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*“It is the fear of collapse, the sense of dissolution, which contaminates the Western images of all diseases, including elusive ones such as schizophrenia. But the fear we have of our own collapse does not remain internalized. Rather, we project this fear onto the world in order to localize it, and, indeed, to domesticate it.” – Sander Gilman in Disease and Representation*

### Drug Wars: South Africa’s Embattled Mother-to-Child Transmission Prevention Policy

South Africa experienced what many refer to as a miracle. After almost 50 years of a regime that systematically imprisoned and killed black South Africans, the country peacefully transitioned from a racist, often violent and exclusionary apartheid state to a racially-inclusive democracy in 1994. Since then, South Africa, with a GDP per capita of \$10,070 and a human development index of 0.666, has been commonly presented by the international media as the economic powerhouse of sub-Saharan Africa (UNDP). Indeed, when compared to many failed states in the continent, such as its neighbor Zimbabwe, South Africa appears to be a pillar of political, economic and social stability. Yet, this image has been complicated in recent years by the fact that South Africa has the largest number of people living with HIV/AIDS in the world. Despite rapidly increasing numbers of people infected with HIV throughout the 1990s, the South African government waited until 2003 to agree to offer free antiretrovirals to the public in a country with one of the highest rates of inequality in the world (Sunday Times 11/28/2004, UNDP). In the meantime, South African leaders including President Thabo Mbeki and Manto Tshabalala-Msimang, the Minister of Health, questioned widely-accepted knowledge about HIV/AIDS and its treatment, dabbling in a body of alternative theories of HIV/AIDS, Mbeki going as far as to question the link between HIV and AIDS. The government’s response to the HIV/AIDS crisis came to a head in 2001 when, the Treatment Action Campaign (TAC), a

grassroots AIDS treatment lobbying organization, filed a lawsuit against the South African Minister of Health and others regarding the government's refusal to make the drug Nevirapine – which prevents mother-to-child transmission of HIV – widely available, arguing that the government policy of not making the drug available in the public sector violated South Africans' social rights. Indeed, the compelling question here is: Why did the South African state in spite of a plethora of scientific evidence, domestic pressure via the TAC, and simple common sense – seeing babies die of AIDS when a pill was available that would reduce the chances of contraction – refuse to make available a drug that would reduce mother-to-child transmission of HIV?

In understanding this issue, it is important to examine not only the complexities, but also the effects of history. It would be too easy and quite a cursory explanation of this issue to argue that South African political leaders such as Mbeki and Tshabalala-Msimang have simply gone insane. Yet, in a nation such as South Africa, where a radical political transformation occurred only 10 years ago, the effects of history cannot be ignored. Thus, I will argue that the ideological and state structural effects of apartheid in combination with the government's desire to assert itself as an institution which controlled society (as the head of state) maintained the seemingly illogical national policy of the South African government in the late 1990s and early 2000 of refusing to make Nevirapine widely available in the public health sector.

## BACKGROUND

The debate about Nevirapine must first be situated within the broader landscape of HIV/AIDS in South Africa. More than 4 million people, or 19.4 percent of the adult population, live with HIV/AIDS in South Africa, making it the country with the largest number of people living with the virus in the world (Barnard 160). The first two official AIDS deaths were documented in 1982 and by the early 1990s, HIV had begun to spread at rapid rates (Sunday

Times 11/28/04). Yet, government policy was slow to respond (Outwater, et al. 143). It was only in 2003 that President Thabo Mbeki announced plans to implement a national roll-out treatment program (LaFranier, 2/20/04). Until then, the national government had prohibited the use of some antiretroviral drugs that were commonly used around the world, noting that the government was in the process of determining drug safety and cost efficiency (TAC v Minister of Health 5, 14). Previously unsuccessful attempts at AIDS education, such as a project in 1996 that spent 14.3 million rand on an AIDS-focused sequel to a widely popular play about a young girl's experience with the apartheid resistance movement, "Serafina," sparked wide public criticism (Sunday Times 11/28/04). The government suffered another blow in 1998 when the AIDS medication that it was attempting to produce, Virodene, was discovered to contain a toxic industrial solvent (Sunday Times 11/28/04). President Thabo Mbeki found himself in the midst of international controversy when he, drawing from a field of dissident science<sup>1</sup>, publicly questioned the link between HIV and AIDS during a parliamentary debate in 2000 (Sunday Times 11/28/04). The Minister of Health also adhering to dissident thinking, recommended a diet of beetroot, olive oil, African potato, and garlic to combat HIV/AIDS (Sunday Times 11/28/04). Until recently, public access to Nevirapine, a drug endorsed by the World Health Organization which can decrease the risk of transmission of HIV from mother to child from its original 30 percent to 13 percent, was also very limited, available in the public health field at only 18 test sites in the country (UN Information Network 6/14/05, Willan 114). Such action, or inaction, has continued to incite international criticism. For example, Stephen Lewis, the United Nation's special envoy to Africa on AIDS, recently said, "virtually every other nation in eastern and

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<sup>1</sup> Dissident science encompasses what Nicoli Nattrass defines as alternative theories about AIDS that "include the proposition that HIV is a harmless passenger virus and that the symptoms associated with AIDS are the result of poverty, lifestyle choices – even the result of antiretroviral medication" (Nattrass 49).

southern Africa ‘is working harder at treatment than is South Africa with relatively fewer resources, and in most cases nowhere near the infrastructure or human capacity of South Africa’” (LaFraniere 10/25/05). In short, the recent history of South African HIV/AIDS policy has been fraught with not only domestic, but also international dissatisfaction.

