Ignorance is Bliss: The Political Use of Denialism in Thabo Mbeki's AIDS Response

by
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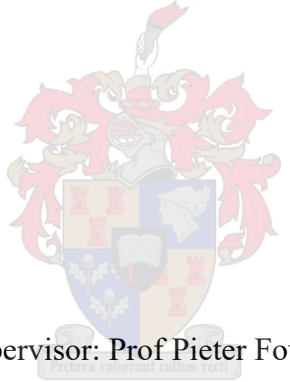

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Abstract

This study analyses Thabo Mbeki's use of denialism in his approach to HIV and AIDS in South Africa, between 1994 and 2008. While in office, Mbeki subscribed to, and promoted, various radical policies regarding the disease. He was severely criticized for the way he dealt with the HIV/AIDS crisis in South Africa. He employed various denial tactics in order to discredit Western medicine, as well as scientific proof of its effectiveness. He held on to the use of traditional medicine, while promoting toxic "alternative" medicine developed in South Africa.

Denialism has been well-documented by Stanley Cohen, a former professor in psychology at the London School of Economics (LSE). In his book, States of Denial (2001), Cohen describes the various types of denial that can be used in either the public sector or in an individual person's private capacity. By looking at the AIDS-related events that occurred between 1994 and 2008, and analyzing those through the lens of Cohen's theory of denialism, it becomes clear which tactics Mbeki employed in order to promote his own agenda and opinions.

The study will, throughout, describe theoretical aspects of denialism, by studying the work of theoretical experts. The reason for this is that, in order to explain the reaction to a problem, the problem must first be properly defined. Following this, Mbeki's years in office are divided into his term as Deputy President, and his two presidential terms. For each of those terms, the study will focus on the most important and memorable events and Mbeki's statements, followed by an analysis based on Cohen's theory in order to answer the research questions.

The aim of the study is to problematise how Thabo Mbeki did not act from a place of ignorance or a lack of knowledge, but how he acted in a detrimental manner in order to retain his position as a "leading figure" in Africa. He was eager to promote Africa as a thriving continent, and he was adamant that the problem of HIV and AIDS could be solved without help from Western scientists.

Opsomming

Hierdie tesis ontleed hoe Thabo Mbeki gedurende 1994 en 2008, in sy benadering tot MIV en VIGS in Suid Afrika, `n beleid van ontkenning toegepas het. Tydens sy ampstydperk het Mbeki verskeie radikale benaderings teenoor die siekte onderskryf en bevorder. Hy is skerp gekritiseer oor die manier waarop hy die MIV/VIGS-krisis in Suid-Afrika hanteer het. Hy het op verskeie, berekende wyses ontkenning as `n beleid toegepas, met die oog daarop om die Westerse medisyne, sowel as wetenskaplike bewyse van die doeltreffendheid daarvan, te diskrediteer. Hy het aan die gebruik van tradisionele medisyne vasgehou, terwyl hy ook gehelp het om toksiese "alternatiewe" middels wat in Suid-Afrika ontwikkel is, te bevorder.

Stanley Cohen, `n voormalige professor in sielkunde aan LSE, het ontkenning as beleidsrigting deeglik gedokumenteer. In sy boek, States of Denial (2001), beskryf Cohen die verskillende soorte ontkenning wat in óf die openbare sektor, óf in individue se privaathoedanigheid gebruik kan word. Wanneer die VIGS-verwante gebeure van tussen 1994 en 2008 bestudeer word, en dié gebeure onder die mikroskoop van Cohen se teorie van ontkenning ontleed word, raak dit duidelik watter benaderings Mbeki toegepas het om sy eie agenda en opinies te bevorder.

Die tesis sal eerstens die teoretiese aspekte van ontkenning ondersoek, deur die werk van teoretiese kenners te bestudeer. Die rede hiervoor is dat, ten einde die reaksie op `n probleem te kan verduidelik, moet die probleem eers behoorlik omskryf word. Daarna word Mbeki se ampsjare tussen sy termyn as Adjunk-president, en sy twee termyne as President, verdeel. Vir elkeen van daardie termyne, sal die tesis fokus op die belangrikste en mees merkwaardige gebeure, asook op Mbeki se verklarings, gevolg deur `n ontleding gegrond op Cohen se teorie, met die doel om die vrae wat in die navorsing ontstaan het, te kan beantwoord.

Die doel van die tesis is om te ondersoek hoe Thabo Mbeki nie uit onkunde of as gevolg van `n gebrek aan kennis opgetree het nie, maar wel hoe hy sy skadelike optrede gevolg het om sy posisie as `n "leierfiguur" in Afrika te behou. Hy was daarop ingestel om Afrika as `n vooruitstrewende vasteland voor te hou, en hy was vasbeslote dat die probleem van MIV en VIGS sonder die hulp van Westerse wetenskaplikes opgelos kon word.

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I would like to take this opportunity to thank everyone who supported me during this process. Firstly, I want to acknowledge my supervisor, Prof Pieter Fourie. His patience, guidance and encouragement are deeply appreciated. Furthermore, I am grateful to my friends and family members who have taken an interest in my studies. My mother, Margaret, was supportive right from the beginning to the end, and always gave me that extra push. I also want to thank my husband, Heinrich, for always believing in me, and for being my biggest cheerleader. I could not have done this without any of you.

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AIDS	Acquired Immunodeficiency Syndrome
ANC	African National Congress
ARV	Antiretroviral
AZT	Azidothymedine
GEAR	Growth, Employment and Redistribution
GNU	Government of National Unity
HAART	Highly Active Antiretroviral Therapy
HIV	Human Immunodeficiency Virus
IMF	International Monetary Fund
MCC	Medicines Control Council
MTCT	Mother to Child Transmission
NACOSA	National AIDS Convention South Africa
NAPWA	National Association of People Living with AIDS
NP	National Party
PIS	Protease Ihibitors
PMTCT	Prevention of Mother to Child Transmission
SA	South Africa
STI	Sexually Transmitted Infection
TAC`	Treatment Action Plan
TRC	Truth and Reconciliation Commission
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
WHO	World Health Organisation

Chapter 1: Problem Statement and Methodology

1.1 The AIDS Epidemic in South Africa

South Africa (SA) and the AIDS epidemic have become almost synonymous during the last three decades. The Human Immunodeficiency Virus (HIV) prevalence rate in South Africa is estimated at 13,1% (Mid-year population estimates, 2018: 7). This means that approximately 7.52 million people are HIV-positive, affecting a large part of the country's possible workforce, caretakers, and infants. Regardless of antiretroviral programmes being implemented, the percentage of people infected with HIV has been increasing, rather than declining. Since 2002, the HIV-positive population has steadily increased from 4,25 million to the most recent estimate of 7.52 million (Mid-year population estimates, 2018: 7). The only demographical group in which HIV infections have been gradually decreasing, is in the youth between the ages of 15 and 24. Overall, HIV prevalence has continued to increase every year.

South Africa's history of the Acquired Immune Deficiency Syndrome (AIDS) began in 1982, when the first cases of infection were identified. Jonathan Mann regarded the period between 1982 and 1985 as years of "intense discovery", unrivalled in pace in medical history (Gallo, 2002: 1728). The government at the time regarded the epidemic as a phenomenon that impacted on the lives of only black people, homosexual people and drug users, and that it could be viewed as their 'punishment'. When Nelson Mandela was elected as the first democratically elected President in 1994, he placed a lot of emphasis on nation building, and reconstructing South Africa after the fall of apartheid. For this reason, combating HIV/AIDS was not a top priority for his government. HIV/AIDS, therefore, took a backseat on the African National Congress (ANC) government agenda before Thabo Mbeki came to power in 1999.

In the HSRC report on HIV and AIDS of 2014 (Shisana *et al*., 2014: xiii), it was stated that treatment programmes had been rolled out successfully throughout the country, and this continues to be true. However, citizens' knowledge about the topic has deteriorated. This leads to the prevalence of dangerous sexual behaviour, which would result in the increased roll-out of antiretrovirals (ARVs) being less effective. Dangerous sexual behaviour includes having sex at too young an age, and not using protective measures.

According to the HSRC report, one of the goals of healthcare specialists is to delay the age at which people have sex for the first time. "Early sexual debut" refers to having sex before the age of 15, and increases the likelihood of young people being infected with HIV (Shisana *et al*., 2014: 65). The report states that having sex at a more mature age reduces the susceptibility, especially for women, to be infected with HIV.

In the HSRC report, it was found that AIDS prevalence rose significantly from 2008 to 2012. The percentage of people living with AIDS had increased from 10.9% to 12.6%. This percentage excludes children under the age of two. AIDS prevalence was also found to be unevenly distributed in SA with regards to "age, sex, race, locality type and province" (Mid-year report, 2016: 7). For example, groups with the highest risks of becoming infected are black African males between the ages of 25 and 49, black African females between the ages of 20 and 34, and people living in informal areas, whether it be in rural or urban areas.

The 2014 HSRC report stated that, of the black African people that are living with AIDS, only 30,9% has access to ART. For other race groups, that percentage was higher, with 41.3% of those patients having access to ART (Shisana *et al*., 2014: 56). This is a clear indication of the unequal level of access to healthcare, based on race.

The major concerns pointed out in the report include the disparity of AIDS prevalence between different socio-economic groups, the fact that co-habiting leads to a higher level of AIDS infection, and that, due to a lack of educational programmes or access to knowledge, large numbers of people are unaware of the fact that they are at risk of being infected (Shisana *et al*., 2014: 125-126).

By observing the statistics mentioned above, it is undeniably clear that AIDS is a severe problem and challenge for South Africa, in more ways than one. Carol Bacchi (2009), David Rochefort and Rodger Cobb (1994), amongst others, have written about policy problem definition. Bacchi describes denialism as one of the methods of defining a problem. Stanley Cohen, a social scientist, refined this viewpoint in his book States of Denial, in which he proposes a model of understanding denialism. This will be the main lens used for analysis in this thesis. Cohen's model proposes many ways of looking at a problem – and, in this case, the problem is AIDS policy in South Africa under Thabo Mbeki.

According to constructivists, public policy problems are social constructs. The theory of constructivism is especially popular amongst science education researchers (Cobern, 1993:

105), and therefore an appropriate tool to use in this research. In regarding problems as being socially constructed, constructivists regard AIDS as being caused purely by the acts of people, rather than a phenomenon that occurs naturally.

The problem of AIDS can, however, be framed in many ways. It can, for example, be viewed as purely a medical problem, an economic problem, or a metaphysical problem. It can also be framed as a social problem, when looking at the discrimination against AIDS patients, as mentioned by Richard Parker and Peter Aggleton (2003). The reason for viewing it as a social problem is that people who have AIDS are often shunned from their communities. The problem of AIDS can also be seen from a Marxist viewpoint, meaning that it is viewed as something which oppresses mainly the working classes. This rings true if one looks back at the statistics above, stating that AIDS affects people in informal living conditions at a much higher rate. Thabo Mbeki supported this Marxist viewpoint, as he blamed the incidence of AIDS in Africa on the difference between classes, reasoning that the continent is poor due to having been exploited by the West for decades.

The many interpretations of the problem led to a difficulty in creating government policy surrounding AIDS. Depending on how a problem is viewed, ideally a relevant solution that compensates for all the interpretations of that particular problem, will be found. For example, if AIDS should be defined as being caused purely by poor personal hygiene, the ideal solution would be to call for immediately improved sanitation facilities in certain areas. If it were caused only by living in poverty, social interventions could help alleviate the problem. However, as stated before, in South Africa and elsewhere, HIV and AIDS is a much more complex problem, partially due to the AIDS denialism employed by Thabo Mbeki.

There have been occurrences of denialism throughout history, such as holocaust denialism and climate change denialism, but the most prominent case for South Africa is that of Thabo Mbeki's AIDS denialism. In fact, Thabo Mbeki's presidency is synonymous with AIDS denialism. Given the proven devastating effects of HIV/AIDS, and resulting effects on health care, economy and society, it is difficult to understand why some individuals choose to deny either the existence of AIDS, the link between HIV and AIDS, or the efficacy of ARVs. Of course, Mbeki is not the only AIDS denialist, but, as former President of the country, he was placed under the spotlight, and his convictions have contributed greatly to the lack of AIDS medication in SA, to the unnecessary deaths of over 300,000 AIDS patients, and to him being recalled as head of state by the ANC.

A basic definition of denialism can be found in Stanley Cohen's book, States of Denial (2001). Cohen was born in Johannesburg in 1942, and studied sociology at Witwatersrand University, followed by a PhD at the LSE (Taylor, 2013). The subject of States of Denial is the "denial of emotion". It deals with ways to avoid uncomfortable situations (Taylor, 2013).

Cohen (2001: 1) states that when a person or organisation is "presented with information that is too disturbing, threatening or anomalous to be fully absorbed or openly acknowledged" the given information is ignored or repressed. In some cases, the provided information is acknowledged, but the possible implications of not taking action are ignored. This is true for all cases of denialism, and also for AIDS denialism.

Seth Kalichman (2014: 14) suggests that AIDS denialism holds seven central beliefs. These are:

- HIV is not a harmful virus, and it is impossible for it to cause AIDS;
- HIV is a benign passenger virus in some people who develop AIDS;
- AIDS is caused by lifestyle, rather than HIV, for example sexual orientation, drug use or living in poverty;
- a person infected with HIV will not always develop AIDS;
- HIV does not fulfil the time-honoured laws of biology, or Koch's Principles, that define infectious diseases;
- AZT and other antiretroviral medicines are toxic and can in fact cause AIDS;
- AIDS in Africa is in fact caused by poverty and not HIV, and is only worsened by the ARVs being distributed, and in other regions it is caused by drug abuse.

Furthermore, both Nathan Geffen and Edwin Cameron (2009: 2) define AIDS denialism as "the systematic rejection, deriving from pseudo-scientific premises, and supported by quasi-rational arguments, of evidence establishing that HIV causes AIDS, that ARVs significantly reduce mortality and morbidity associated with HIV infection, and that there are tens of millions of people in Africa living with HIV or dying from AIDS". When one looks at Mbeki's behaviour, as will be done throughout this study, it is clear that Geffen and Cameron's description is accurate.

According to Jörg Friedrichs (2014: 2), implementing denial is to regard an existing, real problem as unimportant. A real problem is defined as "one that makes us suffer regardless of whether or not we acknowledge it" (Friedrichs, 2014: 4). In South Africa, AIDS has caused

an incredible amount of suffering, not only for patients, but also families. The effect of losing someone through AIDS echoes through generations, both financially and emotionally. For policy makers to view AIDS as a "non-problem", a lot of valid suffering is disregarded.

Heavily connected to 'Aids denialism' is the term 'Mbeki's denial'. Mandisa Mbali, in her article titled *Mbeki's Denialism and the Ghost of Apartheid and Colonialism for post-apartheid AIDS policy-making* (2002: 1), explains the term 'Mbeki's Denial': it is a neologism, in other words a new word, created by AIDS activists in South Africa. It has a stronger meaning than 'scepticism', because it does not refer to a mere "philosophical endeavour" (Mbali, 2002: 1), but rather the denial of scientific facts. The term 'Mbeki's denial' also indicates that his specific form of denial contains fragments of both political beliefs and philosophical ideas, and that it "can be placed in a historical context" (Mbali, 2002: 1). Mbali further states that Mbeki's denialism is in fact a new ideological "-ism", unique to South Africa.

Even though AIDS denialism is one of the prominent cases of denialism in recent history, it is not the only example. Through the disregard of science, AIDS denialism is linked to climate change denialism and evolution denialism (Morrison, 2011: 1). More recently, the case of vaccine deniers has become more common. When these topics are mentioned, emotions can often run high, and people often choose not to discuss them, or to ignore scientific evidence proving the opposite of what they believe. AIDS denialism has also been called "the moral equivalent of holocaust denial" (Bauer, 2007: 116).

HIV and AIDS have led to the demise of millions of people, not only in SA or Africa, but worldwide. However, the way in which the incidence of HIV and AIDS was dealt with by President Mbeki, placed SA in the centre of a controversy. Together with his Minister of Health, Dr Manto Tshabalala-Msimang, he chose to follow the route of AIDS denialism and pseudo-science.

Morris (2011: 3) mentions tactics to promote pseudo-science. He states that denialists, in this case climate change and evolution denialists, reject scientific evidence that is not obvious to them. This means that, if the denialists do not understand an occurrence, they do not believe that it can be explained by science either. This is also true of Thabo Mbeki. He questioned the scientific proof surrounding AIDS as a disease, for example the fact that it is caused by HIV, and the success rates of ARVs. His apparent lack of insight into the disease was displayed in the following statement: "Does HIV cause AIDS? Can a virus cause a syndrome? How? It

can't, because a syndrome is a group of diseases resulting from acquired immune deficiency" (Nattrass, 2005: 1). Instead, he was of the opinion that AIDS was caused by, amongst others, poor nutrition and, in fact, by ARVs themselves. The fact that Mbeki supported the notion that ARVs could cause AIDS, is a prime example of how he aimed to denounce Western science.

AIDS denialism, with its roots in a disregard for science, had a significant impact on the political landscape of SA under the presidency of Mbeki. It has been said that, given Mbeki's nationalist tendencies, he wanted to find an "African solution for an African problem". This can be seen as the reason for him not being supportive of Western medicine. In most areas, Mbeki was seen as a worthy leader. However, his stance on AIDS would unfortunately always be a part of his political legacy.

1.2 Problem Statement and Focus

The information provided above leads to unanswered questions surrounding HIV and AIDS, Thabo Mbeki's presidency, and AIDS denialism. The field of Political Science has not sufficiently dealt with, or described, AIDS denialism. Therefore, this study will focus on the connection between denialism and the AIDS epidemic in SA. When one looks at what AIDS denialists support, it becomes clear that Mbeki was, without a doubt, an AIDS denialist. They deny "that precautions are necessary, that HIV testing is appropriate, that any approved treatments should be used, that treatments save lives, and that AIDS is a real epidemic or condition" (Nattrass, 2007a: 23).

The purpose of this particular study is to identify, describe, and explain the use of political denial, with a focus on AIDS denialism in SA, as used by Thabo Mbeki. The goal is to evaluate whether or not Cohen's model of denial is useful in order to understand and explain Mbeki's actions. It will also aim to understand why Mbeki succumbed to the use of denial. The study will focus on why denialism in general is sometimes chosen – why some controversial issues such as the holocaust are not processed in the public mindset. Denialism has been studied extensively, and the same applies to Thabo Mbeki's stance on HIV/AIDS. However, there has not been a comprehensive, Political Scientific study which specifically focuses on these two fields of study.

Another problem which has to be explored, is the fact that in South Africa, denialism persisted, rather than being rejected, as was the case in other countries. For this reason, the study will focus heavily on Mbeki's reasoning behind his actions.

The importance of this thesis is rooted in the desire to find out why Thabo Mbeki perpetuated AIDS denialism despite the unnecessary deaths that were caused due to a lack of treatment. It is also difficult to understand his reasoning, given the abundance of scientific evidence, and the availability of statistics on successful treatment with ARVs. To understand his reasoning, one must first understand denialism in itself. The function of the thesis will have both descriptive and explanatory value.

Problem definition is discussed in three classic, prominent publications on the topic. These are The Politics of Problem Definition (Rochefort & Cobb, 1994), Frame Reflection (Schön & Rein, 1994) and Constructing the Political Spectacle (Edelman, 1988). These texts will be used to describe the methods used by Thabo Mbeki.

Of course, when looking at a variety of sources, it is not uncommon to find discrepancies surrounding who or what is to blame for a specific problem. However, problem definition is not merely about placing blame somewhere. Problem definition refers to the "process of characterising problems in the political arena" (Rochefort & Cobb, 1994: 3-4).

It should be clear that the existence of AIDS caused a problem for creating public policy, with regards to distributing medicine and providing of care, amongst others. However, the denialist stanc that Mbeki supported, led to such problems being ignored, and therefore the implementation of public policy was severely lacking.

1.3 Research Questions

The topics of AIDS and denialism suggest one primary question that has to be asked, and a series of secondary questions that follow on the primary question. 'Why and how did Thabo Mbeki use political denial as a strategy to respond to the South African AIDS epidemic?' will be the primary focus of this study, supported by these questions: Why is denial often utilised instead of facing controversial issues? What are the implications of following the denialist route instead of looking for solutions? How was the problem of AIDS defined? Why was it denied, despite the prominent problems mentioned in the introduction?

This study is being undertaken to answer the above-mentioned questions. AIDS was, and still is, seen as a challenge for government, but the problem-solving could be aided by finding answers to these questions. The effects of AIDS have been supressed to a certain extent by administering drugs, but the epidemic is far from solved. President Mbeki denied proven and prominent possible solutions, and to get to the bottom of his reasoning, this study will use

Stanley Cohen's model of denial. By using Cohen's model, this study will also aim to explain why Mbeki chose the denialist route in the AIDS epidemic in South Africa.

1.4 Theoretical Points of Departure for Public Policy

In order to address the research problem, Stanley Cohen's types of denial (2001) will be used extensively. States of Denial (2001) is described as a "comprehensive study of both the personal and political ways in which uncomfortable realities are avoided and evaded" (Cohen, 2001). Therefore it will be used to analyse Mbeki's denialist behaviour. The central theoretical aspect in this study is denialism. In the case of Thabo Mbeki and AIDS denialism, there were many forms of denial present. These include literal denial, implicatory denial, and interpretive denial, all described by Stanley Cohen in *States of Denial* (2001). In this case, official denial was used in the public realm to deny that HIV causes AIDS. The implications of AIDS were denied through implicatory denial. Mbeki made use of official denial: this refers to "public, collective, organised" denial, and it is "built into the ideological façade of the state" (Cohen, 2001: 10).

One must also be aware of who the agents involved in AIDS denialism were. Cohen (2001: 15) differentiates between victims, perpetrators and bystanders in what he calls an "atrocity triangle". Victims are people unto whom something detrimental is done. In the case of AIDS denialism, these are the people who did not receive the necessary ARV-treatment. Victims can also deny their HIV-status, when the reality that they face seem too hard (Cohen, 2001: 14). Perpetrators, according to Cohen (2001: 15) are guilty of committing detrimental acts, but during or afterwards, they find ways to deny the meaning of what they are doing. The third factor is the "onlookers, audiences, witnesses, observers, spectators and bystanders". They know about the acts being committed, or hear about those afterwards. There are three types of bystanders. The first type is immediate bystanders, who are "actual witnesses to atrocities and suffering or hear about those at the time from first-hand sources" (Cohen, 2001: 15). External or metaphorical bystanders hear about the events from secondary sources, for example the media or international organisations. The last type of bystander is bystander states, which refers to other governments or international organisations (Cohen, 2001: 15).

Public policy experts such as Carol Bacchi and Stanley Cohen produced bodies of work that are useful for reaching an answer to the problem statement mentioned above. Stanley Cohen's spectrum of denial is extremely useful in identifying AIDS denial in South Africa, as he looks at the actions of both the perpetrators and the victims.

Public policy is "a system of laws, regulatory measures, courses of action, and funding priorities concerning a given topic promulgated by a governmental entity or its representatives" (Kilpatrick, 2000). According to Thomas Dye**,** in simpler terms, it is "whatever governments choose to do or not to do". For this study, South Africa's health policy will be the focus. This means that it will focus on the measures that the government did, or did not, take in relation to the AIDS epidemic. To better define this, one can refer to what is called non-public policy. This is described as "un-codified, non-legislated actions of government that are in themselves a form of public policy" (Kilpatrick, 2000). This means that when a government decides to ignore, or *deny*, a problem, it is in fact displaying a form of public policy. This is particularly true when referring to the Mbeki government and its reaction to the crisis of AIDS in South Africa.

Carol Bacchi (2009: 25), an Emeritus Professor at the University of Adelaide, proposes a "What's the Problem Represented to be" (WPR) approach. An approach like this consists of three propositions. These are "that people are governed through problematisations, that the problematisations, rather than the problem itself, should be studied, and that the problematisations on offer need to be problematized and analysed by scrutinising the premises and effects of the problem representations they contain".

In policy, Bacchi (2009) identifies two competing theoretical paradigms to which this research can be applied: the biomedical paradigm, and the social paradigm. The former "focuses on technology-based medical care and biomedical public health interventions such as immunisation and health screening". In this paradigm, health is viewed as the absence of disease, and an emphasis is placed on physical diseases, rather than mental disorders (Bacchi, 2009: 128-129). The latter "understands health as a social phenomenon, a product of complex environmental and social factors" (Bacchi, 2009: 128). In the social paradigm, health is equated to wellbeing, meaning that it refers to more than physical health. According to the World Health Organisation, health is defined as "a state of complete physical, mental and social wellbeing" (Bacchi, 2009: 129).

In South Africa, the two paradigms had differing support bases. Thabo Mbeki very publically described AIDS as a social problem, something caused by poverty, colonisation, and the oppression of Africa by the West. This viewpoint is of course also linked to the overall mental wellbeing of a person, as mentioned by Bacchi. When a person is oppressed, his or her mental wellbeing will also suffer. Mbeki's opposition was focused more on the

biomedical paradigm, and was looking for proven medical solutions to the AIDS problem in South Africa. When deciding in which manner to take on the problem of AIDS in South Africa, it was difficult to reach a conclusion about the best practice to follow, as there were so many varying viewpoints about what type of problem the country was facing.

1.5 Research Design and Methods

This study will primarily be qualitative. Qualitative research refers to a research approach in social research "according to which research takes as its departure point the insider perspective on social action" (Babbie & Mouton, 2012: 270). The aim of using qualitative methods of study is "to study human actions from the perspective of the social actors themselves" (Babbie & Mouton, 2012: 270). Qualitative methods are used when it is necessary to describe and understand human behaviour, rather than explaining it (Babbie & Mouton, 2012: 270). In order to understand the human behaviour in this study, new insights must be gained (Mouton & Marais, 1996: 43). This will be done by analysing the orders of events from 1994 to 2008, based on Cohen's model of denialism.

Qualitative researchers are interested in "describing the actions of research participants in great detail, and then attempting to understand these actions in terms of the actor's own beliefs, history and context" (Babbie & Mouton, 2012: 270). For this study, it means that Thabo Mbeki's reaction to the HIV-epidemic will be thoroughly studied in line with his own convictions regarding his history and beliefs.

This study will rely on secondary sources related to the research question. These will include books, journal articles, news articles and grey literature, which refers to official policy documents and statements. It will focus on political denial in the first section, with a case study on Thabo Mbeki and AIDS denialism in the second section, to illustrate the use of political denial in SA.

Case studies, such as this one, allows the researcher to gather a wealth of information on a specific topic or theme, in order to gain insight into a current phenomenon. The case study design was chosen as it is the most useful research method for this part of South Africa's modern history that had, and still has, an indescribably large impact on various levels. The case of AIDS denialism in South Africa, and the policies surrounding it and resulting from it, is completely unique, and cannot be compared to any other case of denialism that has ever occurred. It is for this very reason that a case study design will be followed, as this method is particularly suitable when one has to take an in-depth look at an issue (Crowe, Cresswell,

Robertson, Huby, Avery & Sheikh, 2011: 1). Case studies are also useful when one has to understand in which way, and through which events, certain phenomena are connected (Crowe *et al*., 2011: 4). However, prior to the case study, which will make up the main body of this research, theoretical frameworks that will help to answer the main research questions, will be observed.

