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South Africa's Grown-Up Response to the AIDS Crisis

An Interview with Health Minister Manto Tshabalala-Msimang

By Roger Bate

South Africa has one of the most extensive and robust HIV diagnosis and treatment program in Africa, second only to Brazil's in the developing world. Yet because South Africa's president once denied that AIDS is caused by HIV, and because his country has run its HIV program on its own terms rather than on those of the United Nations, the international media have castigated its efforts. Today, as South Africa slowly but steadily improves treatment for its people, it is attacked for yesterday's rhetoric and practices, not praised for today's success in treating HIV.

In the past six weeks, South Africa's response to AIDS has been called "obtuse," "dilatory," "immoral," and "indefensible."[1] The United Nations (UN) special envoy for HIV/AIDS in Africa, Stephen Lewis, described the South African health minister, Manto Tshabalala-Msimang, as part of the "lunatic fringe,"[2] and a well-known comedian dubbed her the "angel of death."[3] Historically, South Africa has dealt with AIDS woefully. President Thabo Mbeki's flirtation with bizarre opinions on the cause of AIDS and Tshabalala-Msimang's erratic rhetoric have not been helpful.

But such concerns ignore the reality of what is happening on the ground in South Africa today. The country has been increasing prevention campaigns, and its treatment program is Africa's most extensive and one of the best, approaching the quality of care and number of patients under treatment in Brazil's program, the developing world's gold standard. Despite these strides, activists, scientists, and even Lewis have called for the health minister's head, using the unflattering language described above.

Roger Bate (rbate@aei.org) is a resident fellow at AEI.

To find out whether Tshabalala-Msimang is as "idiotic" as she is made out to be, and whether AIDS treatment is proceeding despite her or because of her, I decided to interview her myself. Through phone calls and e-mails in early September, it became clear to me that she has largely been misunderstood. Her outbursts in response to UN provocation appear to be a thing of the past. Her new grown-up approach to AIDS seems to indicate that the South African government is serious about fighting the disease.

Roger Bate (RB): *In a letter calling for your dismissal as South Africa's minister of health, eighty-one scientists working on HIV/AIDS recently wrote that "to deny that HIV causes AIDS is farcical in the face of the scientific evidence." Do you agree?*

Dr. Manto Tshabalala-Msimang (MTM): Everything we do starts from the assumption that HIV causes AIDS. Louis Pasteur said that in fighting disease, the terrain is as important as the germ. Our comprehensive HIV and AIDS program is founded on the premise that we have to make South Africa as inhospitable to HIV as we possibly can. We are spending billions of dollars to prevent the spread of HIV, to care for

people infected with HIV, and to develop a vaccine against HIV.

RB: *When you speak of HIV and AIDS rather than simply saying HIV/AIDS, some people think you are signaling that you think the two may not be connected. Is that intentional?*
MTM: We have used the phrase "HIV and AIDS" because we think it helps clarify the specific challenges we confront. These are, first, to prevent the transmission of HIV; second, to slow progression to AIDS-defining illness once transmission of HIV has occurred; and third, to treat and support HIV-infected patients to the best of our ability when they present with AIDS-defining illness.

RB: *In a recent interview on ABC's* Nightline, *you seemed to suggest that HIV might not be the only cause of AIDS.*
MTM: The point I was making is that the transmission of HIV, the rate at which people infected with the virus start to suffer from AIDS-related illness, and how well patients cope with the illness when it strikes—all these things are affected by a number of variables, including nutrition, preexisting health status, and lifestyle. All such variables must be factored into our response to this challenge. I don't think anyone would disagree with that.

"The transmission of HIV, the rate at which people infected with the virus start to suffer from AIDS-related illness, and how well patients cope with the illness when it strikes . . . [are] affected by a number of variables, including nutrition, preexisting health status, and lifestyle."

RB: *It is said that you question the efficacy of antiretroviral drugs (ARVs) and that this is the reason your comprehensive plan's antiretroviral rollout targets have not been met. Is that true?*
MTM: Antiretrovirals are an essential part of the arsenal in the fight against HIV and AIDS. They are not a cure but can prolong patients' lives. We have gone to great lengths to ensure that we have access to reliable supplies of ARVs and other essential medicines at affordable prices. By the end of next year, we expect to have spent $500 million on procuring ARVs for patients in the state health sector. But it is critically important to recognize that antiretroviral treatment cannot be the sole pillar of our strategy, nor can the number of patients receiving such treatment be the only measure of our success or failure. If we let that happen, we risk shortchanging all the other interventions we have to make to secure the health of our people. As of June, some 178,635 patients had embarked on antiretroviral treatment (ART) in the public sector. Are we running behind the schedule we originally set ourselves? Yes. But we are not going to cut corners in terms of the systems that must be put in place and the medical protocols that must be followed if treatment is to be as effective and life-prolonging as we can make it and the program is to be fully sustainable. If we don't do these things, we are likely to accelerate the failure of first- and second-line treatment regimens, raising serious sustainability issues. The more care we take now, the more lives we will be able to extend over the long term. Until we find a vaccine or some other cure for HIV, treating AIDS is going to be a very long-term proposition.

