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**The deadly hand of denial:  
Governance and politically-instigated  
AIDS denialism in South Africa**

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# The deadly hand of denial: Governance and politically-instigated AIDS denialism in South Africa

## Introduction; death from denialism

The 26 May 2005 issue of *Drum* magazine, a widely-read South African monthly, featured a comparison of two deeply contrasting approaches to treating HIV. The strap-line was ‘They both look the picture of health. And they're both living with HIV/AIDS. Yet Judge Edwin Cameron and Nozipho Bhengu each do it their way’. Bhengu, daughter of African National Congress (ANC) grandee, Ruth Bhengu (a close associate in exile of former President Thabo Mbeki), was, so the article claimed, controlling her infection and CD4 count with a nutritional concoction. ‘Like [the former] health minister Manto Tshabala-Msimang’, the article recorded, ‘Nozipho believes there is a direct link between nutrition and AIDS’. An interview with one of the writers, Edwin Cameron, was posted alongside. Cameron explained how he was treating his HIV infection using scientifically proven antiretroviral (ARV) treatment. The article epitomised the fraught debate on HIV in South Africa at the time.

Just a year later, on 19 May 2006, Nozipho Bhengu died of AIDS. At her well-publicised funeral, Chriselda Kananda, a health programme host on one of South Africa's largest radio stations, denounced ARV treatment and the Treatment Action Campaign, the organisation that has played a leading role in fighting for access to treatment in South Africa. Peggy Nkonyeni, until recently the political executive responsible for health in Kwazulu-Natal and now facing corruption charges as speaker of the Kwazulu-Natal legislature<sup>1</sup>, South Africa's province with the highest prevalence of HIV infection, raised conspiratorialist spectres about the aetiology of AIDS:

‘I came to realize that there is this thing called bioterrorism or biological warfare. This is whereby people can manufacture a certain virus and target a particular community that will be spread amongst a certain group of the population. The question is this: What is this HIV/AIDS and where does it come from? We need to answer those

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<sup>1</sup> Mhlaba Memela, “Trial date set for Nkonyeni's graft case”, *Sowetan* 15 June 2009. Available at <http://www.sowetan.co.za/News/Article.aspx?id=1018124> (accessed 6/7/2009).

questions.’<sup>2</sup>

As the Treatment Action Campaign (TAC) pointed out, Bhengu's death was ‘a tragedy that goes beyond her family’. She was one of the very few middle-class people of African descent who promoted openness by choosing to identify herself as living with HIV. The poignancy of her death lay in the fact that she had the means to afford not only care and nutrition, but the best medicine. Had she chosen to take ARV treatment when she developed AIDS, it is highly likely that she would be alive today

‘Her death’, the TAC observed, ‘reminds us how important it is for friends and families of people with HIV to help them get the best available medicine and medical advice, based on the best available science’.<sup>3</sup>

Bhengu's premature death was a graphic product of former President Mbeki's response to the AIDS epidemic. Her case is well-known because Bhengu's mother was a public figure from a well-connected ANC family and Bhengu was open about her HIV status. But many more people in South Africa have died of AIDS as avoidably as Bhengu did, silently, horribly and without the palliative care and comforts that Bhengu's affluent circumstances made possible for her.

Former President Thabo Mbeki's support for AIDS denialist tenets has rightly dominated analysis of South Africa's HIV epidemic. By AIDS denialism, we mean the systematic rejection, deriving from pseudo-scientific premises, and supported by quasi-rational arguments, of evidence establishing that HIV causes AIDS, that ARVs significantly reduce mortality and morbidity associated with HIV infection, and that there are tens of millions of people in Africa living with HIV or dying from AIDS.<sup>4</sup> From October 1999, President Mbeki repeatedly cast doubt on the viral aetiology of AIDS, on the efficacy and safety of ARVs, and on the reliability and significance of statistics relating to AIDS illnesses and deaths in South Africa.<sup>5</sup> The effects have been calamitous.

So far, over 2 million people have died of AIDS in South Africa, mostly in the

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<sup>2</sup> Translated by Treatment Action Campaign (TAC) researcher Nokhwezi Hoboyi from Zulu from a video recording of the event.

<sup>3</sup> Treatment Action Campaign. 2006. TAC statement on the death of Nozipho Bhengu. <http://www.tac.org.za/community/node/2210>. Accessed 18 April 2008.

<sup>4</sup> The 2008 Report on the Global AIDS Epidemic, *UNAIDS*, 214 (2008). Available at [http://data.unaids.org/pub/GlobalReport/2008/jc1510\\_2008\\_global\\_report\\_pp211\\_234\\_en.pdf](http://data.unaids.org/pub/GlobalReport/2008/jc1510_2008_global_report_pp211_234_en.pdf) (accessed 6/7/2009).

<sup>5</sup> Kiran van Rijn, “The Politics of Uncertainty: The AIDS Debate, Thabo Mbeki and the South African Government Response”, 19 *Social History of Medicine* 521 (2006).

last decade.<sup>6</sup> Nicoli Nattrass has estimated that, had ARV treatment been offered timeously, government leadership and action could have prevented over 340,000 deaths between 1999 and 2007.<sup>7</sup> Many more children's lives could have been saved if prophylaxis to prevent mother-to-child transmission had been implemented earlier and more effectively.

But the damage done by AIDS denialism is quantified only partly by the deaths caused through delayed and sub-optimal programme implementation. Denialism is also partly responsible for more opaquely measured consequences: unnecessary infections because of the myth that HIV is not sexually transmitted, a generally muted and insipid state-run prevention programme, delayed appropriate health-seeking behaviour by people with AIDS because of the proliferation of charlatans permitted or encouraged by the health minister to peddle their wares, and heightened public mistrust of medical science and the breakdown of the scientific governance of medicine.

In the face of these egregious facts, there is a sizeable paradox. It is this: despite the ruinous effects of denialism, much progress has been made in South Africa in dealing with the epidemic. As of mid-2008 over 550,000 people were on ARV treatment in South Africa, the vast majority in the public health system, making it the largest public-sector programme in the world.<sup>8</sup> Thousands of people now live openly with the disease and awareness of the epidemic has long been widely disseminated through the population.<sup>9</sup>

This is primarily a consequence of the strong civil society reaction against Mbeki's posture on AIDS, led by TAC and its allies, the enormous efforts of HIV health workers (many of whom work under exacting conditions) and a few principled civil servants (including Fareed Abdullah, the former head of the Western Cape province's AIDS programme and now Global Fund Director for the Africa Unit). It is also a consequence of the successful ARV pilot programmes run in Cape Town and in the rural town of Lusikisiki by Medecins Sans Frontieres (MSF), for these supplied the unequivocal proof-of-concept that

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<sup>6</sup> Actuarial Society of South Africa. ASSA2003 Interventions Model. <http://www.actuarialsociety.co.za/aids/content.asp?id=1000000449>. Accessed 18 April 2008.

<sup>7</sup> Nattrass, N. Aids and the Scientific Governance of Medicine in Post-Apartheid South Africa. Nicoli Nattrass. African Affairs Advance Access published online on February 7, 2008. African Affairs, 0/0, 1–20; doi:10.1093/afraf/adm087. <http://afraf.oxfordjournals.org/cgi/content/abstract/adm087v1>. Accessed 17-03-2008.