It is within this context that the Treatment Action Campaign and others sued the South African Minister of Health and others in 2001 for not adequately addressing the issue of mother-to-child transmission of HIV/AIDS. Claiming that the state was failing to provide citizens with a Constitutionally-given right of health care, the TAC demanded that the state make the mother-to-child transmission prevention (MTCTP) drug, Nevirapine, available in public health facilities around the country (TAC and Others v Minister of Health and Others 2, 9). Government policy at that point had only allowed Nevirapine to be distributed at a limited number of public health facilities (Heywood 285,6). The TAC’s legal action against the state in 2001 marked a recent history of animosity between the South African state and an element of society, the TAC, within the scope of the HIV/AIDS crisis. As documented in the court ruling, the TAC vehemently accused the state of depriving society of basic human rights by not making certain HIV/AIDS drugs easily accessible to the public (TAC and Others v Minister of Health and Others 9). The state, however, disagreed and soon requested an appeal to the ruling in favor of the civil society organization where it again lost its case.

By closely reading the language of the state’s various arguments justifying the lack of widespread availability of Nevirapine in the public sector, it is clear that not only are some arguments that the state makes for not making Nevirapine widely accessible to the public a result of particular histories of the apartheid regime, but also that similar strategies that the ANC used during the apartheid regime to combat state violence and other forms of repression were

rearticulated in the discourse surrounding Nevirapine. First, it is necessary to outline the three fundamental arguments that the state used in justifying its policy – safety, effectiveness and cost. Regarding safety, Dr. Ayanda Ntsaluba, the Director-General of Health cited the possibilities of resistance to the drug, skin reactions and hepatitis as a reason why Nevirapine should not have been widely available to the public (*TAC and Others v Minister of Health and Others* 14). He also argued that not only could the South African health department not afford a widespread Nevirapine policy, but that “it would cause a public health crisis if Nevirapine is administered without the necessary support” (*TAC and Others v Minister of Health and Others* 15). Finally, Dr. Nono Simelela, the Chief Director of HIV/AIDS for the Department of Health, argued that in the South African context where breast-feeding, rather than bottle-feeding, is prevalent, Nevirapine, which does not prevent the transmission of HIV through breast milk, simply wouldn’t work (*TAC and Others v Minister of Health and Others* 17). By unpacking both the language of such statements and the history of violence experienced by black South Africans from the apartheid state, it will be clear that the seemingly odd articulations by the contemporary South African government regarding HIV/AIDS and Nevirapine is, at least in part, a legacy of apartheid.

Before proceeding, however, it is necessary to unpack one of the primary justifications that the South African government used for its Nevirapine policy -- that implementing a comprehensive, widespread Nevirapine program in the public health sector would simply be too expensive. Ntsaluba argued in the court case that, “due to a dearth of resources, the demand for Nevirapine cannot be met immediately” (*TAC and Others v Minister of Health and Others* 17). Thus, the state argued that it simply did not have the resources to pay for immediate access to Nevirapine for all public health sites.

The argument that the government lacks the resources, however, was simply not true. Nicoli Nattrass and Mark Heywood offer compelling evidence that the South African government can indeed afford a widespread Nevirapine program. In 2001, an Intergovernmental Fiscal Review showed that the health department actually underspent its budget (Heywood 297). Despite the assertions of several provincial health departments that they could not afford the R250 million that they estimated the provincial rollout Nevirapine program would cost, the provinces in fact had a budget surplus of R473million (Heywood 297). Nattrass argues that it would cost the South African government more money to treat the children who contracted HIV from their parents during childbirth than to implement a mother-to-children transmission prevention program. According to Nattrass, for every 1,000 pregnant women, 24.5 percent will be HIV-positive, and of those women, 30 percent will transmit the virus to their child without a prevention program available (Nattrass 70). This 30 percent – or 74 children – who are HIV-positive, is estimated to spend 10.8 days in the hospital during their lives due to opportunistic infections (Nattrass 70). For these 74 HIV-positive children per 1,000 pregnant women, the health sector will accrue costs of R980,700 (Nattrass 70). In comparison, the total cost of a Nevirapine program plus the cost of treating HIV-positive children is estimated to be R783,300. It is clear that it was costing the state significantly more money to treat children infected with HIV due to mother-to-child transmission than to finance the availability of Nevirapine in the public health sector and avoid infection altogether. Not only could the South African government afford to finance a Nevirapine program, it was actually fiscally detrimental to not implement one. Thus, affordability cannot have been an issue that would compel the South African state to resist the widespread policy that the TAC demanded. Other factors must have been at work in influencing the state's seemingly irrational Nevirapine policy.

