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HIV/AIDS policy-making in post-apartheid South Africa

Mandisa Mbali

Introduction

Recent post-apartheid Acquired Immune Deficiency Syndrome (AIDS) policy-making in South Africa has been contested terrain, where civil society organisations like the Treatment Action Campaign (TAC) and the Government have assumed radically differing positions over what appropriate government responses to the pandemic ought to be. Central to the conflict over policy are two inter-related issues: President Mbeki's advocacy of a denialist[1] position on AIDS and the dispute over the provision of anti-retroviral drugs in the state sector.

AIDS infection in post-apartheid South Africa represents a fundamental crisis for the country. A recent national survey concluded that 11,4 per cent of South Africans are HIV-positive (Shisana et al. 2002). According to the Department of Health (DoH 2001), the number of HIV-infected persons in South Africa has topped four million. This gives South Africa the dubious distinction of being the country with, if not the highest, certainly one of the highest rates of HIV infection in the world. Among numerous indications of the scale of the crisis are the increasing number of press reports to the effect that in heavily-affected areas in KwaZulu-Natal, for example, cemeteries are running out of burial space (*Daily News* 10.02.03). Others are warning of an AIDS-orphans crisis, with estimates that by 2001 there will be three million such orphans (Dorrington & Johnson 2002). At the household level, the death of breadwinners and primary caregivers is contributing to the deepening of the poverty experienced by the poorest children and families (Gow, Desmond & Ewing 2002).

AIDS is also impacting heavily upon the productivity of workers, with rising morbidity and mortality leading to increases in employee absenteeism as well as sickness and death amongst workers. One study has estimated that AIDS shaved at least 0,3 percent off South Africa's GDP in 2001 alone (Quattek cited in Barnett & Whiteside 2002).

AIDS has also had other important impacts on, for example, the status of women and children in South Africa. The so-called 'virgin-cleansing myth' has led to an upsurge in incidents of rape and female child abuse, while in masculine-dominated and conservative circles women are increasingly stigmatised and blamed for the spread of AIDS (Leclerc Madlala 1996, 2002). To top this, it does seem that in South Africa women are more vulnerable to HIV infection due to a range of biological, socio-economic and cultural factors related to gender inequality (Abdool Karim, Soldan & Zondi 1995; Strebel 1992).

Increasingly, this escalating national crisis over AIDS in post-apartheid South Africa has led to calls from civil society and the media for firm policy and planning responses to the crisis by the government. However, the response has been uneven and insufficient for a range of reasons.

Early post-apartheid AIDS policy-making: the Mandela era

In the early1980s, the ANC-in-exile spoke boldly of the architecture of a post-apartheid health system. Speaking at a WHO conference on apartheid and health, Secretary General Alfred Nzo declared that the ANC aimed for a 'health revolution in service of our people' where '... a preventative health scheme shall be run by the state; free medical care and hospitalisation shall be provided for all, with special care for mothers and young children; the aged, the orphans, the disabled and the sick shall be cared for by the state' (Nzo 1981: 12).

The ANC won an overwhelming majority in the first democratic elections in 1994. This was due in no small part to the developmentalist agenda espoused in the RDP, in which promises of 'health for all' mirrored the buoyant promises of jobs, houses, water and electricity for all South Africans. The ANC's *National Health Plan for South Africa* (1994) strongly asserted the right to health for all and the responsibility of the state to provide health services. These pledges placed specific emphasis on maternal and child health, and recognised that conservative economic policies could adversely affect the provision of health and social services.

In the early post-apartheid period, the challenges posed to the health sector by the apartheid legacy were enormous. There were many key priorities in health policy, including integrating nine bantustan health departments into one national and nine provincial departments; co-ordinating policy at local,

provincial and national levels; finding an appropriate balance between spending on health and other budgetary priorities and ensuring equitable access to health care (Price & van den Heever 1995).

None of this has proved to be easy. Schneider and Stein (2001) have argued that the difficulties of co-ordinating health policies at local, provincial and national levels of government has complicated the AIDS policy-implementation process. Schneider (1998) has also argued elsewhere that in regard to the provincial allocations, the provinces have shown differing levels of commitment to the issue of AIDS, causing uneven implementation of spending and policy recommendations.

