and HIV-positive prevalence by province

Order of rank (1= worst position among all provinces – 9= best position among all provinces)

Provinces	Unemployment rate (1999)	Poverty rate (1995)	Female-headed households in extreme poverty (1996)	Per capita public health spending (2000/01)	Women ever abused (1998)	Women ever raped (1998)	HIV-positive prevalence (%)
KZN	**3**	**4**	6	6	6	4	**11.7**
MPU	**4**	**3**	7	1	**3**	**1**	**14.1**
GP	7	8	8	9	**1**	**2**	**14.7**
FS	6	7	**1**	7	5	6	**14.9**
NW	5	5	3	3	9	7	10.3
EC	2	2	2	5	8	5	6.6
LP	1	1	5	2	7	4	9.8
NC	8	6	4	4	4	3	8.4
WC	9	9	9	8	2	2	10.7

Source: Pelser's own calculations 2002; Nelson Mandela & HSRC Study of HIV/Aids 2002[1]

South Africa's nine provinces present remarkable differences concerning factors of socio-economic status and HIV-positive prevalence level. According to table 1, three of the four provinces with the highest HIV-positive rate (Mpumalanga, Free State and KwaZulu-Natal) present a close relationship with poverty. The Free State, for instance exhibits a high level of women headed households in extreme poverty and KwaZulu-Natal and Mpumalanga present high unemployment and poverty rates. In addition, Mpumalanga exhibits a high prevalence of rape and gender inequalities as well as Gauteng, which also has a very high HIV-prevalence level.

Nevertheless, Nettleton's calculations of poverty and unemployment differ from the results presented by Stats South Africa (2000). Stats SA labour force survey (2001) shows that the Free State had the highest unemployment rate in the country by 1996, although for Nettleton these levels are not significant in the province. It is important to point out the role that the differences between studies' results play on the debate on Aids in South Africa.

Table 1 shows that, on the one hand, Free State, Mpumalanga and KwaZulu-Natal have high poverty and unemployment levels, and simultaneously present the first, third, and forth highest

[1] The thesis uses the Nelson Mandela/HSRC study of HIV/Aids because it is the first systematically sampled, nationwide community-based survey of the prevalence of HIV in South Africa.

HIV-positive rates among provinces. In Mpumalanga, rape is a risk indicator that must be connected to the prevalence of infection, since this is one of the greatest transmitters of HIV in South Africa. On the other hand, although poverty and unemployment are not relevant indicators in Gauteng, this province has the highest HIV-positive prevalence.

There are different factors of inequality in Gauteng which might explain this figure, such as gender inequalities manifested in women's abuse and rape. Furthermore, Gauteng presents a pattern of mobility produced by mining work and a high rate of people living in informal settlements, which play a fundamental role in the transmission of the virus.

According to the *Nelson Mandela/HSRC study*, the highest HIV prevalence percentages are in urban informal settlements (21.3%) in respect of the overall HIV-infected people percentage of 11.4%. In Gauteng, for instance, the high HIV prevalence is tightly related to its percentage of people who live in informal localities (19.9%). In the case of the Free State, the high HIV prevalence can be linked to its pattern of female-headed households in extreme poverty which, simultaneously, can be related to patterns of mobility produced by migration of labour. Furthermore, the percentage of people living in urban informal settlements in the country is also very high (16.9%).

Summarising, the provinces with the highest HIV prevalence levels present a pattern of inequality at different levels. Although each region has particular risk factors, in general terms the spread of the virus is linked to poverty, unemployment, abuse and rape, all of them indicators of social inequalities.

1.2.1. Are social inequalities responsible for people's risk behaviours?

The particularity of HIV/Aids in South Africa concerns the risk patterns associated to the epidemic. While, according to UNAids (2000), in North America, HIV transmission is higher among homosexuals (41%) and intravenous drug users (30%) and lower among heterosexuals (22%), in sub-Saharan Africa the highest prevalence is found among sexually active heterosexuals. In South Africa, the significant difference between the percentage of HIV infected men (9.5%) and that of women (12.8%), confirms that the virus is mainly heterosexually transmitted in the country.

The epidemic in South Africa can be understood, mainly, according to two arguments that will be taken into account in this research. The first one, which has been presented earlier in the chapter, relates HIV/Aids prevalence to social inequalities (Gilbert and Walker 2002; Pelser 2002; Farmer 1998). This position is based on the relationship between indicators of inequality such as poverty and unemployment, and race and gender. In respect of the HIV/Aids epidemic, this relationship prevails since, for instance, the percentage of infected women is higher than that of men. In addition, there is a direct correlation between racial groups and HIV/Aids prevalence. With a percentage of 12.9%, black Africans have the highest HIV-positive prevalence. The gap between this percentage and those among white, coloured and Indian people is conspicuous. According to the *Nelson Mandela/HSRC study*, there is an HIV-positive prevalence of 6.2% among white people, followed by 6.1% among coloureds and 1.6 among Indians.

The second line of argument, relates levels of prevalence to people's risk behaviours (Campbell 1997; Marks 2002). This position maintains that although epidemiologically the poor and unemployed are at a higher risk to contract HIV/Aids, high-risk behaviours play a key role in its transmission. Marks says: "many professionals, teachers and nurses, as well as profile politicians with considerable education and affluence have also been victims of the disease: for the most part they cannot be described as malnourished" (*2002: 22).*

Taking the above mentioned arguments into account, this section will link HIV-positive rates to patterns of inequality such as low income, and environmental factors such as geographical location of certain groups of people. At the same time, it will look at the relationship between prevalence and risk behaviours.

1.2.2 Poverty and migration of labour: a lethal combination

In South Africa, mining, plantation, highway and border towns often experience the highest infection prevalence. For instance, in 1997 the highest HIV prevalence in Gauteng (22.5%) was in the gold mining areas, and in KwaZulu-Natal (35%) in the sugar plantation, trucking and rail town of Empangeni (2001; ECI quoted in Pelser 2002: 58).

For Pelser, there is a close link between patterns of HIV/Aids in South Africa and the system of migrant labour, which is inextricably linked to the mining industry, practice that in the colonial past facilitated the transmission of various STDs, especially syphilis (2002:38). Mine workers in

South Africa are rural men from within and outside the country who, owing to their poor living conditions, have to leave their women and families to work. This situation erodes family bonds, creating the conditions for rapid transmission of STDs and HIV.

From a behavioural point of view, Marks observes that when social bonds loosen there is "increased risk taking and reduced social concern about casual sexual relationships" (2002:17). In this sense, because these men's family bonds weaken they tend to adopt a promiscuous sexual behaviour.

For instance, the goldmines employ 350 000 workers, 95% of whom are migrants from rural areas within South Africa, and others from surrounding countries such as Lesotho, Botswana and Mozambique (Campbell 1997:273). Campbell explains that they often live together in male-only hostels, spending their free time in townships near to the mines where they have contact with sex workers. In this sense, their life-styles make promiscuous sexual behaviour likely. From these sexual encounters men pick up STDs and HIV, whose spread occurs when they go back to visit their women, without even knowing they carry the virus.

Marks and Campbell's explanations point out that the workers' sexual behaviour makes them vulnerable to contract the epidemic. However, their precarious living conditions also facilitate the spread of all sorts of STDs. In this sense, it is important to analyse the extent of high-risk situations and high-risk behaviours because, the conjunction of these two might explain the high prevalence levels among mine workers.

Regarding HIV transmission, Pelser highlights that it is bi-directional because female sexual behaviour may also be promiscuous. For instance, in KwaZulu-Natal it is common for males and females to have more than one sexual partner. Family disruption, plus the promiscuity and mobility of workers referred to above, contributes to HIV transmission in South Africa's rural areas as well as across borders.

The levels of HIV prevalence among mining workers are very high. Current figures show that the proportion of HIV-infected mineworkers in the country is between 20% and 30% (2002; Horwitz quoted in Pelser 2002)[2]. According to these figures, this group can be considered as high-risk. For instance, in 1999 approximately 29% of migrant mine workers in Carletonville (Gauteng), home

[2] Horwitz S. 2002. "Migrancy and Aids: an historical perspective." *South African Historical Journal,* 46.

to 100. 000 mineworkers, were HIV-positive. Simultaneously, the prevalence was 69% among sex workers and 22% among the settled adult population in the town in the same year.

Based on the previous figures, and taking into account that desperate to earn money, rural workers unsettle and leave their families in pursuit of employment, it is possible to state that labour migrancy is linked to poverty. This fact, however, does not show a direct link between poverty and HIV prevalence although the latter is directly related to type of settlement. For instance, Gauteng, and Free State have the highest HIV prevalence and the highest number of people living in informal urban settlements with 19.9% and 16.9% respectively (*Nelson Mandela/HSRC study of HIV/Aids* 2002). Summarising, it seems that poverty is linked to type of settlement which is directly related to HIV prevalence.

In KwaZulu-Natal, patterns of migration are also related to HIV-positive levels. This province was known for having the highest HIV-positive rates according to Department of Health statistics (1998). Nevertheless, for the *Nelson Mandela/HSRC study of HIV/Aids*, this province has the fourth highest prevalence rates. The statistics differ because of the sampling and the balance of types of locality in KwaZulu-Natal. Furthermore, the calculations of the Health Department were based on the surveys of women attending antenatal clinics (approximately 80%). This methodology, despite being adequate to measure the prevalence by provinces and by age cohorts, presents inaccuracies such as the age of the women, since the surveys include only those who are pregnant and recently, or currently, sexually active.

In sum, some dimensions of social inequality produce high-risk situations that might make people vulnerable to HIV. Nevertheless, individuals choose to adopt high-risk behaviours. In this respect, the question that emerges is to what extent do social inequalities influence people's behaviours? This research argues that migration of labour and the disruption of family bonds that this entails put people who live in provinces with a high number of informal urban settlements in a vulnerable position. However, at the end, people contract HIV/Aids because of their high-risk behaviour.

The next section will show the link between HIV prevalence and gender, which is important to understand why women are more vulnerable to contract HIV/Aids than men.

1.2.3 The link between HIV/Aids transmission and Gender inequalities

Gilbert and Walker argue that African women are more vulnerable to HIV than any other group. They explain that women are particularly affected by poverty, unemployment and sexual abuse, while simultaneously their rate of infection is higher than men's (2002:34).

TABLE 2

HIV prevalence by sex and race

Sex & Race	HIV-positive (%)
Total	11.4
Male	9.5
Female	**12.8**
African	**12.9**
African female	**17.6**
African male	13.5
White	6.2
Coloured	6.1
Indian	1.6

Source: Nelson Mandela/HSRC study of HIV/Aids 2002

Table 2 shows that women and African people have the highest rate of infection. According to these figures, the rate of HIV prevalence among African women (17.6%) differs notably from that of African men (13.5%) while the other races do not present any significant difference in respect of sex. According to this information, because HIV prevalence varies according to gender, especially among African people, women are more vulnerable to the epidemic.

To grasp the link between HIV and gender, it is necessary to analyse cultural, socio-economic and behavioural patterns of the relationship between men and women. This is very important to understand why HIV prevalence is so high among women and, above all, among African women. Gender differences and female subordination greatly influence the spread of the epidemic. Pelser writes: "Gender based inequalities often overlap with other social, cultural, economic and political inequalities between men and women" (2002:29). The next paragraphs will develop this idea, pointing out some socio-economic and cultural factors of inequality between genders, which are related to HIV transmission.

Indicators of the low status of women in society are sexual violence, abuse and rape. According to Pelser, rape has become a very potent method of spreading HIV in South Africa, especially when one considers the high-risk sexual behaviour of the rapists and the levels of HIV prevalence (2002:32). Table 1 shows that Mpumalanga and Gauteng are affected to a large extent by rape and women abuse. In 1998, the percentage of women who had been raped in Mpumalanga and Gauteng was 7.1 and 6.5% respectively (*Rape and post-exposure prophylaxis in SA* 2003).

Pelser points out that women are at greater risk of HIV in sub-Saharan Africa, because "their diminished socio-economic status compromises their ability to choose safer and healthier life styles" (2001; UNAids, quoted in Pelser 2002:29). She refers to statistics that show the relationship between sex and violence patterns (UCSF 2001; SAIRR 2001; CASE 2000). For instance, according to the South African Institute of Race Relations (SAIRR) statistics, 25% of men acknowledged that they had had sex with someone without that person's consent. The Community Agency for Social Enquire (CASE) states that for 31% of women their first sexual experience was not voluntary. Furthermore, culturally women are seen as 'morally clean', therefore men see condom use as unnecessary with such women, putting them at higher risk.

Jewkes, Levin and Penn-kekana observe that in South Africa women do not ask men to use condoms because of concerns about men's sexual pleasure or other preconceptions about sex. For instance, women feel inhibited about talking openly about sex with their partners for fear of appearing promiscuous (2003:126).

Gender inequalities can be seen, not only from a cultural perspective, but also from the economic and material aspect of the relationship between women and men. Rao Gupta argues that gender power imbalance translates into a power imbalance in sexual relations, which increases vulnerability to HIV (2000; Gupta quoted in Jewkes, et al 2003:125).[3] This argument is also presented by Nattrass when referring to gender inequality in terms of power relations, which illustrates a different situation of women's subordination:

> The 'social reality' is one in which the power relations are skewed in favour of men, and where sex is a currency by which African women and girls are frequently 'expected to pay for life's opportunities […] The trading of sexual favours out of desperation has been

[3] Gupta, R. 2000. *Gender, sexuality and HIV/Aids: the what, the why and the how.* Plenary address at XIII International Aids Conference. Durban, South Africa. 9-14 July 2000.

> dubbed 'survival sex' […] Unfortunately, the price of participating in this 'sexual economy' is greater vulnerability to HIV infection, especially for young women. (Nattrass 2004:28)

For Nattrass the scale of the epidemic must not be understood only according to an individual's sexual behaviour. She thinks: "It is the *combination* of socio-economic and biomedical factors with unsafe sexual practices that produces the lethal basis for the spread of HIV" (2004:28). For her, sexual practices put women in a vulnerable situation that is exacerbated by poverty.

Pelser reaffirms Nattrass's point by explaining teacher-student and young women-old men sexual relationships, which have become very common among young South African women. *The Nelson Mandela/HSRC study* (2002) shows that 8% of women aged 15–24 have partners who are 11–25 years older than them. The so-called sugar daddy phenomenon has put girls and young women in a vulnerable position with regard to HIV in the country. The figures estimate that women aged 1–-24 have a prevalence rate of 12% while men aged 15–24 have a prevalence of 6.1%. The highest peak of infection, however, is found among women aged 25–29 years (32%)

Pelser explains that in addition to personal benefits from these relationships – for example obtaining high grades and commodities – school-going and young girls are propelled into such a situation by their socio-economic conditions. Coming back to Nattrass's point, 'economic factors reinforce unsafe practices'. In other words, women's economic vulnerability places them in a subordinate position to negotiate safe sex.

There is a different kind of female subordination common among migrant workers' wives. Owing to their socio-economic living conditions, these women often have more than one sexual partner. They explain they have extra-marital relations because of the need for financial support and sexual gratification. These women do not perceive themselves as being at risk of getting HIV, although in nearly 40% of migrant couples it is the woman who is infected first (2000; Lurie quoted in Pelser 2002).

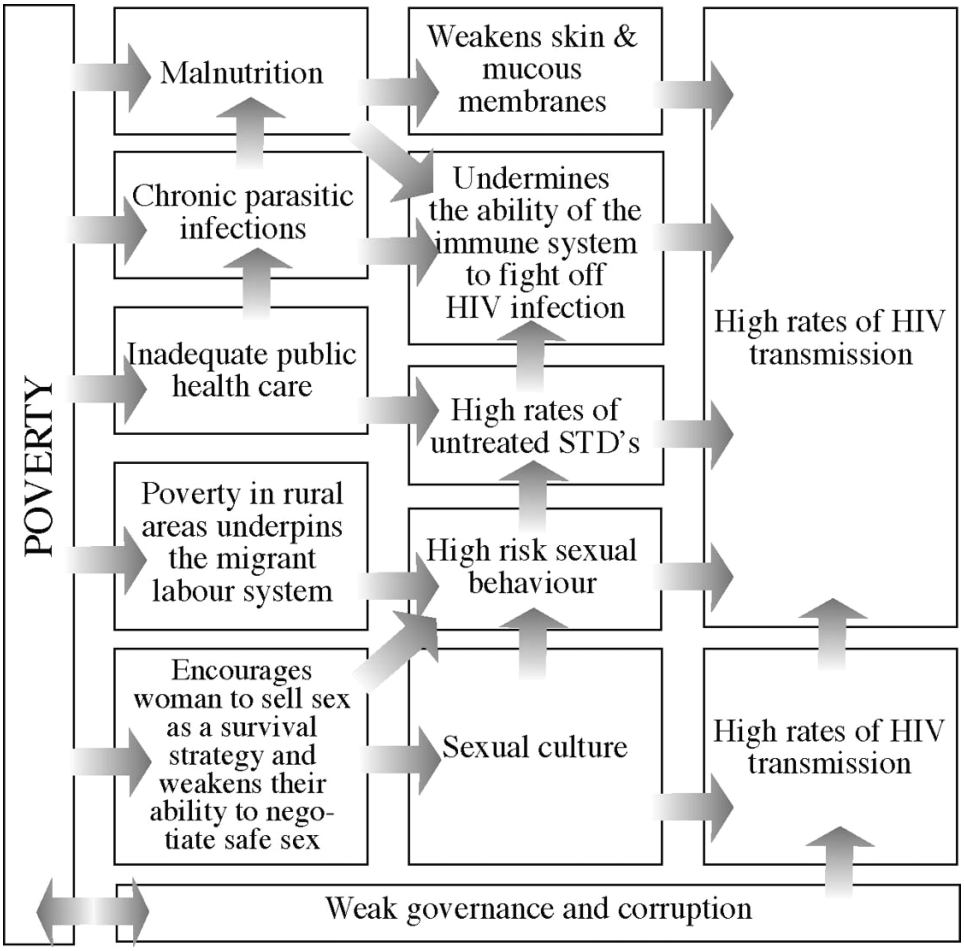
The negotiation of condom use, as Jewkes et al explain, also depends on the women's education levels. The authors affirm that the ability of a woman to suggest condom use is remarkably influenced by her higher educational status (2003:130). This sort of information suggests that

HIV prevalence is lower in more highly educated sectors. Nattrass affirms that education and economic development are crucial components in an integrated approach to combating Aids.

Gilbert and Walker conclude that a mixture and interaction of social, cultural and behavioural factors shape the nature, process and outcome of the HIV/Aids epidemic in South Africa (2003:37). Such an intertwining was described and explained in the section according to geographical location, socio-economic status and gender inequalities. Nattrass and Pelser observe that in studying the spread of HIV/Aids poverty cannot be isolated from gender and circumstances such as lack of education and sexual behaviour. Nattrass is especially concerned about it, and figure 1 summarises her understanding of HIV according to the link between social and health inequalities, as was explained in this section.

FIGURE 1

Links between socio-economic, biomedical and behavioural determinants of Aids in Africa



Source: Nattrass 2004.

2. The HIV/Aids treatment policy process 2000– 2003: an overview

This section focuses on the HIV/Aids treatment policy process, its continuities and changes. Although the chapter summarises the official side of the process, its respective documents, plans and Cabinet statements, it also recognises the role that NGOs, donor agencies and media educational campaigns have played in the fight against HIV/Aids before and during the process.

