

South Africa, AIDS, and the Development of a Counter-Epistemic Community

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Abstract:

The South African government's open challenging of the international AIDS control regime presents a paradox for the study of international regimes and epistemic communities: why would a state that would presumably benefit the most from a regime not only refuse to adhere to its precepts, but openly challenge its basic tenets? I argue that a fundamental disjuncture exists between the identity commitments of the international AIDS control regime and South Africa's identity, and that this disjuncture is rooted in the country's negative past experiences with public health interventions and the attempts to forge a new, African Renaissance-inspired self-identity. This disjuncture finds its expression through the development of a counter-epistemic community which offers scientific expertise and policy recommendations to the South African government. The counter-epistemic community offers a mechanism for the South African government to engage the international AIDS control regime.

Over five million South Africans are HIV-positive and will die from AIDS in the next few years. This number represents approximately one-quarter of the country's adult population. The vast majority of these people are between the ages of 15 and 39, in the midst of their most productive years of life. The South African economy stands to lose billions of dollars, and the potential consequences for the political system are enormous. Even if South Africa managed to stop the spread of AIDS today, the country essentially faces the loss of an entire generation. Given such a grim scenario, we would expect the South African government to take the lead on treating those infected with the disease and preventing further infection. We would expect the South African government to take advantage of the resources offered by the international AIDS control regime to stem the tide of the regime. We would expect the epistemic community that has sprung up around AIDS to play a prominent role in formulating South Africa's AIDS policies. We would expect the South African government to be a leader in the fight against AIDS. Paradoxically, though, the South African government has not failed to take an active and aggressive approach to the disease, but it has publicly shunned the international AIDS control regime and its epistemic community.

In light of overwhelming international pressure, and the apparent success of the international AIDS control regime in other parts of the world, why has the South African government consistently refused to follow the recommendations of the regime? Why is the country with the highest number of HIV-positive persons in the world also the most prominent and outspoken holdout from this regime? I argue that this situation has arisen because of the conflicting identity commitments between the regime constructor, the international AIDS control regime, and a regime participant, the South Africa government. The international AIDS control regime challenges the South African government's self-identity. At the same time, the South African government has had negative experiences with 'Western' public health campaigns and has expressed desire for an autonomous voice in international affairs. The South African government's identity, especially in this post-apartheid era, is intertwined with avoiding the post-colonial paternalism that has often accompanied international policy toward Africa, while simultaneously promoting the need for African states to take an active role in African affairs. As a result, the South African government has responded to this identity disjuncture by actively encouraging the formation of a *counter-epistemic community*, which translates South Africa's history with public health interventions and its self-identity into actual policy outcomes. This international counter-epistemic community of scientists and experts shapes the discourse surrounding AIDS and offer advice and policy suggestions to the South African government. It serves as a counterweight to the epistemic community embraced by the international AIDS control regime. It translates the somewhat amorphous notions of 'history' and 'self-identity' into policy outcomes, giving them real-world weight.

This paper proceeds in six sections. First, I define 'regime' and show how it applies to AIDS. Second, I develop the concept of counter-epistemic communities, discussing why such groupings may exist and how they come into being. Third, I explore South Africa's history of public health interventions, showing how these have been used for political purposes in the past. Fourth, I examine South Africa's attempts to forge a new self-identity based on the African Renaissance, noting in particular its emphasis on finding "African solutions for African problems." Fifth, I discuss how South Africa's history and identity feed into the formation and operation of a counter-epistemic community on AIDS. Finally, I conclude by discussing the policy relevance of these findings and suggesting avenues for future research.

I. Defining the terms

Young offers a definition of a regime that successfully allows for investigations into the impact regimes have on state identities, while simultaneously preventing the definition from being either too narrow or too broad. He writes that regimes are “sets of rules, decision-making procedures, and/or programs that give rise to social practices, assign roles to the participants in these practices, and govern their interaction” (1999: 5). One major strength of this definition, as Young himself notes, is that it avoids necessarily taking a firm position on whether regimes are contractual or constitutive; it instead allows both processes to operate under this rubric. Second, Young specifically notes the social framework inherent in any international regime. His definition allows for regimes to be entities within international relations worthy of study on their own merits. Along that same line, he differentiates regimes from international organizations by emphasizing how regimes guide action. To paraphrase Kratochwil’s statement about the role of norms, regimes do not cause behavior; they allow for it to happen. Third, Young’s definition provides analysts with detail and direction for useful studies of international regimes. How do regimes give rise to these social practices? Do they operate in the same manner in all issue-areas? Do state interactions within regimes impact those interactions outside of the particular regime? These are important questions, and employing Young’s definition of regime helps give rise to them. Finally, Young’s definition is sufficiently broad to guide investigations about regimes in a number of different areas, but not so broad as to assume that regimes exist in *all* issue-areas. For these reasons, I employ Young’s definition of regimes to guide my research.

It also important to explicate what is meant by the international AIDS control regime. One cannot necessarily define regimes by the behaviors exhibited by their members, since regimes possess counterfactual validity (Kratochwil and Ruggie 1986). By presenting some of the basic tenets of the beliefs about controlling and treating AIDS held by regime members, we find ourselves in a better position for analyzing the regime. The Joint United Nations Program on HIV/AIDS describes its mission as comprising four distinct parts: preventing the transmission of AIDS, providing care and support, reducing community vulnerability to HIV/AIDS, and alleviating the disease’s impact (UNAIDS 2003: 2). UNAIDS also emphasizes the importance of assuring that HIV-positive persons are accorded basic human rights like non-discrimination, equal protection under the law, and privacy (UNAIDS 2004). These five components provide a general sense of the beliefs and identity commitments embodied within the international AIDS control regime.

II. Epistemic communities and counter-epistemic communities

How does a state’s history and identity then translate into actual policies? One could simply state, “History and identity matter,” and leave it at that. This would tell us very little, though. How do they matter? Through what means do a state’s history and identity translate themselves into policy outcomes? Where is the *Via Media*, to use Wendt’s (1999) terminology, to generate real-world consequences from these rather abstract, nebulous ideas? This is where epistemic communities enter the picture. Haas famously defined an epistemic community as “a network of professional with recognized expertise and competence in a particular domain and an authoritative claim to policy-relevant knowledge within that domain or issue-area” (Haas 1992: 3). Four important characteristics distinguish an epistemic community: shared normative and principled beliefs; shared causal beliefs; shared notions of validity; and a set of shared common practices associated with the problem within the particular issue-area (Haas 1992: 3). Epistemic communities provide crucial information to international regimes by interpreting problems and offering solutions to those problems. These communities and their regimes are co-constituted, meaning that the identity commitments and history of the regime necessarily impact the epistemic community and vice versa.

The knowledge and suggestions offered by the community reflect their co-constituted nature, as its information and suggestions are “informed by its own broader worldview” (Haas 1992: 4).

In so doing, epistemic communities necessarily frame how the problem is interpreted and framed by others. “Epistemic communities are the cognitive baggage handlers of constructivist analyses of politics and ideas” (Haas 2001: 11579). Framing is immensely powerful. It sets the terms of the debate, and dictates how others view the problem. It lays the groundwork for privileging certain ideas and approaches. Framing is *not* value-neutral, though. Along with framing comes the framer’s ideas, prejudices, and outlooks. It immediately imbues a certain moral and ethical context to the problem that encompasses a state’s history and identity. When AIDS was framed as “gay cancer” in the United States, the national response was distinctly different than when AIDS was framed as an infectious disease that could strike anyone¹. Through the framing process that is central to epistemic communities, a state’s history and identity is translated into something more concrete that can guide policymakers.

This is not to say, though, that an epistemic community only includes citizens of one state, or that an epistemic community only includes the history and identity of one state. An epistemic community is not a monolithic bloc in which all members march in lockstep with one another. Members of an epistemic community can and do disagree with one another. Shared causal and normative beliefs will not necessarily lead members of an epistemic community to interpret data in an identical manner at all times (Haas 1992: 3-4). What is important for an epistemic community is that members share a general worldview and approach to a problem.