<sup>8</sup> Johnson L. "How big is the need for antiretroviral treatment?", Fourth South African AIDS Conference, Durban, 31 March - 3 April 2009.

<sup>9</sup> Shisana, O. et al. 2005. South African national HIV prevalence, HIV incidence, behaviour and communication survey, 2005. Cape Town: HSRC Press.

ARV treatment could be successfully provided in resource-poor settings.<sup>10</sup>

Much remains to be done. It is estimated that half-a-million people need treatment now but are not receiving it, while the Actuarial Society of SA estimates that in 2007 about 370 000 people died of AIDS.<sup>11</sup> Over the next ten to fifteen years nearly all the 5 million South Africans living with HIV will fall ill and need treatment.<sup>12</sup> In addition, partly in consequence of rampant HIV, an epidemic of drug-resistant TB has escalated in the last few years. The public health system is under tremendous strain with a dire personnel shortage. Both symptomatic of and further exacerbating the problems in the healthcare industry, doctors across the country participated in a strike lasting more than two weeks in June and July 2009.<sup>13</sup> There is not enough decisive leadership from the state to address these issues and at least part of this dragging lack of political will comprises the lag-end of government-supported denialism.

Our contribution briefly describes some of the events behind the AIDS denialist debacle in South Africa. It then poses some questions that have been insufficiently explored in the copious literature on this saga. We offer only preliminary answers to these questions.

## The struggle for treatment access in South Africa

In December 1998, when the TAC was founded, the salient obstacle to treatment access was the inordinately high cost of ARV treatments. The standard current first-line regimen of stavudine, lamivudine and nevirapine was available in the private sector at that time but it cost a patient R3,419 (or, at current exchange values, some USD\$430) per month.<sup>14</sup> Meanwhile, 77 percent of South African

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<sup>10</sup> Cullinan, K., “Rural Lusikisiki is winning AIDS battle”, *Health e-news Service*, 31/10/2005. <http://www.csa.za.org/article/articleview/387/1/1/>. Accessed 8/7/2009.

<sup>11</sup> See the statistics comprehensively collated from various authorities at <http://www.tac.org.za/community/keystatistics>.

<sup>12</sup> There are three reputable sources that estimate the size of the South African HIV epidemic and all estimate close to or more than 5 million infections. These are the Human Sciences Research Council, the Actuarial Society of South Africa and the Department of Health. See Geffen. 2006. What do South Africa's AIDS statistics mean? A TAC briefing paper. <http://www.tac.org.za/community/aidsstats>. Accessed 7/7/2009.

<sup>13</sup> “ANC urges doctors to return to work”, *The Times*, 3/7/2009. <http://www.thetimes.co.za/News/Article.aspx?id=1028137> Accessed 7/7/2009.

<sup>14</sup> This price was calculated using then-current data from the Blue Book, a regularly updated pharmaceutical price list published at the time. It includes 14% VAT.

households earned less than R4,000 per month – rendering ARV treatment unaffordable for all but the country's highest income earners.<sup>15</sup> Patents on these and other ARV medicines meant they were sold under monopolistic conditions.<sup>16</sup> Only the well-off could afford them. In the rest of Africa, outside the relative prosperity of South Africa, the position was even more dire.

‘My presence here embodies the injustices of AIDS in Africa. Amidst the poverty of Africa, I stand before you because I am able to purchase health and vigour. I am here because I can afford to pay for life itself,’ one of the writers told the International AIDS Conference in Durban in July 2000.<sup>17</sup>

Furthermore, the country's pharmaceutical industry lobbying body, the Pharmaceutical Manufacturer's Association (PMA), together with nearly 40 pharmaceutical companies, instituted legal action to block legislation the South African government sought to pass to give it greater powers to reduce prices.<sup>18</sup> The United States threatened to put South Africa on a trade watch list even though similar legislation existed in other developed countries.

The PMA case came to a head in early 2001, when the TAC, represented by the AIDS Law Project (ALP), joined the case as an amicus curiae (friend of the court) and coordinated worldwide protests against the pharmaceutical industry.<sup>19</sup> The PMA and pharmaceutical companies withdrew their court action. Some attributed this to the protest actions.<sup>20,21</sup>

In the following months and years, TAC and the ALP - with the support of the government-aligned Congress of South African Trade Unions (COSATU), its affiliates and activist groups in Europe and the United States - mounted

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<sup>15</sup> “South Africa Survey 1999/2000”, *South African Institute of Race Relations*, 296 (2000).

<sup>16</sup> Joseph, S., “Pharmaceutical Corporations and Access to Drugs: The ‘Fourth Wave’ of Corporate Human Rights Scrutiny”, *Human Rights Quarterly*, Vol 25 No. 2 (2003) 425-452.

<sup>17</sup> Cameron, E. First Jonathan Mann Memorial Lecture: The Deafening Silence of AIDS, *Harvard Health and Human Rights Journal* Vol 5 No. 1 (2000) 7–24.

<sup>18</sup> The legislation proposed was the Medicines and Related Substances Control Amendment Act, 90 of 1997. See Cameron E & Jonathan Berger ‘Patents and Public Health: Principle, Politics and Paradox’ (2005) 131 *Proceedings of the British Academy* 331-369; also published in David Vaver (ed), *Intellectual Property Rights* (Routledge, London: 2005)

<sup>19</sup> TAC            Electronic            Newsletter            27            February            2001.  
<http://www.tac.org.za/newsletter/2001/ns010227.txt>. Accessed 7/7/2009.

<sup>20</sup> TAC            Electronic            Newsletter            19            April            2001.  
<http://www.tac.org.za/newsletter/2001/ns010419.txt>. Accessed 7/7/2009.

<sup>21</sup> TAC            Electronic            Newsletter            24            April            2001.  
<http://www.tac.org.za/newsletter/2001/ns010424.txt>. Accessed 7/7/2009.

successful campaigns to compel several pharmaceutical companies to reduce their prices and to allow generic competitors to manufacture patented drugs under license.

In 2001 Bristol Myers Squibb, following intense pressure, agreed not to enforce patent protection on its medicines didanosine and stavudine, and instead to sell them for a combined daily price of one US dollar.<sup>22</sup> In December 2003, GlaxoSmithKline and Boehringer Ingelheim concluded settlement agreements with the TAC and others, following a complaint against them which the Competition Commission upheld. The pharmaceutical companies undertook to enter licensing agreements with generic companies to produce the ARVs AZT, lamivudine and nevirapine. These licenses extended to other African countries and provided for substantially reduced royalty fees.<sup>23</sup> Merck has also made progress in providing access to its AIDS medications, but there remains room for improvement.

Somewhat successful outcomes were achieved in pressing Pfizer and Bristol Myers Squibb to reduce the prices of fluconazole and Amphotericin B<sup>24,25</sup> (used for treating opportunistic infections). Pressure has also been exerted on Roche, Gilead and other pharmaceutical companies to reduce the prices of their ARV medications, thus far with less success.<sup>26</sup>

The result of these campaigns is that the entire current first-line ARV regimen is available in the private sector for R211 (about USD\$26) per patient per month.<sup>27</sup> The state purchases an equivalent regimen for the public health system at almost half the price (R116 per month).<sup>28</sup> In other words the price of first-line ARV

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<sup>22</sup> TAC Electronic Newsletter 8 May 2001. <http://www.tac.org.za/newsletter/2001/ns010508b.txt>. Accessed 7/7/2009.