Schneider and Stein write that, prior to 1994, strong networks were organised between NGOs, researchers and health workers to combat Aids through counselling and information, and centres in metropolitan local governments, with the help of anti-apartheid groups (2000:723). In 1994 the NGO 'The Soul City Institute for Health and Development' was created with the purpose of

educating people to make better health choices. Combining prime time TV and radio dramas with print material, the Soul City project informs the public, raises debate and shifts attitudes and behaviour around health, especially about HIV/Aids (*Soul City: Media Edutainment and Advocacy for Health and Development* 2001). Soul City was a pioneer in the field of modifying behaviour through mass-media campaigns, although the 'Beyond Awareness' campaign also supported the free Aids helpline in 1992. The latter used mass media to inform people from 1998 to 2000.

Simultaneously, in 1999 the educational campaign 'Lovelife' was launched to attempt to reduce teenage pregnancy, the spread of HIV/Aids and sexually transmitted infections. 'Lovelife', as well as the 'Soul City' project, is founded on the idea that campaigns of sexual health education must modify people's behaviour; otherwise infection rates are not going to decrease. The last of these educational campaigns was promoted by the government in 2001 through the Aids Communication Team (ACT), which emerged to implement a two-year media campaign to educate people about the dangers of HIV.

These projects have been very influential on the field of HIV educational campaigns, although some analyses of the policy process do not include them as part of their historiography. This section underlines that besides the official side, these attempts cannot be overlooked in analysing the HIV policy process because they play a crucial role in preventing the spread of the epidemic in the country. Nevertheless, I observe, these efforts have focused on educating people in order to modify risky sexual behaviours, but this strategy barely works with groups such as the mine-workers since their poor living conditions limit their access to media. In this sense, the educational campaigns should also take into account indicators of social inequality such as poverty, and environmental factors such as geographical location.

The treatment policy process has been the subject of heated political debate and confrontation between the African National Congress (ANC), and non-governmental actors such as the TAC. The process has been a scenario for discussions about the causes of Aids, the toxicity of ARVs and the affordability of treatment, which have delayed the response to the epidemic. In other words, according to Nattrass, the government's retarded response to HIV has had a damaging effect for the country. The next official documents summarize the policy process since 1992.

- **NACOSA Aids Plan (1992)**: The National Aids Committee of South Africa (NACOSA) was formed to coordinate the process of policy development and the writing of an Aids plan. The plan aimed to a) prevent HIV transmission, b) reduce the impact of HIV in society, c) mobilise and unify provincial, international and local resources to combat HIV.
- **Five-year HIV/Aids Strategic Plan for South Africa (2000):** A wide sector of civil society participated in the formulation of this plan, which was the beginning of an open battle against the virus on four different fronts: prevention, treatment and care, human and legal rights and monitoring, research and surveillance.
- **Cabinet Statement 17 April 2002:** The Cabinet announced treatment and the provision of ARVs to HIV/Aids infected people in public hospitals. The statement accepted that HIV causes Aids, recognising that the provision of ARVs could be useful and effective for victims of sexual assault and occupational injury.
- **Cabinet Statement 8 August 2003:** The Cabinet stated that ARVs do help improve the quality of life of those at a certain stage of Aids. In the statement the Cabinet asked the Department of Health to develop an operational plan to guarantee the treatment roll-out.

The NACOSA Aids plan emerged during South Africa's transition to democracy, although this timing complicated its execution. In this sense, Schneider and Stein wrote that this was a detailed and lengthy document that was beyond the skill sets of the newly formed government (Schneider & Stein quoted in Schneider 2002:146). The plan proposed a multi-sectoral structure that included the implementation of units in the Ministries of Health, Welfare, Education and Defence (Nattrass 2004:43). It recognised the multi-faceted nature of the HIV epidemic, that is, its economic, political and social sides. Therefore, it required the involvement of all sectors of society to combat its effects (Ngwena & Rensburg 2002:62). Nevertheless, this aim was marginalised by the huge tasks of government restructuring that delayed the discussion of an Aids policy with non-governmental actors.

According to Schneider and Stein, from 1994 until 1998 the Aids policy context was characterised by the slow start of the policy implementation, which did not facilitate the Aids plan success. They highlight, however, that the gap between rhetorical 'intentions' and implementation

is a general feature of policy processes in South Africa, and therefore is not unique to Aids (1997; Pieterse quoted in Schneider & Stein 2000:726).[4]

Schneider and Stein point to the South African political context as the principal cause of the failure of the Aids plan: "In a period where Aids was a rapidly expanding but still largely invisible problem, national and provincial governments naturally focused on other immediate priorities" (2001:726). At that time, in the post-1994 period, there was no multi-sectoral response to the epidemic, although some people suggested integrating Aids programming into primary health care.

For Nattrass, instead, there is a different reason for the government's response. She observes that in 1994, when the ANC started to govern, the Aids plan was adopted and was declared a presidential-led project, which gave it preferential access to funds. Nevertheless, after a while a national Aids programme director was appointed. At this point, Nattrass says, the initiative changed the plan's original direction. She explains that one characteristic of the situation was that the Aids programme director was placed in the Department of Health and not in the President's Office. Because of this, responsibility for Aids programmes was placed in the Health Ministries of provincial governments. At this stage, the epidemic itself was considered a health problem rather than a social problem, which constrained and limited the potential for a multi-sectoral coordinated response (2004:43).

The HIV/Aids Strategic Plan 2000 was preceded by two public scandals. The first occurred in 1995 when the government came up with the idea of an HIV-prevention play: Sarafina II. Although the government was attempting to attack the epidemic through a cultural medium, the economic cost was significant and the message confusing and irrelevant (Schneider & Stein 2001; Nattrass 2004). Seen in retrospect, however, the event did not have major consequences for the HIV/Aids policy process.

The second mistake committed by the government was the official announcement in 1997 of Virodene, a medication for treating Aids. Surprisingly, this drug, which was far from being a genuine solution, was an industrial solvent that had previously been tested in cancer therapy. Consequently, after these two scandals, the government's credibility was publicly questioned.

[4] Pieterse, E. 1997. National Resource Allocation: The winning road to equity. *Development Update: Quarterly Journal of the South African National NGO coalition and INTERFUND.*

In 1998, representatives from the National Association of People Living with Aids (NAPWA) and Aids researchers discussed the provision of treatment for preventing MTCT of HIV/Aids. Their call was answered by the Western Cape Province, which was not controlled by the ANC, and where a mother-to-child treatment programme (MTCTP) had been implemented. This, however, was the only province that adopted such a programme. Elsewhere, arguments about the toxicity of ARVs and their prohibitive cost were grounds for rejection of their provision of and MTCT treatment (Schneider 2001). These two sorts of arguments, one practical, related to the costs and affordability of treatment, and the second principled, related to ARVs toxicity – were supported by Mbeki, as this chapter will present. Under these circumstances, the TAC emerged in the same year (1998) with the aim of openly facing HIV and promoting MTCTP and its implementation.

In June 1999, when Thabo Mbeki became South Africa's president the policy-making process was strongly influenced by his ideology. In this sense, the process became more centralised (Nattrass 2004). Nevertheless, this centralisation has been partial to date, because the policy for the provision of HIV treatment is still executed differently among provinces. For instance, of all South Africa's provinces only KwaZulu-Natal, Gauteng and Western Cape have started an effective MTCTP roll-out (2004:48).

The political changes of 1999 accompanied the formulation of *the HIV/Aids Strategic Plan for South Africa*. This document has had a crucial role in the implementation of the HIV/Aids policy process, above all because it was a call for participation of many sectors, including governmental actors at national, provincial and local level, and also all the country's sectors and HIV stakeholders (Ngwena & Rensburg 2002:65). [5] This broke with the traditional conception of HIV policy processes controlled by the Department Of Health.

Second, the strategic plan proposed two important goals that Ngwena and Rensburg summarise as the reduction of new infections, above all, among the youth; and the reduction of the impact of

[5] Representatives of faith based organisations, people living with HIV infection and Aids, human rights organisations, academic institutions, the civil military alliance, the salvation army, the media, organised labour, organised sports, organised business, insurance companies, women's organisations, youth organisations, international donor organisations, health professionals and health consulting organisations, political parties, and relevant government departments, attended to the meeting to discuss the strategic plan in July 1999 (Government of South Africa: HIV/Aids Strategic plan for South Africa, 2000:6).

HIV/Aids on individuals, families and communities (2002:65). These goals could only be achieved through the participation of civil society and the organisation of committees.[6] The hierarchical structure of the strategic plan is as follows:

- The South African Aids Council (SANAC), which advises the government on HIV/Aids policy
- Representatives from government and civil society, including business, trade unions, religious organisations, traditional healers and NGOs
- Supportive task-teams in prevention, care and support, information and education, research and legal issues and human rights.

Nevertheless the first team of representatives, which was chaired by the deputy president, excluded important medical researchers and NGO groupings, among them TAC and NAPWA (Schneider 2002:149).These sorts of deliberated decisions underlined the plan's weakest points. The most serious of them, Ngwena and Rensburg observe, was the lack of commitment for the provision of anti-retroviral therapy (2002:67). The plan limited the provision of ARVs to two designated sites in each province, therefore excluding a large majority of women who would not have access to the drugs unless they were available at public hospitals and clinics (*Mail & Guardian* 23-29 November 2001). At the same time, as stated, the government's arguments about the toxicity of ARVs and their unaffordability were typical in justifying the policy implementation's delay. In this respect, this study observes that these arguments were not mentioned by the ANC or by presidency before 2000. It was not until Mbeki started to flirt with dissident ideas that the reliability of ARVs was questioned.

Nattrass points out that a while after the launch of SANAC, Mbeki created the 'Presidential International Panel of Scientists of HIV in Africa' and some members of the Panel were HIV dissidents – they deny that HIV causes Aids and argue that if there is such a thing as Aids it is caused by poverty rather than by a single virus (2004:50). In this respect, Mbeki's flirting with dissident views, expressed through his belief in the ARV's toxicity, influenced the delay in the provision of anti-retroviral treatment. I observe, however, that within the ANC there is not consensus about Mbeki's dissident inquiries. On the contrary, few people in government, such as the Minister of Health Tshabala-Msimang, have supported his stance. The position of these few,

[6]This study uses the term civil society to refer to non-governmental entities, stakeholders and non-profit organisations.

however, has influenced government's decisions concerning the provision of HIV treatment, as this chapter and chapter 3 will show.

Owing to the government's inaction regarding the provision of ARVs, the TAC took the Minister of Health and provincial health functionaries to Court in 2001. Its argument was based on the premise that access to health care is a human right and not a commodity, therefore the provision of Nevirapine to prevent MTCT of HIV must be available at all state hospitals and clinics. The TAC's initiative was also based on other countries' experience concerning ARVs provision and MTCTP. For instance, in the United States of America (USA) the health care system is precarious for poor people, but thanks to the work of activist organisations these people have access to special programmes for HIV/Aids infected people and some of these cover many drugs. Brazil is an admirable example in that it provides medications to thousands of persons although it is a developing country (Harrington 2000).

At this stage of the process, although there was a complete strategy to support an HIV/Aids treatment policy, Mbeki's inquiries questioning the link between HIV and Aids, and scepticism towards treatment provision interrupted the progress of the battle against the epidemic. In December 2001 a document posted in the ANC's website referred to the ongoing disputes concerning the reliability of HIV tests. According to the journalist Jaspreet Kindra, such a document was merely the background of the support given by the ANC National Executive Committee (NEC) to Mbeki and the Minister of Health's inquiries about the effectiveness of ARVs (*Mail & Guardian*, 7–19 December 2001). A statement produced by the NEC mentioned the incipient stage of the treatment provision, pointing out the still unknown long-term effects of ARV drugs, and the shortage of infrastructure and resources to administer them.

Nevertheless, despite the government's reasons for not introducing MTCTP a Cabinet Statement was announced after the High Court favoured the applicants' petition. However, the process of contestation between activists and the government persisted because, despite the High Court's judgment, the government's response to an HIV policy has been slow and inefficient. Although in April 2002 a Cabinet Statement was formulated, the government still doubted the reliability of ARVs and it questioned that HIV/Aids is the single biggest cause of death in South Africa (Schneider 20002; Ngwena & Rensburg 2002). The Cabinet announcement established that:

> […] with regard to cases of sexual assault, government will endeavour to provide a package of care for victims, including counselling, testing for HIV, pregnancy and STIs […] On anti-retroviral treatments in general, Cabinet noted that they could help improve the conditions of PWAs administered at certain stages in the progression of the condition, in accordance with the international standard. However, because these drugs are too costly for universal access and, because they can cause harm if incorrectly used and if the health systems are inadequate, government will continue to work for the lowering cost of drugs, and intensify the campaign to ensure that patients observe treatment advice given to them by doctors. (*Cabinet Statement* 17 April 2002)

Although the statement promised an improvement in the provision of ARVs, its outcome was the partial roll-out of MTCTP, which was restricted to pilot sites in some public hospitals. The programme had various degrees of commitment and success depending on the provinces. For instance, according to Nattrass the few provinces that succeeded were Western Cape, Gauteng and KwaZulu-Natal because they did not confine Nevirapine (ARV), to pilot sites, as the policy suggested (2004:48). Furthermore, the state only provided ARVs for infected mothers but not for every HIV/Aids infected person.

At this stage the TAC and COSATU (Congress of South African Trade Unions), supported by the National Economic Development and Labour Council (NEDLAC), were actively involved on the creation of a treatment plan to complete the HIV/Aids strategic plan by 2000. In June 2002 NGOs, religious groupings, trade unions and the scientific sector, met at an Aids conference in Durban to discuss the implementations of Nevirapine and provision of ARVs in the public health sector (*National HIV/Aids Treatment Congress* 2002).

Consequently, In October 2002 the Cabinet announced its plan to implement the MTCTP in all the provinces as the Constitutional Court demanded. Regarding the roll-out plan, the Statement said that it was still on track, defying challenges such as training, budget and health facilities (*Cabinet Statement* 9 October 2002).

Nevertheless, despite the statement, the delay to the MTCTP continued. Neither the provision of Nevirapine nor the roll-out plan have been completely effective. The debate between government and activists continues, discussing the feasibility, affordability and implementation of a national treatment plan (Nattrass 2004:55).

In this respect, it is worth mentioning the government's responses to the HIV treatment issue in 2003. In February Health Minister Tshabalala-Msimang refused to sign the agreement on Aids treatment negotiated by NEDLAC in 2002. The explanation for this position was that "the government was waiting for the results of the task team into the costs of procuring and dispensing anti-retrovirals before making a decision about how to proceed on the issue" (Nattrass 2004:55).

The most important protest against the government's response was led by the TAC in March 2003. On this occasion, more than 20 000 citizens expressed their discontent and indignation over the government's lack of compromise regarding the provision of ARVs and the policy process implementation. The protest was also supported by the international community, which has provided the civil movements in South Africa with high credibility (*Dying for treatment: TAC briefing document on the civil disobedience campaign*).

Dying for treatment: TAC civil disobedience campaign, was rooted in the above treatment plan that TAC and COSATU, supported by NEDLAC, discussed in June 2002. These organisations expected the government to sign a formal agreement in December 2002 supporting the document. Nevertheless, the government defied this agreement discrediting the process:

> The government has said that we must wait until April or May, when the report of an investigation into the costs of an ARV programme is complete, before a decision is made. TAC disagrees with this. TAC says that a policy decision and commitment must to be made now (*Dying for treatment: document on the civil disobedience campaign* 2003).

The TAC suspended its disobedience campaign in April, deciding to give the government the benefit of the doubt concerning NEDLAC's agreement on a treatment programme (*Mail & Guardian* 20 April–7 May 2003).

The direct consequence of the public pressure was the Cabinet Statement August 2003 in support of anti-retroviral treatment. The Cabinet, however, was very cautious because rather than agreeing to the immediate provision of ARVs in all hospitals, it asked the Department of Health to develop an operational plan (Nattrass 2004:55). The government's justification for this new delay was based on its known discourse of unaffordability and lack of infrastructure. For instance, the Minister of Finance said in March 2003 that the designated expenditures on Aids should be on

prevention rather than treatment. For Nattrass ARV treatment was not a priority in the mind of the Minister of Finance (2004:57). Since the position of the government about the costs of a treatment programme is explicit, Nattrass refers to a moral economy of 'triage' in South Africa.

The concept of triage became very popular during the Crimean War, when there was a huge imbalance between the numbers of people needing medical attention and the scarcity of resources for providing it. Then, the triage consisted of making an optimal use of the available resources. During the war resources were allocated first to those with good prospects of recovery if they obtained treatment, and last to the heavily wounded (2004:57). Nattrass argues that the same principle has been applied to the Aids epidemic in South Africa. For her, affirmations such as those by the Minister of Finance clearly show that the first target of the government is non-infected people, since the Aids-infected cannot be cured. This position, however, does not consider that treatment programmes can also be preventive – for example MTCTP. Furthermore, Nattrass' economic analysis shows that the costs of treatment programmes in the longer term are lower than the costs of Aids deaths without treatment.

As the debate around treatment provision and its affordability has not concluded, there is not a known final step to the policy process. It is important to underline that the success of the policy implementation is partial, since the effective provision of ARVs varies according to province. For instance, according to the *Mail and Guardian*'s investigations into the matter, access to ARVs is very uneven in the country and the main delay is caused by the accreditation of sites by the National Health Department. Accreditation requires the National Health Department's approval of sites for ARV roll-out. Nevertheless, the provinces experience lack of training of health workers, insufficient human resources, and the need for specialised equipment, among others, which produces delays in the procurement of the drugs. Concomitantly, Aids activists argue that "the process for the provision of ARVs should have begun last year while the national plan was being drafted. The result is that even sites ready to implement the plan have to wait until the overall tender process is complete" (*Mail and Guardian* 27 February 2004). To sum up, the accreditation process is interfering with the progress of the provision of ARVs in the provinces, although some of them have overcome the difficulties. The Western Cape, for instance, already has 13 sites providing treatment and Gauteng has 23 service points. Nevertheless, the TAC says: 'the delay in ARV roll-out is killing us'.

This section draws a chronology of the facts throughout the policy process from 1994 to 2003, which is useful in understanding its conjunctures and the government's responses to the epidemic. I add to this chronology some unofficial responses to the epidemic since 1994, and also some of the TAC's most important interventions.