The current alienation of civil society groups and medical and scientific researchers from the government over AIDS policy dates back to early in the post-apartheid period, pre-dating the emergence of both President Mbeki's denialism and the TAC's campaign for anti-retroviral therapy. However, as will be demonstrated in this chapter, the tense relations of the Mandela era have in the present frayed to the point of breakdown through the President's (and his Health Minister's) denialism and the long-running conflict over anti-retroviral policy. Even so, it is worth reminding ourselves that the scandal of South Africa's current AIDS policy was preceded by some bizarre scandals in the Mandela presidency.

Sarafina and Virodene

The first of these was the so-called 'Sarafina II' scandal. It hinged around less than opaque tendering procedures and a grant in excess of R14 million to the prominent director, Mbongeni Ngema, for an AIDS-awareness musical. Sarafina II attracted criticism from civil society organisations, opposition parties, and even some members of the ANC, who felt that the play's budget was excessive and that there had been a lack of transparency in tendering and financing for the project. Critics pointed out that much less money could have been better spent on funding a number of community-based drama groups, while the fact that the funds came from the European Union (EU) also soured the relationship between the EU and the Government (*Mail & Guardian* 09.02.96).

With the Sarafina debacle receding, Government's policy on AIDS took another baffling turn when in 1997 it began to champion a new experimental drug, Virodene, as an 'AIDS cure'. Developed by three scientists attached to the

University of Pretoria, Government went to the extraordinary lengths of giving the three a hearing before Cabinet in which they appealed for government funding for their research (*Mail & Guardian* 24.01.97). The media fanfare created by what became billed as the 'miracle AIDS cure' was accentuated by apparent support for further human trials to research the drug by then Health Minister Nkosasana Zuma and Deputy President Thabo Mbeki (*Mail & Guardian* 28.02.97).

The farce was brought to an end when the Medicines Control Council (MCC) cast doubt on the safety and efficacy of the drug and banned any further clinical trials of the drug. It also turned out that the researchers had not submitted their findings to peer review by the scientific community, while the tests upon which the researchers had made their claim to having found an 'AIDS cure', turned out to be only a phase-one trial. This is insufficient grounds upon which to claim conclusive proof of the safety and efficacy of a drug (*Mail & Guardian* 24.01.97). Ultimately it was established that Virodene was little more chemically than an industrial solvent, which was blocked for human use in South Africa and elsewhere internationally due to its dangerous side-effects (*Mail & Guardian* 19.03.99). Indeed, some research by virologists went so far as to suggest that the main chemical component of Virodene may even activate HIV and prompt the more efficient replication of the virus (*Mail & Guardian* 20.03.98).

This late 1990s clash between the Health Minister and the then Deputy President and the MCC set a precedent of high-profile South African government figures taking on recognised medical authorities in the AIDS policy arena while also coming out in support of unorthodox dissident scientists in disputes over science.

AIDS policy in the Mbeki era

The state's current AIDS policy is articulated in the *2000–2005 HIV/AIDS/STD Strategic Plan for South Africa* (DoH 2000). Despite its controversial features, not all aspects of the policy are deemed as failures. Indeed, AIDS policy analysts note successes in such areas as the increased provision of male condoms; the widespread training of secondary school teachers in HIV/AIDS awareness; the continuation of the annual antenatal survey of HIV and syphilis prevalence; and the DoH's AIDS Directorate's establishment of a

moderately successful Beyond Awareness Campaign (Dorrington & Johnson 2002; Whiteside & Sunter 2000).

Before analysing the AIDS policy debacles over Mbeki's AIDS denialism and access to anti-retroviral drugs in the public sector, it is worth considering government AIDS policy in more general terms in three key policy areas.

Prevention

Prevention is still the key focus of government AIDS policy (Tshabalala-Msimang 2002b) and there is some evidence that efforts to promote HIV prevention may be bearing some fruit. The recent Nelson Mandela Foundation/HSRC study has shown that more people are using condoms in the early 2000s compared to the late 1990s. It also shows that this is due to fear of contracting HIV, indicating that knowledge of the epidemic may be translating into behaviour change (Shisana et al. 2002).

