AIDS Policy in Post-Apartheid South Africa.

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Abstract

South Africa's approach to AIDS has been shaped by persistent antipathy on the part of President Mbeki and his Health Minister towards the use of antiretroviral treatment, either for mother to child transmission prevention (MTCTP) or in highly active antiretroviral therapy (HAART) regimens for the already-infected. Their opposition was initially framed by Mbeki's questioning of the science of AIDS and association with AIDS denialists. But they were resisted in this stance both by civil society organisations, most notably the Treatment Action Campaign, and within the African National Congress and its allies. A constitutional court case ruled in favour of a national MTCTP programme, and in October 2003, the Cabinet committed the government to providing HAART in the public sector. Having lost that battle, the Health Minister has continued a war of attrition by portraying antiretrovirals as 'poison' and by supporting and protecting purveyors of scientifically untested alternatives to antiretrovirals.

Introduction

South Africa's strategy for combating AIDS has been shaped by a long-standing antipathy on the part of President Thabo Mbeki and his Health Minister towards antiretroviral therapy. In the early years of his Presidency (1999-2000), this was framed by Mbeki's questioning of the science of AIDS and his support for AIDS denialists who believe that HIV is harmless and that AIDS symptoms are caused by malnutrition and even by antiretroviral therapy itself. This openly denialist phase proved so controversial that Mbeki withdrew from the public debate in October 2000. Since then, his Health Minister, Dr Manto Tshabalala-Msimang has fought a rear-guard action by resisting the introduction of antiretrovirals for mother-to-child transmission prevention (MTCTP) – until she was forced to do by a Constitutional Court ruling – and by resisting the introduction of highly active antiretroviral therapy (HAART) for AIDS-sick people until a cabinet revolt in late 2003 forced her to back down on this too. Nevertheless, she has continued to undermine the 'rollout' of HAART in the public sector, *inter alia* by supporting unproven substances, and by couching this within a dissident discourse that highlights the side-effects of antiretrovirals – even describing them as 'poison'.

In both periods, Mbeki and Tshabalala-Msimang have demonstrated a disregard for the orthodox scientific cannon on AIDS by a) portraying it as but one of several viewpoints and; b) undermining the credibility of scientists by accusing them of being salesmen for the

pharmaceutical industry. The clearest demonstation of Mbeki's attitude to the scientific mainstream was his setting up of a Presidential Panel in 2000 comprised of equal numbers of AIDS denailists and mainstream scientists. He portrayed the issue as one of genuine scientific debate, when in reality, the AIDS denialists are a very small minority whose eccentric beliefs on AIDS have long been rejected by the scientific community. In supporting this obscure minority opinion, Mbeki and his Health Minister undermined the authority of established science and have eroded the independence and effectiveness of the institutions governing the scientific regulation of medicines. This paper traces the history and legacy of Mbeki's AIDS denialism.

Deputy President Mbeki's Conflict with the Medicines Control Council over Virodene

The first major confrontation between Mbeki and scientific governance occurred in 1997 when he was Deputy President. This so-called 'Virodene saga' began in January 1997 when University of Pretoria scientists 'Ziggie' and Olga Visser informed the Health Minister (then Nkosazana Dlamini-Zuma) about an unofficial trial they were conducting on AIDS patients using a freezing solution (dimethylformamide) which they called 'Virodene'. They told the Health Minister that their results were promising but that 'the AIDS Establishment' was blocking their research because it threatened the profits of large pharmaceutical companies (Myburgh, 2005). The Health Minister responded by inviting the Vissers (and some of their patients) to a cabinet meeting.

Writing in the ANC magazine, *Mayibuye*, Mbeki described what a 'privilege' it was 'to hear the moving testimonies of AIDS sufferers who had been treated with Virodene, with seemingly very encouraging results' (Mbeki, 1998). After giving the Vissers a standing ovation, the Cabinet took a decision to help them win approval for a scientific drug trial and to 'support the Virodene research up to the completion of the MCC process' (*ibid*).

The Medicines Control Council (MCC) operates through a network of committees drawing on independent scientists, usually based in universities, to manage the registration of medicines and ongoing assurance of the quality of medicines on the market and control over their distribution and use. As part of its work, the MCC evaluates clinical trial protocols and at times also assess the evidence from such trials. To Mbeki's evident dismay (1998), the MCC refused the Visser's permission to continue their trial.

Conflict subsequently escalated between the Health Minister and the MCC over Virodene and a range of other issues relating to her emerging plans to restructure the MCC. The Health Minister excluded the MCC from the process she had initiated to restructure South Africa's drug legislation (Gray *et al*, 2002: 53) and set up a 'review team' to evaluate the MCC. This team, which was 'widely seen as working on behalf of the minister of health for political ends' (Sidley, 1998a: 1037), recommended that the MCC should 'cease to exist' and that an entirely new structure be created (Dukes *et al*, 1998: 2-3). Ironically, the new MCC which emerged out of this conflictual process, and which was at the time regarded as more sympathetic to the Health Minister's concerns (Sidley, 1998b: 1696) continued to deny the Vissers permission to conduct Virodene trials. It also acted quickly to shut down a quack operation offering experimental 'oxytherapy' (i.e. injecting ozone into people's blood vessels) to AIDS patients even though the Health Minister was reportedly about to visit the project providing it (Sidley, 1998b: 1969).

However, in subsequent periods, the MCC was more susceptible to political pressure, most notably its delayed response in registering Nevirapine for MTCTP (2001/2) and its failure to act against the Rath Foundation's illegal experiments (discussed below).

The Link between Virodene and AIDS Denialism

According to Myburgh (2005), it was the Vissers who, in March 1999, alerted Mbeki to a debate between Anthony Brink (a South African AIDS denialist with no training in medical science) and Dr. Des Martin (president of the Southern African HIV/Aids Clinicians Society) in the pages of *The Citizen*. In his article 'AZT: A medicine from hell', Brink defended the Health Minister's decision not to make AZT available for MTCTP, comparing her to the FDA's Francis Kelsey who saved the USA from thalidomide by delaying the drug's approval. He asserted that AZT was so toxic that prescribing it 'was akin to napalm-bombing a school to kill some roof-rats'. Prof Martin responded by pointing out that HAART in the USA had resulted in a 40% decline in AIDS mortality between 1995 and 1997, and that AZT has been shown to cut mother to child transmission by 67%. He agreed that the toxicity of AZT was a 'very real issue' requiring constant monitoring and vigilance on the part of clinicians. However, its benefits for MTCTP rendered the drug in his view, 'a medicine from heaven'.

In some respects, this 'debate' rehearsed the often emotional clash of perspectives over AZT in the United States during the early 1990s. Given the contestable (and contested) results of the early AZT trials, the issue of how to balance up unclear long-term therapeutic benefits with the side-effects of taking the drug, was source of great anxiety and contestation in the AIDS activist community (see Epstein, 1996). However, by 1999, the anti-AZT position had been relegated to fringe websites by the therapeutic success of HAART and by AZT's proven success in MTCTP. The overwhelming consensus in both activist and scientific communities was that the benefits of AZT outweighed the risks.