1.6 Structure of the Thesis

Chapter One: Research Proposal and Design

The study will begin with an introduction, in which a history of AIDS in SA will be given. It will also look at denialism in general, with regards to Stanley Cohen's model. Furthermore, previous research into denialism will be explored.

Chapter Two: History of Mbeki's AIDS Denialism

This chapter will have two sections. The first will focus on the existing literature on denialism, with reference to, amongst others, climate change denial and holocaust denial. The second section will focus on literature on AIDS, Thabo Mbeki's method of governance, and why he was in favour of AIDS denialism. It will also mention the way in which HIV and AIDS were denied by both the apartheid government, and the presidency of Nelson Mandela.

Chapter three: Theoretical Approach of Mbeki's AIDS Denialism

Chapter Three will focus on the theory surrounding denialism. Firstly it will discuss Carol Bacchi's work surrounding problem definition, especially regarding AIDS as a non-problem. This will link to Stanley Cohen's work on denialism. His model for denialism will be analysed, and emphasis will be placed on the application thereof on AIDS denialism by Thabo Mbeki.

Chapter four: Mbeki as Deputy President

Following the theoretical section, the first chapter on Thabo Mbeki will focus on the period from 1994 until he was elected as President. This will include the Virodene-saga, the play Sarafina II, tension between Thabo Mbeki and the Medicine Control Council, and the consequences of the use of Virodene.

Chapter five: Mbeki's First Term as President

This section will focus on Mbeki's first term as President. In September 1999, he was labelled as an AIDS denialist. AIDS became politicised, and was seen as a nationalist issue. By the end of this period, Mbeki had withdrawn from public commentary on HIV and AIDS.

Chapter six: Mbeki's Second Term as President

This section will focus on the period 2003 to 2008, when Mbeki was recalled as President of the ANC, and of SA. During this phase, the "Lazarus Programme" was being suggested as a cure for AIDS – a diet of lemons, garlic, and beetroot, amongst other things. By the middle of 2007, donors and members of AIDS organisations came to realise that South Africa's AIDS pandemic would not be combatted while Mbeki and his Minister of Health, Manto Tshabalala-Msimang, were in government

Chapter seven: Conclusion

The conclusion will provide a summary of the study, and solve the problem and answer the Research Questions. Finally it will identify areas for further research.

Chapter 2: History of Mbeki's AIDS Denialism

2.1 Introduction

In the previous chapter, the research proposal was set out, the problem of AIDS denialism was defined, and a brief history of AIDS denialism in SA was given. Following the research proposal, this chapter will discuss the existing literature on Thabo Mbeki and AIDS denialism. The chapter is organised chronologically, consisting of five sections. The sections focus on the era of apartheid (up to 1994), Mbeki's term as Deputy President (1994 to 1999), his two presidential terms (1999 to 2004, and 2004 to 2008), and finally the chapter will describe the consequences of his denialism, in the years following 2008. The chapter focuses on the problems surrounding AIDS in South Africa. More specifically, it looks at the sources that describe how the problem was dealt with in South Africa. It briefly mentions the attitudes of the apartheid government and the Mandela regime, after which the focus falls on Thabo Mbeki. Mbeki's connection with AIDS can be divided into three distinct periods with distinct characteristics. The first period spans the years from 1994 up to 1999, when he was Deputy President of SA. The second period ranges from 1999 to 2004. During this period, the notorious Manto Tshabalala-Msimang became the Minister of Health (Butler, 2005: 594). The final period lasted from 2004 to September 2008, when he was ousted from the ANC and replaced by Jacob Zuma as the leader of the party.

2.2 AIDS Statistics for South Africa

To understand AIDS denialism, one must first understand its history. The spread of AIDS denialism can, at least partially, be blamed on Peter Deusberg. In the 1970s, he was one of the first scientists to discover the key properties of retroviruses. For this, he received international acclaim and recognition from the international science community. However, in 1987, he published a paper in which he made the claim that HIV is a "passenger" virus which does not cause any harm to the body or immune system. Together with his colleague, David Rasnick, Duesberg claimed that HIV "did not conform to the expected epidemiological patterns for viral pathogens. Instead, it looked more like a linear progression of illnesses caused by environmental factors" (Decoteau, 2013: 79). The factors they mentioned include poverty and pollution. Through this reasoning, they concluded that HIV does not cause AIDS. Their study managed to convey the message of two theories to Mbeki: that the drugs that were being used to treat AIDS were in fact causing the illness, and "because parasites and bacterial and viral infections are carried at a higher disease load by people living in

poverty, many Africans were probably already infected with AIDS by the time they contracted HIV" (Decoteau, 2013: 80). Based on AIDS denialism, Mbeki aligned himself with a strategy that perpetuated certain beliefs about the West, and disregarded science in order to represent himself as someone who was extremely loyal to the African continent and his voter base.

Since AIDS is still a prominent issue in SA, there are countless publications, both academic and non-academic, on the topic. In *HIV/AIDS in South Africa* (Karim & Karim, 2005: 48), some experts give thorough accounts of all issues related to the pandemic. SA has experienced one of the fastest growing HIV epidemics in the world. The epidemic is characterised by high HIV prevalence, fuelled by high rates of new infections in young women.

Since the epidemic has been such an enormous challenge for the country, there is an abundance of literature on the topic. These range between books, academic articles, grey literature, and opinion editorial pieces. The sources originate with academics, health care workers, victims, and politicians, amongst others. However, the focus here will fall on academic literature.

As stated in the first chapter, approximately 13,1% of the South African population is HIV positive, and it has steadily increased over the decades, rather than showing a decrease. With the latest statistics released, the HIV-positive population is estimated to be at 7,52 million people.

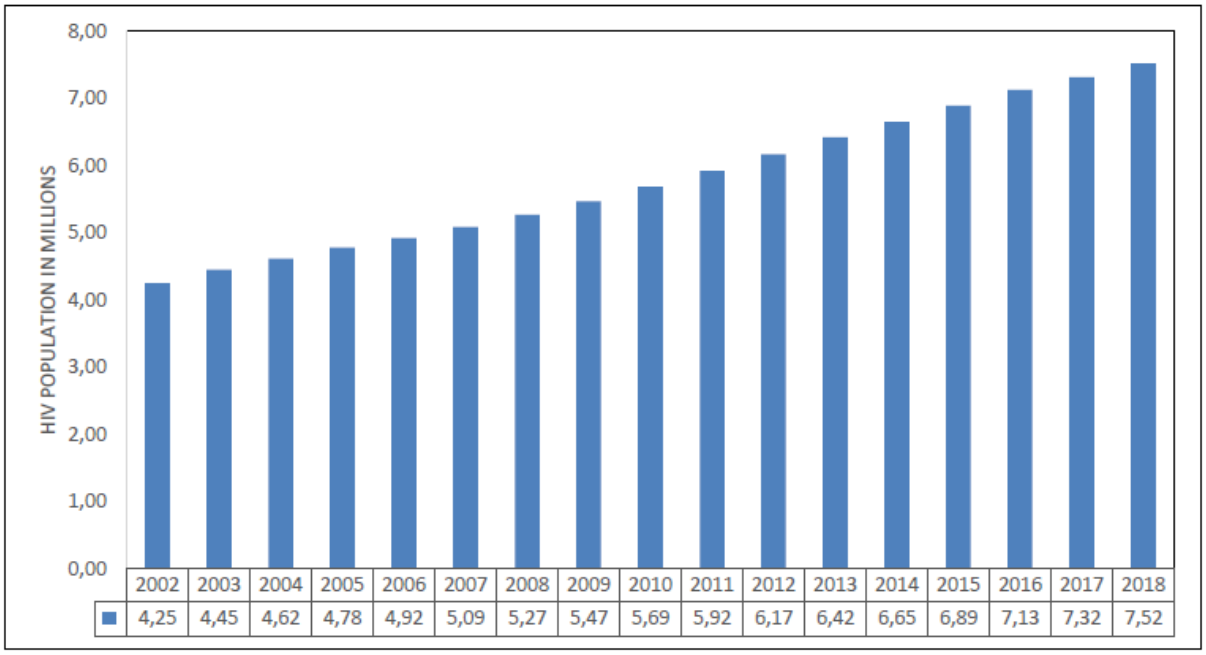

Figure 2.1: Number of citizens living with HIV

Source: Statistics South Africa, 2018

One can also look to the UNAIDS regional report of 2013, titled *Getting to Zero: HIV in Eastern and Southern Africa*, which states that AIDS denialism caused the unnecessary deaths of more than 300,000 people. The detrimental social and economic effect of AIDS denialism will be explored in this chapter.

Given the number of people who have been affected by the disease, whether directly or indirectly, it is clear why a vast amount of literature has been written about it from many points of view. AIDS does not only affect the people who are infected with it. Families and health workers are affected, and it also has a large impact on the country's economy, as well as the fabric of society.

Edwin Cameron, well-known South African Constitutional Court judge, has been very open about his HIV status. Cameron states that the denialist position originated on the west coast of America amongst a small group of scientists. They were of the opinion that HIV is an epidemic which is limited to the "gay lifestyle". These scientists also stated that the virus was neither viral nor infectious (Currell, 2002: 416). Cameron also explains how AIDS denialism has made its way from the American scientists to members of the South African government, hinting at Thabo Mbeki. He states that the beliefs of "powerful people in South Africa" stems from their own ideas about race and sex (Currell, 2002: 416). Cameron goes further by

stating that AIDS dissidents, people who go against the status quo, try to draw a distinction between African and European practices. Furthermore, Cameron states, the dissidents are trying to infer that "if you explain HIV transmission sexually you are condemning Africans' sexual behaviour" (Currell, 2002: 417). This opinion of Cameron can be linked to Mbeki's statements about AIDS as a problem that requires an African solution. One of the refrains that Thabo Mbeki often repeated, was that Africans were being blamed by the West for the spreading of HIV.

The policy followed by Mbeki was based on denialism, and although it was not the official stance of the South African government, there was enough evidence of it to warrant thorough research of his stance on HIV and AIDS. Literature on policy creation, such as that of Carol Bacchi (2009) will be used to properly analyse the policy changes in South Africa. Psychology and Political Science can be linked through denialism, since denialism has its origins in the field of Psychology, and when linked to Carol Bacchi's work on public policy, Psychology becomes relevant to Political Science.

Writings on AIDS denialism have come from dissidents, but there are also many publications that are critical of the denialists. The literature on AIDS denial in SA can be divided into two categories, according to Fourie & Meyer (2010: 50). The first selection of literature provides a historic overview of official denial during the AIDS epidemic, and the second category of literature attempts to explain AIDS denialism by suggesting possible motives and other agendas.

There are two types of denial surrounding HIV (Altman, 2006). Firstly, the existence of the disease itself has been denied. Secondly, the manners in which the disease is being spread were also denied (Altman, 2006: 257). This links to the spread of AIDS being blamed on, e.g., poverty and poor nutrition rather than on the virus.

The same applies to a speech that Edwin Cameron delivered in 2000 at the Jonathan Mann Memorial Lecture. The speech was published as an article titled *The Deafening Silence of AIDS* (2000). Cameron makes the statement that people living with AIDS have been discriminated against and stigmatised without exceptions (Cameron, 2000: 9). Cameron also mentions that the epidemic shifted from victimising the homosexual communities in North America and Western Europe to the primarily heterosexual population of the African continent as well as other parts of the developing world.

The surrendering to "conspiracy theories, quack medicine, bogus science and fake history" is a prominent part of AIDS denialism (Thompson, 2008: title page). "Counter-knowledge" is defined as "misinformation packaged to look like fact – packaged so effectively, indeed, that the twenty-first century is facing a pandemic of credulous thinking" (Thompson, 2008: 1). Thomson's book is relevant to AIDS denialism since many people, specifically quacks, tried to profit from the misery of desperately ill people who were willing to try any remedy available.

Martin McKee (2009: 2) tells of the Hoofnagle brothers of the USA, who have worked extensively to establish a sure definition of denialism. The brothers, a lawyer and a physiologist, define denialism as "the employment of rhetorical arguments to give the appearance of legitimate debate where there is none, an approach that has the ultimate goal of rejecting a proposition on which a scientific consensus exists". Thabo Mbeki can be regarded as the epitome of a denialist, as he publicly and blatantly disregarded any and all scientific proof of the benefits of Western medicine, denied the link between HIV and AIDS, and promoted traditional methods in favour of proven scientific remedies.

McKee (2009:3) further states that each instance of denialism employs one or more of five characteristics. These characteristics are the identification of conspiracy theories, supporting fake experts, the use of carefully selected sources and articles that are against the generally accepted scientific standpoint, harbouring unrealistic expectations of what scientific researchers should be able to prove, and misrepresentation and the use of logical fallacies.

2.3 AIDS under Apartheid

South Africans started to become aware of AIDS in the early 1980s, when cases of homosexual men having contracted AIDS, and patients who received unsafe blood transfusions, came to light (Karim & Karim, 2005: 31). Since then, the number of AIDS patients in SA has increased exponentially, and many of the cases could have been prevented if it was not for the denialist stance taken by Thabo Mbeki, former President, and his Minister of Health, Manto Tshabalala-Msimang (Butler, 2005: 593).

The fact that the South African government paid little attention to the looming AIDS threat since 1982, has resulted in a serious, on-going crisis with regards to economic and social issues. It is pointed out that since the National Party (NP) government ruled SA, government policies failed to address the problem in a suitable manner. The reasons for this included homophobic and racist assumptions regarding the cause of the disease and an exclusivist

manner of policy consultation. This led to inappropriate and unsuitable policies being created, ineffective actions being taken and a lack of legitimacy to the actions taken (Fourie, 2006: 4).

One of the most comprehensive sources on the topic of the apartheid government's response to the epidemic is the first chapter in *HIV/AIDS in South Africa* (2010). The reason for the lack of information on this topic is that the government of that time − specifically between 1982 when AIDS was becoming public knowledge in South Africa, and 1994 − regarded AIDS as a "gay epidemic" which would be contained to high-risk groups in urban areas (Karim & Baxter, 2010: 40-41).

The involvement of civil society in responding to crises stems from the apartheid government's refusal to involve citizens in combatting HIV/AIDS during the 1980s (Heywood, 2004: 94). Heywood also mentions that these partnerships were very necessary since the government's own strategies were reflections of its "prejudices and ignorance". One can deduce once again, that the NP government did not deem it necessary to do any work to stop the spread of HIV because, according to them, it was only affecting marginalised groups which were of no interest to them.

In connection to this, in 1990 the "Maputo Statement on HIV and AIDS in South Africa" was issued by the then-banned ANC in conjunction with many local anti-apartheid groups such as the National Medical and Dental Association, and the AIDS Consortium (Karim & Baxter, 2010: 41). This statement prioritised the government's need to act regarding the prevention of AIDS. In 1993, the National AIDS Convention of South Africa (NACOSA) was created. This organisation involved representatives from both the apartheid government, and anti-apartheid activists (Karim & Baxter, 2010: 41).

There is a 'unique' history that HIV and AIDS has in South Africa (Altman & Buse, 2012) given its early connection to homosexuality and drug use. The authors also state that early activism by homosexual people set the model for effective mobilisation. 'Thinking politically about HIV' is a UNAIDS and International AIDS Society initiative. Their paper explains the discussions around the initiative, as well as the challenges facing AIDS policy makers. The authors further argue that Political Science has ignored the epidemic, but that "other disciplines and traditions provide rich accounts of the exceptional response" (Altman & Buse 2012: 127).

Contrary to the above-mentioned article, Paxton (2012: 141) makes the statement that Political Science has already extensively dealt with the politics surrounding AIDS, and the policies that go along with it. However, it does state that the epidemic has not yet become a research agenda in its own right. It is suggested that Political Science has organised the study of HIV and AIDS into four groups or themes. Those are:

- The growth and extension of global and comparative health policy;
- How the spreading of the epidemic has affected the progress of international development;
- Effects on state security environments, internally and externally;
- How the politics of HIV have affected, and have been affected by, trends in governance, on all political levels" (Paxton, 2012: 142).

These four groups can indicate a gap in the existing literature, especially given that the epidemic itself is not yet an independent academic field. For there to be sufficient literature on HIV, AIDS, and the themes surrounding it, it has to be recognised as a full-fledged academic field.

Fourie and Meyer offer a theory of denial (2010: 36). They state that all government action that has taken place since the first two South African AIDS cases were publicised in 1982, are considered in the forming of their theory. Also, they attempt to find a tool suited to facilitate closer investigation into this theory. Fourie and Meyer used Stanley Cohen's typology of official denial as it is the most suited means to identify and analyse occurrences of AIDS denial by the government. The hypothesis proposed by Fourie and Meyers (2010: 45) is as follows: "that South African governments have been in a state of denial over the HIV epidemic long before Mbeki's controversial tenure".

Fourie (2006) describes HIV-policy in SA during the apartheid era, i.e. under the governance of P.W. Botha and F.W. de Klerk of the National Party (NP). Fourie states that the spread of diseases depend as much on the virus itself as on the circumstances of the country in which it can be found. In 1982, when SA became aware of the first case of AIDS in the country, the government followed the apartheid policy, based on racial segregation and discrimination. The situation in SA was one of "unequal distribution of resources, widespread poverty, the profligate duplication of civil services, international isolation and regional military insurgencies, the absence of democracy and effective/good governance, domestic political instability and gender inequality" (Fourie, 2006: 51). Also, the population of SA was ignorant

about HIV and what it entailed. Add ignorance in all spheres, to a government which did not favour rural health care, and it becomes clear why the disease had a favourable environment in which it could spread.

Boundaries of Contagion: How Ethnic Politics Have Shaped Government Responses to AIDS (Lieberman, 2009) attempts to answer the question of why governments respond in such different ways to HIV, especially in developing states. The book contains three case studies – India, Brazil, and South Africa, which are the most useful for this study. AIDS policy in Brazil and South Africa is compared and contrasted, focusing on the period from 1982 to 1996. It is stated that the Brazilian federal government responded in a strong manner, and has had successes in the areas of prevention and treatment while, on the other hand, South Africa's government is described as dragging its feet (Lieberman, 2009: 110-111). An explanation given for the difference in actions is the influence of "boundary institutions, particularly with respect to the ethnic cleavage of race" (Lieberman, 2009: 111).

To understand the apartheid regime's responses to the AIDS epidemic, one must also understand the social effects of the disease (Kauffman & Lindauer, 2004). Virginia van der Vliet maps out what she calls "the rocky road to a united response" (Kauffman & Lindauer, 2004: 49). She dedicates a section to each government regime since the onset of the epidemic in South Africa, thus starting with the apartheid regime in 1982, and ending at 2003, at the end of Mbeki's first term as President. By 2003, government responses to the epidemic were still lacking a link between "rhetoric and reality" (Patterson, 2005: 145).

It is often useful to gain a perspective from someone who has personally been affected by AIDS. Constitutional Court Justice Cameron was infected with HIV in 1986 (Cameron, 2014:64), and therefore he knows what it is that AIDS-sufferers in South Africa have to endure. Cameron's earlier book, *Witness to AIDS* (2005), is described as both an autobiography and an analysis of the AIDS-situation in South Africa. It contains a chapter called *The tragedy of AIDS denialism in South Africa* (2005:103-122).

2.4 Mbeki's Years as Deputy President

Mbeki was South Africa's Deputy President from 1994-1999. Celia Farber, described as "the most dangerous AIDS reporter" states that even though it was claimed that AIDS originated in Africa, this is untrue since it was discovered in the United States of America in 1981, and was not detected in Africa until 1983 (2006: 185). This is significant, because the disease is such a big problem for the African continent. Also, Mbeki described AIDS as an African

problem, and thus stated that it is imperative to find a purely African solution. In fact, Farber's statement threatens Mbeki's stance on AIDS being an African problem. It might be seen as a problem *for* Africa, but it is not uniquely African.

There are two focus questions that can be considered when looking at the AIDS crisis in SA. These are: "why does South Africa have one of the worst AIDS epidemics in the world, and why have all attempts to deal with it led to deepening controversy and strife?" (Lawson, 2008).

AIDS denialism has been compared to holocaust denial (Bauer, 2007: 117) Bauer quotes John P. Moore and Robert Gallo, who wrote that:

> "Analogous to holocaust denialism, AIDS denialism is an insult to the memory of those who have died of AIDS, as well as to the dignity of their families, friends and survivors. As with holocaust denialism, AIDS denialism is pseudoscientific and contradicts an immense body of research. But in contrast to holocaust denialism, AIDS denialism directly threatens lives today by trying to fool laypeople at risk of HIV not to get tested for the virus or not to practice safer sex. It also tries to fool those who need ARVs not to take them".

It is interesting to note that denial is referred to as "useful lies" by Jörg Friederichs in the title of his article *Useful Lies: The Twisted Rationality of Denial*. Indeed, it is a different perspective on the problem of AIDS denialism. Friederichs defines denial as "the habit of treating a real problem as if it were a non-issue" (2014). He employs a quote by MacKenzie (2010) to illustrate the detrimental effect that denial can have:

> "Denialism has already killed. AIDS denial has killed an estimated 330,000 South Africans. Tobacco denial delayed action to prevent smoking-related deaths. Vaccine denial has given a new lease of life to killer diseases like measles and polio. Meanwhile, climate change denial delays action to prevent warming".

The ANC came to power with the ideal plan on paper to combat AIDS (Butler, 2005: 593). At the National AIDS Convention of South Africa (NACOSA) held in 1992, the ANC, UDF and NP were brought together to create the plan. The plan was in place when the ANC took office in 1994. Butler, however, mentions that with the creation of the plan, South Africa's

available economic and human resources were overestimated (2005: 593). Butler defines Mbeki's denialist thoughts as focusing "on the unreliability of biomedical science, the unscrupulous profit-mongering of international drug companies, and the racial denigration that lies behind attributions of African HIV-prevalence, to sexual excess or perversity" (Butler, 2005: 603).

Butler (2005: 591) also explains what he describes as the "controversial post-1994 HIV/AIDS policy". He mentions two sets of policy prescriptions; the "mobilization/biomedical paradigm" and the "nationalist/ameliorative paradigm" (Butler, 2005: 595). Butler describes both paradigms in detail, and mentions that the ANC-government employed aspects of both policy paradigms. The "mobilization/biomedical" paradigm placed emphasis on the importance of social mobilisation, political leaders and the availability of ARVs. The "nationalist/ameliorative" paradigm focuses on poverty reduction, "palliative care, traditional medicine, and appropriate nutrition" (Butler, 2005: 591). Butler further makes the statement that the ameliorative paradigm was more popular with the state than the biomedical/mobilization paradigm (Butler, 2005: 592). He clearly explains the ways in which the post-1994 government went about implementing a national AIDS strategy, and highlights some of the most important points of criticism against Thabo Mbeki (Butler, 2005: 597).

Karim and Baxter (2010: 41) also refer to the government's AIDS strategy after the first democratic election in 1994. The Mandela-government adopted the NACOSA plan. According to the authors, it was the "first credible response to the HIV epidemic", and was ranked as a top priority as part of the ANC's Reconstruction and Development Programme Lead Projects. As mentioned in the first chapter, HIV did, however, not receive a lot of political support, since the construction of a non-racial, post-apartheid society was deemed top priority.

Hadland & Rantao (1999: 99) explain how Mbeki came to support the controversial drug Virodene. In 1996, Winnie Madikizela-Mandela was fired from her position of Deputy Minister due to her ignoring commands from her superiors, and abusing privileges. Following her expulsion, Mbeki became involved with a group of South African researchers who announced that they had developed a cure for AIDS. Even though the product was rejected by medical professionals, Mbeki supported the Minister of Health at the time, Nkosazana Dlamini-Zuma. He allowed her to present the researchers' findings to the cabinet, and

became a serious supporter of the product, which has still not been proven to be effective in combatting AIDS.

During Mbeki's time as Deputy President of South Africa, the issue of Prevention of Mother to Child Transmission (PMTCT) was widely discussed. It was in 1998 that Nkosazana Dlamini-Zuma announced that the drug Azidothymedine (AZT) would not be made available for MTCTP (Nattrass, 2004: 47). Fourie (2006: 5) further divides the ANC's handling of AIDS into the Mandela era and the Mbeki era. He states that a lack of capacity between different government spheres led to the government failing to effectively implement the AIDS strategy which was, in fact, at its disposal in 1994. The problems surrounding the Mandela-government were compounded by the Mbeki-government – a government which was extremely defensive when criticised.

2.5 Mbeki's First Presidential Term

This section of work focuses on the period from when Mbeki was elected as President of South Africa, to the end of his first term, between 1999 and 2004. Mbeki has come under intense scrutiny for his statements on AIDS during this time, and this section will provide a better understanding of this era.

In 1999, as part of the Treatment Action Campaign's (TAC) PMTCT campaign, the organisation provided more and more AZT and nevirapine to pregnant women who came to their antenatal clinics. In reaction to the TAC's actions, Mbeki questioned the safety of AZT, and labelled it as "toxic" (Decoteau, 2013: 79). In June of that year, Thabo Mbeki appointed Manto Tshabalala-Msimang as his Minister of Health (Butler, 2005: 593). Over the following decade, their denial of AIDS, and the mismanagement of the health system would lead to many unnecessary deaths. Since October 1999, shortly after being elected President, Mbeki expressed scepticism about the use of the ARV AZT. He responded to requests to make AZT available in SA by saying that there is "a large volume of scientific literature alleging that, among other things, the toxicity of this drug is such that it is in fact a danger to health" (Louw *et al*., 2010: 10). However, his denial of AIDS became known even before that, in 1997 when he expressed his support of Virodene, developed at Pretoria University.

In 1997, when Mbeki was still the Deputy President of South Africa, he voiced his support for clinical trials on Virodene. According to a cabinet member, Mbeki "couldn't wait to prove Africa's potential in the field of science and technology". As mentioned in other sources too,

the Medicine Control Council (MCC) eventually blocked clinical trials in the country (Decoteau, 2013: 79).

Mbeki's denialist stance can partly be blamed on his independent research conducted on the internet. According to Seth Kalichman (2014: 20), "denialism flourishes on the internet". He further states that there is much more unreliable, unscientific information on HIV and AIDS available.

AIDS denialism became a well-known topic during the Mbeki-government's era. Many publications deal with this as it is one of the causes of the widespread AIDS epidemic in SA. Mark Heywood stated in a journal article (2009: 16) that the TAC did not start out with the goal of tackling the South African government. When the TAC was launched, they regarded large, privately-owned pharmaceutical companies. However, it has already been stated many times that the aims of the TAC changed when they were faced with a denialist government. Heywood stated that the TAC's starting point was to insist that the excessive pricing of essential medicines by multi-national pharmaceutical companies violated a range of human rights.