## LEGACIES OF APARTHEID: RACISM, SCIENCE AND EUGENICS

One of the primary explanations that the state gave for its limited Nevirapine program was the idea that the drug's safety was not proven. Yet, a deeper examination of the language of this explanation shows that the current South African government's response to Nevirapine was in part a response to the history of ideological and medicalized violence targeted toward black South Africans during the apartheid regime. In defending their position of resisting widespread use of Nevirapine in the public health sector, the Minister of Health and her witnesses repeatedly pointed to "safety" as justification. For example, in the Nevirapine case, Simelela pointed to a study that suggested that a long-term study of Nevirapine was necessary in order to determine whether the drug causes resistance. Nevirapine, according to her, was found to develop resistant strains of HIV in women who were exposed to a single dose of Nevirapine (TAC and Others v Minister of Health and Others 19). Despite the fact that the resistant strain disappeared after six weeks, it warranted further study to determine safety, she said (TAC and Others v Minister of Health and Others 20). In a more explicit expression of concern for public safety, advisors to the government have argued that Nevirapine "is a toxic drug that could poison mothers and their babies, and which would not be used in the First World" (Mail and Guardian 5/10/02). State leaders expressed skepticism regarding Nevirapine either due to its suspected toxicity or potential for causing resistance. Such deep skepticism, however, does not emerge from nowhere. The language of the South African government's skeptical approach to medicine indicates a long-term effect of the apartheid regime's use of science, particularly, medicine, to implement eugenic<sup>2</sup> programs targeted at the black South African majority.

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<sup>2</sup> Jeannelle de Guchy and Laurel Baldwin-Ragaven define eugenics, influenced by Darwin's theory of social evolution and survival of the fittest as being concerned with "improving the 'quality' of 'a people' through engineering the 'fit' to reproduce and the 'unfit' to be prevented

The abuse of science to reinforce and perpetuate racist ideology has a long history in South Africa. Starting in the late 19<sup>th</sup> century and well into the apartheid regime in the mid-20<sup>th</sup> century, systematized theories and research regarding the biological differences between races were prominent in South Africa. At the turn of the century, racist notions of evolutionary biological science became popular through such texts as George W. Stow's *The Native Races of South Africa* (1905) and George McCall Theal's *Yellow and Dark-skinned People of Africa South of the Zambesi* (1910) (Dubow 67, 69). Such "scientific" works established a sense of racial superiority by whites over blacks. For example, "Bushmen" were seen as inferior to "Hottentots," who were weaker than the Bantu, whose physical attributes were similar to Europeans, who were implicitly presented as superior (Dubow 70). According to Saul Dubow, such logic fell under the umbrella of Social Darwinism, which he defines as an ideology that "describes social evolution in terms of laws of natural selection and stresses the importance of biological inheritance" (Dubow 120). Eugenics – and its desire to manipulate this evolution – arises out of this philosophy that the best "breed" survives through competition" (Dubow 120).

Such racial ideologies were adopted by many Afrikaner nationalists in their attempt to maintain political and economic power in South Africa. Dubow notes that the fear of white racial denigration among Afrikaner nationalists was a continuous issue of concern among the white minority beginning in the late nineteenth century (Dubow 167). Afrikaner nationalists feared that contact with black South Africans, particularly sexual contact, would diminish the white South African race due to the assumed biological inferiority of black South Africans. For example, Ernest Stubbs, a well-known "native administrator" and prominent advocate of segregation in the 1920s, placed denigration at the center of his thinking about social order in

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from doing so. 'Fitness' is defined through discourses such as 'race,' 'national stock,' class and intelligence" (Gucy and Baldwin-Ragaven 316).

South Africa (Dubow 169). In 1925, he wrote that “continued contact between blacks and whites would mean ‘the utter and irretrievable ruin of the White races of South Africa. Stubbs regarded South Africa as a ‘slave state’ in which a ‘White Aristocracy’ was super-imposed upon a ‘Black Proletariat’” (Dubow 169). Even before the Apartheid regime came into place, the imagined racial denigration of the white race in South Africa fueled an ideology that segregation was necessary to protect the “purity” of the naturally superior white race. By disenfranchising the majority of blacks and privileging the minority of whites, whiteness was thought to be preserved from the impending danger of “inferior” blacks (Dubow 169).