A small group of AIDS denailists have, however, in the face of substantive criticism and evidence to the contrary, been arguing for nearly two decades that AZT is a cause of, rather than a treatment for, AIDS. These denialists have very limited (if any) credibility in the scientific community. As far back as 1995, an investigation by *Science* concluded that none of the claims made by the leading denialist, Peter Duesberg (a professor of molecular and cell biology at the University of California), stood up to scrutiny (Cohen, 1995). In 1998, the journal *Genetica* published an article by Duesberg and Rasnick (1998) summarizing the key denialist claims – followed immediately by a point by point refutation (Galea and Chermann, 1998).

According to Bialy, Duesberg's biographer and fellow denialist on Mbeki's Presidential Panel, the Duesberg and Rasnick article had a major impression on Mbeki (2004: 182). This suggests that either Mbeki was not aware of the rebuttal by Galea and Chermann, or if he was, that he rejected it along with the many substantial arguments available at the time that HIV causes AIDS (e.g. NIAID, 1995) as being part of the existing corrupt scientific establishment.

One of the hallmarks of AIDS dissidents is that they believe the entire cannon of established science on AIDS is faulty and hence that *none* of its conclusions about the relationship between

HIV and AIDS, or about the efficacy of antiretroviral drugs, can be trusted. In short, losing respect for the established scientific community appears to be a necessary condition for becoming an AIDS dissident. As Papadopulos-Eleopulos (a dissident biophysicist at the Royal Perth hospital) puts it, conventional AIDS science is "all just rubbish, rubbish" (quoted in Brink, 2000: 104). Unsurprising, conventional scientists are offended by this attitude as it implies that 'tens of thousands of health care professionals and research scientists are either too stupid to realize that HIV is not the cause of AIDS, or too venal to do anything about it for fear of losing income from the government or drug companies' (Moore, 1996: 293).

Challenging Orthodox Science: Mbeki's Openly Denialist Phase

By the time that Mbeki became President in June 1999, it would appear that he had already immersed himself in the denialist AIDS literature and was in close contact with Brink, Rasnick and Duesberg (Brink, 2000; Bialy, 2004). Mbeki launched his first broadside when he addressed the National Council of Provinces (a body bringing together national and provincial government ministers) in October 1999. He reported that AZT was toxic and formally asked the Health Minister to find out 'where the truth lies' (a process which culminated in the setting up of the Presidential AIDS Advisory Panel the following year, comprising both dissident and conventional scientists). Mbeki also urged council members "to access the huge volume of literature on this matter available on the internet" (Mbeki, 1999).

The notion that government ministers should educate themselves about the science of AIDS through internet research was a less-than-subtle shot across the bows of the scientific community. It implied a belief that "the truth might be on the internet, free of 'Western' or US self-interested censorship" (Sheckels, 2004: 72) rather than in the pages of peer-reviewed academic journals (see also Price, 2005: 165). As such, it demonstrated a clear disregard for the authority and credibility of established scientific expertise.

In his opening address to the first meeting of the Presidential AIDS Advisory Panel in May 2000, Mbeki (2000) describes his process of self-education in disarming detail:

> "I faced this difficult problem of reading all these complicated things that you scientists write about, in this language I don't understand. So I ploughed through lots and lots of documentation, with dictionaries all around me in case there were words that seemed difficult to understand. I would phone the Minister of Health and say, 'Minister, what does this word mean?' And she would explain. I am somewhat embarrassed to say that I discovered that there had been a controversy around these matters for quite some time. I honestly didn't know. I was a bit comforted later when I checked with a number of our Ministers and found that they were as ignorant as I, so I wasn't quite alone."

This is strongly reminiscent of the way that AIDS activists in the USA came to grips with the science of their disease through self-education (Epstein, 1996: 229-30). But unlike these AIDS activists, Mbeki was head of state. Why did he not instead seek the advice of South Africa's internationally recognised medical scientists – including for example, Professor Malegapuru Makgoba, an immunologist and head of the Medical Research Council (MRC)? The MRC, an

autonomous research institution located institutionally within the ambit of the Department of Health, has a large body of research scientists any number of which would have been up to the task. However, by this stage, it appears that Mbeki had already developed a strong distrust of the scientific establishment, and was poised to argue with orthodox scientists rather than seek their advice.

In January 2000, Dr Michael Cherry (a zoologist from the University of Stellenbosch and, inter alia, correspondent for *Nature*) published a newspaper article quoting Makgoba as saying that he had 'read nothing in the scientific or medical literature that indicates that AZT should not be provided to people' (Cherry, 2000). Mbeki promptly sent both Cherry and Makgoba a paper by Papadopulos-Eleopulos *et al* (1999) arguing that because the prevailing scientific understanding of the way that AZT worked was (in her view) inadequate, whereas its toxic effects were demonstrable, the drug should not be prescribed.

Makgoba responded to Mbeki, providing detailed counter-arguments (Cohen, 2000: 590). He subsequently complained about Mbeki's enthusiastic embrace of Virodene without any scientific evidence and his apparent support for dissident 'pseudo-science' on AIDS – concluding that 'this undermining of scientists and the scientific method was especially dangerous in a developing country still in the process of establishing a strong scientific research base' (Makgoba, 2000: 1171). Makgoba's approach was thus to reassert the authority and integrity of the scientific community, and to tell Mbeki to 'leave science to the scientists'. When, in April 2000, Mbeki wrote to world leaders (including Clinton, Blair and Annan) defending his support for the dissident scientists, Makgoba described the action as 'emotional and irrational' (quoted in Cohen, 2000: 150-1).

Cherry's approach was less confrontational. After consulting with several specialists, he replied by arguing that Papadopulos-Eleopulos *et al* had presented no original research, had based their case against AZT on a very selective (and dated) set of references (thereby ignoring the best available science on the effectiveness of AZT), and had failed to weigh the costs of the drug (toxicity) against the benefits of MTCTP (personal correspondence with Cherry). Mbeki forwarded these comments to Papadopulos-Eleopulos, who wrote a response, which Mbeki passed on to Cherry, to which Cherry responded once more, as did she.

This correspondence, the latter part of which is publicly available on one of the dissident websites (www.tig.org.za), is a typical example of the way in which dissident scientists counter the conventional science on AIDS. In her response to every reference that Cherry made to the scientific literature, Papadopulos-Eleopulos asserted that none of it amounted to sufficient 'proof', in her view, of the efficacy of AZT. When he pointed out that AZT in combination with other antiretroviral drugs has been shown to reduce the viral load in patients, she responded, not by disputing the evidence, but by arguing that in terms of her understanding of virology, AZT could not possibly be effective. When Cherry observed that studies had shown that HAART had resulted in a large drop in mortality and morbidity, she responded by complaining about its side effects.

On the issue of MTCTP, Cherry argued that her reading of the literature was selective and that any toxic side effects had to be balanced against the benefits of reduced transmission of HIV. He

pointed out that the authors of one of the articles she referred to in support of her 'AZT is toxic' argument had themselves concluded that the side effects should not be regarded as a reason not to use AZT for MTCTP. She responded by saying that those authors had no choice but to add this qualification to their work in order to get it published. Unable to deal with what he saw as her 'intellectual dishonesty', Cherry ended the exchange (personal correspondence).