TABLE 3

Chronology of fight against HIV/Aids since 1994

1992	The NACOSA Aids plan was reviewed
1994	The 'Soul City Institute for Health and Development' was formed
1996	Sarafina II musical criticised
1996	International conference for people living with Aids
1997	Virodene announced
1997	Aids made notifiable by the Minister of Health
1998	**ARV drugs considered toxic**
1998	TAC foundation
1999	Launch of 'Lovelife' educational campaign
2000	Launch of National Aids Council by the government, excluding activists and scientists
2000	Five-years strategic plan for South Africa
2001	The Aids communication team (ACT) was formed by the government
2001	**Cause of Aids questioned by the presidency: Durban declaration by scientists**
2001	Use of ARVs in the public sector rejected by Ministry of Health
2001	Delays in implementation of MTCT by the Ministry of Health
2001	**Mortality statistics questioned by presidency**
2002	HIV treatment Cabinet Statement 17 April 2002
2003	'The Stand Up for our Lives' TAC march to Parliament, 14 February 2003
2003	TAC Civil Disobedience Campaign 26 March 2003
2003	Statement on Special Cabinet Meeting: enhanced programme against HIV and Aids, 8 August 2003
2003	Operational plan for comprehensive HIV and Aids care and treatment for South Africa, 19 November 2003

Source: Schneider 2002; my own compilation

Table 3 underlines three specific events which show that Mbeki's position on Aids has influenced the course of the policy process. These events are his belief in the ARV drugs' toxicity in 1998, the questioning of the cause of Aids in 2000 and the mortality statistics in 2001. The reasons that Mbeki's position on Aids has affected the policy process are summarised in the next two arguments:

- By saying that ARVs are toxic Mbeki and the Health Minister assumed the responsibility of looking for the consequences of their toxicity among HIV-infected people. When

searching for these effects, the policy implementation was delayed since 2000 until the High Court ordered the provision of treatment only in pilot sites in 2001.

- In questioning the cause of Aids, Mbeki pointed out the influence of socio-economic factors in the spread of the epidemic. In this sense, he and the Health Minister delayed the provision of ARVs, arguing that if poverty was the main problem, ARV medication was not the solution. Following the same line of reasoning, when Mbeki questioned the mortality statistics, he asked for in-depth research on the causes of death in South Africa. This questioning minimised the magnitude of the epidemic and hence diminished the importance of HIV treatment.

The specific turns of the HIV treatment policy process concerning Mbeki's denialist arguments will be the subject of chapter 3, which will deal with the scientific and ideological side of the process rather than with the political debate described and explained throughout this chapter.

In this arrangement of ideas, chapter 2 will present the theoretical framework for understanding Mbeki's statements on Aids, and his perceptions of past images of Africa in the present. The point of departure will be Foucault's theory of power and knowledge, which is crucial to understanding the functioning of power in society and its relationship with systems of knowledge. The chapter will show how Said and Escobar have applied Foucault's theory to their own explanations of the discourse of Orientalism and development. I will articulate Foucault's theoretical guidelines, Said's orientalism, and Escobar's views on development in order to understand Mbeki's line of reasoning in talking about Aids.

CHAPTER 2
POWER AND KNOWLEDGE IN MBEKI'S DISCOURSE ON AIDS

2.1 Introduction to a discussion about power and knowledge

Mbeki's questioning of the conventional scientific view on Aids has significantly affected the development of the HIV policy process, as chapter 1 pointed out. Using the lectures on Power and knowledge by Michel Foucault (1980), the work on Culture and imperialism by Edward Said (1993), and the criticism of development in The Making and unmaking of the Third World by Arturo Escobar (1995), the chapter will provide the basis to understanding Mbeki's arguments about science and disease and their connection with the African Renaissance. It is important to underline, however, that as a theoretical framework this chapter does not discus in detail Mbeki's arguments in connection with the theory presented. Instead, this is a guideline for the reader to grasp this research's line of argument.

In the first place, the chapter presents Foucault's views, since they provide the conceptual framework of power and knowledge that I will use to analyse the HIV/Aids treatment policy process as a situation in which power and knowledge interact. It will then introduce Said's analysis of the colonial experience and its consequences in post-colonial times. This explanation is important for understanding Mbeki's arguments on race and disease, as this work links them to his dissident position on Aids.

Since Foucault's and Said's analyses point out the role of power in determining relationships between subjects, they focus on situations of domination (Said more drastically than Foucault) rather than on the possibilities of resistance that these produce. This is why the chapter will explore the concept of alternative modernities developed by social theorists such as Dilip Parameshwar, Charles Taylor and Nestor Garcia Canclini, as an alternative viewpoint to understanding post-colonial cultural forms in terms of resistance and contestation. Lastly, Escobar's criticism of development is presented, since it links Foucault and Said's views to the possibilities to contest situations and discourses resulting from relationships between power and knowledge. Furthermore, Escobar's analysis is useful for understanding the role of development in Mbeki's Renaissance, as chapter 3 will explain in detail.

The chapter's point of departure is the interaction between power and knowledge under certain historical circumstances. Foucault's genealogy of power, understood as a history of the present,

reveals a relationship between power and knowledge that presents discourses as sites of struggle where knowledge is produced (Delanty 2003:125). Since power is "neither given, nor exchanged, nor recovered, but rather exercised and it only exists in action", Foucault asks about the mechanisms and instruments that make its exercise possible (Foucault 1980:89). In doing so, he focuses on the functioning of institutions in a society that is constituted by relationships of power that can only be consolidated and complemented by a disciplinary discourse.

Following this line of analysis, but paying more attention to relations of domination, Said places power and knowledge in the terrain of the colonial conquest and resistance to colonialism. His work takes into account the mechanisms and instruments that facilitated the authority of the coloniser over the colonised, and it examines how these instruments produced an apparatus of knowledge to represent the reality of colonised countries.

The third example of interaction between power and knowledge criticises and questions the discourse of development that has been epistemologically constructed by Western principles. This analysis, which is presented by Escobar, exhibits the relationship between power and knowledge in explaining how development, as a dominant discourse, has intervened in the social construction of the local reality of regions such as Latin America, Africa and Asia.

This chapter will show how the analyses introduced above relate to each other as follows. The point of departure for understanding Foucault's views on power is his historical review of the transformation of sovereignty into an order of right. The latter produced what Foucault refers to as disciplinary power, that is, a power by which the knowledge is systematised through the exercise of disciplinary mechanisms. This kind of power produced the development of techniques that were applied in order to control individuals. These made possible the exclusion of the abnormal and the coercion of human sexuality, among others.

The disciplinary power also became conspicuous in the nineteenth century with the emergence of classificatory disciplines such as biology, entomology and anthropology that systematised knowledges according to categories. Foucault observes that this power is especially concerned about who is speaking and in whose hands lies the authority to enunciate a statement. However, Foucault goes beyond these questions by asking how the subject who speaks exercises authority, this is, what are the mechanisms of power that the subject uses to speak with authority in the name of truth, science, or a certain kind of knowledge?

According to this line of thought, I argue that Foucault's point is related to Mbeki's position on Aids as Mbeki asks in whose hands the power to talk about Aids lies, and who has the authority to talk about such a subject. Nevertheless, unlike Foucault, he does not ask how the mechanisms and instruments of power are exercised to produce knowledge about the HIV/Aids epidemic.

In the second place, Said (1978) and Escobar (1995) complement Foucault's perspective, as they observe how two different systems of knowledge, colonialism and development, which accompanied the development of the disciplinary power, represented the reality of a subject that was in a subordinate position to those who had the authority to speak. According to this schema, the reality of the colonised is dominated and even taken over by the coloniser. In line with these analyses, I stress Mbeki's determination to break away with the historic position of subordination experienced by the African continent. In this sense, Mbeki focuses on the authority of the continent to decide its own future.

2.2. Apparatuses of knowledge and systems of representation

In his lectures at the College de France (1975–76), Foucault underlines some "precautions" in studying power. The most important of them is that power is not a phenomenon of mass domination, but something that circulates and functions only when it is part of a chain (1976; Foucault 2003:29). Since power circulates in society, nobody possesses it and therefore it must be analysed, not from the subject's perspective, but according to its concrete exercise. It is very important to understand, however, that Foucault's explanation of power does not focus on the individual's actions, or on social structures, though it is closer to the latter (Foucault 2003; Delanty, in Elliot and Ray 2003:124).

His interest concerns the mechanisms of power and subjugation produced by discourses at a certain historical moment. In this sense, the ideal place to study power is the field of practice, that is, the field of application where power produces its real effects over the subjects (Foucault 1980:97).

In this context, the study of the techniques and instruments of disciplinary power must be done in this field of practice where relations of subjugation manufacture subjects. These techniques, such as the exclusion of the mad, must be analysed as historical products that, once exercised and disciplinarised, produce apparatuses of knowledge. Stated differently, for Foucault the disciplinary power engenders apparatuses of knowledge, which is the most obvious relation between power and knowledge.

Taking into account Foucault's considerations about disciplinary power but focusing on the phenomenon of domination, Said deals with the political consequences of the relationship between colonisers and colonised. Simultaneously, he focuses on the emergence of a dominant apparatus of knowledge that resulted from the systematic knowledge that disciplines such as anthropology and history had about the colonised and the colonial experience. In other words, following Foucault, Said explains that the discourse of orientalism created the reality of the colonised. This point is very clear in *The archaeology of knowledge,* where Foucault defines discourse as a group of statements that are continuous in time and space according to certain rules that define the ordering of objects:

> Words and things is the entirely serious title of a problem […] the task consists of not treating discourses as groups of signs but as practices that systematically form the objects of which they speak. (1972:49)

Considering that 'discourses systematically form the objects of which they speak' regimes of representation form the reality of countries and peoples. This point is very important in grasping Mbeki's understanding of the past and its consequences in the present situation of the African continent, as chapter 3 will explain and analyse.

Said illustrates the mechanisms that an apparatus of knowledge that originated in the West used to represent the reality of colonised regions such as Africa, Latin America and Asia. In this respect, understanding of the process of systematisation of knowledge by which history, anthropology and other sciences were produced is crucial, since this operation produced orientalism, which is:

> The systematic discipline by which the European culture was able to manage, and even produce, the Orient politically, sociologically, militarily, ideologically, scientifically and imaginatively, during the post-enlightenment period (Said 1978:3).

According to Said, since the second half of the eighteenth century systematic knowledge about the local reality of the colonies has been increasing. This knowledge was reinforced by the colonial encounter, and exploited by developing sciences such as ethnology, history and philology (1978:39). The emergence of this disciplinary power, as Foucault denominates it, created a language of hierarchical classification that underlined concepts such as inferior, subject races, subordinate peoples and authority. In this context the discourse of orientalism emerges, and the Orient that appears with it is "a system of representations framed by a whole set of forces that

brought the Orient into Western learning, Western consciousness and, later, Western empire" (Said 1978:203).

In this context, Said writes in *Culture and imperialism* that "the past's bearing upon cultural attitudes in the present is more important than the past itself" (1993:17). For Said, the division between coloniser and colonised re-emerges in the present through racist attitudes and rhetorical and ideological struggles. In this sense, Mbeki shares with Said an awareness of the influence of the colonial past in defining cultural boundaries and cultural forms in the present. Nevertheless, Said goes beyond Mbeki's point, since he asks for possibilities to rethink the imperial experience, in order to change the understanding of the past and the present and attitudes towards the future (1993:17).

Said argues that the colonial phenomenon that created anti-colonial resistance in the past developed into a conflict that continues in the present. This occurs because the knowledge accumulated by imperialist countries has been historically reproduced through dominant discourses such as orientalism. Nevertheless, I observe that the focus of the debate on Aids must not be on whether Western representations of Africa continue in the present, but on the plane of policy formulation and implementation.

What is central to Said's analysis is that despite the dramatic effects of the colonial discourse, the reading of such a phenomenon in the present must get beyond a simple opposition between apparatuses of knowledge. Thus, the language of binarisms and polarities that the colonial discourse promoted is not appropriate for understanding a hybrid reality, that is, an overlapped reality where traditional and modern forms of knowledge coexist. In Said's words: "Cultural forms are hybrid, mixed, impure and the time has come in cultural analysis to reconnect their analysis with their actuality" (1993:15). In this sense, Said and Escobar stress the importance of understanding how new cultural forms emerge in local systems of knowledge.

In essence, this chapter has explained, following Foucault, that power circulates in society through mechanisms and institutions that control and disciplinarise subjects. The exercise of these mechanisms of power produces apparatuses of knowledge that struggle with one another in an unending movement. Based on Foucault's brilliant explanation, but distancing himself from it, Said observes that this continuous disciplinarisation produces a struggle between apparatuses of knowledge, becoming a phenomenon of domination. This is why apparatuses such as imperialism and orientalism present a schema of dominator versus dominated and/or coloniser versus

colonised. For Said, the knowledge that the dominator has about the dominated gives him authority to represent the reality of the latter.

Said and Foucault share a view of history, since for them the past must be analysed in the field of practice in the present. That is, although the consequences of the past in the present are crucial in modifying attitudes towards the future, it is fundamental to understand first why and how a particular effect is produced.

Said explains that the primary effect of the imperial, and hence colonial, exercise of power in the past was the artificial division between East and West. This division is artificial because the reality of the East is the result of dynamics of representation of a pre-existent reality that was colonised, devastated and, according to Said (1978), even taken over. In colonial times theses of Oriental inequality with the West were associated with ideas of racial inequality. As a consequence of this representation, the political debate around imperialism and anti-imperialism was set upon the basis of a binary 'typology of advanced and backward races'. The Oriental thus represented the abnormal and excluded individual, according to the Western typology. In this sense, Orientals were seen as problems to be solved through the colonial power and so on.

2.3 Anti-colonial resistance and alternative modernities

This section presents that situations of domination can be contested in varied ways. For Said, the authority of the coloniser over the colonised produced the historical necessity of creating anti-colonial resistance (1993:39). He observes, however, that colonial situations present a dichotomy as, on the one hand, cultures might come back to their traditional roots and traditions to combat and resist the West. On the other hand, modernisation appears to be the best way to compete with it (1993:34). Nonetheless, although Said recognises the existence of struggles for dominance among nationalisms, ethnic groups, regions and cultural entities, his main concern is about the tension that exists between dominants and dominators. This chapter presents a third solution to relationships between cultures and apparatuses of knowledge, which is provided by the concept of alternative modernities.

Dilip Parameshwar explains that there are many possible paths to modernity. That is, cultures are not compelled to follow the teleological movement of Western modernity, but each can find its 'own unique way of adaptation' to Western institutional forms such as the market economy

(*Public Culture,* 14 (1) 2002). In this context, the notion of alternative modernities emerges as a counter-response to the binary model of the modern versus the primitive, and dominator versus dominated, that anti-colonial movements prolong. The results, according to Saurabh Dube, are syncretic blends of Western and non-metropolitan cultures, such as the 'Zapatistas' in Mexico. This movement, combines ideas from a revolutionary nationalism with the terms of a colonial modernity. In this respect, the next chapter asks if in the context of Aids, Mbeki proposes an alternative solution to the conventional scientific view that he criticises.

Nestor Garcia Canclini stresses that ethnic cultures and new technologies, and artisanal and industrial forms of production, coexist in the present, constituting a hybrid reality, as Said points out. In other words, the concept of alternative modernities incorporates questions of difference to the relationship between power and knowledge. This new element of difference and alterity has been explored by social movements in the present. For instance, Escobar explains that in contestation against the dynamics of representation of development, some cultural movements emerged in the 1980s in the 'Third World'. Nevertheless, whether these manifestations succeed or not is not concern of this study, but the exercise of its techniques and mechanisms to reformulate concepts and deconstruct realities. The next chapter will deal with this issue in more detail concerning Mbeki's position on Aids throughout the policy process, and the contestation it has produced among journalists, politicians and scientists.

Said's posture about the political struggles within and between nations and peoples in the present is also very important to understanding Mbeki's arguments on Aids. For Said: "The struggle is complex and interesting because it is not only about soldiers and cannon but also about ideas, about forms, about images and imaginings" (1993:7). Said's observation is fundamental, as Mbeki's struggle in the present is about images and ideas that people such as scientists and journalists have of Aids in Africa.

Summarising, by integrating the concept of alternative modernities to Foucault's scheme of power and knowledge and Said's model of domination, a new perspective emerges for analysing Mbeki's views.

The next section will complete the points explained throughout the chapter by integrating Escobar's deconstruction of the development discourse with Mbeki's determination to decide on the future of the African continent.

2.3 Power, knowledge and resistance

Coming back to Foucault's definition of discourse, Escobar conceives of development as "the process through which social reality comes into being, that is, the articulation of power and knowledge and power of the visible and the expressible" (1995:39). This point is also linked to Said's views of discourses as regimes of representations.

In *The invention of the Third World,* Escobar analyses critically the way in which development has produced permissible modes of being and thinking, while disqualifying and making others impossible (Escobar 1995:5). In line with Foucault and Said, his point of departure for studying development is to ask how it became a space for the systematic creation of concepts, theories and practices. In answering this question, he provides a review of the principles of disciplinarisation of knowledge explained above.

Escobar explains that the idea of material and economic progress became popular at the "level of the circles of power" in the early post-World War II period, in the 1940s and 1950s. At this time, in America and Europe, there was increasing interest in issues such as economic growth and its benefits. Under these historical circumstances the discourse of development emerged, constituting the reality of the Third World. This discourse labelled the reality of regions such as Africa, Asia and Latin America as poor and underdeveloped.

In line with Said's views of orientalism, Escobar observes that the Western system of knowledge has diminished the economic, cultural and political capital of non-Western societies. In this sense, the discourse of development created the necessity of developing techniques and mechanisms to combat Asia, Africa and Latin America shared backwardness. This characteristic was historically assumed by the West and apparatuses such as colonialism and imperialism. In this context, the discourse of development turned into a teleology, by which underdeveloped countries must follow the path and the stages of modernisation and development traced by the West.

Among the techniques that development promoted, technology, industrialisation, agricultural development, commerce and trade were the most important. Nevertheless, development was not the consequence of a combination of these factors, or the product of ideas of modernisation and international institutions. Rather, development was:

> […] the result of the establishment of a set of relations among these elements, institutions, and practices and of the systematization of these relations to form a whole. The development discourse was constituted not by the array of possible objects under its domain but by the way in which, thanks to this set of relations, it was able to form systematically the objects of which it spoke, to group them and arrange them in certain ways, and to give them a unity of their own. (1995:40)

Once the elements of the discourse were systematised and normalised by the set of relations that Escobar mentions, a discursive practice emerged. Consequently the discursive practice defined the rules of the game, that is, who has the authority to speak, which in terms of this analysis means who has the knowledge to speak from a position of authority on the subject. In the case of development, this knowledge and authority are capitalised by the interventions of expert systems such as the World Bank.

In the context of Mbeki's 'politics of truth', paraphrasing Escobar, the question about who has the authority to speak is reconsidered in a very particular way. First of all, Mbeki emphasises his role as an African leader who is firmly determined to change the continent's image of backwardness and underdevelopment. On the other hand, this autonomy is constrained by the limits and conditions of the discourse of development that Mbeki supports. This rhetorical contradiction, however, is common to countries with colonial experiences, since they debate the dominant ideology that oppressed them and, simultaneously, enjoy the benefits of liberal ideas and technological goods (Said 1993:18).

According to this line of thought, Mbeki's determination to decide the future of Africa is constrained by the confines of the development discourse. Escobar explains that development emerged from a discursive practice that systematically produced interrelated theories, concepts and strategies (1995:42). The discourse allowed new technologies and modes of operation, although always within its confines. That is, the reproduction of strategies and sub-strategies inevitably obeyed the same principle of development.

