"A Long Illness": Towards a History of NGO, Government and Medical discourse around AIDS policy-making in South Africa

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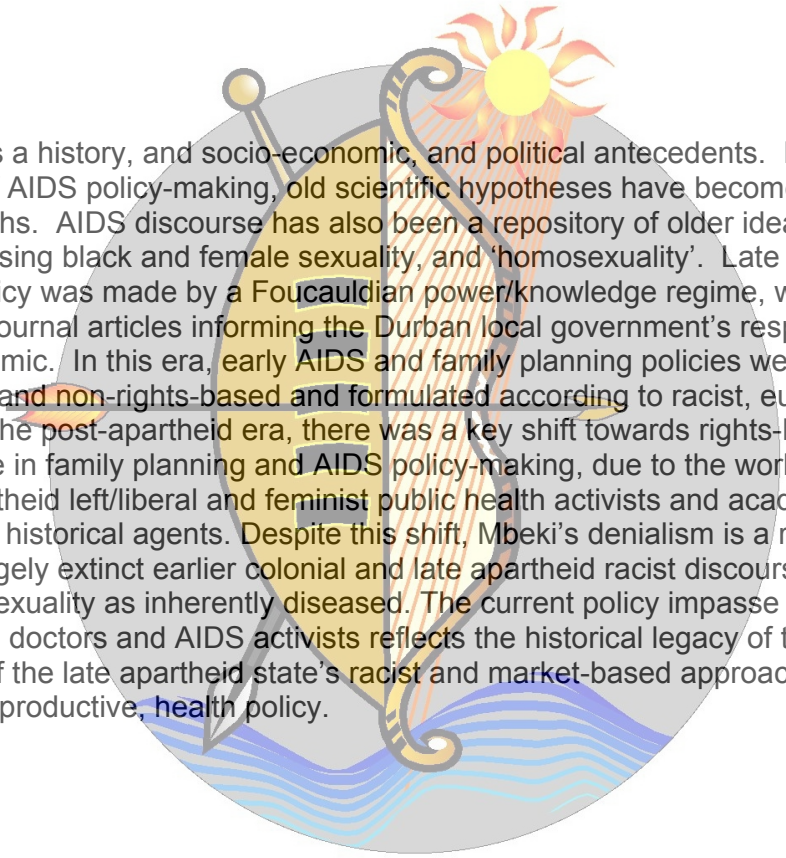
Abstract



AIDS has a history, and socio-economic, and political antecedents. In the history of AIDS policy-making, old scientific hypotheses have become the next era's myths. AIDS discourse has also been a repository of older ideas pathologising black and female sexuality, and 'homosexuality'. Late Apartheid AIDS policy was made by a Foucauldian power/knowledge regime, with medical journal articles informing the Durban local government's response to the epidemic. In this era, early AIDS and family planning policies were coercive and non-rights-based and formulated according to racist, eugenicist aims. In the post-apartheid era, there was a key shift towards rights-based discourse in family planning and AIDS policy-making, due to the work of key anti-apartheid left/liberal and feminist public health activists and academics, acting as historical agents. Despite this shift, Mbeki's denialism is a response to the largely extinct earlier colonial and late apartheid racist discourse around African sexuality as inherently diseased. The current policy impasse between the state, doctors and AIDS activists reflects the historical legacy of the failings of the late apartheid state's racist and market-based approach to public, reproductive, health policy.

Acknowledgements

Written in memory of Tsepho and more than four million others...

As with any major academic undertaking this project has in many ways been a group effort. The idea of historicising AIDS arose from my own conviction, as an AIDS activist and social feminist lobbying on AIDS policy issues, that a history of the input of activists, academics, medics and the state into AIDS policy had to be written. Endless ahistorical talk about the epidemic's newness, hopeless nihilistic approaches, and apocalyptic talk of an infinity of corpses and coffins, will not help any of us political actors find effective solutions.

I would like to say a special thank you to Catherine Burns for telling me that I could write on this topic without being entirely presentist, and for giving me research funds to go to Johannesburg for vital archival research. Thank you for listening to all my crazy ideas, and believing such a project was possible, before I had even found suitable primary evidence.

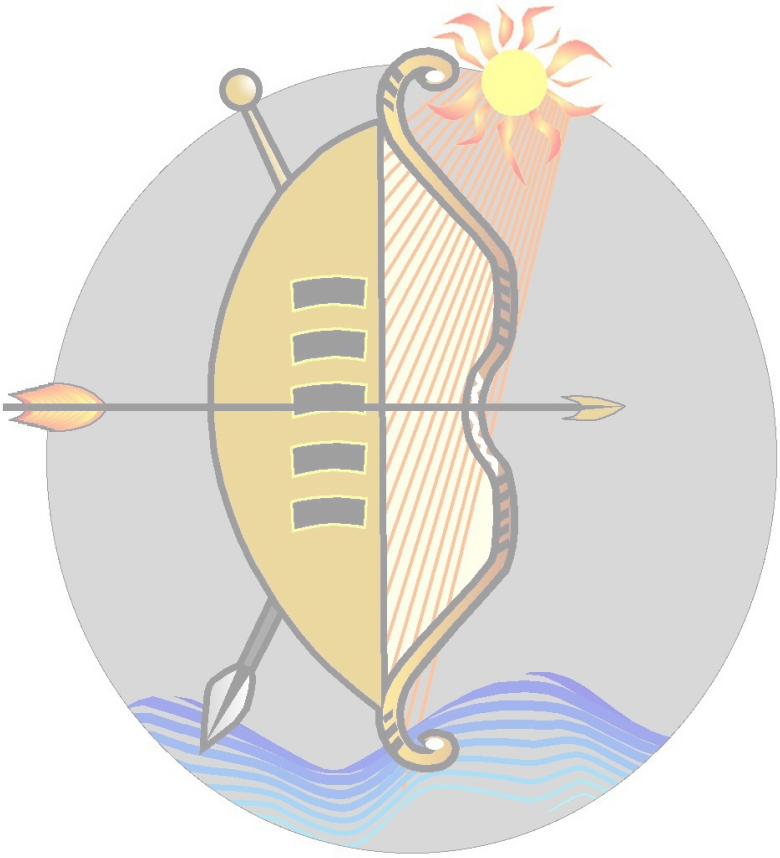
Thank you to all the wonderful people at the University of the Witwatersrand's Centre for Health Policy (CHP) and Women's Health Project (WHP), who allowed me to interview them, photocopy papers, articles, policy recommendations and government policy documents, including: Helen Schneider, Duane Blaauw, Marion Stevens, Nicola Christofides.

To all the amazing AIDS activists who have inspired me over the years at conferences, meetings, demonstrations, workshops, you made me understand the true political nature of the epidemic. Wonderful HIV positive activists like Judge Edwin Cameron, Zackie Achmat and Promise Mtembu of TAC have helped me to humanise the figures and see the immense benefits of new treatment breakthroughs.

Mark Heywood (AIDS Law Project) and Sheldon Magardie (Lawyers for Human Rights) have helped clarify the legal and rights-based implications of AIDS.

Of course, where would all historians be without the services of librarians and archivists? I owe thanks to the kind people at: the University of the Witwatersrand Historical Papers Collection; the University of Natal Medical School library; and the keepers of the CHP and WHP resource rooms.

On a personal note, thanks to Sheldon, Julian, Annie, Thandi, Jali and Mum and Dad for putting up with my endless boring chatter about AIDS, STDs, bodily fluids, immunity, retro-viruses, post-structuralism, feminism, colonialism, health economics etc. Special thanks for listening to me talk about Habermas and Foucault almost non-stop for two months.



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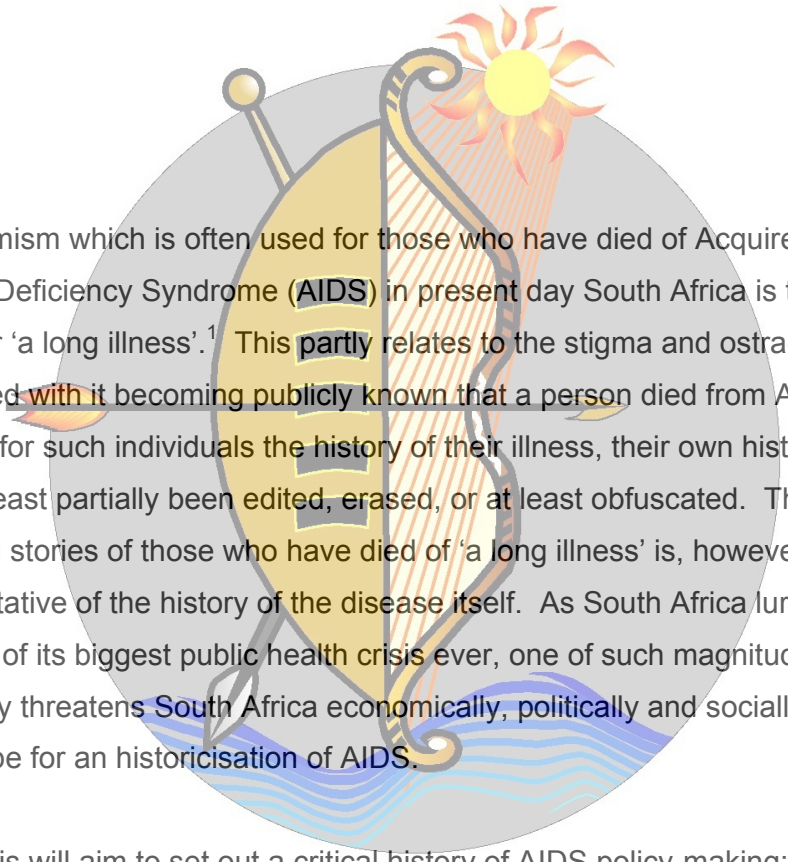
Introduction



A euphemism which is often used for those who have died of Acquired Immune Deficiency Syndrome (AIDS) in present day South Africa is that they died after 'a long illness'.[1] This partly relates to the stigma and ostracism associated with it becoming publicly known that a person died from AIDS. In a sense, for such individuals the history of their illness, their own histories have at least partially been edited, erased, or at least obfuscated. The individual stories of those who have died of 'a long illness' is, however, representative of the history of the disease itself. As South Africa lurches on the edge of its biggest public health crisis ever, one of such magnitude it potentially threatens South Africa economically, politically and socially, the time is ripe for an historicisation of AIDS.

This thesis will aim to set out a critical history of AIDS policy-making: using the records of the Family Planning Association of South Africa; the University of the Witwatersrand's Centre for Health Policy and Women's Health Project; late and post-apartheid government policy documents; relevant articles in

[1] To explain a little my choice of the term 'AIDS', in South Africa it is common to write HIV/AIDS to imply the causal linkages between the two phenomena, I am of the opinion, unlike President Mbeki and other 'dissidents', that the best science, has for almost two decades argued that HIV is the cause of AIDS. However, in the first few years under discussion in this dissertation this was not always known, so for the purposes of chronology, avoidance of anachronism and correct historical method, I will use the term AIDS to denote the phenomenon in general, and refer to HIV where applicable.

South African and international medical journals; the Durban Medical Officer of Health Reports; relevant newspaper and magazine articles and interviews with health policy academics conducted by the author. Using this primary evidence, it will argue that the current AIDS policy impasse between medics[2], Non-Governmental Organsations (NGOs) and the state is ultimately over how the present government's thinking on AIDS is fundamentally constrained by the spectres of late apartheid and colonial discourse around Africans and their relationship to medicine and disease.

Influential health policy analysts have increasingly scrabbled to search for effective responses to the epidemic, to gather information about its effects, to alter models of family planning and even alter public health policy itself. The metaphors of time that the clock is ticking, AIDS is a time-bomb, time is running out and dying, are frequently employed today, as in Salvador Dali's famous painting, where clocks and watches melt.[3] The fact remains though, that for decent policy responses to AIDS to be made, its history, however recent, must be examined. To explore the history of AIDS policy-making in South Africa, an older history of linked phenomena can be evoked: a history of family planning in South Africa; of the racist and sexist and heterosexist ideas of Africans, women and gays as inherently diseased; and of debates around what the structure and financing of public health ought to be in South Africa.

Because historicising AIDS policy is necessarily a long and arduous task, if not purely by virtue of the sheer volume of possible sources and archives, most of which have not yet even been made available to the public and historians a thorough analysis of all the possible sources will not be in the scope of this project. Rather its aim is to highlight some possible archives at this early stage of the historicisation of the epidemic, and to provide the beginnings of a possible theoretical approach to analysing AIDS historically.

[2] By using the term medics I am referring to medical doctors, members of medical professional organisations, and, in particular, doctors who have published articles in medical journals and newspapers.
[3] Salvador Dali. "Persistence of Memory", (popularly known as Soft Watches). (1931). Currently housed at the Museum of Modern Art in New York City.

In the history of AIDS policy making old scientific hypotheses have died hard; the myths of one era were once the respectable science of another.[4] For instance, current South African President Thabo Mbeki holds to idea that Human Immune Deficiency Virus (HIV) is not the cause of AIDS, which he widely promoted in the year 2000 (and still implicitly seems to support): this was not an altogether ridiculous proposition in the early 1980s when AIDS first emerged. Racist ideas linked to AIDS, moreover, can be traced back to the discredited racist science of eugenics (or racial hygiene), which had its South African heyday in the early twentieth century. 'Homosexuality' was pathologised up until recently, understood by the psychological/psychiatric institutions of the West as a treatable disorder.

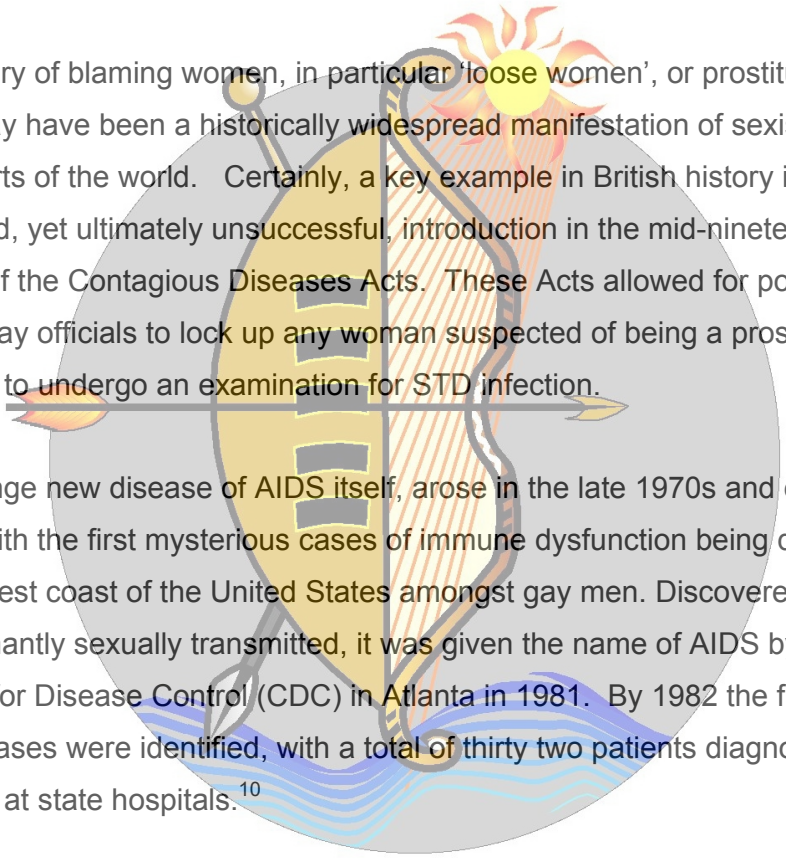
Whilst science, and particularly biomedicine, cannot be deemed responsible for all the shortcomings of modern AIDS policy, racist, sexist and homophobic myths about AIDS are often derived from earlier science. These myths, even once scientifically discredited, in turn have influenced policy. At a deep cultural level, the connections between 'sin', sex, disease and 'other', so often prevalent in discourse around Sexually Transmitted Diseases (STD's) and AIDS have a long history in the West.[5] Of particular relevance to South African history, fears over interracial sex, and resulting 'racial pollution' or STD-infection almost certainly formed part of the constellation of racist ideas influencing segregation and apartheid.[6]

AIDS has become a repository of older ideas about black sexuality, female sexuality, disease and homosexuality.[7] As Megan Vaughan has said

[4] This was argued most intriguingly in a recent lecture inaugurating a new Medical Research Chair of the University of Natal Medical School by Prof Jerry Coovadia.
[5] Sexually Transmitted Infections (STIs) is now the favoured term in public health circles, however, I will stick to using STD's though because it is a term that has been consistently in use throughout the period under discussion.
[6] Here the work of Laura Anne Stoler on the effect of the arrival of white women and the colonies, and the emerging discourse of eugenics in the metropole, on colonial policy is potentially of relevance: Laura Anne Stoler. "Carnal Knowledge and Imperial Power: Gender Race and Morality in Colonial Asia". *Gender at the Crossroads of Knowledge: Feminist Anthropology in the Postmodern Era.* (Berkeley: University of California Press, 1991), 72-82.; Also in a more direct way Vron Ware has argued that white women and fear of STD infection by interracial sex directly lead to the development of segregationist ideology in colonies. Vron Ware. *Beyond the Pale: White Women, Racism and History.* (London: Verso Books, 1992).
[7] Sander Gillman. *Difference and Pathology: Stereotypes of Sexuality, Race and Madness.*

> In Europe and North America both medical and journalistic accounts of AIDS in Africa indicated once again the durability of that European tradition which sees Africans as synonymous with disease, death and uncontrolled sexuality. Africans, it seems in this socio-medical discourse, never get sick innocently.[8]

Blaming the 'other' for disease, especially sexually transmitted diseases, has a long history, at least in the West. When the first documented deadly outbreaks of syphilis occurred in Western Europe in the fifteenth century, the Italians called it the French disease and the French, the Italian disease, the English the French disease.[9]



The history of blaming women, in particular 'loose women', or prostitutes for STDs may have been a historically widespread manifestation of sexism in many parts of the world. Certainly, a key example in British history is the attempted, yet ultimately unsuccessful, introduction in the mid-nineteenth century of the Contagious Diseases Acts. These Acts allowed for police, port and railway officials to lock up any woman suspected of being a prostitute and force her to undergo an examination for STD infection.

The strange new disease of AIDS itself, arose in the late 1970s and early 1980s, with the first mysterious cases of immune dysfunction being diagnosed on the West coast of the United States amongst gay men. Discovered to be predominantly sexually transmitted, it was given the name of AIDS by the Centres for Disease Control (CDC) in Atlanta in 1981. By 1982 the first South African cases were identified, with a total of thirty two patients diagnosed and cared for at state hospitals.[10]

The starting date of 1985 for the bulk of this narrative is a convenient one

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(Ithaca, New York, 1985), 79, 83,101; Megan Vaughan. *Curing their Ills: Colonial Power and African Illness*. (Cambridge and Oxford: Polity Press, 1991); Michel Foucault. *History of Sexuality Vol. 1.* Trans. Robert Hurley. (Harmondsworth: Penguin, 1977)

[8] Megan Vaughan. "Chapter Nine: Conclusion: The Changing Nature of Biomedical Discourse on Africa". *Curing Their Ills: Colonial Power and African Illness.* (Cambridge and Oxford: Polity Press, 1991), 205.

[9] Richard and Rosalind Chirimuta make this point, see: Chirumuta, R.C., Chirumuta, R.J. "Introduction". *AIDS, Africa and Racism*. (London: Free Association Books, 1989).

[10] Marais Malan. "AIDS in the USA and RSA- An Update". *South African Medical Journal.* 70. (1986), 119.

because many of the key props were in place to set the scene for the major events by this period. By 1985, AIDS had been identified and named, medics were beginning to fear the spread of the disease to the stage where it would become an epidemic to the same extent that it was one in America, HTLV-III/LAV (later renamed HIV) had been discovered to be the pathogen responsible for the immune deficiency, and antibody tests had been devised to determine whether an individual was infected.[11] The main manners of transmission were known: sexual; from pregnant mother to child; through intravenous drug use; and via blood transfusions.

In early articles about AIDS in the *South African Medical Journal*, to be discussed in Chapter One, the trend of characterising the AIDS epidemic in South Africa as being primarily one which involved 'homosexuals'/gays and black prostitutes was fairly common.[12] Unsurprisingly, for apartheid-era South Africa, the epidemic was characterised as being two racially different epidemics in its early years in South Africa (the mid-1980s), with the one epidemic having followed a 'European/American' pattern of infecting white 'homosexuals'/gays, the other having been a heterosexual epidemic, which descended fairly vaguely from somewhere further North in Africa to afflict black prostitutes, their clients and the occasional white man who defied apartheid norms by having sex with African women further North in Africa.[13]

As Chapter One will show, these figures were not necessarily epidemiologically accurate, as the were only gained from those already in the terminal stages of AIDS seeking medical assistance at hospitals (not necessarily an accurate chart for trends in its spread, because of the long

[11] R. Sher. "AIDS and Related Conditions: Infection Control". *South African Medical Journal.* 68. (1985), 843-844. Note that in this article the homosexual epidemic was seen to be white and the heterosexual epidemic black.

[12] The reason 'homosexual' is placed in inverted commas, whereas gay is not relates to the history of both terms. Whilst 'homosexual' is a medicalised pathologising term, gay is the term that has been adopted by the emancipatory gay rights movement, the aims of which I sympathise with. Note that whilst heterosexual isn't placed in inverted commas I fully realise the constructedness of that category too.

[13] Marais Malan. "AIDS in the USA and RSA- An Update." *South African Medical Journal* 70 (1986),119; B. D. Schoub, A. N. Smith, S. F. Lyons, S. Johnson, D.J. Martin, G. McGillivray, G. N. Padayachee, S. Naidoo, E. L. Fisher, H. S. Hurwitz. "Epidemiological considerations of the present status and future growth of the AIDS Epidemic in South Africa." *South African*

period of remaining HIV positive and 'symptom-free'). Accurate figures for HIV positive South Africans were, especially for those living in the Bantustans, almost non-existent, which rendered these estimations largely speculative.

Aims of public health policies advocated by medics such as Schoub *et al* in 1988 included shrinking the 'promiscuous core' of female prostitution, if it was necessary through 'legislative control'.[14] Whether this was to be modelled along the lines of the CD Acts of the mid-nineteenth century England remained unspecified. In a diagram included in the article it is clear that the 'intermediate population' (that is the 'normal', 'innocent' heterosexual population) was seen to be threatened by 'Homosexual men', 'Prostitutes', 'Intravenous Drug Users', and migrant labourers from the 'Africa' presented as a vague, and deeply threatening entity to the North.[15]

In Chapter One, it will be argued that a local health centre sample, such as the one chosen in the Durban Medical Officer of Health (MOH) Reports from 1985 to 1990 can be read alongside several early *South African Medical Journal (SAMJ)* articles, like the one just cited by Schoub *et al,* to flesh out the disparities and congruencies between national and local expertise and practice. It will be the contention of that chapter that the *SAMJ* articles and the Durban MOH Reports can be viewed as having interlocked, as a Foucauldian power/knowledge regime, writing the power of late apartheid spaces, conceptions of race and stereotypes around erotically marginalised populations, onto HIV positive patients' bodies. Coercive and non-rights-based containment of the new disease, under the auspices of the medical disciplinary gaze of the council health machinery and the medics writing early articles in *SAMJ*, did not ultimately succeed though, due to the fact that the discourse around AIDS was very much constrained in its broader societal impact by the crude racial and sexual stereotypes it employed.

Academic feminists, in South Africa and internationally, took longer to respond

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Medical Journal 74 (1988), 153-156.
[14] Schoub et al. "AIDS Epidemic in South Africa", 153, 155-156.
[15] See figure three: Schoub et al. "AIDS Epidemic in South Africa", 156.

than the still relatively new gay liberation movement. The fact that the syndrome predominantly seemed to affect gays around the time of its discovery on the West coast of America from the late seventies to the early 1980s, made it a perfect excuse to tack all sorts of discriminatory ideas and practices on to gay people.[16] It was even initially called Gay Related Immune Deficiency (GRID). Against such a context, unsurprisingly enough, it appears that in South Africa the AIDS Action Group of the Gay Association of South Africa was one of the first groups distributing accurate information about the transmission of HTLV-III/LAV (an early term for the virus that causes AIDS, HIV), before even the government was, in 1986.[17] Some of these early gay-liberation/AIDS activists, would continue to be influential figures in South African AIDS policy-making, such as Zackie Achmat the charismatic openly HIV-positive leader of the Treatment Action Campaign.

The international and South African academic feminist response to AIDS was inadequate at the early stages, and relatively slow in coming, in part due to complex relations between the gay liberation and feminist movements internationally, and in part due to a relatively late recognition by the broader academic and health activist communities of the potential threat of a mass heterosexual epidemic. For South African feminists, there was also the larger South African feminist project of securing political, and constitutional rights and socio-economic equality for all South African women as part of a new democratic South Africa, which absorbed most of the energy of all left/liberal South African feminists in the late 1980s and early 1990s.

Internationally, there were still several aspects related to female sexuality and physiology and AIDS that were not fully understood at different phases of the epidemic. Unanswered questions in the mid-1980s included: what woman-focused forms of HIV transmission prevention could be developed; what risks faced women who had sex with women (lesbians and bisexuals) ; and what the HIV-related implications were in developing countries of practises like dry

[16] Simon Watney. *Policing Desire: Pornography, AIDS and the Media*. (Minneapolis: University of Minnesota Press, 1987).
[17] G.J. Knobel. "AIDS: prevention through education." *South African Journal of Medicine* 70

sex and female genital mutilation. Internationally, in the spread of the early scientific idea (and later unscientific myth), that AIDS was exclusively a 'gay [male] plague', or a disease of the excessively promiscuous, lesbians, women who considered themselves not to be 'promiscuous', and feminists became lulled into a sense of complacency.

American feminists like Nancy Roth and Katie Hogan argued in the late 1990s that "feminists with a few remarkable exceptions have been slow to recognise the impact of AIDS on women and the implications of HIV for feminist theory".[18] This assessment may not, though, be totally fair to South African feminists, and in particular academics who looked into health policy and gender, such as the group of academics based at the University of the Witwatersrand Women's Health Project (WHP). AIDS in the late 1980s was but one of the research and lobbying priorities in family planning, amongst others like: the legalisation of termination of pregnancy; fostering a culture of rights as opposed to coercion in family planning; and even decreasing the high rates of maternal and infant mortality.

AIDS policy-making simultaneously operated in a wider grid of socio-economic forces like the trend towards privatisation of the health system in the late apartheid era, and the failure of the new state to establish a national health system. More generally, other factors were influential in the late apartheid era such as, the gross disparities of wealth in South Africa and the mass poverty of Africans, indicated by a high infant mortality rate and endemic TB, and STD epidemics. The late Apartheid state's failure to provide adequate health-care to poor black South Africans was documented by several left-wing academics working in the field of public health in the late 1980s such as Max Price and Solomon Benatar[19]. As a culmination of these trends, almost as much was being spent on the twenty percent of the

(1986), 119-120.

[18] Nancy Roth and Katie Hogan. *Gendered Epidemic: Representations of Women in the Age of AIDS*. (New York and London: Routledge, 1998), xv.

[19] Max Price. "Explaining Trends in the Privatisation of Health Services in South Africa." *Health Policy and Planning* 4, no. 2 (1989).; Max Price. "The Consequences of Health Service Privatisation for Equality, and Equity in South Africa." *South Science and Medicine* 27 (1988).; Solomon Benatar. "Medicine and Healthcare in South Africa- five years later." *The New*

population who had access to private health care as on the eighty percent who utilised public government facilities.

Many of these academics were based at the University of the Witwatersrand Centre for Health Policy (CHP) formed in the late 1980s. Like those feminist academics looking into public health, such as those based at the WHP, they often doubled as anti-apartheid activists and lobbyists, formulating responses to health policy and spending in the late apartheid era. Along with the ANC-in exile, they were arguing for the establishment of a National Health System modelled on that of the post-war United Kingdom, a trend which may have been in the post-apartheid era subsequently thwarted. Chapter Two will demonstrate this in more detail, by focusing on the response of anti-apartheid feminist and liberal/left academics to the epidemic, their critiques of the late apartheid public health system, and their role in the rise of a rights-based discourse around family planning and AIDS,

I have undertaken a study of the Durban City Council Medical Officer of Health reports (Durban MOH Reports) from 1985-1995 to bring into conversation national policy-making and critique and local health practices and shifts in policy. Analysis of the Durban MOH Reports revealed that child mortality rates amongst Africans in Durban and across South Africa were excessively high as will be shown in Chapter Two. There was also a severe ongoing STD epidemic in the city, which by the late 1980s was increasingly ringing alarm bells, for municipal public health officials, of the possibility of a growing AIDS epidemic, in which infection rates almost doubled every second year from 1987 onwards.[20]

The late Apartheid state had developed family planning policies which were coercive and did not operate in terms of a rights-based discourse. The international scandal over the use of the injectable contraceptive Depo-Provera on African women in South African state hospitals, before it had been

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England Journal of Medicine 325 (1991): 30-36.