Such ideology during the apartheid regime resulted in the use of medicine by the apartheid state to articulate violence against the black majority. Barbara Brown, in “Facing the ‘Black Peril’: The Politics of Population Control in South Africa,” writes of the ways in which the fear of the “black peril”<sup>3</sup> — an extension of the idea of racial denigration — propelled the apartheid state to encourage black South African women to use sometimes untested birth control during the 1970s. She writes that the idea of the “black peril” “has been a central part of white political rhetoric, reminding whites of the common threat they face from blacks and the need for unity” (Brown 262). The fear of denigration thus led the apartheid state to implicitly campaign to limit the numbers of black South Africans through medicine. For example, members of the House of Assembly remarked that, “blacks are unable to make a contribution to South African society and so should be encouraged to limit their numbers” (Brown 264). By 1974, the South African government started its birth control program (Brown 265). By 1983, the program had over 36,000 “family planning service points” (Brown 266). Indeed, birth control distributed by

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<sup>3</sup> Dubow defines the “black peril” as the notion that black men would articulate sexual violence against white women, revealing an underlying fear of racial mixing and anxieties regarding sexuality (Dubow 181).

the government was technically available to both white and black patients, but the racist implementation of the program can be seen by the fact that “little government money is spent on education and medical services for the white population, as they generally use private physicians. In any case, the birth rate among whites has been in gradual decline since ‘at least the beginning of the century’” (Brown 266). The state had intended its birth control program for black women, not the white women who in general did not frequent public clinics. For example, advertising campaigns were set up in black neighborhoods while white families were encouraged through tax breaks by the state, to produce white children (Brown 267). White women were encouraged to reproduce and thus contribute to building a white South Africa while black women were encouraged by the state to stop reproducing children the state deemed to be inferior. Within its birth control program, the government offered contraception such as Depo Provera, which, at the time, “was banned in many countries as unsafe but ‘it is being used to an increasing extent in South Africa among black women, particularly in the rural areas’” (Brown 271). In many cases, women were not informed of the risks, such as cancer and loss of fertility (Brown 271). Not only was the state using medicine to articulate symbolic violence against black South Africans by perpetuating notions that blacks were inferior but was also articulating physical violence by giving black women medicine that could be harmful. By 1993, 70 to 80 percent of “all black female clients in South Africa were using injectables, as compared to 10 percent of all white female clients” (De Gruchy and Baldwin-Ragaven 322). A significant population of black women who were using this form of contraception had been put at risk. In 1985, the ANC caught on and accused the government of using Depo Provera as a way to reduce the black population (The Gazette, 7/19/85). Thus, it is clear that the contemporary South African state’s concern for the safety of Nevirapine – another reproduction-related drug – had roots in this

history. The state was attempting to respond to the issue of mother-to-child transmission by using the same strategies that it used as the ANC to survive the apartheid state's attempts to use medication as a way implement its eugenic ideas.

The apartheid state also used forced sterilizations as a method of limiting the numbers of black South Africans. TRC hearings revealed that scientists at the South African Defence Force were trying to develop an antifertility vaccine that "could have been used clandestinely on black people" (De Gruchy and Baldwin-Ragaven 321). According to De Gruchy and Baldwin, it was not uncommon for doctors to sterilize patients during appendectomies and intentionally manipulated fallopian tubes in order to cause infertility – all without the patients' knowledge (De Gruchy and Baldwin 320). It is within this context that many black South African leaders came of age. Time and again, science, medicine, and particularly reproduction-related drugs were used both to buttress the apartheid regime and to implement the eugenic projects of decreasing the black population. During the apartheid regime, the ANC had survived within such a violently disenfranchising social environment by maintaining a critical stance toward the West (Sparks in Mind of South Africa 239). Without such skepticism, it is quite possible that many black South Africans would not have survived such physically and symbolically violent Western abuses of science. Thus, Mbeki's recent accusation that Nevirapine was a ploy by U.S. health officials to treat "Africans like 'guinea pigs' and lying to promote a key AIDS drug" shows that the deep legacy of racial violence articulated against blacks by the white minority in South Africa influences the state's Nevirapine policy (Zavis 12/17//2004). In the past, the powerful white minority in South Africa actually did use black South Africans as test subjects for Depo Provera. With this in mind, it is clear that within the context of the Nevirapine battle, the state, by using of the rhetoric of safety and skepticism toward Western-originated science, was using the same

strategies that the state – during that period, the ANC – had used under the apartheid regime. Yet, the state’s response to Nevirapine does not simply recollect the history of medical violence articulated against black South Africans in general. It is important to note that doctors surreptitiously prevented black *women* from reproducing black children. Thus, the new South African state’s resistance toward the Western Nevirapine can also be seen as a masculinized act of protecting black women and black children from violence in a way that the ANC could not do as an underground guerilla group. In other words, the current state’s refusal to make Nevirapine accessible can be seen as an attempt by the state to control black women’s bodies, a response – regardless of intent – to the history of white men controlling black women’s bodies during the apartheid regime.