The relationship between Foucault's arguments and Said's is very clear in Escobar's explanation. Discourses are historically produced, therefore development is not simply 'there', paraphrasing Said, but it is the product of mechanisms of power that produce it and entrench it. As the chapter has emphasised, having clarity about this point is fundamental to challenging, contesting and

resisting regimes of representation. In this respect, though, Escobar distances himself from Foucault by arguing that the 'politics of truth' of development, that is, the way by which its knowledge was recognised as being legitimate, must not be replaced by a substitute regime of representation. Escobar explains that regimes of this sort, such as colonialism and more recently development, are accompanied by a regime of violence. He refers to the violence that produces the suppression of local cultures and identities as the result of relationships of domination. If the discourse is replaced by another regime of representation there are not possibilities to change and deconstruction. For Escobar, initiatives such as criticism and deconstruction of the discourse must be adopted to formulate alternatives to development.

Nevertheless, this process of contestation is difficult, particularly because the solution seems to be constrained by the limits of the discursive field, that is to the same categories it uses (e.g. underdevelopment, extreme poverty, economic growth, specialisation and expertise). I observe that Mbeki's stance on development faces the consequences of this contradiction, since he is trying to control Africa's opening up to the world by establishing his own 'politics of truth'. Although there are solutions such as that proposed by the concept of alternative modernities, Mbeki exercises the politics of leadership and 'redemptionism', which is particularly concerned with the question of who has the authority to speak about science, politics, economics or whatever the field is. This point will be developed in chapter 3, which is concerned with Mbeki's particular exercise of this kind of politics.

Summing up, the point that the theoretical framework highlights is the resistance that every situation of domination produces. According to Escobar, opposition and contestation to development and regimes of representation can emerge from the core of a hybrid reality, that is, one that combines local and traditional elements with modern techniques and expertise (1995:216). In other words, this new reality is constituted by colonial and alternative modernities.

From a different viewpoint, Said focuses on modifying understanding of the effects of the past in the present. This contestation is fundamentally political and involves the revision of the polarities of East versus West. This attempt, in Escobar words, is "a political question that entails the collective practice of social actors and the restructuring of existing political economies of truth" (1995:216). In this sense, since there is a chance to contest development, the emergence of new forms of power and knowledge is necessary. The struggle of antidevelopment movements can contribute to such a transformation,

although this also depends on new historical transformations such as the influence of high technology over the social division of labour.

This chapter presented three different perspectives of the interaction between power and knowledge, and how these can be applied to Mbeki's views on Aids, African identity and development. The main observation after examining Foucault's, Said's and Escobar's main concepts is that it is possible to modify situations of domination, although as the following chapter will explain, Mbeki is does not clearly presents alternatives to development as a dominant category of knowledge.

In essence, Foucault provides the theoretical elements for analysing situations of power embedded in historical circumstances. His view of mechanisms of power as causes and effects of knowledge is the basis for understanding the phenomenon of domination that the colonial model institutionalised in the past, as Said observes. This point is the basis for approaching Mbeki's views on Aids and development, since his statements pose questions such as who has the authority to talk about Aids in Africa. Furthermore, Mbeki constantly refers to the legacy of colonialism and apartheid, in reformulating the concept of African identity in a postcolonial context.

Since the schema of dominator/dominated has prevailed from colonial times, Said and Escobar call for a rupture with the model in order to modify attitudes in the future. For Said, this is possible through the understanding of a hybrid reality and new cultural forms. Escobar proposes a radical measure to challenge the paradigms of development, since for him the rules can only be modified through a reinterpretation of modernity. Although Latin America is his case study, his analysis can be applied to an African reality that has been represented and imagined as pre-modern, modern and even anti-modern. Thus, the solution that the concept of alternative modernities grasps, and that Escobar points out, is a dialogue between traditional forms and new technologies. Such dialectic breaks up with the binarisms of the relationship of dominator and dominated, and creates a new space of formulation that is still incipient in some countries. The new space is a hybrid and constitutes a challenge and a combination between what is modern and what is not. The next chapter will come back to this matter in looking at three different models of alternative modernities in Africa that emerged as a response to HIV/Aids. These cases will be compared to Mbeki's response to the epidemic in South Africa.

CHAPTER 3
ANALYTICAL VIEW OF MBEKI'S POSITION ON AIDS

Chapter 1 explained the conjunctures about the HIV treatment policy process and its implementation thereof. It also described the debate around the toxicity of ARVs, emphasising the questioning by Mbeki and Health Minister Manto Tshabalala Msimang of the cause of Aids throughout the process. Taking this as the point of departure, this chapter will analyse Mbeki's position on Aids since 2000. The analysis will use the observations about power and knowledge as tools to understand Mbeki's statements.

The first part of the chapter descriptively presents Mbeki's statements that point out his questioning of HIV being the single cause of Aids and his scepticism about the reliability of ARVs, line of argument that I label counter-scientific. This part will also include the criticisms that people in the public domain have made of his approach. Based on Mbeki's statements on science and the public debate that they raised, the second part will critically analyse Mbeki's position on HIV/Aids and address the questions that his statements raise regarding issues such as race and identity. Lastly, Mbeki's views on science and disease will be connected with the core points of the African Renaissance which are: the relationship between Africa and the West, African identity, and the continent's development.

3.1 Mbeki's counter-scientific line of reasoning and his links with Aids dissidence

The dissident premise is that HIV does not cause Aids. For the dissidents, HIV is a harmless retrovirus that plays no role in the spread of the syndrome of immune deficiency that conventional scientists call Aids. The dissident position, led by American scientist Peter Duesberg, argues that the body's disability to prevent infections is produced by pathogenic factors such as the use of drugs, promiscuous homosexual activity, blood transfusions, parasitic infections and malnutrition. Denialists also say that Aids treatments promote diseases, since they combat a virus that does not exist. In other words, to say that HIV does not cause Aids is the equivalent of saying that Aids does not exist, but a group of diseases do exist that are the products of poverty and lifestyle choices and are not in any way the consequence of HIV (Nattrass 2004:49).

This theory, however, has been discredited by orthodox scientists who have probed the definite connection between HIV and Aids, as well as the effectiveness of ARVs in preventing MTCT of the virus. Nevertheless, from 2000 to 2004 Mbeki and the Minister of Health, Tshabalala-Msimang, argued that ARVs were toxic and unreliable in order to justify the delay in the provision of treatment. During this period, Mbeki showed his increasing interest in and sympathy for dissident arguments as he had contact with these ideas through information on the Internet Because of his interest in an alternative view of Aids, dissidents were included in the Advisory Panel on Aids, as chapter 1 stated.

3.1.1. Mbeki's questioning of 'scientific truths'

This section stresses that although Mbeki's position on Aids has been related to some dissident arguments, he has not agreed explicitly with the core premise, which states that HIV does not produce Aids. In fact, the Cabinet Statement of April 2002 states clearly the causal relationship between these two. Mbeki's messages, however, have been ambiguous, as the journalist Drew Forrest said:

> He has never unequivocally conceded that viral infection is a necessary condition for the disease. He has never clearly stated that drugs can improve the life expectancy and quality of life of infected people (*Mail and Guardian,* 26 October 2001). Mbeki.

Taking this consideration into account, the section summarises two general points that relate Mbeki's assertions to those of the dissidents. These concern his scepticism about absolute truths about Aids and the reliability of ARVs.

Supporters of Aids dissidence, aware of the refutable character of scientific theories, question the nature of Aids, though they do not provide a viable scientific alternative to the orthodox view of the epidemic. Any reference to conventional science throughout this work refers to "research firmly based upon one or more past scientific achievements that some particular scientific community acknowledges for a time as supplying the foundation for its further practice" (Kuhn 1970:10).

Agreeing to some extent with dissidents, Mbeki expressed his counter-scientific inquiries about the origin and nature of the epidemic in his speech at the first meeting of the Presidential Advisory Panel on Aids:

> There is an approach which asks why this President of South Africa is trying to give legitimacy to discredited scientists, because, after all, all the questions of science concerning this matter had been resolved by the year 1984. I don't know of any science that gets resolved in that manner with a cut-off year beyond which science does not develop any further. *It sounds like a biblical absolute truth and I do not imagine that science consists of biblical absolute truths* [my emphasis] (Mbeki 2000).

Because science does not consist of 'biblical absolute truths', scientific progress, for Mbeki, requires openness to alternative views. He emphasises the importance of considering heterodox scientific views in order to understand the nature of Aids. This search for a different scientific explanation was first made known in 2000. According to Mbeki's spokesperson, Parks Mankahlana, who reported this to the *Village Voice* newspaper, Mbeki asked the Minister of Health to assemble an international panel to look into everything about Aids concerning ARV treatment: "whether there is such a thing called Aids, what it is, and whether HIV causes Aids" (*Village Voice,* 21 March 2000).

Mbeki's counter-scientific line of reasoning coincides with dissidents' arguments in their shared scepticism towards a unique scientific truth. For him, scientific consensus about the origin of Aids does not make 'HIV causes Aids' an accurate statement. For instance, in his address at the first meeting of the Advisory Panel, he said:

> "It seems to be implied that one of the important measures to judge whether a scientific view is correct is to count numbers: how many scientists are on this side of the issue and how many on the other" (Mbeki 2000).

Mbeki's scepticism about a conventional scientific view on HIV/Aids increased at this stage. In April 2000, Joan Shenton, who has produced several documentaries on health issues, asked Mbeki for his support of non-conventional views of Aids. On this occasion Mbeki referred to the need to subject an orthodox notion of science to enquiry, saying: "Why don't we bring all points of view? Sit around a table and discuss this evidence and produce evidence as it may be, and let's see what the outcome is." In referring to 'all points of view' Mbeki included the arguments of dissidents and orthodox scientific statements, that is, he gave both positions the same status of credibility, which provoked agitation among leading virologists and intellectuals. His response to this was:

> I get the sense we've all been educated into one school of thought […] It's very worrying at this time that any point of view should be prohibited, that's banned, there are heretics that should be burned at the stake. And it's all said in the name of science and health. It can't be right (2000).

Mbeki's statement is clear in this respect: he does not agree with the narrowness of a conventional scientific view; that is, with the precepts of a 'unique school of thought' that accepts 'absolute scientific truths'. Following this line of reasoning, in his letter to world leaders in 2000 Mbeki pointed out that scientists speak in the name of Aids patterns in the West. He said: "As Africans, we have to deal with this uniquely African catastrophe", recalling that in 1984 in Europe and the USA, the groups that were at high risk of contracting HIV were homosexual and bi-sexual males, intravenous drug users and haemophiliacs. However, he explained at the first meeting of the Advisory Panel that when Aids was reported in Central Africa, none of the high-risk groups that were indicated in the West were detected as high-risk groups in Africa. On the contrary, the percentage of people who were infected with Aids in Africa was very high among heterosexual people.

In essence, regarding the differences between the patterns of spread of the epidemic in Africa and Europe and America, Mbeki underlines that scientists speak in the name of Aids patterns in the West based on their local experience of the epidemic. In response to this, Mbeki maintains that the peculiarity of the African epidemic is still an open question that must be answered by contrasting different opinions and views, including the dissident's (Mbeki 2000).

Mbeki addresses the difference between the epidemic in Africa and the West by questioning scientific truths, observing that views of the epidemic in Africa must not be constrained by statements that discredit the country, as he said in his letter to Tony Leon:

> In this regard, you might care to consider what it is that distinguishes Africa from the United States […] I imagine that all manufacturers of antiretroviral drugs pay great attention to the very false figures about the incidence of rape in our country, that are regularly peddled by those who seem so determined to project a negative image of our country. The hysterical estimates of the incidence of HIV in our country and sub-Saharan Africa made by some international organisations, coupled with the earlier wild and insulting claims about the African and Haitian origins of HIV, powerfully reinforce these dangerous and firmly entrenched prejudices. (Mbeki 2000)

On this occasion, Mbeki raised his doubts about the effectiveness of ARVs, when referred to the differences between the epidemics in Africa and the West, and the 'hysterical estimates' promoted by International Organisations. This connection was very clear in Mbeki's subsequent statements, in which he questions the link between HIV and Aids and therefore the reliability of ARV medicaments. These statements will be presented in the next section.

3.1.2 Mbeki's questioning of HIV as the cause of Aids and the reliability of ARVs

In 2000, Mbeki's counter-scientific line of reasoning pointed out new denialist arguments such as the questioning of HIV and the reliability of ARVs, which greatly affected the credibility of the policy process. At this stage the political arena became the scene of a confrontation between an orthodox scientific view, supported by the TAC, scientists, intellectuals, trade unions, business, faith and non-profit organisations, journalists and politicians, and a heterodox view, supported by President Mbeki, the Minister of Health Tshabalala-Msimang, and some scientists and intellectuals.

In the opening session at the conference on Aids in Durban 2000, Mbeki questioned HIV as the cause of Aids in presenting his view of poverty as the major cause of ill health in the world: "As I listened and heard the whole story about our own country, it seemed to me that we could not blame everything on a single virus" (2000).

This message was described as confusing by Judge Edwin Cameron. According to Nattrass, whether Mbeki was pointing to the remarkable influence of poverty on HIV transmission or actually adopting a denialist position is an open question. The confusion and uncertainty that Cameron and Nattrass point out became even more obvious after this intervention.

Linked to the questioning of HIV, the toxicity of ARVs is the second of the dissident arguments that Mbeki supported. He presented this argument in response to the criticism that Tony Leon, politician and leader of the Democratic Party (DP), made of the government's delay in the provision of ARVs. Mbeki wrote a letter pointing out that he could not defend an immutable truth about HIV/Aids because of his public responsibility as South Africa's president. In addition he affirmed: "We have no right to be proponents and blind defenders of dogma," referring directly to his responsibility regarding the provision of ARVs (*Sunday Times,* 9 July 2000).

Since the refutation of the reliability of ARVs follows Mbeki's counter-scientific line of reasoning, the problem of immutable truths emerges once again. To trust the reliability of ARVs

means, for Mbeki, to support a dogma that defends an absolute statement: 'ARVs are the solution for Aids'.

Three months later, in September 2000, Mbeki reiterated his scepticism over ARVs as the correct and only medium to combat the epidemic. He said to *Time Magazine*:

> The problem is that once you say immune deficiency is acquired from that virus (HIV) your response will be anti-retroviral drugs. But if you say the reason we are getting collapsed immune systems is a whole variety of reasons, including the poverty question, which is very critical, then you have a more comprehensive response to the health condition of a person […] But to say this is the sole cause therefore the only response to it is anti-retroviral drugs, I am saying we'll never be able to solve the Aids problem (South African Press Association, 10 September 2000).

This statement shows clearly that, for him, the explanation for the immune deficiency of the body, which is not the same as Aids, is multi-causal. That is, socio-economic factors such as poverty cause this deficiency and not necessarily HIV. Hence, his line of analysis was that if poverty is one of the causes of immune deficiency, the solution to the problem is not ARV drugs. This argument is very similar to the dissident one which maintains that poverty is the main cause of the collapse of the immune system.

The link between his declarations and dissident arguments affected the implementation of the MTCTP because instead of formulating an statement on HIV/Aids treatment provision, the government looked for the consequences of the ARVs toxicity until the High Court ordered the provision of treatment in pilot sites in 2001.

In line with the questioning of the link between HIV and Aids Mbeki questioned the reliability of the MRC mortality statistics. In 2001 Mbeki wrote a letter to Tshabalala-Msimang expressing his scepticism about the subject. The statistics showed a rise in adult mortality due to HIV, and also found that HIV/Aids was the single biggest cause of death in South Africa, accounting for 25% of all deaths in 2000 (*The Impact of the HIV/Aids Epidemic on Adult Mortality in South Africa* 2001). This data provoked misunderstandings, according to Mbeki, who said: "Neither government policy nor programmes should be informed by misperceptions, however widespread and well established they may seem to be" (*Business Day,* 10 September 2001).

In essence, Mbeki questioned the conventional scientific paradigm by arguing that poverty produces immunodeficiency, hence, the only cause of death in the country is not HIV but diseases caused by poverty. In one of his weekly letters to the ANC in 2002, he pointed out that poverty produces disease and death, and that the only health challenge for poor and black people, as 'some people impose it', is not HIV/Aids and 'complex anti-retroviral drugs', but every disease related to poverty such as tuberculosis, malaria, childhood diseases, and HIV/Aids (*ANC Today,* (2) 14 2002).

In 2003, subsequent to his questioning of the MRC mortality statistics, Mbeki denied his questioning of the link between HIV and Aids, and adopted a hermetic position concerning the HIV treatment policy debate. For instance, in July 2003, when Gavin Esler asked him about his doubts about the relationship between HIV and Aids, Mbeki's answer was: "I never raised that question. I don't know where that comes from" (*Newsnight BBC*, 2003).

His justification for such an inquiry was to say that the issue was raised in terms of a comprehensive response to Aids and not just in terms of the provision of ARVs. Concerning the latter, Mbeki said that drugs to prevent MTCT had been provided as well as drugs for people who suffered injuries at work and for victims of rape. Esler also asked if the TAC's complaints were accurate, and Mbeki answered they were completely incorrect, because the solution to controlling the epidemic did not consist merely of ARVs. However, the confirmation of the MTCTP roll-out is partially true. Although the statement was made in August 2003, according to a research conducted by the Mail and Guardian, the roll-out of the treatment is still a matter for discussion in South Africa for the reasons of affordability and health infrastructure.

The final events that complete the saga concerning Mbeki's position on HIV/Aids happened in 2003 and 2004. In September 2003 he said in New York City that he did not know anyone who had died of Aids, despite the extent of the epidemic in South Africa. In February 2004 he referred to the inaccuracy of the research into causes of mortality in South Africa, pointing out the extent of diseases such as diabetes (Interview with R Direko and J Perlman, 2004).

Commenting on Mbeki's first assertion, Mike Waters, the spokesperson of the DP, called him insensitive and unsympathetic towards all the infected people who die of Aids in the country. Patricia de Lille, leader of the Independent Democrats, said in a statement: "It is a shame to think that the country is run by a dissident" (*The Star,* 26 September 2003).

Finally, pointing out Mbeki's lack of empathy, compassion and identification with Aids-infected people, on 8 February 2004, he answered some questions about a previous speech in which he referred vaguely to the budget and allocation of resources to combat Aids. On that occasion, one of the questions that Direko and Perlman asked him was why he did not speak with compassion and identification, considering the extent of the epidemic in the country. His answer was, "I don't know what that means," and he proceeded to argue that the government has allocated resources for running local and national programmes. Furthermore, he said that he does not understand why people in general do not pay attention to the proportions of other diseases such as TB and even diabetes. He also said that there is no systematic record of mortality statistics for either the country as a whole or by province. In his own words: "We don't know how many people die of Aids in South Africa". That is, the reaffirmation of his opposition and denial of the MRC mortality statistics.

Summing up, the questioning of the causal link between HIV and Aids and the ARVs reliability, and his doubts about the MRC mortality statistics, exhibit the influence of denialist ideas on Mbeki's line of thinking. These counter-scientific arguments have caused a heated political debate in South Africa concerning the roll-out of ARVs treatment. Based on this fact, the second part of the chapter will analyse Mbeki's counter-scientific line of thinking, pointing out the contradictions of his position and the variety of issues it raises.

3.1.3 Is Mbeki's counter-scientific line of reasoning accurate?

The questions that emerge when looking at Mbeki's statements on science and disease are how accurate are his views of science and how coherent is his line of argument?

In looking at the accuracy of Mbeki's line of argument, it is necessary to clarify the dissidents' position about a conventional scientific paradigm. The questioning of absolute scientific truths can be considered as the point of departure of Mbeki's discussion of science. In this respect, he coincides with dissidents because he does not blindly accept the principles of a 'unique school of thought'.