On the other hand, there have been problems with the ways in which condoms are distributed and the numbers which government distributes. Critics of government's AIDS policy, such as the TAC, have pointed out that in 2002 Government only distributed 200 million condoms. This is on average sufficient for sexually-active South Africans to have sex using a condom 20 times per annum (TAC 2003a). There is also criticism of state policy on the provision of condoms in prisons which are currently provided by health professionals, as part of AIDS counselling and not in a more discreet manner that is, without requiring face-to-face interaction (Goyer 2003).

AIDS orphans and the social security system

Child-support and foster-parent grants have been made available to caregivers of AIDS orphans. However, there have been numerous problems with the poor administration and uptake of these grants, including lack of transport and money for orphans and their care-givers to get to Department of Social Welfare and Department of Home Affairs' offices; applicants lacking relevant documents such as birth certificates and identity documents and potential applicants lacking information about the availability of grants (Streak 2002). On the other hand, the 2003 budget made provision for the phased extension of the child-support grant to 14 years of age.

Prevention of Mother to Child Transmission (MTCT)

The long-running dispute between civil society and the Government over the efficacy, affordability and safety of anti-retroviral drugs can be traced back to 1998. This was when the National Association of People Living with HIV/AIDS (NAPWA) began to demand that the anti-retroviral AZT be made available to HIV-positive pregnant women to prevent them passing the virus to their children. It was this campaign that led to the formation of the TAC (Schneider 2001).

Rapidly developing into a nationwide social movement, TAC's mobilisation of thousands in demonstrations and its pursuit of court action against the state seemed to have borne fruit in the Cabinet's April 2002 statement. In it, the government relaxed its opposition to the provision of anti-retrovirals to survivors of sexual assault and their babies. Prior to this, the government had only been committed to researching the use of anti-retrovirals for post-exposure prophylaxis in the case of rape, and to review, revise and monitor policy in line with research on MTCT.

Many at the time interpreted the statement as an official repudiation of Mbeki's AIDS denialism. And indeed it was partially so. Nonetheless, the government remained opposed to providing anti-retrovirals in the public sector in the form of Highly Active Anti-Retroviral Therapy (HAART – also referred to as 'triple therapy'). HAART is a combination/cocktail of anti-retroviral drugs prescribed to HIV-positive people for life, which can dramatically extend the lifespan and health of HIV-positive people by suppressing HIV and thereby preventing opportunistic infections. Government's position against triple-therapy provision in the public sector rested on arguments about the drugs' expense, side-effects and lack of a sufficient health infrastructure to provide them. These arguments were reiterated in the Health Minister's address on 9 October 2002 and her 2002 World AIDS Day address (Tshabalala-Msimang 2002a, b).

In the light of government's overall capitulation over the provision of anti-retrovirals to prevent HIV transmission in the case of rape and from mothers to infants during and following birth, the major remaining disagreement between the state and the TAC is over the TAC's demand that the government provide HAART in the state sector.

The TAC and its allies, like Cosatu and the South African Medical Association (Sama), favour the provision of triple therapy in the public sector. This

position has been framed in the language of socio-economic rights and the courts have been used to force the state to provide anti-retrovirals to prevent MTCT (Annas 2003). Their stance on anti-retrovirals has implied a firm faith in the latest orthodox medical views on how best to treat HIV and to prevent new infections. Their campaign is deeply rooted in mainstream western biomedical understandings of the disease and epidemic. This has placed it on a direct collision course with that handful of powerfully-placed government figures who have publicly supported AIDS denialism. The result has been a paralysis in serious policy-making engagement between the TAC and its allies and senior government officials over AIDS policy.

The origins of AIDS denialism and its relevance to government policy-making on AIDS

It is now widely recognised that decisive leadership on AIDS policy by heads of state can be crucial in turning the tide of the epidemic, especially in developing countries. Thailand and Uganda are often cited as cases in point, where infection levels have either stopped rising, or have actually declined, and where the government's leadership has assumed a high profile in their prevention campaigns (Barnett & Whiteside 2002).