This is at the root of the problem with the literature on epistemic communities and the theoretical innovation presented here. The epistemic communities literature speaks of the one epistemic community that gains influence when policymakers attempt to devise responses to transnational problems. However, if epistemic communities are set apart by their shared worldview and interpretation of a socially constructed reality, then why would anyone assume that there is only *one*? Arguing that only one epistemic community gains influence essentially says that most or all policymakers, though they may be scattered across the globe with radically different histories, identities, and worldviews, will interpret these new, complex transnational problems *in the exact same manner*. This simply does not make logical sense. If this is the case, then the literature on epistemic communities contradicts its knowledge-based epistemological heritage. Policymakers turn to epistemic communities because they need high-quality information in order to interpret and respond to emerging, complex transnational issues. It does not then follow that the responses from a community of experts on a new, complex problem would be the same. Different people are likely to have different interpretations and frames for this socially-constructed reality. Litfin (1995) partially makes this point when she discusses the importance of studying the discursive narratives within epistemic communities. She notes how problem frames are inherently contested, and that one must examine the associated discourse to explain which ideas carry the day. The Italian School of international relations, with its Gramscian intellectual heritage, picks up on this point. The manner in which problems are framed is contested, but the Italian School argues that those frames which reinforce the dominance of the hegemon will trump others (Lavelle 2001, Murphy 1998). Both Litfin and the Italian School make a similar oversight, though. They both assume that epistemic communities are essentially engaged in zero-sum games to acquire influence. If Community A is

¹ For more on the framing of AIDS in the United States and the attendant political and social responses, see Shilts 1987 and Sontag 1989.

recognized for its expertise on a particular issue, then Community A is *the* expert community for that issue. No other challengers need apply, for Community A has vanquished its competitors and all policymakers will turn to Community A for advice.

Why should this be the case? Could Community B find its own niche? After all, the problems being dealt with by epistemic communities are complex and transnational. Would it not be better to suppose that Community A and Community B, both made up of scientists and experts recognized for their expertise and turned to for advice, could *both* find a place in the world? The members of both communities may have similar impeccable, recognized credentials, but that does not necessarily mean that they share the same general worldview. They could interpret the realities of a particular problem in radically different ways, and those differing interpretations could lead to wildly divergent policy recommendations. This is more like what happens every day with domestic political issues that emerge, be they as mundane as grazing fees or as important as responses to international terrorism. Why, then, should one assume that responses to transnational problems would not be similarly contested? Anyone who has examined international relations on even a cursory level (or, for that matter, has skimmed the front page of a newspaper) knows that the international arena is not one of peaceful agreement. States vigorously disagree with one another. These disagreements could be rooted in epistemic communities opposed to one another. Though there may be a dominant epistemic community, that does not necessarily preclude the emergence of a *counter-epistemic community* which presents problem frames and policy suggestions in opposition to the dominant epistemic community. As states interpret problems in different ways, they will respond to different policy suggestions and privilege different epistemic communities.

Building off Peter Haas' definition of epistemic community, I define a counter-epistemic community as a network of professionals with recognized expertise and competence in a particular domain and an authoritative claim to policy-relevant knowledge within that domain or issue-area in opposition to the recognized expertise of the dominant epistemic community. It serves as a counterweight to the dominant epistemic community by attempting to reframe the problem and offering alternative solutions to problems faced by the international community. It empowers a state or group of states to challenge the dominant position. It is important that a counter-epistemic community's expertise be recognized by policymakers in some state. The mere existence of a group of people with policy views on a particular issue is theoretically meaningless unless those policy views are embraced by policymakers within a state. This embrace is crucial for recognizing the community's expertise and for considering the community a relevant actor on a particular problem. Counter-epistemic communities give voice to identities and histories that the dominant epistemic community overlooks or ignores.

Counter-epistemic communities need not necessarily arise after the dominant epistemic community. Both could develop simultaneously, especially during the tentative early days of a new problem. Though one community may eventually be recognized as dominant, that does not automatically mean that the other community will wither away. No a priori reason exists why the recognition of one community by a group of states automatically eliminates the possibility of another community being recognized by a different group of states.

The disagreements between the international AIDS control regime and the South African government provide an illuminating illustration of how identity and history provide fodder for the construction of a counter-epistemic community. I first examine South Africa's public health history before turning to the attempts to foster a new state identity.

III. Public health interventions in South Africa

Given its general apathy toward the public health of blacks, responses by the colonial government to disease outbreaks among blacks were often greeted with suspicion and mistrust. In the mid to late 1890s, a rinderpest epizootic spread throughout South Africa. Rinderpest is an acute viral disease that primarily affects the respiratory and gastrointestinal systems in cattle. Outbreaks of the disease, though rare, are devastating because nearly all animals infected with the disease die, usually within a week of infection. The spread of rinderpest caused a great deal of consternation, as cattle were a symbol of one's wealth among both whites and blacks. In response to the outbreak, colonial officials in late 1896 began a program to quarantine "promiscuous," black-owned herds to prevent them from spreading the disease to white-owned herds. As a part of the quarantine program, black-owned herds and their herders were doused with harsh chemical disinfectants in an attempt to eliminate rinderpest (Carton 2003: 204). The disinfectant had almost no effect on rinderpest, but it did lead to the destruction of large numbers of black-owned cattle. The next year, colonial officials began a program that inoculated cattle against rinderpest with a serum taken from the gall bladders of infected cattle. Unfortunately, the serum only had a limited effectiveness. More problematically, though, injecting healthy cattle with the serum temporarily induced symptoms of rinderpest. As a result, colonial officials were telling black herd owners that they were coming to protect their cattle, but the herd owners saw little improvement—and instead witnessed their cattle appearing to come down with the very disease against which colonial officials claimed to be protecting the cattle. This led to suspicion and resistance among black cattle owners. Carton writes, "If the Europeans came to cure, they [black herd owners] asked, why was he 'bringing the disease nearer'? This question was often posed by black people in southern Africa, who suspected rinderpest was the 'white man's' weapon of death in 'the imperial apocalypse' wasting their land" (Carton 2003: 204). Black cattle owners thus came to link rinderpest with malevolent intentions on the parts of white colonial officials. Colonial officials claimed to be helping the black herd owners, but their motivations were to protect white-owned herds. Further, their methods of protecting black-owned herds seemed to work *against* preventing the spread of the disease.

This is not the only example of colonial inoculation programs leading to mistrust among blacks about the intentions of colonial authorities. In the fall of 1918, the world fell victim to a massive epidemic of Spanish influenza. Between 20 and 40 million people worldwide died before the epidemic ended in 1919. South Africa was not spared from the devastating consequences of this outbreak. Called *umbathalala* or 'disaster' in Xhosa, influenza spread rampantly throughout the rural eastern Cape region between September and October 1918. In response, colonial officials sent flu inoculations to the region, hoping to stop the spread of the disease before it hit urban areas. The response among blacks to the inoculation program was largely negative. Blacks claimed that "the 'long needle' of the 'white man' came to inject more harm" (Carton 2003: 204). Again, the black population distrusted the intentions of public health interventions led by white colonial officials.

Public health measures soon came to play a defining role in implementing segregationist policies in South Africa and the creation of the apartheid system. Starting in the 1870s, fear of diseases like cholera, plague, and plague inspired and rationalized calls among whites to segregate blacks and Indians. "The metaphoric equation of 'coolies' with urban poverty and disease became a steady refrain of white opinion and a preoccupation of police and health officers in the South African colonies long before 1900" (Swanson 1977: 390). Public health and prevention of epidemics then largely justified movements toward racial segregation. In fact, South Africa's first segregationist law

was the Public Health Act of 1883 (Fassin and Schneider 2003). This act mandated vaccinations and public notification of infectious diseases, and gave local authorities extensive emergency powers, including the ability to establish quarantines and sanitary corridors. Medical officials in South Africa during this time often saw infections and the spread of disease as a social metaphor that interacted powerfully with current racial attitudes in both Great Britain and South Africa (Swanson 1977: 387).

Around this same time, germ theory was gaining acceptance within the medical establishment. Thanks to the findings of people like Robert Koch, doctors came to believe that diseases spread due to the transmission of germs and bacteria. While this finding revolutionized medical science, it also contributed to the development of segregationist ideologies in South Africa because it showed the need for the races to be separated. Bear in mind that much of the South African medical establishment at this time argued that Africans were inherently more prone to contract and spread diseases, and the medical establishment wanted to prevent the diseases of blacks from spreading to the white population. With germ theory, South African medical authorities saw that social intercourse could in fact be dangerous to the health of whites. It was no longer a simple matter of Africans being more prone to disease. Now, they could spread those diseases to the white population simply by being in close proximity to whites. Black bodies now constituted a direct threat to the health of whites (Lund 2003: 96). With such a framework in place, it is but a small leap to argue that blacks and whites must be physically separated from one another.

