SOUTH AFRICAN

MEDICINES REGULATORY AUTHORITY (MCC) &

DEPARTMENT OF NATIONAL HEALTH

TRADITIONAL AFRICAN MEDICINE

GENOCIDE AND ETHNOPIRACY

AGAINST THE AFRICAN PEOPLE.

By

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INTRODUCTION - Whilst we have no desire to bring African traditional healers and medicinal vendors under any undue regulatory pressure, preferring education to suppression, the blatant traditional African medicine (TAM) regulatory double-standard exercised by the State, amounting to protracted *genocidal negligence* by the Medicines Regulatory Authority (MCC); *ethnopiracy* by the Department of Health, other State machinery and Universities; and also a *cover-up* by the South African Parliament, are unacceptable to us.

It is ludicrous that these authorities, entrusted with public health and safety, intend that new regulations for so-called "complementary medicines", at tremendous burden to role-players and taxpayers alike, should only serve to "regulate" (suppress) so-called "marketed/labelled" health and therapeutic substances, and "not" the **traditional African medicines supplied by sangomas, nyangas and other informal vendors, the actual sources of *shockingly high rates of morbidity (millions) and mortality conservatively estimated to be in excess of several thousand annually (between 10,000-20,000 deaths)*.**

These mortality extrapolations eclipse the excessive allopathic iatrogenicity and AIDS pandemic. Various experts and authorities are ignorantly or purposely wastefully aiming at virtually innocent targets when discriminating against the internationally established relatively innocuous nutritionals and herbals, now strategically falsely reclassified as "complementary medicines", so as to enable their market expropriation by the established pharmaceutical sector, via imposition of so-called good manufacturing procedure (GMP) criteria and so ensure control of the public's access to the natural means to health by the New World Order manipulators of a once relatively free humanity.

CONTENTS

This report is structured in 5 parts:

TRADITIONAL AFRICAN MEDICINES TOXICITY REGULATORY DOUBLE-STANDARD

We are impressed by how perceptive the public are regarding natural health suppression, as they often remark ***"but what about traditional African healer's herbs and muti-medicines?"*** In the past, these were "apparently" exempt from Act 101/65 regulation and now under the new Act it is intended that future regulations not extend to these "unlabeled" medicines. **We challenge morally and constitutionally this double-standard. Section 9 of the Constitution (Equality), subsection (3), states: *"The State may not unfairly discriminate against anyone on one or more grounds…, including ethnic origin or culture".*** Significantly **subsection (5)** moreover, specifically states that: ***"Discrimination on one or more grounds in subsection (3) is unfair, unless it is established that the discrimination is fair."*** The onus is thus uniquely on the party wishing to discriminate, and hence **to enforce compliance, the authority would have to, at their specific initiative, convince the Constitutional Court that the discrimination in these circumstances is fair,** which is **clearly impossible, given the facts** to be presented hereunder.

Consider the political hot potato issues that the authorities fail to adequately address, if at all: Medicines regulation, in the public interest, comprises of 3 integral aspects: quality, safety and efficacy. The first aspect is only meaningful to the extent that it relates to the other aspects. There is no point in ensuring quality if this does not positively enhance and/or ensure safety and/or efficacy.

In terms of **"quality",** the hygienic and contamination situation relating to **the pavement on which these wares are displayed in the urban setting are of legitimate concern, being as they are, often tainted with sputum, urine and faeces etc from human, animal and pedestrian traffic**, plus a fair measure of vehicular combustion petrochemical deposits. We must however, be careful not to pursue purity to absurdity, as with the **pharmaceutical (GMP) manufacturing standards** insisted on for **natural health substances**, which **we insist ought logically to be maximally set at those for food standards,** which latter are **consumed in far more significant quantities**, ironically also annually responsible for tens of thousands of equally preventable morbidities and thousands of mortalities, due to non-enforcement.