[20] "City of Durban: Annual Report of the City Medical Officer of Health." : Durban City Council, (1987), iii; "City of Durban: Annual Report of the City Medical Officer of Health." : Durban City

proven safe, catalysed many South African feminists including ANC activist Manto Mabalala Msimang, and Helen Rees, to critique apartheid reproductive health policy. They increasingly saw it as not adhering to the principle of protecting the rights of women to control their fertility safely, according to the principle of informed consent. Some of these key academic figures were based at or worked with the WHP.

Coercive late apartheid family planning policy operated with the implicit racist aim of limiting the number of Africans in South Africa. Analyses of documents in two archives reveal this: those of the Family Planning Association of South Africa (FPASA), kept at the Historical Papers Collection of the University of the Witwatersrand; and the Medical Officer of Health reports from the mid- to late-1980s. The FPASA was fifty percent state-funded and organised its operations very much in accordance with the policy and practice of the state's Department of Health and Population Development. The state also spent disproportionately on family planning clinics as opposed to on clinics dealing with general health problems.

For instance, documents to be found in the FPASA's archive which date from 1977-1980, demonstrate a willingness to propose legislative measures to discriminate against South Africans with large families and imply that Africans were unable and unwilling to understand the implications of what was termed as the 'population' problem. According to one document, entitled "Beyond Family Planning (the author of whom is not yet apparent from the archives) the two major problems Africa faced were

> ...size and an over-sensitivity to the genocide issue, which is probably a hangover from the colonial era...there is still plenty of 'lebensraum' and 'miles and miles of bloody Africa...Family planners have to face a two-fold built-in resistance to the small family concept.[21]

Another prime example from the same archives of racist, eugenicist thought was made in a document entitled "Draft: Background to Family Planning In South Africa"

Council, (1988), iv.

[21] Unknown. "Beyond Family Planning". AG2619 (B8) FPASA: Minutes and Correspondence (1977-1980).

> There have been similar problems encountered [as in the United States and other parts of Africa] in the political philosophy among the Black people of South Africa, who see their strength in numbers, and who do not readily understand the demographic and mathematical implications of controlled or uncontrolled population growth.[22]

If, as these documents would tend to suggest, the state and officials at the virtually 'parastatal' FPASA can really be characterised as having viewed Africans in such a racist and paternalistic way, it is not at all surprising that the response to AIDS, was so unsuccessful in these years, particularly in terms of informing Africans about prevention and care. To put it crudely, if the state and allied organisations like the FPASA thought that Africans 'bred like rabbits', evinced uncontrollable sexuality, and could not rationally appreciate arguments around controlling their own fertility, they would not, according to such logic, be able to understand messages about the 'new' disease of AIDS. Perhaps, even more so, it seems the state may not have even begun to have had an understanding of the social and cultural factors driving the epidemic in South Africa, around which effective policy would have to be structured. The state and its surrogate the FPASA looked at family planning divorced from the idea of the rights of the patient, and in terms of eugenicist and racist ideas. The obvious implication in the context of a rising AIDS epidemic, was that it fitted, in a crude way, with their eugenicist, racist aims. Outside a rights-based framework such racist and eugenicist aims included eliminating or lessening the numbers of the 'racially polluted', those too inferior to control their sexuality, who were perceived to be at the root of all social ills, according to such a mindset. It also seems that racist, coercive family planning may have alienated some Africans from listening to important messages abut AIDS, perhaps believing it to be part of the "Black genocide' of family planning, as will be argued in Chapter Two.

Ironically enough, this trend harks back to recommendations made at meeting of the Maternal and Family Welfare Society (an earlier manifestation of FPASA) meeting held in the significant year of 1938, where a Mr Laidler congratulated the eugenicist sterilisation policies of the mentally unfit of

[22] Unknown. "Draft: Background to Family Planning in South Africa". AG2619 (B8) FPASA:

German law at the time.[23] Notoriously, as Gisela Bock has charted, these policies resulted in the mass sterilisation or drunks, the poor, or anyone the Nazi state deemed inappropriate to bear children.[24] As the rest of this project will demonstrate, old discredited ideas relating to reproductive health policies and practices die hard.

The almost total lack of state action (a case of too little too late) by the late Apartheid state, in spite of relatively, and in some cases remarkably, accurate warnings of the extent of the epidemic, by medics and academics on the eve of the 1990s (from 1988-1989 onwards) suggests that underfunded AIDS policy was certainly at best negligent, and formed a part of the same coercive, racist framework as family planning.[25] From the late 1980s AIDS Testing Training Information and Counselling Centres (ATTIC) were set up around the country and this seemed to have constituted the main pillar of state action. However, the Durban branch only had two members of staff for the first two years of its existence (1988-1989), indicating a deliberately crippling lack of funding and, therefore, political commitment by the state to spend on AIDS policy. Meanwhile, by the late 1980s the number of people who were HIV-infected in Durban was already running into the hundreds and countrywide into the thousands.

From the 1980s though, anti-apartheid liberal/left and feminist academics and activists had been critiquing apartheid's political abuses of medicine, its unequal provision of health care along the lines of race and class, and its coercive and racist family planning policies. For these academics/activists, 'overpopulation' that the 'neo-Malthusians' argued was the cause of ill-health in South Africa was a chimera; the main engine for African ill-health for these

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Minutes and Correspondence (1977-1980).

[23] "Minutes of the postponed general meeting of the South African National Council for Maternal and Family Welfare, Held at the Martin Melck House on Tuesday and Wednesday the 27th and 28th of September, 1938". AG2619: FPASA: Race Welfare Society Minutes (1930-1944), 28-29

[24] Gisela Bock. "Racism and Sexism in Nazi Germany: Motherhood, Compulsory Sterilisation and the State". *Signs,* Spring: 1983.

[25] Schoub *et al*. . "AIDS Epidemic in South Africa"; Whiteside, Alan. *AIDS in South Africa: A position paper for the Development Bank of South Africa*. (Durban: Economic Research Unit, University of Natal, and Development Bank of South Africa,1990).

activists was apartheid itself, its economic inequalities and racialised and Bantustan-ised political manipulations of health.

As opposed to seeing medical modernity in South Africa in terms of being a rigid post-modern/Foucauldian 'iron cage' of modern power/knowledge, with no space for normative or political agency , or action, against repressive power, Chapter Two will argue that in a Habermasian sense these activists used their agency to shift discourse around reproductive public health and AIDS policy-making to being rights-based, in the tradition of rational humanism, amidst the backdrop of negotiations for democracy.

The reformist and negotiating state in the 1990s, during the era of the 'negotiations', like late colonial states across Africa in the 1950s, used public health and AIDS-policy to legitimate itself (to show its 'softer-side', its supposed levels of social concern). The first in a long series of publicly available government AIDS plans began to be made, setting a pattern that would last for at least a decade of long and elaborate AIDS Action programmes being drawn up by different governments in consultation with various 'stakeholders' (such as NGOs, academics, various 'experts', people living with AIDS). These AIDS plans have consistently had reasonable recommendations, often in line with what is generally accepted as being effective policy in terms of things like encouraging the spread of information to the general public about prevention of HIV transmission, advice about caring for people with HIV, and non-discrimination of HIV positive people, up to the most recent ones published by the present government.

One key problem since this period has been underfunding of proposals and a lack of a clear chain of command or division of activities within the civil service, at local, provincial and national levels of government, as the CHP's Helen Schneider has identified.[26] This has formed a part of the legacy of integrating the many Bantustan departments of health into nine provincial Departments of Health and one national Department of Health.

[26] Interview, by author, with Helen Schneider, Director of the Centre for Health Policy, Johannesburg, August 2001.

The post-apartheid (post-1994) era represented a massive shift towards rights-based discourse in family planning, largely due to the efforts of feminist health activists and women parliamentarians, and anti-apartheid critics of coercive late apartheid family planning policy and practices. This trend was driven by NGO (Non-Governmental Organisations) and government involvement the United Nations international processes such as the Cairo Conference on Population in 1990 and the Beijing International Conference on Women.[27] Important gains were made by women's health activists and academics and women in the new democratic parliament, acting as historical agents, according to rights-based discourse. Foremost amongst these were the legalisation of abortion with Termination of Pregnancy Act and the provision of free health-care for pregnant women and children under six at state facilities.

However, as Chapter Three will show, an early breakdown in NGO/academic-government relations seriously hampered attempts to develop relevant, rational, and scientifically-sound AIDS policy.[28] A whole set of well-documented debacles in the mid-1990s slowly eroded relations between the state, NGOs, and academics, and medics, such as those over state interference in the dubious experimental drug Virodene, and unfair state tendering and an excessive budget for *Sarafina II,* Mbongeni Ngema's controversial AIDS awareness play. Although relatively predictable in the light of earlier estimates, the shocking statistic was released by the state that a third of pregnant women screened at King Edward the VIII hospital in Durban were HIV positive. This indicated that HIV prevalence amongst the sexually active population was already devastatingly high, and heightened pressure on the state to increase and improve its response.

[27] Interview, by author, with Marion Stevens, former Women's Health Policy researcher and currently a researcher at the Women's Health Project, Johannesburg, August 2001.
[28] Helen Schneider. "Politics Behind AIDS: The case of South Africa". *Politics Behind AIDS policies: Case Studies from India, Russia and South Africa.* (Berlin: Public Health Policy, Wissenschatszentrum Berlin fur Sozialforschung,1998); Helen Schneider and Joanne Stein. "Implementing AIDS policy in post-apartheid South Africa." *Social Science and Medicine* 52 (2001): 723-731.

In 1999 President Thabo Mbeki dropped the bombshell that he did not believe that HIV was the cause of AIDS. Mbeki's denialism represents a reaction to earlier late apartheid racist ideas about Africans and AIDS.[29] It is also a convenient abdication of the enormous expectations of the government, in the face of the enormous infrastructural problems with the functioning of the health-care system revealed by AIDS. Whilst the official state archives of the last few years have yet to be released, other Africans have made similar arguments before, for similar reasons. By the time Mbeki's denialism arose, African academics like Chirimuta and Chirimuta had already argued in the late 1980s ,in response to racist notions attached to AIDS by scientists, politicians and the media, against the idea of AIDS as a disease with African origins, and had already called into question the link between HIV and AIDS and the toxicity of anti-retroviral drugs like zidovudine (AZT).[30] Therefore, Mbeki's response can be characterised as fitting into a longer trend of a rebuttal against perceived racism amongst key groups in the AIDS research and policy-making world of the West.

However, for the most part, due to the actions of left/liberal and feminist anti-apartheid activists, the emergence and dominance of rights-based discourse around AIDS, including the principle of non-discrimination, meant that racism was virtually extinct by the mid-1990s in the work of most key actors in the 'AIDS world' of NGOs, researchers, medics and policy-makers. In such a context, Mbeki can be seen to be arguing against the racist spectres of colonial and late apartheid medical discourse. As will also be argued in Chapter Three, these events must also be seen against the infrastructural legacies of a collapsing public health system. These infrastructural legacies included those of the health sector privatisation in the late-apartheid era and the difficulties in transforming the civil service, which was to administer the

[29] 'Mbeki's denialism' is a neologism that has been coined by AIDS activists in South Africa. To use the more neutral term 'scepticism', would tend to imply that it is a fruitful philosophical endeavour, in the Western philosophical tradition. On the other hand, Mbeki is denying the scientific facts. The reason why I am using the more loaded term denialism is to indicate my own disagreement with him. It is also to indicate that his denial is made up of a complex set of political and philosophical beliefs, which can be placed in a historical context: in a true sense it is a new ideological '-ism' in South Africa.

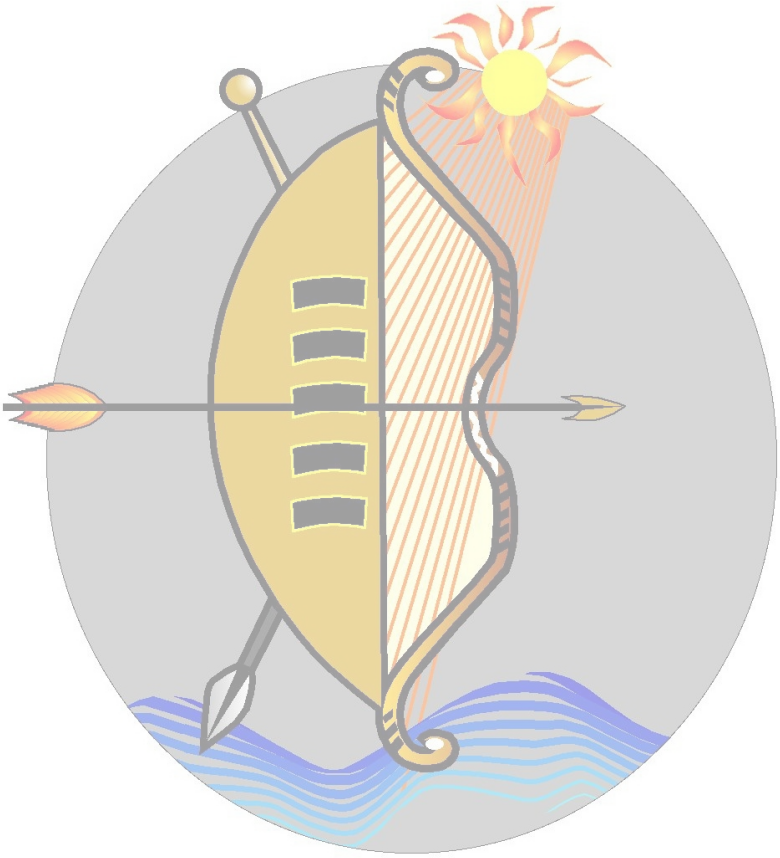
[30] Richard and Rosalind Chirimuta. *AIDS, Africa and Racism.* (London: Free Association Books, 1989).

public health system.

Massive medical breakthroughs were made in the treatment of HIV with the announcement in 1996 at the International AIDS Conference held in Montreal of conclusive studies proving the efficacy of triple combinations of anti-retroviral medication in killing HIV in the bodies of infected people, thus substantially elongating their healthy life-spans in ways previously thought impossible. Anti-retroviral therapy had also been proven to reduce the incidence of vertical transmission of HIV from pregnant mothers to their unborn children during labour. Mbeki questioned the efficacy and safety of these drugs, amidst the beginnings of a massive national and international campaign under the auspices of the Treatment Action Campaign (TAC) and *Medicins sans Frontiers* (Doctors without Borders) for a reduction of the price of such drugs in developing countries and their increased availability to the poor. In spite of AIDS activists globally having forced a drug company climb-down on the issues of drug prices and patents, Mbeki's denialism persists as the key stumbling block to providing this effective new treatment to HIV positive patients in the public sector, causing further ongoing vituperative conflict between the state and NGOs.

It will be the central argument of this project that the current impasse between activists, the state, and NGOs and the lack of progress in AIDS policy-making represents an expression of, reaction to and the historical culmination of the failings of the apartheid state's racist and market-based approach to public reproductive health policy. It must be re-emphasised that AIDS does indeed have a history, which must be brought to light, at least in a provisional way, in order for various actors in policy-making today, to understand the beginnings of more effective AIDS policy-making and to not repeat, or perpetuate, the mistakes of the past. This historicising process cannot at this stage tell the stories of all the four million South Africans who are HIV positive today, for many of whom time is literally running out, in terms of their life-spans. However, it can at least answer how it came to be that the 'long illnesses' of racism, sexist, heterosexism and underfunding came to influence public health policy and, hence, how the overflowing, understaffed hospitals, the lack of

provision of crucial medicine to treat HIV at state health facilities, and the post-apartheid state's denial of the problem came to pass.



Chapter One

Containment, The New Disease and The Medical Disciplinary Gaze: *South African Medical Journal Articles* and Durban City Council Medical Officer of Health Reports 1985-1990.

The primary concern of doctors writing in the *SAMJ* about AIDS public health policy, such as Ruben Sher writing in 1985, was containment of infection, along with minimising the risk of clinicians becoming infected through contact with AIDS patients. It is clear that at this stage many doctors and nurses simply did not want to treat AIDS patients for fear of infection. The emphasis was on 'decontamination' and 'protection' from infected bodily fluids.[1] This was a discourse of the 'clean' and the 'dirty', the 'contaminated' and the 'uncontaminated': the clinicians hands were to be washed before and after contact with a person with AIDS; 'contaminated' and 'infectious' waste was to be treated specially; anaesthetists were to separate materials into 'clean and dirty trolleys'.[2]

[1] Sher. "Infection Control", 845.
[2] Sher. "Infection Control", 845.

Although ostensibly only talking about bodily fluids infected with a virus, there was a wider significance of this for the representation of AIDS patients in these early years; according to such a discourse they were not humans they were disease-carriers, a threat to the 'normal', non-promiscuous population, and a threat to doctors and nurses, who were in nearly all the early articles assumed not to have been infected.[3] They were to be counselled as 'infectious'; not as people whose health was rapidly deteriorating, who were dying from a mysterious and heavily stigmatised terminal illness, who were probably undergoing massive personal crises around their situation. They had to be counselled, according to such a view, not to infect others, to use condoms, to limit partners, avoid anal sex, wet kissing and oral sex : for many gay men, who constituted the bulk of those infected at this stage, this virtually meant giving up having sex altogether.

Michel Foucault argued in his work that modern power functions through the 'human sciences', including medicine, which revolve around the Western humanist, post-Enlightenment notion of 'man'. 'Man' was observed, categorised, counted and quantified by the new human sciences, which existed to exercise power over individuals, and were far from merely benign. Modern power was deeply inscribed on people's bodies, bodies were not 'natural', eternal and unchanging, they were highly technologised and representations of them changed in medical thought[4].

Sexuality was, for Foucault, not something 'natural' and essential. He argued in his *History of Sexuality: An Introduction* that it was controlled in the West in the post-Enlightenment era through schools, psychiatry, psychology, medicine[5]. Feminist critics of Foucault have pointed out how potentially useful

[3] Foucault has spoken about how in modern clinical medicine the focus is disease itself rather than the patient, about how the patient becomes an little more than an example of disease. Michel Foucault. *The Birth of the Clinic; An Archaeology of Medical Perception.* Transl. A. M. Sheridan. Ed. R. D. Laing. (London: Tavistock, 1973), 59

[4] Foucault in some ways coined my approach in *The Birth of the Clinic* where he uses his method of a genealogy/archaeology of knowledge to show how portrayals and conceptualisations of the body changed, just as who could practice medicine and the spaces in which it was to be performed rigidified. Foucault. *The Birth of the Clinic*, 16, 44, 65-69.

[5] Michel Foucault. "Chapter 3: Domain". *A History of Sexuality: An Introduction.* Trans. Robert Hurley. (Harmondsworth: Penguin, 1976),104-105. Foucault outlines four key ways power/knowledge controlled Western sexuality: by a "hysterization of women's bodies", "a

his notion of productive power is: sexuality far from being repressed by modern power, was everywhere, was given expression through modern institutions.[6] For instance Jana Sawacki has argued, quoting Gayle Rubin, in turn taking her cue from Foucault in *Discipline and Punish*

> that we displace the categories of thought about sexuality from 'the more traditional ones of sin, disease, neurosis, pathology [etc.]' (those that Foucault has described as part of the deployment of sexuality) to 'populations, neighborhoods, settlement patters, migration, urban conflict, epidemiology'...to provide detailed analyses of the relationships between 'stigmatised erotic populations and the social forces which regulate them'".[7]

Working in a Foucauldian framework of power/knowledge (that power and knowledge, work together and are inseparable), we will now dig into the paper trail that the early medical power/knowledge regime left behind.[8] The stethoscope of this chapter will turn to the past of the living, breathing body of the medical power/knowledge regime.

Why then place the *SAMJ* articles alongside the Durban City Council Medical Officer of Health Annual Reports (Durban MOH Reports)? This relates to my theoretical approach, strongly informed by the Foucault's critiques of modern Western biomedicine, and the nature of modern power in general. To look at the *SAMJ* articles without referring to the Durban MOH reports would be to imagine that public health as it actually functioned on the ground was divorced from the writings of medical academics.

In response to their stigmatisation, the South African and international gay community responded vociferously and copiously to what they viewed as an

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pedagogization of children's sex", a "socialization of procreative behaviour" and a "psychiatrization of perverse pleasure".

[6] Jana Sawacki. "Identity Politics and Sexual Freedom: Foucault and Feminism". *Feminism and Foucault: Reflections on Resistance.* (Boston: Northeastern University Press, 1988). To see the original: Michel Foucault. "Part One: We The Other Victorians", "The Repressive Hypothesis: Chapter Two: The Perverse Implantation". *The History of Sexuality: An Introduction.* Transl. Robert Hurley. (Harmondsworth: Penguin, 1976), 10-12, 17-18, 33-35.

[7] Jana Sawacki. "Foucault and Feminism", 185.

[8] Unfortunately, I can't start to look to closely at things from the perspective of the patient as Roy Porter and others have, in this dissertation, in part because of the stigma attached to AIDS, which would make it hard to interview many HIV positive people. Also, many people infected in 1985 are tragically no longer alive. Lastly, this is impossible due to space

attack on their identity and lifestyle, and even the very real threat of an elimination of their community by the spread of AIDS, as was pointed out in the Introduction.[9] Indeed, they were the first true 'AIDS activists'. The relatively new and assertive gay rights community built on its gains as a movement in the 1960s and 1970s in the distigmatisation of same-sex sexuality, and its de-pathologisation, in mounting its response. Furthermore, many of these activists were well aware of Foucault's work on sexuality, and how 'homosexuality' was defined as a psychological and psychiatric illness, something they stringently fought against.

Sympathetic to this new movement to fight against AIDS, largely led by gay rights activists, Knobel argued in the *SAMJ* not only for the spread of accurate information about means of infection, prevention of infection and care of infected individuals, but also emphasised the need for both confidentiality to encourage individuals suspecting infection to come forward, and that "patients with AIDS not only need our [medical] professional help but also our sympathy and understanding".[10] In terms of policy, he explicitly called for the government's Department of Health and Population Studies to become involved with medics and the Gay Association of South Africa, in making an information pamphlet for the general public on AIDS.

Those identified as having AIDS in this period were still disproportionately gay and bisexual men: Malan estimated in the mid-1980s that they constituted seventy three percent of those infected as against one percent heterosexuals of both genders.[11] Already, by 1985, infection figures nationally had a doubling time of 6-12 months.[12] By comparison, in the Durban MOH 1985 Report, AIDS only bore a paragraph's worth of a mention, mainly typified as a 'homosexual' disease; the only two antibody test positive cases in Durban

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limitations of this dissertation. See Porter's work for more on this approach: Roy Porter. "The Patient's View: Doing Medical History from Below". *Theory and Society.* 14 (1985), 175-198.
[9] G. J. Knobel. 1986. "AIDS: prevention through education". *South African Journal of Medicine* 70:119-120. Simon Watney. *Policing Desire: Pornography, AIDS and the Media*. (Minneapolis: University of Minnesota Press, 1987).
[10] Knobel. "prevention through education", 120.
[11] Marais Malan. "AIDS in the USA and RSA- An Update". (1986). *South African Medical Journal* 70:119.
[12] Malan. "AIDS in the USA and RSA", 119.

mentioned were two unrelated cases of heterosexual males who were exposed during trips to Zaire[13]. Emphasis was placed on prevention and control, but AIDS was still talked about more in terms of being an international public health problem, more as a generalised abstraction, than in terms of the city health machinery's exact plans or response[14].

It would only be by 1986 that the Durban MOH Reports would begin to register the problem of AIDS as a potentially serious public health problem in the city. AIDS received mention far earlier in the 1986 reports, under the heading Notifiable and Communicable Medical Conditions, with the establishment of a National AIDS Advisory Committee having received mention.[15] The first two cases of AIDS in the city of Durban were mentioned as having been two "White bi-sexual males", who had "demised" by the time the report was written, confirming yet again the widespread notion of AIDS as a largely gay disease at this stage.[16]

However, the future spread of AIDS in the heterosexual population may not have been so far fetched an idea by this stage. Other STDs were highly prevalent in the Durban area amongst heterosexuals and, as has been remarked on above, at least two heterosexually acquired positive tests for the virus causing AIDS were already confirmed. Gonorrhoea was the most prevalent STD, with ninety percent of males presenting with abnormal genital discharge at the municipal STD clinic having been infected with it.[17]

The fact that the majority of patients presented with certain STDs like gonorrhoea was conflated with the fact that the clinics also largely catered for 'Blacks'. This re-established the older link between race, sexuality and disease that was common in late apartheid discourse. Many patients at municipal STD clinics were also presenting with multiple STD infection.[18] By this period it was known that AIDS could be heterosexually transmitted.

[13] Durban City MOH report 1985, 15.
[14] Durban City MOH report 1985, 15.
[15] Durban City MOH Report 1986, iii.
[16] Durban City MOH Report 1986, iii.
[17] Durban City MOH Report 1986, iv.

Certainly, high STD rates should have indicated to local public health officials in Durban that it was highly possible that a major AIDS epidemic could have been in the offing, especially given that the total number of attendances at STD clinics in 1986 was 61 356, with 32 977 of these having been new cases.[19]

In contrast, fears were growing of a potentially massive heterosexual epidemic in South Africa by writers in the *SAMJ.* It was increasingly becoming clear to medics like Ijsselmuiden *et al*, that a potential South African epidemic would mainly turn out to be along the 'African' lines, being largely heterosexually transmitted, with heterosexual 'promiscuity' and vertical mother to child transmission to blame.[20] For the first time, in 1988 it was unequivocally stated that an epidemic was beginning, as the writers said, "It is reasonable to presume that we are witnessing the beginnings of the epidemic".[21] HIV positivity was the best potential indicator of where the epidemic was going and 1 560 of 1 708 HIV positive blood donors were black.[22] STD infection rates could indicate future epidemiological patterns.[23] One study cited also indicated an HIV positive carrier rate of 437 per million.[24]

The Ijsselmuiden *et al* series of articles in the *SAMJ* were groundbreaking in several respects. Public health advice around HIV testing, education, counselling, and non-discrimination and confidentiality for HIV positive people were included in the article series; all being public health measures which would form a part of any well-considered, efficacious public health response to AIDS today.[25]

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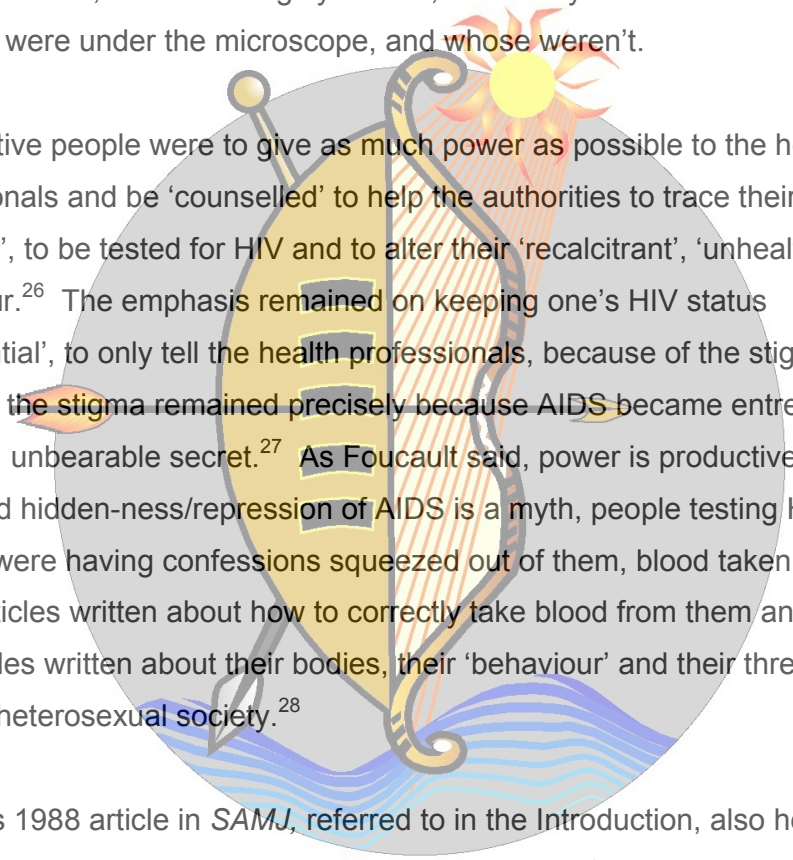
[18] Durban City MOH Report 1986, 37.
[19] Durban City MOH Report 1986, 41.
[20] C.B. Ijsselmuiden, M.H. Steinberg, G.N. Padayachee, B.D. Schoub, S.A. Strauss, E. Buch, J.C.A. Davies, C. De Beer, J.S.S. Gear, H.S. Hurwitz. "AIDS and South Africa- towards a comprehensive strategy. Part I. The worldwide experience". *South African Medical Journal* 73. (1988), 456
[21] Ijsselmuiden *et al.* "towards a comprehensive strategy", 457.
[22] Ijsselmuiden *et al.* "towards a comprehensive strategy", 457.
[23] Ijsselmuiden *et al.* "towards a comprehensive strategy", 457.
[24] Ijsselmuiden *et al.* "towards a comprehensive strategy", 457.
[25] C.B. Ijsselmuiden, M.H. Steinberg, G.N. Padayachee, B.D. Schoub, S.A. Strauss, E. Buch, J.C.A. Davies, C. De Beer, J.S.S. Gear, H.S. Hurwitz. "AIDS and South Africa- towards a comprehensive strategy. Part II. Screening and control". *South African Medical Journal.* 73. (1988.-a.); C.B. Ijsselmuiden, M.H. Steinberg, G.N. Padayachee, B.D. Schoub, S.A. Strauss,

Yet the categories of black and white, heterosexual and 'homosexual', infected and non-infected remained set in stone, and whilst some of the social, legal and ethical aspects of the impending epidemic were given some thought, the power dynamics involved in making those categories were left unanalysed: as if patients had automatic characteristics, risk profiles, social and cultural traits, purely on the basis of those categories. Also, interestingly enough, the risk profile of middle class, heterosexual white professionals, such as doctors, remained largely absent; it is utterly clear whose bodies and sex lives were under the microscope, and whose weren't.