It is hard to know what anyone who is not a medical scientist could make of their 'debate'. The issues are clouded by complex medical terminology, by what appears to be interminable quibbling over what can or cannot be learned from existing studies, and by apparent rival understandings of virology, immunology and pharmacology. Ultimately, the issue of who to believe boils down to credibility and scientific authority. As Epstein puts it, "Since no one can 'know' all or even a fraction of the corpus of scientific knowledge through direct experience, science is made possible through the allocation of trust" (1996: 15). Trust, in turn, rests on the reputation of experts, which in turn derives from their being able to publish in peer reviewed journals. In this regard, most reasonable non-specialists will opt to trust mainstream science on the assumption that the scientific cannon rests on the best available information and that when existing theory is shown to be incorrect by new evidence, theories change. While it is of course true that scientific advance is often shaped by commercial interests, that people with an intellectual or material stake in an existing paradigm may resist the implications of new evidence as long as possible (Kuhn, 1962), and that the construction of scientific fact is a contested social process (Epstein, 1996), revolutions in scientific thinking are ultimately achieved through persuasion. Unfortunately, what characterises *all* exchanges between dissident and conventional scientists on AIDS is an impenetrable persuasive barrier resulting from an extraordinary tenacity on the part of the dissidents to resist counter evidence (see also Maddox, 1993) and by their pervasive mistrust of the integrity and credibility of orthodox scientists.

How, then, Mbeki believed that rational debate was possible between the denialist and conventional scientist is something of a puzzle. What did he think he was going to achieve by bringing denialist and conventional scientists together in his 'Presidential AIDS Advisory Panel' to debate the science of AIDS? He certainly had bold ambitions as evidenced by the line-up he proposed for the panel. He invited all the major dissidents as well as the co-discoverers of the HIV virus, Robert Gallo and Luc Montagnier (but only Montagnier was able to attend) and a few senior international and South African scientists (including Makgoba). This panel met in May 2000 and again in July that year, finally reporting in March 2001. The results were predictable: ignoring the evidence presented by conventional scientists showing that HIV-infected babies succumbed rapidly to AIDS and that antiretroviral treatment reduced HIV transmission substantially (PAAPR, 2001: 22, 33), the dissidents argued "AIDS would disappear instantaneously if all HIV testing was outlawed and the use of antiretroviral drugs was terminated" (*ibid*: 15). The result was total non agreement between the dissident and orthodox scientists.

Whether Mbeki was simply naïve in assuming that any other outcome was possible, or whether he was simply using the panel as a means of boosting the authority of the dissidents and as a delaying tactic in the battle over antiretroviral therapy, will never be known. What we do know, is that the panel served as a means for Mbeki and the Health Minister to portray AIDS science and policy formation as deeply contested, and contestable. This, in turn, provided them with the

space to resist the introduction of AZT and other antiretrovirals on the grounds that 'more research was needed' into their toxicity and effectiveness. For example, in a news conference in February 2000, the Health Minister revealed that she had turned down two reports from the MCC concluding that the benefits of AZT outweighed the risks on the grounds that more information was needed about toxicity. This suggests that the Health Minister believed that she knew better than the MCC about weighing up the risks and benefits of AZT – an extraordinary assumption of authority on her part over that of the scientists represented on the MCC.

We also know that Mbeki and his spokesmen were quick to heap contempt on conventional scientists by accusing them of being stooges for pharmaceutical companies. In the run-up to the International AIDS Conference held in early July in Durban, Prof Jerry Coovadia (the chair of the conference) pleaded with Mbeki to keep clear of scientific debates. The Health Minister and two cabinet colleagues responded by describing him as one of the 'frontline troops for the pharmaceutical industry' (*Sunday Independent*, 25/6/00). For Mbeki and his supporters, the established scientific cannon was merely a viewpoint (and probably a corrupt one at that) rather than a respected elite body of knowledge subject to constant and critical examination. In a letter he wrote to Tony Leon, the leader of the parliamentary opposition, this view is spelled out very clearly:

> "The idea that as the executive, we should take decisions we can defend simply because views have been expressed by scientist-economists, scientist-agriculturalists, scientist-environmentalists, scientists-pedagogues, scientist-soldiers, scientist-health workers, scientists-communicators is absurd in the extreme. It is sad that you feel compelled to sink to such absurdity, simply to promote the sale of AZT" (*Mail and Guardian*, 6/10/00).

In response to Mbeki's questioning of the science of AIDS, 5,000 scientists put their names to what became known as 'the Durban Declaration' (subsequently published in *Nature*) spelling out the established scientific cannon. Mbeki's spokesman, Parks Mankahlana, was more forthright, warning that if the Declaration was given to the president "it would find its comfortable place among the dustbins of the office' (Van der Vliet, 2004: 60).

Despite their efforts, Mbeki and his Health Minister were unable to win what Gramsci would call the 'war of position' they were fighting over AIDS science, and by implication, over the authority of the scientific community to shape AIDS policy. They were ridiculed in the mainstream media and ran into increasing opposition within their own ranks and from allies like the Congress of South African Trade Unions. Last ditch attempts by Mbeki to swing internal support behind him by telling the ANC caucus that the CIA (working with the large drug companies) was part of the conspiracy to promote the view that HIV causes AIDS could not unite his own party behind him (*Mail and Guardian*, 6/10/00). In mid-October he announced his withdrawal from the public debate on AIDS science.

Mbeki's Ongoing Conflict with the MRC

This 'withdrawal' from the debate was, however, far from total. In September 2001, he crossed swords once again with the head of the MRC, Makgoba. Mbeki suggested, on the basis of 1995

figures he found on the internet, that only 2.2% of recorded deaths are listed as AIDS deaths, and therefore the government's social and health priorities should be revisited (Van der Vliet, 2004: 66). At this time, it was common knowledge in academic circles that an MRC cause-of-death study had come to diametrically opposite conclusions, but was being embargoed by government. The following month, this study was leaked to the media. It showed that death rates had increased substantially in the population especially for young people and that this was consistent with the results of demographic modelling of the impact of AIDS (Dorrington *et al*, 2001). The Department of Health responded by putting out a joint statement with Statistics South Africa (South Africa's official statistics body) saying that the "MRC research is not absolutely definitive and its mortality rates are estimates rather than exact calculations because they rest on various assumptions" (DOH, 2001). This resulted in a tense exchange between Statistics South Africa and the MRC researchers who argued that Statistics South Africa had misunderstood and misrepresented their findings. Individual members of the MRC were placed under political pressure to disassociate themselves from the report and Makgoba was put under pressure to withdraw it, which he refused to do (Malan, 2003).

Why was the cause-of-death study such a political hot potato? The answer has to do with the importance of death statistics for AIDS denialists who claim that so-called 'AIDS deaths' are simply deaths from other diseases that have been relabelled as AIDS deaths. If it can be shown that AIDS deaths by age and gender have been rising in line with what we would expect given HIV prevalence data over time – which is precisely what the MRC report did – then this amounts to serious blow to their argument.