Since Thabo Mbeki is the central figure in this study, it is also necessary to study one of his biographies, *Fit to Govern* (Roberts, 2007). However, Ronald S. Roberts makes the statement that it is, in fact, not a biography but rather "a displacement of certain fictions – an engagement with many of the myths that have piled themselves high around Thabo Mbeki. Roberts dedicates two chapters to what he calls "a clash of fundamentalisms", or, the politics of AIDS. The first of the chapters focuses on the medical politics, while the second one focuses on the racial politics surrounding HIV and AIDS. The credibility of this source can come into question, given that it is written from a biased perspective. The intention of the book is to defend some of his actions as President, most notably his controversial stance surrounding HIV and AIDS. When analysing other, more scientific, sources, one will come to realise that his defence is weak.

Taking into consideration the fact that there are so many opinions about HIV and AIDS, there are bound to be conflicting opinions. In reaction to *Fit to Govern* (Roberts, 2007) Anthony Brink (2008) published *Lying and Thieving: The fraudulent scholarship of Ronald Suresh Roberts in 'Fit to Govern: The Native Intelligence of Thabo Mbeki'*. It is, to quote Brink, "a critical analysis" of the two chapters in *Fit to Govern* (Roberts, 2007) which focus on Mbeki's AIDS policies. According to Brink, Roberts is an "extensive plagiarist, a fabricator

and falsifier of history, and the author of a colossal literary fraud". Brink goes further by calling Roberts an "unprofessional and discreditable" writer.

Gevisser (2007: 277) wastes no time in pointing out some of Mbeki's cringe-worthy moments during his presidency. For example, he mentions Mbeki opening the global AIDS conference in Durban during the first year of his presidency, where he made the statement that AIDS is not caused by HIV but rather circumstances such as poverty and poor nutrition (Gevisser, 2007: 277).

Patrick Bond contributes to Gevisser's publications, by mentioning other scapegoats with his article called *South Africa's Deadly Decade of HIV Denial* (2004). It describes the period of 1994 to 2004. He states that, apart from Thabo Mbeki, the other saboteurs were the Minister of Health, Manto Tshabalala-Msimang the Minister of Trade and Industry, Alec Irwin, who were both accused by the Treatment Action Campaign, founded at the end of 1998, of culpable homicide (Bond, 2004). In the article, Bond quotes the late Parks Mankahlana, who was Mbeki's spokesperson. His given reason as to why the government did not provide pregnant women with ARVs was that: "That mother is going to die and that HIV negative child will be an orphan. That child must be brought up. Who is going to bring the child up? It's the state, the state. That's resources, you see". This made it clear that the government did not prioritise saving lives at all (Bond, 2004).

Mbeki's name and AIDS denialis have become almost synonymous, due to his controversial statements throughout his Presidential years. The definitive text on denial is certainly *States of Denial: Knowing about Atrocities and Suffering* by Stanley Cohen (2001). As mentioned in the previous chapter, the book is described as a "comprehensive study of both the personal and political ways in which uncomfortable realities are avoided and dealt with" (Cohen, 2001: 10). The reason this publication is so useful to this study is that, in order to understand Thabo Mbeki's AIDS denialism, one first has to understand the reasoning behind denialism and the types of denial. The following chapter will explore this publication in more detail.

It is interesting to note the lack of literature on denialist attitudes held by politicians. The only publication that deals with the psychology behind these denialist attitudes, is *The Psychology of Politicians* (2012), edited by Ashley Weinberg. The book is useful to connect denial in the field of psychology to politics. It contains a chapter edited by Max V. Metselaar, titled, *When cognitions reach boiling point: the impact of denial and avoidance by policy-makers during a foreign policy crisis*. Even though the chapter focuses on foreign threats rather than on HIV,

the four claims made can be applied to Thabo Mbeki. Firstly, denial and avoidance of a problem is a coping mechanism used by politicians when they are faced with a threatening situation. Secondly, regardless of the regime-type of a country, politicians are more likely to deny or avoid threat-related information (TRI) when the threat, in this case HIV, may be taxing on available resources or can lead to "political and moral dilemmas and psychological strain". Thirdly, different regime types have different stances on denial. It is stated that democracies typically do not encourage politicians to have a denialist stance on issues. However, Thabo Mbeki's actions create a point of interest here, since he did not follow the so-called democratic model. Finally, it is stated that denial and avoidance by an individual in a "pre-encounter phase" can lead to a state being unprepared when the situation turns more serious (Metselaar, 2012: 143-144).

Since Fourie and Meyer produced a comprehensive book on AIDS denialism in the form of *The Politics of AIDS Denialism* (2010), it was also necessary for them to use Stanley Cohen's model. They gave their own interpretation of the model in their book. In the field of politics, denial is most often used as an explanation for government responses, especially when facing controversial topics. Denial is also often the cause of governments not taking useful action when facing difficult issues. Stanley Cohen has written extensively on denial, with his main theme being denial as a response to claims of human rights being abused. In 1996, Cohen devised a typology of denial against which government responses can be measured. This typology was refined in 2001, and this revised typology is very effective in analysing government rhetoric to highlight elements of official denial (Fourie & Meyer, 2010: 49).

Cohen's typology sets out three broad categories of government denial. These are classic official denial, counter-offensive denial, where the shortfalls of offenders are pointed out as an attempt to discredit them, and partial acknowledgement, where the event is acknowledged to an extent, but no recourse occurs. Classic denial in itself can be divided into three categories, namely literal denial (arguing that an event did not occur), interpretive denial (challenging the existing definition of the event with an alternative version), and implicatory denial (attempting to pass the event off as being justified) Fourie & Meyers, 2010: 49).

The TAC's struggle against the apartheid regime is best set out in *Debunking Delusions: The Inside Story of the TAC by Nathan Geffen* (2010). Due to this denialist attitude, the TAC had its work cut out for it to secure treatment for AIDS patients in South Africa.

In *Debunking Delusions* (2010, 49), Nathan Geffen explains the route that the TAC took to become what it was by 2004. It was started within the National Association of People with AIDS (NAPWA). Geffen also mentions the launch of the TAC on the steps of the St. George's Cathedral, where a small group of people fasted for a day. They addressed the Minister of Health, Nkosazana Dlamini-Zuma as well as Minister of Finance, Trevor Manuel. Despite their claims being addressed to the state, it was clear that the problem lay with the pharmaceutical companies. During the first two years, the TAC fought primarily against the pharmaceutical industry.

In a review of *Debunking Delusions* (Geffen, 2010), JP de Villiers van Niekerk also mentions that South Africa's AIDS denialism was led by then President Thabo Mbeki, together with Manto Tshabalala-Msimang. In praise of the TAC, Van Niekerk states that it was due to their work that AIDS denialism, supported by the state, was defeated (Van Niekerk, 2010: 479).

There are a number of publications on Thabo Mbeki and his style of governance, which include references to his stance on HIV and AIDS. In a collection of articles from ANC Today, there are two articles that are relevant to his stance on HIV/AIDS. In *Health for the poor is a fundamental human right* (Mbeki, 2001: 10), he refers to the importance of combatting poverty with the goal of improving people's health. He continues to explain that this relates to providing access to "nutritious food, clean water, modern sanitation and a clean and healthy environment". He goes further by stating that primary health care also includes access to medical services. This indicates that he is not unaware of the practicalities of medicine. So the question which arises is this: why did he not support AIDS medication which was proven to be effective in reducing the effects of the disease?

Mark Heywood (2004) wrote that South Africa in fact had a sound AIDS policy, but that it was hijacked by Thabo Mbeki and his Minister of Health, Manto Tshabalala-Msimang. At the first meeting of the Presidential Advisory Panel on AIDS on 6 May 2000, Mbeki stated that: "You have to respond to a catastrophe in a way that recognises that you are facing a catastrophe. And here we are talking about people – it is not the death of animal stock or something like that, but people. Millions and millions of people" (Heywood, 2004: 94). The question remains, however, why Mbeki did not indeed respond to this particular catastrophe in a proper manner.

Another publication on Thabo Mbeki's style of governance is *African Responses to HIV/AIDS: Between Speech and Action* (2012). The most relevant chapter is *Confusing*

Public Health with Militant Nationalism: South Africa's AIDS Policy under Thabo Mbeki. The chapter "is a critical appraisal of the ethos within the denialist agenda that marked Thabo Mbeki's tenure as South Africa's president" (Kunda & Tomaselli, 2012: 109). The authors state that the way Thabo Mbeki reacted towards the AIDS crisis, was the result of a combination of resistance to imperialism and his philosophy of an African renaissance. Mbeki's years as President were characterised by a "stagnant ideology, rather than the necessary reinvigoration of an African ethic to contain the HIV/AIDS epidemic" (Kunda & Tomaselli, 2012: 109).

The idea of an African renaissance is discussed by Claire Decoteau (2013: 84). She states that it is due to this "fantasy of independence" that sense can be made of AIDS denialism and its consequences. When talking about the idea of an African renaissance, one should also refer to indigenous healing. According to Decoteau (2013: 91), there are two reasons why the government under Mbeki promoted indigenous medicine. These were, firstly, to aim to prove that biomedical measures were not capable of treating African diseases. The second reason was to gain support for AIDS denialism from those who already relied heavily on traditional medicine.

A case is made for the fact that Mbeki's reaction to the AIDS epidemic in South Africa can be explained in relation to the country's past, referring to colonial and apartheid-era understandings of African sexuality (Mbali, 2002: 8-9). Mbali substantiates her argument by mentioning that "African sexuality was constructed in colonial medical discourse as primitive, uncontrolled and excessive".

Thabo Mbeki's position on the link between HIV and AIDS is properly described in a document called "Castro Hlongwane, Caravans, Cats, Geese, Foot and Mouth Statistics: HIV/AIDS and the Struggle for the Humanisation of the African" (Sitze, 2004). The document was circulated amongst the ANC National Executive in early-2002, and it was suspected that Peter Mokaba was the author. Mokaba passed away later in that year, with the cause of death being "acute pneumonia linked to a respiratory problem". This led to rumours of him dying of AIDS (Sitze, 2004: 769) (Decoteau, 2013: 80).

Sitze (2004: 770) stated that the above-mentioned document can be regarded as either "Mokaba's oblique, extended suicide note (explaining why he would not take ARVs even though he could afford them) or as Mbeki's unwilling political last will and testament (allowing a name to be given to his disavowal of a deadly condition's given name)".

By 2002, Mbeki had retreated from making denialist statements in public. The Minister of Health, Manto Tshabalala-Msimang, took over as the public defender of AIDS denialism. In accordance with other authors, Decoteau also mentions Tshabalala-Msimang's promotion of a healthy lifestyle in order to combat AIDS, rather than promoting ARVs (Decoteau, 2013: 81).

2.6 Mbeki's Second Presidential Term

Mbeki's second presidential term started in 2004, and lasted until he was ousted by the ANC in 2008, being replaced by Jacob Zuma. It was becoming more and more prevalent to see organisations which functioned independently from the ANC, being delegitimised if they ran "contrary to the party line" (Glaser, 2010: 128-129).

It is interesting to note that, according to Glaser (2010: 129), AIDS denialism should not have been possible under post-apartheid laws, since the new Constitution aimed to establish social equality. Glaser explains that denialism is a subjective and personal state of mind, and that the views of one person should not have been able to spread in the ANC or government as a whole. Glaser states that denial in any sense essentially means "closing one's mind to reason, evidence and better judgement". According to Glaser, Mbeki's "obsessions" led to unofficial 'anti-policy' on AIDS which was condemned internationally (Glaser, 2010: 129).

A critical point made by Glaser (2010) is that, according to Nathan Geffen and Edwin Cameron, Mbeki's support of AIDS denialism was caused by a mixture of personal and political reasons (Glaser, 2010: 140). This relates to the central theme of this study which is to establish exactly how Mbeki implemented AIDS denialism, and why he chose to do so. If it was in fact a combination of personal and political reasons, the study has to establish exactly what those reasons were.

Nathan Geffen is also the author of *Echoes of Lysenko: State-sponsored Pseudo-Science in South Africa* (2006). In the article, Geffen describes the reasons why ARV roll-out was not supported by the state, and why the state rather supported pseudo-science. He mentions Matthias Rath and his claims that Highly Active Antiretroviral Therapy (HAART) was not an effective drug, and that patients should rather follow his suggested treatment. The title stems from a comparison with the former Soviet Union, and that state's support for a pseudo-scientist called Trofim Lysenko.

There are a couple of sources that specifically mention race when referring to Thabo Mbeki and AIDS. One of these is a chapter by G. Daniels (2005): *Thabo Mbeki and the issue of HIV/AIDS and race*. Daniels refers to Mbeki's stance on AIDS which he prefers to blame on colonialism and the resulting poverty, instead of choosing to believe the science behind it all (Daniels, 2005: 130). In South Africa specifically, AIDS is closely connected to race, as the people infected by the disease are predominantly black South Africans.

Another race-related article is *AIDS denialism and 'The humanisation of the African'* by Joy Wang (2008). Wang calls Mbeki's AIDS denialism "the most significant controversy to beleaguer the post-apartheid ANC government in South Africa" (2008: 2).

A title which summarises the issue of AIDS denialism in South Africa is *Thabo Mbeki's strange relationship with the truth continues* (2009). In the introduction, the term "plausible deniability" is defined: "One makes a statement that everyone who hears it believes it to mean X. The generally accepted meaning of X is, however, untrue. But one has parsed the words in such a way that one could always later claim never to have said what everyone thought one had said – even if one had not contested the generally accepted interpretation shortly after it was made. Or evades responsibility for one's words by denying ever having said something that others have not really claimed one has said" (Thabo Mbeki's strange relationship with the truth continues, 2009).

The book *The Virus, Vitamins and Vegetables* (Cullinan & Thom, 2009) is a collection of essays on HIV and AIDS denialism, including comments on quackery and the infamous Lazarus diet – a diet proposed by the then-Minister of Health, Dr Manto Tshabalala-Msimang and consisting of amongst others beetroot, lemons and garlic, believed to combat the effect of HIV. This diet has become synonymous with the South African AIDS epidemic, and is linked to the idea of Mbeki's hope to find an African solution for the AIDS epidemic that was storming through SA.

There are specific chapters in the book which are most useful for the purpose of this research. These include *Remembering a Decade of the Treatment Action Campaign* by Z. Achmat, *'Saints and Sinners': The Treatment Action Campaign* by J. Stephen, and *Garlic, Olive Oil, Lemons and Beetroot* by L. McGregor.

The authors P. Chigwedere, G. R. Seade III, S. Gruskin, T. Lee, and M. Essex (2008) reiterate in *Estimating the Lost Benefits of Antiretroviral Drug Use in South Africa* what so

many have said before them: that successful ARV roll-out during the peak of the epidemic would have saved countless lives. They prove this by using a model which compares the actual amount of PMTCT treatment provided between 2000 and 2005, with what was possible to roll out during those years. They reach the conclusion that approximately 330,000 lives or 2,2 million "person-years" were lost unnecessarily (Chigwedere *et al*., 2008: 1).

Decoteau (2013: 82) also mentions that although ARV roll-out in South Africa began in 2004, less than a third of the number of people who were scheduled to receive HAART treatment had, in fact, received it.

Decoteau further mentions the National Strategic Plan for HIV/AIDS and STDs, which was approved by the South African cabinet in 2007. The civil society of South Africa regarded the plan - created by Acting Health Minister Jeff Radebe, Deputy President Phumzile Mlambo-Ngcuka, and Deputy Health Minister Nozizwe Madlala-Routledge - to be the end of AIDS denialism. However, Mbeki reinstated Tshabalala-Msimang in August 2007 after firing Radebe (2013: 82), and up to the point when Mbeki was ousted from the ANC in December of the same year, AIDS denialism was still the order of the day. This continued until Mbeki formally resigned from his position as President in September 2008. Decoteau (2013: 83) describes how Tshabalala-Msimang was replaced by Barbara Hogan, and that the rhetoric surrounding AIDS immediately changed. In her first public speech as Minister of Health, Hogan acknowledged that HIV does, in fact, cause AIDS. She lauded the efforts of the South African science, medical and activist communities for their ongoing efforts to fight AIDS denialism, for compelling the government to achieve the goals set out in the National Strategic Plan.

2.7 Mbeki's AIDS Legacy

The situation surrounding AIDS in South Africa had become so dire that there had even been requests for an HIV Truth and Reconciliation Commission (TRC) (South Africa needs an HIV truth and reconciliation commission, 2006: 1629). Along the same lines, Nathan Geffen (2009: 454) asked whether or not prosecution of Mbeki, Tshabalala-Msimang and their accomplices should take place, and whether or not families who had lost family members due to the effects of AIDS denialism should receive compensation from the South African government. The reason for his questions is that, according to the Rome Statute of the International Criminal Court, the "intentional infliction of conditions of life, inter alia the deprivation of access to food and medicine, calculated to bring about the destruction of part

of a population" is a crime against humanity. Therefore, Geffen reasons, Mbeki should be held accountable for the consequences of his policies. Geffen further states that the same should go for the people who supported his policies, and those who did not stop them (Geffen, 2009: 455).

Together with Edwin Cameron, Nathan Geffen produced an article *The Deadly Hand of Denial: Governance and politically-instigated AIDS denialism in South Africa* (2009). Geffen is one of the most prominent writers on AIDS-related issues in South Africa, and has produced numerous publications. In the article, they neatly summarise the consequences of AIDS denialism, going much further than the known fact that AIDS denialism led to the unnecessary deaths of more than 340,000 people. They state that denialism caused infections that could have been preventable if it was not for the myth that HIV is not sexually transmitted. Furthermore, the government's denial led to a weak state-run prevention programme. Appropriate healthcare was also delayed due to the "proliferation of charlatans" allowed by the Minister of Health to take advantage of AIDS victims. Finally, the general public lost a part of their trust in medical science (Cameron & Geffen, 2009: 3).

HIV/AIDS in South Africa 25 Years On: Psychosocial (2009) states that, in 2009, 12% of South Africans were infected with HIV. The authors state that they have reached the conclusion that the explanations offered thus far for Mbeki's support of AIDS denialism areunsatisfactory, and that a more psychological approach will be necessary to ultimately reach a conclusion (Nattrass & Kalichman, 2009: 123).

Thabo Mbeki's World (Jacobs & Calland, 2002) sets out to explain Mbeki's ideologies. The editors mention that Mbeki has both positive and negative opinions surrounding him. It has been argued that Mbeki was against the idea of Western medicine since he was adamant about an African renaissance, and wanted to find a purely African solution for the epidemic facing South Africa.

2.8 Conclusion

By considering the above, it can be said that AIDS denialism led to the spreading of false information regarding ARVs and AIDS. It is estimated that the attitude of the government cost about 300,000 lives. The TAC definitely became frustrated with the government. Due to Mbeki's statements, he burned bridges that were in fact necessary to fight HIV/AIDS (Patterson, 2005: 41).

Since the beginning of the AIDS epidemic in SA, it has been approached from a human rights perspective. The fact that SA adopted a temporary constitution in 1994, and a new one in 1996, proved that the law can be adapted after being used as a tool of oppression, in favour of constitutional principles that promises human rights and the progressive realisation of human security for all. This mentality has underscored the national response to AIDS. It was to be expected that AIDS activists turned to the Constitution to frame and enforce their claims about how the government should respond to the epidemic (Ndinga-Muvumba & Pharoah, 2008: 63-64).

The existing literature answers questions such as "what is denialism", "was Thabo Mbeki an AIDS denialist?", and "what is the difference between denial of AIDS and AIDS denialism?" However, there are no sources which explicitly deal with the question, "Why was Thabo Mbeki an AIDS denialist?" Therefore, the following study will aim to answer this question.

It is near impossible to compile an exhaustive list of publications on HIV/AIDS and AIDS denialism, given its centrality in the South African society. This chapter is an attempt at finding the most relevant publications, and analysing them for their worth, finding gaps and identifying conflicting information from different publications.

To conclude, one can turn to the statement by Robyn Pharoah in *HIV/AIDS and Society in South Africa*. She is of the opinion that HIV/AIDS is "unique in its profile, magnitude and likely duration". Furthermore, she makes the statement that HIV/AIDS will have lasting "demographic, social, economic and governance" effects (Ndinga-Muvumba & Pharoah, 2008: 247 - 249).

The next chapter will focus on the theoretical aspects of the research topic. The work of Carol Bacchi on problem definition will be explained. Following that, the study will turn to Stanley Cohen's publication, *States of Denial* (2001). Cohen's work is of the utmost importance for this research topic, since he was central to the creation of denial as an academic field.

Chapter 3: Theoretical Analysis of Mbeki's AIDS denialism

3.1 Introduction

In order to understand denialism surrounding AIDS in South Africa, this chapter explains problem framing and public policy creation, and how those can be applied to the theme being studied. After explaining problem framing, and ways to go about it, the chapter will turn to public policy creation. The way AIDS as a crisis, was defined in South Africa, strongly influenced the policies that were created and implemented.

In order to solve the research problem, there are a number of research questions which will be answered. These questions are:

- Why did Mbeki succumb to denialism?
- Why is denialism often chosen as a response in a crisis? and
- Why did denialism continue in South Africa, rather than fade, as it did in other cases?

The most important question that has to be answered, is why Mbeki denied the link between HIV and AIDS, despite the deaths that occurred due to a lack of ARVs. The purpose of this chapter is to set out Cohen's model, which will be applied later to attempt to understand Mbeki's actions.

The chapter firstly explains policy problem definition, and describes the many ways a problem can be interpreted, as set out by David Rochefort and Roger Cobb (1994). Following that, the chapter will turn to policy creation, and public policy controversies. By going about the chapter in this order, it becomes clear how much of an influence problem definition has on policy creation.

The research for this thesis is based on Stanley Cohen's work surrounding denial, as explained in his book, *States of Denial* (2001). This chapter will analyse and explain his model of denialism. Firstly, however, this chapter will briefly look at the work of authors on public policy. This includes Carol Bacchi, Donald Schön and Martin Rein, and David Rochefort and Roger Cobb. These authors' work will be used since they touch on the various forms in which AIDS was defined as a problem. Government officials could not agree upon one certain way of framing the problem. This comes back to the many ways of looking at problems as mentioned above. When a problem has a clear definition, it is easier to find the best solution.

By focusing on the work of Stanley Cohen, one can get a better grasp of his model as it is essential to understand and explain Mbeki's actions. The reason for this is that denialism shaped Mbeki's thoughts, ideas, and policies. Denialism is a central theme in social sciences, especially in psychology and sociology. The theme of this study, however, is not psychological or sociological, but rather political, and Cohen's focus is on denialism, rather than AIDS denialism. It is for this reason that the literature is combined with other sources, some focussing specifically on AIDS denialism, in order to gain a clear understanding of Thabo Mbeki's AIDS denialism.

By the end of the chapter, the theory at hand would have been linked to the case of HIV and AIDS in South Africa. The application thereof will take place in the following three chapters. Furthermore, a conclusion would have been reached regarding which theoretical literature is the most useful for answering the research problems. It is important to interpret and apply the literature correctly, in order to gain the clearest and most comprehensive understanding of Mbeki's actions.

As proven in the first chapter, HIV/AIDS is an indisputable problem in South Africa. This fact becomes especially clear when one considers the statistics provided in Chapter One. However, while the majority of people agreed that HIV is a life-threatening issue, Thabo Mbeki sought to explain it in ways other than a biomedical approach. When facing a health problem, there are at least four ways people can choose to understand it. Firstly, it can be understood as a biomedical problem, where one acknowledges that a virus is causing a disease. In this case, one acknowledges that HIV causes AIDS, and that ARVs are available to ease the suffering. The second way is a metaphysical approach, for example a person can see an illness as an act of God – that they are being punished for their sins, and that they have to pray for forgiveness in order to get better. Also included in the metaphysical way of understanding an illness, is as a traditional or spiritual method. Some people choose to believe that a spell has been cast upon them, and that they can only be healed by a traditional healer. The final way of understanding AIDS is as an illness caused by people's circumstances, i.e. living in poverty. This is the approach that Mbeki supported. He believed that Africans had been victimised for decades, or even centuries, due to colonisation and apartheid, that AIDS is just a term for the symptoms of poverty, and that it is the fault of the West.

3.2 Problem Definition

In Policy Studies, problem definition has been well-theorised. Murray Edelman's work is especially useful in this regard. He mentions the ways of interpreting a problem in *Constructing the Political Spectacle* (1988:17). He states that the cause of a problem can be either concrete or abstract. In the description given above, concerning the four ways of looking at problems, the biomedical approach is concrete, meaning that HIV is a concrete cause for AIDS. Religion, traditional beliefs and socio-economic conditions are abstract. Furthermore, Edelman (1988: 17) describes how reasons for problems are constructed. He states that the reasons provided for problems are significant due to the variety of causes and ideologies to which they point, rather than due to their "rigour, verifiability, or explanatory power" (Edelman, 1988: 17). When trying to explain why a problem exists, many parties or socio-economic issues are blamed. These include those who benefit, those who suffer, nationality, climate, and the state of development (Edelman, 1988: 17). Edelman further dedicates a chapter to "political language and political reality" (1988: 103). He mentions how metaphors, ambiguity and other figures of speech allow people to, firstly, convince themselves of some facts, and then to influence others. In Philosophy, Psychology and Literature Studies, the "linguistic turn" describes the tricks that can be employed by using very specific language.

Evidently, there are many ways to analyse a problem, and one's understanding of a problem will determine the course of action one takes to remedy it. The work of David Rochefort and Roger Cobb is especially useful to explain this. In their book, they provide an explanation of *problem definition* (1994: 1). They mention that the purpose of problem definition is "to explain, to describe, to recommend, and, above all, to persuade" (Rochefort & Cobb, 1994: 15). They also refer to the flexibility of social issues – how an issue can appear different, depending on a person's perspective on it. Rochefort and Cobb provide nine categories under which problems can be defined (Rochefort & Cobb, 1994: 15). These categories are causality, severity, incidence, novelty, proximity, crisis, problem populations, instrumental versus expressive orientations, and solutions.

Causality refers to the origins of a problem, and how those shape the definition of the problem (Goodman, Ullman & Tennenbaum, 2011: 1). According to Rochefort and Cobb, the origin of the problem is the most crucial aspect of problem definition. It is important to distinguish between individual versus impersonal causes. This means that either a system, or a single person, can be blamed for a problem (Rochefort & Cobb, 1994: 15).

The case of AIDS denialism in South Africa was one of individual causes, since Mbeki was the main advocate. When it comes to *severity*, the seriousness of the problem and the scope of its consequences will determine whether or not it deserves a space on the agenda, and which type of action will be taken to counteract it (Dery, 2000: 37). Rochefort and Cobb (1994: 17) state that the severity of a problem can increase if onlookers ignore it, or if they choose not to recognise it. This was the case of AIDS in South Africa, since Thabo Mbeki did not recognise AIDS as a problem.

A problem can also be described according to *incidence*. Depending on how frequently a problem comes to the forefront, and at which level of danger it is perceived, it will be regarded as a social problem or not. Patterns of incidence can further be illustrated as a social-class dimension (Cook, 1995: 1035). The social-class aspect of a problem can either be highlighted or downplayed. In the case of AIDS, the problem was framed along the lines of social classes, since Mbeki insisted that AIDS was caused by the poor living conditions in which some people lived, rather than by HIV. Rochefort and Cobb (1994: 20-21) specifically refer to AIDS, and state that age and gender are also categories used to frame the problem, given the high numbers of teenage girls being infected with HIV and AIDS.