HIV positive people were to give as much power as possible to the health professionals and be 'counselled' to help the authorities to trace their 'contacts', to be tested for HIV and to alter their 'recalcitrant', 'unhealthy' behaviour.[26] The emphasis remained on keeping one's HIV status 'confidential', to only tell the health professionals, because of the stigma, yet ironically the stigma remained precisely because AIDS became entrenched as the filthy, unbearable secret.[27] As Foucault said, power is productive: the supposed hidden-ness/repression of AIDS is a myth, people testing HIV positive were having confessions squeezed out of them, blood taken from them, articles written about how to correctly take blood from them and test it, and articles written about their bodies, their 'behaviour' and their threat to 'normal' heterosexual society.[28]

Schoub's 1988 article in *SAMJ*, referred to in the Introduction, also heavily depended on racialised categories and stereotypes of certain kinds of sexuality, particularly that of black prostitutes. The 'promiscuous core of black prostitutes had to be shrunk:

E. Buch, J.C.A. Davies, C. De Beer, J.S.S. Gear, H.S. Hurwitz. "AIDS and South Africa-towards a comprehensive strategy: Part III. The role of education". *South African Medical Journal* 73. (1988.-b.)

[26] Ijsselmuiden *et al.* "Part II. Screening and control", 462-463.

[27] For a strong challenge to certain notions of 'confidentiality', in AIDS counselling and how it can disempower patients and alienate them from family and community support see: Gill Siedel. "Confidentiality and Gender Status in Kwa-Zulu/Natal, South Africa: implications, resistances and challenges". *Health Policy and Planning.* 11(4). (1996).

[28] Michel Foucault. "The Perverse Implantation", 48-49, 60-63.

> Serious consideration will have to be given to efforts to shrink the promiscuous core of prostitution, irrespective of the guise under which it is practised. The role of legislative control of prostitution needs to be investigated, but what is more important is addressing the social and societal conditions which lead to prostitution. [29]

On the other hand, the article should not be written off entirely, it had good recommendations about ways of charting the epidemic, such as using HIV and STD infection as a measure of where the epidemic was going.[30]

Without focusing too much on this article, as it has already been strongly critiqued in the Introduction, it focused on targeting prostitutes, without looking at how promiscuous their customers might have been, or how to have effectively empowered prostitutes to have actually been able to use protective measures, like male condoms, that were known to reduce risk of transmission, with clients.

Stigmatising, or reducing, prostitution through legislative means, apart from being impossible to enforce, would not necessarily have lessened STD infection, because as Campbell has shown the lines were often blurred between economically dependent, non-faithful relationships and commercial sex, and prostitutes in the strictest sense of the word (commercial sex workers) rarely defined themselves as such.[31] As has been argued above, power/knowledge institutions like epidemiology can often function to further stigmatise stigmatised erotic populations. The image of the black prostitute was so strong in the article, and in Western culture, because of 'othering'. 'Othering' was the pasting of everything that was deemed negative in Western culture onto the racial and cultural 'other'. By this process the negatives of female sexuality, its 'uncontrollability' and 'pathology', got pushed onto black

[29] B.D. Schoub, A.N. Smith, S.F. Lyons, S. Johnson, D.J. Martin, G. McGillivray, G. N. Padayachee, S. Naidoo, E. L. Fisher, H. S. Hurwitz. "Epidemiological considerations of the present status and future growth of the AIDS Epidemic in South Africa". *South African Medical Journal.* 74 (1988), 156.
[30] Shoub *et al.* "Epidemiological considerations", 155-156.
[31] Catherine Campbell. "Selling sex in the time of AIDS: the psychosocial context of condom use by sex workers on a South African mine" *Social Science and Medicine.* 50: 479-494 (1997).

women; as Vaughan has argued it is not for nothing that Freud referred to female sexuality as the 'Dark continent'.[32]

At a municipal level in Durban, the Durban MOH reports reveal a lack of planning and mobilisation in 1987-1988. The municipal clinic did not routinely detect and screen patients: 'suspicious' cases were sent to the Provincial Hospital Out-patients wards, the Medical School and the District Surgeons for testing.[33] The 1987 report also claimed that a "massive health education programme" had been launched "in the interim".[34] Yet the overwhelming emphasis of family planning's activities focused on getting people the have smaller families (those fertile and not on contraceptives were 'problem clients'), and encouraging teenagers to "say NO to sexual experimentation".[35]

By 1988 AIDS was finally beginning to register as a serious problem at the municipal STD clinics. Forty two patients had been found to be HIV positive by testing, and high STD prevalence, along with 'promiscuity', was found to be a risk factor.[36] Throughout this period patients were divided into city ('White', 'Coloured' and 'Indian' areas) and ex-city (from the Bantustan of Kwa-Zulu, to which belonged Umlazi, Kwa-Mashu and other big townships around Durban).[37] Late apartheid boundaries were also written on bodies, especially sick bodies, but as the report-writers formed part of local government, they did not question this. They noticed that black patients had unacceptably high rates of tuberculosis, and that the socio-economic problems of informal settlements might be to blame, they agreed to treat ex-city patients, but would not go so far as to say that apartheid boundaries and the entire edifice of racial discrimination was linked to ill-health, and to ill bodies, on a mass scale.[38]

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[32] Megan Vaughan. "Introduction; Discourse, Subjectivity and Differences". *Curing Their Ills: Colonial Power and African Illness.* (Cambridge and Oxford: Polity Press, 1991), 8-9, 19. Sander Gilman. *Difference and Pathology: Stereotypes of Sexuality, Race and Madness.* (Ithaca and London: Cornell University Press, 1985).
[33] Durban MOH Report. 1987. 40.
[34] Durban MOH Report. 1987. 40.
[35] Durban MOH Report. 1987. 48-50.
[36] Durban MOH Report. 1988. 38.
[37] Durban MOH Report. 1988. iv.
[38] Durban MOH Report. 1988. iv.

It is impossible not to miss the glaring differences in approaches to health indicators of different race groups in the Durban MOH Reports. In the 1989 report White Infant Mortality's increase was cited as a concern, but the black infant mortality rate was not specifically cited as a concern, although the following figures were quoted: in 1988 the white infant mortality rate was 5,37 per thousand and the black 39,34; in 1989 the figures were 15,24 amongst the white population and 25,91 amongst the black.[39] The juggling of figures for numbers of each population group in Durban by the crazy Bantustan system is also evident when analysing the 1989 MOH Report: they attempted to claim that only 62 277 Black people lived in Durban, as opposed to 190 672 White people, certainly a massive under-estimation of the African population of Durban.[40]

Municipal family planning services, through the 1989 MOH Report, patronisingly talked of convincing 'the community' (implying black people) that unwanted and ill-fed children were a "strain on human and natural resources", of the "great social, health and economic benefits of responsible sexuality and controlled fertility".[41] As if eliminating the social, economic and health problems of South African society and poor people were reducible to putting everyone on the contraceptive pill or injection, or encouraging sterilisation.

The AIDS Training Information Centre (ATIC) in Durban was opened in September 1989, and actually started functioning in November 1989 with two members of staff (one AIDS Training officer and a secretarial assistant).[42] The ATIC's were set up on the advice of the National AIDS Advisory Group, in all the major cities in South Africa.[43] It is important to note that none were set up in either townships, informal settlements, or rural Bantustan areas.[44]

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[39] Durban MOH Report. 1989. iii. Also, note that the report cited the World Health Organisation's acceptable infant mortality limit for cities in developed countries to be in the range of 10-20 deaths per 1 000 live births.
[40] Durban MOH Report. 1989. iii.
[41] Durban MOH Report. 1989. v.
[42] Durban MOH Report. 1989. ix.
[43] Durban MOH Report. 1989. 103. Marais Malan, one of the *SAMJ* journal article writers, sat on the AIDS Advisory Committee in 1986, underscoring the links between the medical academics and the management of Durban city health.

By the 1989 report's own admission the centre was still at this stage grossly understaffed, which would tend to indicate underfunding.[45] The centres aimed to provide training for counsellors, and ensure that "factual information" reached "the population"; however, the Durban ATIC only seemed to have tested Whites and Indians, and no Blacks, to some extent, underscoring who used the facility, and for whose use it was exclusively designed.[46]

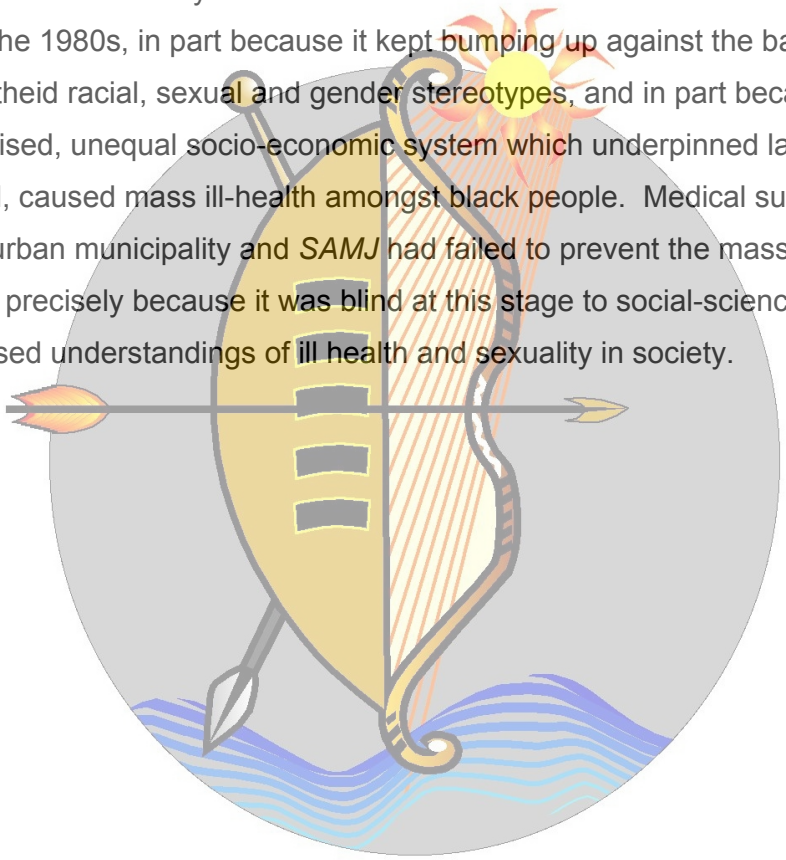
This chapter has charted the beginnings of doctors in *SAMJ* making public health policy recommendations around AIDS, and the actual, gradual implementation of some of their recommendations by the Durban city health infrastructure, evident in the MOH Reports. Both institutions interlocked as a Foucauldian power/knowledge regime, writing power onto patients bodies: the power of the boundaries of apartheid spaces, apartheid conceptions of race, and stereotypes around erotically marginalised populations like prostitutes and gays. In some cases, good recommendations were made and implemented, which could have actually caused the spread of accurate information to some, assisted the state and doctors more precisely chart the epidemic, and helped AIDS patients receive more humane treatment at hospitals.

Yet, those susceptible to contracting the virus causing AIDS were still seen less in terms of being individuals with complex life histories, and social and cultural backgrounds, and more in terms of being 'types': black prostitutes, 'homosexuals', promiscuous people, as opposed to non-promiscuous 'normal' heterosexuals. This stereotyping was perhaps the greatest failing of the information spread as part of local and national public health interventions, because it may have lulled people, who did not feel that they fitted into these crude stereotypes, into potentially dangerous complacency about their potential risk of contracting the virus. Also, the arguments for keeping infection

[44] These are the places where most Africans lived, and if the centres were to have limited the feared black heterosexual epidemic this would have been the obvious starting point.
[45] Durban MOH Report. 1989. 103.
[46] Durban MOH Report. 1989. 103, 106.

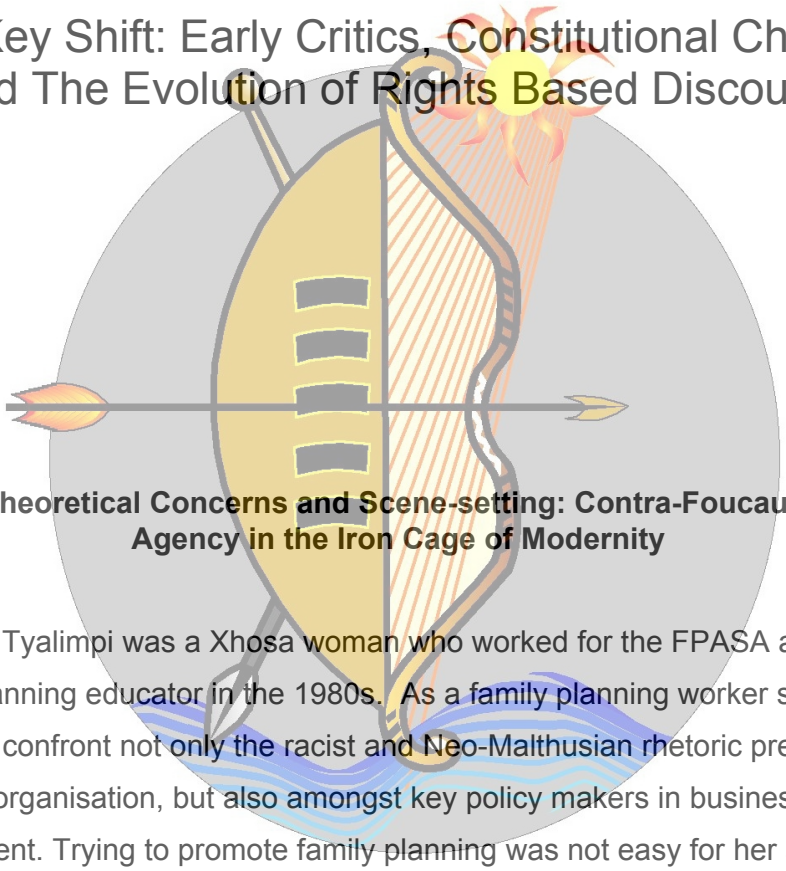
confidential enhanced the power of doctors; far from being hidden AIDS in this era is a classic example of Foucault's notion of productive power.

Key shifts of the early to mid-1990s, which will be charted in the next chapter, had yet to take place. A new emphasis would come to be placed on human rights and choice for patients in family planning, along with a more serious recognition of the impact of AIDS, with better statistical modelling. At the same time, studies began appearing in medical journals with deeper social, gender, cultural and ethical analyses. The aim of 'containment' of the new disease failed in the 1980s, in part because it kept bumping up against the barrier of late apartheid racial, sexual and gender stereotypes, and in part because of the racialised, unequal socio-economic system which underpinned late apartheid, caused mass ill-health amongst black people. Medical surveillance by the Durban municipality and *SAMJ* had failed to prevent the mass-scale epidemic precisely because it was blind at this stage to social-science and rights-based understandings of ill health and sexuality in society.



Chapter Two

The Key Shift: Early Critics, Constitutional Changes and The Evolution of Rights Based Discourse



Theoretical Concerns and Scene-setting: Contra-Foucault, Agency in the Iron Cage of Modernity

Patience Tyalimpi was a Xhosa woman who worked for the FPASA as a family planning educator in the 1980s. As a family planning worker she was forced to confront not only the racist and Neo-Malthusian rhetoric prevalent in her own organisation, but also amongst key policy makers in business and in government. Trying to promote family planning was not easy for her at that time in the townships of the Transvaal as people were often aware of the fact that the government and key policy makers saw 'overpopulation' and not apartheid as responsible for poverty, environmental problems and a range of social problems. As this chapter will show, in small and subtle ways she used her agency to assert her own resistance to certain aspects of state and FPASA family planning policy.

In the last chapter it was asserted that a Foucauldian power/knowledge regime operated to control and inscribe power on HIV positive people's bodies. But the power of the doctors and the state and the absence of a rights-based discourse around AIDS and family planning is only half the story. There was also agency and resistance in response to that same system, which rose in prominence with the political changes, which happened in South Africa in the 1990s.

Foucault has often been criticised for not allowing for political resistance and agency in his account of modern power. His account of modern power is seen by his critics as lacking normative and political commitment and agency. Chief amongst these critics has been Jηrgen Habermas. Habermas argues that modernity should not be left unscathed by recent critiques of it; yet at the same time ideas within modernity itself, such as reason, truth and justice, can be used to criticise the humanist traditions of thought the West has inherited.[1] Habermas characterises postmodernism, a rubric under which he places Foucault's work, as aiming to

> pull [the] veil of reason from the sheer will to power, [postmodernism] at the same time is supposed to shake the iron cage in which the spirit of modernity has been objectified in the societal form.[2]

Habermas is deeply critical of the whole post-modern/post-structural project of undermining the metaphysical content of modernity. He sees attempts like Foucault's to do this, as being deeply flawed, as undermining modernity and its 'language games', rather than trying to reveal the humanistic self-understanding of modernity and its normative content (notions of citizenhood, human rights, autonomy and rationality).[3]

Habermas posits communicative action as an alternative model to subjective reasoning for understanding the way that claims are rationally assessed in

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[1] McCarthy. "Introduction", x; Jηrgen Habermas. "Chapter X: Some Questions Concerning the Theory of Power: Foucault Again". *The Philosophic Discourse of Modernity.* (Cambridge: Polity Press), 282-283; Jηrgen Habermas. "Beyond the Temporalized Philosophy of Origins: Jacques Derrida's Critique of Phonocentrism". *The Philosophic Discourse of Modernity.* (Cambridge: Polity Press, 1987), 181-182.

[2] Jηrgen Habermas. "Chapter I: Modernity's Consciousness of Time and Its Need for Self-Reassurance". *The Philosophic Discourse of Modernity.* (Cambridge: Polity Press, 1987), 4.

society.[4] Rationalisation, for Habermas, happens through the weaving of a web of intersubjective threads of language-based communication, which holds together culture, society and the individual person.[5]

Several feminist critics of Foucault have been drawn to Habermas's attempt to reconstruct or rehabilitate modernity, not least for its ethical and political possibilities. Habermas noted the empowering aspects of conceiving of humanistic modernity as having the capacity to both keep people subject to modern power *and* empowered as citizens.[6] Nancy Fraser, like Habermas, whilst admiring the possibilities Foucault's theories for feminist scholarship is concerned about his conception of modern power/knowledge regime's lack of potential for political resistance and assessing the normative claims of arguments.[7]

In Fraser's account of Foucault's conception of the functioning of modern power itself, she shows him as having conceived of it as being productive as opposed to prohibitive (something that comes out very strongly in the *History of Sexuality* in particular) and capillary as opposed to merely concentrated around the state[8]. Power was, for Foucault to be found in a multiplicity of "micropractices" of the power/knowledge regime, and a crucial part of its functioning was through replacing violence with the type of uninterrupted, unidirectional visibility which made individuals operate self-surveillance (as laid out in *Discipline and Punish* and *History of Sexuality*).[9] It also made

[3] Habermas. "Foucault: Theory of Power", 282-283.
[4] Jηrgen Habermas. "Chapter XII: The Normative Content of Modernity. *The Philosophic Discourse of Modernity.* (Cambridge: Polity Press, 1987), 341, 343, 346.
[5] Habermas. "The Normative Content of Modernity", 346.
[6] Habermas. "Foucault: Theory of Power", 271.
[7] Nancy Fraser. "A 'Young Conservative'" *Unruly Practices: Power, Discourse and Gender in Contemporary Social Theory. (*Cambridge: University of Minnesota Press, 1989), 52-53.
[8] Nancy Fraser. "Foucault on Modern Power", *Unruly Practices: Power, Discourse and Gender in Contemporary Social Theory. (*Cambridge: University of Minnesota Press, 1989), 17; Foucault. Michel Foucault. "We The Other Victorians", "The Perverse Implantation". *The History of Sexuality: An Introduction*, 10-12, 17-18, 33-35.
[9] Fraser. "Foucault on Modern Power", 20-23.; Michel Foucault. "Chapter One:The Body of the Condemned". *Discipline and Punish: The Birth of the Prison.* (Harmondsworth: Penguin, 1977), 27-30.

people into 'docile and useful bodies'[10]. It is this Foucauldian notion of power, which Habermas refers to as being the iron cage of modernity, which postmodernism aims to reveal. As shall be shown, Foucault's theories of modern power/knowledge have serious implications for historical notions of agency, particularly, female agency in history, not least in this history of AIDS policy-making.

Enlightenment ideals like progress, autonomy, subjectivity and selfhood are actually seen by Foucault as part of the controlling disciplinary regime. According to Fraser and Habermas, to Foucault humanism was just the latest transitory version of the power/knowledge regime, which was inherently oppressive.[11] It was a political and scientific praxis focused on the new object "man" which dated back to the late eighteenth and early nineteenth century and the emergence of the new disciplinary power/knowledge regime of the Enlightenment and post-Enlightenment period.[12]. It is clear here that this is where Habermas and feminist followers of his, like Fraser, part company with Foucault, believing these to be useful ideals to political movements, including feminism

Foucault's characterisation of modern power will be retained in this chapter. As was explored in the previous chapter, it was a vision of power as being inscribed on bodies, of sexuality as controlled by different institutions, and of power as productive. However, the central contention of this chapter will be that anti-apartheid activists and academics, and even people working for the state appealed to humanistic ideals like autonomy, citizenship and human rights, to actively change discourse around family planning and its close sibling AIDS policy.

It is in the rumblings of the change towards a rights-based discourse in public health around AIDS began, where the story of this chapter begins, in the

[10] Fraser. "Foucault on Modern Power", 20-23.; Michel Foucault. "Chapter One:The Body of the Condemned". *Discipline and Punish: The Birth of the Prison.* (Harmondsworth: Penguin, 1977), 27-30.
[11] Fraser. "A 'Young Conservative'", 38.; Habermas. "Foucault:Theory of Power", 279; Foucault. "Body of the Condemned", 29-30.

nineteen eighties. Anti-apartheid activists, left wing and feminist academics based at University of the Witwatersrand and in the academic journals published in the United Kingdom and the United States were challenging both broader socio-economic trends in health care and, in particular, the issue of medical ethics and rights as attached to family planning. For these activists and academics, both the health of individuals and the state of the health system were determined by the socio-economic and political conditions created by apartheid. These academics/activist's critiques of family planning are particularly pertinent when looking at the FPASA archive and Durban City Council's and the state's policies in having used Depo-Provera, and the nature of the state's overwhelming sponsorship of family planning to the detriment of other health crises like tuberculosis. With the beginning of the nineties came the negotiations between the National Party government and the African National Congress for a democratic constitution in South Africa; this in many ways moved the notion of rights in the humanist tradition into the mainstream, particularly women's rights in health care, and also raised the prospect of establishing a National Health System, which had been proposed by left-wing academic in South Africa and the ANC-in-exile in the 1980s. In the 1990s detailed studies also began appearing which analysed the socio-economic and cultural conditions in which made certain groups of women and men, such as truck drivers, miners and prostitutes vulnerable to HIV and STD infection. Feminists largely writing in publications like *Agenda* began writing about the experiences which barred vulnerable women from using preventative measures against HIV infection. The central argument of this chapter will then be that the state, NGOs (both pro- and anti-state), left and conservative writers on public health matters and feminist activists and academics' work operated in a dialectic web, which dramatically changed public health policy discourse. They came from both inside and outside the medical power/knowledge regime around AIDS and family planning policy and practice, and affected the key shift in discourse at a time when with sweeping political shifts were taking place.[13]

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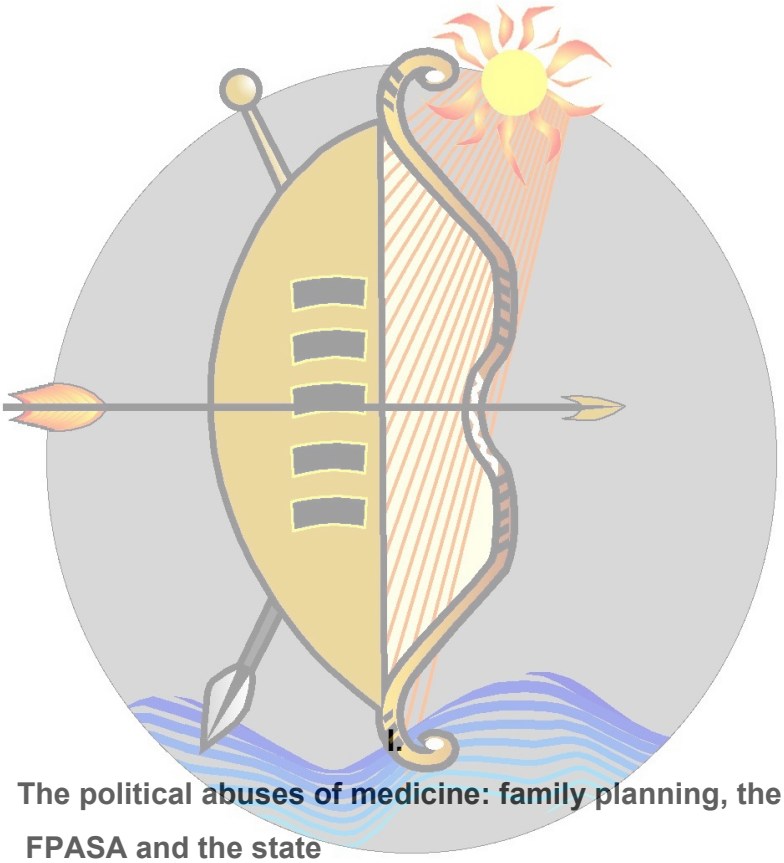
[12] Fraser. "A 'Young Conservative'", 39.

[13] In speaking of a dialectic web, I am referring to the work of Hegel and Marx. This term is being employed here to argue that internal contradictions in family planning policy and AIDS



I.