However, in South Africa the coherence and effectiveness of official state anti-AIDS programmes has been undermined by the highly public articulation of AIDS-denialist positions by President Thabo Mbeki and Health Minister Manto Tshabalala-Msimang. At the core of this position is a denial of the viral causation of AIDS, as well as of the extent of the infection and the efficacy and safety of anti-retroviral therapy. Until the adoption by the President of these views, AIDS denialists (or AIDS 'dissident' scientists as they like to refer to themselves) were virtual unknowns in South Africa. Nor did anyone take seriously the claims of the likes of Peter Duesburg and David Rassnick, who argued that HIV was not the cause of AIDS, that HIV tests were inaccurate and that anti-retrovirals were poisonous to the extent of causing AIDS deaths themselves (see Schüklenck 2002). These ideas were fringe notions circulating on remote internet sites like Virusmyth.com. President Mbeki has changed all that, and these ideas, which fall outside mainstream biomedical understandings of the disease, have seriously impacted on AIDS policy-making since the late 1990s.

While he had given hints earlier on in the Mandela era that he was partial to unorthodox views on the causes of HIV/AIDS, the extent to which the new President was prepared to identify himself with denialism only became clear in 2000 when he convened a Presidential Advisory Panel on AIDS and included on it such dissident scientists as Duesburg and Rassnick, along with other medical and scientific researchers holding orthodox views on AIDS. Their brief was to debate the basic tenets underpinning mainstream medical and scientific approaches to AIDS, explore the accuracy of HIV tests and the issue of whether HIV caused AIDS.

International controversy over his views grew when, at the 2000 International AIDS Conference in Durban, President Mbeki used this global forum to reiterate his dissidence. He claimed that not everything could be 'blamed on a single virus' and that poverty killed more people around the world than AIDS (Mbeki 2000: 4). The link between poverty and inequality and AIDS had been made before and might not have been so controversial had it not been for the President's questioning in the speech of 'the reliability of and the information communicated by our current HIV tests' (Mbeki 2000: 5). Soon thereafter in an interview with *Time* magazine (11.09.02), and again during parliamentary question time, Mbeki claimed that HIV could not cause AIDS on the grounds that a virus could not cause an immune-deficiency syndrome (see Schücklenk 2002).

Further evidence of the extent to which denialism had penetrated the ANC's thinking came in the form of an article posted on the organisation's online newsletter *ANC Today* in 2001. Almost certainly written by the President, it again expressed doubt as to the cause of AIDS and questioned the accuracy of HIV tests, stating that:

> Scientists have been grappling with these questions for 20 years, and yet there are still some disputes on these issues. The first relates to the virus itself. The questions to be answered are:
> - Does an infectious agent exist? If it does, is it a virus? Is this virus then the main cause of the immune-suppression seen in patients who have tested HIV-positive?
> - Are the tests that we use to detect the virus reliable?
> - Do the tests measure HIV? (ANC 2001: 7)

Consistent with this thinking, the DoH in the same year began circulating pamphlets to clinics promoting denialist views.[2] These were views which the

President repeated time and again, until in the face of growing public alarm and national and international ridicule, he decided to withdraw from the public debate on AIDS in April 2002.

AIDS and racism

In one key respect the AIDS denialism of President Mbeki and those in the ANC who subscribe to his views differs from the international variant of AIDS dissidence, and that is that it exhibits a preoccupation with racialised notions of the epidemic. This can be linked, in terms of intellectual history, to the historical legacy of certain racist public health responses to the epidemic in South Africa and internationally. The question, therefore, of what has led to such beliefs holding sway in the corridors of power can be answered at least partially by analysing AIDS denialism in historical context and as a reaction to the legacy of apartheid and colonial discourse around Africans, medicine and disease.

Speaking at Fort Hare University in October 2001, Mbeki argued that mainstream scientific views on AIDS were racist:

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

This theme was echoed in a pamphlet allegedly authored by Peter Mokaba (2002), an ANC MP and confidante of the President, which presented conspiratorial arguments that an 'omnipotent apparatus' of AIDS doctors, scientists, activists and the pharmaceutical companies aimed to kill black people in South Africa by prescribing 'toxic' anti-retrovirals.[3]

President Mbeki was not the first prominent African to make the link between AIDS causation and racism. In 1989, Richard and Rosalind Chirimuuta, Zimbabwean tropical health specialists at the London School of Hygiene and Tropical Medicine, published an AIDS denialist text entitled *AIDS, Africa and Racism*. In what they considered a defence of African sexuality and humanity, they pushed many of the lines later espoused by Mbeki – that HIV did not cause AIDS, that AIDS did not originate in Africa, and that anti-retrovirals were 'poison' (Chirimuuta & Chirimuuta 1989). They also argued that the extent of the epidemic was exaggerated as part of a racist plot to discredit African culture and sexuality. They cited early medical journal articles that made insulting and culturally inaccurate speculations about African sexuality. For instance, they criticised researchers who claimed that HIV passed from monkeys to Africans through bizarre sexual practices involving monkey blood, that Africans engaged in anal intercourse more frequently than other race groups, and that in general they were 'excessively' promiscuous.