A problem is often described as new, or as a *novelty*, in order to gain attention (Rochefort & Cobb, 1994: 21). Furthermore, the authors state that new problems are difficult to frame, as there is no familiar solution. Therefore, it can lead to conflict and tension, since onlookers expect results while policy makers struggle to come up with solutions. HIV and AIDS was not a new problem in South Africa, since it has been around since the early-1980s. However, previous Presidents have chosen to focus on other problems. Thus it can be argued that it was *still* a new problem when Mbeki was elected President.

Proximity refers to whether or not one is directly affected by a problem. The more people are affected, the more people will become concerned and take action. One can discern between national tragedies and personal tragedies (Rochefort & Cobb, 1994: 21). Regarding AIDS in SA, it could be seen as both. AIDS patients were personally affected, along with their families, while the population of SA was affected by Mbeki's actions, with SA being regarded as a social pariah.

Crisis, according to Rochefort and Cobb (1994: 21), is an over-used word in the political realm. It refers to a period when a problem has already escalated to its most severe level, and where the time to take action is long overdue. Activists tend to use the word *crisis* instead of

problem, as it draws more attention to the incident. According to social-constructivists, *crisis* is used as part of the "rhetoric of calamity" (Sauro, 2014: 18), as it elevates a problem to a more serious level.

A problem is also categorised according to which section of a population is affected. These groups are given definitions, alongside the problem itself. This way of problem framing is specifically used in social welfare policy making, where the purpose is to provide resources or services to target groups (Caulton, 2001: 2). The way a problem is defined, guides the way a solution is shaped. Regarding AIDS in South Africa, the *problem population* was people infected with HIV, including mothers who needed ARVs to prevent MTCT.

The way a problem is framed also depends on who is doing the framing, and what their end goals are. In some instances, a way of going about to find a solution will be clearly defined in order to achieve a very specific goal. In other cases, the means will be more important than the actual goal. This is referred to as *instrumental versus expressive orientations* (Rochefort & Cobb, 1994: 23).

The final category that Rochefort and Cobb propose is *solutions* (1994: 24). Some policy makers will not entertain a problem, unless there is a proposed solution. This means that "the solution begets the problem" (Rochefort & Cobb, 1994: 24). They point out that some policy makers believe that "a problem is only a problem if something can be done about it". Furthermore, it is mentioned that as soon as a problem is solved according to the proposed solution, a new aspect of the problem will come to the fore, meaning that no problem will ever be completely solved. This category of problem framing is very relevant for AIDS in SA. Since Thabo Mbeki did not recognise ARVs as a suitable solution for HIV, he decided to ignore the virus, and instead blamed AIDS on other factors, such as poor living conditions.

One thing that becomes clear when considering Rochefort and Cobb's categories, is that there is rarely only one way of looking at a problem. To cosmopolitans, it seems obvious that medical care is needed. Often, the decision to trust medical practitioners will be combined with another possible solution, for example prayer, or homeopathy.

Another theoretical aspect related to this chapter is post-colonialism. Post-colonial theory clarifies the boundaries of mainstream feminist thought on the health of women by calling for critical "intersectional" analysis on the topic, which take into account "class, race, gender, sexualities, and colonial history". Such analysis of women's health allows one to see the way

colonial and neo-colonial practices continue to describe non-European women in essentialising terms, often as inferior or subordinate (Jungar, 2011: 66).

An intersectional analysis does not only describe differences related to the various social categories mentioned above, but also involves looking at the situatedness and personal investment of the researcher in creating these categories. Thus, post-colonial theory teaches one to be aware of how one understands oneself in relation to, and through, others (Jungar, 2011: 66).

In a post-colonial and developing society like SA, there are many issues that affect responses to the epidemic. Kenneth Shalden (2004: 1169) argued that stable access to affordable ARVs was necessary to lower the impact of HIV/AIDS. A challenge that SA faces is the "price-infrastructure trap". The implication of this "trap" is that high prices of ARVs prevent better treatment programmes. This is exactly what the TAC based their existence on: promoting access to affordable ARVs, to better serve South Africa's AIDS patients.

The expansive field of HIV/AIDS research in a post-colonial context is extremely complicated. The intertwined themes of "death, illness, sexuality, medicine, poverty, globalisation, gender, femininities, masculinities, and nationalism" create an almost explosive field of competing investments. Post-colonial theory is helpful in clarifying and deconstructing the discourses that shape what we understand under the title of HIV/AIDS. Post-colonial theory reveals the ways in which these discourses construct those who write and speak about AIDS, as being distinct from the "infected others" (Jungar, 2011: 66).

The statements made by Mthathi and Achmat can be seen as both a post-colonial as well as a post-structuralist critical perspective. This link between the statements and the theory not only involves an analysis of AIDS as a disease, or a health issue, but also of the construction of power and meaning through an intersectional approach. The TAC itself describes its politics as inspired by post-structuralism, stating that: "Foucault's ideas about the principles of truth and power continue to inform the TAC's approach to politics" (Jungar, 2011: 67).

In addition to the fact that the TAC's analysis of power could be described as post-structuralist, the TAC's politics can also be seen as being in line with what Gayatri Spivak calls "strategic essentialism". This involves a strategic adoption of an identity or a position, to enable effective campaigning for political change (Jungar, 2011: 67).

3.3 Public Policy Controversies

Now that the definition of policy problems has been introduced, this chapter will turn to how policy controversies are solved. Schön & Rhein (1994) emphasise the difference between two types of policy disputes. The first type can be settled through rational discourse, while the second type is more stubborn, and resists resolution by refusing to take reason into consideration (Schön & Rhein, 1994: 3).

Schön and Rhein (1994: 23) explain policy controversy very clearly. According to them, policy positions are influenced by frames such as "underlying structures of belief, perception, and appreciation". These frames are generally tacit, which means that they are not easily influenced by reasoning.

As mentioned in Chapter 1, public policy and problem framing are key issues to keep in mind when researching AIDS denialism in South Africa. However, this is not the main concern when researching AIDS denialism. Therefore, this section will only be a prelude to the main theoretical component.

Carol Bacchi herself refers to her book *Analysing Policy: What's the Problem Represented to be?* (2009) as an unconventional book about policy, explaining that it uses a post-structural approach to analysing policy. She quotes Beilharz (1987: 393): "The object becomes that of seeking to understand policy, rather than its authors". Bacchi (2009: ix) introduces an approach to policy analysis called 'What's the Problem Represented to be?', or the WPR approach. Through this analysis method, the notion of 'policy' becomes questioned. This means that the role of government comes under investigation.

According to Bacchi (2009: 2), the WPR approach rests on six questions. By answering the questions, one will find out what the specific problem is represented to be, by the policy makers concerned. In this study, questions will be answered with regards to AIDS in South Africa, to gain an understanding of Mbeki's reaction to the problem, and the policies surrounding it. The first question is: What is the 'problem' represented to be in a specific policy? This approach suggests that the way you feel about something will influence how you react to it, and what the suggested/consequential plan of action will be. When considering Mbeki's response to AIDS, it can be argued that he viewed the problem as being caused by the legacies of apartheid and colonisation, and socio-economic factors like sanitation and poor health care (Altman, 2006: 257). Given his unique understanding of the problem, the policies he implemented reflected *his* understanding of the problem.

The second question is "What presuppositions or assumptions underlie this representation of the 'problem'?" (Bacchi, 2009: 4). This means, what are the reasons for this interpretation of the problem. Mbeki's thoughts were heavily influenced by his studies at the Lenin Institute in Moscow (Kenyon, 2008: 31), and this caused the beginning of his communist thoughts and his own worldview.

Question three asks how the representation of the 'problem' came about. The question seeks to understand, firstly, which events and decisions leading up to the present era contributed to the understanding of the problem. These are called non-discursive practices. Also, according to Bacchi (2009: 10), it is necessary to recognise that contrasting interpretations of a specific problem do exist, over both time and space. This means that many factors led to a problem being interpreted in its specific way. In short, Bacchi (2009: 11) states that the purpose of this question is to seek out the specific events which allowed a specific problem representation to be formed, and to come out as the main understanding. To apply this question to the case of Mbeki, it can be said that the actions of the Presidents preceding him influenced how the problem of AIDS came to be represented in South Africa. The apartheid government's programmes about AIDS awareness was severely lacking in integrity, and were rather often seen as a way of establishing white dominance (Nattrass, 2013: 121). This way of thinking made its way into Mbeki's thoughts, and could be part of the explanation of *why* he was so adamant about finding an African solution, rather than using Western medicine.

The fourth question asks "What is left unproblematic in this problem representation?" (Bacchi, 2009: 12). It further asks if the problem can be thought about differently. The question aims to find out which aspects of a problem have been left out while trying to problematise the problem. When applying the question to the problem being studied, one can mention that an aspect left out by Mbeki is the influence that a lack of PMTCT treatment would have on the social sphere of South Africa, meaning the influence on mothers and their babies.

Question five asks what the consequences are of a problem being represented in a certain way. Bacchi (2009: 15) mentions three types of effects that have to be kept in mind. These are discursive effects, subjectification effects, and lived effects. Bacchi clarifies the question by stating that its goal is to "identify the effects of specific problem representations so that they can be critically assessed".

Question six asks where the interpretation of a problem is produced, disseminated, and defended. Also, can the representation be questioned, disrupted or replaced? In asking this question, one aims to establish how a representation of a problem became the accepted problematisation, and whether or not a representation of a problem is too risky (Bacchi, 2009: 19).

Rochefort and Cobb (1994) describe the notion of problem definition as an emerging perspective. Therefore, one can reason that Bacchi's work builds on the work of these two authors, as she expanded on the idea of problem definition by developing the idea of a WPR-approach.

Murray Edelman is the author of a classic text, *Constructing the Political Spectacle* (1988). Its second chapter is titled *The Construction and Uses of Social Problems* (Edelman, 1988: 12). A section of the chapter which is very relevant to this study is called *The Construction of Reasons for Problems* (Edelman, 1988: 17). Edelman states that "explanations blame social institutions, social classes, those who suffer, or those who benefit. They may locate the cause of a problem in regional characteristics, nationality, ethnicity, climate, stage of historical development, personality, or a combination of several such categories". These categories can be either concrete or abstract (Edelman, 1988: 17). Edelman further makes the point that to pinpoint the origin of a problem is to assign praise or blame.

The above statements by Edelman (1988) can be linked to Thabo Mbeki's reasoning, and the reasons provided by him as to why people became ill with AIDS, other than the HI-virus. As mentioned earlier, he placed the blame on colonisation, poverty, and pressure from the West.

Anthony Butler (2005: 600) points to a number of institutional factors which explain why the ameliorative/nationalist paradigm was so popular with Thabo Mbeki and Manto Tshabalala-Msimang. The first of these is that AIDS-policy making was contained in the Department of Health, and the Treasury, and later the Presidency. The cabinet was not involved. Butler (2005: 602) uses his distinction between the biomedical/mobilization and nationalist/ameliorative paradigms by stating that these paradigms provide different languages which can be used to analyse HIV as a policy problem.

3.4 Denialism in Psychology

The utility of Cohen's model is proven when it is used to answer the research questions mentioned earlier in this chapter. Specifically official denial, as described by Cohen (2001:

10), is the most suitable for understanding the link between denialism and policy creation. As we attempt to align Cohen's model with Mbeki's AIDS denialism, it is important that we get a firm grasp on Cohen's categories of denial. All of the categories organised in this table can be applied to the AIDS-crisis in South Africa.

Table 3.1: Cohen's Categories of Denial

Cohen's categories of denial	
Literal denial	When a specific, proven fact or incident is blatantly denied.
Interpretive denial	Concrete facts are given a different meaning and are interpreted to suit a specific agenda.
Implicatory denial	The implications of events or facts are denied or downplayed.
Personal or Individual	Facts that affect someone personally or directly, for example a fateful diagnosis, is blocked out mentally. This type of denial is private.
Official denial	This category of denial plays out in public. It is used to hide the truth, and to cover up atrocities. This type of denial becomes part of public policy.
Cultural denial	This type of denial falls between private and state-organised denial. A society as a whole can choose what to believe.
Historical denial	When denying a past event, either by victims or by an administration.
Contemporary denial	To ignore information or facts being shared in the current era.
Victim denial	As a self-preservation mechanism, victims can block what is happening to them or what has happened to them.
Perpetrator denial	Perpetrators deny or play down the extent of their actions, and the impact on their victims.
Bystander denial	This type of denial can either refer to denial in the public realm, for example denial by other states, or private denial, as something witnessed by friends or family members.

Cohen starts by plainly setting out the basic ideas surrounding denial. He starts with the description of *conscious* or *unconscious* denial, which indicates a psychological status (Cohen, 2001: 3). Cohen starts the section off by mentioning that "statements of denial are assertions that something did not happen, does not exist, is not true, or is not known about. Conscious denial also refers to the notion of actually putting in some effort to *not* know something, in order to maintain one's own positive impressions of an individual, group, crisis, or nation. (Noorgaard, 2011: 400).

Cohen (2001: 7) proposes three categories into which one can divide what exactly is being denied. These categories are literal denial, interpretive denial, and implicatory denial. Literal denial, also called factual or blatant denial, is when a specific incident did not occur or that a statement is not true. In the public realm, literal denial refers to the denial of genocides, for example. This ties in with the "elephant in the room" metaphor, as one is ignoring a problem that is staring one in the face. It can take a certain amount of effort *not* to hand out empathy, or to turn a blind eye to an atrocity (Eliasoph, 1998: 6).

Interpretive denial refers to when concrete facts are given a different meaning from the accepted interpretation (Norgaard, 2011: 405). The example used by Cohen is to refer to ethnic cleansing as "population exchange". An occurrence is given a different name, in order to downplay its severity. Events are not denied; rather their impact is. Interpretive denial uses euphemisms and jargon, thereby obscuring the actual meaning (Cohen, 2001: 8).

Through the use of implicatory denial, events, facts, and their standard interpretation are not denied (Cohen, 2001: 8). However, the resulting implications are denied or downplayed. This type of denial occurs when a person is a witness to a certain event, for example mass rape during a war, but they choose not to do anything about it, or they block it out completely. Often, responsibility is also denied. This means that bystanders choose to ignore these occurrences, because they believe that someone else will solve it, or that getting involved will also harm them, either physically or psychologically.

Denial can also be individual/personal, psychological, or private (Wyatt & Brisman, 2016: 4). Personal, or individual, denial refers to people who seem to forget a fateful diagnosis, or who do not want to know whether or not their partner is having an affair. This type of denial is often only discovered after professional help.

With *official* denial (Cohen, 2001: 10), denial is "public, collective and highly organised". Official denial is often used to cover up atrocities such as genocide. In democratic societies, such as SA, official denial is used subtly, unlike in totalitarian societies. In democratic societies, official denial often hides the truth, and is "built into the ideological façade of the state" (Cohen, 2001: 10). According to Cohen, the circumstances which cause the related suffering become intertwined with the techniques used to deny the suffering. This means that denial becomes a part of the state's official policy. This is true not only for observers, but also for the perpetrators themselves (Cohen, 2001: 10).

Cultural denial sits on the border of private and state-organised denial (Cohen, 2001: 10). A society as a whole, while free from thought control, can agree on what to think or believe of a certain event. People choose to believe false information. This is not very common for democratic societies, yet it does happen sometimes. Cultural denial can be applied to events of the past, for instance the decision to deny the occurrence of the holocaust, or it can be used to ignore current events (Cohen, 2001: 11).

There is a mutual dependency between official and cultural denial, and it is most visible in mass media covering large-scale suffering (Wyatt & Brisman, 2016: 4). During such occasions, the public often chooses to ignore the information provided, to retain their innocence. Official lying and cultural evasion often makes use of invented language, containing euphemisms and analogies which hide the truth (Cohen, 2001: 11).

The timing of denial can be historical or contemporary. Historical denial refers to "memory, forgetting and repression" (Cohen, 2001: 12). Historical denial can refer to victims blocking out past suffering, but for this research, the focus will be placed on the denial of recognised public suffering in the contemporary era. Contemporary denial, in contrast, is the act of blocking out selected information that is currently being distributed. This is mostly done in order to not be overwhelmed by (mostly) negative news stories (Cohen, 2001: 13). It can be argued that Mbeki suffered from contemporary denial, rather than historical denial. He decided to ignore information available on, amongst others, ARVs and the HI-virus, in order to suit his agenda. It must be mentioned that he did not suffer from *compassion fatigue* - when images of suffering is ignored because it is too painful to the viewer. Mbeki merely denied the existence of contemporary evidence that proved his theories about the origin of AIDS wrong.

Denial can have many agents, i.e. victims, perpetrators, or observers (Cohen, 2001: 14). Victims refer to those unto whom something is done, perpetrators commit the actions, and observers witness the actions in progress. These roles are interchangeable. Victims of suffering can choose to repress the memories of their suffering, thereby denying that they ever underwent such an event. Perpetrators deny the meaning and severity of their actions. Denial by perpetrators often allow for atrocities to be committed, and for the perpetrators to continue their lives without consequence. Denial by perpetrators often appears in official discourse and government appeals that aim to persuade its citizens to remain quiet about any type of suffering that is occurring (Cohen, 2001: 15).

Bystanders can be immediate, external, or bystander states (Cohen, 2001: 15). Immediate bystanders witness events first-hand, or hear about instances of suffering from first-hand sources, while external bystanders learn about the events from second-hand sources, most often from mass media. 'Bystander states' refer to "other governments or international organisations" (Cohen, 2001: 15). In the case of AIDS denialism, immediate bystanders can refer to friends and family members of AIDS patients. External bystanders refer to the South African society, specifically people not infected with HIV and AIDS, who read about the effects in the media. Bystander states, specifically international organisations, include The Global Fund to Fight AIDS, Tuberculosis and Malaria), The International AIDS Society, and UNAIDS.

Cohen's model can, of course, also be applied to other instances of denial. David Morrison (2011:1) mentions science denialism, specifically the denial of evolution and climate change. While focusing on the United States of America, some of what he says can be applied elsewhere. Despite being a developed nation, many citizens refuse to accept the science behind evolution and climate change. Morrison mentions the arguments that creationists propose in response to evolution. Creationism can link the religious way of framing HIV and AIDS to denialism. Morrison further mentions the inclination to ignore accepted scientific facts.

Chris Kenyon (2008: 29) from the Department of Medicine of the University of Cape Town proposes the theory of cognitive dissonance as a likely reason for Thabo Mbeki's support of AIDS denialism, and for the fact that denialism in South Africa persisted, rather than faded as in other instances of denial. Cognitive dissonance is described as the impression that contradicting "attitudes, emotions, beliefs, or behaviours" are incompatible. In simple terms,

it is the sensation of having two contrary thoughts at the same time. According to cognitive dissonance theory, the impact that the two competing thoughts have, is for the individual to create new thoughts or beliefs or to adapt existing beliefs, in order to lessen the gap between the competing thoughts (Kenyon, 2008: 29). Kenyon (2008: 30) explains that the sensation of having two competing beliefs is "psychologically uncomfortable", and that the level of uncomfortableness depends on the size of the gap between the two beliefs. Typically, people who are experiencing dissonance will look for information which lessens the gap, and avoid information which will increase it. When people involuntarily come across information which increases dissonance, they will choose to ignore, misinterpret or deny that information.

In the 1980s, HIV and AIDS emerged as a new "cognition" in South Africa. During this era, political ideologies were extremely prominent structural beliefs, both abroad and in SA. It was at this time that the anti-apartheid struggle in SA intensified, and the ANC faced increasing oppression from the white government. This oppression took the shape of, amongst other things, "a covert chemical and biological warfare programme to eliminate black leaders and to create infertility among black people, and an ideology that sought to inculcate feelings of inferiority in black South Africans" (Kenyon, 2008: 30). In 2001, Mbeki reacted to criticism of his beliefs by describing the apartheid regime's ideology as one which enforced the idea that black people are simply inferior people, and carriers of germs.

Kenyon (2008: 31) separates Mbeki's denialism into two phases, namely biological denialism and treatment denialism. Biological denialism stems from Mbeki's message that HIV does not cause AIDS. He stuck to this conviction due to his upbringing, education, and participation in the anti-apartheid struggle. He was raised with the instructions to question the status quo, and while his studies at Sussex University let him continue along this path, his Marxist-Leninist studies counteracted that inquiring style of thinking. Cohen dedicates a chapter to explain the origin of the term in psychoanalysis, and its spread into "theories of self-deception and cognition" (Cohen, 2001: 21).

Long before Cohen's model came to be, Anna Freud explained denial as "an unconscious defence against painful and overwhelming aspects of external reality" (Travis, Pawa, LeBlanc & Rogers, 2011: 1028). Even earlier, Sigmund Freud first used the German term *Verleugnung*, which means denial or disavowal. It appeared in a 1923 paper by Freud on infantile genital organisation. Freud also distinguished between neurotic and psychotic denial of reality. The confusion arose when he described both of them as a form of repression. In

neurosis, the ego, responsible for dealing with reality, suppresses a part of the id, which is the key component in creating a person's personality. However, in psychotic denial, the ego withdraws from reality (Cohen, 2001: 26). For the research being done in this study, psychotic denial is more useful. Furthermore, Freud explained, while trying to clarify the distinction, that "neurosis does not disavow reality, it only ignores it; psychosis disavows it and tries to replace it" (Cohen, 2001: 26). Eventually, Freud came up with a definition of neurotic denial which actually seemed to describe psychosis. It read: "A neurosis usually contents itself with avoiding the piece of reality in question and protecting itself against coming into contact with it" (Cohen, 2001: 26). It would appear that Mbeki suffered from psychotic denial, as the reality of HIV causing AIDS was denied by him. Instead of believing the science surrounding AIDS, he searched for other causes.

Eventually, denialism was also described as a method of self-protection during periods of overwhelming stress. This description can serve as a way of understanding Mbeki's actions – his inability to cope with the demands of a health crisis might have led to his denial of a crisis existing. There is a strong difference between lying and denial. If a government or a government official makes an untrue statement, while knowing that it is not true, with the specific goal to deceive the public, it is merely lying. When the term "strongly denies" is being used, it is most often merely a front being upheld, to hide a lie. However, in some instances, the line between lying and denial becomes blurred. This is where the term *self-deception* comes into play – to lie to oneself (Cohen, 2001: 37). It has to be analysed to which extent Mbeki was lying to the public, and to which extent he was lying to himself.

3.5 Denial in Practice

This chapter will now turn to the everyday use of denial, as described by Stanley Cohen (2001: 51). Normalisation refers to the keeping up of society, meaning denying the existence of anything that is unwanted. The unwanted situation or item is turned into something sinful. This is when private problems become public concerns. Cohen provides the example of domestic abuse against women (Cohen, 2001: 51). Cohen specifically mentions AIDS in a section titled Defence Mechanisms and Cognitive Errors (2001: 52). He states that in modern culture, suffering is often ignored. However, it is not the suffering that was denied by Mbeki, but the science. The illness and consequent suffering would rather be denied by the patients themselves, if they did not wish to acknowledge their fate.

People who commit acts of human rights violations or who commit other serious atrocities often invite the same questions, such as "Why did they do something like that?", or "How could they do such atrocious things, yet think of themselves as good and decent people?" (Cohen, 2001: 58). The second question can be applied to Thabo Mbeki. It seems that his intention was not to disadvantage any person, since he believed that his actions were justified. Denial theory does not seek to understand *why* the specific behaviour by a denialist took place, but rather to understand the reasons provided *by* the denialists for their actions. Thus denial theory tends to focus more on "interpretations and implications" than on literal denial (Cohen, 2001: 58). This will prove especially useful for this research, since Mbeki's interpretation of HIV and AIDS is the central theme concerned.

Denial by victims and denial by perpetrators differ vastly. Where victims ignore facts because they cannot accept either their history, as in holocaust denial, or their future, as in denying a fateful diagnosis, perpetrators deny facts in order to suit their agendas or convictions. Ordinary perpetrators, or as Cohen calls them, delinquents, are not inclined to justify their actions. The perpetrators aim to attach new meanings to their actions, and try to escape blame and legal culpability. Political perpetrators often act in the same way, even though at first glance it would not seem logical to group juvenile delinquents and politicians together. However, political and governmental perpetrators often also choose not to defend their actions (Cohen, 2001: 77).

Should an individual or a state wishes to address the acts it is being accused of, it can do so through one of three types of denial. These types are classic official, counter-offensive, and partial acknowledgement (Cohen, 2001: 102). As referred to earlier, official denial can be separated into literal, interpretive and implicatory denial. To reiterate, literal denial is to deny that anything at all is happening (Cohen, 2001: 104). Due to international transparency, it has become difficult for states to hide cases of literal denial. With regard to this research, Mbeki would have had to state that HIV and AIDS does not exist at all, and that there is no epidemic at all. Interpretive denial refers to attaching a different meaning to what is actually occurring, or to imply that the general population is interpreting an occurrence incorrectly (Cohen, 2001: 105). This is exactly what was happening in South Africa under the Mbeki government, and also prior to that, under Nelson Mandela's presidency and the apartheid government.

There has been a trend towards interpretive denial due to international interdependency, and the fact that states are fully aware of the fact that they can be boycotted, should they be guilty

of, for example, the violation of human rights. Interpretive denial, therefore, does not hide what happened or is happening, but provides very specific interpretations of the events (Cohen, 2001: 105). In the case of HIV and AIDS, Mbeki did not deny the existence of the disease, the epidemic, or the consequences. However, he did deny the link between HIV and AIDS, the existence of HIV, meaning the virus only, and the effectiveness of ARVs.

Interpretive denial is described as a "complex and subtle strategy" by Stanley Cohen (2001: 106). Due to an increase in international media coverage, and the rapid spreading of news via social media, governments are finding it increasingly difficult to cover up events taking place in their specific countries. This is where interpretive denial comes into play. Since news of, for example, genocide or political protest is sure to reach citizens all over the world, government officials often have to find ways of describing events that do not place the perpetrators in a bad light. Thus, governments often admit to the "raw facts" of a situation (Cohen, 2001: 105), but they give the situation an alternative description. This means that responsibility is taken for atrocities, but they are described in ways that make events seem less severe.

Implicatory denial suggests that what is happening can be morally justified (Cohen, 2001: 109). If each and every reason for the violation of human rights should be listed, the list would be inexhaustible. Reasons provided by governments form a subcategory of such an imaginary list. The reasons are provided either in good faith, or can be poorly constructed, blatant lies. The reasons can fall under any of five categories. A state can claim that it acted righteously, meaning that they claim that human rights do not adhere to an international standard, and that each state can act according to its own interpretation thereof. Reasons proposed for government actions are usually something along the line of revolutionary action, or the differences between Western and non-western civilisations (Cohen, 2001: 110). Mbeki certainly placed some blame for the AIDS epidemic on the West. He was of the opinion that the West regarded Africans as an inferior race, and the main perpetrators when it came to the spreading of AIDS.

States can also argue that they had no other option than to act in the way they did. This is what Cohen calls acting out of necessity (Cohen, 2001: 110). This is when states deny the severity of their actions in order to justify it. States can claim that they acted in order to put a stop to a dangerous situation, or to prevent one. Mbeki and his Ministers of Health claim that they acted correctly in order to remedy the situation. They were of the opinion that their

solution of prescribing natural remedies was the correct way of combatting AIDS, since they believed it was caused by personal circumstances, rather than by a virus.