The political abuses of medicine: family planning, the FPASA and the state

Left wing critics of apartheid health policy like Zwi charted the political abuses of medicine in apartheid South Africa. Zwi argued in a 1987 *Social Science*

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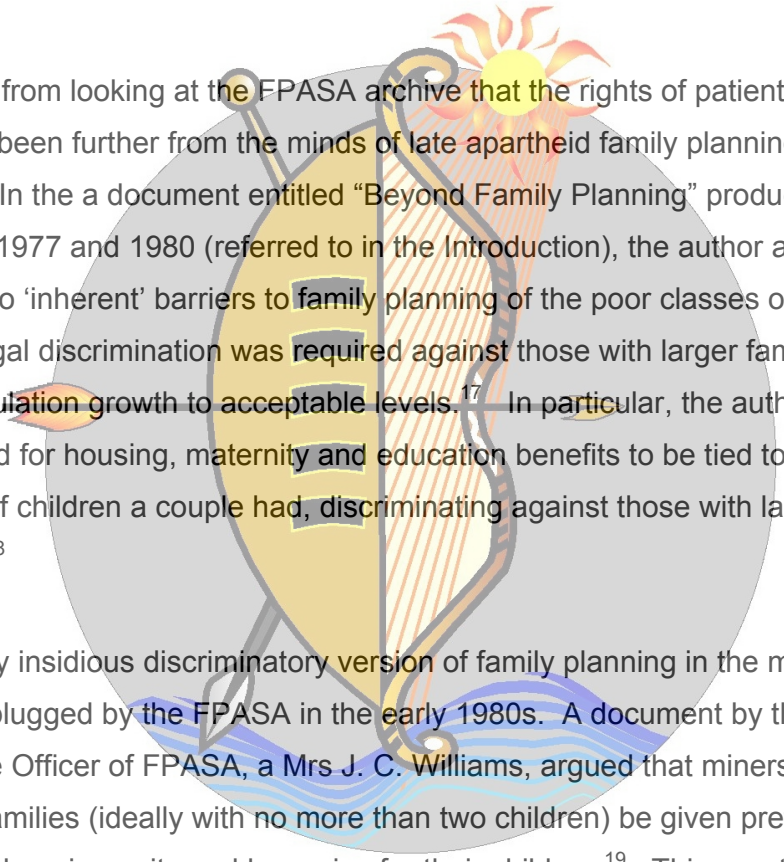
policy gave rise to more 'ethics' and 'rights' orientated discourse in both fields. The critique of the way that what Foucault has termed the 'human sciences' came from within the human sciences themselves, from within the very disciplines of medicine, anthropology, psychology, epidemiology, and so on. I aim to show in a similar way to Habermas, the oppressive and liberating possibilities of post-humanist thought here, and the implications of this for AIDS policy-making. Georg Henry Friedrich Hegel. "Lordship and Bondage". *Phenomenology of Spirit.* (London: George Allen and Unwin, 1931). Karl Marx and Friedrich Engels. *The German Ideology.* Ed. C. J. Arthur. (New York: International Publishers, 1988).

and Medicine article that health was not only political, but open to abuse by undemocratic policies of undemocratic states, and that doctors could be used by manipulative political regimes and their clandestine agencies.[14] In particular, when analysing the case of medicine and the South African state, he pointed out that population control and family planning were open to abuse by the apartheid government, to contain the growth of the black working class.[15] Family planning was promoted as a solution to the social problems of unemployment, overcrowding, malnourishment, without addressing the political and economic determinants of these.[16]



It is clear from looking at the FPASA archive that the rights of patients could not have been further from the minds of late apartheid family planning officials. In the a document entitled "Beyond Family Planning" produced between 1977 and 1980 (referred to in the Introduction), the author argued that due to 'inherent' barriers to family planning of the poor classes of South Africa, legal discrimination was required against those with larger families to slow population growth to acceptable levels.[17] In particular, the author advocated for housing, maternity and education benefits to be tied to the number of children a couple had, discriminating against those with larger families.[18]

A similarly insidious discriminatory version of family planning in the mines was strongly plugged by the FPASA in the early 1980s. A document by the Executive Officer of FPASA, a Mrs J. C. Williams, argued that miners with smaller families (ideally with no more than two children) be given preference for family housing units and bursaries for their children.[19] This was to go with more conventional methods like posters encouraging family planning, and

[14] A. B. Zwi. "The political abuse of medicine and the challenge opposing it". *Social Science and Medicine*. 25. (1987), 649.
[15] Zwi. "political abuses of medicine", 650.
[16] Zwi. "political abuses of medicine", 650.
[17] Unknown. "Beyond Family Planning". AG2619 (B8) FPASA: Minutes and Correspondence (1977-1980), 3.
[18] Unknown. "Beyond Family Planning", 9.
[19] J. C. Williams. "Suggested Incentives for Mineworkers of All Races to Plan their Families and Numbers of Children", FPASA: Minutes and Correspondence (1977-1980). AG2619. (1981), 1.

mineworkers 'of all races', preferably along with their wives, were to be encouraged to be sterilised and more importantly to learn "..how pressure of people affects the economy, national resources and the environment."[20]

According to people in key positions in the FPASA, most of the woes of African South Africans were due to overpopulation. A relevant attachment to a circular to all regional or branch members sent by Elizabeth Du Preez (National Organiser) was a statement by a Mrs. Mary Rose an FPASA Executive Committee member on "Why We Need to Limit the Size of the South African Population".[21] The starvation common in rural areas was seen by Rose as due to overpopulation and over-grazing, as were the 'squatter problem' and unemployment.[22] The fact that these problems were primarily due to apartheid did not strike people who expressed this type of mentality. For those who thought this way, if Africans could have been convinced to control their fertility, then all the social problems of the late apartheid state would have vanished away.

The FPASA's view of family planning is critical to understanding what the state's view was. As was stated in the Introduction, the FPASA was not only fifty percent state funded, it also received all its medical supplies free from the state. Left wing writers like Andersson and Marks, writing around the same time, critiqued this view of the ill health of Africans and their social problems as linked to their supposed irresponsible management of their fertility. For Marks and Andersson, the health of Africans was determined by their physical impoverishment.[23] They spoke of the rise of a "neo-Malthusian rhetoric" amongst the state and corporations: a rhetoric which argued that the primary cause of African poverty, morbidity and mortality was 'population growth'.[24] This rhetoric strongly influenced public health policy, infrastructure and spending too: in the 1983-1984 state budget, twenty nine million rand was

[20] Williams. "Suggested Incentives", 2.
[21] Mary Rose. "Why We Need to Limit the Size of the South African Population". FPASA: Transvaal Regional Correspondence, Reports Etc: 1981-1988. AG2619. (1985).
[22] Rose. "Limit the Size of the South African Population".
[23] Shula Marks and Neil Andersson. "Apartheid and Health in the 1980s". *Social Science and Medicine.* 27 (7). (1988), 668.
[24] Marks and Andersson. "Apartheid and Health", 668.

spent on family planning (some of which surely winged its way to FPASA's coffers); when the article was written (1988), there were fifty percent more public contraceptive clinics in South Africa than general health clinics.[25]

This rhetoric was not new though. As was demonstrated in the Introduction, in the late 1930s some members of the predecessor of FPASA, the Maternal and Child Welfare Society, actively applauded the eugenic sterilisation policies of Nazi Germany as a way of ensuring that the racially unfit did not reproduce. Eugenics and racist science can indeed be seen as the 'dark side' of the history of family planning. Moreover, Malthus's old idea that 'overpopulation' of the poor was at the root of poverty, and that the best way of dealing with poverty was to get the poor to limit their offspring can be linked both to eugenics and late apartheid family planning policy, at least in terms of some of their more extreme rhetorical moments.

By the same token, historians like Alan Brandt, in his history of venereal disease management in the United States, have identified strong links between eugenics and STD management programmes. In America, to 'control' syphilis, syphilitics were not allowed to marry, to avoid passing on their disease to unborn children.[26] Furthermore, Sander Gillman has shown strong linkages between the ideas of Africans' and women's sexuality as inherently diseased in Western culture; particularly some nineteenth and early twentieth century thinkers saw prostitutes and Africans as inherently racially inferior due to their supposed excessive sexuality.[27] As shall be shown, a sharp response to racism attached to black sexuality and fertility by the family planning and AIDS medical power/knowledge regime (of which there was a long history) was elicited by Africans, including some township youths, HIV

[25] Marks and Andersson. "Apartheid and Health", 668.
[26] Alan M. Brandt. "'Chapter I: Damaged Goods': Progressive Medicine and Social Hygiene", "Chapter IV: 'Shadow on the Land': Thomas Parran and the New Deal", *No Magic Bullet: A Social History of Venereal Disease in the United States Since 1880.* (New York and Oxford: Oxford University Press, 1987), 19, 147.
[27] Sander L. Gillman. "Chapter Three: The Hottentot and the Prostitute; Towards an Iconography of Female Sexuality". *Difference and Pathology: Stereotypes of Sexuality, Race and Madness.* (Ithaca and London: Cornell University Press, 1985), 79, 83, 98-101.

positive patients at Baragwanath, and more academicised responses from people like Chirimuuta and Chirimuuta.[28]

What would the fate of a black female nurse working for FPASA have been when confronted with black clients who rejected the 'neo-Malthusian rhetoric' of her organisation? Patience Tyalimpi was just such a women, being a Xhosa woman from the 'Transkei' who had trained in Mid-wifery at McCord's hospital in Durban and General Nursing at Baragwanath, amongst other professional attainments.[29] She started working at FPASA in 1970 as a Nursing Sister, Cytotechnician and Assistant Regional Organiser. Her document "Experiences of Family Planning Worker", which seems to have been some form of speech or address, subtly answered back to many of the racist elements of prevalent 'neo-Malthusian rhetoric'.

Contrary to Africans 'breeding like rabbits', in the Xhosa culture she was raised in the Transkei, fertility was presented by her as having been strongly regulated, with birth spacing and taboos on premarital and post-partum sex.[30] When the cytology laboratory in which she worked closed in 1981 she had the opportunity to "do public education, mainly in the Black community and industry", with women, youth and religious organisations.[31]

Unsurprisingly enough, it was the youth who were most hostile to her work, they often asked her the following type of questions:-

a) 'How can you work for such an organisation which tells Whites to increase their families, whilst they encourage Blacks to decrease theirs?'
b) 'What justification do you have in promoting family planning as a basic human right, when a host of our basic human rights, such as human dignity, education, housing, unemployment, and health are given limited recognition?'
c) 'What justification do you have to talk about a population explosion when 13% of the land is allocated to Blacks and many rural communities uprooted and resettled in barren areas?'
d) 'What justification do you have in promoting the use of Depo

[28] Richard and Rosalind Chirumuuta. *AIDS, Africa and Racism*. (London: Free Association Books, 1989).
[29] Patience Tyalimpi. "Experiences of a Family Planning Worker". FPASA: Transvaal Regional Correspondence etc. 1981-1989. AG2619.
[30] Tyalimpi. "Family Planning Worker", 1-3.
[31] Tyalimpi. "Family Planning Worker", 8.

> Provera when it is banned in countries like America?'.[32]

It was no simple feat to try to spread the type of information the FPASA and the state produced about family planning methods in the 1980s in townships. Black youth who were highly politicised could see through what they termed as 'the Black genocide', and the hated "Two is enough" adverts directed at Blacks which were placed on Putco buses in the townships.[33]

Furthermore, she claims that "the Black community saw us as agents of the government, identifying with the status-quo, especially the belief of the Black genocide".[34] In response to this she had had to adopt a "non-judgemental attitude characterized by understanding and accepting their feelings" about family planning.[35] For her if family planning were to be successful in South Africa family planning programmes would have to "move away from dealing with it on racial lines".[36]

To underscore that she used her position to push for a more rights-based model of family planning, it is worth looking at the closing sentences of her address. She unequivocally stated there the importance of "The stress on the dignity and worth of individuals", quoting psychologist Gordon Allport as having asserted

> No society holds together for long without the respect man shows to man. The individual to-day struggles on under oppression always hoping and planning for a more perfect democracy where dignity...will be prized above all else.[37]

To return to the critique of Foucault's theory of power as not offering enough agency, and having little space for resistance to power, Tyalimpi emerges as an 'in-between' figure, both having participated in Western biomedical regime's control of women's fertility and childbearing capacities, but not in a totalised system that denied her agency. To try to make the generalisation that African women were merely made into 'docile and useful bodies', by

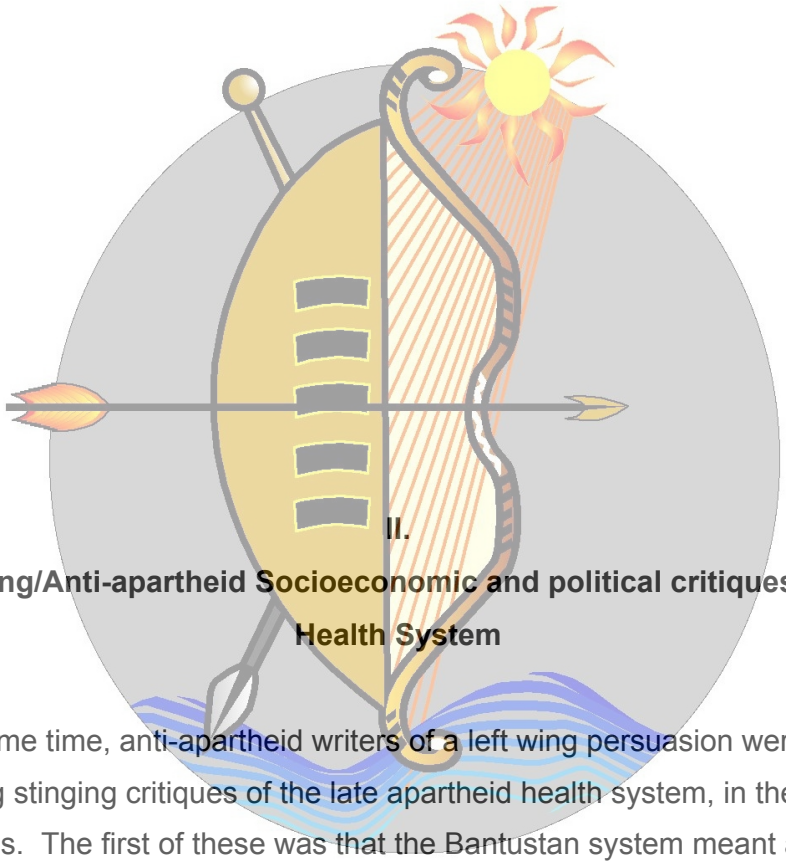
[32]Tyalimpi. "Family Planning Worker", 8.
[33]Tyalimpi. "Family Planning Worker", 9.
[34]Tyalimpi. "Family Planning Worker", 9.
[35]Tyalimpi. "Family Planning Worker", 9.
[36]Tyalimpi. "Family Planning Worker", 9.
[37] Tyalimpi. "Family Planning Worker", 9.

family planning in the Western biomedical paradigm, would deny the real historical role that she had as an agent and as a woman. In history it seems that women can be simultaneously both the jailer and the jailed in the 'iron cage' of modernity.

For those black youths in the townships who believed that state family planning policy was genocidal, was the state to be trusted when it distributed information about AIDS? The FPASA decided in 1987 not to produce its own AIDS policy or information pamphlets, the State Health AIDS Booklet would be distributed to the various FPASA clinics and offices.[38] By 1988 they were also planning a cocktail party with other NGOs like Lifeline, SANCA, and FAMSA to talk about 'family planning education and fertility control'; according to Louise Broomberg, who was by then Transvaal Regional Organiser "Now we have the threat of AIDS which has brought a new element of urgency into the picture...", which is where the condom manufacturers she wrote to could have helped FPASA.[39]

This request was not without reason, in 1987, according to an article entitled "A.I.D.S. SHOCK" from *Personality* magazine, cut out and included in the archive, the state had run out of condoms to distribute, in the light of growing demand due to the scare over AIDS.[40] In the same article the author referred to official assurances earlier in the year that "the killer virus had had only a minimal impact on the black community"; the article warned that the problem of a potential black heterosexual epidemic was very real, with several quotes from different medical and public health experts.[41] Predictably enough though, gays, bisexuals and prostitutes and migrants were given the blame in the article for spreading AIDS amongst heterosexuals.[42]

[38] Du Preez. "Memorandum to: Regional/Branch Organisers: Policy Statements". (4 March 1987). FPASA: Transvaal Regional Correspondence etc. 1981-1989. AG2619. (1987).
[39] Louise Broomberg. Untitled letter dated 25 March to Mr O'Malony of LRC Industries, (1988), 2.
[40] Peter Schirmer. "A.I.D.S. Shock". *Personality.* September 9, (1987), 17. Found in: FPASA: Transvaal Regional Correspondence etc. 1981-1989. AG2619.
[41] Schirmer. "A.I.D.S. Shock", 16.
[42] Schirmer. "A.I.D.S. Shock", 17.



II.

Leftwing/Anti-apartheid Socioeconomic and political critiques of the Health System

At the same time, anti-apartheid writers of a left wing persuasion were delivering stinging critiques of the late apartheid health system, in the mid- to late 1980s. The first of these was that the Bantustan system meant a duplication of health departments. The failure of the 'Gluckman' (National Health Services) commission in the 1940s to reform the health system and create one modelled on the British National Health System had been a tragic one for writers like Marks and Andersson.[43] Indeed, there were thirteen different Bantustan departments of health: this was a political manipulation

[43] Marks and Andersson. "Apartheid and Health", 676. Marks also posits this as a tragic failing in the history of public health in her book *Divided Sisterhood* on the history of nursing in South Africa: Shula Marks. "Chapter Five: In Control of Her Destiny". *Divided Sisterhood:*

that gave legitimacy to the Bantustan system.[44] As with colonial medicine in the late colonial era in other parts of Africa, medicine and the provision of health services were used to legitimate the government.

More crucially, the Bantustan health departments allowed the state to deny responsibility for rural health.[45] Since at least the 1920s, as Randall Packard showed, the migrant system had meant that tuberculosis (TB) had been spread to rural areas.[46] But, more importantly for the history of AIDS policy-making, the Bantustan system meant that the highly embarrassing numbers related to poor health indicators in rural areas could be shifted onto the Bantustans.

In the 1970s, for instance, the infant mortality rate was nearly three times higher in the Bantustans than amongst non-migrant Africans living in cities.[47] Packard somewhat ingeniously referred to the supposed statistical fall in TB, due to the Bantustan system as having been 'the great disappearing act':

> ...the apparent decline in TB incidence since 1965 has largely been an optical illusion, part of what has been referred to as South Africa's 'great disappearing act': the mass removal of millions of Africans to the already overcrowded reserves, alternatively labelled 'bantustans' 'homelands' and 'national states'.[48]

In such a context, claims by the state in 1987, cited above, that there was not a serious risk of a black heterosexual epidemic, that were referred to in the *Personality* article truly were based on guesswork. So far in all my research I have not found any material related to what HIV infection rates were in rural (Bantustan) areas in the 1980s. According to the evidence I have found, none of the ATICs that were being set up in the late 1980s had any coverage in

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Race, Class and Gender in the South African Nursing Profession. (Johannesburg: Witwatersrand University Press, 1994), 125, 132, 144.

[44] Marks and Andersson. "Apartheid and Health", 676.

[45] Marks and Andersson. "Apartheid and Health", 676.

[46] Randall M. Packard. "Introduction: Industrialization and the Political Economy of Tuberculosis". *White Plague, Black Labour: Tuberculosis and the Political Economy of Health and Disease in South Africa.* (Pietermaritzburg: University of Natal Press, 1990), 11.

[47] Randall M. Packard. "Chapter IX: Tuberculosis and Apartheid: The Great Disappearing Act 1948-1980". *White Plague, Black Labour: Tuberculosis and the Political Economy of Health and Disease in South Africa.* (Pietermaritzburg: University of Natal Press, 1990), 274.

[48] Packard. "The Great Disappearing Act", 252.

rural/Bantustan areas, in spite of the fact that the migrancy that existed in all these areas was a serious risk factor for the spread of an AIDS epidemic.

Aside from its enormous fragmentation, the health system was also facing increasing privatisation, as Max Price showed working at the embryonic University of Witwatersrand Centre for Health Policy (CHP). Price defined privatisation as being: the use of private funds for health care; reimbursement of health care providers on a fee-for service basis; and the existence of multiple private providers and privately owned health care facilities.[49] Privatisation was important in the distribution of financial and human resources in the health care sector. Roughly half of all doctors practising in South Africa were working in the private sector serving only the sixteen percent of the population covered by medical aid.[50]

Price rather convincingly argued that like the state's creation of the thirteen Bantustan health departments, the switch towards privatisation was a grasp at legitimising the state. Through privatisation, responsibility for health, a contentious political issue, could at least partially be shifted onto 'market forces'; black people who could afford it could use non-segregated relatively luxurious facilities; black nurses could work for more pay, and in better conditions, in private hospitals.[51] Put differently, Price argued that the state attempted to co-opt middle class black elites like nurses, and union leaders by offering them better social services and improved living conditions, albeit for a price.[52]

He also argued against privatisation, in so much as medical aid schemes excluded the poor and those at high risk of getting sick, or chronically, or

[49] Max Price. "The Consequences of Health Service Privatisation for Equality and Equity in South Africa". *Social Science and Medicine.* 27. (1988), 703.
[50] Price. "Health Service Privatisation", 704.
[51] Price. "Health Service Privatisation", 704-705.
[52] Price. "Health Service Privatisation", 704. Note here that union leaders in the 1980s often pushed in negotiations with employers for medical aid to be included as a part of benefits packages. Price is not necessarily arguing that the black 'elite' were indeed 'bought off' by this, merely that it led to a gradual draining of funds and personnel from the already collapsing public health infrastructure serving poorer Africans.

terminally ill.[53] In terms of the history of AIDS in South Africa, this would have had obvious potential to have meant discrimination against HIV positive people and would have added to the stigma and discrimination against them. However, his strongest argument against privatisation was that it was fundamentally inefficient: prices were not kept down in the private sector because it was profit orientated and because there was no incentive for consumers of medical aid schemes, or their service providers in the private sector, to keep costs down.[54]

The ANC-in-exile had argued similarly for the creation of a National Health System. It also aimed to present the poor condition of the health system as an indictment of the apartheid 'Pretoria regime'. An address by Alfred Nzo Secretary General of the African National Congress at the World Health Organization conference on Apartheid and Health held in Brazzaville in 1981 shows this

> Soon [at this conference] you will hear of the most shocking indicators of ill-health in South Africa. These will range from the politico-socio-economic indicators of dispossession, dehumanization poverty, hunger and death, and will also include [racial] disparities in indicators of health policy...we indict the Pretoria regime for genocide.[55]

According to Nzo, and the ANC-in-exile, what was called for was a "health revolution in service of our people", along the lines of what the Freedom Charter said of the issue in 1955

> ...a preventative health scheme shall be run by the State; free medical care and hospitalisation be provided for all, with special care to mothers and young children; the aged, the orphans, the disabled and the sick shall be cared for by the state.[56]

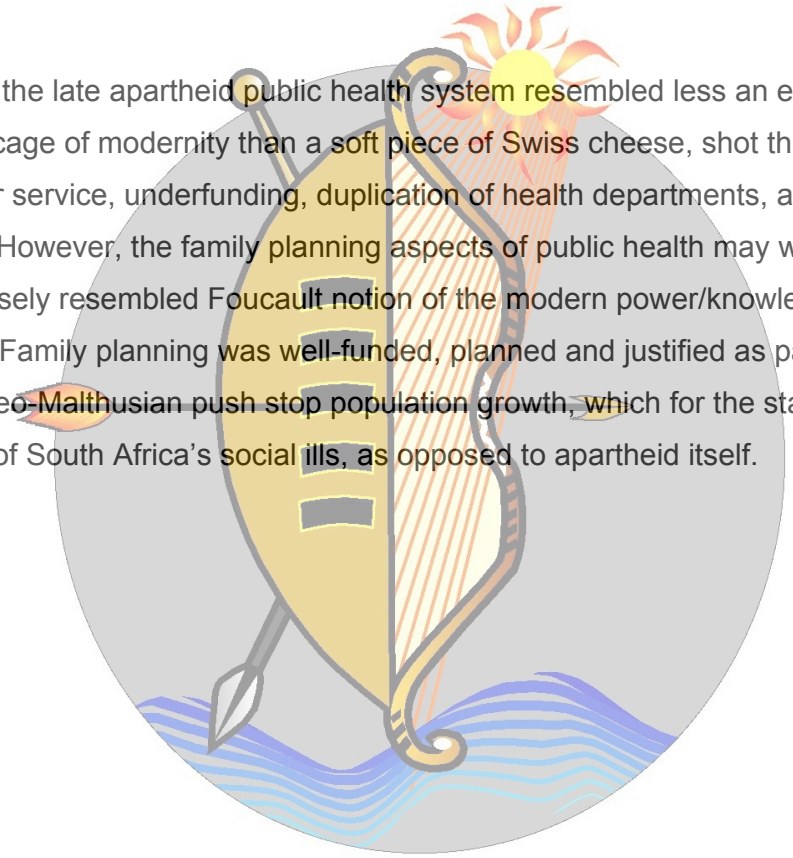
As the Chapter Three will show this noble vision would be stretched to its ultimate limits, and eventually even largely discarded by the post-1994 ANC

[53] Price. "Health Service Privatisation", 707.
[54] Price. "Health Service Privatisation", 708-709.

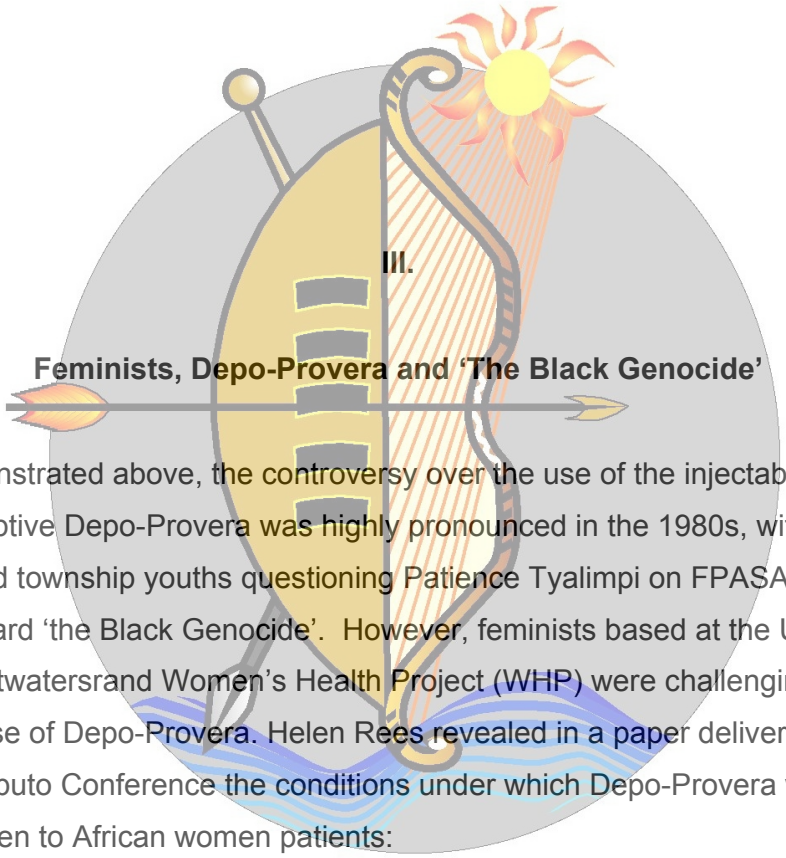
[55] Alfred Nzo. "Address by Alfred Nzo, Secretary-General of the African National Congress". *Health and Apartheid: World Health Organization.* Ed. Shula Marks. (Geneva: World Health Organization, 1983), 11.
[56] Nzo. "African National Congress", 12.

government, which increasingly faced an enormous health challenge from the mushrooming AIDS epidemic.

A strong critique of privatised and Bantustan-ised late apartheid health clearly emerges from the critiques of these anti-apartheid and leftist academics in the 1980s. The potential for resistance to power is clearly in evidence, using critiques based in Western humanism of the apartheid medical power/knowledge regime, in the way that Habermas and Fraser show is possible.



Perhaps the late apartheid public health system resembled less an example of the iron cage of modernity than a soft piece of Swiss cheese, shot through with poor service, underfunding, duplication of health departments, and racism. However, the family planning aspects of public health may well have more closely resembled Foucault notion of the modern power/knowledge regime. Family planning was well-funded, planned and justified as part of the state's neo-Malthusian push stop population growth, which for the state lay at the root of South Africa's social ills, as opposed to apartheid itself.



III.

Feminists, Depo-Provera and 'The Black Genocide'

As demonstrated above, the controversy over the use of the injectable contraceptive Depo-Provera was highly pronounced in the 1980s, with politicised township youths questioning Patience Tyalimpi on FPASA's use of it to forward 'the Black Genocide'. However, feminists based at the University of the Witwatersrand Women's Health Project (WHP) were challenging the state's use of Depo-Provera. Helen Rees revealed in a paper delivered at the 1990 Maputo Conference the conditions under which Depo-Provera was being given to African women patients:

> "On a much larger scale we are seeing the abuse of injectable contraceptives. A joke that comes out of many of our black hospitals is that depo [-provera] is the fourth stage of labour. Many women do not give their informed consent for the injection, and women who try to refuse are given a hard time.".[57]

Factory owners were also coercively injecting black female workers with Depo-Provera, in the Western Cape and Natal, on pain of losing their jobs.[58]

[57] Helen Rees. "Women and Health in South Africa- Towards a Women's Health Charter". Paper presented at the 1990 Maputo conference on Women's Health. WHP Archive. 1.3; 678. (1990), 7.