<sup>23</sup> TAC Electronic Newsletter 10 December 2003. [http://www.tac.org.za/newsletter/2003/ns10\\_12\\_2003.htm](http://www.tac.org.za/newsletter/2003/ns10_12_2003.htm). Accessed 7/7/2009.

<sup>24</sup> TAC Electronic Newsletter 19 July 2001. [http://www.tac.org.za/newsletter/2001/ns19\\_07\\_2001.txt](http://www.tac.org.za/newsletter/2001/ns19_07_2001.txt). Accessed 7/7/2009.

<sup>25</sup> TAC Electronic Newsletter 19 May 2005. [http://www.tac.org.za/newsletter/2005/ns19\\_05\\_2005.htm](http://www.tac.org.za/newsletter/2005/ns19_05_2005.htm). Accessed 7/7/2009.

<sup>26</sup> See for example TAC. 2007. TAC complains to the Competition Commission about the anti-competitive conduct of the world's largest pharmaceutical company. <http://www.tac.org.za/community/node/2127>. Accessed 7/7/2009. TAC and the ALP have been negotiating with Merck (and its South African subsidiary MSD) for years to reduce the price of efavirenz and grant multiple licenses. The campaign has not been without success: the price of efavirenz has come down dramatically, and there are now some generic versions of the drug on the market.

<sup>27</sup> ARV price list supplied by Medprax updated regularly on the TAC website. <http://www.tac.org.za/community/node/2021>. Accessed 7/7/2009.

<sup>28</sup> Kwazulu-Natal Provincial Depot. 2008. ARV Catalogue & Price List 8.1.2008 (RT71-

treatment is less than a tenth of the 1998 price even before correcting for inflation. This is a very considerable achievement. It removed what had seemed to be the greatest obstacle, i.e. cost, to a country-wide public health system ARV treatment programme.

But the bizarre supervening circumstance of government-instigated denialism threatened to intrude an even bigger barrier to treatment access than drug prices.

## Onset of Denialism

President Mbeki's support for AIDS denialist positions has been well documented.<sup>29,30</sup> His conversion to at least some AIDS denialist tenets was not instant, at least not so far as the public record shows. Speaking on behalf of President Nelson Mandela on 9 October 1998 he declared a Partnership Against HIV/AIDS in terms that seemed presciently to disavow all the subsequent scepticism he would lavish on accepted wisdom about the epidemic:

'HIV/AIDS is among us. It is real. It is spreading. We can only win against HIV/AIDS if we join hands to save our nation. For too long we have closed our eyes as a nation, hoping the truth was not so real. For many years, we have allowed the H-I-Virus to spread, and at a rate in our country which is one of the fastest in the world. Every single day a further 1 500 people in South Africa get infected. To date, more than 3 million people have been infected. ... Many more face the danger of being affected by HIV/AIDS. Because it is carried and transmitted by human beings, it is with us in our workplaces, in our classrooms and our lecture halls.'<sup>31</sup>

But Mbeki's dalliance with pseudo-science had already begun. Under Mbeki's

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2004).

<http://www.tac.org.za/community/files/PublicSectorARVCATALOGUEAndPriceList2008.pdf>. Accessed 7/7/2009.

<sup>29</sup> Heywood, M., 2004 Price of Denial. Development Update 5(3). Interfund. <http://www.tac.org.za/Documents/PriceOfDenial.doc>. Accessed 7/7/2009.

<sup>30</sup> See these books that collectively give a comprehensive account of Mbeki's denialism: Cameron, E., *Witness to AIDS* (2005); Nattrass, N., *Mortal Combat* (2007); Gevisser, M., *Thabo Mbeki: The Dream Deferred* (2007); Feinstein A., *After the Party* (2007).

<sup>31</sup> Address by Deputy President Thabo Mbeki: Declaration of Partnership Against AIDS - 9 October 1998. [http://www.info.gov.za/speeches/1998/98a30\\_5229811299.htm](http://www.info.gov.za/speeches/1998/98a30_5229811299.htm). Accessed 7/7/2009.

direction, the Cabinet began courting the makers of a fake AIDS ‘cure’ called Virodene in 1997. This has been documented in meticulous detail using public sources.<sup>32</sup> The Medicines Control Council (MCC), South Africa's medicines regulatory authority, blocked human trials of Virodene, because its active ingredient is a toxic industrial solvent.<sup>33</sup>

Yet in January 1997 the then health minister, Nkosazana Dlamini-Zuma, arranged for Mbeki (then deputy-President) to present the Virodene researchers to Cabinet. One of the researchers ‘claimed that her solution “destroyed” the virus. “This had never been done before with a chemical which could also be safely administered to people. Medicines developed previously only succeeded in temporarily reducing the virus count.”’<sup>34</sup>

The Cabinet was reported to have stood and applauded the presentation. Mbeki commented afterwards ‘The AIDS victims [sic] described what had happened to them as a result of the treatment. They were in the cabinet room, walking about, perfectly all right. It was a worthy thing to see because the general assumption is that if you get to a particular point with AIDS it really is a matter of time before you die.’<sup>35</sup>

The Virodene researchers had undertaken a ‘trial’, enrolling eleven patients, even though they had not received MCC authorisation - claiming they had received permission from the health minister (there is no such provision in South African law). The MCC intervened to stop this unlawful and unethical process. This elicited Mbeki’s wrath, who asserted derisively that ‘The cruel games of those who do not care should not be allowed to set the national agenda’.<sup>36</sup>

The head of the MCC at the time, Professor Peter Folb, a distinguished pharmacologist, was dismissed as chair and pressed into resigning from the council.<sup>37</sup>

Links between the Virodene researchers and some members of the ruling ANC continued. In 2007, the *Saturday Star* newspaper reported that before 2001, tens of millions of rands from the presidency had been invested in Virodene.

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<sup>32</sup> Myburgh, J. “The Virodene Affair”, *politicsweb*, 17/9/2007. <http://www.politicsweb.co.za/politicsweb/view/politicsweb/en/page71619?oid=83156&sn=Detail>. Accessed 7/7/2009.

<sup>33</sup> Myburgh, J., “In the beginning there was Virodene”, in *The Virus Vitamins, & Vegetables*, 4-7 (Cullinan, K., & Thom, A. eds. 2009).

<sup>34</sup> Ibid.

<sup>35</sup> Ibid.

<sup>36</sup> Id. at 6.

<sup>37</sup> Id. at 7.

According to the article, the President's spokesperson admitted that the President had been in contact with the drug's researchers but that 'As far I have been able to establish, it is not true that substantial amounts of cash were collected from the presidency during the years in question.'<sup>38</sup>

No evidence meeting basic scientific standards ever indicated that Virodene could be an effective treatment even after extensive testing. By 2002, there was conclusive evidence that it was unfit for human consumption, let alone for administration to AIDS-vulnerable subjects.<sup>39</sup>

Mbeki's involvement with Virodene provided an ominous portent. For the next decade the scientific governance of medicine would be systematically undermined; the legislation that regulates registration, distribution and advertising of medicines, as well as clinical trials,<sup>40</sup> would be poorly enforced and even flouted.