Interviewed shortly before his tenure came to an end at the MRC in August 2002, Makgoba observed that the cause-of-death study was "a ground-breaking report in a country where denials rule the day" and complained about the 'politicisation of scientific research' which he said would be the 'death knell to science' (see http://www.mrc.ac.za/mrcnews/aug2002/makgoba.htm).

How Can Mbeki's Actions be Explained?

It is worth pausing at this point in the narrative to ask the question, 'so why did he do it?' Why did Mbeki adopt a position that flew in the face of the scientific cannon on AIDS and which cost him an enormous amount of political capital at home and abroad? One option is to follow Gumede's view, that the strength of his personal beliefs was key. He describes Mbeki as an intellectual at heart who was 'seduced' by the AIDS denialist arguments during his nocturnal internet forays, and who is sincere in his support for the 'dissident' position: "He stoically believes that he is a modern-day Copernicus who will ultimately be vindicated, even if posthumously" (2005: 159).

As this entails accepting that Mbeki has a tragic character flaw of Shakespearian proportion, not everyone accepts that Mbeki is a member of what amounts to a lunatic fringe of AIDS denialists. Alternative explanations of his actions have thus been put forward. The obvious candidate in this regard is economic, as it has been on economic grounds that government has resisted legal challenges to rollout antiretrovirals. Both the post-apartheid Health Ministers (Zuma and Tshabala-Msimang) cited 'affordability' as one of their concerns about using antiretrovirals for

MTCTP (Nattrass, 2004). But this argument cannot explain why the Health Minister turned down the offer from Boehringer Ingelheim (to provide Nevirapine free for five years to government clinics). Furthermore, it flies in the face of studies that were available at the time and which showed that the additional burden on the health sector of treating the opportunist infections of children born HIV-positive in the absence of a MTCTP programme (using AZT or Nevirapine) were greater than the costs of implementing such a programme (Nattrass, 1998; McIntyre and Gray, 1999; Skordis, 2000; Hensher, 2000; Geffen, 2000). In other words, the health sector would have actually saved resources if it had introduced MTCTP.

Another take on the affordability argument extends the analysis from the health sector to potential welfare costs as well. In this regard, Parks Mankahlana infamously justified the government's refusal to provide MTCTP in terms of the costs associated with surviving orphans: "That mother is going to die, and that HIV-negative child will be an orphan. That child must be brought up. Who's going to bring the child up? It's the state, the state. That's resources, you see?'" (quoted in Cohen, 2000b: 2170). The Pan Africanist Congress's Costa Gazi agreed that this was probably an important reason for the government's refusal to implement MTCTP, but went on to posit that government probably saw the use of antiretrovirals for MTCTP as the top of a slippery slope ending in far greater cost implications:

> "The government is frightened that if it starts to provide anti-retroviral drugs to pregnant women it won't be long before women who have been raped will demand them – and then the 4 million or so who are HIV-positive but who cannot afford the drugs. There's no way the government's economic policy can accommodate such expenditure".[1]

Butler (2005) makes a similar point by arguing that the government's 'cruel inability to muster human resources for a universal ARV [antiretroviral] programme' may have been an important factor predisposing the government towards 'delay and obfuscation' (2005: 612). Thenjiwe Mtintso, the assistant secretary general of the ANC at the time, made a similar claim that resource constraints were key (quoted in Gumede, 2005: 162). In Gumede's view, Mbeki was sincere in his beliefs, but was supported by the 'economic mandarins' such as the Finance Minister, who did not want expend resources on the poor and unemployed (2005: 162-3)

The trouble with this argument is that it requires us to believe that Mbeki was the public face of a deeply cynical government agenda to mislead the public on AIDS in order to balance its budget. This is story is inconsistent with the resistance Mbeki experienced from within the ANC-Cosatu-SACP alliance, from the cabinet itself (from 2003 onwards) and by the subsequent willingness of the Minister of Finance to allocate resources to the HAART rollout (Nattrass, 2006). Furthermore, the argument takes for granted that providing antiretrovirals was impossible within the existing resource envelope when in fact this envelop could have been stretched through higher taxation (Nattrass, 2004) and the cost burden reduced through negotiations with pharmaceutical companies. In short, the argument requires that government lacked any policy flexibility with regard to the economic challenges, and that Mbeki and the government were prepared to sacrifice the lives of children and adults in a cynical pursuit of fiscal discipline, which they had to disguise in a cloak of AIDS denialist mythology. While the idea of a State President becoming an AIDS denialist may seem implausible to some, this alternative scenario seems even more so. It flies in the face of the fact that politicians are human beings who do not easily

[1] "Government wrong about AZT", interview with *The Citizen*, 3 March 2000, available on: http://www.virusmyth.net/aids/news/citizen2.htm

sacrifice the lives of children easily for a few cents. One only has to consider the emotional speech made by the Premier of KwaZulu Natal, Lionel Mtshali (2002), when he broke with government policy and announced that his province would be rolling out MTCTP to appreciate the power of moral forces. Asking for God's forgiveness for not having acted sooner, he lambasted economic arguments for failing to take into account the 'physical, emotional and moral costs' and then declared:

> "No leader worth his or her salt would turn a blind eye to the suffering our children go through. This is a moral position. It is not a political issue. Let us stand together, without division or doubts, as one family who share a common determination to save our children" (Mtshali, 2002).

Another possibility that has been mooted in the academic literature is that Mbeki was fighting a political battle whose contours extended beyond the mere detail of AIDS policy and into the broader arena of state-civil society relations. Thus once he encountered resistance from scientists and activists, both of whom could mobilise different forms of social and political capital, he was locked into a battle over the nature of state power itself. In Schneider's view, the conflict over AIDS policy 'represents a battle between certain state and non-state actors to define who has the right to speak about AIDS, to determine the response to AIDS, and even to define the problem itself" (2002: 153):

> "High level state interventions in the AIDS field have perhaps less to do with the differences in the content of policy than with a discomfort, and at times active exclusion of, social movements that express certain styles of activism and that fall outside of the immediate networks of political patronage and influence within the tripartite alliance" (*ibid*).

While this is plausible, it doesn't address the prior question, namely why Mbeki decided to disbelieve the scientific cannon on AIDS, gamble his political career on the eccentric views of a small group of denialists, and ultimately place the health of the nation at risk? Most journalists and commentators have addressed this question by pointing to his character. The rudest of them all, R.W. Johnson, went as far as suggesting in *The Spectator* (2000) that Mbeki had effectively gone insane. "Crudely put", he wrote:

> "many now believe that Mbeki is no longer playing with a full pack – that he's off his rocker. (A Russian friend said to me, 'It's strange about Mbeki. In Russia it generally takes about five years for our presidents to go mad. He's done it in one')"

Other commentators chose instead to focus on what they saw to be key character flaws. For example, Van der Vliet argues that Mbeki's:

> 'hypersensitivity to criticism, especially where he believes there is a racist dimension to the comment, and his suspicions, some say paranoia, concerning the pharmaceutical industry, the media and conspiracies aimed at him and his government, make it particularly difficult for him to deal effectively with AIDS…. As time passes, Mbeki comes more and more to bear the hallmarks of the classic tragic hero – a man so driven by a vision that, combined with a fatal dose of hubris, he is unable to heed the warnings all around him, and destroys himself' (2004: 88).