It was not only African intellectuals who ascribed to this latter view at the time. African health ministers and leaders were at the time contesting the HIV prevalence statistics being presented by the World Health Organization and medical researchers from the US and Europe (Garrett 1994). At the same time, articulations by South African health authorities (primarily white) and many white South African doctors as to what was driving the epidemic relied heavily on racist and sexist stereotypes of a diseased African sexuality (Mbali 2001).

In this regard, they were espousing a view that went far back into colonial and apartheid medicine. As the noted Africanist scholar, Megan Vaughan (1991), has shown, colonial medical discourse about Africans was highly sexualised, especially in regard to programmes designed to manage the transmission of sexual diseases. It portrayed Africans as sexually primitive and lacking in control in regard to their 'excessive' sexual appetites. In similar vein, Gillman has shown how in western post-enlightenment culture and science 'the black' was represented as 'an icon for deviant sexuality in general' and the female black 'an icon for black sexuality' (1985: 79, 83).

The impact of denialism on state policy

Given that it is official state policy that HIV causes AIDS, the question arises as to whether denialism still has any impact on AIDS policy. The answer must be that it does. First, it must be a contributory factor to the high levels of public scepticism about the sincerity and degree of commitment of the DoH to its policies, given the continuing stewardship of the Department by Minister Tshabalala-Msimang. Second, it offers in large part an explanation for the snail's pace at which the DoH has moved to implement the court-ordered

roll-out of anti-retroviral therapy for prevention of MTCT in some provinces (especially Mpumalanga). Third, given the national shortage of skilled personnel, how else can one explain the many punitive measures directed at doctors and nurses who have pushed beyond the limits of official state policy in regard to HIVAIDS, and in particular its policy on anti-retroviral provision? The case of Dr Thuys Von Mollendorf stands out here. Disciplinary proceedings were instituted against him in 2002 for allowing an NGO providing anti-retrovirals to sexual assault survivors as post-exposure prophylaxis to operate within the premises of a large state hospital in Mpumalanga where he was superintendent (Landman et al. 2002).

Overall, the denialists have overly prolonged a national debate which has undoubtedly diverted government resources and the attention of government officials from the main policy tasks at hand: using the latest mainstream medical and scientific research to prevent new infections and provide the best standards of treatment and care for HIV-infected persons and AIDS orphans.

The TAC position

From its origins in 1998 as a campaign by HIV-positive AIDS activists for anti-retrovirals to be provided to prevent MTCT, the TAC has expanded into a broad-based nationwide civil society campaign which has lobbied for multinational pharmaceuticals to lower costs of anti-retrovirals and for government to roll out anti-retrovirals in the public sector for post-exposure prophylaxis in the case of sexual assault, prevention of MTCT and triple therapy.

According to its February 2003 submission to the Parliamentary Portfolio Committee on Health, the TAC has eight objectives. They are to:

- Campaign for affordable treatment for all people with HIV/AIDS.
- Campaign and support the prevention and elimination of all HIV infections.
- Promote and sponsor legislation to ensure equal access and equal treatment of all people with HIV/AIDS.
- Challenge by means of litigation, lobbying, advocacy and all forms of legitimate social mobilisation any type of discrimination relating to the treatment of AIDS in the public sector.
- Educate, promote and develop an understanding and commitment within communities of developments in HIV/AIDS treatment and care.

- Campaign for affordable and quality access to health care for all people in South Africa.
- Train and develop a representative and effective leadership of people living with HIV/AIDS in the basis of equality.
- Campaign for an effective regional and global network comprising organisations with similar aims and objectives. (TAC 2003c: 1)

In action, the TAC has campaigned on two fronts. One has been directed at the pharmaceutical industry using patent monopolies to retain high profits on AIDS drugs, which inflates their price. The second has been directed at the Government to provide access to anti-retrovirals in the public sector. This latter fact has not prevented the TAC and Government from operating in harmony at times, as in the case of the TAC's support of the Government in its defence of the *Medicines Act* in 2000, against the Pharmaceutical Manufacturers' Association's (PMA) attempt to strike it down in a court case.