"Denial of the victim" means to place the blame on the people who actually suffered due to government actions. This type of denial was not employed by Thabo Mbeki. He did not claim that AIDS patients "got what they deserved" (Cohen, 2001: 110-111).

By contextualising an action, and claiming that it is unique, governments can blame critics for not understanding the context in which a specific act has occurred, or the conditions which led to specific reactions from the government. Cohen (2001: 111) clarifies what this means by stating that what is being said, is that an external observer cannot possibly understand the reasons for certain actions because the observer does not know enough about the context of the problem, the history of the state which they are blaming, or the current politics. Mbeki made use of this strategy, by describing the AIDS epidemic as an African problem, for which he wanted to find an African solution. It is for this reason that he was against the import and use of ARVs.

The final subcategory of implicatory denial is advantageous comparisons (Cohen, 2001: 111). By comparing one's own shameful actions to even more severe actions of human rights violations, the actions under discussion seems less severe. This counter-offensive strategy relies on finding actions committed by others, that are far worse than those committed by the party defending itself.

3.6 Conclusion

To understand the AIDS crisis of SA and Mbeki's actions that contributed to it, the research questions will be answered by applying the categories listed in table 3.1. The questions are:

1. Why and how did Thabo Mbeki use political denial as a strategy to respond to the South African AIDS epidemic?
2. Why is denial often utilised instead of facing controversial issues?
3. What are the implications of following the denialist route instead of looking for solutions?
4. How was the problem of AIDS defined?
5. Why was it denied, despite the prominent problems mentioned in the introduction?

These research questions point to various instances of denial, and indicate where Cohen's model can be applied to answer the various research questions. Various categories of Cohen's model will be used to answer the research questions, but some categories stand out as being more useful than others for this study.

To answer question one, the main research question, the spectrum of Cohen's model will be applied to the actions of Mbeki and his co-conspirators during the period 1994 to 2008. By answering the four subsequent research questions in the following three chapters, this study will reach a conclusion for the main research question. To answer question two, the study will use official denial, literal denial and contemporary denial. For question three, perpetrator denial and implicatory denial can be used to answer the question. Question four will utilise official denial and perpetrator denial, and finally, question five will explore cultural denial and official denial.

Chapter 4: Mbeki's Years as Deputy President

4.1 Introduction

In the previous chapter, the theoretical aspects of HIV and AIDS problem definition, the South African context thereof, Thabo Mbeki's policies, and denialism were discussed. A thorough grasp of the theory literature is helpful when answering the research questions, i.e. how useful is Stanley Cohen's model of denialism for understanding Mbeki's attitude towards HIV and AIDS in South Africa, why was a denialist route chosen instead of honest dialogue, and which types of denialism were the most prevalent in South Africa during the period 1994 to 2008.

When analysing Mbeki's decisions and policies using Cohen's model (2001), one should look at Mbeki's psychological status, the way the content was being interpreted, whether he was acting in a personal or official capacity, whether he was denying historic or contemporary events, which agents were involved, what types of bystanders were involved, and whether he was denying something taking place in his immediate surroundings, or events taking place elsewhere. These steps will be followed throughout the next three chapters, in order to assess the usefulness of Cohen's model in analysing Mbeki's AIDS denialism.

This chapter, the first of three on Thabo Mbeki, will focus on Mbeki's period as Deputy President of South Africa (1994-1999), and specifically on his support of the locally-developed drug Virodene, and the scandal surrounding the play Sarafina II. During the first democratic elections in South Africa in April of 1994, Nelson Mandela was elected as President, and Mbeki was appointed as his deputy. Mbeki was often referred to as a Prime Minister in South Africa, acting on behalf of Mandela as well as FW De Klerk, until 1996, since Mandela and De Klerk often were on trips abroad, with Mbeki having to step into their shoes in SA. Thabo Mbeki found himself amidst some controversy not long after his appointment as Deputy President. His controversial statements led to increased international attention being paid to South Africa's AIDS policies. In this chapter, each event that had an influence on Mbeki or the country's AIDS policy will be identified, described, and analysed according to the various suitable categories of Cohen's model of denialism.

The events covered in this chapter will follow this timeline:

Table 4.1: Important Events During Mbeki's Years as Deputy President

1994	The first democratic elections are held in SA, and Nelson Mandela becomes the first democratically elected President of SA.
1996	GEAR economic strategy is put in place.
1996	South Africa's new constitution is adopted.
1996	National Party leaves the GNU.
1996	Virodene is created.
1996	Sarafina II turns into a scandal.
1996	UNAIDS is created.
1996	HAART is developed.
1997	Virodene hits headlines.
1998	TAC is founded.
1998	It is announced that AZT will not be dispensed to prevent PMTCT.

The issue of AIDS was largely ignored in SA during the 1980s and early 1990s. Not enough was known about the disease, it was surrounded by a stigma, and people who were HIV-positive or had AIDS, mostly hid the fact from their families or social circles. It is due to these reasons that AIDS did not actually feature on the government's agenda until after Nelson Mandela's presidency. As the first democratically elected President of South Africa, Mandela was focused on creating a cohesive nation, and AIDS was placed on the back-burner. By 1996, the South African population became much more aware of AIDS and that year was also characterised by major changes in the AIDS landscape. The major events for 1996 that will be discussed, are the Growth, Employment and Redistribution (GEAR) policy, South Africa's new constitution, the National Party (NP) leaving the Government of National unity (GNU), the development of Virodene, the Sarafina II production, the founding of UNAIDS, and the development of HAART.

4.2 A Landmark Year

In terms of AIDS-related events in South Africa, 1996 will be imprinted in memories as the year in which some of the most impactful events occurred. Thabo Mbeki had been Deputy-President for two years at that time, but he was already having a large influence on the HIV and AIDS landscape of South Africa. The year 1996 can be regarded as a landmark year in

the struggle against HIV and AIDS in SA for many reasons, both local and international. These include the Growth, Employment and Redistribution (GEAR) economic strategy, the adoption of South Africa's new constitution, the National Party (NP) leaving the government of national unity, the promotion of Virodene in South Africa, and the Sarafina II scandal. Internationally, the year was significant due to the announcement of HAART, and the inception of UNAIDS. Each of these events will be dealt with separately.

4.3 Local Events Surrounding HIV and AIDS

By 1996, South Africa was two years into its first democratic government, with the new constitution having just been accepted, and the promises of an equal, prosperous society abounded. However, these expectations would not be met, and were already starting to fade. HIV and AIDS was not a top priority for the government, even though it should have been. Mandela's government was focused on healing the damages of the past, and Thabo Mbeki was starting to make his mark on the HIV/AIDS landscape. A few specific events that took place during this phase had lasting impressions in South Africa.

4.3.1 GEAR Economic Strategy

Trevor Manuel took office on 4 April 1996 as Minister of Finance and was immediately roped into what would become the Growth, Employment and Redistribution strategy. Mbeki had been working on it since the previous year, with help from, amongst others, academics and consultants from the World Bank (Gevisser, 2007: 664). The GEAR programme replaced the Redistribution and Development Programme (RDP) in June of 1996, when it was presented to the public (Gevisser, 2007: 666). The main goal of GEAR was to develop a "competitive, fast-growing economy" through strict and disciplined spending, and by rather seeking more international and local investment. However, the results were not what was expected (Harsch, 2001: 14). Between 1996 and 1999, South Africa's gross domestic product (GDP) grew by only 2.1% annually, while the GEAR programme estimated that a growth of 3.8% would be required. Eventually, there was not any change in the inequality with which South Africa's citizens lived (Harsch, 2001: 14).

GEAR gave more control to the Minister of Finance to determine spending priorities. As will be explained below, the Minister of Finance, Trevor Manuel, allocated money to Manto Tshabalala-Msimang to ensure the successful roll-out of ARVs. However, it did not go as planned, since she did not use all the available funding, and the idea backfired (Fourie &

Meyer, 2010: 92). GEAR led to a ban on spending in the public sector, and damaged healthcare services by not replacing staff.

GEAR displayed a disconnect between government and the economic reality in SA. Their estimates were unreachable, and ultimately did more bad than good. This lack of awareness is a clear display of literal denial (Cohen, 2001: 7). As described in chapter three, literal denial is the implication that something did not happen, or is just not true. It is apparent that the government was conveniently not aware of the economic misfortune that would arise due to GEAR, and that they continued with the plan despite not knowing what the impact would be.

4.3.2 South Africa's New Constitution

South Africa's new Constitution was adopted in 1996. According to Section 27 of South Africa's Bill of Rights, every citizen has the right to have access to health care services, including reproductive health services. Section 27 of the Constitution also states that the government is obliged to do anything within its power and capabilities to ensure that these rights are achieved. By not providing ARVs for AIDS patients as soon as it was possible, and by Tshabalala-Msimang not using all the resources at her disposal, the government in fact did not comply with their responsibilities as set out in the Bill of Rights (De Waal, Currie & Erasmus, 2001: 448-449).

When an organisation, any organisation, shuns its responsibilities, it can be interpreted as conscious denial (Cohen, 2001: 4). This behaviour is deliberate and intentional. The agent in this case is the government as perpetrator. At an organizational level, as opposed to the personal level, this type of behaviour can also be described as "propaganda, disinformation, whitewash, manipulation, spin, misinformation, fraud, cover-up". The perpetrators are fully aware of the fact that they are not committing to their responsibilities, and it can also be interpreted as them denying their responsibilities. It can also be argued that what was taking place was interpretive denial (Cohen, 2001: 7). Interpretive denial is what takes place when facts are given a meaning that differs from what would be accepted as the standard interpretation. Examples can include euphemisms such as "population exchange" for ethnic cleansing, "collateral damage" or claims such as "it's not what it looks like" (Cohen, 2001: 8). The content of the constitution was not being denied, rather the responsibilities that rested on the government. Therefore, the government was interpreting the constitution in a way that suited it.

The new Constitution was preceded by an interim Constitution, which was enforced in 1994 after South Africa's first democratic election. It is mentioned in the preface to the interim Constitution (Basson, 1995: v) that South Africa's pre-democratic Constitution was lacking "democratic accountability, constitutionalism, and a rights culture". The fundamental rights of South African citizens are set out in chapter three of the interim Constitution. Basson mentions that it is easy to recognise that most of the rights set out in chapter three were, in some way or another, violated by the apartheid-regime of pre-1994. These rights included the right to equality, the right to human dignity, and the right to freedom of expression (Basson, 1995: x). The interim Constitution came into play at the same time that Thabo Mbeki became South Africa's Deputy President, and therefore it contributed to the milieu of that period.

South Africa's new Constitution was adopted on 4 December 1996, and was implemented on 4 February 1997. As set out in Section 27 of Chapter Two of the Constitution, each citizen has the right of access to health care, including reproductive health care. The constitution also states that the government should take all necessary steps, within its ability, to ensure that these services are available to those who need it (Constitution of the Republic of South Africa, 1996 - Chapter 2: Bill of Rights, 1996). For Mbeki to not have followed the constitution was a blatant act of official denial and of contemporary denial, in that it was part of a public policy, and that current events and proven science of the era was being denied. The new constitution would later take centre stage during Thabo Mbeki's first term as President in the case of the TAC against the government of South Africa, with regards to the provision of ARVs.

In Chapter Two of the South African Constitution, the Bill of Rights is set out. Section 27 refers to the right to health care, food, water and social security (Republic of South Africa, 1996). According to the Bill of Rights, every citizen has the right to have access to health care services, including reproductive health care. It also states that the state must take reasonable legislative and other measures, within its available resources, to achieve the progressive realisation of each of these rights. Finally, no-one may be refused emergency medical treatment.

Since the beginning of the AIDS epidemic in SA, it has been approached from a human rights perspective. The fact that SA adopted a temporary constitution in 1994, and a new one in 1996, proved that the law can be adapted after being used as a tool of oppression, in favour of constitutional principles that promise human rights and the progressive realisation of human security for all. This mentality has underscored the national response to AIDS. It was to be

expected that AIDS activists turned to the Constitution to frame and enforce their claims about how the government should respond to the epidemic (Ndinga-Muvumba & Pharoah, 2008: 63-64).

4.3.3 Government of National Unity

A Government of National Unity (GNU) was created after South Africa's first democratic election in 1994 (Fourie & Meyer, 2010: 77). During the early years of democracy, under the leadership of Nelson Mandela, the government paid great attention to programmes such as housing and education. The decision to not place any emphasis HIV and AIDS was due to the fact that such a topic was not agreeable with the euphoric post-apartheid era (Patterson, 2005: 127). Nelson Mandela focused on creating a stable post-apartheid nation. It is possible that he thought that promoting AIDS treatment would put too much emphasis on the disease. The occurrences under the GNU can fall under conscious and official denial (Cohen, 2001: 10).

Official denial is an extremely public occurrence, and is highly organised. Official denial can be used to distract from other occurrences as well, as was the case in SA. Therefore, one can also argue that it was not so much official *denial*, but official strategy. A deliberate effort was made to focus on issues other than the looming AIDS epidemic. The denial can be described as official since the government as a whole worked together on other projects. In 1996 the National Party left the GNU, and the national government was ruled by the ANC majority.

4.3.4 Virodene and the Medicine Control Council

The work done by Thabo Mbeki during his time as Deputy President of South Africa is overshadowed by his support of the controversial, locally developed, drug, Virodene. Virodene was created at the Pretoria University and was touted as a promising ARV. Mbeki promoted Virodene as a way of showing support for the Minister of Health, Nkosazana Dlamini-Zuma who succeeded Winnie Madikizela-Mandela. He also supported Virodene because he believed it to be a local solution to HIV and AIDS in the country that had the highest infection rate in the world.

Nathan Geffen's (2006) focus in his writings is mainly on Matthias Raath, and his claim that HAART was ineffective, but in fact, state support for both Raath as well as Virodene had the same impact, i.e. no support for effective ARVs, delayed response to the epidemic, and detrimental effects on AIDS patients. Here one can already see instances of denial being adhered to by Thabo Mbeki. It can be argued that cultural denial was his chosen route, in that

his actions were not completely personal or official (Cohen, 2001: 11). Cultural denial creates a "belief" for the public to hold on to, as Mbeki did, while promoting his ideas to his base.

A more complicated issue arises when one is tasked with evaluating whether or not Mbeki's endorsement of Virodene was a case of conscious or unconscious denial. It could be argued that he was in fact aware of the unhealthy, detrimental consequences of the newly-developed drug, but chose to support it in public in order to show support for South African innovation, however detrimental that support could end up being. Should this be true, it can be described as Mbeki consciously denying the arguments and evidence against Virodene as provided by many academics and scientists. On the other hand, it is possible, although unlikely, that Mbeki really supported Virodene because he believed it could be successful. This would mean that he believed the scientists at Pretoria University, and that he considered the evidence against Virodene as spiteful acts from pharmaceutical companies. Should this be the case, one can say that Mbeki unconsciously denied the effectiveness of proven ARVs in order to convince himself that a South African drug could be as effective, if not more so. The bizarreness of the Virodene issue escalates when one considers the fact that, while he was promoting Virodene as the best possible solution for the AIDS epidemic staring SA in the face, he was also slamming ARVs that had been proven to be successful. This indicates a contradiction in Mbeki's thinking process. If he believed Virodene to be a successful ARV, why did he not lend the same type of support to readily available treatment?

When the Virodene controversy hit South Africa in 1997, the government was criticised afresh, with the main argument being that the government was not performing its most important task – "governing the country and implementing policies" (Fourie, 2006: 125). It was stated that the government should not occupy itself with pseudo-science, but rather focus on the primary tasks. The developers of Virodene were allowed to present the drug to Cabinet before it had been, in any way, proven successful or even safe. Mbeki was impressed by the claims of two AIDS patients, who had stated that their lives were drastically improved by the drug.

The MCC had the legal responsibility to decide to test drugs on people. Only after clinical trials can such a decision be made. There was no authorisation to test Virodene, and therefore ongoing tests were stopped. The conflict that followed between Mbeki and Professor Peter Folb, chair of the MCC, signalled the beginning of a less independent MCC (Geffen, 2010: 3). Prior to the Virodene debacle, the MCC had an excellent reputation abroad. Folb

explained his refusal to allow for testing Virodene by stating that there was no evidence that Virodene had even the slightest chance of succeeding, and that he was not willing to take such a big chance. Folb was dismissed as the chairperson of the MCC, in large part due to his criticism of Virodene. The MCC also lost most of its top staff members. Once again, this is a case in which it is difficult to decide whether or not to ascribe Mbeki's behaviour to conscious or unconscious denial. It seems impossible that an educated individual could hold on to his beliefs about something for which there was no scientific proof. However, the support for Virodene could also merely be due to his insistence on supporting local products, especially for what he referred to as an "African problem". This can be linked to his idea of an African renaissance, and the famous "I am an African" speech.

Mbeki's policy decisions can be ascribed to what Anthony Butler (2005: 591) calls a "nationalist/ameliorative paradigm". This type of policy stands in opposition to a "mobilization/biomedical approach" to policy making. Mbeki denied the effectiveness of proven treatment many times, and therefore he decided not to follow a biomedical approach to create an AIDS policy for South Africa. The ameliorative approach has the aim of improving the patient's situation through proper nutrition, traditional medicine, education about personal responsibility, and better sanitation facilities. None of these tactics include the use of Western medicine. By choosing an ameliorative strategy, Mbeki proved that he consciously denied the effectiveness of Western medicine. He denied the truth (Cohen, 2001: 3).

It is possible that the tactic chosen by Mbeki is the "deliberate, intentional and conscious statement which is meant to deceive" (Cohen, 2001: 4). This is merely what one would call lying. It makes sense to ascribe Mbeki's actions to this method, because, as stated above, it does not seem logical that an educated person would not believe scientific facts with proven evidence. This would mean that he lied in the public sphere since it suited his political agenda. By supporting only African "solutions" such as Virodene and a healthier diet, he could show that he was a nationalist, and a "proudly South African" person – ideas captured in his famous speech.

4.3.5 The Sarafina II Saga

As part of ongoing educational projects regarding HIV and AIDS, Sarafina II, a musical production, was launched. This musical was to be a follow-up of the 1992 movie *Sarafina*, which starred Whoopi Goldberg as a Soweto-based teacher who supports her students during

uprisings against apartheid. In the follow-up, Sarafina II, the main character from the movie was now an adult, who had to teach children about the risks of having unprotected sex (Daley,1996).

Described as an AIDS-awareness play, Sarafina II was the sequel to Sarafina, and the play premiered on Broadway in 1988. The first play was centred on the student activist uprisings against Afrikaans education in 1976 in Soweto. It was also turned into a film which premiered in 1992. Mark Gevisser states in *Thabo Mbeki: The Dream Deferred* (2007: 732) that Sarafina II was born out of desperation caused by a sense of impending doom brought on by the epidemic.

On World AIDS Day in 1995, Sarafina II opened in KwaZulu-Natal, the province hit the hardest by the epidemic. However, it did not run for very long, and closed after only six months. Sarafina II is central to explaining the AIDS epidemic in South Africa. According to Fourie and Meyer (2010: 93-94), Sarafina II was the first disaster to hit South Africa's AIDS policy.

In 1995, the National Department of Health awarded a R14,27 million tender to the playwright of Sarafina, Mbongeni Ngema, to produce the educational play. Educational theatre productions had been very successful in other areas, and the idea was to make students aware of the risks associated with HIV and AIDS (Fassin, 2007: 36). According to Didier Fassin (2007: 37), the idea of putting on a play was unoriginal, but it could be seen as a serious effort from the Department of Health to show its commitment to AIDS education.

Sarafina II was dumped in scandal when the allocated budget became public knowledge, since it was approximately one-fifth of the total budget allocated to combatting the AIDS epidemic (Fassin, 2007: 37). The process of securing the funds also did not go through the approved channels. Dlamini-Zuma defended herself by saying that the apartheid government did not do nearly as much as the ANC regime in the fight against AIDS, and that she therefore had the right to allocate the budget in any way she chooses to (Fassin, 2007: 38).

The money allocated to Ngema was a large part of the national AIDS budget, and the Minister of Health, Nkosazana Dlamini-Zuma, accelerated Ngema's appointment, and found herself at the receiving end of sharp criticism from the opposition in Parliament and the media that she did not follow the correct tendering protocol. Furthermore, the message and accuracy of Sarafina II was questioned by AIDS activists, and it was labelled as inaccurate

and misinforming. South Africa's AIDS civil society was not consulted with regards to the content of the play, and therefore it was ineffective in getting the necessary message across (Fourie & Meyer, 2010: 94).

The ultimate failure of Sarafina II led to a weakening of the relationship between civil society and the government (Fourie, 2006: 124). Sarafina II was regarded as a waste of money, and it can be argued that ultimately it had no impact on the fight against HIV and AIDS. The Department of Health designated R14,27 million to the project, amidst outcries from the public against the producer, Mbongeni Ngema. It was stated that he had a reputation for over-spending, and that his productions were mediocre. Still, the production went ahead (Geffen, 2010: 3).

Despite all the failures of Sarafina II, be it financial or educational, the biggest let-down for South Africans was that no blame was placed on a single person. Even Nelson Mandela, who was President of South Africa at that time, criticised the media for going overboard on this story, reprimanding them for going after Nkosazana Dlamini-Zuma. Rather than placing blame with the people responsible for the failure, the ANC stated that the criticism was mostly received from drug companies out to "get" Dlamini-Zuma due to her efforts to make prescription medicine more affordable (Daley, 1996).

The local actions and events discussed here can be explained by labelling it as conscious denial, official denial, and denial by the perpetrator. The arguments against Ngema was well-known, and still he received the grant. Therefore, it can be argued that Mbeki and the Department of Health consciously denied the existence of these complaints, and went about their actions regardless of the warning signs. This is typical of conscious denial – the blocking or ignoring of proven facts. Official denial can also offer an explanation, since the denial of Ngema's inadequacy became part of official policy. In the case of Sarafina II, the perpetrator is the Department of Health. Perpetrators implement denial in order to continue with their lives in a casual manner, and to place the atrocities in the back of their minds, hoping that such atrocities will eventually be forgotten by everyone affected by the actions (Cohen, 2001: 15). Not only was the department complicit in corruption, the play also sent out "vague and confusing" messages about AIDS, rendering the musical useless and uninformative (Daley, 1996).

4.4 Global Events Surrounding HIV/AIDS

AIDS is not only a South African, or even African, problem, but the continent seems to bear the brunt of international scrutiny of its management of the crisis. In addition to everything that was happening in South Africa at that stage, two international events also placed HIV and AIDS in the spotlight. These are the founding of the Joint United Nations Programme on HIV/AIDS (UNAIDS), and the evolvement of highly active antiretroviral therapy (HAART).

4.4.1 Creation of UNAIDS

The Joint United Nations Programme on HIV/AIDS (UNAIDS) was launched publicly at the start of 1996. In *UNAIDS: The First Ten Years* (1998: 40), L. Knight quotes Chan-Kam who said that "All of us involved in AIDS for several years knew it was all about prevention, about getting through to young people… political leadership". This quote contradicts the situation in South Africa, since it is exactly *because of* the country's political leadership that the battle against AIDS was hindered. This provides more evidence that the government acted from a place of conscious and official denial. UNAIDS's goal to educate young people can be compared to the South African's government's plan to educate young people on HIV and AIDS through the play Sarafina II.

The lack of political leadership was explained by Dennis Altman (2006: 258), who stated that preventing the rapid spread of the disease was possible, if the government were willing to acknowledge the real cause of HIV and AIDS, including sexual behaviour and drug use. By sticking their heads in the sand, the government was committing cultural denial (Cohen, 2001: 10). This type of denial is neither completely personal nor official. A group reaches a decision about what is acceptable to believe and promote, and through this, the society they have control over, becomes influenced by them. According to Cohen, cultural denial is not uncommon in democratic societies. He states that in cases of cultural denial, people pretend that they believe false information. The most common case of cultural denial is holocaust denial, where a whole society chooses to downplay the effect the holocaust had. In explaining holocaust denialism, Catriona McKinnon (2007: 10) supplies three facts about the holocaust. These are: the holocaust was a well-organised programme to eliminate Jews, that roughly six million Jews were killed through the programme, and that there was a solid intention of ridding (at least) Germany of Jews, based on a racial ideology. These three facts are fiercely denied by holocaust deniers. They are of the opinion that the gas chambers used to exterminate the Jews could not have, and in fact did not, exist, that the number of Jews killed

was far less than six million, and that there was no plan based on a racial ideology to get rid of Jews (McKinnon, 2007: 11).

With regards to cultural denial in South Africa, the manner through which HIV is spread was denied, since sex and drug use was seen as taboo or shameful topics. It was stigmatised, and although it has become a normal topic to discuss, the stigma is still clinging, and HIV-positive people are victims of discrimination, as stated by Michel Sidibém (Agenda for zero discrimination in health-care settings, 2017: 3), who served as the Executive Director of UNAIDS from January 2009 to May 2019:

> Whenever AIDS has won, stigma, shame, distrust, discrimination and apathy was on its side. Every time AIDS has been defeated, it has been because of trust, openness, dialogue between individuals and communities, family support, human solidarity, and the human perseverance to find new paths and solutions.

People who are the most vulnerable to AIDS, when looking at the populations that are most affected, are also those who face the most discrimination in their societies (Agenda for zero discrimination in health-care settings, 2017: 3).

If the government allowed themselves to talk about topics like these, it would sooner have been common knowledge that, for example, HIV can be transmitted through infected needles, or that the use of condoms is essential in preventing the transmission of HIV when having sex. If South African citizens had this vital information sooner, it is likely that a lot less HIV infections would have occurred.

4.4.2 Development of HAART

The ARV era started in 1987, when zidovudine (AZT) was announced. AZT targets the reverse transcriptase enzyme, which causes the replication of HIV, therefore AZT prevents the replication of the HI-virus. Highly active antiretroviral treatment (HAART), introduced at the eleventh International Conference on AIDS in Toronto, Canada in 1996, is a very effective method of medication used to combat HIV. It requires the usage of two reverse transcriptase inhibitors and one protease inhibitor (Barnett & Whiteside, 2006: 47). It decreases the effects of the virus, supports the patient's immune system, and prevents additional infections that can attack the immune system and possibly lead to death (Moore & Chaisson, 1999: 1934). It also prevents the transmission of the virus between an infected person and their sexual partners (Eissinger, Dieffenbach & Faussi, 2019: 451). HAART

therapy became a reality due to the availability of protease inhibitors (PIS), a new form of ARVs with which it was possible to observe the virus's response to the powerful therapy (Cassone, Tacconelli, De Bernardis, Tumbarello, Torosantucci, Chiani & Cauda, 2002: 188). Patients who have received HAART have shown dramatic improvement with regards to mortality and quality of life. Effectively, HIV infection could now be viewed as a manageable disease rather than a death sentence (Cassone et al., 2002: 188).