RB: *I recently read an article about the Thembalethu Clinic for HIV/AIDS patients at Helen Joseph Hospital in Johannesburg, which your department has certified as a delivery point for state-funded ARV therapy and which is now said to one of the largest treatment sites in the world. In the article, a patient is quoted as saying, "Adherence [to a drug regimen] is the most important thing. And don't mix ARVs with traditional medicine and don't waste your money on immune boosters. These ARVs are very, very helpful, but you must also have good nutrition, avoid alcohol and don't have sex without a condom."[4] What is your opinion of this advice?*
MTM: Adherence is absolutely essential. A healthy diet and avoiding alcohol are very important too, as is practicing safe sex. The World Health Organization reports that 75 percent of people living with HIV and AIDS in San Francisco and London use some form of traditional, complementary, or alternative medicine. In Africa, this rises to about 80 percent.

RB: *Protesters calling for your resignation outside the South African embassy in Washington, D.C., carried placards saying that lemons and garlic are not the same as antiretroviral drugs, suggesting that you consider them equally valid treatment alternatives. Do you?*
MTM: We have never said that lemons or beetroot or garlic are therapeutically equivalent to ART. What we do say is that is that they contain micronutrients that

make them valuable in strengthening the body to respond to certain health conditions associated with HIV and AIDS. A good diet, the right micronutrients, and a healthy lifestyle can help a patient infected with HIV stave off the onset of AIDS-related illness. When a patient exhibits stage 4 AIDS-defining illness as defined by the World Health Organization or presents with a CD4 cell count of two hundred cubic millimeters or less, he or she is eligible for ART at the public expense. The decision to initiate treatment is ultimately the patient's, and we do provide counseling on what treatment is going to entail. But we never tell patients that diet can be a substitute for ART. It is important for a patient on ART to have a healthy diet.

RB: *What role do you see for traditional medicine?*

MTM: Many of our people put their trust in traditional healers and traditional medicine. There are some who seem to think we should try to eradicate what they regard as quackery and superstition. We say we must enlist and empower whomever in our communities commands trust and respect to be partners in the implementation of our comprehensive plan. That is what we are working to do. Traditional healers can contribute in many important ways, from encouraging safe and healthy lifestyles, to combating stigma and persuading people to get tested, to seeing that patients adhere to treatment. As for traditional medicine, we think it is important to investigate the therapeutic value and the safety of remedies upon which many of our people have been relying for generations. So, for example, our Medical Research Council has been looking at the plant *Sutherlandia microphylla*, traditionally used as a tonic, to see whether it may be safe and effective in increasing energy, appetite, and body mass for people living with HIV. Research of this kind is going on all over the world. I recently saw an article by researchers in London and India who have found that plants used in ayurvedic medicine to enhance memory may be as effective as conventional treatments for Alzheimer's disease.

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RB: *It would seem that your views have been subject to caricature. To what do you attribute this?*

MTM: It is perfectly understandable that people living with HIV and their families, friends, and loved ones should want their government to do everything in its power to help them live long, healthy, and productive lives. That is what we as a government are working to achieve. But in the real world where resources are limited, knowledge is imperfect, and the problems that cry out for attention are legion, we have to make judgments and set priorities. We have to think about the medium- and long-term consequences of everything we do so that what we do is sustainable. Obviously, when we make choices, there are going to be differences of opinion, and people who disagree with us will campaign vigorously for their point of view. To govern is to make difficult choices. The people of South Africa have elected the present government to make choices in the best interests of our country. We serve at their pleasure and they can replace us if they conclude the choices we make are wrong.