Regarding **"efficacy and safety"** aspects, it is imperative to evaluate **the relative risk from herbs and other traditional African medicinal substances**, since some 75% of the African population are estimated to use traditional substances, usually in combinations. According to the electronic **database established by Noristan Laboratories, now with TramedF , of the 350 plant extracts assayed, some 79 % showed definite pharmacological activity,** and **12 % definite toxic effects**. (Hughson L, Pharmaceutical & Cosmetic Review, Jul/Aug 1995) **How can these traditional medicines ideologically escape the claimed need for urgent appropriate quality, safety and efficacy regulatory action?**

Professors **Folb** and **Schlebusch**, past chairman and registrar of the **MCCy** respectively, opinioned internationally **a decade ago** that ***"the issues of traditional medicines need to be addressed"*** (Folb P et al, J Clin Pharmacol 1988: 28), **yet apparently a moratorium exists iro traditional medicines**, in spite of **Folb** again writing, under the heading "Traditional drugs and indigenised pharmaceuticals", that ***"some give rise to serious adverse reactions, and others contain chemicals that have long term effects such as carcinogenicity and hepatoxicity."*** (Folb P, SA Jour Sci, Vol. 85. 1989 Aug) **Why no urgent action?**

PHARMAPACT and its allies consider it **ludicrous** that these professors and now their successors, Dr Helen **Rees** (chair), Precious **Matsoso** (registrar) and especially Prof **Eagles** (vice-chair) **claim jurisdiction over exotic herbal and other natural health substances as medicines when it is clear that these are impacting positively on health and negatively on medical profits, but not to have jurisdiction when some of the indigenised medicines are impacting negatively on health and positively on medical profits**, whilst hypocritically using **public safety as a red herring** to suppress public access to those improving health. With current budget constraints, we cannot conceive of bureaucratic systems receiving the disproportionately high priority afforded it for relatively safe products, when an urgent traditional medicines **Toxics List / educational programme** is the only practical way to act in the consumer's interest and save several thousand lives each year, not to mention untold suffering.

Whilst there is little difference between an African medicinal and the exotics, all of which except for the former are currently the target of such vicious regulatory fervour by the regulatory authorities, the only difference we have identified, is that the latter have had their problematically toxic items excluded from international commerce for fear of litigation, whereas this process has not occurred with the indigenous substances, but for very few items. Some **serious reprioritisation** is called for and the authorities are obliged to honestly face this dilemma. **Toxicity is an adverse effect on health.** In the final analysis, regulatory authorities deal not with toxicity, but with risk. **Risk is the probability that the toxic properties of a substance will be produced in populations of individuals under their actual conditions of exposure. We can prove convincingly with scientific evidence that there is no real risk from the natural substances about to be regulated, but exceptional risk from that which will not be.**

Dr. Pieter H. Joubert, M.D., author of several locally and internationally published article to be abstracted in the next few pages, as **Professor with the Dept. of Pharmacology & Therapeutics at the Medical University of South Africa (Medunsa) has been responsible for most of the epidemiological work in the shamefully neglected field of local indigenised medical toxicology. In spite of Joubert (and several others) attempting for almost three decades to draw urgent practical attention to this serious problem, virtually nothing has been done to address this highly suspect apartheid oversight. Who needs a Third Force, when traditional African muti-medicine and a blind-eye by the authorities to these serious problems, known to them for decades, will suffice as a silent tool for racist and / or genocidal population control (against the prolific African traditionist)?**

Whilst researching an earlier report, we assumed that the morbidity and mortality incidence for South Africans using indigenous medicines would be minuscule, but we were stunned to uncover the shocking scientifically recorded and published clinical observation that *"in South Africa, the major cause of death (from acute poisoning) among black South Africans are traditional medicines!!!!!!!!"*
To reassure the reader that this was not a typographical error, the editor, a Clinical Professor of Medical Toxicology, added in brackets *"(about 50 % of deaths)"*. (Ellenhorn's Medical Toxicity: Diagnosis and Treatment of Human Poisoning, Williams & Wilkins, 2nd Edn. 1997)

Some scientists are unscientifically, or more likely, insincerely in denial. Professor **Drewes**, ex Head of Chemistry, Natal University, clearly states: *"What is certain, is that the nyangas are not going to poison their patients."* Professor **Laing**, of the same department agreed, claiming that: *"no one dies from nyanga's prescriptions. It doesn't hurt them."* (Muti: Myth, Magic or Medically Sound? Peta Lee, Longevity, May 1996). Is it pure coincidence that Prof Drewes has done extensive commercial drug investigative work on indigenous traditional medicinal plants, including the "African potato", Hypoxis rooperi, now on the commercial market in synthesied form, as have so many of his colleagues at universities throughout the country? The ignorant or controlled press are, as always, willing allies in perpetuating the lies. This theme will be revisited on pages 10 and 11.