The third worldwide plague epidemic² galvanized colonial officials into using public health measures to establish segregationist policies. In South Africa, the discovery of bubonic plague in Cape Town in 1900 led to the forced movement of the city's African population into "native locations" on the basis of the aforementioned Public Health Act of 1883 (Fassin and Schneider 2003). *This was the first time that separate locations for blacks, a hallmark of apartheid, were created in South Africa.* Colonial officials argued that plague came to South Africa because of the Africans and their unsanitary conditions, even though there were fewer cases of plague among Africans than among whites or Coloureds (Swanson 1977: 392-393). Echenberg notes, "Throughout the epidemic, fingers were pointed at the 'raw natives' and the 'dirty Jews'; little mention was made of the South African War, which turned Cape Town into an overcrowded military and refugee center" (Echenberg 2002: 447). Ironically, by placing Africans into these crowded "native locations" which lacked appropriate infrastructure and sanitation, colonial officials actually created the conditions for plague to spread among Africans—which only served to reinforce their ideas about the need to segregate the city's African population away from whites.

The African population was well aware of how white colonial officials used public health measures to justify segregation. Swanson writes, "Blacks were especially resentful at the discriminatory application of the plague quarantine regulations...The horses of blacks had been quarantined; those of neighboring whites had not. The possessions of blacks had been burned; the goods, the stores, and the warehouses where they worked and contracted the plague had not been touched because those belonged to whites" (Swanson 1977: 402). As with the rinderpest epizootic, white colonial officials told the black populations that measures were being taken to protect their health, but Africans saw that these measures actually made them worse off. Africans saw that these public health measures served to extend the reach of the colonial state over them (Lund 2003: 92). Durban's 'deverminization' campaigns inspired strikes by the Industrial and Commercial Workers'

² The third plague epidemic is generally thought to have started around 1894 and ended around 1904, though the dates for individual countries and regions differs.

Union, leading to a temporary cessation of the practice. Even after the strike, these campaigns “remained a constant source of serious discontent amongst Coloureds and the African elite, and a focus for political action” (Marks and Andersson 1984: 34).

It is important to emphasize that the outbreak of plague did not *create* the calls for segregation. Swanson notes, “[T]he plague itself did not create anxieties full-blown, but it focused them sensationally” (Swanson 1977: 392). Plague concentrated the anxieties and fears that already existed among the white population, and provided to advance the segregationist agendas. During this time, whites, especially in the urban areas, became increasingly vocal about the dangers posed to them by the poor health of the poor black workers (Packard 1989: 15). These white urban voices were not necessarily promoting new ideas; rather, they had found a ‘hook’ for segregationist ideas that already existed among South Africa’s whites. Through the logic of the times, though, segregation was both a conservative and a liberal idea. Conservatives argued for segregating blacks because they spread disease to whites. Liberals argued for segregating blacks because they wanted to protect blacks from the dangers and squalor of urban life (Lund 2003: 92; Packard 1989: 194-195). Both sides could advance segregationist agendas under the guise of protecting the black population through public health measures.

Concerns about blacks spreading infectious diseases to the white population continued through the 1980s. Government-sponsored health services were poorly coordinated and highly fragmented during this era because it was oriented toward furthering the political aims of apartheid rather than the health needs of the black population (Zwi and Bachmayer 1990: 319). Epidemics of polio, cholera, and typhoid swept through the South African Bantustans during the 1980s. The South African government did little to address the actual disease outbreaks themselves. Instead, it focused on covering up these epidemics to prevent “moments of hysteria when it was feared they would cross the lines into ‘white’ Durban, or even Johannesburg and Pretoria” (Marks and Andersson 1984: 32). Marks and Andersson, commenting on apartheid-era public health programs among blacks, remark, “For blacks, typhoid is now an everyday occurrence, but it is only when it encroaches on the ‘white preserve’ that it causes a stir. In general, the state has been able to take its *laissez faire* attitude because the epidemics have remained amongst South Africa’s ‘surplus population’ within the Bantustan borders” (Marks and Andersson 1984: 32).

With the advent of AIDS, the negative image of public health and outside health interventions returned. AIDS was almost immediately imbued with particular judgments about those infected with the disease, just as earlier epidemics were. Hendriks notes, “AIDS became almost immediately surrounded by value judgments and prejudices, which made it that epidemic can hardly be viewed neutrally... This all makes AIDS a value-laden epidemic” (Hendriks 1991: 8). Many of these value judgments originated with the theories about the origins of AIDS. To this day, questions over the origins of AIDS remain controversial and hotly contested. When AIDS first emerged, many people blamed Africa for the disease. They claimed that it moved from monkeys to humans through the eating of chimpanzees or elaborate tribal rituals involving monkey blood (Sabatier 1988: 88). These accusations immediately led to suspicion among African researchers about *any* hypothesis that placed AIDS’ origins within the African continent. Sabatier notes that these early theories often included racist, ill-informed speculations and offensive assumptions about African sexualities, and that little, if any, of this research was conducted by Africans or even in Africa (Sabatier 1988: 88-90). Many in Africa saw these accusations as symptomatic of continued Western racism. African leaders claimed that Western states were engaged in “imperialist scapegoating” by blaming Africa for AIDS (Packard and Epstein 1991: 773). They were also suspicious of Western interest in the disease, as many

stories circulated in the press that AIDS was created in and deliberately spread by American labs (Fassin 2002: 64). *Sechaba*, an official publication of the African National Congress during the apartheid era, implied a direct connection between biological weapons research programs in the United States and its allies and the spread of AIDS (Mzala 1988). This helped lay the foundation for suspicion and hostility about public health and outside intervention when it came to AIDS.

In South Africa, the policy of apartheid did little to assuage fears and doubts about AIDS among Africans. Early government efforts to prevent an AIDS epidemic focused on testing and repatriating migrant Malawian workers, not preventing the spread of disease among local populations (Larson 1990: 11). Anti-apartheid groups decried early government anti-AIDS programs as “typical racist propaganda” for focusing on stereotypical images of African sexuality (Van der Vliet 1994: 110). Apartheid provided almost ideal social conditions for fostering the AIDS epidemic, with its migrant labor systems and disruption of traditional norms and cultural systems. Given that the disease’s spread among the black population, politicians quickly found an ideological basis for talking about the disease in strictly racial terms (Fassin 2002a: 64). In a debate in Parliament in 1990, Dr. F.H. Pauw, a Conservative Party member, alleged that members of the ruling National Party were telling white South Africans that they need not worry about majority rule because “AIDS will be responsible for the large-scale elimination of the Black population, to such an extent that Blacks will in reality become a minority in South Africa within five years” (Republic of South Africa 1990: 9761). Dr. E.H. Venter, the Minister of National Health and Population Development, denied these accusations. She responded that it was actually the Conservative Party that was at fault. She quoted Conservative Party Member of Parliament Clive Derby-Lewis, who stated, “If AIDS stops Black population growth, it would be like Father Christmas”³ (Republic of South Africa 1990: 9797). Crewe notes that the Conservative Party during the 1980s spread the view that AIDS could be spread through “coughing and sneezing, by water, milk, food and fruit; by personal contact and by biting insects” (Crewe 1992: 73). Right-wing newspapers in the day regularly published so-called evidence that HIV could be spread through casual contact to “low-risk groups,” i.e. whites (Van der Vliet 2001: 157). Apartheid’s supporters used this rhetoric to argue against scrapping apartheid, *employing nearly identical rhetorical tools as used in the early 1900s to justify segregation along the lines of public health.*

Such claims would be patently absurd if there were not an element of truth to them. Rumors spread throughout the 1980s in South Africa, and around the world, that AIDS was a plot by whites to cripple Third World countries (Fassin 2003: 55-56). Later evidence showed that this rumor may not have been as far off as some people thought. After the first multi-racial elections in South Africa in 1994, the government established the Truth and Reconciliation Commission to uncover the horrors of the apartheid era and explain some of the atrocities that took place by all sides. During the commission’s hearings, one man testified about his work for Roodeplat Research Laboratories (RRL). RRL was a front for the government’s secret biological weapons program. One of the projects RRL worked on was to develop an infectious agent that would induce sterility among African women. High levels of sterility would lead to declining African birth rates, with the hopes that this would reduce the domestic resistance to apartheid. This man reported that RRL spent a great deal of time and money on utilizing HIV as this agent, though the effort ultimately failed (Fassin and Schneider 2003). This resonated with rumors that spread among Zulu-speaking communities in the 1980s and early 1990s. These rumors talked about a white ‘doctor of death’ who