In the meanwhile, the TAC's drug-pricing campaign took flower. On 10 December 1998, a small group of activists held a day-long fast and demonstration at St Georges Cathedral, one of Cape Town's landmarks, pregnant with symbolism and history in the struggle against apartheid. Their statement called on the ministers of health and finance to meet immediately with HIV/AIDS organisations 'to plan for resources to introduce free AZT for pregnant mothers with HIV/AIDS'. The TAC also called on government 'to develop a comprehensive and affordable treatment plan for all people living with HIV/AIDS'. The statement condemned the 'unaffordability of HIV/AIDS treatment' and promised to pressurise 'government and the pharmaceutical sector to ... address the need for equitable and affordable access to treatment and care for all people with HIV/AIDS'.<sup>41</sup> Almost all this energy had to be diverted, however, to deal with Mbeki's denialist nightmare.

Politically-supported AIDS denialism reached its public apogee in 2000 when Mbeki established a 'Presidential AIDS Advisory Panel', which included to almost half its number discredited but vocal AIDS denialists. One of the key aims of the panel was stated to be 'to determine if HIV was the cause of AIDS' –

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<sup>38</sup> Forde, F. 2007. Mbeki link to toxic 'cure'. *Saturday Star* 15/9/2007. [http://www.iol.co.za/index.php?set\\_id=1&click\\_id=13&art\\_id=vn20070915081047136C406709](http://www.iol.co.za/index.php?set_id=1&click_id=13&art_id=vn20070915081047136C406709). Accessed 7/7/2009.

<sup>39</sup> Myburgh, J., "In the beginning there was Virodene", in *The Virus Vitamins, & Vegetables*, 14 (Cullinan, K., & Thom, A. eds. 2009).

<sup>40</sup> Medicine and Related Substances Act, 101 of 1965.

<sup>41</sup> TAC. <http://www.tac.org.za/community/share/2454>. Accessed 7/7/2009.

a ludicrous inquiry in view of scientifically established knowledge that it was.<sup>42</sup> Mbeki responded vehemently to the panel's critics, writing that they were engaged in an orchestrated 'campaign of intellectual intimidation and terrorism' against him. Defending his increasingly strong association with the denialists, he lionised them as martyrs to true inquiry, exclaiming that 'At an earlier period in human history, these would be heretics that would be burnt at the stake!'<sup>43</sup>

Mbeki's flirtations with pseudoscientists dismayed AIDS activists, but it was then health minister Manto Tshabalala-Msimang's hostile positioning after the withdrawal of the PMA case that permanently damaged treatment activists' relations with the Mbeki government. There was an expectation that the seeming victory of government over the pharmaceutical industry – facilitated by the efforts of TAC, ALP and activist groups around the world – and the campaign since 1998 to induce government to introduce ARVs for the prevention of mother-to-child transmission, would be rewarded with some commitment toward ARV provision.

Instead Tshabalala-Msimang 'made it clear' at a media conference the next day 'that buying quantities of anti-retrovirals was not likely soon'. Instead, she mouthed questions about affordability (despite offers of price cuts) and the infrastructure required for ARV therapy.<sup>44</sup>

At this point it started becoming clear that President Mbeki and his health minister would supplant the pharmaceutical industry as the biggest barrier to treatment and prevention access.

In a television interview in April 2001, Mbeki deflected a question about whether he would have an HIV test on the basis that it would merely be 'confirming a particular paradigm'. He also endorsed a key denialist tenet, that the drugs are not life-saving, but toxic, by saying that 'it would be criminal if our government did not deal with the toxicity of these drugs'.<sup>45</sup>

In a letter to Tshabalala-Msimang in September 2001, Mbeki wrote:

'These are the people whose prejudices led them to discover the false

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<sup>42</sup> Sildey, P., "Mbeki appoints team to look at cause of AIDS", *British Medical Journal*, Vol 320, 1291 (2000). <http://www.pubmedcentral.nih.gov/articlerender.fcgi?artid=1127296>. Accessed 7/7/2009.

<sup>43</sup> See Cameron, E. 2005. Witness to AIDS. Tafelberg. p. 106, and President Mbeki's letter of 3/4/2000 to President Clinton, Prime Minister Blair, President Schroeder and others, <http://www.pbs.org/wgbh/pages/frontline/aids/docs/mbeki.html>. Accessed on 7/7/2009.

<sup>44</sup> "Cosatu and TAC signal intention to continue activism for greater access to medicines", *Business Day*, 20/4/2001..

<sup>45</sup> Cohen, Mike. 'Mbeki Questions HIV Testing.' *The Associated Press*, 24/4/2001.

reality, among other things, that we are running out of space in our cemeteries as a result of unprecedented deaths caused by HIV/AIDS. In this context, I must also make a point that we have to act without delay on the proposal made by the Presidential AIDS Panel that, among other things, an investigation be made of the HIV and AIDS statistics that are regularly peddled as a true representation of what is happening in our country.<sup>46</sup>

This intransigence elicited perhaps the most celebrated litigation on AIDS anywhere. Represented by a renowned anti-apartheid public-interest law group, the Legal Resources Centre (LRC), the TAC applied to compel the state to make ARVs available for the purpose of mother-to-child transmission. In December 2001, the Pretoria High Court ruled in the TAC's favour. The government appealed. It also appealed an interim order compelling it to make the drugs available pending the appeal. Not only was this unusual, it seemed to point to the dogmatism behind the government stand, and the extreme lengths it was prepared to go to block ARVs.<sup>47</sup>

On 5 July 2002, the country's highest court, the Constitutional Court, ordered government to 'permit and facilitate the use of nevirapine for the purpose of reducing the risk of mother-to-child transmission of HIV and to make it available for this purpose at hospitals and clinics when in the judgment of the attending medical practitioner acting in consultation with the medical superintendent of the facility concerned this is medically indicated, which shall if necessary include that the mother concerned has been appropriately tested and counselled.'<sup>48</sup>

This was a ringing victory for treatment activism. Although strictly it dealt only with prophylaxis for mother-to-child transmission, it constituted a heavy legal portent for a future wider order, and prepared the ground that would impel government, nearly two years later, to introduce a comprehensive commitment to treatment for people with HIV.<sup>49</sup>

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<sup>46</sup> "Mbeki questions spending on AIDS." *Business Day*. 10/9/2001.

<sup>47</sup> For numerous documents about this court case including much of the court record, see <http://www.tac.org.za/Documents/MTCTCourtCase/MTCTCourtCase.htm>. Accessed 7/7/2009.

<sup>48</sup> *Minister of Health v Treatment Action Campaign* 2002 (5) SA 703 (CC). The health minister misrepresented this order as casting the allusion to Nevirapine in stone. This is false. The court's order says expressly (para 4) that 'The orders made in paragraph 3 do not preclude government from adapting its policy in a manner consistent with the Constitution if equally appropriate or better methods become available to it for the prevention of mother-to-child transmission of HIV'.