It would also be interesting to speculate what role the Durban City Council's 'family planning awareness talks' in Durban factories in the 1980s may have played in this type of workplace company health policy. From oral sources I have also discovered that figures like Barbara Klugman of the Women's Health Project, steered the campaign against indiscriminate and coercive administration of Depo-Provera to black female patients.[59]

This is not to say that feminist health activists were saying that black women did not want to use contraceptives, period. Far from it, as the Durban MOH Reports from the 1980s show 'ex-city' (from 'across the KwaZulu border' surrounding places like KwaMashu) black women were flocking into town to the municipal clinics to gain access to contraceptives, wanting to use them so much that they were even prepared to give bogus addresses to qualify for treatment within city limits.[60]

Feminist health activists like Rees began critiquing the state's AIDS policy. For Rees, the state's policy of giving AIDS education hardly anywhere else other than at antenatal clinics excluded high risk women who did not attend antenatal clinics as much, like teenagers and poor women.[61] Men's engagement in multiple relationships, prostitution caused by poverty and migrancy, and women's weak position to negotiate condom use in the gendered power dynamics of relationships, all fuelled the epidemic, which disproportionately affected women.[62]

For Manto Mabalala Msimang of the ANC, who presented a paper at the same 1990 Maputo conference similar social gendered dynamics were at work in the spread of AIDS amongst women:

> In a situation where women have no control over their fertility and the sexual behaviour of their partners, the prevention of

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[58] Rees. "Women and Health", 7.
[59] Interview, by the author, with Marion Stevens of the CHP, a former employee of the WHP, Johannesburg, August 2001.
[60] Annual Report of the City of Durban City Medical Officer of Health. (Durban: Durban City Council, 1986), 59.
[61] Rees. "Women and Health", 10.
[62] Rees. "Women and Health", 11.

AIDS becomes difficult.[63]

She went on in the paper to argue that prostitution, created by migrancy, was the main cause of the spread of AIDS, and that changes in the social conditions leading to prostitution needed to change, as prevention was not just about condom promotion.[64] As shall be shown in Chapter Three Mabalala Msimang would go on to become Minister of Health in the ANC government in 1999, endorsing President Thabo Mbeki's AIDS denialism.

In both these papers presented at the 1990 Maputo conference AIDS only demanded the attention of a few paragraphs; there were other seemingly more pressing issues, like women's economic status, dismantling apartheid, legalising abortion and reducing maternal mortality. Also, given the fact that both attributed the spread of AIDS to prostitutes, how much of a threat could it really be seen to constitute to 'ordinary', 'non-promiscuous women'? Roth and Hogan have pointed out that the slowness of the response by the feminist community in America to the threat of AIDS was linked to the distorted perception of 'ordinary' women's risk that many feminists had in at least the first decade of the epidemic.[65]

An important element to all feminist history, including this dissertation project, is the assertion of women's agency as historical actors. This is something a Foucauldian paradigm of the 'iron cage of modern power' at times seems to rule out. Women often know that ideas and institutions descended from the Western humanist tradition have both oppressive and liberating possibilities, and use whatever means available to gain the positive elements and fight the negative. All the women referred to as historical actors in this section of the chapter, utilised their agency as actors to articulate humanistically based arguments to push not only for reform to family planning policy, for it to become more orientated around the rights and needs of women, but also to

[63] Manto Mabalala Msimang. "An Overview of Some of The Considerations in Formulating Policy on Women's Health". Paper presented at the 1990 Maputo conference on Women's Health. WHP Archive. 1.3;27. (1990), 2.
[64] Mabalala Msimang. "Policy on Women's Health", 2.
[65] Nancy Roth and Katie Hogan. "Chapter Seven: Maybe Next Year: Feminist Silence and the AIDS Epidemic". *Gendered Epidemic: Representations of Women in the Age of AIDS*. (New York and London: Routledge, 1998), 118, 136, 138.

argue that women were in a gendered way more vulnerable to AIDS, and that policy would have to take this into account.

All this goes to show the immense utility of the normative framework of humanism for rights-based political projects, as shown by Fraser and Habermas. Monique Deveaux, has similarly argued that autonomy is particularly important to any feminist political project, or conception of power, based on humanist visions of self-actualisation, self-definition, self-determination and empowerment; all of which are denied in Foucault's all encompassing vision of power and rejection of identities based on sex.[66] Deveaux goes on to argue that Foucault's dismissiveness of sex as a rallying point for resistance to the deployment of sexuality denies the personal and political affirmation that gay and gendered identities can offer:

> Isn't it necessary, both for reasons of personal affirmation and political efficacy- in order to make rights-based claims, for instance- to assert the existence of 'categories' of women, lesbians and gay men?[67]

Whilst it is important to consider multiple and shifting meanings attached to sexed and gendered identities, Deveaux points out that participants in political and social movements orientated around sexual and gendered identities creatively perceive and inhabit their identities.[68]

Without any type of autonomy or agency, though, what capacity do women have to act in the history, except as robotic cogs in the machine of the modern power/knowledge regime? The evidence that I collected of women's mobilisation against a model of family planning which was not rights-based, and their focus on the gendered conditions that made women vulnerable to AIDS, would tend to indicate that women did resist, even under the difficult

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[66] Monique Deveaux. "Feminism and Empowerment". *Feminist Studies.* 20 (2). (1994), 241. Judith Butler has also, in a very much Foucauldian mold, taken up these ideas to argue that sex is fundamentally performative, a contructed fantasy made up by the disciplinary power/knowledge regime. According to Deveaux's account of her work, for Butler, sex in its undeconstructed, binary form is not a viable basis on which to build political programs. See: Judith Butler. "Chapter 35: Excerpt from 'Introduction' to *Bodies that Matter". The Gender/Sexuality Reader: Culture, History, Political Economy.* Eds. Roger N. Lancaster and Micaela di Leonardo. (New York and London: Routledge), 532.

[67] Deveaux. "Feminism and Empowerment", 241-242.

[68] Deveaux. "Feminism and Empowerment", 241-242.

conditions of apartheid, using humanist rights-based discourse the policies of what could be termed as the medical/state/corporate family planning and AIDS policy-making power/knowledge regime.

IV.

Political Changes and the Shift of Left/Feminist Critiques to the Mainstream of Public Health Theory and Praxis

1990 marked a clear watershed in South African history. With President F. W. De Klerk's unexpected announcement of the unbanning of the ANC and the Pan-Africanist Congress, the dramatic release of ANC leader Nelson Mandela from prison and the beginning of negotiations for constitutional change, the landscape of the possible in South African public health policy-making changed. In the same year, statistical modelling of the potential growth of the AIDS epidemic became more sophisticated which sparked off an enormous growth in interest by public health theorists and practitioners in the problem of AIDS. Discourse around family planning, by the branches of the local state, such as the Durban city council public health machinery, also began to change towards the new 'non-racial' and rights-based model of the new polity which was in the making.

Helen Schneider of the CHP, when recently interviewed for this dissertation project, credited the projections and development of the Doyle model with stimulating her first major interest in AIDS as a public health policy problem, in the early 1990s.[69] Peter Doyle, an actuarial scientist at Metropolitan Life

[69] Interview, by author, with Helen Schneider, Director of the Centre for Health Policy, Johannesburg, August 2001.

insurance company developed an important actuarial model for predicting the future spread of the AIDS epidemic in South Africa.[70]

By 1993 Doyle had published some important findings for the future of the epidemic in South Africa. He predicted that the AIDS epidemic would peak at a prevalence rate below thirty percent.[71] He, and other expert statisticians and economists, made startlingly accurate predictions, with important implications for South Africa's political and economic life, which bear out quoting at some length:

> The HIV epidemic will cause sickness and death of many young adults in South Africa and could have the following critical effects; many of those affected will be skilled and educated persons in the workplace and this will affect productivity and training. It is likely that health-care facilities will be placed under severe pressure, and difficult policy decisions will be required about treatment of persons with AIDS...Many family units will be affected, creating large numbers of orphans and a noticeable change in the structure of the population.[72]

Solomon Benatar, in a 1991 article in the *New England Journal of Medicine*, also made remarkably accurate predictions about future HIV prevalence in South Africa. He estimated that prevalence would be about thirty percent of the population within ten years.[73] By 1989, according to Benatar, 0,45% of black male blood donors and 0,49% of black female blood donors tested HIV positive.[74] In the same vein 1,38% of black male and 1,95% of black female STD clinic attenders in Johannesburg had tested HIV positive.[75]

Simultaneously, in the early 1990s AIDS became predominantly heterosexual in Durban with the number of HIV positive heterosexuals exceeding the number of HIV positive 'homosexuals' for the first time in the city in 1990, according to the Durban City MOH Reports.[76] HIV testing began to be offered

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[70] Peter Doyle. "The Demographic Impact of AIDS on the South African Population". *Facing Up to AIDS: The Socio-Economic Impact in Southern Africa.* 87,110-111
[71] Doyle. "The Demographic Impact of AIDS", 110.
[72] Doyle. "The Demographic Impact of AIDS", 110.
[73] Solomon Benatar. "Medicine and Health Care in South Africa - Five Years Later". *The New England Journal of Medicine.* 325 (1). (1991), 34.
[74] Benatar. "Medicine and Health Care", 34.
[75] Benatar. "Medicine and Health Care", 34.
[76] City of Durban Annual Report of the City Medical Officer of Health. (Durban: Durban City Council, 1990), iii.

on a much wider basis to all frequent STD clinic attenders and all patients with STDs causing genital ulceration; of those tested in 1990, 5,9% turned out to be HIV positive.[77] HIV infection in Durban was certainly higher in the late 1980s and early 1990s than in Johannesburg, as is shown by a comparison of the figures that Benatar and the MOH reports gave for HIV prevalence amongst STD clinic attenders in Johannesburg and Durban.

Crucially though, changes began bubbling beneath the surface of the rhetoric of family planning and AIDS policy in the Durban city health machinery. Women had the "...right to health and protection from disease and unwanted pregnancy".[78] At least in terms of rhetoric, this represents a shift towards the idea that women and not the state had the 'right' to have control over their own bodies and health. It was at least a superficial shift towards the type of rights-based discourse that this chapter aims to chart. Clients who were sexually active and didn't use contraception "for no good reason" were still, however, referred to as 'problem clients'.[79] This indicates that in spite of the family planning advisor's putative "holistic approach which sees the woman (or teenager) in the context of her community and family", perjoratives were still attached to women who were deemed to not be exercising adequate 'control' over their fertility.[80]

The Durban ATIC expanded in 1990 to have four new staff members including a doctor, a clinical psychologist and a counsellor/educator; they trained AIDS Educators and Counsellors at a rapid rate.[81] ATIC was by this stage working in other regions of Natal province, and had a wider reach. They found that of the people who tested positive for HIV, a substantial proportion were black heterosexuals.[82]

[77] Durban 1990 MOH Report, 45.
[78] Durban 1990 MOH Report, 47.
[79] Durban 1990 MOH Report, 47.
[80] Durban 1990 MOH Report, 48.
[81] Durban 1990 MOH Report, 123, 126.
[82] Durban 1990 MOH Report, 129.

By 1991 14,3% of STD clinic attenders were testing positive.[83] The education section of city health was deciding though that it needed

> ...a more modern approach- more group participation rather than top-down talks- more community involvement and a more holistic approach to health matters.[84]

Clients no longer belonged to 'Race groups' but were now members of 'Community groups', though still defined according to apartheid racial categories of 'Black', 'White', 'Coloured' and 'Indian'.[85] As family planning had received hefty and skewed state subsidy, relative to public health in general, in late apartheid, the City Health family planning department might have been arguing its corner by statements like this, hoping for a post apartheid government to keep family planning funding at the same high levels as during late apartheid.

The family planning activities of City Health became more and more explained in terms of the new rhetoric of the 'new' South Africa emerging from the negotiations. It now served women 'of all community groups' and more importantly,

> As the political and economic climate in the Republic of South Africa changes, so the need for family planning becomes both more critical and more difficult to promote.[86]

In the same year the Regional AIDS Planning Sub-Group of the Regional AIDS Advisory Group, bringing together different major role players in Natal/KwaZulu began to hold workshops with different commissions delegated to discuss issues like Counselling, Care, Education, Legal and Ethical issues, Research and Condom Distribution.[87]

However, for critics like Benatar, key aspects of the failings of the late apartheid health system in the 1980s remained in the early 1990s, with the government still in favour of a two tier health system, and the ANC still not

[83] City of Durban Annual Report of the City Medical Officer of Health. (Durban: Durban City Council, 1991), 46.
[84] Durban 1991 MOH Report, 51.
[85] Durban 1991 MOH Report, 60.
[86] City of Durban Annual Report of the City Medical Officer of Health. (Durban: Durban City Council, 1992), iv.
[87] Durban 1992 MOH Report, 122.

having a coherent policy.[88] According to Benatar by 1986 3,3% of Gross National Product (GNP) was being spent on public health care as opposed to the 2,6% of GNP spent on private sector health care; only 53% of all expenditures on health care in South Africa were in the public sector serving 80% of the population.[89] The rapid urbanisation of the late 1980s and early 1990s was causing enormous pressure to be placed from at least 1986 onwards on large public hospitals, especially teaching hospitals.[90]

One such large hospital, to which Benatar referred, was Baragwanath hospital in Soweto Johannesburg, which was creaking under the strain of the drain of finances and personnel into the private sector, serving the urban African poor, and beginning to face the impact of AIDS in the early 1990s. A series of articles appeared in the *SAMJ* in 1992 outlining how Baragwanath was dealing with AIDS. According to Friedland *et al* Baragwanath had seen HIV positive patients since 1985 and from 1987-1988 began a counselling and training programme to give information and support to HIV positive patients and eliminate discriminatory practices amongst staff.[91]

Kaerstadt pointed out in article three of the series that "The major brunt of the HIV epidemic in South Africa in expected to be borne by heterosexual adults and infants in the black population".[92] The nascent counselling project to train nurses (mostly African) as counsellors was aimed at addressing the stigmatisation of patients who were 'People with AIDS' (PWAs). Prior to when the programme to train 'nurse-counsellors' was implemented HIV infected patients were apparently, labelled, isolated and stigmatised before being told that they were HIV positive.[93]

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[88] Benatar. "Medicine and Health Care", 30.
[89] Benatar. "Medicine and Health Care", 32-33.
[90] Benatar. "Medicine and Health Care", 31.
[91] I.R. Friedland, K.P. Klugman, A.S. Karstaedt, J. Patel, J.A. McIntyre, C. W. Allwood. "AIDS-the Baragwanath experience. Part I. Epidemiology of HIV Infection at Baragwanath Hospital, 1988-1990". *South African Medical Journal.* 82. (1992), 86, 88.
[92] Kaerstad, A.S. 1992. "AIDS: the Baragwanath experience: Part III. HIV infection in adults at Baragwanath hospital". *South African Medical Journal.* 82. (1992), 95.

The aims of the nurse-counsellor project were to: provide short term support to patients, while in hospital; give patients information about their condition; teach patients how to avoid spreading the disease; encourage patients to tell doctors, nurses and sex partners; tell patients how to improve their quality of life and what community services were available after their discharge.[94] However, it was not all plain sailing with meeting those aims, for two linked reasons: firstly, the nurses often had very heavy workloads, and so AIDS counselling over and above regular nursing duties exacted a heavy burden; secondly, the behaviour expected of the patients as infectious HIV positive people often did not tie in with their own worldviews, aims for their lives and understandings of AIDS.

Much to the article writers' dismay HIV positive patients were often most concerned about their jobs and having more children, than their lifespans or practising safe sex with partners; they had often not known anyone with AIDS and

> ...sexuality is not often a subject spoken about but presumed an inalienable right for men...AIDS was seen as a 'white illness' and teaching about it was seen as another attempt to deny people pleasure...[it had] no genital manifestations...traditional healers had been known to say it was not a new disease, but an old one they could cure.[95]

The reference to "another attempt to deny people pleasure" may be referring to the resistance to late apartheid family planning policies in townships that Patience Tyalimpi encountered. Like family planning, AIDS may have been seen by some patients as some sort of conspiracy/plot to deny them sexual pleasure and freedom to enjoy and utilise their fertility.

Nurse-counsellors also began to feel stressed and vulnerable about being exposed to the same social and gendered factors of multiple sexual partners amongst men and resistance to condoms that made their patients vulnerable to HIV infection

As women exposed to the same factors in society that caused the patients

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[93] C.W. Allwood, I.R. Friedland, A.S. Kaerstaedt, J.A. McIntyre. "AIDS- the Baragwanath experience. Part IV. Counselling and ethical issues". *South African Medical Journal.* 82. (1992), 98.
[94] Allwood *et al.* "Baragwanath: Counselling and ethical issues", 98.
[95] Allwood *et al.* "Baragwanath: Counselling and ethical issues", 100.

> to become infected, the counsellors expressed anxiety and anger when they realised their own vulnerability.[96]

The common reaction of anger on the part of patients, as opposed to guilt or remorse, may have had something to do with the fact that most patients were tested for HIV as a part of a battery of investigations without their consent;[97] under such circumstances, where patients' right to informed consent was obviously violated, it can hardly have been easy for nurse-counsellors to break the news that they were HIV positive. The article also implied that guilt, or remorse, would have been more appropriate responses, implying that HIV positive patients had to have committed some sort of 'sin' in becoming infected and needed to 'repent'. Therefore, it possible to link it to older discourses of STDs as linked to 'sin' and requiring fundamental 'moral' behaviour changes over a non-judgmental technical, medical, or public health response based around treatment, prevention and prophylaxis.[98]

The response of Baragwanath probably boiled down more to an attempt to be ethical in dealing with patients, than to protect patients rights. Indeed, patients were not counselled as to what their rights were, but reminded of their 'responsibility', primarily, not to infect others. Although lip service was paid to informed consent for testing and non-discrimination, these terms are not unpacked or debated in the articles. Was not AIDS, though, a socially created monster derived from poverty and gender, race and class inequality in South African society? Blaming the 'irresponsible individual' did not recognise the social causes of AIDS, let alone attempt to analyse them in the way, that a new set of studies on fusing biomedical and social-scientific approaches would.

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[96] Allwood *et al.* "Baragwanath: Counselling and ethical issues", 100.
[97] Allwood *et al.* "Baragwanath: Counselling and ethical issues", 98.
[98] Megan Vaughan has charted this sort of conflict in colonial African medicine, as has Alan Brandt in this history of 'venereal disease' management in twentieth century America. In Allwood et al's defence though, in the case of AIDS there wasn't yet the type of sophisticated anti-retroviral drug combination therapy, or anti-retroviral prophylaxis that is available now, making a straightforward, instrumental, morally-neutral, effective medical solution possible, in the same way the invention of the 'magic bullet' altered syphilis discourse. See: Alan M. Brandt. *No Magic Bullet: A Social History of Venereal Disease in the United States Since 1880".* (New York and Oxford: Oxford University Press, 1987), 50-51.; Megan Vaughan. "Syphilis and Sexuality". *Curing Their Ills: Colonial Power and African Illness.* (Cambridge and Oxford: Polity Press, 1991), 148-149.

This shift to a more 'ethical' approach to dealing with HIV positive patients was also evident in a Communication Strategy produced in 1991 by the National Dept of Health and Population Development. Longer term aims spoken about in the strategy included rights based ones like "prevention of discrimination [against HIV positive people]", and "An improvement in the status of women'.[99] For the national government's health department, by 1990, "AIDS and STDs have severe consequences on all social, economical, educational, demographic, political, health, legal and ethical levels of society", which called for a "multisectoral approach".[100]

However, for all the high sounding ethical and rights-based shifts in discourse "Minimal budgetary provision" was made available, necessitating "fundraising campaigns".[101] As budgets are usually an indication of a state's political commitment to an issue, the fact, by its own admission, that the Department had basically been allocated 'peanuts' would tend to indicate, in spite of the rhetoric about the non-discrimination against HIV positive people, that it was less than serious about spreading AIDS prevention messages to the public; let alone spending on the creaking, fragmented health system in a way that truly would have helped people with HIV receive better care.

[99] "National Communication Strategy". Pretoria: Department of National Health and Population Development, South Africa, AIDS Unit. (1991), 3. University of Witwatersrand, Centre for Health Policy Resource Centre. 3036.
[100] "National Communication Strategy", 11.
[101] "National Communication Strategy", 14.

V.

More In Depth Studies start appearing: The Pollution Complex, Sexism and Prostitution

Commercial sex work formed the focus for several key studies in the 1990s which revealed the complex social and cultural ways that AIDS interacted with gender. As opposed to the unsubstantiated and under-analysed assertions that prostitution was to blame, which were commonly made by medics, and even feminist activists, these studies showed way that prostitutes saw themselves and the barriers that they faced to getting clients to use male condoms. They emerged from these studies as poor women, with little bargaining power to negotiate condom use. Therefore, they were very vulnerable to HIV infection, which they were keen to avoid.

An instance of such a study is the one conducted by the Abdool Karims and Zondi, which appeared in the *American Journal of Public Health* in 1995.[102] The article was an epidemiological study of prostitutes and truck drivers at a truck stop, attempting to explain why prostitutes and truck drivers they serviced along truck routes in Kwa-Zulu/Natal seemed not to be changing their sexual practices to prevent HIV and STD infection.

The study found that prostitutes were unable to negotiate male condom usage, in part because of the context of violence in which they worked.[103] Clients with whom they attempted to use condoms sometimes beat them up, due to feeling sexually unsatisfied, and condom use was often linked to client

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[102]Quarraisha Abdool Karim, Salim S. Abdool Karim, Kate Soldan and Martin Zondi. "Reducing the Risk of HIV Infection among South African Sex Workers: Socioeconomic and Gender Barriers". *American Journal of Public Health.* 85 (11): 1521-1525.
[103] Abdool Karim *et al.* "HIV Infection among South African Sex Workers", 1521.

loss and non-payment.[104] Those who used condoms, used them infrequently for the above reasons.[105]

Vaginal douching, with Dettol, Jik, Savlon and traditional herbal poultices, was found to be a common practice amongst the women to prevent pregnancy and STDs, a practice that the authors pointed out had been linked to ascending genital tract infection in women.[106] It is interesting to speculate that such douching may be linked to the notion in Zulu culture, highlighted by Harriet Ngubane, that women's bodily emissions during sex are polluted and dangerous to male virility.[107] Either way, it is a cruel irony that the very method women were trying to use to prevent STD infection may have in fact aided it. Far from the 'irresponsible' vectors of disease image of black prostitution that the Shoub *et al,* and Marais *et al SAMJ* articles present, in reality these poor and disempowered group of women were trying within their limited means, and from their incomplete knowledge base, to prevent STD infection. The article ended by arguing that these women needed access to barrier methods they could control, arguing for more research into possible prevention methods like vaginal microbicides.[108]

Catherine Campbell's excellent work on prostitution and AIDS around the mines at Carltonville in Gauteng province in made similar points, but went a little further into looking at the narratives prostitutes made around their lives.[109] Due to the social stigmatisation of their profession, the prostitutes she interviewed only reluctantly admitted the nature of their occupation, that is that they had sex with men for money.[110] They structured their life stories in such a way as to claim they were forced into becoming prostitutes. Campbell asserted that strong, if informal bonds existed between the prostitutes, who

[104] Abdool Karim *et al.* "HIV Infection among South African Sex Workers", 1523.
[105] Abdool Karim *et al.* "HIV Infection among South African Sex Workers", 1523.
[106] Abdool Karim *et al.* "HIV Infection among South African Sex Workers", 1522, 1524.
[107] Harriet Ngubane. "Chapter Five: Pollution". *Body and mind in Zulu Medicine: An Ethnography of health and disease in Nyuswa-Zulu thought and practice.* (London: Academic Press, 1977), 93-95.
[108] Abdool Karim *et al.* "HIV Infection among South African Sex Workers", 1524.
[109] Catherine Campbell. "Selling sex in the time of AIDS: the psychosocial context of condom use by sex workers on a Southern African mines". *Social Science and Medicine.* 50. (2000), 482-483.

helped each other if they became sick or were beaten up by a client.[111] These bonds were what prostitutes in that community would have to build upon if they were to have forced a change towards condom use. All the prostitutes would have had to have switched to insisting their clients wore condoms, or other women would have made more money by having agreed to have sex with men without them, hence, having reduced the ability of the women who did insist on condoms to have had clients, or have made money.[112]

According to Campbell, the very nature of most commercial sexual encounters these women engaged in militated against condom use. Mostly consisting of brief encounters costing twenty rand, in the veld around the mines, with the only conversation being about prices, condom negotiation was almost impossible as it involved discussing issues of health, masculinity, and risk of STD infection.[113]

A picture then emerges from these two studies of women who wanted very strongly to protect their health, but were prevented by socio-economic and cultural circumstances, very much bound up with their gender from doing so. Separating 'ordinary' heterosexual women from prostitutes may not have been so simple though; many women, in South Africa, were in economically dependent relationships, and while they didn't necessarily openly sell their bodies to strangers, were oppressed by the same violence and refusal of men to wear condoms. Indeed, the rigid distinctions which existed in AIDS discourse between 'low risk' and 'high risk' women and promiscuous and non-promiscuous women may have been not only misguided, but lethal to women who didn't perceive themselves to be at risk and don't take necessary precautions.

Citing Mhoyi and Mhoyi's 1994 study in Uganda and Zimbabwe Kitts and Hatcher Roberts have argued that

> Consistent with the frequent belief that sexually transmitted diseases

[110] Campbell. "Selling sex", 485.
[111] Campbell. "Selling sex", 485.
[112] Campbell. "Selling sex", 487.
[113] Campbell. "Selling sex", 484.

> are a 'women's disease' and that women are 'reservoirs of infection' or vectors of transmission, whereas men are victims, the majority of respondents thought that AIDS was caused by women, prostitutes and soldiers.[114]

They also have pointed out that many married women, or women in stable relationships find it hard to think of themselves as being at risk of HIV infection: this can be summarised as being the 'not my man' or 'he would never' attitude, that such women often can't accept that their partners could have been cheating on them.[115] Whilst it was inaccurate and unfair to blame HIV/STD infection solely on women, it was important for women to have a true understanding of their risk profile. It is precisely these tragically mistaken beliefs that they were not at risk, which may have exposed many 'faithful' women to STDs, and HIV.

Furthermore, the efforts that some South African women were forced to go to so as to be 'hygienic' and 'unpolluted', increased their risk of HIV and STD infection. Practises like dry sex (inserting preparations into the vagina to dry it out, to make it seem more pleasing and 'clean' to men) increased women's chances of contracting these diseases.[116]

It might be tempting here to enter into the old trap that Western culture, colonial medicine, and even some medical academics in the eighties did and turn this into an exercise of 'blaming the victim'. However, in spite of the fact that women agreed to and even perpetuated these types of practices and consented to unprotected sex, sexuality is socially mediated as Campbell has persuasively argued.[117] It was not simply a matter of giving 'rational agents' 'the facts' and trying to get them to follow them: structural socio-economic and cultural constraints operate on the sexuality of individuals, especially if they happened to be women.

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[114] J. Kitts and J Hatcher Roberts. "Chapter Four: AIDS". *The Health Gap: Beyond Pregnancy and Reproduction.* (Ottawa: International Development Resource Centre, 1996), 57.
[115] Kitts and Hatcher. "AIDS", 60.
[116] Kitts and Hatcher. "AIDS", 72.
[117] See: Catherine Campbell, Yodwa Mzaidume and Brian Williams. "Gender as an Obstacle to Condom Use: HIV Prevention amongst commercial sex workers in a mining community". *Agenda: A Journal About Women and Gender.* 39. (1998), 51.; Campbell. "Selling sex", 480.

In her study on black HIV positive women in the Western Cape published in *Agenda* in 1992, Anna Strebel identified two crucial common traits: "A striking feature of these black women living with AIDS was their lack of economic independence and security"; they also had "...a powerlessness to influence their lives".[118] Condom usage often necessitated discussion of STDs, and because STDs had been so strongly linked to prostitution, female 'pollution' and female promiscuity, historically, a strong stigma had existed around their usage, or even discussion of it. Strebel showed that threats of physical violence and suspicions of unfaithfulness operated as a strong disincentive to use condoms for black women living with HIV in the Western Cape in the early 1990s.[119]

The pollution complex in Western and African cultures, the stigma around women as inherently polluted and diseased, and prostitutes, as some how summarising the evils of female sexuality would have to be addressed if effective public health policy were to have been made around STDs and AIDS. A more sophisticated a degree of social analysis of prostitution and gendered forms of oppression linked to sexuality that women faced, would take some time to filter down to health policy, at least at a local level.

The rhetoric underpinning family planning policy would undergo a massive change though. In Durban according to the 1993 MOH report, family planning officials were to go into communities "sensitive to the broad issues of socio-economic development and address problems in a holistic fashion" and to avoid being narrowly seen as being involved in 'birth control', with all the "negative connotations" that attracted.[120] The focus was to shift power over 'sexual health' to the individual and making her confident and comfortable about sex and sexuality; family planning could even become a part of

[118] Anna Strebel. "'There's Absolutely Nothing I Can Do, Just Believe in God': South African women with AIDS". *Agenda: A Journal About Women and Gender.* 12. (1992), 52, 56.
[119] Strebel. "'There's Absolutely Nothing I Can Do'", 58.
[120] City of Durban Annual Report of the City Medical Officer of Health. (Durban: Durban City Council, 1993), 49.