However, although Aids dissidence means a questioning of a conventional view of Aids, it is not a successful paradigm, in the sense that these gain their status because they are more successful than their competitors in solving a few problems (Kuhn 1970:23). In this case, the conventional scientific view of Aids is the successful paradigm. This does not mean that dissident arguments are non-scientific. On the contrary, Kuhn points out that some scientific paradigms occupy a

privileged position because they solved problems that their competitors could not, which puts the other paradigms in a subordinate position.

Regarding the accuracy of Mbeki's views on science and disease, the previous observation is crucial since Mbeki focuses on consensus in science as the matter of discussion, but he does not contrast and compare systematically the conventional scientific method with that of the dissidents.

For instance, in his address at the first meeting of the Advisory Panel (2000), he criticises the importance of 'counting' how many scientists agree with one position or the other. In this respect, Kuhn says that the accuracy of a scientific statement does not depend on consensus but on its conceptual, theoretical, instrumental and methodological efficacy (1970:42). In this sense, although Mbeki is right in observing that consensus does not make a scientific statement successful, he is not completely accurate since dissidence is a subordinate paradigm and hence its methodological efficacy cannot be easily probed. Stated differently, Mbeki does not develop his criticism of consensus in science, and seems to overlook the fact that the scientific efficacy of denialist arguments is unreliable.

Mbeki's questioning of the conventional scientific view of Aids continued in 2000 until 2004 as well as the scientific inaccuracies of his line of reasoning. The arguments that he presented in order to justify the delay in the provision of ARVs, contradict the premise that science exists because there is commitment to a scientific paradigm. For instance, in his letter to Tony Leon he wrote "We have no right to be proponents and blind defenders of dogma", and in 2001 when he was asked to take a public HIV test, he said: "I go and do a test – I am confirming a particular paradigm"(*The Associated Press,* 24 April 2001).). However, by refusing to take the test, he is supporting a paradigm that differs from the conventional one. Furthermore, these statements overlook that:

> without commitment to a paradigm, there could not be normal science. Furthermore, that commitment must extend to areas and to degrees of precision for which there is no full precedent. If it did not, the paradigm could provide no puzzles that had not already been solved (Kuhn 1970:100).

Some important questions emerge from Mbeki's refusal to openly support a particular scientific paradigm. In the first place, if the conventional scientific view of Aids must be questioned in order to understand the nature of the disease, why does Mbeki not use scientific rigour to defend

statements such as those questioning the cause of Aids and the reliability of ARVs? Second, in repeated occasions he has argued that the epidemic must be analysed as a scientific matter:

> Let's stop politicising this question, let's deal with the science of it […] We have to look at all these [Aids] matters, not as a matter of a religious belief, as matters about which you campaign in the street, but as matters we focus on properly, accurately" (*The Associated Press,* 24 April 2001; *Mail and Guardian,* 26 October 2001).

This assertion highlights Mbeki's efforts in de-politicising the epidemic in South Africa which might be considered an excuse not to assume the responsibility of rolling out a comprehensive treatment programme. The quoted statement can be linked to his opinion in his interview with *Time Magazine*, in which he says: "to say this (HIV) is the sole cause therefore the only response to it is anti-retroviral drugs, I am saying we'll never be able to solve the Aids problem"(2000). His scepticism over the effectiveness of ARVs is conspicuous as the chronology of the treatment policy process shows. As chapter 1 presented, the TAC took the Minister of Health and provincial health functionaries to court in 2001 and it was not until April 2002 that a Cabinet Statement regarding treatment was announced.

In this respect, Mbeki's attempts to look at HIV/Aids as a strict matter of science and not of politics resulted in a conspicuous delay of the policy process. It is then important to ask what role can he play as a political and layperson in a debate that according to him is scientific?

In sum, it seems that Mbeki defends a non-conventional view of Aids and calls for scientific rigour as a public figure, thereby assuming a role in what, for him, is a scientific debate, but with no basis for doing it. Consequently, his views on science are very imprecise and his line of argument is very weak. Its main weakness is its lack of consistency. For instance, in trying to understand the epidemic from a scientific point of view, Mbeki raises issues such as the toxicity of ARVs, which rather than giving the epidemic an in-depth look delays the roll-out of the medicaments. However, the provision of ARVs is a political matter because it concerns HIV infected people's right to be treated, therefore, in questioning the reliability of the medicaments, Mbeki implicitly engages in a political discussion with organisations such as the TAC. This contradicts his call to restrict Aids to the scientific realm and his attempt to de-politicise the epidemic.

Mbeki's line of reasoning is not consistent as it stands, because despite his attempts to constrain the epidemic to the scientific realm, Mbeki does not develop a scientific argument that provides a

better understanding of the epidemic in the country. His scepticism about absolute scientific truths, and his questioning of a conventional scientific view of Aids take the discussion of science and disease to a different level. Instead of focusing on the accuracy and efficacy of dissident and conventional scientific statements, Mbeki discusses issues such as who has the authority to talk about Aids, when comparing the patterns of disease in the West to those in Africa. On the other hand, he argues that, based on their images about African people, conventional scientists explain the African epidemic. In this sense, Mbeki's counter-scientific arguments point out a discussion on racial prejudices and African identity as the next section will show and explain.

Concerning his statements on poverty as the main cause of disease and death in the country, he underlines that scientific reports and the MRC mortality statistics promote a link between race and disease, because they emphasise that black people are at high risk of contracting HIV/Aids. In this sense, he turns the scientific discussion into an allegation on race and national identity. This argument will be developed further in the next section.

In sum, Mbeki's questioning of HIV/Aids and ARVs reliability must be understood in a broader context than the scientific because his statements might suggest a world-view that transcends a discussion of scientific accuracy. In such a case, the question that emerges is what is the relevance of raising topics such as race and national identity in the context of the epidemic? The previous inquiry and the question about the authority to talk about HIV/Aids will be answered as follows.

3.2 Mbeki's parallel line of reasoning: A discussion on race, disease and African Identity

This section argues that Mbeki's statements on science and disease raise a parallel discussion that concerns two specific matters: his views on the Western perception of the African epidemic, his rejection of the link between race, sexuality and disease and its link with his formulation of African identity.

3.2.1 Mbeki' views of the relationship between Africa and the West

In his interview with Joan Shenton Mbeki defended a non-conventional view of Aids by saying that it should not be 'banned or prohibited' in the 'name of science' (2000). This statement rises the question of who has the authority to speak about Aids in Africa, which must be connected to

Mbeki's understanding of Western views of the African epidemic, and his call to deal with a 'uniquely African catastrophe'.

In his letter to world leaders, he questions the knowledge of Western scientists to speak about Aids in Africa, because the epidemic's patterns of spread are different in both contexts. According to UNAids the epidemic has manifested differently in Africa than in the USA and some European countries. For instance, Aids in Africa prevails among heterosexual people as the percentage of HIV infected women (12.8%) differs considerably from that among men (9.5%) from a total of 11.4% of infected people, while in the USA the predominant mode of HIV exposure is male-to-male sexual contact with 41% of HIV infected men infected in this way (*HIV/Aids in the Americas an Epidemic with Many Faces* 2001). Mbeki argued then:

> "It is obvious that whatever lessons we have to and may draw from the West about the grave issue of HIV-AIDS, a simple superimposition of Western experience on African reality would be absurd and illogical" (2000).

This assertion not only questioned the knowledge that the West has about the African epidemic but it also refuted its authority to talk about a 'unique African disease'. In referring to a 'superimposition' of scientific explanations, Mbeki implicitly points out that the 'real' patterns of the African epidemic are obscured by the interpretations of the Western scientists. For instance, as presented in the first section, in his letter to Tony Leon, Mbeki links Western interpretations of the disease with the false figures about the incidence of the epidemic in Africa. He also states that these 'hysterical estimates' defend the use of ARVs: "None of these [false figures] bode well for a rational discussion of HIV-AIDS and an effective response to this matter, including the use of anti-retroviral drugs" (2000).

This point is very contradictory, because Mbeki does not radically oppose Western views of the epidemic since HIV/Aids dissidence also emerged in the West. Instead, he might question the authority of an orthodox view that, based on prejudices about Africa, explains the African epidemic according to Western patterns and supports ARVs treatment.

This point can be related to the discussion of power and knowledge presented in chapter 2. In the realm of culture, following Said's explanation, Eastern and Western experiences cannot be considered pure because they interact with each other and "they assume more foreign elements, alterities, differences, than they consciously exclude" (Said 1993:15). In this sense, the cultural geography of the West and the East overlap and not necessarily impose or 'superimpose' as

Mbeki suggests in his letter to world leaders. However, it is important to observe that the struggle between ideas and images persists in post-colonial contexts such as South Africa. Mbeki's questioning of who has the authority to talk about the epidemic in Africa might be formulated on the terrain of this struggle, and his confrontation with the president of the MRC is a good example of it.

Regarding the MRC mortality statistics, Mbeki engages in an argument with Malegapuru Makgoba, because the president of the MRC and a known Africanist has openly confronted Mbeki's and the dissidents' arguments about Aids:

> The implications of us adopting this unorthodox view are quite serious […] It will set back all the efforts we have so far put into this epidemic; it will represent a form of national denial by default; it will be extremely costly for the country in the short and long term and we shall become the laughing stock, if not the pariah, of the world again. (*The Guardian* 16 May 2002)

Responding to this, a letter addressed to Makgoba, presumably written by Mbeki and signed by Limpopo premier Ngoako Ramatlhodi, criticised Makgoba's scientific position:

> What concerns me and others like me is that [the] media uses you as the countervailing and educated voice of scientific truth and sanity, that is opposed to the uneducated and irrational voice of President Thabo Mbeki […] I hope that you will continue to walk tall among your people, with pride, and they will continue to shake your hand, despite your seeming readiness to embrace and propagate this 'science'. (*The Guardian,* 16 May 2002)

In this letter, Makgoba's right to speak is questioned because, on the one hand, he criticises Mbeki's counter-scientific position and speaks in the name of a conventional view of the epidemic. On the other hand, the statistics' results showed that 25% of the deaths in South Africa are caused by Aids and this information, according to Mbeki, is based on prejudices. In a letter to Tshabalala-Msimang he wrote:

> "These are the people whose prejudices led them to discover the false reality, among other things, that we are running out of space in our cemeteries as a result of unprecedented deaths caused by HIV/AIDS" (Mbeki 2001).

The previous statement points to Mbeki's views of the conventional scientific interpretation of Aids and the prejudices that it reinforces about the African epidemic. Taking this into account, what are the prejudices that he refers to when questioning the reliability of the MRC mortality statistics?

Mbeki's scepticism over Aids as the cause of death in the country, as well as his personal confrontation with Makgoba, might point out his struggle against racist images and ideas about Africa that conventional scientific figures of Aids reinforce in the present.

In the first place, in connection with his questioning of HIV as the cause of Aids, Mbeki states that people who are engaged in politics and public health lead a campaign to deny the direct relationship between poverty and diseases related to Aids in the country. In his letter to the ANC (2002) he underlines that the direct victims of this plan are black people who happen to be the poorest and also the majority of the South African population:

> "If we allow these agendas and falsehoods to form the basis of our health policies and programmes, we will condemn ourselves to the further and criminal deterioration of the health condition of the majority of our people […] That we are poor and black does not mean that we cannot think for ourselves and determine what is good for us" (Mbeki 2002).

Following Mbeki's reasoning, since African people are mainly black and poor those who question the link between health and poverty and, hence, who talk about HIV/Aids, are not black. Nevertheless, despite being black, Makgoba supports the figures that present Aids as the main cause of deaths in the country. Consequently, Mbeki engages in an argument with him because his supportive of a conventional scientific view goes against the welfare of his 'own' people, since he is a black African. According to Mbeki: "We are both the victims and fully understand the legacy of centuries-old and current racism on our society and ourselves" (Mbeki 2002).

Mbeki's statement makes clear that his discussion with Makgoba transcends the scientific realm. In saying that he fully understands 'the legacy of centuries-old and current racism', Mbeki raises a discussion of racial prejudices that, according to his previous statements, 'false' figures of Aids in Africa have reinforced in the present. Furthermore, according to Makgoba, Mbeki and his supporters question his identity based on the premise that as a black African he should support the view that poverty causes infectious diseases, and not a conventional scientific view of Aids that

discredits the country. In answering to the accusations stated in the letter signed by Ramatlhodi, Makgoba says:

> "They appeal to a very basic instinct: that I'm an African like them and therefore I should be in their camp and if not, I'm a stooge of whites, I'm less of an African and therefore I'm open to having my standing questioned, *even my identity"* [my emphasis] (*The Guardian* 16 May 2002).

Mbeki's argument with Makgoba gives hints to look at his rejection of Western interpretations of the African epidemic as a matter that reinforces racist images of the past and, therefore, jeopardises Mbeki's reformulation of categories such as African identity in the present.

In sum, Mbeki starts a discussion about the differences between the epidemics in Africa and the West by questioning who has the knowledge and, therefore, the authority to talk about Aids. In doing so, he argues that figures about the incidence of Aids in the country are the result of prejudices reinforced by the Western view of the epidemic in Africa. At the same time, he argues with Makgoba because, although he is a black African, he supports the same views of science that have pictured African people as diseased.

The next section will deal with Mbeki's struggle against the images of the past, his views on race and disease and their relationship with a discourse on African Identity in the present.

3.2.2 Race, sexuality and disease: A matter of African Identity

As stated earlier, Mbeki brings up a discussion of racial prejudices while claiming that HIV/Aids is a strict scientific matter, which makes difficult to grasp his line of argument. Hence, it is necessary to question why is he so concerned about these matters and what is the relevance of discussing them in connection with the epidemic, in order to understand his parallel statements on race, disease and identity,

One of Mbeki's most polemic statements since 2000, had place at the University of Fort Hare in 2001. In this speech, Mbeki points out his rejection of the link between race, sexuality and disease that presumably scientists, journalists, intellectuals and other political leaders defend:

> And thus it happens that others who consider themselves our leaders take to the streets carrying their placards, to demand that because we are germ carriers, and human beings of a lower order that cannot subject its [sic] passions 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, unique in the world, they proclaim that our continent is doomed to an inevitable mortal end because of our unconquerable devotion to the sin of lust. (Mbeki 2001)

This message can be interpreted as Mbeki's 'hyper-defensiveness on race", as Drew Forrest (2001) said. Nevertheless, beyond this reading, Mbeki's statement is embedded in his views of the past in the present.

As stated earlier, Mbeki shows a remarkable interest in clearing up images of the past reinforced in the present by Western perceptions of HIV/Aids in Africa. At the university of Fort Hare, he opposes the representation of black people as 'germ carriers that cannot subject its [sic] passions to reason' and that, consequently, acquire a 'self-inflicted disease'. This is, he opposes the immediate correlation between race (social group), sexual behaviour (promiscuity) and the contraction of Aids.

Mbeki has previously opposed this relationship in his letter to Tony Leon (2000), when pointing out that the figures about the incidence of rape in the country were false. This assertion denies the fact that rape, understood as unlawful sexual intercourse, is a very potent method of spreading HIV in South Africa as chapter 1 explained. When pointing out the assumption that black people cannot subject its passions to reason, Mbeki might refer to the figures of rape in the country that reinforce a negative image about African people's sexuality. For instance, in his letter to Tony Leon, he said: "I imagine that all manufacturers of antiretroviral drugs pay great attention to the very false figures about the incidence of rape in our country, that are regularly peddled by those who seem so determined to project a negative image of our country" (2000). Furthermore, Mbeki implicitly overlooks the link between Aids and sexuality by saying that the main cause of disease in the country is poverty but not Aids. This is, he does not support the relationship between high-risk behaviours and HIV prevalence, but the connection between the latter and indicators of inequality.

Mbeki's rejection of the connection between race, sexuality and disease can be understood if analysed according to his views of the African past of oppression, because when questioning the authority of Western scientists in talking about Aids he implicitly questions the West's historical power of representation.

The point of departure for looking at the relationship between Mbeki's references to race, sexuality and disease is Vaughan's analysis of the ideological construction around syphilis in Africa in colonial times. She argues that in the 1920s and 1930s the patterns of syphilis in Uganda changed after social and political transformations occurred. In this period syphilis was labelled a venereal disease, that is, sexually transmitted. Vaughan points out that syphilis was constructed as a particular sort of epidemic directly related to a discourse about female sexuality and the promiscuity and the sin that this represented (1992: 299). Her analysis deals with the way in which African sexuality became the focus of European concern. Vaughan explains that medical missionaries stressed the sinfulness of traditional African society, therefore associating the connection between sin and disease with the spread of venereal diseases such as syphilis. This representation of African peoples was reinforced by the disciplinary discourses of anthropology and colonial psychological studies in the nineteenth century.

According to Vaughan's analysis, Mbeki's reference to African people as 'natural-born, promiscuous carriers of germs' might criticise the way Africans have been represented since colonial times. However, whether at the University of Fort Hare he referred to the link between disease and race as a construction by the West that resulted from a disciplinary discourse developed in colonial times; or whether the statement itself was constructed by him with the specific purpose of justifying his sceptical position about Aids is an open question.

Mbeki's statements on Aids do not develop a consistent argument that explains the connection between race, sexuality and HIV/Aids in the present as the product of Western representations of Africans in the past although he understands the historical power of representation of the West when referring to identity issues. In this sense, if his intervention at the University of Fort Hare is analysed in connection with his speeches on African identity, it is possible to grasp that, for him, Western interpretations of HIV/Aids in Africa reinforce historical prejudices of race, and images that picture African people as 'devoted to the sin of lust'.

For instance, in the speech *I'm an African*, Mbeki underlines that being an African requires a consciousness of a shared African past of oppression. His formulation of African identity and his consciousness of the past of repression point to the necessity of removing prejudices from the rhetoric of nation-building in the present. In *I'm an African,* Mbeki says that it is necessary to break up with the oppression of the past to reformulate the African identity:

> As an African, one has seen the concrete expression of the denial of the dignity of a human being resulting from systemic and deliberate oppression and repression […] Being part of all these people, and in the knowledge that none dare contest that assertion, I shall claim that – I am an African. (Mbeki 1996)

On this occasion, Mbeki emphasises that the African identity is a continental category, and stresses that this consciousness of a shared African past links South African people with the people of the continent.

Following Chipkin's argument, Mbeki situates being an African in the context of the struggle against colonialism (Chipkin 2003:30). That is, for Mbeki it is impossible to forget about the influences of the past on the present formulation of African identity. In this respect, the most important question, according to Chipkin, is not about who are the people that comprise the nation, since Mbeki systematically refers to different subjects. Thus, he points to the perpetrators and the survivors of colonial crime as Africans, but he also says that the perpetrators only become Africans when they recognise the injustices of the past. The appropriate question is about the responsibility that being an African implies. This means refusing to be defined in terms of race, colour, gender or historical origins. In other words, being an African means a refusal to be defined by others, which coincides with the point that Mbeki raises when discussing who has the authority to define the African epidemic. His rejection of the link between race, disease and sexuality is in line with the same idea of refusal.