Politicians in particular are also in denial, both insincerely and also professionally so. Government health spin-doctor supremo, **Dr Abe Nkomo**, Chairman of the Parliamentary Portfolio Health Committee, on 26 October 1998, evicted the author of this Report from Parliament, struck the document from the Parliamentary record and confiscated all copies from Parliamentary committee members, delegates, and the press present in the chamber, when the author was legally presenting an earlier version of this Report to Parliament. Nkomo revealingly went on record in the Health Independent magazine, just a month later, emphasising that ***"Traditional African Medicines have never killed anyone!"*** This is the very antithesis of at least 8-pages of documentary proof to the contrary forming an integral part of our suppressed submission. See the PHARMAPACT archive: <http://www.angelfire.com/biz/pharmapact/setup.html> & <http://www.angelfire.com/biz/pharmapact/nkomo.html> for authentification and comprehensive details.

THE ESTIMATED MORTALITY BURDEN FROM TRADITIONAL AFRICAN MEDICINES

The author of this report scientifically estimates that annually several thousand deaths from traditional African medicines occur, far in excess of those dying of AIDS. Dr Mike Stewart, Department of Chemical Pathology, SA Institute for Medical Research, concurred with this assessment, having recently determined *"70 traditonal African medicine deaths in 8 months at Coronation Hospital, Johannesburg, and this just the few that made it to the hospital alive, only to die there, not to mention those who were/are extremely close to death."* (Personal comm, 31 March 1999) ***"It is suspected that many cases are undiagnosed, especially so in South Africa, where patients may die without reaching hospital and do not often admit to ingestion of a traditional remedy."*** (**Steenkamp** V, et al, Hum Exp Toxicol 1999 Oct; 18(10)) Significantly, the symptoms and causes of death from traditional medicines mirror the major causes of death among the black population: **hypoglycaemia, diarrhoea, various infections, fetal & respiratory distress and renal, hepatic & cardiac failure.**

"Information on cause of death among adults in sub-Saharan Africa is essentially non-existent, mostly extrapolations and outright guesses. Non-communicable diseases account for a significant portion, yet the empirical bases for public health policies and interventions are essentially absent." (Kaufman J, et al, Bull World Health Organisation, 1997, 75(5)) ***"Data on mortality and morbidity in South Africa are inadequate. The absence of a comprehensive national health information system, poses problems for an analysis of mortality."*** (White Paper on Population Policy, RSA, March 1998)

"In the developing world, ***medically certified information is available for less than 30% of all deaths*** *that occur and* ***98% of deaths in children younger than 15 years and 83% and 59% of deaths at 15-59 and 70 years, respectively occur there. The probability of dying from a "non-communicable disease" is higher in sub-Saharan Africa than in other market economies****. The paradox of higher non-communicable death rates in the adults of the developing world must be attributable to other major determinants of mortality that are more common in these regions.* ***The estimates that are most uncertain are those for sub-Saharan Africa, particularly for the exact composition of non-communicable and injury mortality.*** *As more regions undergo epidemiological transition,* ***particularly premature death among adults will increasingly become a major public-health concern****. Surveillance and research to measure and monitor mortality must anticipate this trend."* (Murray C, Lopez A, Mortality by cause for 8 regions of the world: Global Burden of Disease Study, Lancet 1997; 349)