"affirmative action", as they quoted from the *Lancet,* by helping women "escape from the confines of their own bodies".[121]

The heady rhetoric of development, and family planning as affirmative action, in the Durban City MOH Report, probably did not reduce women's vulnerability to AIDS. The Report quoted World Bank estimates that of Durban's population, 2,3 million people were living in "low income settlements"; over 50% of people living in these 'low income settlements' had "seriously deficient levels" of basic essential services.[122] Approximately 400 000 condoms, meanwhile, were distributed at three hundred and two distribution points in Durban.[123] That was enough free condoms for each of the people living in 'low income settlements' to have had protected sex 0,17 times in that year. Clearly condom distribution was inadequate and probably a very small proportion of people living in 'low income settlements', or any other part of Durban for that matter, were regularly using the free condoms the Durban council provided for sex. The rhetoric was clearly not matched by the type of aggressive campaign, or funding for such a campaign, that the high general prevalence, indicated by a 14% infection rate amongst STD clinic attenders, would have tended to show the need for.

Whilst the ATIC section of the Report admitted that in spite of general public awareness about the threat of AIDS, few were changing their behaviour in line with public health messages, no analysis of why that was the case was offered in the report, or whether city health's campaigns were making any difference in terms of slowing the spread of the epidemic.[124] This would tend to cast serious doubts over whether the framing of their family planning policy as affirmative action for women, as female empowerment designed as a development strategy that formed part of the discourse of the era of 'transformation' and 'change' in the new South Africa, in any way went beyond

[121] Durban City MOH 1993 Report, 49.
[122] Durban City MOH 1993 Report, 49.
[123] Durban City MOH 1993 Report, 55.
[124] Durban City MOH 1993 Report, 113.

the fashionable rhetoric in empowering women to protect themselves against contracting HIV

The 1994 Durban MOH Report continued in the same vein, keen to present their work in terms of the rhetoric of female empowerment, commonly part of election platforms in the first democratic elections that year: the report claimed that

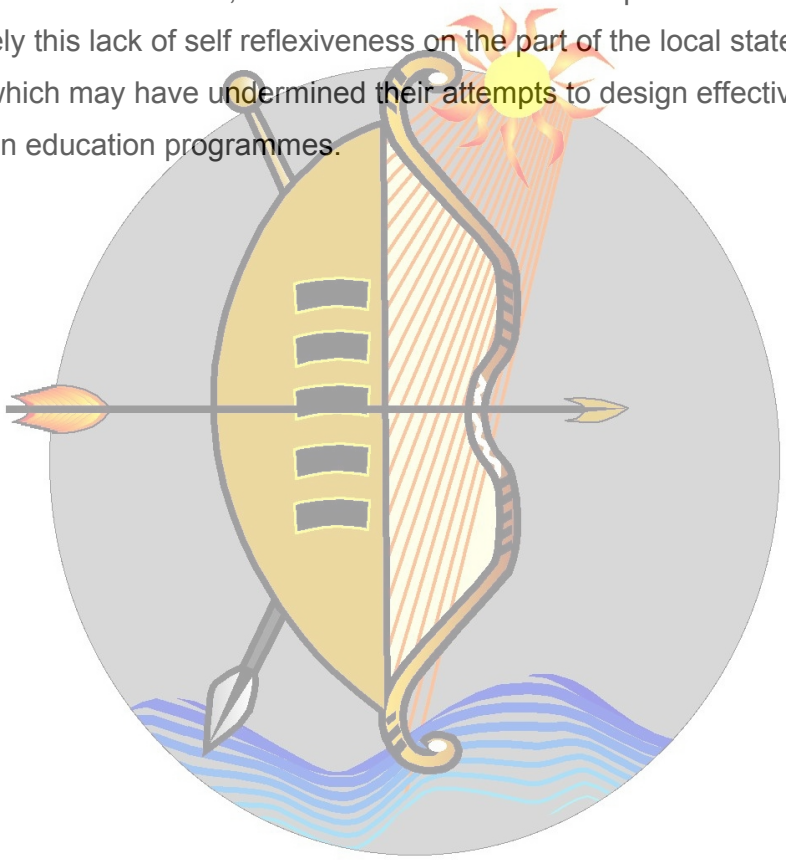
> The prominence given to women's issues and sexuality education by many political spokespersons in 1994 gave extra credence to the work being done by family planning advisors...[they] were able to feel comfortable with their chief objectives of empowering women and teenagers so that they can stand by their rights to control their own fertility.[125]

But the rapid spread of AIDS tended to reveal the hollow-ness of the rhetoric of family planning allowing women to control their own bodies with the help of family planning officials in the new South Africa. That same year there were still 13 484 new female cases of STDs seen at the municipal clinics.[126] Furthermore, the 1993 fourth annual antenatal prevalence survey had shown an HIV prevalence among pregnant women attending state clinics and hospitals in KwaZulu Natal of 9,62%; AIDS also had a doubling time of thirteen months in the province.[127] The myth of AIDS as only affecting 'high risk' groups would also have tended to have been undermined by the fact that fifty seven of the ATIC's two hundred and seventy six HIV positive clients were married.[128] 'Ordinary' heterosexuals in 'faithful' relationships were also at risk; it is unclear in the 1994 report whether 'married' and 'faithful' people, and women, in particular, were made aware of their own true risk profile.

The personalities, aspirations and fears of HIV positive people simply do not emerge so strongly in the Durban City MOH reports, where they are simply seen as being clients, or clinic attenders. Like all modern annual reports of big institutions, successes were highlighted, rhetoric was phrased in a way

[125] City of Durban Annual Report of the City Medical Officer of Health. (Durban: Durban City Council, 1994), vi.
[126] Durban City MOH 1994 Report, 33.
[127] Durban City MOH 1994 Report, 131.
[128] Durban City MOH 1994 Report, 133.

that counsellors and colleagues would have liked, and statistics of numbers of courses run, clients counselled and events organised were foregrounded. In admidst all this the patient became the statistic, the unanalysed and socially, or culturally, ungrounded 'type', in a similar way to the *SAMJ* articles analysed in Chapter One. HIV positive people became types: married, or single, homosexual or heterosexual, prior STD infections, or no prior STD infections. Unlike the Campbell articles, those of Strebel and Abdool Karim *et al,* there is no sense of the agency of HIV-vulnerable and infected women, the gendered complications of their lives, their own thwarted desire to protect their health. It is precisely this lack of self reflexiveness on the part of the local state in Durban which may have undermined their attempts to design effective HIV prevention education programmes.



Conclusions

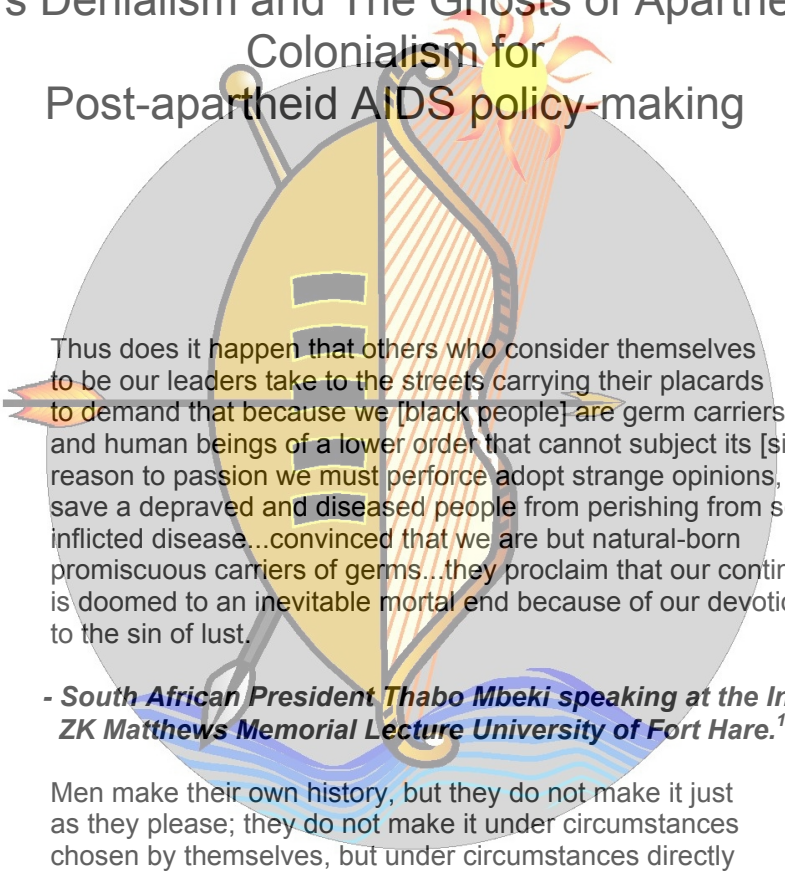
Admidst those years of political change with the eddies of negotiation and brinkmanship leading up to the 1994 elections, two other changes were happening. Feminists and left-wing and anti-apartheid academics and activists, and people like Patience Tyalimpi who worked for, or with, the state, critiquing reproductive public health policy in South Africa, had managed to

shift the local and national state's rhetoric by the 1990s to one more orientated around rights and ethics towards patients. Simultaneously, the AIDS epidemic had expanded from having had largely white 'homosexual' disease sufferers, to having become characterised by most writers as being a mainly black 'heterosexual' disease. Although the health system, by the democratic elections in 1994, remained in a parlous state from infrastructural and economic perspectives, with the public sector being fragmented and over-stretched and drained of money and resources by the private sector, they had changed the way that debates around health policy reform in the 'new' South Africa would be framed. The 'iron cage' of modernity around health policy may not have been so rigid after all, as the medical power/knowledge regime around AIDS and family planning policy had been changed by historical actors using their agency, in terms of normative and political convictions.

However, the problems which thwarted any efforts to built sustained and well developed responses to AIDS would haunt the post-1994 era. Spending on health would remain skewed in the direction of private medicine, as opposed to public health. Personnel shortages in the public sector would become more acute. The legacy of the thirteen Bantustan health departments would remain in bad co-ordination between the central, provincial and local arms of the state. The ANC's desire to establish a national health system would remain only a partially fulfilled legacy. A lack of funding would continue to hamper AIDS policy-making. For all these remaining problems these agents had forced a key shift in terms of the way that the future debate and future battles would be formed: from then onwards HIV infected patients would be assumed by all actors to have rights and medicine and the state and society to have ethical responsibilities towards them. What policies best articulated those rights and responsibilities would become the contentious issue.

Chapter Three

Mbeki's Denialism and The Ghosts of Apartheid and Colonialism for Post-apartheid AIDS policy-making



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

- South African President Thabo Mbeki speaking at the Inaugural ZK Matthews Memorial Lecture University of Fort Hare.[1]

Men make their own history, but they do not make it just as they please; they do not make it under circumstances chosen by themselves, but under circumstances directly encountered, given and transmitted from the past.

-Karl Marx. The Eighteenth Brumaire of Louis Bonaparte. [2]

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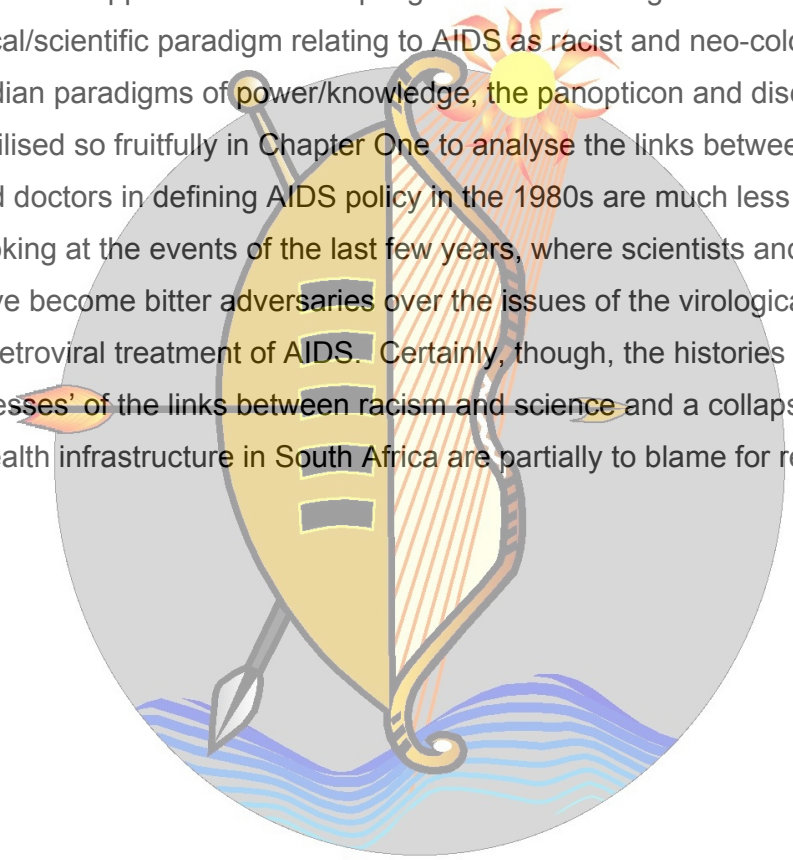
[1] Thabo Mbeki's recent speak at Fort Hare University is quoted in *The Mail and Guardian* online*:* Drew Forrest and Barry Streek. "Mbeki in bizarre Aids outburst". *The Mail and Guardian.* October 26 2001. (Johannesburg: www.mg.co.za)

[2] Karl Marx. *The Eighteenth Brumaire of Louis Bonaparte.* (New York: International Publishers, 1987), 15.

Two days before I handed in the first draft of this chapter to my supervisor, the lawyers representing the Treatment Action Campaign (TAC) opened a monumental court case to seek an order for the South African state to provide anti-retroviral treatment to pregnant women and their new-borns to prevent mother to child transmission (MTCT) at all public hospitals and clinics with antenatal facilities in the country. Trade Unionists, pregnant women, students, religious leaders, doctors, AIDS activists, women's, children's and gay rights activists took to the streets of Cape Town, Johannesburg and Durban and toyi-toyi-ed against government AIDS policy

This new court case highlights that recent events in AIDS policy-making in South Africa have been both baffling and tragic both in terms of attempting to mount an effective response to the epidemic and in terms of how rapidly and dramatically it has grown since 1994. Most controversially, in the scheme of recent events, has been South African President Thabo Mbeki's denial of the causal link between the HIV virus and AIDS, and claims that antiretroviral drugs are ineffective and lethally toxic, in the face of massive scientific evidence to the contrary. The purpose of this chapter will not be so much to try to offer an exacting account of the evolution of the president's warped and irrational logic on HIV, and its causes, effects and implications, but to understand a way to frame governmental policy in terms of both the apartheid legacy of a crumbling and fractured health system, and the legacies of colonial and Western discourse around Africans as inherently diseased. At stake here are paradigms of how AIDS both infects and sickens infected individuals' bodies and notions of a diseased body politic. Perhaps more crucially though, Mbeki's recent comments on AIDS seem to indicate that he believes several key tenets of science around AIDS to be racist and that he himself is defending Africans against racism and neo-imperialism through his denialism. The ANC government also appears to have backtracked on its Reconstruction and Development Programme (RDP) orientated commitments to maternal and child health in its refusal to provide anti-retroviral drugs to prevent mother to child transmission of HIV.

A series of AIDS policy blunders and 'public relations nightmares' beginning with the scandal of Sarafina II have shown patterns of authoritarian leadership and a breakdown in relations between government and civil society over AIDS policy. In a broader philosophical sense though, recent post-apartheid fights over the science underpinning AIDS policy have been over who has scientific 'expertise', who has the right to speak authoritatively on science, what the scientific method is, and what constitutes valid scientific evidence. Instead of merely pointing to and condemning very real examples of racism in the history of AIDS, Mbeki appears to be attempting to throw out altogether the Western biomedical/scientific paradigm relating to AIDS as racist and neo-colonial. Foucauldian paradigms of power/knowledge, the panopticon and disciplinary power utilised so fruitfully in Chapter One to analyse the links between the state and doctors in defining AIDS policy in the 1980s are much less useful when looking at the events of the last few years, where scientists and the state have become bitter adversaries over the issues of the virological cause and antiretroviral treatment of AIDS. Certainly, though, the histories of the 'long illnesses' of the links between racism and science and a collapsing public health infrastructure in South Africa are partially to blame for recent events.



I.

The overwhelming majority of with which the ANC won the 1994 elections was at least partly due to its promises to adopt a developmentalist agenda under the slogan of Reconstruction and Development, with buoyant promises of jobs, houses, water and health for all South Africans. In their 1994 *National Health Plan for South Africa* they asserted that

> Every person has the right to achieve optimal health, and it is the responsibility of the state to provide the conditions to achieve this. Health and health care like other social services, and particularly where they serve women and children, must not be allowed to suffer as a result of foreign debt or Structural Adjustment Programmes.[3]

In 1994 health care was to be a priority of RDP. Free health care for children under six and pregnant women was promised, as was an eventual expansion of free quality health care to all South Africans.[4]

Crucially, for the current MTCT debate the 1994 Health Plan prioritised

> Promotion of the survival, protection and development of children and their mothers through a system of appropriate health care delivery, health personnel training and support, research and a range of related programmes.[5]

The sense for many AIDS activists and doctors is that this vision of free public health with a particular accent on maternal and child health has been betrayed by the refusal both to provide treatment to prevent mother to child transmission, and in state failure to provide triple antiretroviral therapy to HIV positive South Africans. Part of the state's argument in the current courtcase is that providing treatment to prevent MTCT is too expensive. Whilst on the other hand, the state has just massively expanded its foreign debt to spend on its ambition re-armament project which, this year alone, will cost several times the health budget.

People like Max Price were still making strategic interventions in 1994 into RDP health policy, such as his collaborative Occasional paper for the Southern African Development Bank on RDP health policy written with Alex

[3] African National Congress. *A National Health Plan for South Africa.* (Johannesburg: African National Congress, 1994), 19.
[4] ANC. *National Health Plan,* 45.
[5] ANC. *National Health Plan,* 45.

van den Heever; both authors were from the Centre for Health Policy (CHP).[6] Key recommendations included: integrating the old Bantustan health departments into the one national and nine provincial departments, and ensuring that policy at local, provincial and national levels of government was properly co-ordinated; finding an effective balance budgetary between health spending and other spending priorities; and ensuring equal access to quality health care.[7] Health policy, for the authors, should not just have been deemed as being confined to the Department of Health, as government departments like the Department of Welfare could play a key role in providing services to women who had been raped and psychologically scarred by violence and people living with HIV needed support and community services.[8]

Price and van den Heever's critique of fragmentation of the health care sector still holds true in some ways. As Helen Schneider has shown, problems co-ordinating policy making and division of tasks and responsibilities between local, provincial and national levels of government have made the policy process complex.[9] Also, as Schneider has pointed out government money for health spending is allocated at a provincial level, with the low commitment of some provinces to the issue of AIDS leading to underspending and patchy national implementation of spending and policy recommendations.[10]

By 1999 the Department of Health's *Health Sector Strategic Framework 1999-2004* called for the establishment of an Inter-Ministerial Committee chaired by the President to deal with the AIDS epidemic.[11] The government was, according to the report, to 'Declare HIV/AIDS a national emergency, if not a global emergency' and strengthen its prevention programme, prioritise

[6] Max Price and Alex van den Heever. *Strategic health policy issues for the Reconstruction and Development Programme.* (Johannesburg: Development Bank of Southern Africa, 1995).
[7] Price and van den Heever. *Strategic health policy*, iii, 1-3.
[8] Price and van den Heever. *Strategic health policy*, 3.
[9] Helen Schneider and Joane Stein. "Implementing AIDS policy in post-apartheid South Africa". *Social Science and Medicine.* 52. (2001), 724, 726.
[10] Helen Schneider. "The Politics Behind AIDS: The Case of South Africa". *Politics Behind AIDS policies: Case Studies from India, Russia and South Africa.* Ed Rolf Rosenbrock. (Berlin: Wissenschaftszentrum Berlin fηr Sozialforschung, 1998), 10-12.
[11] Department of Health. *Health Sector Strategic Framework 1999-2004.* (Pretoria: Department of Health, 1999), 21.

vaccine development, administer affordable packages of care and support for those infected, affected and orphaned by the epidemic and look for affordable and practical strategies to reduce mother-to-child transmission.[12]

Despite progressive sentiments expressed in documents like the 1999 *Strategic Framework*, since the *Sarafina II* scandal in 1995, the state's AIDS policy had been highly politicised and characterised by conflictual relationships with civil society and medics/scientists. In 1995, a very public scandal arose over the opaque tendering procedures for, and excessive fourteen million two hundred thousand rand budget of, an AIDS awareness musical produced by director Mbongeni Ngema.[13] Then in 1997 the government championed the use of Virodene, after ignoring the Medical Research Council concerns about the experimental drug on the grounds of safety; researchers at University of Pretoria, after a few tests on human subjects with skin patches, had claimed was a miracle new treatment for HIV, but it turned out to be little more, chemically, than an industrial solvent.[14] Also in 1997, the government attempted to make AIDS notifiable[15], which was rejected by many critics because it was seen to undermine the right to privacy, and to be a coercive, heavy handed response to attempting to chart the epidemic.[16]

New conflict which was even more vociferous began in 1998 when the National Association of People living with HIV/AIDS called for the antiretroviral AZT to be made available to HIV positive pregnant women to avoid passing on HIV to their unborn children.[17] The use of AZT, and subsequently Nevirapine, to reduce mother-to child transmission had been conclusively proven by several studies by the late 1990s. The government's response

[12] Health. *Strategy Framework,* 21.
[13] Along with subsequent AIDS scandals, the turn of events around *Sarafina II* has been excellently charted by Helen Schneider*:* Schneider. "The Politics Behind AIDS", 13.
[14] Schneider. "The Politics Behind AIDS", 14.
[15] The word 'notifiable' means that doctors would have had to report cases to the public health authorities, hence potentially undermining the patient's right to confidentiality.
[16] Schneider. "The Politics Behind AIDS", 14.
[17] Helen Schneider. "The AIDS impasse in South Africa as a struggle for symbolic power". AIDS in Context History Workshop. 4-7 April 2001. (Johannesburg: Centre for Health Policy University of Witwatersrand, 2001), 9.

was to argue against the use of such anti-retroviral drugs to prevent MTCT on the grounds of affordability, efficacy and safety: what their legal defence will apparently consist of in the current trial.[18]

Mbeki's denialism certainly needs to be seen in the context of a fraught and conflictual relationship between the state and AIDS NGOs, the media, scientists over AIDS policy, and the state's often authoritarian rather than consensual common-vision fuelled leadership in the post-1994 era, but there are some deeper causative factors behind Mbeki's stance that relate to the history of racism in AIDS science and Mbeki's positioning of himself as an African Nationalist in the postcolonial world. Whilst Schneider of the CHP has convincingly argued that "debates over whether or not HIV causes AIDS are less relevant than debates on how civil society can best influence policy processes through the new state",[19] that the current conflict is over who has the right to speak about, define and shape the response to AIDS.[20] However, I want to make the argument that Mbeki is fundamentally constrained in his thinking by the ghosts of apartheid and colonial discourse around Africans, medicine and disease.

II.

In concluding her masterful 1991 book on the history of colonial medicine in Africa, Megan Vaughan argues that Africa is still looked at as "the only hotbed

[18] Note here that David and Nomsa Wilkinson showed in a recent study at Hlabisa that the vast majority of pregnant women there thought formula feeding, HIV testing and treatment to prevent MTCT would be acceptable if they were HIV positive: David Wilkinson and Nomsa Wilkinson. "The Acceptability of Prenatal Voluntary HIV Counselling, Testing and Interventions to Reduce Mother- to Child Transmission of HIV infection in rural South Africa". South Africa Medical Journal. 91(1). (2001). Due to lobbying by the Treatment Action Campaign (TAC), drug companies have now offered Nevirapine free to the state for use in MTCT prevention, even if this offer falls through, the estimated cost of implementing the programme would only be R250 million, as against Mbeki's brand new R300 million private jet, and the new R70 billion arms acquisition deal.

[19] Helen Schneider. "The AIDS impasse", 11.

[20] Helen Schneider. "Abstract: The AIDS impasse", 2.

of disease".[21] She argues that in European and North American medical and journalistic accounts of AIDS in Africa, Africa is still seen as synonymous with disease, death and uncontrolled sexuality.[22] Most interestingly, she shows how some Africans have argued AIDS is a Western health problem skilfully blamed on Africa and Africans, when it is really, according to such a view, seen as being due to Western degeneracy and homosexuality.[23]

According to such views, in what she sees as an inversion of colonial discourse on Africa, it is seen as a place of social stability and morality in which sexuality is still ordered by traditional norms.[24] This is an entirely ahistorical view, though, which sees African sexuality as unchanging, undynamic and undialectic and draws on the same notions of 'Merrie Africa', that the indirect rule colonialism drew on in places like Kenya and Uganda, where it was argued that African sexuality should not be meddled with, lest the patriarchal authority of African men on African women was loosened. Also, it represents the same kind of othering of the West, applying that deemed to be negative in ones own culture onto the Other, that was applied to Africa by the colonial authorities. Clams Western sexuality is degenerate, and more promiscuous and that 'homosexuality' is a Western invention, are homophobic, sweeping generalisations, and generally indefensible arguments. Unfortunately these arguments have often shaped policy responses in African countries to modern public reproductive health crises like AIDS.

As Vaughan points out, AIDS is a serious medical and public health problem in Africa requiring many thoughtful responses.[25] It is out of the limitations of

[21] Megan Vaughan. "Conclusion: The Changing Nature of Biomedical Discourse on Africa". *Curing Their Ills: Colonial Power and African Illness.* (Cambridge and Oxford: Polity Press, 1991), 200.
[22] Vaughan. "Conclusion", 205.
[23] Here she is citing authors like Richard and Rosalind Chirimuuta, who argued against the African origin of AIDS, that HIV might not be the cause of AIDS and that antiretrovirals like AZT are toxic and may even cause AIDS. These are all the pillars of South African President Thabo Mbeki's current 'AIDS scepticism', or as I would prefer to call it AIDS denialism: Richard and Rosalind Chirimuuta. *AIDS, Africa and Racism.* London: Free Association Books; Vaughan. "Conclusion", 205.
[24] Vaughan. "Conclusion", 205.
[25] Vaughan. "Conclusion", 205.

discourse framed by the colonial authorities that African leaders like President Thabo Mbeki must step in order to be able to formulate a response fitting to the problem. To attempt to construct arguments that AIDS is a Western biomedical plot to discredit Africans and their sexuality, and on that basis make complicated and unjustifiable denials of its causative roots in HIV, and the existence of effective treatment for HIV, is a tragic and inappropriate response by Mbeki to largely non-extinct remnants of racist colonial-style discourse on AIDS, rarely made anymore by the mid 1990s or 2000s, by doctors and the media in the West.

As the quotation from one of Mbeki's recent speeches at the opening of this chapter shows, he genuinely seems to believe that critics of his denialism believe that Africans are "natural born, promiscuous germ carriers" with an "unconquerable devotion to the sin of lust".[26] This is not a new position amongst African leaders and intellectuals though; Chirimuuta and Chirimuuta in the 1987 book *AIDS, Africa and Racism* questioned HIV as the cause of AIDS, AIDS as originating in Africa and argued drugs like AZT were excessively toxic, and like Mbeki does now, claimed that HIV prevalence and AIDS deaths in Africa were dramatically exaggerated as part of a racist plot to discredit African culture and sexuality.[27]

Chirimuuta and Chirimuuta's book is not entirely without merit though, particularly some early arguments made about the origins of AIDS in Africa do appear to have relied on fairly flimsy evidence, to have made insulting and culturally inaccurate speculations about African sexuality and to have led to overwhelming discrimination in the West against Africans and people of African descent. Some researchers apparently tried to claim that HIV passed from monkeys to Africans in Central Africa due to bizarre sexual practices like Africans injecting monkey blood into their anuses and vaginas, and claims that Africans had more anal intercourse, had intercourse during menstruation and were excessively promiscuous; this obviously had more to do with racist

[26] Mbeki was quoted in the Mail and Guardian: Forrest and Streek. "Mbeki in bizarre Aids outburst".

beliefs Africans were somehow closer to apes than white people on the evolutionary scale, and neo-nineteenth-century-style anxieties about Africans as hypersexualised and having animalistic sexuality.[28]

These racist conceits about African sexuality, which characterised the writings of some AIDS researchers in the 1980s, obviously required strong criticism and careful anthropological, sociological and psychological analysis of true sexual practices and their social and cultural determinants in different African societies. Crude racist notion of the 'diseased' African prostitute as responsible for the spread of AIDS emerged in *SAMJ* articles in the mid-nineteen eighties, as I showed in Chapter One. But also, as I showed in Chapter Two, they were simultaneously refuted as apartheid health and socio-economic inequalities were shown by leftist anti-apartheid and feminist academics to be the true engine for ill health and the spread of AIDS in South Africa. Furthermore, feminist academics were showing by the 1990s that gender imbalances in sexual relations and poverty were forcing poor South African women into socially and economically unequal and dependent sexual relationships. Finally, as was shown in Chapter Two careful case studies began about the gender dynamics around AIDS began emerging, such as Suzanne Leclerc Madlala's 1996 monograph highlighting cultural beliefs around AIDS in a certain Zulu-speaking community in Kwa-Zulu/Natal, which blamed women for the spread of AIDS.[29]

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

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[27] For instances of this in the book see: Richard and Rosalind Chirimuuta. *AIDS Africa and Racism.* (London: Free Association Books, 1989), 2, 39, 47, 80-81.
[28] Richard and Rosalind Chirimuuta. "Chapter Seven: Robert C. Gallo and Some monkey Business.", "Chapter Twelve: Racism or Science" *AIDS Africa and Racism.* (London: Free Association Books, 1989), 134, 71.