<sup>49</sup> Marshall, S.J., "South Africa unveils national HIV / AIDS treatment programme",

But initially the state proceeded to implement the mother-to-child transmission programme only sub-optimally and seemingly reluctantly. And it made no effort to make wider ARV treatment available. It was only after the intervention of Nelson Mandela, who paid a public visit to Zackie Achmat, Chairman of the TAC and a pilot treatment programme run by Medecins Sans Frontieres, a forceful TAC-led march of at least 10,000 people to Parliament on 14 February 2003 demanding a treatment plan and an acrimonious TAC-led civil disobedience campaign initiated in March 2003 (in which dozens were arrested) that the Cabinet eventually disavowed denialism and instructed the health minister to develop a treatment plan.<sup>50</sup>

The plan was published on 19 November 2003. But the minister's department claimed that the rollout could not begin until the tender for ARV medicines had been finalised. Inexplicable delays then ensued. The TAC threatened legal action. Faced with possible embarrassment preceding the 2004 general elections, the government relented by allowing interim procurement of ARVs until the tender was finalised. Treatment provision began in earnest in March 2004.<sup>51</sup>

Throughout much of this period Mbeki and Tshabalala-Msimang continued to make sceptical and adverse claims regarding ARV treatment. Their discourse invoked African nationalist sentiments and traditional African values in which the pharmaceutical industry was demonised as an agent of Western imperialism. In April 2002, Mbeki wrote:

‘Because of the pursuit of particular agendas, regardless of the health challenges facing the majority of our people, who happen to be black, in our country there is a studied and sustained attempt to hide the truth about diseases of poverty.

If we allow these agendas and falsehoods to form the basis of our health policies and programmes, we will condemn ourselves to the further and criminal deterioration of the health condition of the majority of our people. We cannot and will not follow this disastrous route. We are both the victims and fully understand the legacy of

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*Bulletin of the World Health Organization*, Vol. 82 No. 1 (2004).  
[http://www.scielosp.org/scielo.php?pid=S0042-96862004000100019&script=sci\\_arttext](http://www.scielosp.org/scielo.php?pid=S0042-96862004000100019&script=sci_arttext).  
Accessed 7/7/2009.

<sup>50</sup> The TAC website has many documents describing this period. See, in particular, Mark Heywood's *Price of Denial* (Ibid).

<sup>51</sup> TAC. 2004. MinMEC Agrees to Interim Procurement of ARV Medicines. Court Action Averted at Last Moment. [http://www.tac.org.za/newsletter/2004/ns25\\_03\\_2004.htm](http://www.tac.org.za/newsletter/2004/ns25_03_2004.htm).  
Accessed 7/7/2009.

centuries-old and current racism on our society and ourselves.

We will not be intimidated, terrorised, bludgeoned, manipulated, stampeded, or in any other way forced to adopt policies and programmes inimical to the health of our people. That we are poor and black does not mean that we cannot think for ourselves and determine what is good for us. Neither does it mean that we are available to be bought, whatever the price.’<sup>52</sup>

When, despite this conspiratorialist suspicion-mongering, government was forced to commit to treatment provision, the health minister shifted to sowing suspicion about ARVs and supporting instead the proliferation of alternative ‘remedies’ for AIDS.

Tshabalala-Msimang's support for garlic and other vegetables in the context of treatments for HIV was widely and justly parodied.<sup>53</sup> Her public pronouncements created a false dichotomy between nutrition and medicine. Yet Tshabalala-Msimang indubitably promoted what Nicoli Nattrass had dubbed a ‘discourse of choice’, confusingly suggesting that ARVs were but one legitimate option for AIDS-sick persons. Thus at a media conference in June 2005 she stated: ‘I know I get attacked if I say it's nutrition OR micro-nutrients OR ARVs and people want me to say, and, and, and. I think we need to give South Africans options.’<sup>54</sup>

The ‘options’ she offered proved tragically fatal. These have ranged from overstating the value of traditional medicines to outright support for unproven remedies. She appeared supportively in a propaganda video called *Power to the People* produced by Tine van der Maas, a Dutch nurse who claims that a garlic concoction treats AIDS (as well as a whole range of other diseases).<sup>55</sup> She and her department issued two statements supportive of an untested, mysterious product called Ubhejane, whose purveyor claims it cures AIDS.<sup>56,57</sup> Tshabalala-

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52 Mbeki, T. 2002. ANC Today, Volume 2, No. 14. 5 - 11 April 2002. <http://www.anc.org.za/ancdocs/anctoday/2002/at14.htm>. Accessed 7/7/2009.

53 See for example, “AIDS experts condemn SA minister”, *BBC*, 6/9/2006. <http://news.bbc.co.uk/2/hi/africa/5319680.stm>. Accessed 7/7/2009.

54 News24. 2005. Manto rolls out 'Aids mantra'. [http://www.news24.com/News24/South\\_Africa/Aids\\_Focus/0,,2-7-659\\_1717650,00.html](http://www.news24.com/News24/South_Africa/Aids_Focus/0,,2-7-659_1717650,00.html). Accessed 7/7/2009.

55 Video available at <http://www.tinevandermaas.com/video-clips/>. Accessed 7/7/2009.

56 Department of Health. 2006. DA undermines indigenous knowledge. <http://www.tac.org.za/community/files/DOHOnTraditionalMedicineAndUbhejane-20060213.txt>. Accessed 7/7/2009.

57 Tshabalala-Msimang, M. 2006. Traditional medicine is here to stay.

Msimang also consistently supported a German vitamin salesman, Matthias Rath, who claims multivitamins treat AIDS, heart disease, cancer, numerous other ailments and even bird flu.<sup>58,59</sup>

In November 2004, the Traditional Healers Organisation marched on the offices of the TAC in Cape Town and Johannesburg. They distributed a pamphlet accusing the TAC of being in the pocket of the pharmaceutical industry, an absurd claim considering the overtly confrontational relationship between the TAC and that industry. Their rhetoric and slogans indicated that they supported and had the support of Tshabalala-Msimang.<sup>60</sup> Despite this, many traditional healers continued to support and receive training from the TAC. But the event showed the lengths the denialist opponents of ARVs were prepared to go to undermine scientifically-based health responses to the AIDS epidemic.

And so the battle for a scientific approach to HIV prevention and treatment has proceeded. By mid-2006, progress was still mixed. At the International AIDS Conference in Toronto in 2006, the South African stand prominently displayed lemons and garlic. ARVs were displayed as an afterthought. Tshabalala-Msimang made further comments undermining ARVs, eliciting widespread disbelief, dismay and condemnation.<sup>61</sup>

The TAC initiated another civil disobedience campaign. What followed was a brief golden period in South Africa's response to the epidemic. When Tshabalala-Msimang became ill and unable to work, her deputy, Nozizwe Madlala-Routledge, together with then Deputy-President Phumzile Mlambo-Ngcuka, used the opportunity to work with the TAC to develop a much-lauded national strategic HIV/AIDS plan.<sup>62</sup>

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<http://www.tac.org.za/community/files/DOHOnTraditionalMedicineAndUbhejane-20060218.txt>. Accessed 7/7/2009.

58 Geffen, N. 2005. Founding Affidavit in TAC and SAMA versus Rath and Others. [http://www.tac.org.za/Documents/Court\\_Cases/Rath/Interdict/Geffen-1.pdf](http://www.tac.org.za/Documents/Court_Cases/Rath/Interdict/Geffen-1.pdf). Accessed 7/7/2009.