Similarly, Mbeki’s contestation of the way that the West represented the broader HIV/AIDS situation in South Africa points to the ways in which the state may have also been trying to resist the image perpetuated throughout South African history of blacks as being diseased within the issue of Nevirapine as well. For example, Mbeki wrote to opposition leader Tony Leon in 2000 that:

You may be... unaware of the desperate attempt made by some scientists in the past to blame HIV/AIDS on Africans, even at a time when the United States was the epicenter of reported deaths from AIDS. To me as an African, it is both interesting and disturbing that the signatories of the so-called ‘Durban Declaration’ return to the thesis about the alleged original transmission of HIV from (African) animals to humans, given what science has said about AIDS during the past two decades (Sparks, Beyond the Miracle 294).

According to Mbeki, the entire discourse surrounding HIV/AIDS was problematic in that it invoked racist assumptions about black South Africans as being biologically closer to animals than whites, thus perpetuating notions of Africans as being prone to disease and the subsequently blaming of the HIV/AIDS crisis on black South Africans. Thus, scientific explanations regarding the transmission of HIV were suspect to Mbeki. If the theories surrounding AIDS were questionable, according to this logic, then internationally-endorsed treatment of mother-to-

child transmission of HIV would by association have been questionable as well. Mbeki's resistance toward implementing a more widespread Nevirapine policy due to the assumption that supporters of HIV/AIDS treatment believed that HIV/AIDS was an African disease may appear illogical. Yet, this rhetoric reveals a response to a history of racialist discourse surrounding black South Africans.

Black South Africans have been represented throughout South African history by many white South Africans as being diseased, or susceptible to disease. In The Colour of Disease, Syphilis and Racism in South Africa, 1880 – 1950, Karen Jochelson highlights the ways in which discourses surrounding syphilis in particular reproduced racist notions of black people in South Africa. Between 1880 and 1910, the notion that syphilis was sweeping South Africa was quite prevalent (Jochelson 11). Similar to the discourse surrounding AIDS, one district surgeon in 1885 estimated that, “one in every three of natives is inflicted’ and warned that syphilis was ‘ravaging the district in its most malignant and loathsome forms” (Jochelson 11). Africans, many doctors believed, were responsible for spreading the disease due to beliefs about their low evolutionary status and the idea that “Africans were inherently promiscuous, and thus once the disease entered a community it would spread rapidly” (Jochelson 27). Drawing on these notions of Africans as being inherently diseased and sexually promiscuous, General Jan Smuts – a British South African political leader who later unsuccessfully ran against Daniel Malan and his Nationalist party, which ultimately established Afrikaner nationalism as the dominant national policy for most of post-war South Africa – said in 1937 that, “the natives of this country are becoming rotten with disease and a menace to civilization, instead of a first class nation” (Sparks, The Mind of South Africa 48, Jochelson 93). In other words, some white South Africans saw black South Africans as an inherently diseased race. Black South Africans were

stigmatized as a diseased race and disease was stigmatized as a black phenomenon. In addition, black South Africans were thought to denigrate not only the health of the country, but also its socio-economic development. Yet, later studies have shown that doctors often confused venereal syphilis, which is deadly, with endemic syphilis, which is neither deadly nor sexually transmitted (Jochelson 20). The tendency of doctors to diagnose black South Africans as having contracted venereal syphilis rather than endemic syphilis shows that many doctors simply assumed that blacks would have contracted the sexually transmitted disease due to racist notions of black South Africans. Thus, it is clear that racism against black South Africans was reinforced through the framework of disease.

With this history in mind, it is clear that the language that Mbeki used to resist widespread access to Nevirapine in South Africa was a response, regardless of intent, to this history. At a lecture at Fort Hare University in 2001 in which Mbeki insinuated that AIDS scientists were working under the assumption that blacks were inherently diseased, Mbeki said: “And thus does it happen that others who consider themselves to be our leaders... demand that because we are germ carriers, and human beings of a lower order that cannot subject its passion to reason, we must perforce adopt strange options, to save a depraved and diseased people from perishing from self-inflicted disease” (Sparks, *Beyond the Miracle* 293). Mbeki’s reference to this notion of blacks as “diseased Others,” regardless of consciousness or intent, marks one way in which the state’s response to mother-to-child transmission of HIV is partly influenced by the history of white racist ideologies about blacks. Mbeki uses the same language of “depraved and diseased people,” living with “self-inflicted disease” used during the syphilis outbreak in his attempt to resist these same notions in the context of HIV transmission. Thus, it is clear that the alignment of disease with blacks in South Africa is so loaded with historical significance and

productions of racist ideologies that state leaders have become reactionary by rebutting any vestige of such ideologies. Memories of the ideological violence produced through the collusion of black South Africans with disease reverberate in the language of Mbeki's resistant to widespread use of Nevirapine, showing the legacy of apartheid on Nevirapine policy. Thus, the state's Nevirapine policy was not a response to the problem of mother-to-child transmission in and of itself, but tainted by a reaction to the historical alignment of blacks with disease.