[29] I am drawing here from Riona Govender's "Critical Review of Leclerc Madlala's PhD thesis" presented at the Gender and Health Graduate Seminar: on 6 November 2001. Suzanne Leclerc Madlala. *Demonising women in the era of AIDS: An analysis of the Gendered Construction of HIV/AIDS in KwaZulu-Natal.* (Durban: University of Natal, Durban).

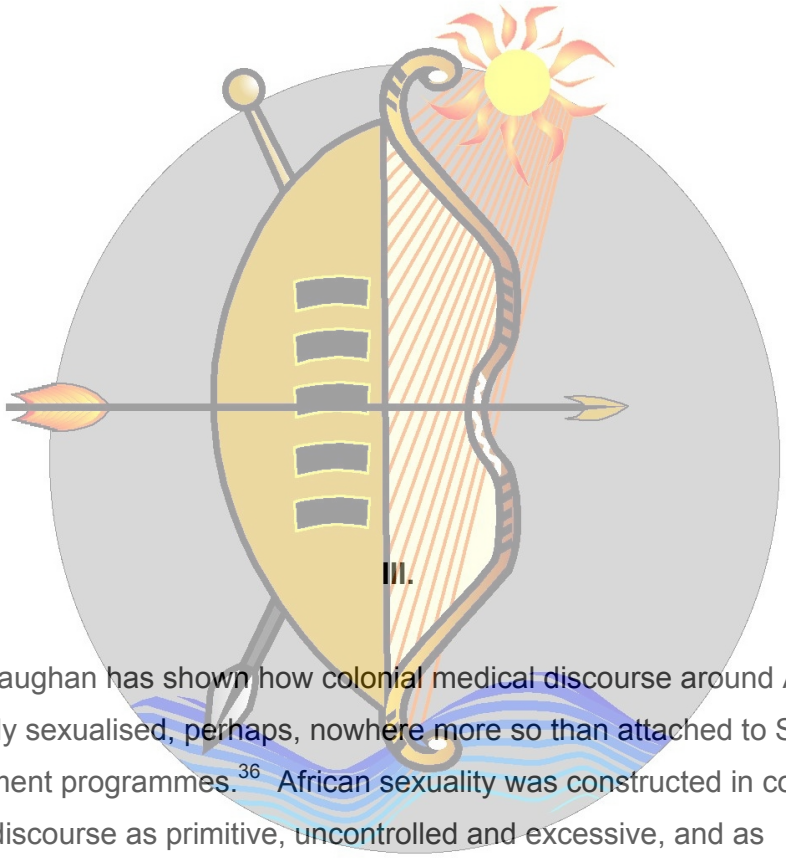
accepted for certain academic scholarships.[30] People with HIV or AIDS were not allowed entrance into America.[31]

This formed part of a larger battery of proposed discrimination measures in the West in the 1980s against gays, blacks, prostitutes, drug users (people deemed to be at 'high risk' of contracting HIV) and HIV positive people. In America institutionalised and legal discrimination against HIV positive people on the basis of their HIV status, and 'high risk' groups became common in the 1980s: firemen in New York apparently often refused to give mouth to mouth resuscitation to people they suspected of being gay, for irrational fear of contracting HIV; some doctors refused to treat HIV positive patients and the Justice Department made it legal to bar HIV positive employees from work.[32] Conservative columnist William F Buckley Jnr even notoriously argued for universal mandatory testing for HIV and for HIV positive individuals to be tattooed on their buttocks and forearms to indicate their HIV status.[33]

I would tend to argue though, that anti-discrimination has been an important principle in AIDS policy making circles internationally for quite some time. Jonathan Mann's assertion as head of the World Health Organisation in the of the need for AIDS policy internationally to protect rather than infringe on the rights of HIV positive individuals, has meant that rights-based notions of AIDS policy have had international currency for quite some time now.[34] Also, as charted in Chapter Two, various actors in South Africa in the 1980s and early 1990s managed to force a shift in the way that AIDS and family planning policy would be framed, coercive practices outside a human rights framework ceased to form a legitimate part of discourse produced by government, medical and public health quite some time ago in the country. As a recent article in the *Mail and Guardian* has shown only the "loony right" and Mbeki continue to assert that the epidemic "should reflect on the moral character of

[30] Richard and Rosalind Chirimuuta. "Chapter Two: Haiti". *AIDS Africa and Racism.* (London: Free Association Books, 1989), 134, 71.
[31] Chirimuuta and Chirimuuta. "Haiti", 134, 71.
[32] Alan M. Brandt. "Chapter VI: Plagues and Peoples: The AIDS Epidemic". *No Magic Bullet: A Social History of Venereal Disease in the United States since 1880.* (New York and Oxford: Oxford University Press, 1987), 192, 194.
[33] Brandt. "Plagues and Peoples", 196.

Africans".[35] Mbeki's denialism is a reaction to racism attached to AIDS and can only be explained in terms of its hauntings by the ghosts of colonial medicine and Western culture, and their characterisation of Africans as diseased. It is to this largely extinct racist discourse he is reacting against, which saw Africans as inherently pathological, which this chapter will now turn.



III.

Megan Vaughan has shown how colonial medical discourse around Africans was highly sexualised, perhaps, nowhere more so than attached to STD management programmes.[36] African sexuality was constructed in colonial medical discourse as primitive, uncontrolled and excessive, and as representative of the darkness of the continent itself.[37] On the other hand,

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[34] Schneider. "AIDS impasse", 10.
[35] Drew Forrest. "Behind the smokescreen", October 26 2001. (Johannesburg: www.mg.co.za)
[36] Megan Vaughan. "Introduction". *Curing Their Ills: Colonial Power and African Illness.* (Cambridge and Oxford: Polity Press, 1991), 19.
[37] Megan Vaughan. "Chapter Six: Syphilis and Sexuality: The Limits of Colonial Medical Power". *Curing Their Ills: Colonial Power and African Illness.* (Cambridge and Oxford: Polity Press, 1991), 129.

other colonial actors saw colonisation's social and economic transformations as causing the 'degeneration' of an 'innocent' African sexuality.[38]

The influence of both of these views are evident in Mbeki's denialism. Firstly, in so much as he argues Western biomedicine attached to AIDS aims to stigmatise African sexuality and, secondly, in his frequent appeals to unspecified 'African' solutions to the problem, he imagines a pristine and essentialised notion of African culture, which in reality has permanently been altered by Western culture through colonisation. Through colonisation Western biomedicine became in the twentieth century a form of African healing, as Megan Vaughan has argued.[39] Controversially enough for African feminists things which have been posited as 'African' solutions to AIDS have included virginity testing for adolescent girls, and in Swaziland the mandatory wearing of tassels by adolescents and teenagers to indicate virginity.[40] All this tends to point to an ahistorical 'Merrie Africa' vision of Africa's past, where there were no 'promiscuous', corrupted, Westernised African women, and all African women avoided sex before marriage and did not 'spread' STDs and AIDS.

In Sander Gillman's *Difference and Pathology* he examines the history of the representations of black sexuality, as inherently diseased in Western scientific, artistic and intellectual discourse.[41] Gillman, looking at how and why humans project their bad qualities onto the Other argues that stereotypes are "...projections of internalised, often repressed models of the self and the Other...a rejection or distortion of the self"; in relation to pathology he argues that

[38] Vaughan. "Syphilis and Sexuality", 129.
[39] Megan Vaughan. "Conclusion". *Curing Their Ills: Colonial Power and African Illness.* (Cambridge and Oxford: Polity Press, 1991), 205.
[40] Virginity testing, currently condoned by traditionalists in the Kwa Zulu/Natal provincial government, consists of inserting a reed into the girl or young woman's vagina to 'check' if her hymen is 'in tact'. I heard Deputy President Jacob Zuma advocate it as an 'African solution' to the problem of AIDS at the National Beyond Awareness National Tertiary Education and AIDS conference at Kopanong Conference Centre in Gauteng in 1999. The South African Gender Commission, and prominent gender activists have been highly critical of the practice, because it cannot definitely establish virginity, is deemed to undermine girls' dignity, and there is no equivalent practice for boys or men.

> ...the very concept of the pathological is a line drawn between the 'good' and the 'bad'. This accounts for the power that metaphors of illness have.[42]

The enduring and recurrent nature of the image of blacks as inherently diseased, and disease-carrying, evident in mid-1980s South African medical discourse around AIDS, discussed in Chapter One, can be linked to a strong desire in post-Enlightenment Western culture to push its own fears and perceived negative qualities onto the Other.

According to Gillman's account, there was a strong racial element to the Othering involved in Western depictions of black and especially, female sexuality: 'the black' in most Western art, science and culture became an "icon for deviant sexuality in general"; the black female simultaneously became "an icon for black sexuality".[43] The 'primitive' qualities of blackness became equated with those of prostitute to the extent that the two merged.[44]

Black female sexuality, in particular, became linked in the nineteenth century to syphilophobia (fear of syphilis).[45] In nineteenth century public health discourse the diseased-ness and corruption of female sexuality and that of the Other was also linked to smell, especially that of the menses; female genitalia was also linked to urination and therefore shame for men.[46] It is this deeply rooted Othering cultural belief in the West that Africans have inherently diseased sexuality, to which Mbeki seems to be reacting in his AIDS denialism. Other Africans may have been inverting the Western racialised process of Othering, by claiming that AIDS is a 'white man's disease' due to certain 'white' types of degeneracy, like 'homosexuality'. This is a type of

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[41]Sander L. Gillman. *Difference and Pathology: Stereotypes of Sexuality, Race and Madness.* (Ithaca and London: Cornell University Press, 1985).
[42] Sander L. Gillman. "Introduction: What Are Stereotypes and Why Use Texts to Study Them?". *Difference and Pathology: Stereotypes of Sexuality, Race and Madness.* (Ithaca and London: Cornell University Press, 1985), 23.
[43] Sander L. Gillman. "Chapter Three: The Hottentot and the Prostitute: Towards an Iconography of Female Desire". *Difference and Pathology: Stereotypes of Sexuality, Race and Madness.* (Ithaca and London: Cornell University Press, 1985), 79, 83.
[44] Gillman. "The Hottentot and the Prostitute", 99.
[45]Gillman. "The Hottentot and the Prostitute", 101.
[46] Sander L. Gillman. "Chapter Four: Black Sexuality and Modern Consciousness". *Difference and Pathology: Stereotypes of Sexuality, Race and Madness.* (Ithaca and London: Cornell University Press, 1985), 114-115.

discourse that appears to have been attractive as some HIV positive patients at Baragwanath hospital in the early 1990s, as Chapter Two shows.

Ann Laura Stoler, in her work on the application of Foucault's *History of Sexuality* in Colonial Studies, has shown that Foucault's notion of biopower can be expanded to understand how 'normalising' society in the West simultaneously excluded and differentiated itself from those of other races.[47] Part of the regulating state's actions in dividing the normal from the abnormal, those who conformed to bourgeois respectability and those who were sexually deviant, the degenerates from the eugenically clean was about building the nation, protecting the health of the state;[48] Europe made itself, its own sexual self-image and values, in the colonies by creating historical Others

> One could argue that the history of Western sexuality must be located in the production of historical Others, in the broader force field of empire where technologies of sex, self and power were defined as 'European' and 'Western' as they were refracted and remade.

In other words, the nation in the West was made by differentiating sexualised, racial Others from 'white' Westerners; European power and prestige in colonies ideologically depended on controlling the way that Europeans had sex, and with whom, and defining heterosexual monogamous norms of Western sexuality as 'normal' and 'native' sexuality as diseased, through the new types of instruments and methods of modern power charted by Foucault, referred to in Chapters One and Two.

If Western nationhood in the late nineteenth and early twentieth century was defined in Europe, against the negative of 'native' sexuality and its diseased-ness, should we see Mbeki's misguided attempt to rehabilitate African sexuality as an attempt to redefine South Africa nationhood and the body politic, in terms of his misty concept of the 'African Renaissance'? Can Mbeki's attempt to re-mould images of African sexuality, by denying the veracity of mainstream Western biomedicine's model of AIDS, be seen as a

[47] Ann Laura Stoler. "Chapter IV: Cultivating Bourgeois Bodies and Racial Selves". *Race and the Education of Desire. Foucault's* History of Sexuality *and the Colonial Order of Things.* (Durham and London: Duke University Press, 1995), 134-135.

nationalistic attempt to defend the nation against ideas that it is degenerate? Certainly metaphors of, and technologies of power based around, notions of contaminated/pure blood, protecting the health of the racially-defined 'nation's' children formed part of the legitimisation of institutionalised control of sexuality by the power/knowledge regime, both in colonies and the metropole and in late apartheid South Africa. In spite of arguing with the spectres of racialised late apartheid and colonial medicine, it certainly doesn't seem that Mbeki is attempting social engineering on the scale of segregation and coercive health measures in the belief that such measures would be effective in STD or HIV management programmes. Far from it, in fact, it appears that in his rhetoric he has gone back to the past, as if in a time machine to argue against discourse, which for the most part has been massively surpassed in the 'AIDS world' by rights-based, anti-discrimination discourse and a shift to a medical, technical, non-'moralistic'/stigmatising approach. Arguing in terms of (even if racially inverting) old colonial racialised and Western concepts like moral contamination and degeneration as the causes of STDs, and middle class 'virtue' as the solution will certainly not help. More importantly, for the future of AIDS policy-making, whilst he and others who think similarly on the issue in his party are still in power in South Africa, will the key governmental actors be able to get out of the constraints of discourse defined by the boundaries nationalism and colonialism? Even if, as I have contended above, Mbeki is arguing against a delusion of his own making, that those who believe AIDS is caused by a retrovirus are out to besmirch the name of Africans in a colonial/apartheid mode, the gridlock must end by appeals to both human rights discourse around access to treatment and the human dignity of Africans infected with HIV, and the predictive and interpretative power of biomedicine. At a microbiological level, Western biomedicine provides a powerful model for understanding the direct physical causes of disease and developing affective treatments, preventions and cures for them. Such rights-based and Western biomedical models will have to be used to devise rational government policies to alleviate the very real human suffering that the virus is causing. In contrast

[48] Ann Laura Stoler. "Placing Race in the *History of Sexuality*". *Race and the Education of Desire. Foucault's* History of Sexuality *and the Colonial Order of Things.* (Durham and London: Duke University Press, 1995), 33-34.

to Mbeki's denialism's claims that all AIDS activists who believe in 'AIDS orthodoxy' and disagree with him on AIDS policy are racist,[49] this is the argument being made by people like Zackie Achmat, leader of the Treatment Action Campaign, Malegapuru Makgoba and Desmond Tutu, all of whom are black and are certainly not stereotypical 'racists' in a colonial or apartheid mode.

As was said very eloquently in the *Mail and Guardian* in 2000 about the issue

> Faced with this crisis, we can legitimately expect of our president that he ensure that state policy on the issue is coherent well-understood by the public at large, energetic and based on the best available scientific knowledge...Instead, he has at times behaved like someone trying to be the Boy's Own basement lab hero of Aids science. He has allowed his attention to be diverted by abstruse debates on immunology and related science...In the process, the nation's attempt to deal with this national health crisis has been plunged into confusion. And the four million-odd South Africans who have contracted the syndrome can be forgiven for feeling, if not exactly abused, certainly neglected.[50]

Indeed, doctors have been some of the most vocal people against Mbeki's denialism and its poisonous effects on rational AIDS policy-making. In particular, they have often relied most heavily on their respected and professional status to argue against his views. In *SAMJ* in 2000 when Mbeki was perhaps most vociferous about attempting to prove his denialism the South African Medical Association (SAMA) came out with a firmly worded statement on HIV as the cause of AIDS, the efficacy of HIV combination antiretroviral treatment to prevent HIV positive people from getting the set of symptoms constituting AIDS, and use of single antiretrovirals to prevent MTCT: as they said,

> Whilst SAMA welcomes any debate on health it is obliged to point out that the view HIV may not cause AIDS has been thoroughly discredited by several recent scientific studies. This view is dangerous and its propagation may lead to cases of AIDS that may have otherwise been prevented.[51]

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

[50] Mail and Guardian. "What's behind Mbeki's crusade?". *Mail and Guardian.* March 31, 2000. (Johannesburg: www.mg.co.za)

[51] "SAMA Official: HIV causes AIDS". *South African Medical Journal.* 90 (5). (2000), 461.

Several doctors also refuted Mbeki's claim that HIV does not cause AIDS because a "virus cannot cause a syndrome", arguments that HIV tests are inaccurate and that TB and malnutrition are the true medical causes of AIDS, and have shown Mbeki is doing a disservice to scientific research and education, and on a broader scale South African society with his unscientific views.[52]

Western biomedicine certainly has a lot to answer for in colonial medicine, its historical complicity in the subjugation of women, mentally ill people and so on, charted by those operating in a Foucauldian tradition. However, in a Habermasian sense, critiques of the human rights abuses of medicine in certain eras and societies, its objectification and potential dehumanising effects on patients, have been made by medics and others operating in a paradigm of what Foucault has called 'the human sciences', from inside a rational humanist and, at times, specifically medical paradigm. This is not to say that because for the most part medicine has incorporated human rights based discourse it will certainly be free of abuses in the future, but it does have enormous potential to alleviate pain, improve people's quality of life and fight disease; certainly strong arguments in favour of maintaining and encouraging the medical way of understanding and treating disease. The fact is that Mbeki offers no feasible alternative for reducing AIDS mortality and effectively preventing HIV, or explaining at a microbiological level the cause of AIDS. Convoluted conspiracy theories that AIDS is an American Central Intelligent Agency (CIA) and pharmaceutical industry plot to sell 'toxic' AIDS drugs and discredit his government, claims he made in 2000, have gone nowhere to abating the phenomenal and massively growing death rate amongst young South Africans due to AIDS.[53] More importantly, it is clear

[52] Malegapuru Makgoba. "HIV greatest threat to the 'African Renaissance'" *Mail and Guardian.* May 25, 2001 (Johannesburg: www.mg.co.za); Denise Ford. "A startling level of scientific ignorance". *Mail and Guardian.* September 15, 2000 (Johannesburg: www.mg.co.za); Micheal Berger. "Mbeki's Aids letter deifies belief". *Mail and Guardian.* April 28, 2000 (Johannesburg: www.mg.co.za); Michel D Kazatchkine and Didier Fassin. "Time to Break the Silence". *Mail and Guardian.* June 23, 2000 (Johannesburg: www.mg.co.za);

[53] Howard Barrell. "Mbeki fingers the CIA in Aids conspiracy" October 06, 2000. *Mail and Guardian.* (Johannesburg: www.mg.co.za). The latest Medical Research Council Report on AIDS that the government attempted to suppress, due to Mbeki's denialism, has apparently estimated that about 40% of adult deaths between the ages of 15 and 49 in South Africa in

that his denialism is muddying the waters on key policy issues like prevention of MTCT, which could really save lives of children of HIV positive pregnant mothers.

Mbeki's denialism has been fundamentally a struggle fuelled by his own mistaken belief that Western biomedical mainstream understandings of the causes and treatments of HIV and AIDS are part of a plot to discredit Africans, their culture and sexuality. In arguing this he is wrestling with the ghosts of colonial medicine and old traditions in Western culture projecting 'negative' sexual practices and sexual traits onto the Other.

The fact is, though, for the most part overwhelming consensus has shifted in the 'AIDS world' of doctors, medical researchers, NGOs, and most governments internationally, to a more human rights based response to AIDS. It is now generally understood in the AIDS world that crude discrimination against people who have been deemed to be members of 'high risk' groups, or HIV positive people does not in any way help to contain the epidemic and is a normatively, legally and politically incorrect public health policy response. This gain was not made without a fight, as has been shown, in South Africa in the nineteen eighties and nineteen nineties, a long and arduous fight on the part of feminists and anti-apartheid activists ensued to ensure that the discourse around public health and AIDS in South Africa changed to a human rights based one, as opposed to coercive one, serving the political and economic needs of late apartheid. In the 1980s, when Chirimuuta and Chirimuuta made similar arguments to Mbeki, they did highlight real discrimination against Africans on the basis of their inclusion as members of the 'high risk' category, and racist social and cultural stereotypes about African sexuality in some medical journal articles. AIDS science has made dramatic advances since the 1980s, foremost for improving the health of HIV positive people, being the triple therapy antiretroviral breakthrough in 1996 by American scientist David Ho and breakthroughs around treatment to prevent

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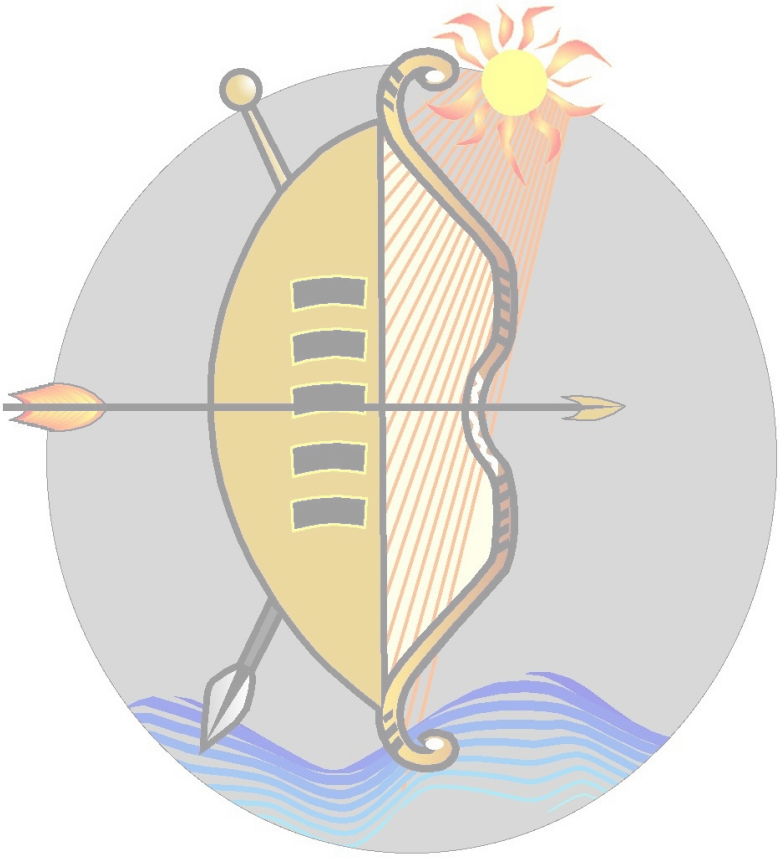
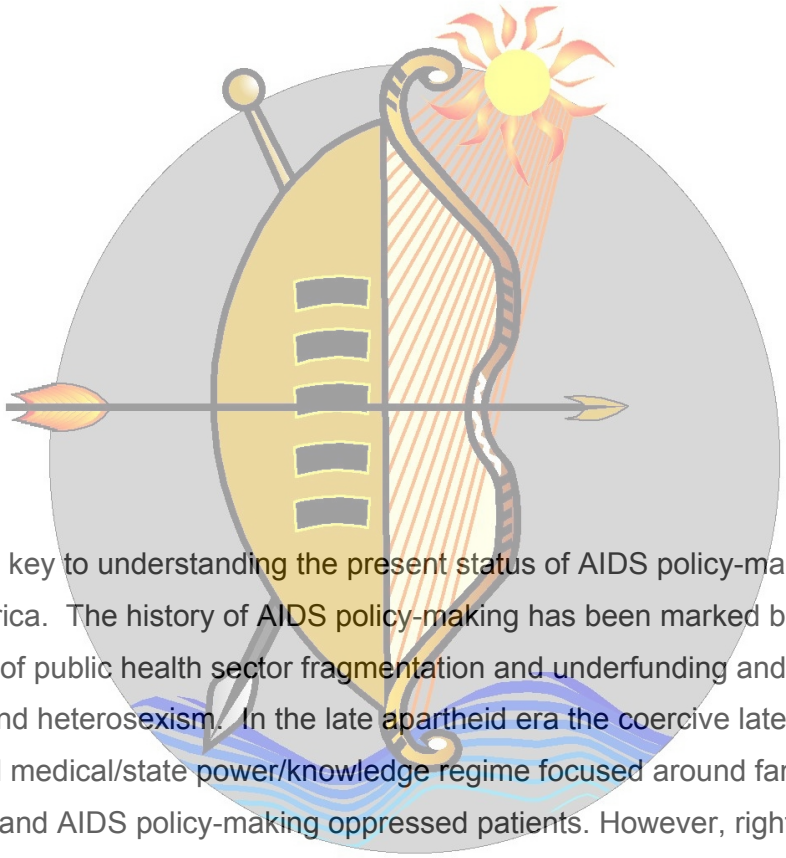
2000 were due to HIV/AIDS, and was the biggest cause of death in South Africa that year. Howard Barrell and Jaspreet Kindra. "Shocking Aids report leaked", October, 05, 2001. *Mail and Guardian.* (Johannesburg: www.mg.co.za).

mother to child transmission in the 1990s. This has meant that a technical, scientific non-moralistic approach has prevailed of simply treating people with HIV and preventing babies, through medication, from getting HIV, and has been yoked with this rights-based discourse. It is this currently prevalent rights-based/treatment vision of AIDS activists, scientists and doctors that Mbeki is denying, and by doing so, closing the only feasible escape hatch from the types of coercive and racist discourses that colonial and late apartheid public health tended to advocate.

Whilst state to civil society relations have been hampered by a trail of 'public-relations nightmares' and policy blunders, and authoritarian leadership approaches by the state, rather than a model of working with civil society, the government has basically betrayed its 1994 developmentalist RDP health vision of improving maternal and child health, in favour of pointless projects, from a public health and poverty alleviation point of view, like ambitious rearmament of South Africa. The government may have inherited a fragmented public health system, which had suffered from years of underfunding and neglect, but at the same time it has done ostensibly little to correct that legacy, except the produce eloquent, but largely unapplied AIDS plans. Meanwhile Mbeki's recent haunting with the spectres of racist pubic health past has done nothing to address what is easily the biggest public health crisis South Africa has ever seen. History may judge him harshly for this. Future generations may well say, as we do of Roman Emperor Nero "He fiddled while Rome burned".



Conclusion



History is key to understanding the present status of AIDS policy-making in South Africa. The history of AIDS policy-making has been marked by the long illnesses of public health sector fragmentation and underfunding and racism, sexism and heterosexism. In the late apartheid era the coercive late apartheid medical/state power/knowledge regime focused around family planning and AIDS policy-making oppressed patients. However, rights-based discourse prevailed over coercive and non-rights policy and practices. A more positive history has emerged from this dissertation: a history of anti-apartheid activists, medics and progressive and feminist academics, who successfully shifted policy-making discourse to being rights-based, and focused on the rights of patients to have equal access to quality health care and to autonomously control their fertility and health. Just at the moment that rights-based discourse achieved dominance in AIDS policy-making in South Africa, relations between the state and civil society over AIDS policy-making began to

progressively deteriorate. This has most recently been due to Mbeki's denialism. This in turn is a reaction to presentation of Africans as having inherently pathological sexuality, common in late apartheid and colonial discourses, but certainly no longer prevalent, or generally deemed acceptable in the 'AIDS world', by the mid-1990s. Mbeki's denialism is then haunted by the ghosts of racist colonial and late apartheid medical discourse.