This table illustrates the impact on CD4+ cell count on patients who started the treatment at various levels of CD4+:

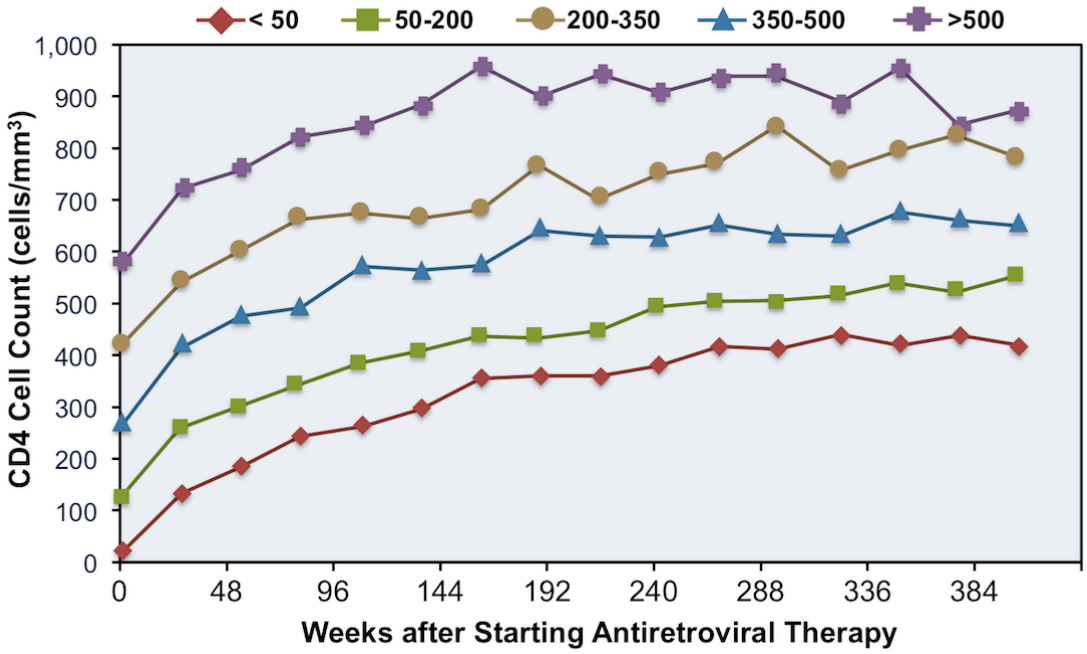

Figure 4.1: Median CD4+ cell count after starting ART (by baseline CD4+ category)

Source: David H. Spach, MD, 2018.

Regardless of the proven successes of HAART, the government remained reluctant to agree to a HAART roll-out, stating that it would be too expensive (Nattrass, 2007: 4). Here already, the action can be described as official denial, since the government acted publicly as a collective, and in a highly organised way − the characteristics of official denial, according to Cohen (2001: 10). By acting as a collective, the government's message came across as very strong and cohesive. This made it more difficult to go against it, or to try to convince the government of altering its ways.

Only in October of 2003 did the government agree to a HAART roll-out. Unfortunately, the roll-out process was extremely slow. Manto Tshabalala-Msimang continuously failed to spend all the resources allocated to the HAART programme by the Minister of Finance (Nattrass, 2007: 5). Thus, 1996 could have been a watershed year for AIDS patients, but unfortunately, people suffering from AIDS had to wait at least seven more years before they were able to receive successful treatment. For some patients, it would have been too late, since the gestation period of the virus varies between three and five years. The fact that Mbeki's government dragged their feet with the roll-out process, indicated reluctance to endorse HAART.

Through a ruling of the Constitutional Court, HAART became available in South Africa only in 2004 (Nattrass, 2004: 41). The existence of HAART meant that the millions of AIDS patients in South Africa could finally be relieved of their pain to a certain extent, and could manage their infection, while prolonging their lives. Unfortunately, the South African government was still under the influence of Mbeki, with their combined disdain for Western medicine, and thus HAART and other ARVs were dismissed as not being useful or effective. South Africa could have escaped the worst of the AIDS impact, if the government were to act faster and more successfully (Fourie & Meyer, 2010: 37).

For outsiders, this reluctance from the government is difficult to grasp, since it could be said that Mbeki merely disregarded it in public, in order to further his ideal of an African solution for an African problem. Mbeki's government's reasoning behind this can possibly be explained on the basis of Cohen's conscious denial (2001: 4). Conscious denial is described as making a "deliberate and conscious statement which is meant to deceive", which Cohen (2001: 4) also blatantly calls lying. The reason for arguing that conscious denial was at play here, is that it seems like Mbeki and his Minister of Health deliberately delayed the roll-out process, meaning that they consciously decided to slow down the process in order to limit their spending. It does not seem plausible that Mbeki delayed the process because of a distrust of HAART.

The fact that Thabo Mbeki and Manto Tshabalala-Msimang referred to HAART as poison, could be an indication of a reluctance to accept or acknowledge HAART's effectiveness in order to further the ideology of finding purely African remedies for what was being referred to as an African disease. But in order to curb government spending (if one is to believe their reasoning), the government denied the effectiveness of HAART. This proves that the

government was implementing conscious denial, in order to support its ideology. When implementing conscious denial, some sources of information are plainly ignored (Cohen, 2001: 3).

Furthermore, one could argue that Mbeki was implementing literal denial. If the delayed roll-out of ARVs was not due to the government's attempt to curb its spending, it could be ascribed to Mbeki's feigned distrust of HAART. It could also be that Mbeki really did not believe the effectiveness of the medication or the studies that proved it to be successful. Should this be the case, he would be denying literal facts. This differs from interpretive denial, since Mbeki did not put another spin on facts to suit him. Implicatory denial could also have been at play here. Implicatory denial is when the consequences of a specific decision are downplayed or denied (Cohen, 2001:8).

It is well-known that Mbeki, both as Deputy President *and* President, downplayed the effects of HIV and AIDS (Altman, 2006: 257). This was done for a couple of reasons. Firstly, Mbeki wanted to protect the idea that traditional prescriptions were the best method available to combat HIV-infections. He was acting from a place of trying to keep some of his African supporters satisfied. However, by acting supportively towards traditional healing rather than towards Western medicine, one can see a case of cognitive dissonance. This is when someone has the perception of "incompatibility between two cognitions, where cognitions can be defined as forms of knowledge, attitude, emotion, belief or behaviour" (Kenyon, 2008: 29). It seems as if Mbeki was denying the fact that he could still be supportive of African medicine, while also supporting the distribution of ARVs to those who wanted and needed it. A person who has cognitive dissonance will specifically disregard information that might lead to increased dissonance (Kenyon, 2008: 30). This theory can be applied to Mbeki, as he vocally disregarded proven science that did not agree with his *chosen* road.

If Mbeki was to wholly support Western medicine instead of African "solutions", he might have been labelled as being disloyal to his heritage. Contemporary denial was taking place, since Mbeki was denying current events – the effectiveness of HAART. He was not referring to something in the distant past. By denying the effectiveness of HAART, he was acting as a perpetrator (Cohen, 2001: 15). In most cases, a person is allowed to commit a crime or, at least, act in a controversial manner, without suffering any consequences. This is due to the fact that perpetrators tend to find a way to put a different, personal perspective, on their past actions. Perpetrators can be guilty of either conscious or unconscious denial.

4.5 Conclusion

Thabo Mbeki's term as Deputy President was eventful on many fronts, but will always be synonymous with the disastrous handling of the HIV/AIDS crisis by the South African government. By looking at the events that occurred in this era, especially during 1996, it becomes clear that denial was at play at many levels.

Official denial plays out in public, and becomes part of public policy. This is the most prevalent type of denial, as members of the government worked together to promote their own agendas, to the detriment of the public and especially AIDS patients. Some occurrences of perpetrator denial are also visible, as Mbeki and the government denied the effectiveness of HAART and other Western medication.

Already it can be seen that Cohen's model is useful for understanding the actions of Mbeki and Mandela's government. In the next two chapters, the focus will be on Mbeki's own terms as President, before he got ousted in 2008, and the study will explain how the events between 1999 and 2008 fit into Cohen's model.

Chapter 5: Mbeki's First Term as President of South Africa

5.1 Introduction

In the previous chapter, the focus was on Mbeki's time as Deputy President of SA, from 1994 to 1999. It examined the most important events of that period, especially focusing on the year 1996. It was the start of explaining Mbeki's personal use of denialism, in order to answer the research questions and solve the main research problem, which is 'Why and how did Thabo Mbeki use political denial as a strategy to respond to the South African AIDS epidemic?'. This chapter will also explain Mbeki's use of denialism to solve the above-mentioned problem, and will, similarly to the preceding and following chapters, focus on the supporting research questions: why is denial often utilised instead of facing controversial issues? What are the implications of following the denialist route instead of looking for solutions? How was the problem of AIDS defined? Why was it denied, despite the prominent problems referred to in the introduction?

In June 1999 Thabo Mbeki became President of SA, and he appointed Manto Tshabalala-Msimang as his Minister of Health. Over the following decade, their denial of AIDS, and the mismanagement of the health system would lead to many unnecessary deaths. Since October 1999, shortly after being elected President, Mbeki expressed scepticism about the use of the antiretroviral medicine, AZT. He responded to requests to make AZT available in SA by saying that there is "a large volume of scientific literature alleging that, among other things, the toxicity of this drug is such that it is in fact a danger to health" (Louw *et al*., 2010: 10). It was during this period that Mbeki was first labelled as an AIDS denialist, a title bestowed on him which he still carries with him.

As Mbeki's statements about AIDS became more radical, AIDS in South Africa became a more politicised issue. Shortly after taking office, he started to publicly question the link between HIV and AIDS, cementing the link between himself, and anti-intellectualism and pseudo-science (Fourie & Meyer, 2010: 107).

Mbeki's government, alongside him, offered many counter arguments against ARVs, questioning whether they were safe to use, and arguing that it was they were too expensive. Eventually, this reluctance led to the death of more than 300,000 South Africans – deaths that could have been prevented, should there have been a better managed ARV roll-out in South Africa (Roeder, 2009).

Furthermore, one of the largest problems that SA faced regarding AIDS healthcare was the cost of medicine that was licensed to international drug companies, referred to as "Big Pharma". Having to pay for these expensive drugs, put the South African government in a crisis, as it had fiscal limits. The lack of available care pitted the governments against groups like the TAC, which would have liked to see more government spending on ARVs, and also on preventative measures to prevent children from being infected (Bond, 2003: 154). It was because of these inflated prices that the government, in tandem with groups such as the TAC, had to take on these international companies. In 2001, the international pharmaceutical industry dropped its case that tried to prohibit the South African government from importing more affordable, generic versions of available ARVs (Swarns, 2001).

The following sections will explore these core events of Thabo Mbeki's first term as President of South Africa:

Table 5.1: Important Events During Mbeki's First Term as President

1999	Thabo Mbeki becomes President of SA.
1999	The NP acts against the national government, and agrees to provide ARVs at specific sites in the Western Cape.
2000	Mbeki airs his opinions regarding his doubts about the causal link between HIV and AIDS.
2000	International AIDS Conference is held in Durban.
2000	Mbeki appoints Presidential AIDS Panel.
2002	The TAC pushes the government to provide MTCT and HAART.

Thabo Mbeki was the second democratically elected President of SA, following in the footsteps of Nelson Mandela. Already during his time as Deputy President, did he focus on AIDS more than Mandela did, and when he became President, he placed even more emphasis on this, and the issue became increasingly public. Mbeki also aired more, increasingly radical opinions on HIV and Aids. This becomes apparent when looking at the events discussed in this chapter of the study.

AIDS denial is not unique to SA, and has also been seen in the USA, India, and China. But AIDS denialism in SA differed from the denialism in developed countries. The reason for this is that SA was, and still is, a developing nation. Although it is more developed than some other African states, SA has challenges that add to the tragedy caused by HIV and AIDS, such as gender-based violence and poverty (Heywood, 2004: 100).

5.2 Mbeki Escalates as an AIDS Denialist

The situation in SA was one of "unequal distribution of resources, widespread poverty, the profligate duplication of civil services, international isolation and regional military insurgencies, the absence of democracy and effective/good governance, domestic political instability and gender inequality" (Fourie, 2006: 51). Also, the population of SA was ignorant about HIV and what it entailed. Ignorance in all spheres, together with a government that did not favour rural health care, make it clear why the disease had a favourable situation in which it could spread. The problem was not that Mbeki did not believe that HIV/AIDS exists, but rather that he had alternative ideas surrounding how it should be treated. In 1998, Mbeki stated at parliament that "HIV/AIDS is among us. It is real. HIV/AIDS is not someone else's problem. It is my problem. It is your problem" (Govender, 2009: 36), and this statement led the public, and members of his party, the ANC, to believe that he was eager to take action toward combatting AIDS, and that he would follow best practices to reach these goals. However, the opposite would soon be proven to be the case.

The fact that the South African government paid little attention to the looming AIDS threat since 1982, resulted in a serious crisis with regards to economic and social issues, that was out of control by Mbeki's first term as President. It is pointed out that ever since the National Party (NP) government ruled SA, government policies failed to address the problem in a suitable manner. The reasons for this included homophobic and racist assumptions regarding the cause of the disease, and an exclusivist manner of policy consultation. This led to inappropriate policies being created, ineffective actions being taken and a lack of legitimacy to the actions (Fourie, 2006: 4).

By 1999, during Mbeki's first year as President of SA, he was still adhering to the government's plan regarding the distribution of affordable medicine. But towards the end of 1999, the situation changed for the worse. Mbeki had a new Minister of Health, Manto Tshabalala-Msimang, who stated in parliament that AZT would no longer be distributed to people with AIDS, or those who had become infected through rape or needle pricks, on the

grounds of "affordability and… the absence of proper research on the possible side-effects of AZT, in particular its toxic profile" (Govender, 2009: 38).

Tshabalala-Msimang's statement was met with shock, especially due to the fact that she was a medical doctor herself. One would think that she would know that medication can have side-effects, but that those could be managed as well (Govender, 2009: 38). Furthermore, Tshabalala-Msimang distributed selected chapters from the book by AIDS dissident William Cooper, the contents of which implied that AIDS was introduced to Africa by the 'Illuminati' to reduce the continent's population.

This behaviour by Tshabalala-Msimang is a perfect example of literal denial. As explained in States of Denial (Cohen, 2001: 7), literal denial is the "assertion that something …is not true". In this case, Tshabalala-Msimang denied that the possible side-effects of AZT could be properly treated, and as such did more harm than good.

Tshabalala-Msimang also acted as a perpetrator, in that she was the agent who spread the false news (Cohen, 2001: 15). The actions taken by perpetrators allow atrocities to be committed, responsibilities to be neglected, and for offenders to get off scot-free. Governments are often guilty of acting as perpetrators, because by spreading false information, they can keep their populations under their control. In Tshabalala-Msimang's case, false information about AZT and AIDS was spread, in order to place fewer responsibilities on herself and her Department.

In May 2000, Thabo Mbeki established the Presidential Advisory Panel, filled with like-minded people who denied the link between HIV and AIDS (Park, 2012). The panel consisted of 33 scientists who were regarded as experts by Mbeki. Controversially, these "experts" also included denialists such as Peter Duesberg. Duesberg, a former biology professor at the University of California, Berkley, was a vocal AIDS denialist. He was a proponent of the belief that AIDS was misdiagnosed in Africa, and that the disease was more of a myth. Like Mbeki, he claimed that AIDS can be caused by malnutrition and unhealthy living conditions (Duesberg, Koehnlein & Rasnick, 2003: 388). The members of the panel were split between denialists and members who supported the proven science (Sidley, 2000).

The panel had a second meeting in July 2000. One of the panel members, David Rasnick, who was also a denialist, made a request for any and all HIV tests to be banned, giving his reason that he "hadn't seen any evidence of an AIDS catastrophe" (Schoofs, 2000). The AIDS

denialists recommended that, instead of using scientifically proven ARVs, patients should seek “alternative” therapies such as “massage therapy, music therapy, yoga, spiritual care, homeopathy, Indian ayurvedic medicine, light therapy and many other methods” (Nattrass, 2007:32).

On 6 July 2000, the scientific community delivered the Durban Declaration as a response to the damaging statements coming from the panel. It was signed by 5,000 scientists and published in the journal *Nature*. The scientists stated that "HIV causes AIDS. It is unfortunate that a few vocal people continue to deny the evidence. This position will cost countless lives" (The Durban Declaration, 2000). Despite their action, Mbeki rejected their views only three days later when he was giving the opening speech at the International AIDS Conference in Durban. Instead, he reiterated his views that there were no correlations between HIV and AIDS, and that AIDS was rather caused by external factors such as poor nourishment and poverty (Boseley, 2008).

The theme of denialism is closely linked to the practices of so-called quacks. These are people who promote themselves as medical practitioners but who actually promote harmful practices. Mbeki’s attitude became clear when, in 1999, he told parliament that AZT is toxic, and then urged the Medicines Control Council (MCC) to review the drug. At this time, the Minister of Health supported Mbeki’s opinion that AZT is toxic (Karim & Karim, 2005: 544).

The Report on the IDASA/UNDP Regional Governance and AIDS Forum offers a range of emerging theories and perspectives surrounding AIDS and governance issues in South Africa. Firstly, one should look at the crises which are caused by AIDS. These are the crisis of demographics, and the crisis of governance (Chirambo & Caesar, 2004: 5). The crisis of demographics refers to the mortality of people who could potentially be active members of the economy. Society in SA may be reshaped, meaning that more young people would have to leave school to work, or older people might have to return to work to care for their ill children.

The crisis of governance refers to the undermining of state institutions and processes. This includes “possible changes to the way in which institutions are managed; the extent to which institutions are able to fulfil their mandates in the wake of depleted skills bases; the capacity and opportunities for citizens to participate in public political processes and also the barriers to economic growth and establishing economic justice” (Chirambo & Caesar, 2004: 5).

Mbeki's time as President was already being overshadowed by the AIDS crisis, and his denialist stance. He established himself as a social pariah by committing to his beliefs, and sharing them publicly. In April 2000, Mbeki sent a five-page letter to Bill Clinton, United States President at the time, in which he described AIDS as a "uniquely African catastrophe", with three points distinguishing AIDS in Africa from AIDS in the West:

- Contrary to the West, HIV-AIDS in Africa is heterosexually transmitted;
- Contrary to the West, where relatively few people have died from AIDS, itself a matter of serious concern, millions are said to have died in Africa; and,
- Contrary to the West, where AIDS deaths are declining, even greater numbers of Africans are destined to die.

He further stated, "as an essential part of our campaign against HIV-AIDS, we are working to ensure that we focus properly and urgently on the elimination of poverty among the millions of our people" (Thabo Mbeki's letter, 2006). This statement again reiterates his belief that AIDS is caused, amongst other untrue beliefs, by living in poverty. The letter was soon leaked to *The Washington Post*. The publication of the letter exposed Mbeki to public criticism and condemnation (Sidley, 2000: 1291).

Mbeki's response to criticism about his handling of the AIDS crisis, and about his accidentally-leaked, controversial letter, was not calm. His attitude was described as "furious", and he claimed that his critics were "racist, reactionary, and dancing to the tune of pharmaceutical companies" (Cullinan, 2003: 65). This statement about Mbeki's reaction to criticism ties in with, and is proved by, an extract from a different letter published in 2003 (Cullinan, 2003: 66):

> Our opponents will oppose us, presenting their case with the greatest eloquence and erudition ... These opponents remain our opponents, however much they now pretend to be interested in the integrity and revolutionary purity of our movement and government, and the welfare of the masses of our people. Their task is to use all means at their disposal to oppose and defeat us. As long as we remain liberation fighters, so long will we refuse to be told by others, including these historic opponents and others, what we should think or do.

It can be argued that Mbeki was so extremely focused on proving his point, or getting his way, to put it bluntly, partly because he hated criticism so much. By focusing more on the

outcome for his personal happiness and satisfaction, rather than the outcome for the South African public, he displayed personal denial (Cohen, 2001: 10). This type of denial is completely individual, and plays out due to personal beliefs. By placing more emphasis on the outcome for himself, he also displayed perpetrator denial (Cohen, 2001: 15). If one looks at the question posed by Cohen regarding denial by perpetrators, "How can ordinary people do terrible things, yet, during or after the event, they find ways to deny the meaning of what they are doing?", Mbeki's actions come to mind. He is widely regarded as being very intelligent, but his stance on HIV/AIDS has made him a highly criticised politician. Furthermore, he has never admitted that he was wrong about proven science or that he acted in a way that was unbefitting of a President.

Mbeki has never shown any remorse for the deaths caused by his denialism, and by his government's lack of action (Mbeki Shows No Remorse for Role in AIDS Deaths, 2016). Ultimately, he is guilty of delaying providing life-saving medication to AIDS patients in SA, and neglected his responsibilities towards the country that voted him into power. Regardless of how he tried, and still tries to justify his actions, his statement that "a virus cannot cause a syndrome", is simply wrong. He was guilty of so-called 'word games' and this is an example of implicatory denial (Cohen, 2001: 8), where the *meaning* of facts or statements are given a different, slanted perspective, often in order to protect the perpetrators.

5.3 The Government's Case Against the TAC

The TAC was established on 10 December 1998 in Cape Town. Their first statement read as follows (Louw, Tomlinson, Kardas-Nelson, Kim, & Geffen, 2010: 6):

> The National Association of People Living with AIDS (NAPWA) has initiated the Treatment Action Campaign to draw attention to the unnecessary suffering and AIDS-related deaths of thousands of people in Africa, Asia and South America. These human rights violations are the result of poverty and the unaffordability of HIV/AIDS treatment. The Treatment Action Campaign calls on the minister of health, Dr Zuma, and Trevor Manuel, the minister of finance, to meet immediately with NAPWA and HIV/AIDS organisations to plan for resources to introduce free AZT for pregnant mothers with HIV/AIDS. TAC also calls on government to develop a comprehensive and affordable treatment plan for all people living with HIV/AIDS.

NAPWA was formed in 1994, when the majority of South Africans first began to learn about HIV/AIDS. It is one of the largest AIDS groups in SA (Patterson, 2005: 98). It is a "non-political, non-discriminatory, non-governmental, not for profit membership-based organization that does not discriminate based on race, age, creed, sex and sexual orientation", that exists to assist and support people living with AIDS in South Africa (About NAPWA, 2019).

In March 1999, the first TAC-demonstrations were held in Cape Town and Durban and at Chris Hani Baragwanath Hospital. They were calling for a national prevention of mother-to-child transmission programme (Louw *et al*., 2010: 19). The TAC was also determined to establish access to ARVs as a solid human rights issue, and wanted to force the government's hand regarding access to the medication (London, 2006: 12).

On 10 December 1998, International Human Rights Day, the TAC was established by a group of activists. The group's aim was to make "the right of access to treatment" a more mainstream idea in SA. In order to achieve this, they used a combination of protests, mobilization, and legal action (Heywood, 2009: 15). The TAC also criticised the lack of availability and distribution of ARVs, and their actions were later partly fuelled by the policy of AIDS denialism, which was followed by the South African government. Then-president Thabo Mbeki and the Minister of Health were of the opinion that Zidovudine (AZT) is too expensive to distribute, and also that it is toxic (Louw *et al*., 2010: 19). Here, it is already apparent that Mbeki would criticise Western medication and science, and aim to discredit solutions and medicine that was not developed or originated in SA. This is a display of official denial (Cohen, 2001: 10), by Mbeki, as well as by the Minister of Health. Official denial is shaped by the rhetoric of governments, and in this case, the message was "we are right, and our critics are wrong".

Nathan Geffen (2010: 49) explains the route that the TAC took to become what they were by 2004. It was started within NAPWA. He also mentions the launch of the TAC on the steps of the St. George's Cathedral, where a small group of people fasted for a day. They addressed the Minister of Health, Nkosazana Dlamini-Zuma as well as the Minister of Finance, Trevor Manuel. Despite their claims being addressed to the state, it was clear that the problem lay with the pharmaceutical companies. During the first two years, the TAC fought primarily against the pharmaceutical industry.

Mark Heywood stated (2009: 16) that the TAC did not start out with the goal of tackling the South African government. When the TAC was launched, they targeted large, privately-owned pharmaceutical companies. However, it has already been stated many times that the aims of the TAC changed when they were faced with a denialist government. Heywood stated that the TAC's starting point was to insist that the excessive pricing of essential medicines by multi-national pharmaceutical companies violated a range of human rights.

The TAC stated that the aim of their programme was to deal with gender-inequality and gender-based violence (Heywood, 2009: 24). This means that the TAC realises the importance of gender issues with regards to HIV/AIDS. This is clear when one looks at the other women's programmes they launched, i.e. Prevention of Mother to Child Transmission (PMTCT), and Pregnancy in our Lives.

The epidemic clearly shows a convergence of unequal gender relations and an imbalance in gender power. The illness is to the disadvantage of both men and women. It becomes clear that the management of the illness comes down to mainstreaming gender analysis in the understanding of causes and also in the response to the epidemic. It is necessary to examine the epidemic through a gender lens in order to fully understand it. Also, understanding women's relationship with the illness is crucial. More than half of the people living with the disease are women. The cultural, social, economic and political situations of women are the main causes for them being more at risk, than men, to being infected with HIV (Chirambo & Caesar, 2004: 26-27).

In 2005, the TAC's general secretary Sipho Mthathi made the statement that AIDS is not merely a health crisis. He said that AIDS was also a political, social and economic crisis. Furthermore, Zackie Achmat stated that AIDS clearly illustrated the relationship of illness with regard to global inequality, injustice and poverty (Jungar, 2011:67). This means that, when one looks at the difficulties involved in gaining access to ARVs, it is made even more complicated due to global inequality, injustice and poverty. Even though these medicines cannot cure AIDS, the goal is to delay or prevent the progression of AIDS and the death of infected patients (Karim & Karim, 2005: 504). There are many ARV medicines available, but AZT is central to the purpose of the TAC.

The second major battle which the TAC had to fight was against the government itself, its former comrade. The TAC turned on the government due to its denialist attitude (Louw *et al*., 2010: 60). By 2004, the government's treatment roll-out was continuing steadily. However, it

was at this stage that Matthias Rath and his Foundation began promoting their multi-vitamins as a cure for AIDS as well as other illnesses. Matthias Rath was one of the controversial figures in South Africa's fight against AIDS. He promoted his own vitamin pills above ARVs, and claimed that his pills could reverse the effects of AIDS. He provided these pills free of charge, but it is believed that the pills caused many deaths, as some AIDS patients were led to believe that these would be more effective than ARVs (Boseley, 2008).

The Minister of Health, Tshabalala-Msimang supported Rath, even though courts in other countries had previously ruled against him. Tshabalala-Msimang also displayed literal denial, by blatantly ignoring something which, in fact, is true (Cohen, 2001: 7). She disregarded the proof that Rath's pills were toxic. The ANC-aligned organisation South African National Civic Organisation (SANCO) also supported Rath. SANCO volunteers worked in his supposed 'clinics' and endorsed his products (Louw *et al*., 2010: 60). By supporting Rath and his so-called 'clinics', members of SANCO were also guilty of both literal denial and cultural denial. The idea that Rath was credible, was so entrenched with them, that it became part of their narrative and state of mind. Cultural denial (Cohen, 2001: 10) To quote Cohen (2001: 10-1):

> Without being told what to think about (or what not to think about) and without being punished for 'knowing' the wrong things, societies arrive at unwritten agreements about what can be publicly remembered and acknowledged… This happens even in more democratic societies… people may be encouraged to act as if they don't know about the present.