Over 40 multinational pharmaceutical companies took the South African government to court in 2001 to prevent the *Medicines Act* of 1997 becoming law. That particular piece of legislation was controversial as it allowed for the generic production of drugs and their parallel importation, and it would have forced pharmaceutical industry into more transparent pricing mechanisms, all of which would have reduced the price of pharmaceutical drugs in South Africa.

The TAC's support of the Government's defence of the Act took the form of it becoming a 'friend of the court' in the case. It also mobilised thousands to demonstrate against the drug companies' stance both in South Africa and overseas. The TAC also successfully built links with international civil society organisations such as the Health Gap Coalition, Oxfam and Doctors without Borders (*Medicins sans Frontiers*), which, in turn, lobbied and demonstrated around the issue in Europe and the US.

Within South Africa, large and frequent demonstrations increased the pressure on pharmaceutical companies. A march by over 500 staff and students from the University of Durban-Westville on the offices of Merck pharmaceuticals (one of the protagonists in the case) influenced the company to drop out of the case within 24 hours of the protest. In a televised public debate with Miryana Deeb, the representative of the Pharmaceutical Manufacturers Association, Zackie Achmat, the chairperson of the TAC, provided a devastating repudiation of Deeb's argument that the industry used significant proportions of the vast profits generated by patents for research and develop-

ment. In large part due to this local and global public pressure, the court case was dropped in April 2001. It was also due to the fact that the negative publicity generated by the case was impacting negatively on the whole image of the pharmaceutical industry.

Mother to child transmission and AIDS denialism

With the PMA court case settled, the TAC turned its attention to the issue of MTCT and the need for cheaper anti-retrovirals. In government circles, however, articulations of AIDS denialism resurfaced with almost daily accounts of high-profile government officials pronouncing negatively on the affordability and efficacy of anti-retrovirals. On this score, the short-lived unity between the TAC and government dissipated. They once again became adversaries, facing off in the Pretoria High Court and then the Consitutional Court over the issue of a roll-out of anti-retrovirals to prevent MTCT. In July 2001, government opted for a pilot study in the public sphere on the use of Nevirapine for the prevention of MTCT by establishing two pilot sites in each province where the drug could be administered. At all other public sites, doctors and nurses were prohibited from prescribing the drug.

In its arguments in both courts for a public sector roll-out of Nevirapine, the TAC argued that the government was breaching the rights of mothers and newborns to healthcare and life by failing to provide the drug for prevention of MTCT (Annas 2003). By contrast, the Government argued that the infrastructural costs of providing the drug would be prohibitive, and that its safety had not been proven (Annas 2003). In its widely distributed fact sheets and pamphlets, the TAC also repeated the claim that Government had overestimated the cost of preventing MTCT, a claim based on research by economists based at the University of Cape Town. The TAC contended that a MTCT-prevention programme would cost R80 million per year as opposed to the R800 million lost per annum by failing to prevent babies from contracting HIV from their mothers: the Government could not afford *not* to roll out a MTCT prevention programme (TAC 2001; Nattrass cited in HEARD 2001).

The Constitutional Court found in favour of the TAC and the Government has begun, albeit reluctantly and unevenly, to comply with the court decision. Not least of all in its April 2002 Cabinet statement, the Government proceeded with the roll-out of Nevirapine for MTCT prevention. At the time of writing, the TAC was of the view that the roll-out of the programmes was proceeding well in most provinces, with the singular exception of Mpumalanga. It also expressed the view that Finance Minister Trevor Manual's 2003 budgetary provision for the MTCT roll-out was sufficient.

Triple therapy, Nedlac and civil disobedience

For the TAC, the last remaining area of AIDS policy contestation has become the provision of triple therapy in the public sector. There is little doubt that the challenge of providing triple therapy in the public sector is immense. Both Government and the TAC have acknowledged this. However, whereas Government has represented the infrastructural and budgetary challenges as insurmountable, the TAC has consistently argued that ways and means can be found to overcome these obstacles.