The first medics writing in *SAMJ* with AIDS policy recommendations, in the 1980s saw the primary aim of AIDS policy making as containment of infection. The rights of patients were far from top priority. From the Durban MOH Reports from the mid 1980s, it is clear that the policy of Durban local state was influenced by recommendations in *SAMJ*. Indeed, as was the contention of Chapter One, the two institutions operated as a Foucauldian disciplinary medical power/knowledge regime, writing late apartheid racialised, gendered and sexualised power onto patients bodies. STD management programmes have a longer history in the West, and colonial Africa, of having been coercive, and having stigmatised prostitutes, with the forced medical examinations and lock-up hospitals of Britain's Contagious Diseases Acts being perhaps one of the most famous historical examples of this. The early aim of containment failed in part because of the crude late apartheid social and cultural types that were employed to 'type' those infected and at risk, and in part, because the real engine of AIDS in these years was the racialised unequal socio-economic system which underpinned apartheid

Progressive and feminist anti-apartheid academics and activists responded fiercely to this powerful, coercive late apartheid model of reproductive public health. They showed that apartheid itself, and its racialised political and socio-economic system, was the major cause of African ill-health. Furthermore, they debunked prevalent neo-Malthusian rhetoric that black 'overpopulation' was the cause of South Africa's political, socio-economic and environmental problems, a view commonly expressed by the state and actors close to it such as the FPASA. These activists and academics exercised what may be termed as agency in the iron cage of modern power, along with people like Patience Tyalimpi, who resisted from 'within'. In a Habermasian

sense, the critique of late apartheid South African modernity expressed in AIDS and family planning policy came from within humanistic ideals which form part of the intellectual constellation of Western modernity itself.

Leftist writers working at the Centre for Health Policy (CHP), such as Price showed how privatised late apartheid health had drained money and resources from the public sector[1]. At the same time writers like Zwi and Marks and Andersson highlighted that medicine in South Africa was open to political abuse by the undemocratic apartheid regime for coercive non-rights based purposes[2]. Feminist health academics also attacked the indiscriminate, unsafe and coercive use of Depo Provera on African women as not respecting their right to control their fertility safely.[3]

Chapter Two also demonstrated that in depth studies began appearing in the 1990s, which showed the real psychosocial, socio-economic and cultural gendered factors which made women, like commercial sex workers, vulnerable to HIV infection.[4] However, feminist responses to AIDS were slower in coming than those of the gay rights movement. From both physiological and cultural points women's true risk of infection of view was not fully understood early in the epidemic and the presentation of AIDS as a 'gay plague' or a scourge of the excessively promiscuous, like prostitutes, may have given many women false appraisals of their own true risk profile. Academic and activist feminists also had many other focuses of attention in the late 1980s and early 1990s such as working to ensure that women's rights in general were protected in the polity which was coming into being. There

[1] Max Price. "The Consequences of Health Service Privatisation for Equality and Equity in South Africa". *Social Science and Medicine.* 27. (1988).
[2] Shula Marks and Neil Andersson. "Apartheid and Health in the 1980s". *Social Science and Medicine.* 27 (7). (1988); A. B. Zwi. "The political abuse of medicine and the challenge opposing it". *Social Science and Medicine.* 25. (1987).
[3] Helen Rees. "Women and Health in South Africa- Towards a Women's Health Charter". Paper presented at the 1990 Maputo conference on Women's Health. WHP Archive. 1.3; 678. (1990).
[4] Quarraisha Abdool Karim, Salim S. Abdool Karim, Kate Soldan and Martin Zondi. "Reducing the Risk of HIV Infection among South African Sex Workers: Socioeconomic and Gender Barriers". *American Journal of Public Health.* 85 (11). (1995), 1521-1525; Catherine Campbell. "Selling sex in the time of AIDS: the psychosocial context of condom use by sex workers on a Southern African mines". *Social Science and Medicine.* 50. (2000); Anna

were also other women's health policy issues that commanded feminists' attention such a reducing maternal and infant mortality and fighting for safe legal abortions for South African women.

One key feature of early AIDS policy is that the state certainly spent far more on its coercive family planning policy than on AIDS, the ATICs were dramatically underfunded, as were early AIDS awareness campaigns. All the warning signs were there of a major heterosexually transmitted AIDS epidemic amongst Africans in South Africa: ongoing STD epidemics; migrancy; poverty; and patterns of gendered coercive, violent, and economically dependent sexual relations. Such negligence and apathy on the part of the apartheid state in the face of an impending epidemic was staggering, and were almost certainly motivated by neo-Malthusian aims to limit the number of Africans.

AIDS policy-making in South Africa has also been tied up with legacies of colonial and Western racist discourses of Othering and ideas around African, female and 'homosexual' sexuality as inherently diseased. As Chapter Three showed Sander Gillman's understanding of racial stereotyping in the West can be used to understand how and why Western culture has pushed sexual traits it deems negative onto the Other.[5] As Ann Laura Stoler has charted the histories of Western sexuality and colonialism may not be as far apart has been thought in Colonial Studies: policies like segregation and apartheid were almost certainly motivated by fears of STD infection through inter-racial sex.[6] Eugenics, policies around maternity, contraception and STDs were part of modern state making and the modern power/knowledge regime's disciplinary regulation of sexuality. Modern Western sexual and cultural identities were made in the colonies through the articulation of 'native' sexuality as Other, and through the actions of the normalising state, which came to carefully regulate

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Strebel. "'There's Absolutely Nothing I Can Do, Just Believe in God': South African women with AIDS". *Agenda: A Journal About Women and Gender.* 12. (1992)

[5] Sander L. Gillman. *Difference and Pathology: Stereotypes of Sexuality, Race and Madness.* (Ithaca and London: Cornell University Press, 1985).

[6] Ann Laura Stoler. "Placing Race in the *History of Sexuality*". *Race and the Education of Desire. Foucault's* History of Sexuality *and the Colonial Order of Things.* (Durham and London: Duke University Press, 1995).

colonial sexuality. As a part of this, policies around STDs were politicised and racialised in the West and in colonies.

Helen Schneider has shown that the post-1994 history in AIDS policy-making has been characterised by a breakdown of civil society to state relations over various policy blunders and 'public relations nightmares', Mbeki's denialism obviously ought to be seen in the context of these events.[7] At a deeper level though Mbeki's denialism needs to be understood, as a reply to the colonial and late apartheid history of African sexuality being deemed as inherently pathological. It appears that he believes by his refutation of HIV as the cause of AIDS he is striking a blow for anti-racism. The sad fact is though that this position has only put AIDS policy into disarray and may have caused additional needless death and suffering in South Africa. The post-1994 government has also back-peddled on its developmentalist RDP agenda in its health policy; promises to prioritise maternal and child health and AIDS have been undermined by the refusal to implement a programme to prevent Mother-to-Child transmission (MTCT).

In the current court battle over the provision of antiretroviral drugs Nevirapine and AZT in the state sector to prevent MTCT a key new trend of the last few years is evident. Rights-based discourse has become yoked to arguments for a non-moralistic and technical approach of simply treating HIV using new combination antiretroviral drug therapy. Doctors, AIDS activists and a range of sympathisers of religious, union, feminists and those of leftist persuasions have argued strongly against Mbeki's claims that HIV is not the cause of AIDS, and that antiretrovirals are lethally toxic. Fundamentally, these denialist claims are the major stumbling block to state implementation of rational AIDS policies like providing treatment to prevent MTCT at all state facilities.

[7] Helen Schneider. "The AIDS impasse in South Africa as a struggle for symbolic power". AIDS in Context History Workshop. 4-7 April 2001. (Johannesburg: Centre for Health Policy University of Witwatersrand, 2001), 9; Helen Schneider. "The Politics Behind AIDS: The Case of South Africa". *Politics Behind AIDS policies: Case Studies from India, Russia and South Africa.* Ed Rolf Rosenbrock. (Berlin: Wissenschaftszentrum Berlin fηr Sozialforschung, 1998), 10-12.

In their strong opposition to state AIDS policy, doctors have often used their respected professional status to speak out. It is difficult to speculate where this will lead, except to say that doctors as a profession may come to realise that they will have to engage with Foucauldian and postcolonial critiques of their profession, in order to be able to refute Mbeki on his own terms. The cleaving of medical knowledge with state power, so clearly obvious when looking at late apartheid family planning and AIDS policy seems not be an adequate way to describe doctors relation to the state's post-apartheid AIDS policy. However, this may have formed part of earlier trends; even in the late apartheid era there were some doctors and nurses and writers on public health that expressed their resistance to coercive family planning and AIDS policies and practices. Maybe this current break is an inevitable outcome of the rise of certain more positive rights-based and scientific elements in history of the internal contradictions of Western modernity itself: that whilst it has an immensely valuable tradition of human rights, these have not been given to all equally; whilst a technology like medicine has helped humanity control disease, and alleviate pain and suffering, it has also been used to an a coercive instrument of state power and social engineering.

The union of technical medical and rights-based discourses around health, between AIDS activists and doctors is an immensely hope-inspiring development, which is the right approach to the legacies of the use of medicine for coercive colonial and late apartheid racist policies and practices. Mbeki's response to AIDS is neither the correct way to address the past, nor confront the present reality that a sexually transmitted virus is dramatically weakening the immune systems of many South Africans' bodies. It also appears to be highlighting the largely unaddressed legacies of the long illnesses of underspending on health infrastructure, a fragmented health system, the draining of resources and personnel into the private sector, and racist, sexist and heterosexist family planning and AIDS policy.

Instead of confronting the problem head on though he appears like Shakespeare's Hamlet in to be haunted by the ghosts of the past and dithering and procrastinating while the state 'of Denmark' falls apart. As Marx

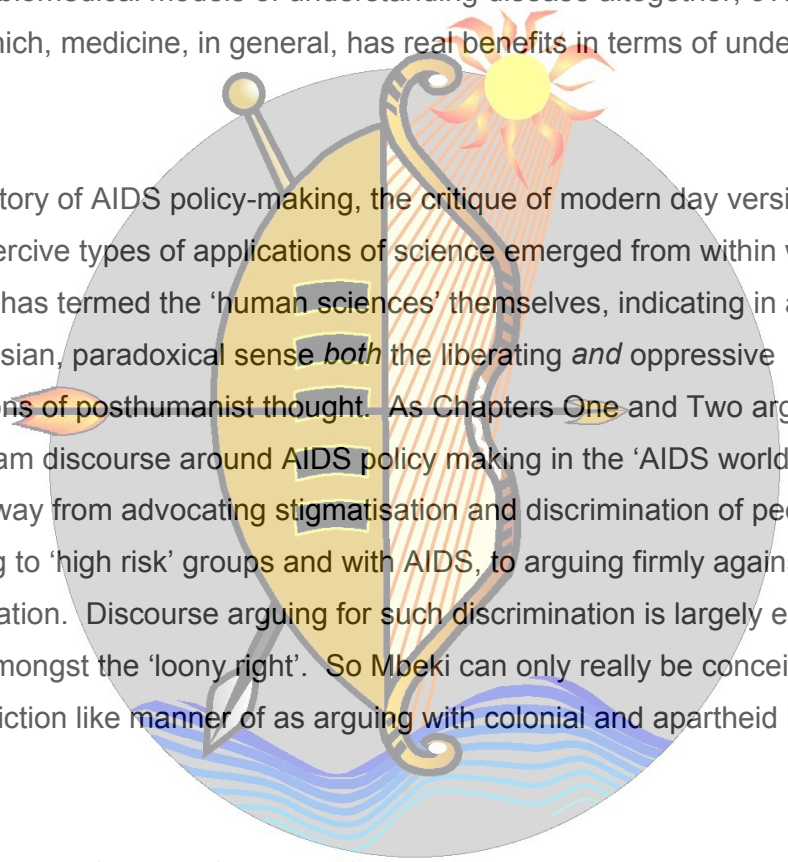
said, the past should rather be used to avoid making the same old mistakes in the present. It should be used and understood to avoid the present revolution putting on the costumes of past revolutions and borrowing their battle cries and to avoid bourgeois complacency.[8] The problem with using history uncritically and rhetorically for political point-scoring, in the way that politicians are wont to do, is that its dialectic complexities, unfinishedness, its disputedness, its ongoing legacy get drowned out to legitimate a certain order of things.

Whilst Mbeki speaks of protecting Africans from being seen as inherent 'germ carriers', a largely silent underclass of ill and dying South Africa is growing in numbers and receiving inadequate alleviation of pain and suffering. As a matter of fact, AIDS is killing off more African South Africans than apartheid ever did, and in terms of African mortality will outstrip any of the racist 'genocidal' dreams of apartheid's secretive state security scientist-henchmen.[9] Poverty, cultural and gendered factors and the socio-economic legacy of apartheid are partially to blame for this, but the fact is that the post-1994 government has had seven years to make decent policy and has failed to bring down, or stabilise infection rates in the same ways that other socio-economically similar countries have, such as developing countries like Thailand, or African countries like Uganda and Senegal.[10]

Let it not be said that this dissertation has at all attempted to argue that 'things were better in the good old days of apartheid'. The late apartheid government did incredibly little to halt an AIDS epidemic, in spite of accurate warnings in the late 1980s about the shape it would take. The histories of family planning and STD management both have their dark sides, and can both be linked to

[8] Karl Marx. *The Eighteenth Brumaire of Louis Bonaparte.* (New York: International Publishers, 1987), 15.
[9] I am referring here to allegations that people like Dr Wouter Basson (often referred to as 'Dr Death) experimented with contraceptives to render the black population of South Africa infertile.
[10] I heard papers from health policy-makers and analysts from these countries pointing out their successful strategies in bringing down or stabilising HIV infection rates at the "3rd HIV Prevention Works Symposium", a Satellite Conference to the International AIDS 2000 Conference, held at Durban's Royal Hotel on the 8th and 9th July 2000. For more on this see the reports on the international status of the epidemic at the UNAIDS website: www.unaids.org.

racist, sexist and classist, Eugenic, Social Darwinist, and Malthusian applications of science. Compulsory sterilisation of the 'racially unfit' in Nazi Germany, and the indiscriminate and coercive administration of Depo-Provera to black women, would tend to show the history of this dark, unethical and abusive side. However, now is the time to separate the wheat from the chaff in terms of medical ethics and medicine's potential to enhance people's rights as citizens, as opposed to oppress them as subjects; the middle of a massive national AIDS epidemic is the worst possible time to attempt to throw out Western biomedical models of understanding disease altogether, over and above which, medicine, in general, has real benefits in terms of understanding disease.



In the history of AIDS policy-making, the critique of modern day versions of these coercive types of applications of science emerged from within what Foucault has termed the 'human sciences' themselves, indicating in a Habermasian, paradoxical sense *both* the liberating *and* oppressive implications of posthumanist thought. As Chapters One and Two argued, mainstream discourse around AIDS policy making in the 'AIDS world' has shifted away from advocating stigmatisation and discrimination of people belonging to 'high risk' groups and with AIDS, to arguing firmly against such discrimination. Discourse arguing for such discrimination is largely extinct except amongst the 'loony right'. So Mbeki can only really be conceived in a science-fiction like manner of as arguing with colonial and apartheid history itself.

If we conceive of some African AIDS denialists as having inverted and reapplied Othering onto the West in the way Megan Vaughan has argued, it becomes clear that there are severe limitations in remaining trapped in colonial era discourse (even if inverting it).[11] Chief amongst these being inverting negative racial and cultural stereotypes around sexuality, without in a detailed way examining real sexual practices among different groups of

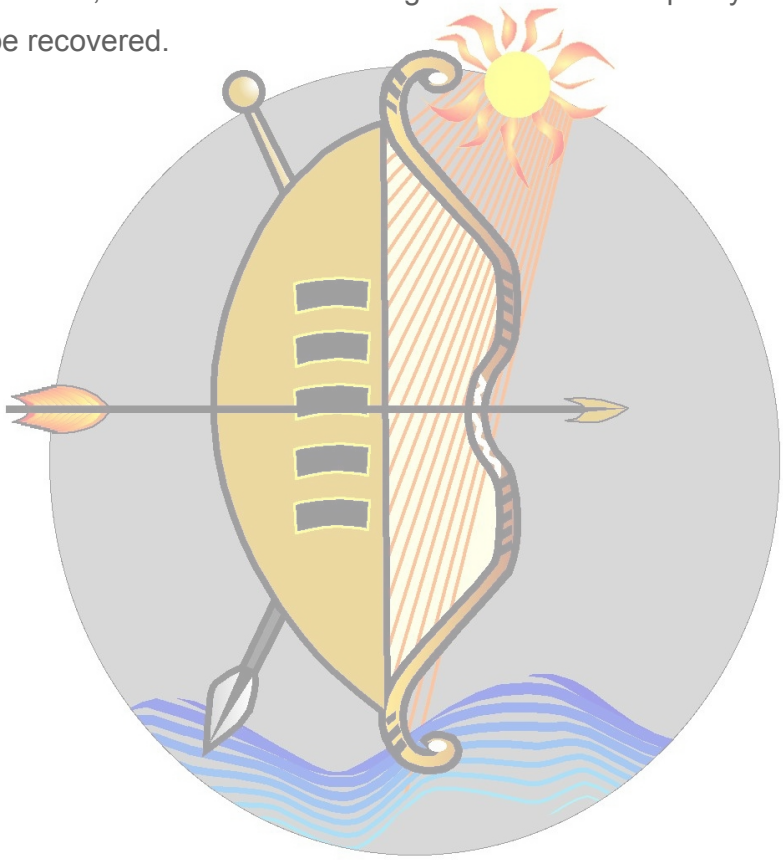
[11] Megan Vaughan. "Conclusion: The Changing Nature of Biomedical Discourse on Africa". *Curing Their Ills: Colonial Power and African Illness.* (Cambridge and Oxford: Polity Press, 1991), 200.

people in different societies over time. Conspiracy theories also get us nowhere in understanding the past and the present: according to the logic whereby AIDS is a CIA/pharmaceutical industry plot, the evidence supporting the thesis cannot be accessed, or has been destroyed by shadowy agencies. In the same way if we are to believe that AIDS is a white plot to wipe out black people or to stop them having sex, (a strange theory I have heard at AIDS workshops), where is the evidence?

In contra-distinction to such AIDS conspiracy theories, history fundamentally consists of archival, evidence-based claims, which are crucial to understanding how South Africa has come to face such a crisis in AIDS policy-making. Conspiracy theories make great Hollywood thriller movies, but very bad history. As opposed to making grandiose, but evidence-hollow claims, I have attempted to build such an archival, evidence-based dissertation project looking at the history of AIDS policy-making using: the FPASA archive; sources from the Centre for Health Policy and Women's Health Project resource centres; relevant South African and international medical journal articles; relevant newspaper and magazine articles; and interviews with health policy researchers. The history I have uncovered in these sources is one of the medical disciplinary gaze and the oppressive iron cage of medical modernity. On the other hand it is a history of the resistance of historical agents in asserting post-humanist right-based discourse. in the present it is one of the ghosts of colonial and late apartheid medicine haunting AIDS policy.

As I write these closing sentences on World AIDS Day, twenty years into the world-wide epidemic, it seems that AIDS might, in spite of its enormous death toll, hold hope in having already successfully reformed discourse justifying coercive and non-rights based practices in biomedicine, and led to a new assertion of medical ethics and the human rights of patients. It is the political front that AIDS policy is failing now. Public health in South Africa has never been more overstretched than by this epidemic, and the time has more than come to ask what state policies have made it so, what past policies they in turn are reacting to, for or against. Whilst how health policy and socio-

economic factors affect health has been written about for some time, the time has also come to see health as a historically-determined phenomena. This historical consciousness will be crucial to identifying effective AIDS policies, and key to that will be identifying change over time in social and cultural determinants of health, and in particular sexuality. HIV positive South Africans today deserve social justice, and equal access to quality health care not merely the symbolic lighting of candles and the wearing of ribbons.[12] If the new broad-based political movement to attain that justice is to succeed in its worthy cause, the histories of the long-illnesses of AIDS policy-making will need to be recovered.



[12] An argument I heard eloquently expressed in a rousing speech by Richard Pithouse of the Durban Social Forum at the Durban TAC demonstration held on the 26 November 2001 outside the Provincial Premier's headquarters at Truro House, Durban, to support TAC's current court case seeking an order for the state to provide treatment to prevent MTCT at antenatal facilities at all state hospitals and clinics.

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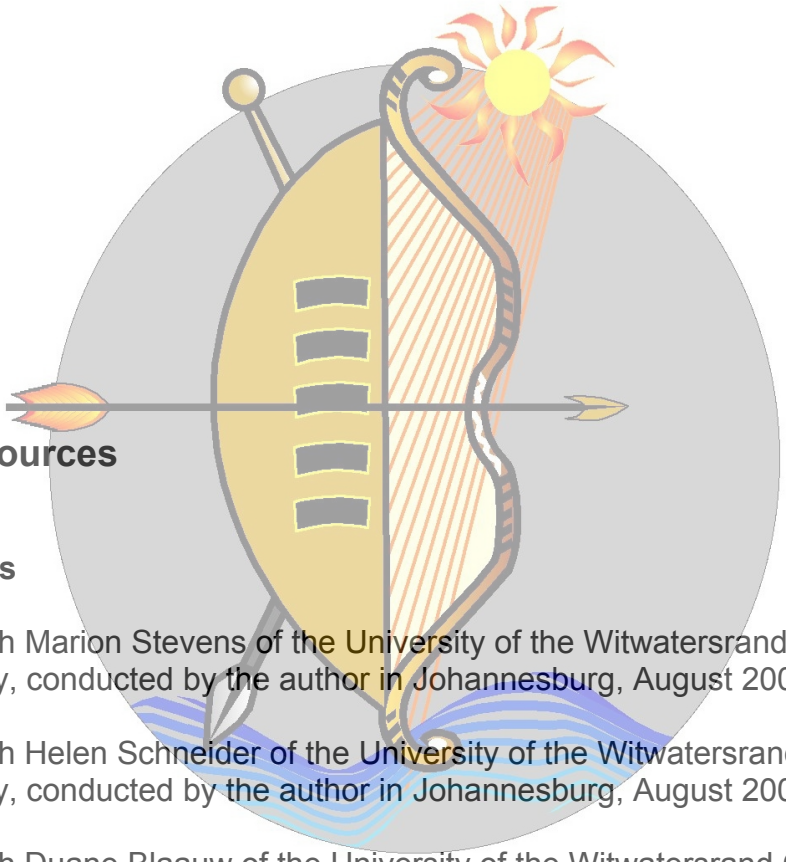

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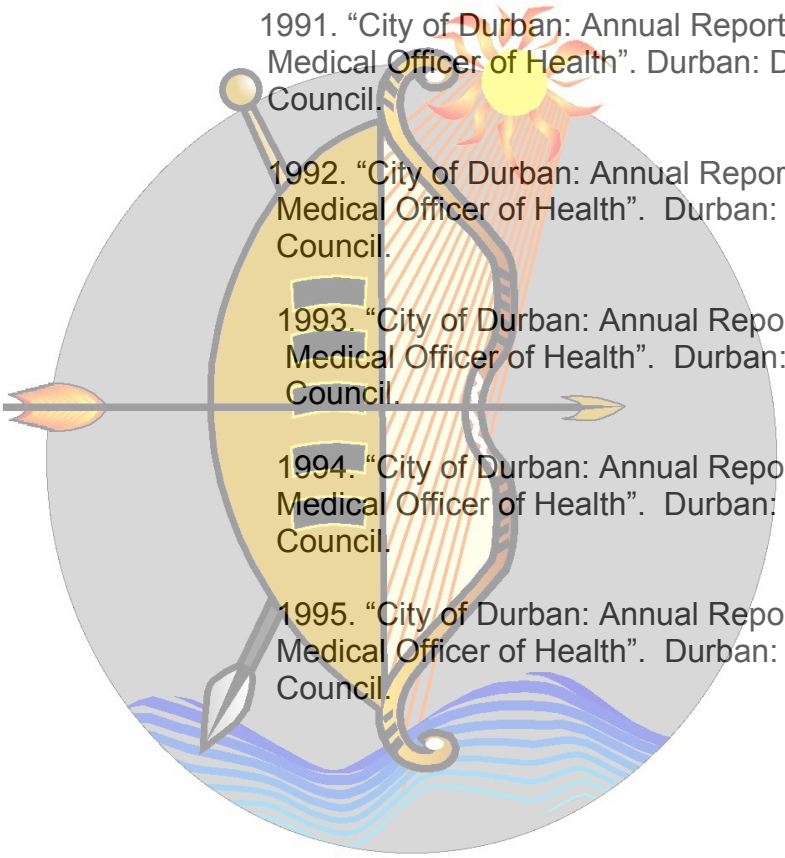

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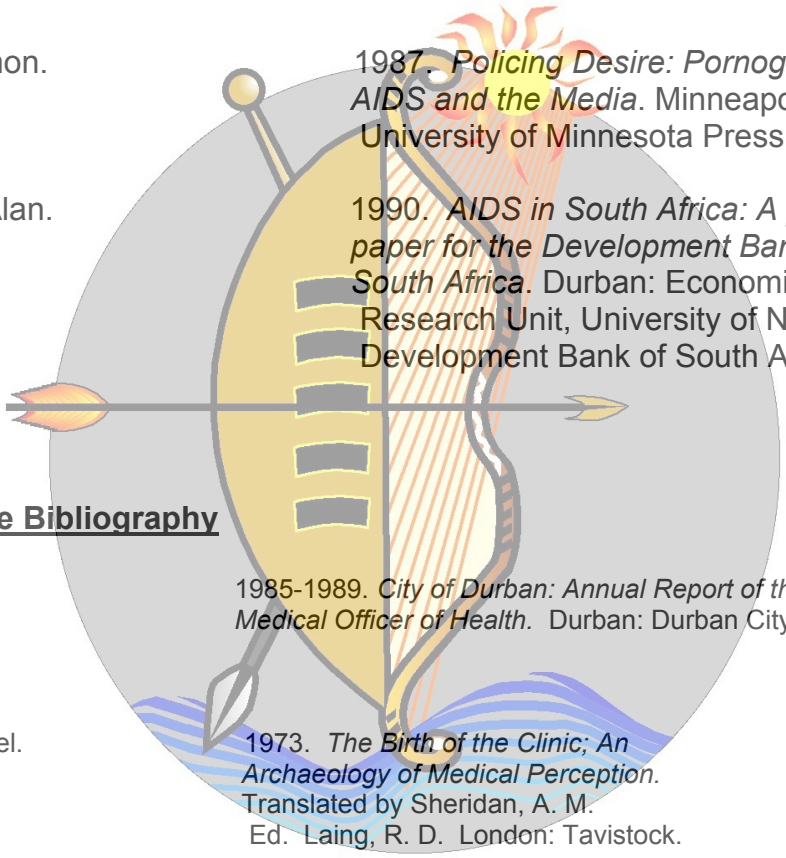

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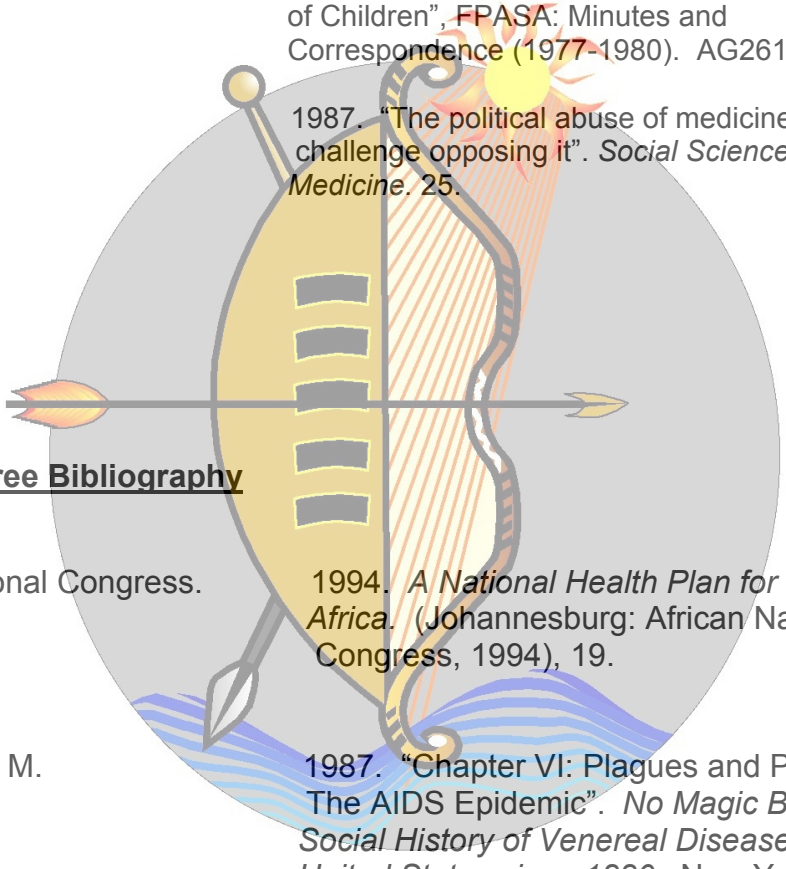

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