59 Geffen, N. 2006. Echoes of Lysenko: State-Sponsored Pseudo-Science in South Africa. CSSR Working Paper No. 149. <http://www.tac.org.za/community/files/wp149.pdf>. Accessed 7/7/2009.

60 TAC. 2004. TAC Supports Traditional Healers. [http://www.tac.org.za/newsletter/2004/ns23\\_11\\_2004.htm](http://www.tac.org.za/newsletter/2004/ns23_11_2004.htm). Accessed 7/7/2009.

61 "AIDS experts condemn SA minister", *BBC*, 6/9/2006. <http://news.bbc.co.uk/2/hi/africa/5319680.stm>. Accessed 7/7/2009.

62 Allen, J., "South Africa: Government Takes Lead in Tackling HIV-AIDS Crisis", *allAfrica.com*, 1/12/2006. <http://allafrica.com/stories/200612010306.html>. Accessed 7/7/2009.

Madlala-Routledge, widely praised as brave, competent and outspoken, condemned government's record of denialism and declared the TAC to be her ally. Then Tshabalala-Msimang returned to work in the second quarter of 2007. In August 2007, Mbeki dismissed Madlala-Routledge.<sup>63</sup>

## Trying to understand President Mbeki's espousal of AIDS denialist doctrines

One of the questions asked most frequently is, what is behind President Mbeki's response to AIDS? Much has been written on the subject.

For example, Anthony Butler has a published widely-cited analysis<sup>64</sup> the central argument of which is that the AIDS struggle in South Africa was between two competing paradigms which he labels (1) the “mobilisation/biomedical” paradigm and (2) the “nationalist/ameliorative” paradigm. He contends that as a rational process of contested policy formulation the ANC accommodated proponents’ of both. His central assertion is that far from Mbeki’s AIDS views being bizarre or irrational, an “instrumental calculation of the dangers of an inequitable and unsustainable anti-retroviral programme best explains the government's continued adherence to a cautious prevention and treatment policy”.<sup>65</sup> This argument would relieve Mbeki and his supporters of responsibility for their grievously misguided AIDS policy.

But Butler’s argument is fatally flawed on at least five counts.

First, contrasting a response to AIDS based on science and reason - what he calls “biomedical” - with one based on superstition and irrationality - what he calls “ameliorative” - as two paradigms of similar truth fundamentally errs as a presentation of the options available to the Mbeki government. The impression of moral, rational and discursive equivalence created by Butler’s presentation is simply false. Mbeki’s policy pick was always out on a very extended limb.<sup>66</sup>

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63 Nozizwe Mbeki didn’t have ‘all the facts’”, *Mail & Guardian*, 10/8/2007. <http://www.mg.co.za/article/2007-08-10-nozizwe-mbeki-didnt-have-all-the-facts>. Accessed 8/7/2009.

64 Butler, A., “South Africa’s HIV / AIDS Policy, 1994-2004: How Can It Be Explained?”, *African Affairs* Vol. 104, 591-614 (2005).

65 *Id.* at 591.

66 The AIDS denialist forces were weak at the time that Mbeki began publicly supporting AIDS denialist positions.

Traditional healers, for example, while a significant force in South African society were never so powerful as to have to influence or expect to influence AIDS health policy,

Second, despite his contention that the ANC accommodated both paradigms, Butler's article offers no evidence that Mbeki accommodated proponents of the "mobilisation/biomedical" paradigm.<sup>67</sup> In fact, it ignores evidence to the contrary.<sup>68</sup> Third, Butler argues that the ANC made an instrumental calculation that implementing Highly Active Anti-Retroviral Treatment (HAART) would have been inequitable and unsustainable.<sup>69</sup> This is not just wrong, but palpably far-fetched. It implies an unlikely conspiracy (that the ANC supported a wrongheaded policy that was highly costly in the long-term to save in the short-term) without any evidence that such a cost calculation was ever even attempted.<sup>70</sup> Moreover, if the difficulties of equitably implementing government treatment for diseases including TB, diabetes, and cancer did not lead the government to promote pseudoscience so why would it have done so in the case of AIDS? Every available indication suggests that Mbeki was specifically and irrationally preoccupied with HIV because of (i) its sexual transmission, and (ii) its peculiar African demography. Fourth, Butler asserts that "Attributions of 'irrationality' and 'denial', no matter how many people hold them to be true, do not constitute adequate explanations of human behaviour".<sup>71</sup> This does not stand up to scrutiny. If one were to apply Butler's logic here to World War II, for example, it would suggest that Hitler's determination to exterminate Jews, gypsies and homosexuals must have been rational. Finally, a major conceptual failing is that Butler neglects to distinguish adequately between ordinary psychological denial, and Mbeki's racially-obsessive and conspiratorialist

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especially more so than COSATU and the SACP which never embraced denialism. Moreover there was no organised traditional healer movement that embraced denialism before Mbeki. The alternative health industry, for its part, was indeed strengthening in the 1990s. Nevertheless, its influence was confined to influencing government in a very narrow way: to allow changes to the Medicines Act that would enable it to sell its products. The organised part of the industry made no significant attempt in the 1990s to promote an anti-ARV position or "HIV does not cause AIDS" position and certainly not at a high political level.

67 Indeed prominent members of the ANC, including Pregs Govender and Saadiq Kariem, who expressed criticism of the Mbeki policy were subsequently marginalized. Butler's contention that "ANC activists have been at the forefront of campaigns against government policy and in support of ARV provision", does not hold up in light of these same activists subsequent marginalization by the party (595).

68 See for example, Cameron, E., *Witness to AIDS* (2005); Powers, S., "The AIDS Rebel", *The New Yorker*, 19/5/2003. <http://www.newyorker.com/archive/2003/05/19/030519fa> fact power. Accessed 8/7/2009; and Sparks, A., *Beyond the Miracle: Inside the New South Africa* (2003).

69 The widespread accessibility of ARV programmes suggests that this concern was misguided at best. Moreover, the challenge of equitably and sustainably providing ARV treatment to all in need was greatly exacerbated by the denialist policies.

70 Economics cannot explain the Mbeki AIDS policy position. Nattrass, N., *Mortal Combat* (2007).

71 Butler (2005) at 598.

ideology of denial.<sup>7273</sup>

James Myburgh has put forward a more likely theory. He largely attributes Mbeki's denialist doctrine to his investment (political and perhaps financial) in Virodene as an endogenously African solution to AIDS.<sup>74</sup> Myburgh's research in this area has made valuable contributions to understanding Mbeki's AIDS policy, and the full extent of the ANC's involvement with Virodene is still unknown. Indeed the ANC's commitment to Virodene may well have been one reason for its unscientific response to AIDS. However, the evidence available

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72 Id. at 603-04.