Gumede adopts a similar perspective, arguing that:

> "Throughout his presidency, Mbeki's Achilles heel has been his uncompromising 'you are with us or against us' attitude. He sees all criticism of government policy as a personal attack, and those who dare express views that contradict his own are categorised as secretly hating him, or worse, wanting to topple him" (2005: 167).

The media, for the most part, adopted a similar view – but less kindly. Michael Dynes, writing in *The Times* (Dynes, 2000), opined that Mbeki was suffering from "a gargantuan persecution complex" and Lodge was quoted in the New York Times as describing Mbeki as a 'compulsive interferer'.[2] Mondli Makhanya, writing in the *Sunday Times* argued "Mbeki has become his own worst enemy" and that a "hallmark of the Mbeki presidency has been what can only be described as an intellectual superiority complex" (Makhanya, 2000). He complained about the decline of debate in the ANC, a process he says that "began during the Mandela years but which accelerated after Mbeki took over the running of the party and the state". Nevertheless, he said, Mbeki is not alone to blame for the "culture of sycophancy" and that a portion of the blame must lie with "the rest of the ANC, which, as a mass-based organisation, should never have allowed itself to fall victim to the personality cult". Gumede also points a finger at the ANC leadership, but puts the problem down to them being intimidated: "Not even the bravest ANC leaders would risk being labelled allies of a hostile 'white' media, greedy drug manufacturers or covert Western intelligence conspiracies" (2005: 168).

Such commentary on Mbeki's personality consistently points to issues of paranoia, tendency toward conspiracy theory and arrogant self-belief. This is consistent with the paranoid narcissism so characteristic of AIDS denialists in general. If Mbeki's personality is to blame, then South Africa's AIDS policy tragedy was to have a talented post-apartheid president who was both ripe for conversion to AIDS denialism, and was in a position to impede progressive AIDS policy as a consequence.

Other analysts have adopted a less psychological perspective, pointing instead to his political history. Sheckels (2004: 72) has argued that Mbeki's background as a revolutionary is crucial to understanding Mbeki's rhetoric on AIDS. Similarly Lodge attributes Mbeki's attraction to conspiracy theories originating in the West to his 'political socialisation' (2002:264) and points to several articles written by Mbeki during the 1980s in the ANC magazine *Sechaba* that talk about a Western military industrial plot against the continent. If so, then Mbeki's intellectual background may have predisposed him to adopting a seemingly 'left-wing' view of science as a self-serving organ of capitalism which actively suppresses views that are not in the interests of those manning its institutional ramparts (see e.g. Price, 2005).

Even so, none of this explains why he fought the battle so hard – even when it was costing him political support – or why his supposedly 'revolutionary' left-wing AIDS policy was so out of step with his own support for the government's orthodox economic policies. Indeed, rather than being an anti-capitalist revolutionary, Mbeki could be construed as acting in the interests of capitalism by denying AIDS treatment to the poor (see discussion in Nattrass, 2004) and Bond GET REFS). For example, an article calling for 'Free HIV drugs for all!' published in *Spartacist South Africa* (newspaper of the South African section of the International Communist League) and *The Workers Vanguard* proclaims:

[2] Lodge, cited in Van der Vliet (2004: 87).

> "Mbeki *et al*'s 'Africanist' denunciations of Western science, race baiting and touting of 'African solutions; are intended to disguise the fact that the bourgeois-nationalist ANC regime is the main political agent of world imperialism and the South African capitalist class. The ANC's nationalism is a wellspring for retrograde consciousness on HIV/AIDS and women's oppression" (Anonymous, 2004).

As suggested in the above quote, a different set of explanations for Mbeki's position on AIDS has centred around his (pan) Africanism, and on issues of race and identity. In this regard, several authors have pointed to the use of medical science by colonial powers to justify oppressive interventions (e.g. the removal of Africans from their homes in 1883 to combat an outbreak of bubonic plague) and to the way that medical science was harnessed to develop biological weapons against black leaders during the anti-apartheid struggle as important factors in understanding Mbeki's suspicion towards science (e.g. Fassin and Schneider, 2003; Sheckels, 2004; Mbali, 2004). Accordingly, some analysts suggest that Mbeki's AIDS denialism was a political project that reflected and appealed to a deep' distrust amongst Africans towards medical science (Fassin and Schneider, 2003: 496; Sheckels, 2004: 80). However, there is no evidence for such wide-spread mistrust of medical science in the general population. Indeed, the very opposite is probably the case. People certainly use a range of healing strategies, but these are typically in conjunction with (rather than instead of) western medical options (Nattrass, 2005a). As Howard Philips observes in the conclusion to study of epidemics in South African history, what distinguishes AIDS from its predecessors is the degree to which biomedicine had permeated South African society:

> "No longer did biomedicine elicit the same level of popular circumspection and even hostility which vaccination or deverminization had during earlier epidemics. That AZT is an acronym probably as familiar in Mtubatuba as in Mayfair is a product of the process of the biomedicialisation of South African society, which means that, in terms of the degree of acceptance of biomedicine, the HIV/AIDS epidemic takes place against a background markedly different from that of earlier epidemics in South Africa" (2004: 44).

Rather than appealing to some 'deep' hostility towards medical science, it seems more likely that Mbeki was leading a cultural charge against what was probably wide-spread acceptance of its benefits. In other words, he was engaging in a cultural battle with the TAC over how AIDS should be understood and treated. But this simply begs the question as to why he would want to do this in the first place.

One answer to this question is that it was part of his broader 'African Renaissance' agenda to recast the image of Africa in more positive terms, and to strengthen Africa's capacity to address domestic problems (Mbali, 2004; Cameron, 2005). In terms of this perspective, the conventional approach to AIDS would have undermined Mbeki's project in two ways: firstly by appearing to judge Africans negatively for the fact that AIDS spread so rapidly (i.e. by pointing to the African origins of the AIDS epidemic and to the sexual promiscuity that underpinned its spread); and secondly by placing Africa in the demeaning position of having to rely, once again, on outside assistance and on Western biomedical advances, to combat it.

The first issue was imbued with the politics of race and identity. There is evidence that Mbeki, like Richard and Rosalind Chirimuuta (1987) before him, saw the scientific search for the origins

of HIV in human-primate interaction as an attempt to 'blame' AIDS on Africa and as demonstrating the world's profoundly racist views of the continent. (Van der Vliet, 2004: 82-3 – Mbali, 2004: 113-114). Such a view reflects very closely the view of AIDS denialists who argue that immune deficiency in Africa can be blamed on poverty (not AIDS) and that those who suggest that HIV is sexually transmitted are merely repeating colonial racist stereo-types about African sexuality (see e.g. Lauer, 2006).

That Mbeki aligns himself with this view is incontrovertible. In his infamous Z K Mathews memorial lecture at Fort Hare in October 2001, he proclaimed:

> "And thus does it happen that other who consider themselves to be our leaders take to the streets carrying their placards, to demand that because we are germ carriers and human beings of a lower order that cannot subject its passions to reason, we must perforce adopt strange opinions, to save a depraved and diseased people from perishing from self-inflicted disease' (Mbeki, 2001).

