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South Africa: Setting the wrong example

December 1st was "World AIDS Day" and despite the welcome attention this brought to the cause of AIDS patients everywhere, it is disappointing to see how little interest the Western media has shown in the real issue of the day—South Africa's recent decision not to treat HIV-positive pregnant women with the anti-viral drug AZT. This is a regrettable decision and South Africa should quickly reconsider.

UNAIDS has estimated that in 1997, more than half a million infants acquired HIV from their mothers. Geraldine Fraser-Moleketi, South African Welfare Minister, admits that South Africa has been slow to deal with the AIDS problem. In South Africa, infant deaths due to AIDS are expected to rise 20% by 2001, and Fraser-Moleketi recently urged her government colleagues to set aside additional funds to implement new anti AIDS programs. Commenting on the problem of mother to infant transmission, Peter Piot, Executive Director of UNAIDS, stated "The question is no longer when or if we should act, but simply how".

In early 1998, a joint Thailand and US Centers for Disease Control study found that a simple four-week course of the anti-HIV drug AZT, given to the mother prior to delivery and at three-hourly intervals during labor can cut mother to infant infection rates by half. Although AZT is one of the cheaper anti-HIV drugs, it is still beyond the purse of many developing countries. Aware of this, Glaxo Wellcome, the maker of AZT, approached Nkosazana Zuma, South Africa's Minister of Health, to discuss preferential pricing as early as 1996. On learning of the Thailand AZT trial, they entered into more serious discussions, resulting in Glaxo's offer to make AZT available at 30% of the normal price. This would mean that the cost to treat one expectant mother would drop from nearly \$200 to less than \$60. Glaxo

also offered to hold that price for five years. Indeed, interest in this program was such that in separate discussions with provincial departments of health for two South African provinces (Gauteng and Western Capetown) treatment under the program was begun in the hope that this provincial experience would form the basis of a national policy.

This arrangement had a lot to recommend it and put South Africa on the brink of an important and innovative policy that would cut infant infection rates dramatically. As is so often the case with HIV infection, there are complications: AZT treatment only cuts infection rates by half and infection via breast feeding is still a major problem. Nonetheless, the ethical and economic arguments in favor of the short course of AZT treatment are overwhelming. Indeed Botswana, who with an adult HIV prevalence rate of 25% face an even worse HIV problem, have accepted Glaxo's five year deal. As *Nature Medicine* went to press, Botswana were planning to implement the program on January 1st.

It was therefore alarming to hear in October 1998 Zuma announce that South Africa would not be implementing the program. The announcement has been met with anger and surprise, both in the South African press and by researchers the world over. Perhaps Nicoli Nattrass, an Associate Professor at the School of Economics in Capetown, summed it up best when he declared in the Johannesburg Mail & Guardian "It is economically illiterate and shockingly ill-informed to argue that we cannot afford to give pregnant women AZT".

In explaining her decision, Zuma has raised efficacy, economic and cultural issues, none of which hold water. Either Zuma simply does not understand the arguments in favor of this treatment—in which case she is not up to the job of

Health Minister and should resign—or else there is another agenda. Senior scientists in the US have speculated that Zuma's decision is politically motivated. Zuma is said to be the main backer of an effort by the South African government to abolish intellectual property rights on pharmaceuticals, with a view to pursuing the local production of patented drugs.

In the year 2000, South Africa will host the 13th World AIDS conference. The meeting organizers and financial backers must be aware that world wide concern for Zuma's AZT decision is so great that talk of a boycott is emerging.

South Africa is in a unique position of influence in sub-Saharan Africa. It has a comparatively good health, education and research infrastructure and an economy that can support coordinated and effective health policies. It also has ambitions as a leader of countries in that region. As such, neighboring countries often follow South Africa's lead and may do so in the case of AIDS. Its president, Nelson Mandela, has been criticized for failing to speak out about AIDS. He now has an opportunity to show South Africa and the rest of the world how serious he is about tackling this problem.

As Glenda Gray, Co-director of the perinatal HIV Research Unit of the Chris Hani Baragwanath Hospital in Soweto, remarked, "South African politicians must know that the whole world is watching them". Any decisions today will have a ripple affect across the continent and possibly beyond. A simple decision by South Africa to reintroduce routine AZT treatment for all infected pregnant women would not only represent sound economic and health policies but would also open the door to a more ethical and humane approach to those suffering the extreme discrimination, ill health and early death that come with HIV infection in Africa.