73 At least nine other failings in Butler's analysis warrant mentioning here. First, Butler suggests that the "ameliorative" approach focused on poverty and implies that those advocating ARV treatment ignored it. He fails, however, to identify any meaningful social welfare policy proposed by the "ameliorative" forces. He also ignores the fact that groups advocating ARV treatment, like TAC, incorporated an analysis of poverty and inequality into their organizing work (TAC organised the first large demonstration for a Basic Income Grant). Second and similarly, Butler's suggestion that the "ameliorative" approach emphasized appropriate nutrition is misleading: the state did not produce a single accurate widely distributed pamphlet on HIV and nutrition during the Tshabalala-Msimang era. Conversely, TAC, Soul City, and groups advocating ARV treatment did. Third, Butler correctly points out examples of how Mbeki promoted the "ameliorative" paradigm at the expense of the "biomedical" paradigm, thus providing evidence against his own argument (594). Fourth, Butler may be right that Mbeki would have been unable to influence public perception on the issue (596-97). But to the extent that Mbeki tried to have influence in this area it was ill-informed and harmful – for example discouraging testing because it would confirm a particular "paradigm" as he once told ETV. Fifth, Butler's suggestion that the medium-term budget framework would have been beyond the control of the executive is misguided (597). Nearly every budget decision under Mbeki was taken with the approval of the relevant government bureaucracy and when the decision to implement HAART was taken, the money to treat hundreds of thousands of people has been made available. Sixth, Butler rightly points out that there are real human resources shortages in the health system but fails to acknowledge the extra burden caused by the systematic decision to leave AIDS untreated (598). Seventh, Butler states that "COSATU has periodically indicated that it is very much behind TAC's campaign for ARVs, however it has been obliged to maintain a troubled silence on AIDS in the public sphere" (601). This is false. Actually, COSATU spoke out publicly on AIDS and supported the TAC position at the risk of exacerbating tensions between it and the ruling party. Eighth, Butler's description of shortcoming of the medical field, scientists and foreign governments in terms of the AIDS epidemic, even if totally accurate, in no way explains or justifies a denialist position (605-06). Ninth, Butler attempts to paint dubious government statements as rational, including favorably quoting from Castro Hlongwane (611-12). In considering only the Mbeki's and his supporters' words he ignores their actions such as their systematic obstructing of PMTCT and HAART programmes.

74 Myburgh, J. "The Virodene Affair", *politicsweb*, 17/9/2007. <http://www.politicsweb.co.za/politicsweb/view/politicsweb/en/page71619?oid=83156&sn=Detail>. Accessed 7/7/2009; Myburgh, J., "In the beginning there was Virodene", in *The Virus Vitamins, & Vegetables*, 1-15 (Cullinan, K., & Thom, A. eds. 2009).

today does not go so far as to suggest that it was the underlying cause of or motivation for Mbeki's position. For example, Mbeki continued to oppose proven medications even after it became clear that Virodene was a failure, indicating a deeper cause of his denialism.

Rather, the most plausible explanation must find its roots in racially-linked paranoia stemming from the fact that so far the only mass heterosexual epidemic of AIDS anywhere in the world has been in Central and Southern Africa.<sup>75</sup>

President Mbeki's speeches and writings appear to attribute conventional scientific analysis of the epidemic to prurient, demeaning and racially-driven preoccupation with African sexuality.<sup>76</sup> It is this racially-driven conspiratorialist thinking that makes the comparison between Holocaust denial and AIDS denialism in Africa so illuminating.<sup>77</sup> In both cases, dark, powerful, racially hostile forces are identified as propagating self-serving myths and falsehoods. An angry, irrational pastiche whose composition and distribution have been linked to President Mbeki<sup>78</sup> was distributed to members of the ANC in 2002. It is a conspiratorialist tirade against scientific rationalism. It describes its own premises thus:

'It recognises the reality that there are many people and institutions across the world that have a vested interest in the propagation of the HIV/AIDS thesis, because they have too much to lose if any important element of this thesis is proved to be false.

It accepts that these include the pharmaceutical companies, which are marketing anti-retroviral drugs that can only be sold, and therefore generate profits, on the basis of the universal acceptance of the assertion that 'HIV causes AIDS'.

It also accepts that among those that share the vested interests of these companies are governments and official health institutions, inter-

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75 Laurance, J., "Threat of world Aids pandemic among heterosexuals is over, report admits", *The Independent*, 8/6/2008. <http://www.independent.co.uk/life-style/health-and-families/health-news/threat-of-world-aids-pandemic-among-heterosexuals-is-over-report-admits-842478.html>. Accessed 8/7/2009.

76 See for example, Mbeki, T. Fort Hare University Speech, 12/10/2001. See also, Forrest, D., and Streek, B., "Mbeki in Bizarre Aids Outburst", *Mail & Guardian*, 26/10/2001. <http://www.aegis.com/news/dmg/2001/MG011021.html>. Accessed 8/7/2009.

77 See Cameron E "AIDS denial and Holocaust denial: AIDS, justice and the courts in South Africa" [Edward A Smith Annual Lecture, Harvard Law School, April 2003] (2003) *South African Law Journal* Vol. 120, 525-539.

78 Gevisser, M., *Thabo Mbeki: The Dream Deferred*, 736 (2007)..

governmental organisations, official medical licensing and registration institutions, scientists and academics, media organisations, non-governmental organisations and individuals.’<sup>79</sup>

Here the racial paranoia lurking powerfully beneath African AIDS denialism comes to the fore. Mark Gevisser's authoritative biography of Mbeki damningly describes the document as veering dangerously close to the ‘kind of essentialist race theory that powered Afrikaner nationalism.’<sup>80</sup>

Mbeki's denialism was not politically inevitable, but his popularisation of a racially-driven pseudo-scientific approach to AIDS has released a deadly genie that has not yet run its course. Perhaps unwittingly, Mbeki has made it more acceptable in South Africa to argue that science necessarily undermines African development, that African science should be carried out under different standards, that tested pharmaceutical medicines should be treated with greater scepticism than those marketed as traditional or alternative and that there is a reasonable choice to be had between ARVs and other remedies for the treatment or cure of HIV. All these positions are false. Yet they have been informed in part by distorted African nationalist sentiment. The twentieth century is rife with examples of this kind of racial science by no means confined to the apartheid example Gevisser gives. The disaster precipitated by Mbeki's racialised approach to science has, like its predecessors, caused acute misery.

Gevisser explains Mbeki, compellingly. But there are some writers who have attempted to excuse or condone his stance. Didier Fassin seeks to account for Mbeki's denialism as a consequence of scientists and activists ignoring the history of the oppression of Africa, racism and poverty.<sup>81</sup> Jonny Steinberg aptly titled this ‘the anthropology of low expectations’:

‘Fassin is quick to talk Mbeki up as the voice of a resonant African experience and a powerful African nationalism. And yet in doing so, he comes close to saying that African nationalism was destined to get the aetiology of AIDS horribly wrong. Berating the orthodox for their blindness to the anguish of the vanquished, he is on the brink of saying that we must expect nothing more from African nationalism than resentment and suspicion.’<sup>82</sup>

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79 Anonymous, “Castro Hlongwane, Caravans, Cats, Geese, Foot & Mouth and Statistics. HIV/AIDS and the Struggle for the Humanisation of the African” (2002). <http://www.virusmyth.com/aids/hiv/ancdoc.htm>. Accessed 7/7/2009.