The definition of identity changes with the advent of democracy since, Mbeki states, being an African means being able to decide for oneself. Such an observation is very relevant to this analysis, since it points out Mbeki's call to construct Africanness from a self-consciousness of identity, and not from the representations of the West imposed by the colonial past and, more recently, by apartheid. Nevertheless, Mbeki's questioning of Makgoba's right to speak contradicts this democratic principle of identity by which the individual decides by himself. In this sense, Makgoba's identity should not be questioned or criticised.

In essence, as chapter 2 explained, the historical position of the West has given it the authority to manipulate and represent the African reality. Mbeki shows an understanding of this history of representations in his speech *I'm an African* (1996), in which he claims that African people must recognise the injustices of the past of oppression in order to reformulate their identity. In 2001, at the University of Fort Hare, he brings up the same subject but this time in the context of his

discussion of Aids. On this occasion, he rejects the representation of Africans as 'natural-born carriers of germs' and 'devoted to the sin of lust' that, presumably, scientific reports and the mortality and rape statistics promote in the present. Following the same line of argument, his discussion with Makgoba, points out that the subject who talks about Aids in Africa must refuse to be defined in terms of race and historical origins. In this sense, in agreeing with a conventional scientific view of Aids, Makgoba does not follow Mbeki's principle of refusal.

Based on these facts, it seems that at the University of Fort Hare Mbeki attempts to justify his position on Aids by rejecting racist images about Africa reinforced by scientific views of Aids in the present. However, he does not explain why and how colonial representations of the past influence the understanding of the epidemic in the present. In other words, he does not elaborate a connection between patterns of disease in Africa in colonial times and the current spread of the epidemic. Rather than providing an ordered explanation to justify his scepticism about Aids and the treatment policy implementation, Mbeki engages in a discussion of race embedded in the past that by itself does not say anything about the epidemic in the present. Therefore, his position on Aids is seen as extremely biased by issues of race and ghosts of the past.

For instance, according to Tony Leon, Mbeki has minimized the dimensions of Aids, insisting instead on making them into a matter of race. Leon said: "SA can never focus on the acute problems of joblessness, HIV/Aids and crime if we remain stuck in the cul-de-sac of racism" (*Business Day,* 24 June 2003).

Through his letter entitled *Forget Race Card*, Leon answered a previous message in which Mbeki defended his use of the politics of race, emphasising that the legacy of colonialism and apartheid still exists among African people. On this occasion Mbeki said that "the struggle against racism will be with us for a long time. This is because the racist legacy of colonialism and apartheid will be with us for a long time" (*Business Day* 20 June 2003). Nevertheless, his consciousness of the past does not manifest a true interest in proposing new possibilities for the future because although he focuses on the opening of Africa to the world on different fronts, his principles to define Africanness are very ambiguous. On the one hand he refers to Africans as the people who inhabit the continent, that is, a territorial principle. On the other hand, he refers to Africans as those who assume the responsibility of defining themselves by rejecting race and historical origins prejudices.

In the context of the Aids debate this ambiguity is very conspicuous, since Mbeki is against representations of Africa that the Western medical system of knowledge produced, but at the same time he supports a dissident posture that also emerged in the West, and that therefore represents the authority and expertise of the Western system of knowledge. On the other hand, he questions Makgoba's right to speak based on principles of race that his discourse on identity opposes.

In order to understand Mbeki's views of the Western medical system of knowledge and his formulation of identity, the next section will look at Mbeki's African Renaissance since this is crucial for the ANC nation-building project.

3.3 The African Renaissance and Mbeki's views on development: an alternative explanation for his position on Aids

The previous section explained that Mbeki's questioning of Western interpretations of Aids in Africa must be understood in line with his formulation of African identity. This section analyses his views on development as a Western category of knowledge in the context of the African Renaissance, and compares his position on this matter with his views on a conventional interpretation of Aids in Africa.

3.3.1 The Genesis and aims of the African Renaissance

The African Renaissance has its roots in the Pan-Africanist ideology. The latter, according to Geiss, appeared among Afro-Americans in 1900 but the historical conditions of the movement were created by the earlier struggles against the slave trade, slavery traditions (abolitionism), and Christian missions.

According to Geiss (1974), the Pan-Africanist movement can be defined in a broader and a narrower sense. Broadly, Pan-Africanism included cultural and intellectual movements that promoted anti-colonialism, and it assumed organisational form in 1900 with the first Pan-Africanist conference in London (Geiss 1974:42).

In a narrower sense, as the movement grew, it became a congregation of African and Afro-American intellectuals who, generally, were educated in Europe, America or West Africa. After the launch of the first conference in 1900, Pan-Africanists organised five congresses until 1958 when, according to Geiss, the movement started formally with the sixth Pan-African Congress

and the first on African soil after the independence of Ghana. In other words, in 1958 the diaspora came back to the "promised land of Africa" (Geiss 1974:8).

In 1958, the year in which the sixth congress was held, Pan-Africanism was centred on the African continent itself, with the West Indies and Afro-Americans providing symbolic presence. At this time, the main concerns of the movement were the anti-colonial struggle, the continent's unification and African modernisation. These promoted ideas such as 'redemption of Africa' and 'Africa for the Africans'.

Above all, Pan-Africanism stressed the economic, technological, social and political modernisation of the African continent. Since African and Afro-American intellectuals were influenced by European and American ideas of modernisation and principles of equality and democracy, the main concern of the movement was liberation from European colonialism and racial discrimination.

Pan-Africanists fought for an Africa for Africans which implied the political and economic development of the continent through democracy and the African economic opening to the world. Considering the aims of the movement, the Mbeki's African Renaissance coincides with the Pan-Africanist tradition regarding the following points:

• African development: aware of the challenges of globalisation, and in order to put an end to the marginalisation of the continent, the African Renaissance looks for a way to lead African countries towards a better position in the 'world-economy system'. This principle is linked to the Pan-Africanist aim of promoting the economic opening up of the continent to the rest of the world and it also stresses that African countries must unite to fight against poverty and underdevelopment.

• Democracy as the best method of government: The African Renaissance points out the importance of a stable system of governance that serves the interests of the people. Since the days of apartheid, the demand of the liberation struggle has been that 'people shall govern'. Thus, the best system of governance is democratic, which emphasises the power people have "to determine their destiny and to resolve any disputes among themselves by peaceful political means" (Mbeki 1998). Mbeki's idea of African Renaissance links democracy with civil participation.

The notion of African Renaissance sums up Mbeki's rhetoric of governance, which attempts reconstruction and development in South Africa, and aims at a successful foreign policy towards the rest of Africa. The Renaissance, instead a simple strategy for development, is an awakening of a renewed African consciousness. According to Mathebe, the Renaissance intends a reformulation of African roots, traditions and the African colonial legacy (2001:120). In this sense, this call for the recognition of identity is an invitation for those who see the continent as their home in a full emotional sense (2001:127). Mbeki raised such an issue in 1996 in *I'm an African*:

> The constitution whose adoption we celebrate […] is a firm assertion made by ourselves that South Africa belongs to all who live in it, black and white […] As an African, this is an achievement of which I am proud without reservation and proud without any feeling of conceit. Our sense of elevation at this moment also derives from the fact that this magnificent product is the unique creation of African hands and African minds. (Mbeki 1996)

For Bullen, however, Mbeki's message is not a revival of the essentialist discourse that defends a common continental identity. Instead, by saying 'I'm an African' Mbeki is recognising that African countries face common problems in the present, and have a shared history of colonialism and oppression (1999:16). Mbeki underlines the importance of this shared colonial past in addressing problems that African countries face within the global world, although, as mentioned above, *I'm an African* is extremely ambivalent in defining the identity of the African people.

The Renaissance refers to the past of recent decades, that is, to the post-independence period. In that sense, the rediscovery of Africanness in post-colonial times is also a rediscovery of this recent African past:

> The political imperatives of the African Renaissance are inspired both by our painful history of recent decades and the recognition of the fact that none of our countries is an island which can isolate itself from the rest, and that none of us can truly succeed if the rest fail (Mbeki 1998).

According to Mbeki, the shared response to this recent past refers first to democracy as the medium for African people to achieve autonomy, that is, to determine their own destiny. Second, such a shared consciousness also emphasises the position of the continent in the dominant Western economic system. This attempt is analogous to the decolonisation discourse that opposed the European notions of identity, although it remained dependent on the colonial discourse of

modernisation and progress (Bullen 1999:17). This contradiction, as Said explains, is typical of countries with a colonial past, and in the case of Mbeki's Renaissance it becomes very conspicuous.

Taking into account the contradictory role of development as a category of a Western system of knowledge, the next section will analyse Mbeki's position about it and how it differs from his views of the Western medical system of knowledge.

3.3.2 The role of development in the African Renaissance

The African Renaissance points out the economic development of Africa and the position of South Africa and the continent in the World economic system:

> "These economic objectives, which result in the elimination of poverty, the establishment of modern multi-sector economies and the growth of Africa's share of world economic activity, are an essential part of the African Renaissance" (Mbeki 1998).

For Mbeki to lead Africa towards development is a demand, but whether this concept is epistemologically revised or reconsidered in his politics of Renaissance is an open question that this section will analyse as follows.

As explained in chapter 2, Escobar explores, analyses, and criticises the way in which the development discourse was introduced in Third World countries, and explains how this discourse has been articulated or confronted by their local realities. This section focuses on one aspect of this analysis, which is the representational power of the development discourse and its influence on the African Renaissance.

According to Escobar, development is a system of knowledge institutionalised by the West. His insight is relevant to understanding how development has formulated other countries' realities very quickly and radically. I observe that development plays a fundamental role in the African Renaissance that Mbeki promotes, although this relationship is ambiguous.

The Renaissance gives the continent the chance to be seen from a different angle. According to Mbeki: "We build a society of which all Africa would be proud because it would address also the wrong and negative view of an Africa that is historically destined to fail" (Mbeki 1998). In this sense, development is necessary to change and improve the continent's position in the world system and, hence, to modify the West's view of Africa. In terms of development Mbeki's

projection of African identity for the West is formulated in a language that responds to a Western system of representation. However, in *I'm an African* he refers to an identity that is exclusive to the people of the continent, that is, an internal identity.

Mbeki's principle of identity in respect of development can be read in terms of the relationship between power and knowledge. For instance, the Renaissance promotes the New Partnership for Africa's Development (NEPAD), which aims for the socio-economic regeneration of the country. In this respect, Mbeki stresses that this is an authentic African initiative. As he said at the High-Level Special Session of the UN General Assembly on the New Partnership for Africa's Development: "As Africans, we now own Africa's development agenda" (2002).

By declaring the development agenda as a pure African attempt, Mbeki points to the dispute for authority and control over the programme. In this sense, although he follows the guidelines of the development discourse, African people must control the programmes for the development of the continent. In other words, this position is in line with the principle of unified identity that the Renaissance emphasizes.

However, Mbeki's language varies when he addresses the people of the continent and the people of the West. In the former case, he refers to the African subject as one with a past of oppression and denigration; that is, as a subject who needs to be 'reborn' after being liberated. This rebirth, hence, implies the continent's unity in solving African problems. On the other hand, he speaks to the West using its own language, that is, the language of development. This, at the same time, defines the continent as underdeveloped and even the principle of self-definition, which is central to the Renaissance, becomes a secondary element.

It seems that Mbeki speaks to the West using its own language because the achievement of Africa's opening up to the world greatly depends on a successful policy of foreign investment. Consequently, he does not challenge development as a system of knowledge and a regime of representation but the authority of the West in identifying and combating African problems. This dispute for authority prevails regarding his views of Western interpretations of the epidemic, although in that respect he opposes representations of the past that he does not in terms of development.

In essence, Mbeki is against the relationship of subordination between a 'developed North and a developing South', and this is why he proposes a partnership with developed countries. This point

takes the analysis back to the question about the subject who speaks in the name of modernisation and development. The question is, who is that African who speaks to the West using its own language, and at the same time speaks to the people of the African continent using a language of identification and consciousness of a shared past?

In his book *Africa: the time has come*, Mbeki points out the importance of an African economic reform to guarantee the success of the continent's opening to the world:

> In addition to the social and political issues we have already addressed, sub-Sahara Africa and the rest of the continent have also embarked on a process of economic reform, which is necessary and vital if the continent is to succeed in attracting a growing slice of foreign investment […] It is clear that we cannot achieve this sustained rate of development unless Africa succeeds to attract the necessary international private sector capital and directs such domestic capital as it can generate to productive uses. (Mbeki 1998:203)

The African Renaissance that Mbeki proposes is linked to the movement of the continent towards development, although he does not propose a radical epistemological revision, as Escobar advocates. For Escobar, the Western epistemological order can only be contested from a culture's self-criticism and reformulation. Following Mudimbe's work *The Invention of Africa*, Escobar points out the importance of critical works that emerged in Africa:

> What is at stake of these latter works, Mudimbe explains, is a critical reinterpretation of African history as it has been seen from Africa's (epistemological, historical, and geographical) exteriority, indeed, a weakening of the very notion of Africa […] Critical work of this kind may open the way for the process by which Africans can have greater autonomy over how they are represented and how they can construct their own social and cultural models in ways not so mediated by a Western episteme and historicity – albeit in an increasingly transnational context. (1988; Mudimbe quoted in Escobar 1995: 7)[7]

Mbeki's attitude, however, does not conform to Escobar's deconstruction of development. On the contrary, according to Calland and Jacobs (2002), his position presents Mbeki *the conformist,* although for this study Mbeki *the strategist* is a more precise category. In this sense, his agreement with economic opening policies recognises globalisation and development as organising and necessary elements of the Renaissance. For instance, regarding the Millennium African Renaissance Program, Mbeki explains:

[7] Mudimbe, VY 1988. *Gnosis, philosophy and the order of knowledge.* USA: Indiana University Press.

> Another important prerequisite is a partnership with the rest of the world, especially the developed countries, multilateral institutions and (global and national) private sector players […] We see a clear role for the many foreign business people who have profitable ties with Africa (Mbeki 2001).

Without the support of foreign investors from developed countries, Africa's position in the system could not change and, therefore, Mbeki's whole idea of the African past's reformulation and his aspirations of having a symmetrical relationship with the West would fail.

In this respect, Calland and Jacobs observe, Mbeki's response to the challenges of globalisation is confusing. They point out the times that Mbeki has confronted world leaders (Blair and Clinton) and international institutions (The United Nations) with "brilliant and incisive expositions on the moral injustice of the contemporary world order." For them, this is Mbeki *the redemptionist*, determined to fight for justice for Africans (Calland and Jacobs 2002:260). In his address at the UN general assembly, Mbeki refers to the 'injustice of the world order' and the importance of challenging it:

> An unprecedented number of Heads of State and Government have gathered at the United Nations to make this commitment to cooperation among the peoples of the world, to peace, prosperity and justice throughout our universe gave hope to the billions throughout the world who know the painful meaning of oppression by another, of war and violent conflict, of poverty and injustice (2002).

His role as a redemptionist, however, is a rhetorical category, since in practise he has not provided an alternative solution to challenge the discourse of development. That is, he has not approached to the local realities of the continent, and their respective systems of knowledge, to figure out an alternative to development. His acting as a *redemptionist* can be considered a rhetorical strategy to, presumably, defending the role of saviour that he has played when addressing the people of the continent, that is, when he is using the language of identification.

The role of the identity element in the African Renaissance has been the subject of various analyses. For Bullen, there are two possible answers. The first is related to the pragmatic considerations of Mbeki's nation-building project. These pragmatic reasons are the development of a common African sense of purpose, that is, the creation of an identity around the uniqueness of African problems. The second reason refers to the reinforcement of this common sense of purpose. Because most African nation-building projects have failed, a better way of creating unity

is through a shared concern about Africa's problems and a commitment to change. Vale and Maseko point out the possibilities that the Renaissance opens for African countries. They highlight that "most Africans consider themselves to be marginalised from the affairs of their countries, the continent, and the world" and the success of the Renaissance depends on recognition of this (2002:130).

In other words, although the Renaissance and Mbeki's thinking are influenced by Pan-Africanism, the importance of the identity card in his discourse is related to a pragmatic approach, such as his view of development, rather than to a purely nationalist attempt.

Mbeki's pragmatic posture can be understood in terms of the dynamics of development. According to Escobar, Western principles have intervened in the social construction of the reality of regions such as Latin America, Africa and Asia that have been denominated *subaltern* or *peripheral*. Concomitantly, the development discourse shows the extent of the West's influence over alternative and local systems of knowledge; therefore, it plays a fundamental role in the dynamics of identity of such societies. This discourse of representation, however, can be contested through the emergence and strengthening of social movements, although the point of departure of such a contestation is the reformulation of categories. Regarding development and the Western views of HIV/Aids in Africa, such a reformulation depends on the creation of alternatives that adapt themselves to the unequal context of South Africa.

However, Mbeki supports development and foreign investment to ensure the Renaissance' success. At the same time, he supports a Western dissident posture to approach one of the biggest of Africa's problems (HIV/Aids), which does not reflect the Africanist notion of African solutions for African issues. In this sense, he does not offer an African alternative to development nor a local approach to Aids. Instead, Mbeki relies on denialist arguments that belong to the Western system of knowledge that represented Africa in the past, which contradicts his own call to deal with a 'uniquely African catastrophe' (Mbeki 2000).

In this respect, the next section looks at two examples of alternative modernities that differ from Mbeki's position on Aids, and show that it is possible to contest dominant discourses without questioning the reliability of conventional scientific views on the epidemic. The first of them is Uganda and Senegal's successful fight against Aids. The second concerns Brazil's efforts to provide generic medicines to HIV infected people.

3.3.3 A comparison between Mbeki's views of development and his position on Aids

In sharp contrast to the South African government's delayed response to HIV/Aids, Uganda and Senegal's fight against the epidemic has been very effective. In Uganda, the levels of HIV/Aids prevalence have drastically reduced, having fallen from 15% in 1991 to 5% in 2001 (*What Happened in Uganda? Declining HIV Prevalence, Behaviour, Change and the National Response*, 2000: 2). This change is mainly due to the 'firm political commitment' that included the personal involvement of the president Yoweri Museveni. This is a case of alternative modernity as the organised government response to HIV/Aids has combined modern communication strategies, based on aggressive media campaigns, with local methods to combat the epidemic. These included the participation of local leaders such as health educators and traditional healers who supplied a culturally appropriate intervention, promoting the behavioural change among communities. In addition, according to the quoted report:

> […] low-tech approaches also led to the sensitisation and subsequent involvement in Aids awareness and education of not only health personnel, traditional healers, and traditional birth attendants, but influential people normally not involved in health issues such as political, community and religious leaders, teachers and administrators, traders, leaders of women and youth associations and other representatives of key stakeholders groups. (*What Happened in Uganda? Declining HIV Prevalence, Behaviour, Change and the National Response*, 2000: 5)

This 'low-tech' solution combined with the effectiveness of media campaigns has greatly influenced the success of Uganda's plan against the epidemic. In Senegal, the participation of local leaders has been central to the government's strategy to combat the epidemic. These responses have been effective because of the government's understanding of the coexistence between traditional and modern orders in the context of HIV/Aids.

On the other hand, although South Africa's strategic plan against Aids emphasised the role of stakeholders and civil society to combat the epidemic, Mbeki's response has not clearly articulated this traditional element inherent in a hybrid society. Rather than providing an alternative solution to Aids, Mbeki has focused on the fight against poverty from the perspective of sustainable development. In repeated occasions he has referred to poverty as the main cause of disease in the country and, consequently, he has put his efforts in combating it: "the new Partnership for Africa's Development, must help us to eradicate poverty and underdevelopment through Africa" (Mbeki 2002).