³ This was hardly Derby-Lewis’ worst offense in support of apartheid. A few years later, he was sent to prison for his role in the assassination of Chris Hani, a major figure within the ANC.

unleashed a poison, widely assumed to be AIDS, on blacks. Shockingly, many of these rumors specifically mentioned one man by name—Wouter Basson. Basson was the head of RRL during the apartheid era and directed the programs that attempted to utilize AIDS as an infectious agent that would decrease African fertility (Carton 2003: 206-207). In another finding from the Truth and Reconciliation Commission, former police officers admitted that they took HIV-positive *askaris*⁴ and deployed them in mining camps around South Africa. The mining camps were inhabited by men separated from their families, and brothels often sprang up around them. The goal of this program was to have the *askaris* patronize the brothels in order to spread HIV to the prostitutes. These prostitutes would then infect the other men in the mining camp. When these men went home to visit their families, they would then infect their wives and any future children. The hope was to slowly infect large swaths of the country's African population with HIV, again with the ultimate aim of weakening domestic opposition to apartheid (Whiteside and Sunter 2001: 64-65). *Thus, the apartheid-era government in South Africa did attempt to deliberately spread AIDS among the black population with the goal of wiping it out and enabling the continued functioning of apartheid.*

IV. The creation of a new South African identity

The South African government has appropriated images of liberation and resistance to justify its AIDS policies and President Mbeki's controversial responses to the disease. AIDS is uniquely placed to function in this capacity. Outsiders (and proponents of apartheid) have used AIDS to highlight the weaknesses of the African state, and South Africa in particular, while members of the South African government have employed the disease in an attempt to place the country at the vanguard of charting new territory and embracing a new image.

Mbeki's efforts to forge this new identity center on the 'African Renaissance.' He first used the term in 1997 during a speech to the Corporate Council on Africa in Virginia, encouraging potential investors to share in the emergence of Africa as a significant player on the world stage (Mbeki 1997). The term 'African Renaissance' is a bit vague, though. Vale and Maseko say that the African Renaissance encompasses five key areas: encouraging cultural exchange, emancipating women from the patriarchy, mobilizing youth, broadening and deepening democracy, and promoting sustainable economic development (Vale and Maseko 1998: 274). Okumu (2002) stresses the rebirth of Africa in all areas—cultural, economic, and political. Stremlau also highlights five core attributes of the African Renaissance, but his consist of economic recovery, establishment of democracy, end of neocolonial relations, mobilization of Africans to control their destinies, and economic systems that focus on meeting the basic needs of the population (Stremlau 1999: 102-103). Stremlau's definition is of particular importance, as he presented it at a 1999 conference on the African Renaissance at which Mbeki was a featured speaker. While most definitions of 'African Renaissance' share common themes of emancipation and responsibility, tensions exist over how to interpret this movement. Is the African Renaissance tied to globalization, positioning the continent as the next Asian tigers, or is it more focused on an Africanist identity, which primarily seeks to remake Africa's image in the world's eyes (Vale and Maseko 1998: 278-281)? This question remains largely unanswered, and many have criticized the proponents of the African Renaissance for failing to attach any substantive policy meaning to the term. Vale and Maseko note, though, that this ambiguity may in fact be strategic. They stress the possible similarities between African Renaissance and other ambitious government programs like the New Deal or Great Society—terms which had

⁴ During the apartheid era, *askaris* were essentially double agents. Generally, they were former members of the various resistance movements who later went to work for the apartheid-era security forces.

little inherent policy meaning, but which provided an opening around which innovative policy initiatives might develop (Vale and Maseko 1998: 276-277). Regardless, it is clear that Mbeki sees promoting the African Renaissance as central to his role as president. Speaking to an audience in Cuba, Mbeki (2001a) stressed that the African Renaissance presented an opportunity for Africans, and others in developing nations, to determine who they are and to challenge the West's conventional wisdom about Africa. Addressing a meeting of African central bank governors, Mbeki stressed, "When we speak of an African Renaissance, we speak of ending poverty and underdevelopment on our continent and, therefore, the building of a better life for the ordinary people of Africa, especially the poor, and the assertion of our pride as human beings, with a culture and identity that define our personality" (Mbeki 2001b: 127).

Mbeki's vision of the African Renaissance thus includes both economic autonomy for Africa and the creation of new African identity to challenge the negative stereotypes that prevail throughout the developed world. This African Renaissance-inspired identity extends to science policy and AIDS. One analysis of Mbeki's attitude characterizes as "defiance towards official scientific knowledge, a deliberate act to challenge established truths of AIDS, whether biological or social, and an identification with those on the margins, whether of science or society. Such heterodoxy takes place within the framework of the ideological model of the African Renaissance, emphasizing the necessity for the black continent to find its own solution to its own problems" (Schneider and Fassin 2002: 549).

One must be careful when describing Mbeki's views on AIDS. It is easy to picture Mbeki as an extremist who denies the suffering of his own people. The reality, though, is far more subtle and complicated. Mbeki's supporters and critics have labeled him as someone who is "a restless intellectual," "no stranger to challenging the establishment," and "a chief executive who challenges convention" (Swarns 2000). Others say that he "rejects Western thinking" and "is very keen on doing things in an African way" (Daley 2000). In keeping with his widely-noted sphinx-like nature (Corrigan 1999, Schoofs 2000), he has never definitively stated that HIV does not cause AIDS. He has, though, convened a panel of scientists and experts, both mainstream and dissident, to, in the words of his spokesman Parks Mankahlana, look into "everything about AIDS"—including whether or not HIV causes AIDS (Schoofs 2000). He has also never denied the existence of AIDS or said that AIDS does not exist, though he has certainly questioned whether it has spread to the degree claimed by international organizations and activists. He is widely considered a champion of AIDS dissidents, but he asked them to stop using his name in connection with their work in 2002—though without renouncing his beliefs in their views (Power 2003: 65). Even as Mbeki called the link between HIV and AIDS into question, he never ordered his Ministry of Health to stop purchasing and distributing condoms. In recent years, Mbeki appears to have softened his rhetoric about AIDS somewhat, but many have expressed doubts about whether such temperance represents a genuine change of heart or a simple matter of political expediency (Copson 2003: 4). Late in 2003, his government announced a comprehensive plan to provide antiretroviral drugs to those who need them, but details of the plans are sketchy and many question whether the government has the resources necessary to undertake such an ambitious goal.

The international outcry over President Mbeki's views on AIDS and the resulting policies began in earnest in 2000. The 13th International AIDS Conference was held in Durban, South Africa that year, the first time the conference had been held in a developing country. During his welcoming address, Mbeki stated, "As I listened to this tale of human woe, I heard the name recur with frightening frequency, Africa, Africa, Africa! As I listened and heard the whole story told about out

country, it seemed to me that we could not blame everything on a single virus. *The world's biggest killer and greatest cause of ill health across the globe, including South Africa, is extreme poverty*" (cited in Fassin 2003: 54; emphasis added). With this speech, Mbeki challenged the scientific and discursive base of the international AIDS control regime—and he did so in front of the regime's most prominent members. He started championing 'AIDS dissidents,' scientists who argue that HIV is actually a harmless virus that has co-existed with humanity for thousands of years. AIDS, they argue, is a convenient political name for a mish-mash of assorted ailments that have nothing to do with each other. They argue that the AIDS epidemic in the United States can be traced back to drug use. The maladies associated with AIDS in the United States and Western Europe are simply the body's reaction to being bombarded with drugs on a regular basis. In Africa and other developing areas, the AIDS dissidents see AIDS as the result of poverty, malnutrition, and lack of adequate health care. AIDS dissidents have also argued that drugs like AZT which are supposed to slow the spread of the disease actually make it worse.

Reaction to Mbeki's address was swift. Over 5000 scientists signed the Durban Declaration, which was published in the scientific journal *Nature* (Sidley 2000: 67). It states in no uncertain terms that HIV does in fact cause AIDS. The declaration lays out the evidence for HIV causing AIDS. The signatories affirm, "HIV causes AIDS. It is unfortunate that a few vocal people continue to deny the evidence. Their position will cost countless lives." It concludes, "There is no end in sight to the AIDS pandemic. By working together, we have the power to reverse the tide of this epidemic. Science will one day triumph over AIDS, just as it did over smallpox. Curbing the spread of HIV will be the first step. Until then, reason, solidarity, political will and courage must be our partners" (Durban Declaration 2000). Instead of generating consensus, though, the Durban Declaration led to greater controversy and disagreement. Parks Mankahlana responded to the declaration by saying, "If the drafters of this declaration expect to give it to the president, or the government, it will find its comfortable place among the dustbins in the office" (Agence France-Presse 2000). A group of AIDS dissidents published a point-by-point refutation of the Durban Declaration on their website, and lambasted the signatories for turning what should be a matter of science into one of public opinion.