80 Gevisser, M., 752.

81 See for example, Fassin, D., *When Bodies Remember*, (2007).

82 Steinberg, J., 2007. “The anthropology of low expectations”, *Business Day*, 5/6/2007.

And indeed, some voices critical of Mbeki have been oblivious to racism, Africa's oppression and poverty as determinants of the extent of the epidemic in Africa. But many scientists and activists have included the link very cogently in their response to the epidemic. Indeed, in its launching statement of 10 December 1998 the TAC denounced 'unnecessary suffering and AIDS-related deaths of thousands of people in Africa' and elsewhere as 'the result of poverty and the unaffordability of HIV/AIDS treatment'.<sup>83</sup>

These insights preceded Mbeki's attraction to tenets of AIDS denialism. Any analysis that tries to excuse or condone Mbeki's stand because his critics did not understand the social conditions of AIDS is consequently misplaced.

Mbeki's denialist stance is perplexing because there was no compelling rational political reason for it. There was no pressure on him from any substantive political force to assume denialist positions. Astounding AIDS activists, medical scientists and many of his ANC colleagues alike, his stance was entirely autonomously adopted. The ANC in exile had an ambivalent relationship with traditional leaders and healers and was, despite some ambiguities, a preponderant force for enlightenment, modernisation and science. The leadership of the treatment activists and their unionist allies likewise emanated from the anti-apartheid struggle, and constituted a natural ally for a scientific response to the epidemic and against the pharmaceutical industry's medicines pricing.

Furthermore, during the Virodene and 'Presidential AIDS Advisory Panel' debacles, traditional healers were not organised in opposition to a scientific response to the epidemic; certainly no historical account paints them as an influential force: a subset of traditional healers only began organising against the TAC long after the conflict between Mbeki and HIV science began.

Mbeki's stance on AIDS is thus aggravated, not alleviated, by an analysis of the political environment in which he operated. That he chose to oppose medical science in the absence of political pressure to do so increases his culpability.

However, if we are to understand why more than 300,000<sup>84</sup> people have died

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[http://community.livejournal.com/ms\\_anthropology/2117.html](http://community.livejournal.com/ms_anthropology/2117.html). Accessed 7/7/2009.

83 TAC. HIV/AIDS Treatment Action Campaign. 10 December 1998 -- Day of Action International Human Rights Day. <http://www.tac.org.za/community/node/2454>. Accessed 7/7/2009.

84 Chigwedere P., Seage G., Gruskin S., Lee T., & Essex M., "Estimating the Lost Benefits of Antiretroviral Drug Use in South Africa", *Pubmed*, 16/102008. <http://www.ncbi.nlm.nih.gov/pubmed/18931626>. Accessed 9/7/2009.

because they could not or did not access medicines in South Africa, there are questions that are surely more important than trying to account subjectively for President Mbeki's beliefs. Seldom asked and insufficiently researched are:

- How did Mbeki's views manage to prevail in the ANC and influence policy, at least from 1999 until March 2004 when the ARV rollout began in earnest? What were, indeed perhaps still are, the weaknesses in governance structures that allowed a pseudo-scientific response to aggravate the country's catastrophic health problem?
- And conversely, what were the strengths in South Africa's democratic structures that enabled a public sector ARV rollout ultimately to occur?
- What are the long-term consequences for South Africa of the disastrous flirtation with AIDS denialism, both from a health policy perspective and for the scientific governance of medicine?

We do not claim to know the answers. But they should be explored, for they go to heart of the functioning of South Africa's fledgling democracy. Our preliminary and speculative suggestions in the rest of this chapter are designed to stir other researchers to consider these questions in more detail.

## **Why did Mbeki's views prevail for a time and why were they overcome?**

There are several features of South Africa's democratic development that made it possible for President Mbeki's idiosyncratic views on AIDS to have such a devastating effect. These included the fact that the ANC was the only political party with mass support. Historically, it led the only movement opposing apartheid that gained mass support. Its history of exile, where it was supported by communist governments, while Western governments colluded with the apartheid regime, nurtured a political culture in which leaders could not be openly criticised. The sole ANC Members of Parliament to speak out about AIDS before Madlala-Routledge was appointed deputy Health Minister, in differing measure, were Pregs Govender and Barbara Hogan: both were penalised. The 'party list system' where parliamentary representatives are allocated by party leaders on a proportional representation basis is considered by many to constitute a disincentive to questioning leaders or opposing the party line.

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Nattrass N., "AIDS and the Scientific Governance of Medicine in Post-Apartheid South Africa", *African Affairs* Vol. 107., 157-176 (2008).  
<http://afraf.oxfordjournals.org/cgi/content/abstract/107/427/157>. Accessed 8/7/2009.

The collapse of Eastern Europe left the ANC's traditional ideological roots much weakened. By the mid- to late-1990s, the ANC – led by Mbeki – had radically altered its economic positions so as to depart markedly from its ideological past as well as from the view of many of its grassroots supporters. This ideological flux, and the consequent conceptual deracination in which the organisation found itself, may have made it easier for the party's leader to sustain irrational and eccentric views within the organisation.

What is more, Mbeki's African nationalist sympathies and Tshabalala-Msimang's appeal to traditionalism did find an audience among segments of South African society, including some in the ANC. In the light of the country's long and agonising history of racial exploitation and oppression this was hardly surprising.

And there is this. Despite all these considerations, Mbeki's stance on AIDS prevailed for only a time. The overwhelming evidence that emerged that AIDS was devastating communities, coupled with increasingly incontrovertible evidence that ARVs were restoring health and saving lives, the relentless courage of Mbeki's media critics on AIDS, the TAC and its allies in COSATU, coupled – crucially – with former President Nelson Mandela's influential intervention all precipitated inner-circle conditions that made it possible to prevail upon Mbeki to permit publicly-funded ARV treatment to be made available. Unfavourable international focus on President Mbeki's stance also assisted in breaking the denialist grip on AIDS policy.

That Mbeki could be challenged at all was undoubtedly due to the extensive rights and freedoms guaranteed in South Africa's Bill of Rights.<sup>85</sup> Never did Mbeki's critics have to be concerned that they would be outlawed or repressed. Allied with this, the South African Constitution guarantees gradual access to socio-economic rights, including healthcare, and makes the courts the arbiter of whether government is making reasonable progress in their attainment.<sup>86</sup> It was government's obligation progressively to realise the right of access to healthcare that formed the basis of the Constitutional Court decision requiring Mbeki's government to make prophylaxis available to pregnant mothers with HIV: many saw the decision as portending a future challenge requiring more general provision of ARVs.

The strategic thinking that South African civil society leaders learned from organizing against apartheid also benefited their campaign against Mbeki's denialist positions.

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85 The Constitution, 1996, ch. 2.

86 The Constitution, 1996, art 27

Many developing countries, including in Africa, lack these advantages.

The treatment rollout in South Africa is now irreversible. The new leadership the ANC elected in 2007, and again in 2009 appear to be opposed to AIDS denialism, whose power is thus likely to diminish. While denialism appears to be behind us, the damage it caused will take many years to rectify. In the case of the hundreds of thousands of lives lost unnecessarily, the damage is truly irreparable.

Ultimately, historians will face a grim calculus in determining the cost of denialism in South Africa. Despite the tragedy of avoidable deaths, suffering and misery caused by AIDS denialism, the victory of reason that is taking place has given cause for hope for South Africa's future, and for the resilience of its people's voices and the constitutional structures of democracy.