This over-written statement is a reference to TAC, the 'other' which supposedly, by virtue of demanding access to AIDS treatment, was endorsing a derogatory view of African sexually (presumably because TAC accepts that HIV is sexually transmitted) and trying to force government to adopt 'strange opinions' (i.e. to accept that antiretrovirals save lives).

In a document circulated within the ANC by Peter Mokaba – but whose style reflects that of Mbeki', has been widely attributed with good reason to Mbeki,[3] the Chirimuuta's arguments are cited approvingly and the suggestion that Africans have brought about the AIDS epidemic through their sexual behaviour is rejected with great dripping irony:

> "Regardless of the fact that the scientific proof is hard to come by, nevertheless the conviction has taken firm hold that sub-Saharan Africa will surely be wiped out by an HIV/AIDS pandemic unless, most important of all, we access anti-retroviral drugs. This urgent and insistent call is made by some of the friends of the Africans, who are intent that the Africans must be saved from a plague worse than the Black Death of many centuries ago. For their part, the Africans believe this story, as told by their friends. They too shout the message that – yes, indeed, we are as you say we are! Yes, we are sex-crazy! Yes, we are diseased! Yes, we spread the deadly HI Virus through our uncontrolled heterosexual sex! In this regard, yes we are different from the US and Western Europe! Yes, we, the men, abuse women and the girl-child with gay abandon! Yes, among us rape is endemic because of our culture! Yes, we do believe that sleeping with young virgins will cure us of AIDS! Yes, as a result of all this, we are threatened with destruction by the HIV/AIDS pandemic! Yes, what we need, and cannot afford, because we are poor, are condoms and anti-retroviral drugs! Help!" (Mbeki and Mokaba, 2002).

In a letter to the leader of the parliamentary opposition he said there was a perception that 'most black (African) men carry the HI virus (and that) rape is an endemic feature of African society'. He went on to say that 'hysterical estimates of the incidence of HIV in our country….coupled

[3] The electronic signature of the document was traced to Mbeki (Shüklenk, 2004; Thom and Cullinan, 2004) and there are clear similarities of style and referencing to other writings of Mbeki. The University of KwaZulu Natal lists Mbeki as the unacknowledged author of this paper (see http://www.ukzn.ac.za/ccs/default.asp?3,28,10,372).

with the earlier wild and insulting claims about the African and Haitian origin of HIV powerfully reinforce these dangerous and firmly entrenched prejudices'.[4]

The second issue, i.e. having to rely on outside assistance, was tied up more with the political project of nationalism. Mbeki's championing of the cause of Virodene, as was the case with Moi's championing of Kemron (Hyden and Lanegran, 1993), could thus be seen in terms of an attempt to pursue home-grown 'African' solutions. But this answer begs the question as to why Mbeki shifted from supporting Virodene within the regulatory framework of science – his initial support for Virodene was, after all, to assist them in obtaining approval from the MCC for clinical trials – to attacking the authority and institutions of science itself. Put differently, he could have pursued nationalist objectives within the framework of science. Why did he not do so?

This question is probably impossible to answer without descending once again into the unproductive speculative soup so characteristic of media pop psychological analysis of Mbeki's character. Maybe he was so frustrated by what he saw as intransigence on the part of the MCC that he lost all faith in the scientific regulation of medicines. Maybe he was so overwhelmed by the scale of the AIDS pandemic that he reached out for the comforts of denialism. He may even have found the denialist arguments appealing as it gave him an excuse to delay reallocating government resources away from other development priorities (although if this were the key reason behind his actions, it would not explain the lengths that Mbeki went to defend the denialists). We will probably never know the balance of factors which underpinned his denialism – and to a large extent, it does not matter what they were. The key problem is that once he became to be seen as a denialist, he seemed unable to repudiate it – the most he could do was 'withdraw' from the public debate. This probably had something to do with personality (as Mandela once said at a Soweto clinic in a clear reference to Mbeki, 'It is necessary to be broad minded, not to feel that your ego has been attacked if you listen to what the public is saying' (quoted in Power, 2003: 3)) but it may also have had to do with his involvement in the self-referencing and self-reinforcing, AIDS denialist community. Having been hailed as a hero and feted by what he understood to be 'leading' and 'respectable' scientists, Mbeki may have found it difficult to just slough off that community like a snake skin.

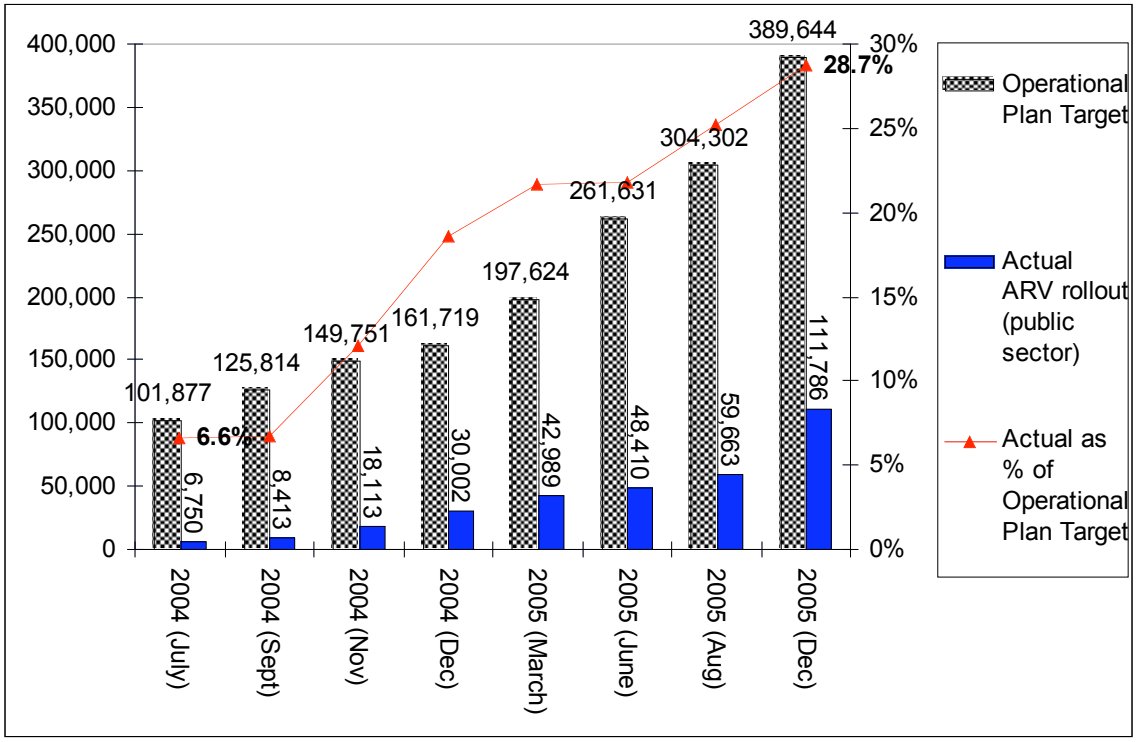
Resisting and undermining the HAART rollout

Just as AIDS dissidents resist epidemiological models of AIDS mortality, so too do they oppose the use of antiretrovirals. When the Health Minister lost her final court battle with the Treatment Action Campaign (TAC) over the introduction of MTCTP, complained bitterly about being forced to 'give my people poison' (quoted in Van der Vliet, 2004: 75). She also resisted the introduction of HAART by pointing to its side-effects and to the complexity of administering it – but was defeated politically on this issue too. Faced with growing internal dissention and a civil disobedience campaign lead by TAC, the cabinet announced in October 2003 that the government would be rolling out HAART in the public health sector.