The condemnation at the 13th International AIDS Conference may have thrust Mbeki's views about AIDS into the international agenda, but this was hardly the first time that the South African government's approach to AIDS caused controversy. In 1997, three scientists at the University of Pretoria, Olga Visser, Dirk du Plessis, and Kallie Landaure, startled the world when they announced that they had found a cheap and effective drug to cure AIDS called Virodene. Newspapers rejoiced that it was a proud day for South African science, and politicians celebrated the low cost of the drug. After making their announcement, the trio approached the government's Medicines Control Council (MCC) for permission to test and sell the drug. The MCC refused. Virodene's active ingredient is dimethyl formamide, an organic industrial solvent that is toxic and, according to some researchers, may actually trigger HIV. Further, the researchers had failed to get their drug cleared for human testing before administering Virodene to AIDS patients and publicizing their findings (Van der Vliet 2001: 163). The drug's makers then approached the Cabinet, directly asking for permission to test the drug. They charged that the MCC refused to license their drug because it was beholden to the Western pharmaceutical companies. The researchers justified their direct appeal to the Cabinet because the MCC and the "AIDS research establishment" blocked their work (Van der Vliet 2001: 164). Mbeki, then South Africa's deputy president and head of the National AIDS Council, came out strongly against the MCC (Powers 2003: 58). He claimed that the MCC was simply doing the bidding of the international pharmaceutical industry, which wanted to deny Africans access to an

inexpensive AIDS drug⁵. The head of the MCC was then sacked (Daley 2000). Mbeki also chastised the MCC for its refusal to certify a product of African science, which he claimed had been suppressed and denigrated for far too long.

Mbeki faced criticism during this same time regarding his policies on anti-AIDS drugs. The Bill of Rights in the South African Constitution guarantees its citizens the right to health care. On this basis, the Treatment Action Campaign (TAC), one of the South Africa's leading anti-AIDS groups, brought suit against the government for its failure to provide AIDS drugs to HIV-positive pregnant women. Drugs like AZT, the TAC noted, had been shown remarkably effective at reducing the risk of HIV-positive mothers passing the disease on to their children, while also improving the quality of life for the mothers. At the same time, Glaxo Wellcome offered to provide the South African government with AZT, then one of the most effective treatments for HIV, at a heavily discounted rate (H. Epstein 2001: 190). Mbeki rejected Glaxo Wellcome's offer and refused to provide anti-AIDS drugs to HIV-positive pregnant women. He specifically cited concerns about safety and possible toxic side effects (H. Epstein 2001: 190). It is indeed true that most anti-AIDS drugs can have side effects, as with nearly all pharmaceuticals. Mbeki, though, was following a line of argumentation first put forward by Duesberg and his cohort of AIDS dissidents. Duesberg asserts that anti-AIDS drugs actually *cause* the disease that they are supposed to combat. Looking at the side effects associated with these drugs, he posits that these side effects are actually symptomatic of infection with a new disease. Mbeki employed some of this same logic in his argument against providing anti-AIDS drugs. He publicly argued that Glaxo Wellcome's offer was not so much a humanitarian effort as an attempt to use Africa as a testing ground for drugs. Because so few people in South Africa have access to these drugs, he argued, international pharmaceutical companies wanted to use South Africa as a dumping ground for untested and potentially dangerous drugs (H. Epstein 2001: 191)—just as drug companies had used developing countries as testing grounds for contraceptives deemed too dangerous for use in developed states (Doyal 1981: 283-284; Brown 1987; Zwi and Bachmayer 1990: 319). In a March 1999 interview, Parks Mankahlana asserted, "Like the marauders of the military-industrial complex who propagated fear to increase their profits, the profit-takers who are benefiting from the scourge of HIV/AIDS will disappear to the affluent beaches because of the world to enjoy wealth accumulated from a humankind ravaged by a dreaded disease...Sure, the shareholders of Glaxo Wellcome will rejoice to hear that the South African government has decided to supply AZT to pregnant women who are HIV-positive. The sources of their joy will not be concern for those people's health, but about profits and shareholders value" (cited in H. Epstein 2001: 190). This again led to an international outcry, with many people unable to believe that a government leader would make such pronouncements that flew in the face of established science and could lead to as many as 60,000 infants born with HIV each year (Schoofs 2000).

The most stunning example of Mbeki's unorthodox views on AIDS came in April 2003. Mbeki wrote a letter about AIDS in Africa to a number of world leaders, including Bill Clinton, Tony Blair, and Kofi Annan. In the context of telling the world leaders about the actions being taken within his country to combat the disease, Mbeki lays out his thinking about AIDS. He cites UNAIDS figures about rates of HIV infection in southern Africa, and implies that these figures might be so high because of the struggle against apartheid. He goes on to examine the characteristics of the AIDS epidemics in the West and in Africa. He writes,

⁵ Ironically, later investigations revealed that the African National Congress, Mbeki's party, stood to profit from Virodene. The ANC received stock in the company that was to produce Virodene (Daley 2000).

Accordingly, as Africans, we have to deal with this uniquely African catastrophe that:

- contrary to the West, HIV-AIDS in Africa is heterosexually transmitted;
- contrary to the West, where relatively few people have died from AIDS, itself a matter of serious concern, millions are said to have died in Africa; and,
- contrary to the West, where AIDS deaths are declining, even greater numbers of Africans are destined to die (Mbeki 2000).

Note the emphasis that Mbeki places on treating the “African catastrophe” by Africans. This is one of his most explicit attempts to connect the struggle against AIDS with the spirit of the African Renaissance. Mbeki goes on to write, “It is obvious that whatever lessons we have to and may draw from the West about the grave issue of HIV-AIDS, *a simple imposition of Western experience on African reality would be absurd and illogical*” (Mbeki 2000; emphasis added). He later added, “We will not eschew this obligation [to treat AIDS in a manner appropriate to Africa] in favour [sic] of the comfort of the recitation of a catechism that may very well be a correct response to the specific manifestations of AIDS in the West” (Mbeki 2000). In both of these sentences, Mbeki emphasizes the need to utilize a distinctly ‘African’ approach to combating AIDS, while simultaneously questioning the scientific assumptions underlying AIDS in the West—including the connection between HIV and AIDS.

Of particular interest are Mbeki’s comments about his discussions with AIDS dissidents. He notes that he has received condemnation from a number of sources for questioning Western orthodoxy on AIDS by consulting them. Mbeki rises to their defense, objecting, “In an earlier period in human history, these [AIDS dissidents] would be heretics that would be burnt at the stake!” (Mbeki 2000). He then proceeds to explicitly tie the work of the AIDS dissidents in with the struggle against apartheid. He writes,

Not long ago, in our own country, people were killed, tortured, imprisoned, and prohibited from being quoted in private, and in public because the established authority believed that their views were dangerous and discredited.

We are now being asked to do *precisely the same thing that the racist apartheid tyranny we opposed did*, because, it is said, there exists a scientific view that is supported by the majority, *against which dissent is prohibited* (Mbeki 2000; emphasis added).

Mbeki not only connects his questioning of the connections between HIV and AIDS with the African Renaissance, but he explicitly identifies it with the struggle against apartheid. Mbeki equates the fight against white minority rule in South Africa with the fight against the international AIDS control regime. He utilizes the trope of the freedom fighter and the continuation of the resistance in an attempt to gain support for his views. One of Mbeki’s aides remarked, “Western scientists once said to us the earth was flat. Now we know it’s round. I bet one day we will look at AIDS the same way....The world will have President Mbeki to thank” (Power 2003: 56). This imagery is in line with the trope of Mbeki as a freedom fighter and liberator. South African commentators note, though, that Mbeki’s notion of creating a unique African identity patterned on the African Renaissance is not necessarily racial, though it has strong racial connotations (Corrigan 1999: 91). Instead, he often invokes images of Africa’s “pre-colonial Golden Age” (Corrigan 1999: 91) with hopes of reviving that glory to the continent.