### STATE ATTEMPTS AT SOCIAL CONTROL

Another justification the state used for the absence of a widespread Nevirapine program was to argue that the program was simply ineffective in the context of South Africa. Specifically, the state argued that any benefits that Nevirapine might have provided in the Western countries where it was tested was negated by the fact that South Africa had a cultural tradition of breastfeeding – a method of transmitting HIV that Nevirapine could not prevent. According to the judge's decision in the Nevirapine case, the Minister of Health argued that, "It is not safe to expose a largely breast feeding population to Nevirapine unless stringent measures are taken" (TAC and Others v Minister of Health and Others 14). Thus, regardless of whether Nevirapine was proven to be effective in other parts of the world, the particular cultural dynamics of South Africa created a special circumstance. South Africa, in other words, needed to find an African solution to a particularly African problem. Such an argument recalls the Africanist movements in South Africa of Garveyism and Black Consciousness, which had widespread influences on resistance movements against the repressive apartheid regime. The fact that the rhetoric of such Africanist movements can be seen in the state's justification of its Nevirapine policy shows that the legacy of apartheid resistance influences the state's response to the Nevirapine issue.

The idea of Africa for the Africans can be seen as early in South African history as the Garveyist movement in the 1920s. Garveyism – which originated in the U.S. as a mode of resistance to racism there – initially found its way to South Africa through African Americans who intended to liberate black South Africans from the repressive Afrikaner-controlled state. They advocated blacks to regain political and economic control of the country, as can be seen by one representative of Marcus Garvey’s Negro Improvement Association, who said: “Tell the Kaffirs to awake, awake, put on the whole armor and prepare for Armageddon” (Hill and Pirio 211). Garveyism’s message of “Africa for the Africans” soon took hold in South Africa, influencing organizations pivotal to the resistance movement such as the ANC Youth League (Hill and Pirio 242). The ANC Youth League’s 1948 manifesto, for example, adopted the Garveyist slogan “Africa for the Africans,” nodding directly to Garveyism (Hill and Pirio 242).

This Africanist ideology was revamped in the 1960s with the Black Consciousness Movement. A significant ideology and movement, which influenced various acts of resistance against the apartheid state such as the Soweto uprising of 1976, Black Consciousness argued that black empowerment and resistance against apartheid needed to be led by black, instead of liberal white South Africans. Steve Biko, the founder of the movement, wrote, “because of their privileged position even the most sympathetic whites would always, albeit unconsciously, seek to control the resistance movement and guide it in directions that would not be too destructive of their interests” (Quoted in Sparks, The Mind of South Africa 260). In other words, Black Consciousness argued that liberal white South Africans, living a privileged socio-economic position in the apartheid structure, would never work to completely dismantle the racialized power structure of apartheid because they ultimately benefited from it. Black South Africans, therefore, had to lead themselves if they wanted to see a complete structural dismantling of the

apartheid regime. Thus emerged the theme, “Black man, you are on your own” (Sparks, The Mind of South Africa 260). Psychological and structural liberation necessitated black South Africans to lead themselves in the resistance movement. African problems needed African-produced solutions for liberation to not only be effective but also to be sustainable. This movement spread to the townships and universities as a way for black students to re-educate themselves from the apartheid regime’s indoctrinating ideologies (Sparks, The Mind of South Africa 263). Despite the fact that the apartheid state banned 17 Black Consciousness organizations by 1977 and eventually banned all anti-apartheid organizations in 1988, this ideology had a significant impact on the youth of the era and subsequently current political leaders of South Africa (Gibson 5). N. Barney Pitso writes that, “Arguably, one can hardly find a notable leader in South Africa today who was in his or her twenties in the early 1970s, who has not been through the Black Consciousness mill, whether in church, the trade-union movement, progressive professional organizations and other community associations” (Pitso 255). Thus, it is clear that leaders of the contemporary South African state were deeply influenced by the ideologies of Africanist movements such as Black Consciousness, which advocated black empowerment through Africans determining specifically African solutions to African problems.

Thus, the South African government’s argument that the South African breastfeeding culture makes Nevirapine somewhat ineffective and subsequently necessitates a limited Nevirapine program does not arise from the delusional thinking of state leaders, but rather, from a legacy of anti-apartheid ideology that advocated African solutions to African problems. The state was re-articulating its method of resisting the apartheid regime in responding to the Nevirapine issue. In other words, the state, trained as the ANC during the apartheid regime to

advocate African solutions to African problems, was responding to the issue of mother-to-child transmission of HIV in the same manner. For example, upon receiving criticism from the UN special envoy to Africa on AIDS, the Minister of Health in July 2004 said that the UN representative knew very little about South Africa's health system (LaFranier 10/25/05). Similarly, Mbeki "repeatedly emphasized (including in letters to the UN secretary general, the British prime minister and the US president) that the search for targeted response to the specifically African nature of the pandemic required an innovative approach, which inter alia entailed taking dissident opinions seriously" (Nattrass 53). This same language of finding African solutions to African problems – to not allow Western ideologies and leadership to dictate indigenous South African development – shows that the state's seemingly strange response to the Nevirapine issue is a result of the continuing legacy of the apartheid regime – or the resistance to the apartheid regime – on the current South African state.