Mbeki's position is very ambiguous, since in talking about underdevelopment he implicitly agrees with the image of African backwardness that development, as a system of knowledge, has reinforced. That is, the Renaissance points out the renewed status of the continent but within the same system that represented it in the past. In other words, the Renaissance aims to contest the West using its same language. The premise is simple: if the language that Mbeki uses to contest the representational power of the West is the same as that used by the development discourse, the nature of the dominant system remains intact. According to this line of thinking, the position of South Africa and the continent might change, but within the boundaries of the Western system of representation.

As presented in chapter 2, this situation exhibits an interaction between power and knowledge as Mbeki's efforts concentrate on controlling the process of Africa's determination of its own future. In this sense, he assumes the authority of guiding Africa's Renaissance, although he does not modify the system of knowledge that represents the reality of the continent as underdeveloped and amodern. The overall picture, however, presents inconsistencies since in the context of Aids he opposes and rejects Western representations of Africa as a diseased continent. That is, he criticises the West's scientific interpretation of the African epidemic. Nevertheless, his challenge does not go beyond a criticism of the Western view of the epidemic in Africa as, once again, he does not propose an African alternative to the scientific conventional view of Aids.

The third case of alternative modernity that I referred to, points out the debate around generic ARVs provision and Mbeki's support for the economic opening of the continent. This issue has been very controversial since the costs of the patented drugs are very high, and South Africa's policy of compulsory licensing restricts the production of generic drugs. This policy reduces the access to ARVs and it only benefits the drug companies that manufacture patented drugs. This has produced a heated debate between the TAC and the government, indicating that for the South African government economic interests take priority over reducing the costs of treatment for HIV infected people.

In sharp contrast, the case of Brazil appears as a case of alternative modernity, as the government of this country produces generic drugs and it has threatened the compulsory licensing policy in getting affordable prices from drug companies when drugs are patented. Thus, the government has challenged the economic interests of private companies in benefiting HIV infected people. I argue that this case shows that there are possibilities to contest dominant systems. Differing from

Uganda, Senegal and Brazil, in South Africa this contestation has not been supported by the government, especially by Mbeki.

According to Said and Escobar, challenging a certain system of knowledge requires a reformulation of concepts and the proposal of alternatives but Mbeki does not explore the alternative from a local African system of knowledge as Uganda, Senegal and Brazil have done. Instead, he questions the authority of scientists and scientific reports in talking about Aids figures in Africa, and situates the debate on the terrain of a dispute about the images and representations that emerged in the past.

On the other hand, regarding development, Africa, and South Africa in particular, as chapter 1 explained, presents profound inequalities on social, economic and political levels. Thus, to talk about modernisation and development in the continent might be equivocal, since there are many localities and groups of people that, despite being considered pre-modern in the teleological sense of the discourse of development, are not isolated from the modern in all cases.

In the context of the fight against HIV/Aids an effective response depends on a consciousness of the coexistence of all kinds of localities in a context that is hybrid - that is, pre-modern, anti-modern and even amodern at the same time. This means that the only way to formulate knowledge from the continent is by creating alternatives that respond to a hybrid order and not to a binary model that opposes pre-modernity and development. For instance, it is important to take into account the living conditions of people such as the mine workers, vulnerable to HIV/Aids, and the type of localities that they inhabit, in formulating prevention and treatment programmes. It is also important to understand the extent of the relationship between high-risk behaviour and HIV/Aids prevalence. In the mine workers context, what is modern coexist with what is not, therefore, effective solutions to the problem of Aids depend on the understanding of their reality. According to the Renaissance's aims, Mbeki follows the development discourse which unfortunately does not offer this possibility.

In essence, it is important to notice that Mbeki's position on Aids greatly differ from his views on development. Regarding the first matter, Mbeki questions the authority of the Western medical knowledge in talking about Aids and also the images of African people as diseased that, according to him, it reinforces. On the other hand, although he emphasises that development programmes must be controlled by Africa, development as a Western category and system of representation is not questioned or challenged. This is, although development has represented

African people as underdeveloped and defined their context as amodern, the Renaissance supports programmes that follow the solutions that the Western discourse presents. Therefore, there is not formulation of alternatives to development nor to the conventional views of Aids.

The following section will present the possible explanations for these two different approaches in the context of Mbeki's African Renaissance and the nation-building project.

3.4 Mbeki's position on Aids and its connection with the African Renaissance's principle of identity

Mandisa Mbali presents Mbeki's opposition to colonial and Western discourses on the view of Africans as inherently diseased (Mbali 2002). The explanation offered by Mbali is that Mbeki's dissidence defends Africans against the racism and neo-imperialism that the conventional view of Aids promotes. In this respect, Bullen's question is pertinent: Does the Renaissance move beyond the discourse of race inherited from the colonial discourse? This section will answer such a question through an analysis of Mbali's interpretations of Mbeki's views of Aids.

Following Mbeki's counter-scientific line of argument, and according to Mbali's line of analysis, the debate around Aids has been "a discussion about scientific authority and expertise and about who has the right to speak authoritatively on science, what the scientific method is, and what constitutes valid scientific evidence" (2002:2). Thus, for Mbali, Mbeki confronts the Western biomedical/scientific paradigm on Aids in considering it racist and neo-colonial. However, Mbeki does not develop this argument from his counter-scientific line of reasoning. His references to race and disease, certainly, point out the issue of the representational power of the West, but he does not present a clear, systematic and ordered explanation of the relationship between race, disease and a Western view on Aids. Furthermore, as stated above, he does not complement his argument with a non-Western view as a counter-response.

For Mbali, Mbeki's opposition to the Western view on Aids is one of an African nationalist in the postcolonial world since "Mbeki is fundamentally constrained in his thinking by the ghosts of apartheid and colonial discourse around Africans, medicine, illness and disease" (2002:4). Stated differently, his dissidence presents Mbeki *the redemptionist*, who is able to defend the new African identity from Western assumptions of African impurity.

Mbali's interpretation of Mbeki as an African nationalist might be questioned by Bullen's observation about the non-Africanist but pragmatic character of Mbeki's Renaissance. In this

sense Mbeki *the strategist,* rather than *the redemptionist*, plays the main role. His strategy can be seen as an attempt to integrate the notion of African identity with the consciousness of a shared colonial and recent past of apartheid that, among others, relates race and disease.

In line with the latter, although Mbeki refuses to define Africans according to categories such as race and ethnicity, which were inherited from colonial times, he has not completely deracialised the identity discourse on Aids. His frequent references to race and inherent disease, underline his consciousness of the presence of the racist legacy of colonialism and apartheid in the present. Mbeki's rejection of the connection between race and disease, rather than clearing up historical prejudices about Africa, stresses the differences between Africa (underdeveloped) and the West (developed), which constrains the possibility to find out alternative solutions to the HIV/Aids epidemic.

Regarding Aids, paraphrasing Arif Dirlik, Mbeki is concerned about the African past, which could "obstruct recognition of problems that have emerged in the present" (*Public Culture* 14(3): 614). Dirlik stresses that although these problems are new, we must recast our understanding of the past in the present. Following his argument, it can be said that the fight against HIV/Aids in the present has been 'obstructed' by Mbeki's emphasis on the concept of African identity, especially by his remarkable interest on the assumed relationship between race and disease, and his rejection of an essentialist definition of African identity.

Following the pragmatic reading of identity in the Renaissance, Mbeki does not focus on race as an organising principle of identity, but on the creation of an image of Africa that will lead African people into the next century through development programmes, and a Renaissance based on a common commitment to Africa (Bullen1998:27). According to Mbeki:

> I say this to emphasize the point that necessarily the African Renaissance, in all its parts, can only succeed if its aims and objectives are defined by Africans themselves, if its programmes are designed by ourselves and if we take responsibility for the success or failure of our policies. (*African Renaissance* 1998)

This alternative view of identity in Mbeki's discourse answers the question about his rupture with the colonial representations in formulating his Renaissance. If the Renaissance proposes an opening up of Africa to the world that transcends the concept of race, the concept should not be read only from an Africanist perspective. However, Mbeki's formulation of identity is ambiguous. On the one hand, he follows the discourse of development to reformulate a new

African identity opened to the world economy, therefore, by implication, the Renaissance goes beyond race. On the other hand, his questioning of Makgoba's identity and his rejection of an apparent link between race and disease, point out that race is still a crucial element of his politics of identity.

In this sense, because who is an African is an ambivalent question, there is an inevitable dispute between a territorial principle of identity that refers to the people who live on the continent, and a principle of responsibility that includes those who are conscious of their past and assume the responsibility of challenging the West's representations. Mbeki pays special attention to this second principle when rejecting the link between race, sexuality and disease that Western interpretations of Aids in Africa have reinforced in the present. However, he does not challenge images of underdevelopment that the Western discourse of development promotes and that discredit the image of Africa. This remarkable contradiction will be addressed in the following and final section of the chapter, which includes my last considerations about Mbeki's counter-scientific and parallel lines of thinking.

3.4.1 The consequences of the link between race, sexuality and disease for the African Renaissance

In *getting the Nation Talking about Sex,* Deborah Posel addresses the political connotations of sexuality in post-apartheid South Africa. This analysis is the point of departure to understand the difference between Mbeki's position on the Western discourse of development and the one on Aids .

As stated earlier, Mbeki's rejection of the link between race, disease and sexuality is related to his views of the past and his consciousness about the West's power of representation. In this respect, Posel and Mbali connect Mbeki's position on Aids with the colonial construction of sexuality in Africa.

According to Mbali, this construction was based on state regulations that consisted of dividing the normal from the abnormal; and those who conformed to bourgeois respectability and those who were sexually deviant. These actions were taken in order to build the nation and protect the health of the state.

Regarding Aids, Mbali's observation points out the political role of sexuality in the context of Mbeki's African Renaissance and the nation-building project. Posel observes that Mbeki's

questioning of the Aids mortality statistics and the causes of Aids; his discourse at Fort Hare University; and his confrontation with Tony Leon about racism in the context of the Aids debate, indicate his rejection of the relationship between Aids and black African sexuality. For instance, according to Mbeki, black people's diseases and deaths are produced by poverty, hence, by implication, not by Aids. According to him: "the reality is that the predominant feature of illnesses that cause *disease and death* [my emphasis] among the black people in our country is poverty"(2002). Following this line of thinking, Mbeki's scepticism over a conventional scientific view of Aids is a refusal to talk about black African sexuality.

According to Posel, for Mbeki, talking about sex is 'offensive and irrelevant', because it brings up issues such as the colonial perception of Africans as 'natural-born, promiscuous carriers of germs'. In other words, talking about sex, in the context of the HIV epidemic, jeopardises Mbeki's attempt to reconstruct the nation and reformulate the African identity. Posel explains:

> In short, in terms of Mbeki's nation-building, to admit to the enormity of the epidemic would be to reinstate the imagery of "the abyss", the "African nightmare" and the death, disintegration and contamination which Mbeki associates with it. Indeed, the imagery of sexuality that Mbeki associates with the orthodox rendition of HIV/Aids is the spectre of the past: the colonial nightmare which imprisoned the black mind and enslaved the black body. It is exactly that which the African Renaissance has to vanquish: the demon within 'our African selves'. (2003:17)

Considering that the Renaissance must 'vanquish the demon within our African selves', the link between race and disease must be completely removed from the rhetoric of nation-building. Mbeki is emphatic in this respect, as the New African people must define their own identity by breaking away from Western representations of Africans in terms of race and historical origins. This point is very interesting, as this principle of self-definition and responsibility does not apply in every case. The principle is flexible when it comes to economic issues such as the provision of ARVs. In such a case, the Renaissance obeys categories and rules set by the dominant discourse without contesting them from local and/or alternative systems of knowledge, as the debate around the production of generic ARV drugs shows.

On the one hand, Mbeki is not interested in challenging the system of knowledge, namely development, or its representations of Africa as underdeveloped and pre-modern, as they do not jeopardise the nation-building project. On the contrary, the Renaissance aims to lead Africa to occupy an advantaged position in the world system, and the best medium to accomplish his goal

is, precisely, the discourse of development. Thus, Mbeki fights against underdevelopment and backwardness from the conceptualisation of the dominant system of knowledge.

On the other hand, he is very concerned about the representation of African people as diseased and 'devoted to the sin of lust'. This interest can be interpreted as a defence of a nation-building project that must reject any link between being African and being diseased. In other words, Mbeki stresses that this connection, which was based on a representation of the past, must not be a principle of identity in the times of a Renaissance.

This argument makes sense if analysed according to the Renaissance aims. In his speech *The African Renaissance, South Africa and the World* (1998) Mbeki says: "how can we be but confident that we are capable of effecting Africa's rebirth?" For Mbeki such a 'rebirth' can only be possible through a re-formulation of the African identity since this exercise requires a 'rediscovery' of the African past. According to his statements on Aids, for Mbeki this rediscovery entails the rejection of prejudices that relate race, sexuality and disease.

In sum, Posel's explanation is particularly relevant because it points out the importance of sexuality as a site of debate and contestation embedded in relations regulated by power. This discussion also underlines the importance of the principles of responsibility and self-definition by which Mbeki defines Africans in the African Renaissance. As was stated in the last section, these principles entail the responsibility and authority to define Africanness from the continent. Mbeki follows them when disputing for the authority to talk About Aids in Africa, and when questioning the reliability of the mortality and rape statistics in the country, which deny the link between Aids and sexuality.

In this arrangement of ideas, paraphrasing Mbali, Mbeki's position on Aids is an attempt to "rehabilitate African sexuality" in order to redefine South African nationhood (2002:8). In this sense, Mbeki *the redemptionist* plays the role of an 'African nationalist in the postcolonial world'.

However, Mbali stresses that although Mbeki's scepticism over Aids is an attempt to rebuild the nation by defeating colonial ideas about race, the epidemic is a matter of human rights that requires immediate solutions such as the provision of treatment. In other words, Aids and the images of the colonial past do not belong to the plane of HIV/Aids policy formulation. In this respect, the earlier mentioned examples of alternative modernities can be a model to follow according to the cultural and social specific circumstances of South Africa.

Lastly, Mbeki's questioning of HIV as well as his views of the past do not contribute to formulating a solution in terms of policy implementation. In this respect, according to Mbali, his language is challenged by the TAC's rights and scientific-based discourse, which, unlike Mbeki's, provides a coherent and sensitive solution for a problem that concerns all countries and races. In this sense, Mbeki's position on Aids affects not only the HIV treatment policy process, but also the integration of human rights into the medical discourse. Mbali explains:

> It is this currently rights-based/treatment vision of Aids activists, scientists and doctors that Mbeki is denying, and by doing so, closing the only feasible escape hatch from the types of coercive and racist discourses that colonial and late apartheid public health tended to advocate. (2002:11)

Mbali emphasises that colonial and late apartheid public health systems were fragmented and had suffered from years of 'underfunding and neglect', and Mbeki's position on Aids has exacerbated this situation in South Africa. Nevertheless, the discourse on human rights has influenced the HIV treatment policy process, overcoming the government's delay in providing ARVs and the influence of Mbeki's position on Aids on the process. In this order of ideas, the TAC discourse can be considered as the closest example of alternative modernity in South Africa. This group challenges economic rules in order to provide ARVs to HIV infected people and simultaneously defends the Western discourse of human rights.

Nevertheless, although the consequences and the role of the TAC in the discourse of human rights in South Africa is a very interesting topic of discussion, it will not be developed in this research. It is important, however, to point it out as one of the multiple possibilities of contestation that Mbeki's position on Aids offers.

In line with this final explanation in terms of the African Renaissance, chapter 4 will conclude with some considerations about the HIV/Aids epidemic in South Africa, the treatment policy process and Mbeki's arguments to defend his scepticism towards the matter.

CHAPTER 4
CONCLUSIONS

This research critically approaches Mbeki's position on Aids throughout the process of the policy on the treatment of HIV/Aids from 2000 to 2004 in South Africa. In order to understand the epidemic as a holistic problem, the thesis presents a comprehensive view of the epidemic in the country, that is, its political, cultural, economic and social dimensions. In addition, a historical unfolding of the implementations and conjunctures of the treatment policy was presented. Based on this review of HIV/Aids in South Africa, these conclusions underline the holistic character of the disease as a social, political, economic and cultural epidemic.

Chapter 1 explained the connection between the prevalence of HIV/Aids and inequality at various levels. The main observation is that in the four provinces with the highest percentage of infected people poverty engenders risky social practices and unsafe behaviours. Migration of labour, tightly linked with poverty levels, appears to be the most dangerous phenomenon in the spread of venereal diseases and HIV. This has become a social and health problem in South Africa, particularly among mining workers, as it has led to the formation of informal urban settlements. This type of locality is an ideal environment for unhealthy living conditions and unsafe sexual practices. Such is the situation that confronts Free State and Gauteng, as they have the two highest HIV prevalence levels in the country and the highest percentage of people living in urban informal localities respectively.

According to this information, it is possible to conclude that social and economic inequalities greatly determine HIV prevalence levels in South Africa. Nevertheless, poverty is not the only indicator of inequality in the country, although it cannot be isolated from other social disparities. The indicators of gender inequalities are very prominent too, such as rape and abuse of women. Gender inequality in South Africa is closely linked to patterns of sexual violence that are also related to poverty and unemployment because women engage in unsafe situations in order to survive. The major consequence of this phenomenon is the percentage of HIV/Aids-infected women, which is considerably higher than that of men. In essence, what is central to the link between inequalities and HIV prevalence is that indicators such as poverty, unemployment, rape and women's abuse relate to risky situations that advance the spread of HIV. In this sense, migration of labour, informal urban settlements, prostitution by young women's and unsafe sexual practices are the consequences of inequalities at all levels, therefore HIV/Aids can be understood as a holistic problem that affects all layers of society.

Central to the overall picture of HIV/Aids in South Africa, the treatment policy process has been the setting for confrontation between all sectors of society and Mbeki, because of his controversial position on the epidemic. The second section of chapter 1 described the chronology of the process, emphasising the government's reasons for delaying the provision of treatment to HIV-infected people.

The discussion on the reliability of research reports on HIV prevalence and causes of mortality in the country appears to be one of these reasons. I conclude that the accuracy of information about the epidemic in the country has played a crucial role in the formulation of health policies. In South Africa, scepticism over the reliability of reports on HIV/Aids has provided justification for the government's precarious provision of treatment. Mbeki debated the results of the MRC report on the impact of HIV/Aids on mortality levels by arguing that the main cause of the collapse of the immune system in the country was diseases related to poverty and not Aids. In line with his scepticism, and adding to his doubts about the statistics reliability, Mbeki argued that anti-retroviral drugs (ARVs) were toxic and therefore did not support their provision. According to this facts, this thesis argues that Mbeki's sceptical position on Aids delayed the formulation and implementation of the treatment roll-out for HIV-infected people.

Chapter 2 provided the theoretical framework of power and knowledge within which analyse Mbeki's views on the epidemic. Chapter 3 presented, compared and connected his statements on Aids, race, and disease with his idea of African Renaissance and the nation-building project. statements.