RB: *Are you concerned about choices being dictated to South Africa from outside?*

MTM: If we are to deal successfully with HIV and AIDS, it must be a collective and collaborative effort, and we must all be pulling in the same direction. Before the UN General Assembly Special Session on AIDS in June, we in Africa consulted widely within and between our countries to strengthen our own consensus on the way forward. We agreed that there had to be a renewed focus on prevention. We also agreed that international bodies of which we are members should seek our input before setting goals and timetables like the World Health Organization's 3 by 5 Initiative, which aimed to provide antiretroviral treatment to 3 million people by 2005. And we agreed that our common purpose would be more effectively served if the international donor community aligned itself more closely with the plans and priorities [that] we, as Africans, are establishing for ourselves at national and regional level[s]. Dealing with the challenge of HIV and AIDS is a hugely complex undertaking, and to be successful, interventions should be designed on the basis of realities on the ground. To fight HIV effectively, you need to be intimately familiar with the terrain.

RB: *Thank you, Dr. Tshabalala-Msimang.*

Conclusions

In a previous *Health Policy Outlook*[5] I discussed the problems that target-setting by the UN has caused. African countries are still being blamed for failing to meet targets set unilaterally by the UN often without consultation with those same African governments. And while the response of many countries to the HIV pandemic has indeed been poor, this often occurred because of preexisting problems. Since HIV is a chronic disease with no cure, treatment for HIV and infections that thrive in its presence must be sustained over the long term. Once treatment has begun, it must be continued indefinitely, something which poor countries cannot necessarily afford, especially since they often have other pressing public health crises. If unrealistic targets are set for the number of people to receive HIV treatment, resources will not be available to sustain care over the long term. Furthermore, such allocations—if sustained—would almost certainly undermine other more effective health care programs.

Given this, it is something of a mystery why such hostility to Tshabalala-Msimang remains, since her agency seems to have turned its AIDS treatment ship around and appears to be heading in the right direction. I can only think of one plausible reason.

As Jeremiah Norris of the Hudson Institute says, South Africa offers a tortoise-like model for AIDS treatment, in contrast to the more hare-like demands of the UN.[6] The UN's reports make no mention of clinical details for the over 1 million people under ARV treatment in poorer nations. We have no knowledge about their viral loads, CD4 cell counts, treatment regimens, or even if patient records have been kept. "The WHO clearly values numbers over patients," says Norris. For South Africa to provide this type of data indirectly points out the failure of the UN approach and may ultimately undermine it.

Furthermore, the UN is immune to any consequences that follow from its recommendations. The UN is "covered by the International Organizations Act and no lawsuit can be brought against it in any jurisdiction by patients who have had adverse reactions due to irresponsible 'scale-up' of treatment. The leaders of poor countries, however, cannot similarly indemnify themselves," says Norris.[7]

The UN model is no model at all, but a numbers game to raise funds without responsibility for failure. The UN raised a great deal of money to help countries meet the unreachable 3 by 5 Initiative target, and blamed African nations for its failure. Today the UN is trying to raise even more money and is apparently laying the groundwork for future failure—and once again African nations will be blamed. The UN's current target for universal access to HIV drugs by 2010 is as unreachable as its past target. Expect the participating countries to be blamed when it is missed sometime toward the end of 2009, or even earlier, as the attacks on Tshabalala-Msimang perhaps demonstrate.[8]

AEI research assistant Kathryn Boateng and editorial assistant Evan Sparks worked with Mr. Bate to edit and produce this Health Policy Outlook.

Notes

1. "South Africa AIDS Policy Attacked," BBC.co.uk, August 19, 2006, available at http://news.bbc.co.uk/2/hi/africa/5265432.stm (accessed September 26, 2006).
2. Ibid.
3. Robyn Davis, "Her Ideas on AIDS Are Called Bad Medicine," *Los Angeles Times*, September 19, 2006, available at www.latimes.com/news/printedition/asection/la-fg-health19sep19,1,1453627.story?coll=la-news-a_section (accessed September 26, 2006).
4. Kerry Cullinan, "Johannesburg Clinic Biggest ARV Site in Africa," Health-E, September 4, 2006, available at www.hivan.org.za/arttemp.asp?id=4635 (accessed September 28, 2006).
5. Roger Bate, "WHO's AIDS Target: An Inevitable Failure," *Health Policy Outlook* (January 2006), available at www.aei.org/publication23712.
6. Jeremiah Norris, personal communication with author, August 28, 2006.
7. Jeremiah Norris, "Critics Ignore Progress on AIDS," *Business Day* (South Africa), September 11, 2006, available at www.businessday.co.za/articles/opinion.aspx?ID=BD4A269210 (accessed September 26, 2006).
8. In a forthcoming paper the author will discuss the continued UN-target setting, as well as what constitutes sustainable treatment.