Yet, the state's resistance toward a widespread Nevirapine policy as seen by the argument that the South African transmission of HIV from mother to child requires a particular South African solution also indicates its attempt to articulate social control as the state<sup>4</sup>. The idea that the particularities of breastfeeding in South Africa requires the state's intervention and determination of a solution rather than that of a Western biomedical company is implicit in the Minister of Health's "falling out" with the United Nations special envoy to Africa on AIDS over the Nevirapine issue. In July 2004, after the Minister of Health publicly questioned the safety of Nevirapine at an international AIDS conference, Stephen Lewis contradicted her statement (LaFranier 10/25/05). In response, Sibani Mngadi, the minister's spokesman, said, "The whole

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<sup>4</sup> Here, I use Joel Migdal's definition of the state as a multi-sectoral body led by an executive authority that attempts to make and implement the rules society follows (Migdal 19). Migdal understands the state as being one element of the larger "web" of society rather than existing outside society (Migdal 37).

approach of Stephen Lewis was to question whether *we as a government* [italics inserted] had a right to take particular approaches, and in that situation it really requires an apology” (LaFrancier 10/25/05). Mngadi’s response shows that the state’s concern was not with Lewis’ disagreement with its Nevirapine policy, but with Lewis’ contestation of the state’s desire to control the physical bodies of South African society members. Lewis’ questioning of the state’s articulation of social control – determining whether children of HIV-positive mothers live or die and how women are able to control their bodies – and the state’s taking offense shows the state’s active desire to control the actions of society. This same attempt to control society can be seen by Ntsaluba’s argument in the court case that, “it was the practice all over the world to test drugs that may be used in the public sector. To allow doctors in the public sector to prescribe any drug would be chaos. Budgets would be strained. If all available drugs were to be stored it would lead to wastage” (TAC and Others v Minister of Health and Others 14). The state was not only attempting to assert its “right” to protect the bodies of members of society, but to also assert itself as the institution capable of financially managing society. Doctors could not be given responsibility for determining the public safety of drugs for fear of jeopardizing the fiscal austerity of the country. The state’s desire to articulate control not only over society’s physical body but to dictate the actions of society can also be seen by the fact that, “today some citizens who challenge the government on treatment have been labeled ‘unpatriotic’ and peaceful protesters during the TAC civil disobedience campaign in March 2003 were sprayed with water cannons and beaten” (Willan 13). The state articulates social control through force. It is this desire to control the bodies and actions of society that fuels the state’s controversial position on Nevirapine. This new state, as the institution that by definition makes and implements the rules that society is expected to follow, is thus attempting to articulate this social rule-making through

the issue of Nevirapine (Migdal 19). This can also be seen by the Minister of Health's assertion that, "HIV/AIDS is not the only illness that the public hospitals have to contend with. If state doctors were to be allowed to operate outside a fiscal and policy framework, it would throw the public health care system in disarray" (TAC and Others v Minister of Health and Others 16).

The state, not doctors, according to Ntsaluba, was capable of carrying out the finances of the country. The state was the actor capable of controlling the resources of society. Thus, the state's policy and justifications for such policy were further fueled and stubbornly maintained by this desire to determine the rules that society follows as the institution that is designated to do so.

#### LEGACIES OF APARTHEID RESISTANCE: HIERARCHICAL STATE STRUCTURE

The state's argument that it was the only institution capable for determining the biological and fiscal health of society indicates another reason for the state's seemingly illogical argument against a widespread Nevirapine policy – the legacy of apartheid in instilling a hierarchical structure in the ANC and subsequently, the new state. In the TAC v Minister of Health case, Ntsaluba argued that, "HIV/AIDS is not the only illness that the public hospitals have to contend with. If state doctors were to be allowed to operate outside a fiscal and policy framework, it would throw the public health system into disarray" (TAC and Others v Minister of Health and Others 13). The state was seen as superior to individual members of society, such as doctors, in determining what was most beneficial for society. The state had the entire network of society – including both the physical safety of Nevirapine and the fiscal feasibility of the program – in mind, making it most qualified for the job. If the state was perceived to supercede members of society, then leaders of the state implicitly would be perceived to hold more authority in determining policy. Such logic points to a hierarchical and inflexible structure of the

ANC – a legacy of its operating structure during the apartheid regime – which perpetuates the state’s arguments against a widespread Nevirapine policy.