This summary of Cohen's cultural denial perfectly describes the members of SANCO, and what they were encouraged to do. Although some of them may have been against the use of Rath's "solution", they were encouraged to be loyal to their party leader, and therefore they fell in line with what was expected of them.

It is clear that the TAC was aiming to construct a narrative surrounding AZT. They wanted to wholly explain the benefits thereof, the dangers of not supplying it to patients, and what the consequences would be if there was not a proper roll-out of the medication.

The TAC decided to investigate the product in order to find out what the government was promoting. An advertisement for Rath's products read: "The Dr Rath Health Foundation Africa has the support of our Minister of Health and our Government…Unlike toxic

antiretroviral drugs, these vitamins are safe. Trust our Government and those who support it… Don't fall for dirty tricks: TAC targets poor communities as markets for the drug industry…and pays crowds to demonstrate". NAPWA, in which the TAC originated, also sided with Rath when the TAC took him to court (Louw *et al*., 2010: 60).

The TAC and the Legal Resources Centre then led a legal battle to stop Rath from getting a stronger hold on people suffering from AIDS and who were falling victim to his promises. The TAC was supported by *Médicins Sans Frontières* (MSF), the South African Medical Association, the Southern African HIV Clinicians Society and other health workers. The legal battle consisted of two court cases. During the first case, the TAC requested the Cape High Court to stop Rath from slandering the organisation. The TAC's name was cleared, and interdicted Rath from making any more such claims (Louw *et al*., 2010: 63).

During the second trial, the TAC filed papers to ask the Cape High Court to find Rath's actions unlawful. This case only came to an end in 2008, when the court decided that Rath's advertising was "false, misleading and unlawful". The Minister of Health was blamed for not enforcing the Medicines Act (Louw *et al*., 2010: 63).

Many sources site the case of the TAC against the Minister of Health, which case was instituted on 21 August 2001. The TAC and its co-applicants were of the opinion that the government's policy violated a number of human rights that form part of the South African Constitution. These human rights included the right to access to healthcare services, including subsection 27(1)(a), embracing 'reproductive healthcare' and the right of every child to basic healthcare services (Ndinga-Muvumba & Pharoah, 2008:71-72).

The ruling of the High Court in December 2001 was in favour of the TAC. Mr. Justice Botha ordered the government to expand its PMTCT programme. The government then appealed the decision, and the case was heard in the Constitutional Court. In July 2002, the result was once again in the favour of the TAC. The government had to expand its PMTCT programme, but also had to immediately remove the restrictions that prevented women with HIV/AIDS to take the drug Nevirapine.

By considering the above, it can be said that AIDS denialism led to the spreading of false information regarding ARVs and AIDS. It has been estimated that the attitude of the government cost about 300,000 lives (Boseley, 2008). The TAC clearly became frustrated with the government. Due to Mbeki's statements, he was distancing himself from the TAC,

while the organisation was in fact necessary to help in the fight against AIDS (Patterson, 2005: 41).

The work of the TAC was started due to their dissatisfaction with the patent system. Therefore, it is clear that the patent system is a central actor in the fight against AIDS, and that any account of the TAC's work cannot be complete without mentioning the patent system. However, it is also important to mention that the patent system is not the only criminal in this story. There are many accounts of how the TAC changed the target of their actions from the pharmaceutical companies to the South African government. This was mainly due to the lack of ARV roll-out, and the state's focus on prevention, rather than cure (Jungar, 2011: 5).

5.4 South Africa Wins Against Big Pharma

Member states of the World Trade Organisation (WTO) are bound to the Trade in Intellectual Property Rights (TRIPS) agreement. Patrick Bond clearly explains the implications of this agreement on the importing of medicine. He states that it appears as if lobbyists of large pharmaceutical companies urge American politicians to change their foreign and trade policies to serve the interests of the companies, without taking into consideration the implications for the USA's image and global health concerns. In South Africa's case, this required US officials to ignore the existing WTO rules that govern TRIPS, that allow parallel imports and compulsory licensing, as well as identical provisions practiced in various areas of US commerce, that SA wanted to impose on life-saving pharmaceutical products (Bond, 2003: 157-158).

James Lowe summarised the South African position as follows (Bond, 2003: 158):

> TRIPS requires 20-year patent on pharmaceutical, and South African has 20-year patent on pharmaceutical. Parallel importing and compulsory licensing are part of the patent system, and both are legal under the WTO TRIPS agreement. The South African government is simply trying to use the patent system in ways that the USA, Germany, England and other countries do, including the use of compulsory licensing, which is a common practice in the US for many years. AZT and ddI, which are two of the prime candidates for compulsory licensing in SA, are US government-funded inventions.

The arguments presented were continuously rejected by American officials. Bond explains the damage that international organisations like the WTO and International Monetary Fund (IMF) and their policies can impose on the developing states. However, he also mentions that the South African civil society has resisted being dominated by globalisation, and that it has fought not only international financial institutions, but also large pharmaceutical companies successfully (Motsoeneng, 2014).

Patrick Bond did research on the issues surrounding limited government spending on ARVs. He states that one of the largest problems that SA faced regarding AIDS healthcare is the cost of pharmaceutical products that were licensed to international drug companies. These companies are more interested in profits than actual healthcare. Having to pay for these expensive drugs put the South African government in a crisis, as it had fiscal limits. The lack of available care pitted the governments against groups like the TAC, which would have liked to see more government spending on ARVs, and also on preventative measures to prevent children from being infected (Bond, 2003: 154).

A possible solution was to provide generic versions of the ARVs, as these are about 50% to 90% cheaper. The South African parliament passed the Pharmacy Amendment Act in 1997 and it was signed by Nelson Mandela to allow for this, but it was challenged by the pharmaceutical companies as being unconstitutional (Bond, 2003: 154).

It is important to mention the events regarding AZT. In early 1999, the Minister of Health, Dr Nkosazana Dlamini-Zuma, claimed that budget shortages prevented her from providing pregnant women who are HIV-positive with zidovudine at ante-natal pilot projects. This action could have saved the lives of thousands of women, but it would have cost $13 million per year. There were cheaper options such as the generic version of AZT. AZT was invented by the American government and produced by Glaxo-Wellcome, and cost $240 a month in SA at the time of publication. A generic version from India cost only $48. Glaxo-Wellcome offered to reduce their price by 70% but the offer was refused by Dlamini-Zuma due to broader budgetary implications (Bond, 2003: 155).

Given the high cost of AZT and other drugs, a pharmaceutical-policy initiative was launched to change the Department of Health's more progressive policies. Consistent with the constitutional right to healthcare, the ministry of health aimed to provide many health services to all permanent South African residents (Bond, 2003: 155).

There were complicated workings behind South Africa's policy on the acquirement of pharmaceutical drugs for AIDS (Bond, 2003: 177). Bond mentions that at the Durban AIDS conference in July 2000, ANC-parliamentarian and Nelson Mandela's ex-wife, Winnie Madikizela-Mandela, accused the government of being "an obedient servant of multinational companies that continue to put their profits above our people". Acting South African Constitutional Court judge Edwin Cameron made the following statement: "The drug companies and African governments seem to have become involved in a kind of collusive paralysis. International agencies, national governments and especially those who have primary power to remedy the iniquity – the international drug companies – have failed us in the quest for accessible treatment" (Bond, 2003: 177). These two statements confirm that AIDS patients and ordinary citizens were powerless in their search or demand for ARVs, as there was too much working against them.

The profit made by pharmaceutical companies remained a hot topic surrounding HIV and AIDS (Jungar, 2011:22). In *Long Live!* there is a photo of graffiti in Cape Town. It makes the statement: *AIDS kills because of drug company profits*. This sentiment links closely to that of the TAC. The TAC's first goal was to reduce the prices of ARVs by using socio-economic and rights-based arguments in court (Mbali, 2013: 7).

Thirty-nine companies, led by the Pharmaceutical Manufacturers' Association (PMA), and supported by the US government, combined their power to take the South African government to court to prevent changes to the Medicines Act from coming into force, the net effect of which would be to reduce drug prices. One of the companies, Pfizer, had created a drug called fluconzale, and one of the TAC's first campaigns was aimed at Pfizer, to have the company reduce the price of the drug. Geffen states that the TAC split from NAPWA soon after its inception. A key disagreement among the management of the two entities was, that the TAC did not want to accept any money from pharmaceutical companies (Geffen, 2010: 49).

By supporting pharmaceutical companies, the South African government was guilty of official denial (Cohen, 2001: 10). Cohen states,

> Denial is thus not a personal matter, but is built into the ideological façade of the state. The social conditions that give rise to atrocities, merge into official techniques for denying these realities – not just to observers, but even to the perpetrators themselves.

Instead of acting against the pharmaceutical companies and in favour of the South African public, the government neglected its responsibilities, and this is ~~also~~ another example of perpetrator denial (Cohen, 2001: 15). The government was solely responsible for distributing ARV drugs, but neglected that role for financial gain.

5.5 Conclusion

Compared to Mbeki's time as Deputy President of SA, which covered the period from 1994 to 1999, his first term as President exposed more of his denialist stance, and firmly placed his ideologies in the international spotlight. Effectively, the main issue was that Mbeki chose to support quacks, and allowed his Minister of Health, Tshabalala-Msimang, to peddle beetroot, garlic, and African potato as treatments for AIDS (Yawa, 2016). To those issues, one could also add his letter to Bill Clinton, as leaked to the Washington Post, and South Africa's case against 'Big Pharma'.

"Any leader would have been overshadowed by the mantle of Mr Mandela. Mr Mbeki, however, has tarnished his political inheritance and weakened South Africa's moral authority" (Is Mbeki a failure?, 2008). Clearly, Mbeki did not live up to the standards set by Mandela as the first democratically elected President of SA. The lag in roll-out of ARVs, amongst other issues, certainly further damaged South Africa's reputation abroad.

The literal denial, blatantly denying a proven fact (Cohen, 2001: 7), as employed by Mbeki, is visible in his statements about HIV and AIDS, for example his reluctance to support AZT as he believed that it was toxic and in fact dangerous to the health of AIDS patients (Louw et al., 2010: 10). Contemporary denial also comes into play, together with perpetrator denial. Contemporary denial refers to Mbeki's actions taking place and statements being made during the height of the AIDS crisis, rather than during the aftermath (Cohen, 2001: 13). Mbeki acted as a perpetrator during his term as Deputy President as well as when he was President of SA. By blocking the availability and distribution of ARVs in SA, he greatly contributed to the scale of the crisis, and he was the main actor in this crisis (Cohen, 2001: 15).

The next chapter will focus on Mbeki's second term as President, which was cut short in 2008. During this period, there were a few disconcerting events, and Mbeki's actions further led to his downfall.

Chapter 6: Mbeki's Last Presidential Term

6.1 Introduction

Throughout the previous two chapters, the focus was on Thabo Mbeki's terms as Deputy President, and his first presidential term. This chapter will focus on his second, abbreviated term as President, and will also assist in understanding and answering the research problems and research question.

The research problem, 'Why and how did Thabo Mbeki use political denial as a strategy to respond to the South African AIDS epidemic?' will be answered by looking at the research questions used in this study. The research questions are organised in such a way to cover all aspects of Mbeki's presidency. Through these questions, the study aims to understand why Mbeki chose the route of denialism, instead of facing controversial issues, what the consequences of his denialist actions were, and why the implications of AIDS were ignored, despite real problems that were arising because of AIDS.

This chapter will be useful in answering these research questions, as Mbeki's second term was quite different from his first term, for one specific reason: instead of completing his term, he was recalled by the ANC and had to resign as President of the political party.

Thabo Mbeki's second term as President lasted from 2004 to 2008. This period was marred by his government's promotion of the so-called Lazarus Programme, which is the term given to their promotion of natural ingredients such as lemon, garlic and beetroot. Dr Manto Tshabalala-Msimang was the biggest proponent of this programme, and her promotion of natural "medicine" greatly contributed to the lack of ARV availability.

Although this phase of Mbeki's presidency is characterised by his removal as President of the ANC, one must understand the factors that contributed to this event. Mbeki's popularity levels kept on dropping, due to both his continued stance on AIDS, and his failure to seem in touch with regular South Africans, especially those suffering from AIDS.

Chris Kenyon (2008: 34) refers to the "costly belief" that Mbeki clung to during his time as Deputy President and President of South Africa. His beliefs can be described as costly for two reasons. Firstly, his refusal to provide ARVs as a means of early intervention resulted in the loss of more than 300,000 lives. Secondly, government expenditure on quackery products

such as Dr Raath's as well as Virodene, wasted enormous amounts of money. The term "costly belief" can also be linked to Mbeki's denialism. The beliefs he held were completely contrary to proven scientific facts.

The AIDS crisis reached a severe high during the last stages of Mbeki's presidency, and the events that occurred explain how the crisis contributed to his removal. The Antiretroviral Treatment (ART) programme seemed highly promising, but there were more failures than successes. Roll-out was slow, and far fewer people were receiving treatment than the programme aimed to deliver.

Access to ARVs became a highly debated topic when the "right to health" movement gained momentum. It pointed out the failure of the government to adhere to the Constitution of SA, when in fact the AIDS epidemic has been continuing for such a long period that it seems surprising that this argument reached its peak only at *this* point. The South African people became despondent about the state of healthcare in SA, they were more than disappointed in Mbeki, and the conditions for AIDS patients were hardly improving. These circumstances were part of the reason that his removal should have been expected, most of all by himself. This chapter will explore the factors mentioned here, and explain how they contributed to his failing reputation.

Table 6.1: Main Events During Mbeki's Second Term as President

2004	Thabo Mbeki is elected as President of SA for the second time.
2004	Lazarus Programme becomes common knowledge.
2005	ART Programme rolls out.
2007	National Strategic Plan is introduced.
2007	Thabo Mbeki is defeated as leader of the ANC.
2008	Thabo Mbeki resigns as President of SA.

Mbeki's second term as President of SA was interrupted, and he did not finish the term. Still, his last four years in office did not lack controversy, and his actions and beliefs led to him being heavily criticised by both his party, and the public at large. It was also during this

period that the government's support of alternative healing, such as a healthier diet consisting of certain vegetables, was heavily promoted and it became an international scandal.

6.2 Lazarus Programme

In August 2004, the International AIDS Conference was held in Toronto, Canada. At that time, Manto Tshabalala-Msimang was South Africa's Minister of Health. She opened the South African stand at the conference, to show a display of garlic, lemon, and beetroot, together with a sparse display of ARVs and both male and female condoms. The display highlighted the South African government's tactic of promoting a healthy lifestyle in order to combat HIV (Blandy, 2006). This healthy lifestyle diet was satirically named the Lazarus Programme, referring to the story of Lazarus in the Bible, who was resurrected by Jesus.

One of the most well-known cases of the failure of the Lazarus Programme, was that of the radio DJ Fana Khaba, who was also known as Khabzela on the radio station Yfm. Early in 2003, he announced on radio that he was HIV-positive. By refusing to use ARVs, his body was attacked by various infections, and he became deathly ill (McGregor, 2009: 130). The Lazarus Programme had such a strong following, since it was promoted and praised by the Minister of Health, Manto Tshabalala-Msimang.

As Khabzela was a high-profile patient, there was a lot of public interest in his health, but also interest from the Minister of Health, who sent a nurse to take care of him full time. By the time that Tine van der Maas arrived at Khabzela's mother's home in Soweto, he was already seriously ill. His CD4 count was 2. CD4 units are white blood cells that play a part in a person's immune system, and the CD4 count refers to the number of blood cells in a cubic millimetre of blood. A person who is not infected with HIV will have a CD4 count of anything between 500 and 1500. People with a count below 200 have a severely high risk of becoming extremely ill (Houghson, 2017). By looking at Khabzela's CD4 count, it becomes clear that he was in fact in desperate need of ARVs. However, this was not to be the case for Khabzela. Fortunately for him and his family, Yfm was taking care of his medical costs, but the company was not in favour of his radical resistance to ARVs. Khabzela's family also favoured traditional healing, and the non-interventionist methods of the Jehovah's Witnesses, the faith to which his mother belonged (McGregor, 2009: 131). Tine van der Maas introduced the Lazarus Programme, and started treating Khabzela with this quack medicine. The programme consisted of ingesting a mixture of beetroot, lemon juice, olive oil, ginger, carrots, tomatoes, spinach, yoghurt, and cereal. The last ingredient was a product called

African Solution, a liquid labelled in the colours of the ANC – green, black and yellow. The ingredients listed on the label included African potato extract, vitamins, grapefruit seed extract, and olive leaf extract. The product was sold by a company called Bermins, owned by a "Professor Chris Barnard", according to Van Der Maas (McGregor, 2009: 131).

The name and design of the product fit in perfectly with Thabo Mbeki's insistence on an "African Solution for an African problem", and his idea of an African renaissance (Deane, 2003). He was adamant about encouraging South Africans to take on an African identity, and to promote a renewal for Africa in social, political, and economic sectors (Adebajo, 2016). He specifically aimed to free Africa from its international debt (Bendile & Whittles, 2018). During Mbeki's famous 'African Renaissance' speech, delivered at the United Nations on 9 April 1998, he even quoted the Latin phrase, "Ex Africa semper aliquid novi", which translates to "Something new always comes out of Africa" (The African Renaissance, South Africa and the World, 1998).

As it turned out, Chris Barnard was not a professor, nor was he a medical doctor. He held a PhD in biochemistry, and set out to create a multivitamin that would appeal to black South Africans, hence the ANC colours on the label. The product was especially aimed at black South Africans with a weak immune system. In a newsletter from Bermins, the company claimed that tests had been done with the product on AIDS patients, and that their infections decreased and their CD4 counts did not decrease any further. The letter also stated that all the patient records from the tests were available from Van der Maas's company, Health Education Series. However, the records have never been seen and she claims that they were stolen during a robbery (McGregor, 2009: 132).

Khabzela's death highlighted two problems surrounding the treatment of AIDS in South Africa. Firstly, the lack of leadership in the AIDS sector, and the fact that ARVs were extremely expensive, caused large numbers of people to fall for cheaper, ineffective "cures", promoted by quacks. Secondly, many South Africans would rather visit traditional healers before going to a general medical practitioner. Considering these two circumstances, Khabzela's response was quite normal for a South African. His beliefs led him down the wrong paths, as he continued to suffer from meningitis, TB and herpes, but persisted in consulting traditional healers who promised to cure him (McGregor, 2004).

Khabzela died on 14 January 2004 at the Johannesburg General Hospital, at the age of 35 (Mataboge, 2004). Despite using his radio programme as a way of educating South Africans

about AIDS, he did not follow his own advice (McGregor, 2004). The implication of his refusal to take ARVs, was that he didn't sufficiently share with AIDS patients how they could ease their suffering. If Khabzela took ARVs, and tracked and shared his progress, he could have set an example to other AIDS patients, to show them the benefits of using ARVs. Although he was open and honest about his illness (Nolen, 2018), he strayed from the reliable medication, and put himself in danger. Khabzela was a victim of his own personal denial. This type of denial occurs when a personal event is blocked out mentally. Khabzela denied the positive effects that ARVs would have had on him. He also practised contemporary denial. This type of denial takes place when facts that are shared in the current era are blatantly denied by an individual or organisation. Khabzela denied the facts that were shared about ARVs, and about the dangers of "alternative" medication.

The promotion of the Lazarus Programme by Tshabalala-Msimang and the government is a clear example of official denial (Cohen, 2001: 10). The lack of efficiency of the programme and its prescribed diet was denied, and the diet was promoted, rather than ARVs. It is an example of official denial, as this type of denial takes place in the public sphere. Official denial hides the truth, covers wrong-doings, and becomes part of public policy.

The Lazarus Programme became part of the official narrative, and was supported from inside the ANC. To quote Cohen (2001: 10), this type of denial is "initiated, structured, and sustained by the massive resources of the modern state". In this case, the Lazarus Programme was particularly sustained and supported by the President and his Minister of Health.

6.3 ART Programme and National Strategic Plan

The ART programme refers to the roll-out and distribution of ARVs in South Africa. By March 2005, there was a treatment facility in each of the country's municipal districts. Despite taking two years after implementation for targets to be reached, the goals were eventually met. Although all nine of South Africa's provinces were now providing ARVs, the distribution mostly took place at hospitals, and many of the hospitals were tertiary facilities which were not able to provide the care and medication that vast numbers of patients urgently needed (Simelela & Venter, 2014: 250).

In a positive turn of events, the National Department of Health stated that patients did not need to present an ID book in order to receive treatment, which opened the facilities to high numbers of foreign nationals. These treatment efforts were also supported by international organisations such as PEPFAR and the Global Fund (Simelela & Venter, 2014: 250).

The next programme to come to the fore was the National Strategic Plan (NSP) for HIV & AIDS and STIs, 2007 to 2011. The programme was signed off by the Cabinet and was prepared by the South African National AIDS Council. The core aim of the NSP was to force the government to commit to providing 80% of AIDS patients with ARVs (Simelela & Venter, 2014: 250).

Although the NSP improved the level of access to treatment, the roll-out was slow. By September 2006, only 35% of the people who were originally targeted in the plan, had received treatment. Approximately 257 000 to 363 000 people were receiving ARVs in the public sector, while there was actually a demand for treatment for about 800 000 to 1 million people (Wouters, Van Rensburg & Meulemans, 2010: 178). However, there is reason to be sceptical about any and all reported AIDS figures, because of improper monitoring.

The slow and unsuccessful roll-out of ARVs consistently damaged Mbeki's relationships with both his Minister of Health, and the AIDS civil society. Furthermore, as previously referred to, this government was heavily criticised at the 16th International AIDS Conference in Toronto, Canada. This criticism led to extreme pressure being placed on the South African government, especially as the event coincided with the publication of the *Adult Mortality Report*, which revealed that, between 1997 and 2004, the mortality rate of women between 20 and 39 years of age, had tripled (Wouters, Van Rensburg & Meulemans, 2010: 178).

The primary aims of the NSP were, firstly, to reduce new HIV infections by 50%, and to extend access to treatment to 80% of AIDS patients. There were four guidelines listed in the NSP, which were to assist in achieving these goals:

1. Prevention: to ensure that the great majority of South Africans who are HIV-negative remain negative, the NSP focused especially on the group aged 15–24 years, in a prevention programme based on behavioural changes, and on lowering the rates of mother-to-child transmission of HIV to below 5% by allocating 40% of the projected budget to HIV treatments.
2. Treatment, care and support: to reduce new infections and to minimize the impact of the epidemic on society, the NSP sought to increase the uptake of voluntary counselling and testing, scaling up access to ART, and addressing the special needs of pregnant women and children.
3. Research, monitoring and surveillance as a policy and management tool: the NSP was to assess the outcomes and pinpoint the shortcomings of the national strategy.

4. Human rights and access to justice: the NSP intended to counter stigmatization and discrimination.

The four points mentioned above were expected to contribute to a "health-enabling community", to encourage "health-enhancing behaviour" (Wouters, Van Rensburg & Meulemans, 2010: 179).

Figuratively speaking, this version of the NSP was the straw that broke the camel's back. It cracked down on AIDS denialism. The programme had a large variety of strategies and goals, every possible programme that had shown at least some promise, and all of those were necessary. The reason for the extremely ambitious programme, was the fact that AIDS denialism placed SA seven years behind the AIDS epidemic in SA, and the response to the disease was still severely lacking at this point (Heywood, 2016).

However, regardless of the promises made by the NSP, it was not very well thought out. The successes of the programme had more to do with the TAC. The TAC mobilised to popularise the plan, and kept its eye on the government, holding it to promises regarding ARV roll-out (Heywood, 2016). The fact that the TAC contributed more to the success of the NSP than the government did, indicates literal denial (Cohen, 2001: 7). The government ignored its responsibilities regarding the plan, and one can argue that the government was aware of the TAC's tenacity, all the while resting assured that the goals would be met, regardless of its own inactivity.

South Africa's achievements under the first NSP are evident from the fact that, between 2007 and 2012, the number of people receiving ARVs grew from fewer than 200,000 to over 1,7 million people. Furthermore, between 2010 and 2012, 15 million people were voluntarily tested for HIV, and PMTCT rates dropped from occurring in about 20% of pregnancies, to occurring in only 2,7% of pregnancies (NSP Review, 2012: 9).

6.4 A Right to Health

South Africa's HIV epidemic has been escalating fast, and the country still has one of the highest infection rates in the world. The country especially suffers from high, new infection rates, of young women (Mid-year population estimates, 2018).

The Treatment Action Campaign (TAC) is one of the South African organisations that fought against the controversial statements made by the government, and used various tactics to

make society and the government aware of the dangers of using false cures, rather than ARVs, to ease the lives of AIDS-patients. Under Mbeki, the South African government supported "natural remedies" such as the African potato and multi-vitamins, offered by Dr M. Rath, as opposed to ARVs which were scientifically proven to be effective. The TAC pressured the government into providing AIDS patients with ARVs, based on citizens' right to health care.

By supporting Rath, the government was guilty of literal and bystander denial. Regarding literal denial, Rath's supporters ignored proven science that discredited his "solution". Bystander denial, specifically by the "immediate, literal, physical" audience (Cohen, 2001: 15) refers to "those who are actually witnesses to atrocities and suffering, or hear about them at the time from first-hand sources". There was plenty of evidence against Rath, and yet he had plenty of public support. This is the same behaviour that was displayed surrounding the Lazarus Programme, described in Chapter 5 of this study.

In Chapter Two of the South African Constitution, the Bill of Rights is set out. Section 27 refers to the right to health care, food, water and social security (Republic of South Africa, 1996). According to the Bill of Rights, every citizen has the right to have access to health care services, including reproductive health care. It also states that the state must take reasonable legislative and other measures, within its available resources, to achieve the progressive realisation of each of these rights. Finally, no-one may be refused emergency medical treatment.

Since the beginning of the AIDS epidemic in SA, it has been approached from a human rights perspective. The fact that SA adopted a temporary constitution in 1994, and a new one in 1996, proved that the law can be adapted after being used as a tool of oppression, in favour of constitutional principles that promise human rights and the progressive realisation of human security for all. This mentality has underscored the national response to AIDS. It was to be expected that AIDS activists turned to the Constitution to frame and enforce their claims about how the government should respond to the epidemic (Ndinga-Muvumba & Pharoah, 2008: 63-64).

It became necessary to have proper and compulsory licensing of essential AIDS medication. Pharmaceutical companies and developed states should have realised that they have a "moral responsibility" to keep the epidemic contained. There are three ways in which these institutions could help countries that were, and still are, being damaged by the AIDS

epidemic. These are "donation of drugs, price discounts, and compulsory licensing to bypass patent protection and permit production of generic versions of HIV/AIDS drugs" (Schüklenk & Ashcroft, 2002: 185).

There was a South African type of moral capital that the TAC brought to the case of HIV treatment. "Moral capital" is a term used to describe how "a civil society can frame a policy as unethical in a politically impactful manner" (Mbali, 2013: 136).