On the back of its success in the court challenge over MTCT, at a special congress in Durban in July 2002 the TAC discussed an extensive 'National Treatment and Prevention Plan.' The plan contained several key points including expansion of voluntary counselling and testing, including education on safer sex; expanded condom distribution; the expansion of MTCT prevention; improvements in management of sexually-transmitted infections; and most crucially, access to HAART (triple therapy). According to research commissioned by the TAC from actuarial scientists at the University of Cape Town, the plan could:

- Reduce by nearly three million the number of HIV-related deaths between 2002–2015.
- Halve the number of children that will otherwise be orphaned by the HIV epidemic by 2015.
- Produce an average life expectancy in South Africa of approximately 50 years of age as opposed to 40 years in the absence of such interventions. (TAC 2003c: 11–13)

By contrast, the Government argues that it would cost R7 billion per annum to provide triple therapy to one million HIV-positive individuals and that the healthcare system will need to be drastically overhauled in order to provide the drugs. The TAC's view is that in the first year of implementation at current generic prices, triple therapy would cost less than R500 million, rising to R7 billion in the fifth year, and peaking at R20 billion in 2015 (TAC 2003c).

Armed with this plan, the TAC decided to negotiate with business, labour and government through Nedlac. It has been a slow and bumpy process. In September 2002, the Nedlac management committee responded to TAC and Cosatu's request for Nedlac to be used as a forum to negotiate for a national treatment plan by establishing an HIV/AIDS task team. By late November, the various sectors had developed a 'framework agreement'. Government's withdrawal from the Nedlac agreement, coupled with the Health Minister's recent championing of AIDS denialist Robert Giraldo's claims that AIDS can only be treated with nutrional supplements such as garlic, olive oil and sweet potato, fanned the flames of the TAC's discontent (*The Mercury* 20.01.03).

At the time of writing, the TAC has launched a campaign of civil disobedience in support of the agreement. At the 2003 opening of Parliament, over 10 000 demonstrators marched on parliament in support of the campaign. This, along with the Nelson Mandela Foundation/HSRC finding that 95 per cent of respondents agreed that anti-retroviral therapy should be provided in the public sector, has added grist to the mill of the TAC's stance. It suggests that the government's delay of a roll-out of triple therapy runs counter to the tide of public opinion (Shisana et al 2002). With an election looming in 2004 this is something the vote-conscious ANC government cannot afford to ignore

Conclusion

The development of a national AIDS treatment policy has been a long and tortuous process. Denialism has deep roots in the upper echelons of the current ANC government and even though it may now be on the wane, it has since its high point in 2000–01, in some vital respects paralysed post-apartheid AIDS policy with lethal consequences for HIV-positive South Africans. It has also revealed disturbing indications of an authoritarian tendency in the government. This has been reflected in its unwillingness to defer to accepted scientific expertise, its foot-dragging in regard to implementation of court rulings, and its reluctance to engage in a serious policy dialogue with civil society.

It has above all, in my view, led to a serious lessening of the moral authority of the post-apartheid state. Unless the government finally repudiates AIDS denialism and rolls out anti-retroviral triple therapy in the public health sector, it is likely that Mbeki's denialism will eradicate from historical memory many of the positive aspects of his tenure in office.

Notes

1 Mbeki publicly distanced himself dramatically from this viewpoint in April 2002. This still does not reduce it as a policy influencing, historically interesting phenomenon. About the term itself: Mbeki's 'denialism' is a neologism that has been coined by AIDS activists in South Africa. To use the more neutral term 'scepticism' would tend to imply that it is a fruitful philosophical endeavour in the western philosophical tradition. On the other hand, Mbeki and his followers have denied the scientific facts. The reason why I am using the more loaded term 'denialism' is to indicate my own disagreement with this viewpoint. It is also to indicate that his denial is made up of a complex set of political and philosophical beliefs, which can be placed in a historical context: in a true sense it is a new ideological '-ism' in South Africa.

2 I saw one such pamphlet in the Campus Clinic at University of Natal, Durban in 2001.

3 It has been claimed that the author of this document is Mbeki himself. However, in the absence of a claim of authorship by Mbeki it is better to work on the assumption that Mokaba wrote the document, as he claimed (*Mail & Guardian* 14.06.02; *Cape Times* 02.04.02).

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