It is tempting to see Mbeki's views on AIDS as misguided and crackpot ideology. Fassin argues, though, that Mbeki's statements on AIDS fit within a collective South African experience with epidemics. Mbeki employs a discourse that employs narratives of political resistance to white domination and its global order, and relies on the tropes of the African Renaissance and rejecting domination by outsiders (Fassin 2002: 66). More importantly, Mbeki's views fit within the larger epidemiological debates about how one frames disease. Instead of relying on the standard Western biomedical discourse about disease, which emphasizes behavior and risk, Mbeki employs a more socioeconomic discourse. Parks Mankahlana, Mbeki's spokesperson, has highlighted the importance of a socioeconomic discourse about disease to the government. Speaking on 24 March 2000, he stated, "He [Mbeki] has broken the tradition that seeks to make the disease just a health problem. HIV/AIDS is a socioeconomic problem. It is a political problem that has reached the proportion of an international crisis" (cited in Altman 2003: 420). This frame focuses on the social conditions which make disease possible. While it is certainly true that certain behaviors will place individuals at a higher risk of contracting HIV, it is also true that certain economic and social conditions make it more likely that a person will be placed in the sort of situation where they are forced to make that choice. People do not willingly choose to expose themselves to fatal, incurable diseases. They make choices, though they may increase exposure to HIV, because they lack the funds or social status to choose otherwise. Mbeki picks up on this socioeconomic discourse, and sees himself as a freedom fighter trying to expand the debate. Limiting the arguments about the AIDS epidemic strictly to the biomedical discourse has consequences. "Had a social epidemiology of HIV been more prominent in the scientific arena, rather than the dominant biomedical and behavioral approach, Mbeki might have found interesting alternatives to the explanation of the epidemic given on the dissidents' websites" (Fassin and Schneider 2003). By circumscribing the realm of debate, large amounts of energy and resources have been diverted away from treating the epidemic and toward recriminations and name-calling.

Mbeki employs the African Renaissance to foster and further a new, unique identity for South Africa in the post-apartheid era. He wants to counter the popular notion that Africa is a place of starvation and failure, and that it has moved beyond the 'Heart of Darkness' imagery that continues to color international perceptions of the continent (Dunn 2003). Mbeki sees this Afro-pessimism as a genuine pattern in international relations, and wants to counter that by demonstrating that African countries can and will take responsibility for their own problems (Corrigan 1999: 93-94). In his attempt to do this, though, he inadvertently opens himself and his government up to *more* criticism because it exposes his tenuous connections with his own population. Themba Sono, the president of the South African Institute for Race Relations, picks up on this lack of connection between Mbeki and the domestic populace, saying, "[W]e must remember that he [Mbeki] was out of the country for a long while, so he has no domestic constituency in his own right. He has spent all this time since he came back building one with his own brand of ideology: this is the so-called African Renaissance" (cited in Corrigan 1999: 81). Recent survey evidence indicates that Sono's contentions may be accurate. Few South Africans think of their personal identities in continent-wide terms. Instead, most South Africans identify with a racial, ethnic, or religious group (Mattes 2004). Though the African Renaissance may not have inspired large-scale identity changes among the public, that does not diminish its importance to government officials like Mbeki.

Why would Mbeki feel the need to create a new African identity? With the demise of the Cold War, Africa largely disappeared from the foreign policy agendas of developed states, and from the study of international relations in general (Benatar 2002: 168; Murphy 2001: ix). During the Cold War, though, African leaders often found themselves co-opted into accepting neoliberal agendas that both

bankrupted their states and left them with little popular legitimacy. By accepting the neoliberal orthodoxy, leaders found themselves opposed to the wants and needs of their populace. Promoting a new identity allows leaders like Mbeki to both enhance their own legitimacy and bring Africa back to the international table. Mbeki highlighted this in a speech to the annual meeting of the Non-Aligned Movement in Durban in 1998. He said, “In as much as the slave cannot ask the slavemaster to provide the strategy and tactics for a successful uprising of the slaves, so must we who are hungry and treated as minors in a world of adults also take upon ourselves the task of defining the new world order of prosperity and development for all and equality among the nations of the world. For the weak to challenge the strong has never been easy. Neither will it be easy to challenge the powerful vested interests on the current and entrenched orthodoxies about the modern world economy” (cited in Corrigan 1999: 42-43). These comments only reiterated comments Mbeki made in 1997 to *The Citizen* newspaper, when he argued, “We in the developing world who have borne the brunt of human injustice over decades and centuries issuing from other nations’ desire to accumulate and aggrandize, should play a central role in defining what should constitute the new world order” (cited in Corrigan 1999: 42). Mbeki ties his efforts to establish a new African Renaissance-inspired identity with challenging the current international order that has largely excluded Africa.

This, though, begs the question of why Mbeki would situate the fight against AIDS as a central part of his attempt to fashion a new identity for South Africa. As a part of this neoliberal agenda against which Mbeki has argued, states were often encouraged, if not outright required, to slash state spending on health care. The International Monetary Fund and the World Bank became powerful players in setting the global health policy agenda (Benatar 2002: 168-169). Through these reductions, states like South Africa found themselves unable to provide an adequate level of public health services. Mbeki himself has argued that one of the chief challenges facing South Africa is to move its medical knowledge outside of major urban centers and into the rural areas (Corrigan 1999: 46). He has also chastised the West for stealing South Africa’s doctors, impoverishing the health of his country. He charged, “South African doctors have, for many years and for various reasons, been leaving South Africa to work in other countries. Recently, we have suffered from the aggressive recruiting campaigns by organizations in relatively wealthy countries, who find it much cheaper to buy individual doctors from South Africa than to train sufficient of their own citizens as medical graduates” (cited in Corrigan 1999: 56). Not only has the West attempted to accumulate natural resources from Africa, according to Mbeki, but it also takes its medical resources, which prevents South Africa from being able to afford its own people the medical attention they need to prosper. South Africans, both inside and outside of the government, started to blame outsiders for reducing Africa’s population (Fassin 2003: 55), which only further fanned the rumors about AIDS being a Western plot to wipe out Africans. This is not necessarily unique to AIDS or Africa. Disease prevention measures often reflect attitudes and prejudices about ourselves and others. Fidler writes, “Infectious disease measures historically have served as demarcations by which ‘we’ protect ourselves from the diseases of ‘others’” (Fidler 1998: 9). Public health measures have long been deeply intertwined with national identities. Mbeki attempts to turn this relationship on its head. Instead of using public health to protect South Africa from others, he wants to use public health to challenge others.

V. Creating an AIDS counter-epistemic community in South Africa

The twin forces of history and identity have made the South African government reluctant to embrace public health interventions for AIDS. This fact alone, though, is not necessarily unique to

South Africa. The colonial experience is rife with examples of justifying repression in the name of protecting the public's health, and most states have attempted to carve out an independent identity for themselves in the post-colonial era. Why, then, do most states accede to the international AIDS control regime? Why would the South African government use this history and identity to challenge the international AIDS control regime? What makes South Africa unique is its ability to develop a counter-epistemic community to provide policymakers with the necessary tools to challenge the international AIDS control regime. This counter-epistemic community translates South Africa's historical experience with public health interventions and its attempts to create a new identity into actual policy outcomes. The members of the counter-epistemic community bring these experiences and feelings with them to the table, and they color the recommendations they offer the government. Science and medicine are not value-neutral. The counter-epistemic community interjects a different set of values and discourses into the debates about how to confront and treat South Africa's AIDS epidemic.

One defining characteristic of any epistemic community is shared causal beliefs, and it is clear that the epistemic community associated with the international AIDS control regime shares common beliefs. The scientific orthodoxy about HIV and AIDS is well-established. The human immunodeficiency virus (HIV) infects individuals through the exchange of bodily fluids, generally transmitted through the sharing of needles for injecting drugs or sexual intercourse. Once infected, the virus gradually weakens the person's immune system by attacking the T-cells that fight infection. With HIV attacking the T-cells, those cells cannot then fend off other opportunistic infections. Once a person loses enough T-cells, they are clinically diagnosed with AIDS. Most scientists believe that HIV causes AIDS, that AIDS is incurable, and that the disease is ultimately fatal in all instances.