The TAC implemented the effective use of anti-apartheid symbols to equate the actions of the pharmaceutical industry to the actions of the apartheid government. The TAC also produced legal arguments that were based on individuals' right to health, as well as the visible, large group of dissatisfied, affected people. It is important to note that the leader of the TAC, Zackie Achmat, was an anti-apartheid activist, and therefore had the knowledge of how to successfully use narratives to claim moral legitimacy for the cause (Mbali, 2013: 136-137).

In a post-colonial and developing society such as SA, there are many issues that affect responses to the epidemic. Kenneth Shalden (2004: 1169) argued that stable access to affordable ARVs were necessary to lower the impact of HIV/AIDS. A challenge that SA faces is the "price-infrastructure trap". The implication of this "trap" is that high prices of ARVs prevent better treatment programmes. This is exactly what the TAC based their existence on: promoting access to affordable ARVs, to better serve South Africa's AIDS patients.

The expansive field of HIV/AIDS research in a post-colonial context is extremely complicated. The intertwined themes of "death, illness, sexuality, medicine, poverty, globalisation, gender, femininities, masculinities, and nationalism" create an almost explosive field of competing investments. Post-colonial theory is helpful in clarifying and deconstructing the discourses that shape what we understand under the title of HIV/AIDS. Post-colonial theory reveals the ways in which these discourses identify those who write and speak about AIDS, as being distinct from the "infected others" (Jungar, 2011: 66).

The fact that the right to health care, food, water and social security (Republic of South Africa, 1996) is concretely stated in South Africa's Constitution, should have been enough of a measure to hold the government to certain standards, and to keep it on its toes regarding service and healthcare delivery. This behaviour has similarities to implicatory denial (Cohen, 2001: 8). Facts and their interpretation are not denied, but rather the implications thereof.

Statements such as “It’s got nothing to do with me”, “Someone else will deal with it”, or “What can an ordinary person do” can be linked to the behaviour of the government, as if it was intimidated by the mammoth task that was expected of it. Denial is also linked to morality (by not recognising responsibility) and action, by not taking steps in response to knowledge (Cohen, 2001: 9).

6.5 A Growing Despair

By mid-2007 donors and members of AIDS societies despaired at South Africa’s inability to combat the AIDS pandemic and high incidence of unnecessary deaths as long as Mbeki and Tshabalala-Msimang were in government, and Mbeki dismissed the Deputy Minister of Health, Nozizwe Madlala-Routledge, who opposed the approach to the AIDS problem as displayed by the President and the Minister of Health.

Nicoli Nattrass, a director of the AIDS and Society Research Unit at the University of Cape Town used demographic modelling to calculate the number of HIV infections and AIDS deaths that could have been prevented between 1999 and 2007, if the government was more proactive in taking appropriate combatting actions (Hundreds of thousands die due to delay in ARV rollout – Studies, 2009).

Nattrass’s study suggested that if the national government followed the Western Cape’s model and used ARVs for treatment at the same rate as the Western Cape (from 10% in 2000 to 65% in 2007), which went *against* the national policy, approximately 171 000 HIV infections and 343 000 deaths could have been prevented (Hundreds of thousands die due to delay in ARV rollout – Studies, 2009). This indicates literal denial (Cohen, 2001: 8) by the national government. By not acknowledging the successes achieved in the Western Cape, the national government caused more damage.

Nattrass also mentions that the Medicines Control Council (MCC) and the Medical Research Council (MRC), two prominent institutions, fell under the control of the National Department of Health. Both institutions therefore suffered from political interference due to them wanting to follow a more scientific approach to the crisis. Fortunately, AIDS policy coordination was handed over to the Deputy President in 2006, but the government’s undermining of scientific facts cannot be ignored, and the Mbeki government’s legacy is blemished by this interference.

Nozizwe Madlala-Routledge held the position of Deputy Minister of Health from 2004 – 2007. She was dismissed by Mbeki because of her disagreement with his beliefs, and her support of scientific methods to help AIDS patients. After her dismissal, she said (Farber, 2019):

> I was happy to be on the side of the vulnerable and those needing state assistance and medication. That, for me, was the reward: to see the change that later happened. So, in many ways, my firing was a catalyst for good and I even felt relief. It put the issue out there in the public domain, with the whole of SA – apart from a few denialists – standing behind the fight for the provision of ARVs.

Madlala-Routledge was known for aiming to cooperate with her adversaries, and when she was first appointed as Deputy Minister of Health, she was hopeful about turning the crisis around from the inside. At first, she was positive about her position, as Mbeki appointed her while her beliefs about AIDS were already public knowledge. Furthermore, Madlala-Routledge knew Tshabalala-Msimang from the women's movement, and assumed that they would have a successful partnership. Unfortunately, it quickly became clear how Madlala-Routledge would be managed regarding her duties and responsibilities. She had to mimic Tshabalala-Msimang, and staff members were fearful of even being seen talking to her. Madlala-Routledge was scheduled to travel to Toronto with Tshabalala-Msimang for the infamous AIDS conference, but was booted at the last minute. She was finally dismissed with immediate effect for a false claim that she had travelled to Spain without the permission of the President (Farber, 2019).

While it is true that the President did not have to provide reasons for firing a minister, it seemed to suit him. Otherwise, he would have had to explain many of his other decisions. It seemed that Mbeki often switched to "ANC President", rather than acting as the President of SA, and he appointed and dismissed Ministers to suit his own agenda. This indicates that he was working with a strategic plan by getting rid of Madlala-Routledge, and that the reason given for her dismissal was merely a ploy.

Some of the decisions Mbeki would have had to explain, centres around Mosoiua Lekota, Linda Mti, and Jackie Selebi – individuals who had committed actions far worse than those of Madlala-Routledge (Joubert & Dawes, 2007).

Mosoiua Lekota continued to serve in Mbeki's Cabinet as a senior minister after he failed to declare his directorship of a winery and shares he had in a petroleum distribution company. His only punishment for these omissions, was that he was found guilty of contravening the Code of Conduct for MPs, given a written reprimand by the Parliamentary Ethics Committee and fined seven days' pay (Joubert & Dawes, 2007).

Linda Mti, the former Commissioner of Correctional services, had business links with companies that greatly benefited from his ties to the Department of Correctional Services. These ties were exposed in 2006. Mti, a senior member of the ANC and former leader of the party in the Eastern Cape, was not even questioned by Mbeki, even though he had the power to hire and fire directors general (Joubert & Dawes, 2007). It is clear that Mti and Mbeki shared ties to the ANC, Mbeki saw Mti as a comrade, and swept his unethical behaviour under the rug merely because it suited him to have an ally so close to him.

Jackie Selebi, Police National Commissioner admitted that he was friends with Glen Agliotti. Agliotti admitted that he was part of a prominent murder case. However, Mbeki let Selebi stay put as the leader of South Africa's police force (Joubert & Dawes, 2007).

The decision to dismiss Madlala-Routledge was heavily criticised by Patricia De Lille, leader of the former political party, the Independent Democrats. De Lille said: "Coming just hours before the dawn of our 13th Women's Day since freedom, this is an insult to every single South African woman who has the courage to stand up for the truth." De Lille further stated that Madlala-Routledge was the victim of a set up, and that she was a woman of integrity. She also criticised Mbeki by saying, "Ms Madlala-Routledge brought hard work, a love for freedom of expression and the ability to admit mistakes to the ANC government and she has been rewarded in such an outrageous way that a dark cloud will hang over our country tomorrow. The President has finally found the courage to fire someone, but he has fired the wrong person, and this will have a direct and deadly impact on the lives of our millions of poor" (Madlala-Routledge relieved of her duties, 9 August, 2007).

The dismissal of Madlala-Routledge further put Mbeki in an unfavourable light, as he was seen as dismissing any person who would dare to disagree with him. He was coming across as insecure, by not being able to stand up to, or defend his beliefs against, anyone who disagreed with him. This contributed to his growing unpopularity and his reputation as an authoritarian President.

6.6 Thabo Mbeki's Failures and Resignation

At the 52nd National ANC Conference in Polokwane, during December 2007, Mbeki was defeated and had to accept that his resignation was pending. On 21 September 2008, he officially resigned as President of South Africa (Ndzamela, 2008).

Mbeki was sometimes labelled as being aloof, or of being out of touch with the average South African. After his term as President came to an end, he continuously tried to defend himself from this accusation, by penning long posts for his Facebook page. However, in his efforts to save his reputation, he never mentioned AIDS in those long-winded Facebook posts. He continued to assert that his accusation of aloofness is what led to him being defeated by Jacob Zuma at the 2007 conference (Geffen, 2016).

Despite his efforts to defend himself, it is pointed out that former leaders are not exiled or shamed for single personality traits. Although it might have been true that he came across as being too intellectual or authoritarian, that was not what led to his downfall. His reputation was deflated because he supported politics and false medical promises which had led to the deaths of hundreds of thousands of people (Geffen 2016). Had he been a strong advocate for proven ARVs, many of those people would have been alive today, or would have lived much longer lives, and would not have their lives ending in pain.

Thabo Mbeki's second term as President started in 2004, when the ANC won the national election with 69% of the vote. When the ANC became the ruling party in South Africa in 1994, it started struggling to keep the balance between the elite members of the party, and the interests of the mass group of voters. Mbeki increasingly lost touch with the voters, and his personal likeability suffered. This was one of the issues that lead to his defeat, alongside with his opinions on HIV. His denial of ARVs has even been called criminal, and he has been blamed for what is equal to genocide in South Africa, through his racially based ideologies (Joubert, 2008).

For Mbeki, the consequences of his loss were plenty. His legacy, for what it was worth, was now even more deflated. His work was forgotten, and his presidency became known as "the dream deferred" (Joubert, 2008).

Still, Mbeki denies the extent of his role in South Africa's AIDS crisis. While thousands of South Africans died, his government supported pseudo-science. The most important, sad and memorable feature of his presidency is that he caused the delay in the dispensing of ARVs

(TAC, 8 March, 2016). Amongst other types, Mbeki was guilty of personal denial (Cohen, 2001: 10). It is impossible for a bystander or outsider to understand such a person's mind or decision-making processes, and this was definitely the case with Mbeki. Despite limitless amounts of proof surrounding the science of AIDS and ARVs, Mbeki clung to his beliefs and ideas.

6.7 Conclusion

Without contesting the decision at the ANC National Conference, Mbeki officially resigned on 21 September 2008. This event ushered in a new era for AIDS care in SA, and Tshabalala-Msimang was replaced by Barbara Hogan as Minister of Health. Hogan announced that "the era of AIDS denialism is over completely in South Africa" (Dugger, 2008).

After Mbeki resigned, Kgalema Motlanthe was sworn in as a replacement until the next election in 2009. Motlanthe had not been in the public eye for a long time at that point, having become an MP only in May of 2008, so his low public profile made him the perfect interim President – someone who would not cause any ructions (Zuma ally 'to be S Africa leader', 25 September, 2008).

Mbeki's legacy will forever be dominated by his failures regarding HIV and AIDS. His response to the AIDS crisis was called "a case of bad, or even evil, public health" by Max Essex, a virologist at Harvard's AIDS research programme (Dugger, 2008). The idea of labelling someone, or something, as *evil*, emphasizes how Mbeki has come to be regarded due to his misguided ideas and statements.

These last three chapters depicting Mbeki's time as Deputy President and President of SA proves that he was indeed guilty of denialism on many fronts, and that he acted to the detriment of the South African public, and also damaged South Africa's reputation abroad. When looking at the main research problem again, "Why and how did Thabo Mbeki use political denial as a strategy to respond to the South African AIDS epidemic?", it is apparent that there is an abundance of proof surrounding his denialist attitude, and the results thereof.

Denial is implemented, as it is seen as an easy way out. Rather than facing responsibilities or atrocities, a different and easier approach is chosen. The implications of following the denialist route was detrimental for SA and AIDS patients. Unnecessary deaths were caused, healthcare facilities and plans were left behind, and SA did not sufficiently deal with the crisis when it was most needed.

The efforts made by the post-apartheid government to combat AIDS in SA, often resembled those of the apartheid government. Despite some promising initiatives and a few successes, there were a number of similarities between the two regimes. This included "the defensiveness and intolerance of the Mbeki administration in particular, such as its often difficult relationship with civil society and its love-hate relationship with capitalism, are reminiscent of the previous era" (Furlong & Ball, 2005: 145). The fact that the Mbeki regime can be compared to the apartheid years, indicate that the combatting of AIDS in SA is far from reaching a definite success plan.

The next chapter will summarise this study, look at the research questions and how they have been answered, and attempt to offer an explanation of Mbeki's AIDS denialism. Furthermore, areas for further research in this field will be explored.

Chapter 7: Conclusion

7.1 Introduction

This chapter will have four distinct sections. Firstly, it will revisit the main research problem and the research questions, and explain the context behind the problems. Following that, a complete overview of the study will be given, in order to create a background against which the research problem and research questions can be answered. Thirdly, the research problem and research question will be answered explicitly, using the information provided in the study. Finally, possible areas for future research will be explored.

The intention of this study was to find out and explain how and why Mbeki applied denialism regarding HIV/AIDS in SA, and for what reasons. Therefore, the study has focused on the instances of denial used by Thabo Mbeki during his respective terms as Deputy President and President of South Africa. By employing and looking at the different types of denial proposed by Stanley Cohen, explained in Chapter 3 of this study, one can differentiate between the different types, and explain why and how, in each different situation, Mbeki applied a different form of denialism in order to further his agenda or to promote his ideas. All these instances can be used to answer the research question and main research problem.

The main question that was answered throughout this study, was 'Why and how did Thabo Mbeki use political denial as a strategy to respond to the South African AIDS epidemic?'. To answer the main research question, some supporting questions were also looked at, such as: Why is denialism often the chosen route in difficult situations; What are the implications of denialism; How was the AIDS problem actually defined; and How was the problem denied, despite there being enough evidence to prove that there was in fact a large problem in SA?

Since 1982, when the first AIDS diagnosis was made in SA, the problems surrounding the disease had grown in scope. The apartheid government completely ignored it as a medical problem, and no programmes had been put in place, and no attempt had been made to provide ARVs. During Mbeki's terms as Deputy President and President, from 1994 to 2008, AIDS was rapidly spreading in SA, escalating the problem. Firstly, it was neglected during the Mandela government, as that government chose to focus on other problems. Following Mandela's term as President, a denialist, in the form of Mbeki, was elected President, which did not help to curb the number of new infections.

The number of new infections, in fact, continued to increase. Despite some efforts made by the government, those efforts were not successful enough, and had a limited effect. To date, approximately 13,1% of the South African population are HIV positive, estimated to be about 7,52 million people. The neglect and inadequate treatment of the disease gave rise to civilian groups such as the TAC taking the government to task, in order to assure that AIDS patients would receive the proper and adequate medical treatment.

When looking at the problem of AIDS in SA, one would think that the government would have been more eager to find possible, and proper, solutions, especially a government led by someone as educated as Mbeki. Thus it seems strange and incomprehensible that the chosen route of dealing with AIDS would be that of denialism. Denialism is followed when the problem being faced seems too difficult to deal with, or when the given facts do not suit the perpetrator. In the case of Mbeki, the latter seems to be more true. Despite some efforts made by his government and Ministers of Health, before and after Manto Tshabalala-Msimang, he stuck to his ideas, and supported unscientific methods of trying to combat AIDS, which methods were proven to be ineffective, and even dangerous to the health of AIDS patients.

Mbeki's name became synonymous with AIDS denialism during his presidency, and he opened himself up to criticism from various sectors. It was felt that he never did enough to work against the AIDS problem in SA. His denialist stance also led to the spreading of a lot of false information regarding ARVs, HIV, and AIDS. Mbeki did not only damage his own reputation, but also that of SA, with the country still having one of the highest levels of HIV infections in the world.

It is clear to see how and why Mbeki earned the label of being an AIDS denialist. Regardless of being surrounded by proof of more effective ARVs, about the damaging effects of Virodene, and the lack of efficiency of the 'Lazarus Programme' Mbeki clung to his denialist stance, and supported other denialists and AIDS dissidents.

Given all these reasons mentioned above, it was important to do a study on how and why exactly Mbeki continued to choose the denialist route. Did he believe it was for political gain? Is he such a traditionalist that he wanted to discredit Western science? For the benefit of future generations, one must understand the rationale behind denialism.

7.2 Overview

To properly answer the research problem and research questions, the study was undertaken in six chapters which focused on various aspects of the problem. Firstly, the research method and structure of the study was explained, with some background information on AIDS and Thabo Mbeki.

The theoretical points of departure for this study are mainly Stanley Cohen's various aspects of denialism, from alternative interpretations of facts to the different types of actors, such as perpetrators and bystanders. Regarding the public policy, which is central to the fight against AIDS in SA, one can use the work of an expert such as Carol Bacchi. Her approach of What's the Problem Represented to be (WPR) has three propositions:

- People are governed through problematisations;
- The problematisations, rather than the problem itself, should be studied;
- The problematisations on offer need to be problematized and analysed by scrutinising the premises and effects of the problem representations they contain.

These propositions were evidently suitable to analyse AIDS denialism in SA, and her second point, especially, applies to the methods and rationale used in this study. To study the problematisation of AIDS and AIDS denialism in SA, a qualitative study in the form of a case study was done using secondary sources.

AIDS was first identified in SA in 1982, but the disease was swept under the rug by the apartheid government as it was seen as a form of punishment for black people, drug users, and homosexuals. Following this era, Mandela became the first democratically elected President of SA and Mbeki was his Deputy President. Although the government put plans on paper, those were too ambitious to pull off. In addition, AIDS was not the principal focus for the new government. It was also already during this period that Mbeki's denialist ideas became public knowledge and that he aired his support for the drug Virodene. This period in SA also included 1996, the year during which a number of prominent events surrounding AIDS occurred. These events included the GEAR strategy being put in place, the adoption of South Africa's new constitution, the NP leaving the GNU, the Sarafina II scandal, creation of UNAIDS, and the development of HAART.

In 1999, Mbeki became President of SA, and appointed Manto Tshabalala-Msimang as his Minister of Health. This ushered in a particularly controversial period in SA, leading to the mismanagement of AIDS and many unnecessary deaths. It was under Tshabalala-Msimang

that the promotion of a healthy diet, including lemon, beetroot, and African potato, was given more attention than the provision of, and education about, ARVs. Mbeki's reputation as an AIDS denialist was cemented. He even included fellow denialists on his Presidential Advisory Panel, which was established in 1999. The fight for ARVs was prominent during this era, with the TAC leading on this matter, and the government taking on big pharmaceutical companies to lower the prices of medication.

Mbeki's second term as President started in 2004. The prominent events for this period include the promotion of the 'Lazarus Programme' (2004), roll-out of the ART Programme (2005), creation of the National Strategic Plan (2007), the defeat of Mbeki as leader of the ANC (2007), and his resignation as President (2008). Mbeki's resignation opened up pathways for new leadership surrounding AIDS in SA, with Tshabalala-Msimang being replaced by Barbara Hogan as Minister of Health and Mbeki being replaced by Kgalema Motlanthe as interim President.

7.3 Solving Research Questions and Research Problems

By completing the study on Thabo Mbeki and AIDS denialism, one can answer the research questions and solve the research problem. To understand Mbeki's denialist stance, one must first find out *why* denialism is often the chosen route in various cases. Most often, it is because the problem, or crisis, that a person or group is facing, is too daunting to take on. Think, for example, of a person diagnosed with cancer. The patient, as well as family members, may develop a mental block, in other words a denialist attitude around the diagnosis so that they do not have to deal with the problem. The patient could ignore the diagnosis, and pretend that it is not there, in an effort to carry on leading an ordinary life.

Furthermore, if patients have their minds set on a certain medication or lifestyle changes they want to take on, they might ignore any advice they receive, purely to stick with their own convictions. Thus, denialism is often the chosen route, as it is the most convenient, for a variety of reasons. In the case of Mbeki and AIDS denialism, he ignored expert opinion in favour of what he chose to believe, regardless of the dangers it posed, just like what would happen if someone diagnosed with cancer ignored doctors' advice about the best treatments. For Mbeki, it was an easier option to view AIDS as a social and economic problem, rather than a biomedical problem, because solutions can be found more easily.

Denialism can also be chosen because it is the *easiest* route for a perpetrator. For example, if a person is guilty of an atrocity, they can simply deny the extent of their actions or put a

certain personal perspective on events to make those events seem less severe. This option makes it easier for perpetrators to process what they did, and to make them feel better about what they did. By not adhering to the belief that AIDS is caused by a virus, Mbeki could wash his hands of the crisis in SA, and rather place his focus on alternative care methods, such as promoting a healthier diet. By his disregard for the biomedical approach, and electing to blame the West, he could air all his opinions on the oppression that Africans have suffered through for many centuries. While it is true that Africans *had* been oppressed, and that many of them lived in very poor conditions, it is not the cause of AIDS. However, Mbeki created policies, panels, and speeches, based on the view that AIDS is caused by external factors.

People who are convinced of certain beliefs or ideas, will also deny other opinions in order to continue with their own agenda. Despite possibly believing what they are told by their opposers, they will publicly deny the opposing ideas in order to suit their plans. This strategy can be used to promote certain agendas, or for personal gain. In the case of Mbeki's AIDS denialism, he, together with Manto Tshabalala-Msimang, publicly disregarded Western science and promoted locally-developed 'solutions', such as Virodene or Dr Rath's pills. By doing so, he was siding with his supporters who he viewed as being oppressed by apartheid and the ensuing poverty. By siding with them, and by publicly criticising the West, he was garnering support from South Africans who also felt that they were oppressed. This strategy seemed to work for a while, and got him re-elected for a second term. The idea of a common enemy is a successful way of aligning with someone who's support one wants, and the idea of an oppressive global West was the ideal embodiment of an enemy of Africans.

Choosing denialism over facing a problem can have extensive and enormous repercussions, as seen in this study. It can have lasting implications, both personally and publicly. Should a person choose denialism in the personal realm, for example by ignoring a fateful diagnosis, it can lead to further illness and even death. On a larger scale, if a government or politician chooses to deny or ignore information about a crisis, it can lead to large numbers of deaths that could have been prevented.

The effects of denialism can also include inviting criticism from the private or public sphere. For example, individuals who chooses to ignore a diagnosis, open themselves up to criticism from their family members and friends, instead of inviting sympathy. On a more public stage, public figures or politicians who blatantly follow a denialist route, open up themselves for ridicule or criticism. Mbeki and the South African government were heavily criticised for the

way AIDS was managed in SA, and Mbeki and the country, respectively, still bear the stigma of 'AIDS denialist' and 'AIDS capital'.

In SA, AIDS was explained in many different ways. Despite widespread agreement that AIDS was, and still is, a major problem in SA, Mbeki did not regard it as a biomedical issue. As mentioned in Chapter Three, people can choose to view it in four different ways: biomedical, metaphysical, traditional or spiritual, or circumstantial. Depending on how people view the problem, they will find various ways of trying to cope with and combat the disease. Individuals, such as Western doctors, who view AIDS as a biomedical, life-threatening problem, acknowledge that HIV causes AIDS, and they support the use of effective ARVs, as they know that it is the best way to confront the problem.

AIDS in SA was also seen by some as a metaphysical problem, as something caused by a deity as punishment for their sins, and that they have to pray and repent in order to receive healing. Linking to the metaphysical problem, South Africans who believe in the power of traditional healers, or sangomas, also saw AIDS as something like a magic spell or curse, that has to be cast out of them by the traditional healer.

The final interpretation of the problem of AIDS in SA, and the approach that Mbeki followed and promoted, is that AIDS is a consequence of a person's living conditions, whether they live in poverty, or follow an unhealthy diet. Mbeki explained AIDS as a consequence of Africa being colonised and exploited by the West, leading to widespread poverty and poor living conditions, which compromised people's immune systems. The causes of problems can be either concrete or abstract. The only *concrete* cause of the problem is the biomedical approach. The other three ways of defining a problem, are purely abstract.

When looking at Bacchi's way of defining problems, a proper impression of Mbeki's understanding of AIDS can be put together. The way individuals feels about a problem, will influence the way they react to it. This means that, because Mbeki saw AIDS as a consequence of colonialism, oppression, and apartheid, he sought African solutions, rather than solutions developed in the West, by the "oppressor". When looking at how the representation of the problem came about, it must also be noted that the way the Presidents who preceded Mbeki handled AIDS, influenced his handling of the problem. The neglect of AIDS by the apartheid government (who saw AIDS as a punishment for black people, drug users, and homosexuals) and Mandela's government (during which Mbeki took most of the

lead on AIDS) influenced his actions as President, where he acted unilaterally and followed his own ideas.

As a collective, the research questions can be used to solve the main research problem of why and how Thabo Mbeki used political denial as a strategy to respond to the South African AIDS epidemic. Clearly, there are a variety of reasons given, from many different sources with competing ideas and impressions. By problematising AIDS in a way that suited him, namely as a social-economic problem caused by abstract factors, Mbeki could push his own ideas and agenda. Mbeki seemed to have an agenda *against* the West, and this is why he disregarded proven ARVs, instead of putting his ego aside, and supporting AIDS patients who were suffering due to not having access to ARVs when they needed those.

He denied the link between the HI-virus and AIDS, as he chose to believe that AIDS is rather caused by the external factors such as a person's poor living conditions and their diet. By promoting his idea, he could focus on finding local "solutions" such as the Lazarus Programme and Virodene, making him seem like a champion of African developments, and as a loyal African. He seemed to think that this strategy would stand him in good stead, but ultimately the lack of ARV roll-out in SA contributed to his downfall in the ANC.

7.4 Areas for Future Research

As AIDS in SA is such an expansive theme, there are many smaller niche areas that can be researched in order to get a complete view of the problem. Throughout this study, some questions have arisen, and by answering them, AIDS denialism in SA will be better understood. Firstly, one can research traditional African healers, and how they dealt with their patients being diagnosed with AIDS. Given that traditional healers are highly respected in their ethnic groups, they play a large societal role.

Mbeki's denialist stance damaged his own reputation as well as that of SA. One can look at the possibility of him salvaging his reputation, and how he would be able to do this. For example, would he regain credibility if he admits that he supported false theories? How would such an admission affect SA, and would it attract more funding for AIDS research and medication?

One can also find out exactly what is needed in order for SA to successfully combat HIV/AIDS? Is the problem more social than economical? Which medical interventions are needed? This could be done as a qualitative study using primary sources such as interviews

and polls, and can also use case studies from countries that are successfully managing AIDS, and reducing new infections.

In contrast with Mbeki, his successor, Jacob Zuma, was not an AIDS denialist. However, he also had radical ideas about AIDS, most famously that if one showers after having sex with an infected person, the virus would not spread. One can analyse the ideas that he spread, and the damage caused by his statements.

Finally, one can also take on a larger study, which ranges from the apartheid regime to the current President, Cyril Ramaphosa. This study can look at a variety of topics surrounding AIDS, through comparing and contrasting. The study can either focus on a specific topic, for example how each government dealt with, and interacted with, civilian organisations, or it can be a broader study about the problem of AIDS, and how it changed from 1982 to the current era.

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