[4] Letter to Tony Leon, 1 July 2000. Available on: http://www.gautengleg.gov.za/Publish/Parliament%20Documents/Archive_House%20Documents/Archive_Second%20Parliament/Atc's/2000/2000-10-05-e.124.doc

Butler (2005: 15-18) argues that this reassertion of cabinet authority over presidential authority was one of the positive impacts of AIDS on governance in South Africa. That this 'Cabinet revolt' was a blow to the Health Minister is clear. She was reportedly despondent and distanced herself from the decision, saying "I am not the one making the decisions; the Cabinet decides collectively" (*Mail and Guardian*, 15-20/8/03). However, as she remained firmly in the driving seat, her power to shape the rollout (or lack of it) remained substantial. Cabinet authority over policy is easily shipwrecked on the rocks of ministerial intransigence over implementation – especially when the minister concerned is acting under the protection of the President. She has interfered with the ability of provinces to raise money from the Global Fund (Naimak, 2006), presided over a very long antiretroviral drug procurement process (TAC had to threaten her with legal action in March 2004 before she agreed to allow provinces to procure their own drugs using interim procurement procedures and the national drug tender was awarded only in March 2005) and she has failed to address adequately the human resources crisis in the health sector (Nattrass, 2006).

Figure 1: Planned and Actual Growth in the Provision of Antiretroviral Treatment



Sources: ASSA2003 demographic model; Department of Health (2003: 52, 248); Hassan and Bosch (2006).

One month after the Cabinet decision on antiretroviral treatment, the government released its 'Operational Plan' to have 54,004 people on treatment by March 2004 (DOH, 2003: 248). However, it was only from late 2004 and into 2005 that the rollout gathered pace – a performance driven in no small measure by outside funding from the Global Fund and PEPFAR (Nattrass,

2006). As can be seen in Figure 1, by the end of 2005, the numbers of people on treatment in the public sector was still less than 30% of the original planned total.

Rather than actively supporting the rollout, the Health Minister constantly points to the side effects of antiretrovirals whilst highlighting the benefits of nutrition (notably garlic, lemon and olive oil), saying that patients must exercise 'choice' in their treatment strategies (e.g. Cullinan, 2005a). This has resulted in AIDS patients being reluctant to take antiretrovirals because they feared they were 'poisonous' (Cullinan, 2005b; JCSMF, 2006: 2). She has also created the space for alternative remedies to compete with antiretrovirals even though their clinical effects are at best unproven.

Support for Alternative (scientifically untested) Remedies

As Ashforth has pointed out, in South Africa's era of AIDS, business for healers of all descriptions is booming (2005: 54). This, in turn, has posed regulatory challenges for the MCC which has had to act against medical charlatans (such as the purveyors of 'oxytherapy') and self-styled 'traditional' healers like Siphiwe Hadebe who made a fortune selling a fake AIDS cure 'umbimbi' made out of salt and two herbs (Smetherham, 2003).

To add to the problems faced by the MCC in assuring the scientific regulation of medicine, the Health Minister appears to be providing both active and passive support for those providing alternative treatment to HAART. For example, in late 2003, the Health Minister sent an alternative therapist to Fana Khaba (a popular DJ for Johannesburg's youth radio station, Yfm) when he lay sick and dying of AIDS (McGregor, 2005). Having initially started taking antiretrovirals, Khaba discarded them after a week in favour of alternative remedies. These included taking *muti* from sangomas and courses of 'Amazing Grace' pills (manufactured by a white woman from Brakpan using 'supermarket ingredients') that cost R100 a course. When these did not work, Tshabalala-Msimang sent Tine van der Maas to the Khaba household (*ibid*: 18).

Van der Maas is a retired Dutch nurse who sells a nostrum called 'Africa's Solution' as an AIDS remedy and recommends that people fight HIV through diet rather than through antiretroviral therapy (McGregor, 2005: 17-23). 'Africa's Solution' comes in liquid form and the label on the bottle (in the ANC colours of gold green and black) says that it contains *inter alia* African potato extract, olive green leaf extract, vitamins and grapefruit seed extract. The bottle also advises patients to take two crushed cloves of garlic a day and to eat one cup of Pronutro (a South African cereal). Even though Khaba's CD4 count was two at the time (i.e. his immune system was very seriously compromised), Van der Maas claimed that she could treat him, saying 'He doesn't want ARVs. I say to him it is not necessary' (quoted in *ibid*: 17). By this time, however, Khaba was simply too desperately ill to be treated by nutritional interventions alone. McGregor describes how Van der Maas gave him a drink made of liquidized beetroot, olive oil, ginger, carrots, tomatoes, spinach, lemon juice olive oil, pawpaw, watermelon, banana, yoghurt and Pronutro – which Khaba promptly vomited up (2005: 21). He died three months later.

The Health Minister appears to have promoted Van der Maas's activities a lot more substantially than merely referring her to potential patients. She also arranged for Van der Maas to address a meeting of all the provincial health ministers, after which she was invited to conduct 'trials' with AIDS patients at various government hospitals and clinics (Cullinan, 2005c). The Health Minister has visited Van der Maas's 'research sites' in Natal more than once, and has appeared on Van der Maas's promotional videos (Geffen, 2005).

It is unclear what was involved in Van der Maas's 'trials'. There is no indication that she applied for or obtained permission from the MCC to run them. She claims to have treated over 40,000 people, but has no records of these patients because a burglar allegedly urinated on them in 2002 (Brits, 2005). She is nevertheless confident that her patients are well, because 'If you don't hear from your patients, they are usually doing well. If it's not going well, they'll phone' (*ibid*). The Health Minister has also allocated an advisor working in the Department of Health to assist and advise Van der Maas. When asked if they would be prepared to take part in a scientific study of the diet, the advisor said: "We don't want to be tied up with scientists in the laboratory. But we would be prepared for the diet to be given to patients in an academic hospital where the benefits can be monitored by an independent neutral person" (Cullinan, 2005c).