Ultimately, the hierarchical structure of the ANC places significant power in the head of the state, inhibiting the free flow of ideas. Krista Johnson, in “The Politics of AIDS Policy and Implementation in Postapartheid South Africa” offers a useful framework for thinking about the hierarchical culture of the South African state. According to Johnson, the state, now led by individuals who were trained to lead society while in exile, cultivated a style of governance as a social organization that gave “primacy to the role of the vanguard party and revolutionary intellectuals, continues to use democratic centralism, tight internal discipline, and strong central coordination” (Johnson 121). In other words, the ANC’s social condition of being banned by the apartheid regime, led it to produce a strategy of survival<sup>5</sup> that was secretive, centralized and top-down. In order to operate at all, the ANC had to work in a secretive, centralized manner. Yet, after the regime change, instead of shifting its bureaucratic governing strategy to address its new condition as *the state*, the ANC continued to operate as it did during the apartheid regime (Johnson 121). Johnson argued that the state’s response to general HIV/AIDS policy came out of a “centralized and closed leadership style has rendered the bureaucracy largely unable and unwilling to mobilize and coordinate around a common vision a range of actors inside and outside the government, and across social and sectoral divides” (Johnson 123). The use of such a bureaucratic style has, according to some scholars, created a political environment where “political leadership [is] so concerned about status that it is prepared to act out of pique when

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<sup>5</sup> Joel Migdal, in Strong Societies and Weak States: State-Society Relations and State Capabilities in the Third World, defines strategies of survival as “blueprints for action and belief in a world that hovers on the brink of a Hobbesian state of nature. Such strategies provide not only a basis for personal survival but also a link for the individual from the realm of personal identity and self-serving action” (Migdal 27).

criticized” (Nattrass 47). In other words, the state’s dictatorial manner of addressing the HIV/AIDS crisis indicates that it was using strategies of survival cultivated by the ANC during the apartheid regime. With little room for debate, ideologies pushed by high-positioned leaders like Mbeki became unquestioningly adopted into the state apparatus. It is this governing structure that explains the Minister of Health’s skepticism of Nevirapine’s safety despite recommendations from such organizations as the World Health Organization (TAC and Others v Minister of Health and Others 20). Although such a strategy might have worked when the ANC was in exile, as the state itself, such a centralized and top-down strategy did not fit. It only incited conflict with the TAC. Re-using a bureaucratic strategy from the apartheid era within the HIV/AIDS context immediately delegitimized the incorporation of civil society voices like that of the TAC within the new democracy. Thus, instead of the TAC’s demands for Nevirapine, Mbeki’s dissident views gained predominance within the state. The re-use of a centralized and top-down method of governance as a strategy to address the mother-to-child transmission program thwarted dissent to Mbeki and others’ embrace of dissident views.

Thus, it is clear that although the South African state appeared to be acting irrationally in its Nevirapine policy during the late 1990s and early 2000, this policy was at least partly a result of the ideological and state structural effects of apartheid in combination with the desire of the state to assert social control. History, is therefore, not a culmination of events that are frozen in the past, but rather, continues to have material effects in the present social environment. This is seen in the Nevirapine case, for example, when the state reacted to mother-to-child transmission of HIV in a manner similar to the way that the ANC resisted the apartheid regime. The material effects of history can also be seen by the state responding to the Nevirapine issue partly as a reaction, regardless of intent, to the violent history of the apartheid regime’s use of medicine for

racist projects. Yet, the legacies of history do not purely dictate South Africa's future. South African state leaders and society have agency beyond their history. For example, after the Constitutional Court ruled that the "National Plan be expanded to offer treatment to all pregnant women who were HIV positive to prevent mother-to-child transmission... the government issued a watershed statement on HIV/AIDS" (Willan 110). The Cabinet announced that it would work under the assumption that HIV causes AIDS and that it would make available "post-exposure prophylaxis" to victims of sexual assault (Willan 110). The act of Boehringer Ingelheim, a German pharmaceutical company, in April 2002 of offering the South African drug manufacturer, Aspen Pharmacare, a voluntary license to make a generic version of Nevirapine – further aided in making the drug accessible to HIV-positive pregnant women in South Africa, since the generics were five times cheaper (Agence France-Presse 10/15/02). According to the United Nations, the implementation of access to Nevirapine in South Africa has significantly improved the chances for having a healthy child from an HIV-positive mother (UNIRIN 6/14/05). According to The Observer, Nevirapine prevents about 4,000 babies from contracting HIV in South Africa per month (Carroll 11/23/03).

The state is quite capable of changing its policies. In doing so, it is clear that the South African state and society's actions are not purely dictated by its history. Yet, problems continue to remain. In July of 2003, amidst concerns that a Ugandan study that approved the drug's safety was flawed, the South African Medicines Control Council "threatened to deregister nevirapine unless Boehringer Ingelheim supplied fresh data" (Carroll 11/23/03). Despite the fact that the state is legally bound to make Nevirapine widely accessible to pregnant women who are HIV-positive, many expectant HIV-positive mothers are not receiving Nevirapine due to a combination of social stigmas associated with HIV/AIDS, lack of resources, and an absence of

an active push for effective implementation of Nevirapine – including counseling – from South African political leaders (Carroll 11/23/03). Thus, it is unclear what the future holds for South Africa's Nevirapine policy and the realization of effective implementation. Indeed, one cannot predict the future. However, knowing the ways in which the past affects the contemporary state's policy is invaluable to providing students of this important issue with a more nuanced and sophisticated understanding of a situation that affects countless people per day.

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