Chapter 3 outlines two lines of arguments in analysing Mbeki's position on Aids. The first, labelled counter-scientific, referred to Mbeki's statements that question the link between HIV and Aids and the reliability of ARVs. Through this reasoning, Mbeki explains the epidemic in terms of power, focusing on the subject who has the authority to talk about HIV/Aids in Africa. However, he does not clearly state the mechanisms by which the conventional scientific view on the epidemic has consolidated his authority in talking about Aids patterns in Africa. Instead, he criticises the kind of power that is derived from the knowledge that orthodox scientists have about their own Western epidemic, pointing out that this is not enough to account for HIV/Aids patterns in Africa. This position is vulnerable to criticism because he supports the arguments of dissidents who oppose the conventional scientific statement that 'HIV causes Aids', but do not provide more extensive local knowledge about the factors affecting the epidemic in the African continent. Furthermore, his views of science are very imprecise and his arguments lack of scientific rigour,

which contradicts his claim to limit the debate on Aids to the scientific realm. Instead, he justifies his questioning of a conventional view of the epidemic by discussing historical racist prejudices that, according to him, the Western view of Aids in Africa has reinforced in the present.

In this respect, the thesis concludes that his scepticism over a conventional scientific view of Aids reflects a dispute for authority and power to control the destiny of the South African nation in the present, therefore, his position on Aids transcends the limits of a scientific discussion and exhibits a broader world view.

In order to understand such a world view in the context of the nation's destiny, this research analysed his concept of African Renaissance and his formulation of African identity. This led me to conclude that Mbeki develops a parallel line of argument in talking about Aids in Africa. This reasoning shows that the reformulation of African identity in the present requires, first of all, a shared consciousness of the past of oppression. This principle entails the responsibility of fighting against these images and ghosts of the African past. In line with the first, the second is a principle of self-definition by which African people must not be defined by any historical prejudice based on categories such as race and/or historical origins.

Based on these principles of identity, it might be argued that Mbeki focuses on the legacy of the past in the present, by reverting to the topic of who has the authority to talk about Aids in Africa. His rejection of the link between African people and disease indicates that those who have the authority to talk about Aids in the present are prolonging the link between race and disease that was entrenched in colonial times. The thesis maintains that the debate on Aids is about the knowledge that the West has about the African epidemic. This knowledge, however, does not refer to local patterns of the epidemic's spread or to the commonest ways of contracting the virus, but is a historical knowledge that operated in the past as a medium to control and dominate the African reality. Nevertheless, Mbeki does not clearly present the link between the historical representation of Africans as diseased and his scepticism towards the conventional scientific view on Aids. Furthermore, the discussion on whether the images of the past continue in the present does not provide an alternative solution to the epidemic in Africa.

In applying the concept of alternative modernities to Mbeki's response to Aids in South Africa, this thesis observes that he does not explore a local form of adaptation to the conventional scientific approach to HIV, as Uganda and Senegal's governments have done. A scrutiny of his rhetoric does not suggest a particular African solution to the epidemic, or a response that

combines local and modern practices. Mbeki's approach to HIV/Aids has been in terms of his own scepticism towards what he calls 'absolute truths' and his concern about the extermination of images of the past in the present in order to control the destiny of the nation.

The Africanness that Mbeki refers to in the African Renaissance is an ambiguous concept, as he points out an identity that is exclusive to the people of the African continent, that is, an 'internal' identity. In this sense, he presents himself as a saviour of the continent by using the politics of 'redemptionism'. This combats the representations of African people as diseased and 'devoted to the sin of lust'.

On the other hand his politics of redemptionism turns into a politics of strategy. The strategy, explained in terms of power and knowledge, consists of controlling the process of guiding the African continent towards development. This idea is central to his Renaissance, and it is a call to the people of the continent to have autonomy in deciding their own future and not let others control the process. This is why he affirms: "As Africans we now own the development agenda" (2003). Nevertheless, Mbeki cannot free himself from the language of development, as this is a Western system of representation. That is, even though he challenges the power and the authority to speak about African problems, he does it from the same discourse that defines Africa as a pre-modern and even a-modern continent.

By comparing his line of argument on development with his counter-scientific reasoning, I conclude that there are two different stances. Mbeki does not combat the Western system of representation that defines the continent according to its own categories and principles. This means that he aims to lead Africa towards development in the teleological order that the discourse establishes. But, concerning the conventional scientific view on Aids, his stance turns into a fierce fight against the ghosts and representations of Africa in the past. Such a twist can be explained by his rejection of the link between race, sexuality and disease. I maintain that in doing so, Mbeki attempts to clear up the images of the past that picture African people as 'devoted to the sin of lust', and as 'carrier of germs' in the present.

In essence, Mbeki rejects the relationship between race, sexuality and HIV/Aids, because this contradicts the principles of self-definition and assumed responsibility that his Renaissance defends. This is, Africans are those who share the oppressions and representations of the colonial past and combat them. The discourse of development, instead, does not jeopardise the nation-

building project to the same extent. In this case, he is presumably concerned mostly about the authority to control the process of guiding the continent towards development, and not very much on the knowledge that the West has of Africa.

Lastly, Mbeki's position on Aids has produced a heated debate in the country that has questioned the human rights culture that the South African constitution defends, since the delay to ARVs provision is against the HIV- infected people's right to be treated. The efforts of the TAC in fighting for the provision of ARVs are overwhelming and, an example of alternative modernity in the context of the debate on Aids. However, although this could be a potential subject for further research, it is not this research's concern on this occasion.

BIBLIOGRAPHY

- Agency for International Development U.S.A. 2002. "What Happened in Uganda? Declining HIV Prevalence, Behaviour, Change and the National Response" [online]. Ed. Hogle, J.A. September 2002. Accessed from: http://www.usaid.gov/our_work/global_health/aids/Countries/africa/uganda_report.pdf [Accessed 26 May 2004].

- ANC Message on HIV/Aids (2001). "Prevention is our best defence". *ANC Today* Vol. 1. Number 3. 9-15 Feb 2001. Accessed from: http://www.anc.org.za/ancdocs/anctoday/2001/at03.htm#art1 [Accessed 27 May 2004].

- Azikiwe, N. 1968. *Renascent Africa.* England: Cass

- Barnet, T and Whiteside, A. 2002. "Government and governance". In: *AIDS in the twenty- first Century: disease and globalization.* New York: Palgrave.

- Bullen, Allison. 1999. *The African Renaissance: an assessment of the African Renaissance discourse as a unique strategy for development in Africa.* Thesis (BA. Honours) University of Cape Town.

- Campbell, C. 1997. "Migrancy, masculine identities and AIDS. The psycho social context of HIV transmission on the South African gold mines." *Social Science Medicine,* 42: 273- 281.

- Chipkin, I. 2003. "The South African nation". *Transformation: Critical Perspectives on Southern Africa,* 51: 25-47.

- Cohen, Mike. "Mbeki questions HIV testing." *The Associated Press*, 24 Apr 2001.

- Dirlif, A. "Historical Colonialism in Contemporary Perspective" [online]. *Public Culture,* 14(3): 611-615. Oasis library online: University of South Africa. Available from: http://oasis.unisa.ac.za/search/spublic+culture/spublic+culture/1,1,1,B/l856FF=spublic+culture&1,0,,1,0 [Accessed May 30 2004].

- Dorrington, R., D. Bowne, D., Bradshaw, R., Laubscher, and I., Timaeus. 2001. "The impact of HIV/AIDS on adult mortality in South Africa" [online]. Technical Burden of Disease research Unit. Pretoria: Medical Research Council of South Africa, September 2001. Available from: http://www.mrc.ac.za/bod/index/htm [Accessed April 19 2004].

- Dube, Saurabh. 2002. "Colonialism, modernity, colonial modernities" [online]. *Views from South* 3.2, 197-219. Oasis library online: University of South Africa. Available from: http://muse.jhu.edu/search/pia.cgi [Accessed May 30 2004].

- Elliot, A. and Ray, L. 2003. *Key contemporary social theorists.* United Kingdom: Blackwell publishing.

- Escobar, A. 1995. *Encountering development: the making and unmaking of the Third World.* Princeton, N.J: Princeton University Press.

- Fine, Alan. 2001. "Mbeki questions spending on Aids". *Business Day* 10 Sep.

- Forrest, D. 2001. "Behind the smokescreen". *Mail & Guardian* October 26 to November 1.

- Forrest, D. and Streek,B. 2001. "Mbeki in bizarre Aids outburst". *Mail and Guardian* 26 October to November 1.

- Foucault, M:

  1972. *The archaeology of knowledge.* Great Britain: Tavistock.

  1980. *Power and knowledge.* New York: Pantheon.

  2003. *Society must be defended.* Translated by David Macey. England: Penguin Press.

- Garcia Canclini, N. 1995. *Hybrid cultures: strategies for entering and leaving modernity.* Minneapolis, MN : University of Minnesota Press.

- Geiss, I (1968). *Pan-African movement.* England: Methuen.

- Gilbert, L. and Walker, L. 2002. "Treading the path of least resistance: HIV/AIDS and social inequalities". *Social Science & Medicine,* 54.

- "Government releases parts of Time Magazine to quell Mbeki AIDS controversy." 2000. *South African Press Association*, 10 Sep 2000.

- Harrington, M. 2000. "Brazil: what went right? The global challenge of access to treatment & the issue of compulsory licensing" [online]. Accessed from: http://www.aidsinfonyc.org/tag/activism/brazil.html [Accessed August 4 2003].

- Hatley, W. 2003. "Mbeki defends his use of politics of race in angry swipe at DA's Leon". *Business Day* 20 Jun 2003.

- Jacobs, S and Calland, R. 2002. *Thabo Mbeki's world: the politics and ideology of the South African president.* Pietermaritzburg: University of Natal Press.

- Jewkes, R.K., Levin, J.B., and Penn-Kekana, L.A. 2003. "Gender inequalities, intimate partner violence and HIV preventive practices: findings of a South African cross-sectional study". *Social Science and Medicine,* 56: 125-134.

- Kindra, J. 2001. "ANC in new AIDS denial". *Mail & Guardian December 7 to 13.*

- Kuhn, T. 1970. *The structure of scientific revolutions.* Chicago: The University of Chicago Press.

- Leon, T. 2003. "Forget race card". *Business Day* June 24 2003.

- Marks, S. 2002. "An epidemic waiting to happen: the spread of HIV in South Africa in social and historical perspective". *African Studies* 61.1.

- Mathebe, L. (2001) *Bound by tradition: the world of Thabo Mbeki.* Pretoria: University of South Africa.

- Mbali, M. (2002). "Mbeki's denialism and the ghosts of apartheid and colonialism for post-apartheid AIDS policy-making". *Paper: Public Health Journal Seminar*. University of Natal Medical School: 1-25.

- Mbeki, T:

  1996. "I am an African" [online]. Statement of deputy president Thabo Mbeki, on behalf of the African National Congress, on the occasion of the adoption by the constitutional assembly of the republic of South Africa constitution bill 1996. Cape Town, 8 May. Accessed from: http://www.anc.org.za/ancdocs/history/mbeki/1996/sp960508.html [Accessed 10 December 2003].

  1998. "The African Renaissance, South Africa and the world" [online]. Speech by deputy president Thabo Mbeki at the United Nations University. Tokyo, 9 April. Accessed from: http://www.anc.org.za/ancdocs/history/mbeki/1998/sp980409.html [Accessed 30 December 2003].

  1998. *Thabo Mbeki Africa: the time has come.* Tafelberg: Cape Town.

  2000. "Mbeki's letter to world leaders". In: Reciting comfortable catechisms on AIDS is not good enough. *Sunday Times,* 23 Apr. 2000.

  2000 "Remarks at the first meeting of the Presidential Advisory Panel on AIDS" [online].Pretoria 6 May from:**http://www.anc.org.za/ancdocs/history/mbeki/2000/tm0506.html** [Accessed 18 January 2004].

2000. “Speech of Thabo Mbeki, President of South Africa at the opening ceremony of the 13th International Aids Conference”. Durban, July 9. accessed from: http://www.actupny.org/reports/durban-mbeki.html [Accessed 20 January 2004].

2000. “Mbeki versus Leon”. *Sunday Times* 09 July 2000.

2000. "Government releases parts of Time Magazine to quell Mbeki AIDS controversy." *South African Press Association*, 10 Sep. 2000.

2001. “Address at the inaugural ZK Matthews memorial lecture” [online]. University of Fort Hare, Eastern Cape. 12 October. Accessed from: http://www.anc.org.za/ancdocs/history/mbeki/2001/tm1012.html [Accessed 12 January 2004].

2002. “Letter from the president: Health, month, human dignity and partners for poverty reduction” [online]. *ANC Today,* Volume 2, No 14. 5- 11 April. Accessed from: http://www.anc.org.za/ancdocs/anctoday/2002/at14.htm [Accessed 10 February 2004].

2002. “Address by president Mbeki at the high-level special session of the UN General Assembly on the new partnership for Africa’s development” [online]. New York, 16 September 2002. Accessed from: http://www.africa-union.org/home/Welcome.htm [Accessed 10 February 2004].

2002. “Address by the president of South Africa and chairperson of the African Union, Thabo Mbeki at the 8th ASEAN summit” [online]. Phnom Penh, 5 November. Accessed from: http://www.africa-union.org/home/Welcome.htm [Accessed 10 February 2004].

2004. Interviewed by R., Direko and J., Perlman. Cape Town, 8 February.

- Mcgreal, C. “Mbeki accused of smearing Aids expert.” *The Guardian* 16 May 2002.

- Medical Research Council. 2002. *HIV/Aids profile in the provinces of South Africa* [online]. Accessed from: http://www.mrc.ac.za/bod/AIDSindicators2002.pdf [Accessed 31 May 2004].

- Medicine sans Frontiers. 2002. “Brazilian generic ARV drugs in South Africa” [online]. A historical account of the use of Brazilian drugs in MSF’s antiretroviral programme in South Africa. Accessed from: http://www.accessmedmsf.org/prod/publications.asp?scntid=291200210 contenttype=PARA& [Accessed 14 May 2004].

- Mwaura, P. “Pioneers in the control of HIV/Aids: Uganda and Senegal show that infection rates can be reduced.” *Africa Recovery Online.* Vol. 12 N.4 1999. 17 May 2004. Accessed from: http://www.un.org/ecosocdev/geninfo/afrec/vol12no4/pioneers.htm [Accessed 20 Apr. 2004].

- Nattrass, N. 2004. *The moral economy of AIDS in South Africa.* South Africa: Cambridge University Press.

- Paramshwar, D. 2002. "Towards new imaginaries; an introduction" [online]. *Public Culture,* 14(1): 1-19. Oasis library online: University of South Africa. Available from: http://oasis.unisa.ac.za/search/spublic+culture/spublic+culture/1,1,1,B/l856FF=spublic+culture&1,0,,1,0 [Accessed May 30 2004].

- Pelser, A. 2002. "Contextualising reproductive health care in South Africa". *Strengthening local government and civic responses to the HIV/AIDS epidemic in South Africa*. Ed. Dingie van Rensburg ... [et al.]. Bloemfontein: Centre for Health Systems Research & Development, University of the Free State.

- Posel, D. 2002. "Getting the nation talking about sex; reflections on the politics of sexuality and nation-building in post-apartheid South Africa". *Paper presented to the Amsterdam School,* University of Amsterdam.

- Said, E:

  1978. *Orientalism*. Great Britain: Routledge & Kegan Paul.

  1993. *Culture and Imperialism.* London: Chatto and Windus.

- Schneider, H:

  2002. On the fault line: the politics of AIDS policy in contemporary South Africa. *AIDS in context: special issue of African studies,* 61.

  2001. *The past in the present: the South African AIDS epidemic and policy responses in the context of inequality.* Paper presented at the Centre for Health policy, University of Witwatersrand.

- Schneider, H. and Stein, J. 2001. Implementing AIDS policy in post-apartheid South Africa. *Social science & Medicine, 52*. 723-731.

- Schoofs, Mark:

  1999. South Africa acts up. *The Village Voice*, 28 Dec.

  2000. Flirting with pseudoscience. *The Village Voice*, 21 Mar.

- Shenton, Joan. 2000. "Sitting down with President Mbeki" [online] *Carte Blanche.* 16 April. M-net. Accessed from: http://www.mnet.co.za/CarteBlanche/Display/Display.asp?Id=149 [Accessed 25 April 2004].

- Soul City 2001. "Soul City: mediaedutainment and advocacy for health and development" [online]. Accessed from: http://www.soulcity.org.za/downloads/Final%20Finn.doc [Accessed February 18 2004].

- South Africa Government:

2000. *HIV/AIDS strategic plan 2000-2005* [online]. Accessed from: http://www.gov.org.za [Accessed 26 January 2004].

2002. *Cabinet Statement on HIV/Aids* [online]. 17 April 2002. Accessed from: http://www.info.gov.za/speeches/cabinetaids02.htm [Accessed 1 June 2004].

2002. Update on Cabinet's Statement of 17 April 2002, on fighting HIV/Aids [online]. 9 October 2002. Accessed from: http://www.info.gov.za/issues/hiv/cabinetaids9oct02.htm [Accessed 2 June 2004].

2003. *Statement on special cabinet meeting; enhanced programme against HIV and Aids* [online]. 8 August 2003. Accessed from: http://www.info.gov.za/speeches/cabinetaids02.htm [Accessed 2 June 2004].

2003. *Operational plan for comprehensive HIV and Aids care and treatment for South Africa* [online]. 19 November 2003. Accessed from: http://www.info.gov.za/issues/hiv/careplan19nov03.htm [Accessed 2 June 2004].

- South Africa. Centre for Aids development, research and evaluation (CADRE) and Department of Health. 2003. *Rape and post-exposure prophylaxis in SA: a review.* South Africa: CADRE/Department of Health.

- South Africa. Department of Health .2003. S*ummary report: national HIV and syphilis antenatal sero-prevalence survey in South Africa 2002* [online]. http://www.doh.gov.za/aids/ [Accessed 28 May 2004].

- Statistics SA (Statistics South Africa):

  2000. *Measuring Poverty in South Africa.* Pretoria: Government Publications.

  2000. *Labour force survey.* Pretoria: Government Publications.

- Treatment Action Campaign:

  2003. "Dying for treatment: TAC briefing document on the civil disobedience campaign" [online].

  http://www.tac.org.za [Accessed 27 May 2004].

  2002. "National HIV/Aids Treatment Congress" [online]. http://www.tac.org.za/invite.pdf [Accessed 27 May 2004].

- Turner, V. 2003. "AIDS is not a party political problem". *Mail & guardian* May 5 to May 12.

- UNAids/WHO. 2001. "HIV and Aids in the Americas: an epidemic with many faces" [online]. 1 Jan 2001. Accessed from: http://www.unaids.org/EN/other/functionalities/Search.asp [Accessed 19 May 2004].

- Vale, P and S, Maseko (2002). “Thabo Mbeki, South Africa and the idea of an African Renaissance”. *Thabo Mbeki’s world: the politics and ideology of the South African president.* Ed. S, Jacobs and R, Calland. Pietermaritzburg: University of Natal Press. 121-138.

- Vaughan, M. 1992. “Syphilis in colonial East and Central Africa. The social construction of an epidemic.” *Epidemics and ideas. Essays on historical perception of pestilence.* Eds. T. Ranger and P. Slack. England: Cambridge University Press.