This speaks volumes about the attitude of Department of Health officials towards scientists and scientific regulation: scientists are not neutral, and their testing procedures are inappropriate for non-orthodox remedies. This has distinct echoes with earlier attempts, e.g. the South African Medicines and Medical Devices Regulatory Authority Act that was repealed in 2002, to free traditional/complementary/alternative remedies from scientific regulation. But despite attempts to create alternative regulatory mechanisms for non-orthodox remedies, the Medicines and Related Substances Control Act of 1965, as amended in 1997 and 2002, endorsed the role of the MCC as scientific regulator of *all* medicines and related substances. According to the Act, a medicine:

> "means any substance or mixture of substances used or purporting to be suitable for use or manufactured or sold for use in –
>
> a) the diagnosis, treatment, mitigation, modification or prevention of disease, abnormal physical or mental state or the symptoms thereof in man; or
>
> b) restoring, correcting or modifying any somatic or psychic or organic function in man, and includes any veterinary medicine".

This clearly includes all orthodox, complementary or traditional medicines (as is stressed by the MCC on its website (www.mccza.org.za)). The Minister's support for the by-passing of scientific testing of alternative AIDS remedies is thus in contravention with both the letter and spirit of the existing legislation.

More worrying even than her involvement with Van der Maas is the Health Minister's support for the activities of Matthias Rath, a wealthy German entrepreneur. His multinational 'Rath Health Foundation' (which employs AIDS dissidents such as Brink, Rasnick and Mhlongo) sells multivitamins which cost more than antiretrovirals, claiming that these micronutrients treat, or cure, a range of illnesses including cancer, asthma and AIDS (Geffen, 2005). As part of its marketing strategy, the Rath Foundation engages in scare-mongering over antiretrovirals, saying that they are "severely toxic" and "attack the immune system of patients already suffering from immune deficiency." Such misleading and aggressive advertising is a hallmark of Rath

Foundation advertising world wide, and he has had a number of warnings and rulings against him by regulatory authorities in several countries (*ibid*).

The Rath Foundation also appears to have conducted an unofficial 'trial' in Khayelitsha (Cape Town) outside of South Africa's regulatory structures and with the tacit (if not active) support of the Health Minister. This trial was conducted under the leadership of Sam Mhlongo (apparently a close friend of Mbeki's (Cullinan, 2005d) and the only dissident African scientist that Mbeki could find to appoint to his Presidential AIDS Panel). This trial, involving the administering of extremely high doses of vitamins to people with HIV, failed to get approval from Mhlongo's home institution, the University of Limpopo's Medunsa campus, which identified 34 problems with the protocol, and was never presented to the MCC (Cullinan and Thom, 2006). The results were subsequently published in newspaper advertisements posted in May 2005, claiming that his micronutrients reversed the course of AIDS (Geffen, 2006). Rasnick and Mhlongo were then invited to present their findings to the National Health Council (a body comprising all the provincial ministers of health) (Cullinan and Thom, 2006).

Responding to question about Rath, the Health Minister told reporters: :

> "We cannot transplant models designed for scientific validation of allopathic medicine and apply it to other remedies. There is need for creativity to come up with relevant and pragmatic models to prove safety, quality and efficiency of complementary, alternative and African traditional medicines' (*ibid*).

She claims that rather than undermining the government's position on AIDS, the Rath Foundation is in fact supporting it by providing vitamins and micronutrients (Cullinan, 2005d). She told reporters that she would only distance herself from Rath "if it can be demonstrated that the vitamin supplements that he is prescribing are poisonous for people infected with HIV" (Cullinan and Thom, 2006).

A De-clawed MCC

Whereas in 2003, the MCC was quick to act against complaints about Hadebe's 'umbimbi' AIDS scam, the opposite has been the case with regard to the Rath Foundation. Despite a series of complaints by TAC, MSF and the opposition Democratic Alliance, no action has been taken against him. Finally, the TAC, together with the South African Medical Association, filed court papers on 29 November 2005 against the Minister of Health, Matthias Rath and several others including Brink, Rasnick and Mhlongo.

It is unclear, precisely, what has been happening in the MCC as there is no annual reporting, minutes are secret and decision-making processes are very opaque. There are some indications that the MCC started an investigation, but that this stalled in late 2005 when the original investigator was removed from the case (Cullinan and Thom, 2006). Furthermore, the Health Minister and her new Director General have sought to downplay the need for such an investigation on the grounds that his vitamins are 'complementary' (*ibid*) – even though he campaigns aggressively against HAART in order to promote his product.

The Health Minister appears to have finally succeeded in de-clawing the MCC – at least in the sense of presiding over a situation where it appears that the MCC is either unwilling or incapable of responding to complaints against the illegal trials undertaken on AIDS patients, by Van der Maas and Rath. Whereas during the Virodene saga, Mbeki and the Health Minister respected the authority of the MCC to rule that the Vissers were not allowed to conduct trials, in the case of Rath and Van der Maas, the Health Minister has simply side-stepped the MCC. In the case of Van der Maas, she gave her access to AIDS patients in hospitals to run trials – none of which appear to have been presented to the MCC for permission. In the case of Rath, she appears to believe that his trials are appropriate, and that she is only obliged to act against him if it can be shown that his vitamins are harmful. In other words, under her stewardship, the burden of proof has shifted from the purveyor of the remedy to those who raise doubts about the remedy. That this undermines the scientific governance of medicine goes without saying.

Although the legislation clearly places all alleged remedies and cures under the ambit of medicines, the Minister of Health appears to be acting according to an alternative set of rules for 'traditional' or 'alternative' remedies – even to the point of supporting their distribution through the public health system without their ever having been tested scientifically. The most recent example of this is the distribution through AIDS clinics in KwaZulu-Natal of a herbal product called 'ubhejane'. Although one of the promoters of ubhejane (a retired sociologist and government health advisor) claimed that research at the University of KwaZulu-Natal had demonstrated its effectiveness (Vilakazi, 2005: 7), the university subsequently released a statement (17/3/06) denying this.

When the opposition Democratic Alliance (DA) complained about the manufacture of 'fake cures' such as ubhejane by what it called 'backyard chemists', the Department of Health retorted that the DA was simply perpetuating racist stereotypes (DOH, 2006). The DA responded by investigating the matter further and laying charges of fraud and of contravening the Medicines and Related Substances Control Act against the manufacturer of ubhejane.

Conclusion

The most pernicious legacy of President Mbeki's dissident stance on AIDS has been the erosion of the authority of science and of scientific regulation of medicine in South Africa. Scientists, including the MCC, have been persistently portrayed as, at worst, biased spokespeople for the pharmaceutical industry, and at best, as promoting scientific protocols that are inappropriate for traditional or alternative medicines. Despite the fact that South Africa's existing legislation requires all medicines (defined very broadly) to be tested by the MCC, the Health Minister has undermined the MCC and increasingly side-stepped this requirement with regard to Van der Maas and Rath.

The Health Minister is apparently formulating additional legislation to free complementary/alternative/traditional remedies from the requirement of scientific testing. According to a Departmental press release (18 March 2006), the Health Minister notes that "in finalising the regulation of these medicines, we are avoiding the pitfall of putting such products in the same regulatory environment as pharmaceutical drugs whose testing is very different".

Not only does this pose serious problems for effective and safe governance within the health sector, but it threatens the health and lives of the many AIDS patients who are ill-equipped to judge the relative efficacy of antiretroviral and alternative therapies. Once science is discarded as the best yard-stick of efficacy, patients are at the mercy of purveyors of unproven substances.

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