AIDS dissidents share their own causal beliefs, challenging the established orthodoxy at almost every turn. They deny that HIV causes AIDS, or that there even exists an actual disease called AIDS. AIDS is, in the words of a recent article by leading dissidents, "a collection of chemical epidemics, caused by recreational drugs, anti-HIV drugs, and malnutrition" (Duesberg et al. 2003: 383; see also Duesberg 1996). They say that the relatively equal prevalence of AIDS in men and women in Africa does not prove that the disease is sexually transmitted (Papadopulos-Eleopulos et al. 1995). They further notes that AIDS in Africa is not a specific clinical disease, but rather a battery of previously known diseases like chronic diarrhea, shingles, candidiasis, and fevers lasting for more than a month. "Since these disease include the most common diseases in Africa and in much of the rest of the world, it is impossible to distinguish clinically African AIDS disease from previously known, and concurrently diagnosed, conventional African disease" (Duesberg 2000: 4). Like in the West, the dissidents argue, AIDS in Africa is not a specific disease, but rather a convenient label for a host of problems that have plagued the continent for years. Duesberg (2000) argues that what the world calls AIDS is simply the result of malnutrition, parasitic infections, and poor sanitation—none of which are new to Africa. Geshetker (1997) says that "African AIDS" is a manifestation of international racism and underdevelopment. Papadopulos-Eleopulos et al. (1995) posit that Western prejudice blinds researchers from appreciating that AIDS is just a name for diseases that have long caused death in Africa.

AIDS dissidents blame the international scientific community for stifling debate and silencing critics. If the scientific community could overcome its collective embarrassment for being wrong about AIDS, it would come to appreciate and celebrate the AIDS dissidents. Instead, AIDS dissidents find themselves shunned by the larger scientific community—which they take as further evidence of the conspiracy against them and their views. Scientific debate, the dissidents argue, is not only good

for science, but is also a sign of a healthy democratic system. AIDS dissidents thus style themselves as the protectors of the democratic system for challenging the authorities and sticking up for the oppressed. Duesberg asserts, “The charge of a scientist is to find the truth, to find the scientific basis of a problem. So you go for it irrespective of the political and moral and ethical consequences....A scientist is not a politically correct crowd please; he is supposed to find the cause of disease” (Guccione 1993). Rasnick writes, “Ultimately, the AIDS blunder is not really about AIDS, nor even about health and disease, nor even about science and medicine. The AIDS blunder is about the health of our democracies. A healthy democracy demands that its citizens keep a skeptical, even suspicious, eye on its institutions in order to prevent them from becoming the autonomous, authoritarian regimes they are now” (Rasnick 2001).

The roots of an AIDS counter-epistemic community have their roots in the earliest days of the epidemic. In 1985, the first international conference addressing AIDS in Africa was held in Brussels. Its organizers hoped that the conference would bring together experts from the West and Africa to create a plan of action for combating the disease. Instead, most African scientists refused to attend the conference. They accused the Western scientific community of unfairly stigmatizing the continent with subtly racist theories about AIDS’ African origins and for not appreciating the experience and wisdom of the African scientists (McFadden 1995: 176). This early conflict heightened the competition for scarce resources for treating the disease, and bred distrust between Western and African scientists.

Other African scientists have reported similar experiences. One Nigerian scientist, commenting on Western interventions and the work of Western AIDS scientists in Africa, observed, “Experts come and say we must be culturally sensitive and then ignore my knowledge” (Fredland 1998: 566). A 1992 article on AIDS in Africa noted that many African elites saw foreigners as the real source of AIDS on the continent, and that Western interventions were attempts to make “Africans conform to Western norms” (Caldwell et al. 1992: 1171). Thus, from the earliest recognition of the AIDS epidemic, conflicts existed among scientists about the best methods for approaching and treating the disease. This fissure finds its contemporary expression in the counter-epistemic community.

The story about Mbeki’s embrace of AIDS dissidents usually goes like this. Mbeki is reputed to enjoy spending his time browsing the Internet for information. In the late 1990s, as his government was being pressed to provide AZT to HIV-pregnant women, he went online to find more information about the drug and its usefulness. During these online ventures, he came across websites devoted to the work of prominent AIDS dissidents like Peter Duesberg and David Rasnick. These websites strenuously argued that AZT and other anti-AIDS drugs do more harm than good, and that they actually cause the maladies that they are supposed to treat. They also noted that Glaxo Wellcome, the maker of AZT, was embroiled in a number of lawsuits in the United States, the United Kingdom, and South Africa for producing a harmful drug. Glaxo Wellcome denied that anyone was suing them over AZT, and argued that their drug had been proven safe and effective by national monitoring bodies. Nevertheless, Mbeki highlighted the dissidents’ arguments against AZT when announcing in Parliament in 1999 that “it would be irresponsible not to heed the dire warnings which medical researchers have been making” (cited in Cherry 1999: 3; *Economist* 1999:46). Around the same time, a high-ranking official in the Ministry of Health gave Mbeki a copy of *Debating AZT*, a book by AIDS dissident Anthony Brink which asserts that AZT is essentially poisonous. Soon thereafter, Mbeki contacted David Rasnick by phone and soon began an intense email correspondence with Rasnick about AIDS and the proper responses to the disease (Power 2003: 61-62). Mbeki also encouraged members of Parliament to read “the huge volume of literature

on this matter available on the Internet so that all of us can approach this issue from the same base of information” (cited in Van der Vliet 2001: 169). These early investigations led to Mbeki reaching out to the dissidents and asking them to serve on his presidential AIDS Advisory Panel.

Much as he dismissed the notion that Western economic orthodoxies were the most appropriate for Africa, Mbeki has rejected accepting the Western scientific discourse on AIDS without subjecting it to stringent tests. Mbeki’s moves to institutionalize a counter-epistemic community on AIDS reflect his critique of the certainty of Western scientific knowledge. His support for Virodene, over the objections of the MCC, was inspired by his championing of the African Renaissance and his support for African-directed scientific knowledge (Schneider 2002: 151-152). He dismissed the scientific consensus about the safety of AZT by noting, in a letter to HIV-positive Constitutional Court justice Edwin Cameron, that a similar consensus once existed on Thalidomide (Power 2003: 62). Mbeki has charged that the West’s focus on AIDS diverts attention away from far more pressing issues in Africa like the impact of neoliberalism on their states or global inequality (Boone and Batsell 2001: 22). The West’s efforts are not seen as attempts to help, but rather as “malevolent attempts to weaken countries already struggling with huge economic and social problems” (Boone and Batsell 2001: 21).

The creation of a counter-epistemic community allows Africa a place at the scientific table. Vital statistics about Africa are often collected without the participation of African states themselves, because Western researchers consider African statistics unreliable or politically motivated. Clinical research on AIDS in Africa is generally sited in locations that fit in with the needs of Western researchers, ignoring the needs and interests of the Africans seeking treatment for AIDS. Most of this research proceeds in a rather ad hoc manner that does not allow for long-term care, or even benefit Africans (Fredland 1998: 564). Creating a counter-epistemic community challenges all of these assumptions. It provides statistics to challenge the ‘official’ international statistics, as those ‘official’ statistics may reflect their own biases. African scientists are more likely to understand the local needs and respect the local wishes of communities in which they conduct clinical trials. They are also more likely to adapt their research methods to ensure that Africans receive the benefits of their research.

Again, it is important to remember that these objections are not necessarily unique to Africa. This is not a simple case of Africa-versus-the West. Most governments are wary of “foreign science” (Litfin 1994: 36). One need not look far for examples of this. The United States’ qualms about allowing the direct importation of Canadian pharmaceuticals have been justified by doubts about whether Canadian scientific and quality standards match those of the United States. Litfin traces the uneasiness about “foreign science” back to fundamental issues of state identity. Science and state power are inherently related to each other, she argues, because scientists are also citizens (Litfin 1994: 36). States want to demonstrate to the world the superiority of their scientists and their abilities to solve problems. They believe that domestic scientists will better safeguard the interests of their fellow citizens, whereas foreigners may have ulterior motives. Litfin writes about the science over the ozone layer in the 1980s and 1990s, but the same lines of thought are present when one considers research on AIDS.

South Africa is in a unique position to encourage the formation of a counter-epistemic community. Though some scientists during the apartheid era did clearly do research designed to promote apartheid, the majority of South African scientists saw their work as apolitical. The South African government also largely left the scientific community alone, even while controlling other vast swaths

of society (Furlong and Ball 1999: 119). This allowed the South African science community to develop and advance during the same era that retarded the growth of many other segments of society. Thus, South Africa's scientific capabilities are superior to other sub-Saharan African states. This is crucially important, as any effective epistemic community requires the cooperation of and research by natural scientists.

As part of his plan to investigate “everything about AIDS,” Mbeki appointed a panel of scientists and experts to review the evidence on HIV, AIDS, and treatments. Thirty-three people from all over the world were chosen. What is so unique about the panel is its composition. Mbeki explicitly included members of the international AIDS control regime's epistemic community and the developing counter-epistemic community. Of the 33 members of the advisory panel⁶, between one-third and one-half are considered ‘AIDS dissidents’.⁷ The panel met during the summer of 2000, but was unable to reach consensus on even the most basic issues, such as whether HIV causes AIDS. Instead, the panel recommended a series of experiments in an attempt to answer some of the debates. The result of these experiments is largely unknown, since it is unclear who is in charge of the advisory panel or whether it even still exists (see Maclennan 2004).

The AIDS dissidents resonate with both South Africa's history with public health interventions and Mbeki's attempts to forge a new identity for the country. A recurring theme among the dissidents is their fight against the establishment. One popular website devoted to debunking the HIV/AIDS connection invites readers to “find out what the AIDS establishment and media do not want you to know” (VirusMyth). Another urges its readers to question “the validity of the most common assumption about HIV and AIDS” (Alive and Well AIDS Alternatives). A third website sees its mission as “challeng[ing] the medical and scientific establishment to explain the many paradoxes within HIV/AIDS theory” (HEAL Toronto). Duesberg often casts himself as a heroic, anti-establishment figure whose genius and expertise, now considered heretical, will later be judged as revolutionary. One interview with him asks, “Is the heretic the medical establishment claims, or a 20th Century Galileo?” (Guccione 1993). Note how this question introduces an oppositional, confrontational stance. One is either with the “medical establishment,” or one sides with the unappreciated-in-his-own-time genius. This leaves little room for compromise and debate, but it further reinforces the notion of the counter-epistemic community fighting against a stifling, hegemonic epistemic community. Further, the dissident scientists charge that the mainstream scientists, with their emphasis on anti-AIDS drugs, are simply playing into the hands of the very international pharmaceutical companies that want to bleed Africa dry. The pro-drug scientists, the dissidents claim, are really elitists and anti-poor, because they care more about the profits of pharmaceutical companies (Schneider 2002: 152). These themes ring true with Mbeki's views. Mbeki often conjures up images of the revolutionary fighting against the entrenched orthodoxies that denigrate Africa's position in the international community. He also frequently refers to the desires of international pharmaceutical companies to extract profits from South Africa, and Africa as a whole, without providing any real benefit to Africans.

⁶ This number does not reflect those scientists invited by Mbeki but unable to attend, nor does it include those who only attended the Panel's second meeting at the invitation of the Panel's Secretariat. For a list of others invited to join the Panel, see Presidential AIDS Advisory Panel 2001: 10-11.

⁷ This number reflects those scientists and experts listed on the Virus Myth (www.virusmyth.net) and Health Education AIDS Liaison-Toronto (www.healtoronto.com) websites as challengers of the international AIDS orthodoxy. Therefore, the number should be used not as an authoritative figure, but rather as illustrative of the deep divide on the panel.

The counter-epistemic community on AIDS in South Africa effectively translates the country's negative history with public health interventions and its desire to create a new, empowered identity into actual policy decisions. The dissident scientists and experts who comprise this counter-epistemic community share causal beliefs, and have access to policymakers who put their views into action. They offer the South African government the expertise and opinions necessary to challenge the dominant epistemic community associated with the international AIDS control regime.

If one compares the traditional experience of epistemic communities with the role and work of AIDS dissidents in South Africa, it becomes apparent that the AIDS dissidents do in fact function as a counter-epistemic community. Members of an epistemic community share similar beliefs about the scope of a particular problem, the appropriate policy responses to alleviate that problem, and the future research needs to address the problem. They share a “core set of beliefs about cause-and-effect relationships” (P. Haas 1989: 385). Because of their shared knowledge and beliefs, the members of an epistemic community gain a significant amount of involvement in policymaking (P. Haas 1989: 388). These factors are clearly at play in South Africa's AIDS policies. The AIDS dissidents share similar beliefs about AIDS being a political creation, rather than an actual infectious disease. Instead, they share a belief that AIDS in Africa is better explained as the result of malnutrition and underdevelopment. Further, the AIDS dissidents agree that governments should not endeavor to provide anti-AIDS drugs as a state policy, as that only causes more illness. Through their work on the Presidential AIDS Advisory Panel, the dissidents have agitated for new research projects intended to demonstrate the validity of their views. Through Mbeki's public statements, it is clear that the views of these dissidents have had an impact on the formulation of governmental AIDS policies, and Mbeki has appointed a number of dissidents to serve on government advisory panels dealing with the issue. An international regime can be transformative, empowering a new group of actors to influence domestic policymaking (P. Haas 1989: 380). This is surely the case in South Africa. A group of scientists and experts whom many in the West had dismissed as deluded found themselves empowered in a new counter-epistemic community because of the transformative effect of the international AIDS control regime. More importantly, though, the members of this community have joined together to influence policy specifically to counter the shared knowledge and policy recommendations of another established epistemic community. Thus, this epistemic community of AIDS dissidents further satisfies the definition of a counter-epistemic community by opposing the recognized expertise of the dominant epistemic community.

Ironically, though, these new actors were empowered because the South African government was agitating *against* the regime. Regimes, then, may empower new actors because they highlight new problems; they may also empower new actors because states and scientists rebel against the identity commitments proffered by those very regimes.

VI. Implications of an AIDS counter-epistemic community

The formation of an AIDS counter-epistemic community has significant implications for the international AIDS control regime. For any regime to operate effectively and transmit its identity commitments in a meaningful way, it is crucial that both the regime constructor and the regime participant share common knowledge, causal beliefs, and meanings. In the case of the international AIDS control regime and the South African government, though, it is apparent that shared intersubjective beliefs and meanings do not exist. As a result, one sees an impasse between the two. The advice and knowledge of the international AIDS control regime is not seen as valuable or

relevant, and the South African government is further marginalized from active participation in the development of programs and knowledge because of its outlier status.

Given the divergent understandings that led to the rift between the international AIDS control regime and the South African government, finding methods to bridge the gap is difficult. I offer three tentative suggestions here, though these are by no means an exhaustive list. First, the international AIDS control regime must demonstrate that it sees value in the socio-economic framing of AIDS. The regime has made important strides in recent years to acknowledge the importance of human rights in combating AIDS and the need for increased resources to mount an effective campaign against AIDS, it still largely embraces a behavioral, biomedical frame for discussing AIDS. Such a frame encourages actors to focus solely on behavioral changes without addressing the underlying concerns and conditions that may place people in the position in which they engage in those behaviors. Many have noted that AIDS is largely a disease of poverty. The international AIDS control regime needs to demonstrate its understanding of that point.

Second, the South African government must understand that seeking the assistance of others is not a sign of weakness. While the development of African solutions to African problems is a laudable goal and one which should be encouraged, that encouragement should not come at the expense of the lives of twenty percent of the adult population of South Africa. Through an active engagement with the international AIDS control regime, the South African government can not only receive the assistance that it needs to stop the AIDS epidemic, but it can also ensure that the programs and suggestions made by the regime for South Africa appropriately match the country's needs. Standing outside the regime prevents South Africa from having a voice in changing the manner in which the regime operates.

Finally, both sides need to engage in good faith measures to demonstrate their joint commitment to fighting AIDS. The South African government's open questioning of the link between HIV and AIDS has made it the object of international ridicule. More importantly, though, such statements have encouraged the perception that the South African government does not care about its own citizens. Though the South African government clearly sees value in its actions, it needs to also consider the perceptions that others have of its actions. By the same token, the international AIDS control regime's continual dismissal of the concerns of the South African government only further alienate the South African government—to the detriment of the five million South Africans already infected with HIV, their families, and their communities. It, too, must understand how its actions are perceived by others. Taking good faith measures to demonstrate their joint commitment to fighting AIDS, whether they be through negotiations, public announcements, or other means, might go a long way toward arriving at common understandings, meanings, and interpretations.

The notion of a counter-epistemic community as an actor in international relations is a new one. As such, numerous avenues for future research are open. One, more research needs to be done into the conditions which encourage or stimulate the creation of counter-epistemic communities. In the case of AIDS and South Africa, history and identity play the key roles. Is this the same for other counter-epistemic communities? Two, research needs to examine other areas in which prominent counter-epistemic communities exist. Is AIDS a unique case, or can we find other examples? As most previous research on epistemic communities focuses on environmental issues, this may prove a fruitful area to begin these explorations. Three, more work should explore how issues of public health intersect with international relations. This is a relatively new area for political science, but one that is starting to show some real promise.

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