"Estimating specific causes of death in South Africa is difficult, the last detailed information being almost a decade old, since the law was changed at that time to exclude the necessity of recording the details of the actual cause of death. The data collection system makes no provision for gathering the type of data needed to determine how many deaths might be attributable to traditional medicines. The overall figures must all be considered to be vast underestimates. There are major problems with the data. Not all deaths in rural areas are registered and many are in the ill-defined category where it was not specified on the certificate." (Pers comm. Dr D Bradshaw, Centre for Epidemiological Research in Southern Africa, **MRC** , 6 April 1999) ***"There is an urgent requirement for development of diagnostic methods in order to reduce the number of cases in which the death certificate refers only to the final pathology and not the causative agent."*** (Stewart M et al, Ther Drug Monit, 1998, Oct, 20(5))

Prof Pieter Joubert, ex **Medunsaf** , has determined that ***"in developing countries, besides infectious conditions, acute poisonings with pesticides, paraffin (kerosene) and traditional medicines are the main causes of morbidity, whilst acute poisonings with traditional medicines is the main cause of mortality."*** (Joubert P, Mathibe L, Acute poisoning in developing countries, Adverse Drug React Acute Poisoning Rev 1989;8(3)) This assessment accurately pertains to local circumstances where ***"amongst black South Africans, the poisoning category is the second in order of importance in the five main causes of death (second only to contagious and parasitic diseases)****, whereas it is only the third and fourth category amongst the other groups."* (Van Rensburg H, Mans A, Profiles of Disease and Health Care in South Africa, R&H Academica, 1982) This is confirmed by the 1990 MRC CERSA 1991 data.

The crude death rate in South Africa is 8.9 per 1 000 (1995 United Nations estimates, & RSA Stats in Brief, Aug 1996; 9.4/1000 according to DoH)**, meaning that approximately 400,000 of 40 million South African's die each year.** In the RSA **20% of all deaths are of unknown causes,** (according to Stats South Africa: **13.71 ill-defined (15.2, DoH), 4.24 undetermined, and 1.61 other external).** (Bradshaw D, Estimated Cause of Death Profiles SA, Based on 1990 Data, CERSA, MRC, 1991) *(Most recent data)*

Deaths from traditional African medicines could constitute a large portion of this 80,000 estimate and it is not unrealistic to assume that traditional medicine poisoning deaths are responsible for at least 10% of the 80,000 annual deaths from unnatural causes, (excluding homicide, violence, accidents & self-inflicted), ie 8,000 traditional medicine mortalities would be conservative and could possibly be doubled to 15,000, and taking into account deaths attributed to other natural causes such as eg cardiac failure, 5000 additional of which may be traditional medicine induced, 20,000 is a conservative maximum estimate for the number of possible annual preventable deaths from traditional medicines.

The main paper referenced in the above-mentioned textbook is Professor Joubert's "Poisoning admissions of black South Africans" (Joubert P, J Toxicol Clin Toxicol 1990; 28(1)), dealing with acute poisoning admissions to Ga-Rankuwa Hospital, Pretoria, 1981-1985, which determined that ***"Overall, the major causes of mortality were traditional medicines, responsible for 51.7 % of the deaths. Of the patients who died, 62 % were poisoning by traditional medicines. None were deliberate self-poisoning".*** **Joubert concluded:** ***"the main issues were the extremely high mortality and the prevention of poisoning by traditional medicines merits high priority in the health care of the indigenous population of South Africa".*** **Labelled "marketed" medicines are not to blame here and so, no remedial action will be taken!**

"The 'traditional healer' was the main source, 83.4 %, while 11.3 % was bought from African medicine shops. In only 0.6% of cases were medicines collected by the patients themselves ***and in 4.4% the substances were obtained from other sources****. The traditional healer is an integral part of African culture and many South Africans make use of traditional African medicines, mostly of plant origin, but also minerals or animal.* ***In most instances these medicines are "crude watery extracts". Most towns and cities have "African medicine shops" where traditional medicines can be bought over the counter. There is currently no legislation controlling traditional African medicines. The traditional African medicine mortality is extremely high. If poisoning due to these substances can be eliminated, the overall mortality will decrease by about 50%".*** *Most frequently implicated* (Ga-Rankuwa) *were* ***Jatropha curcus, Ricinus communis*** *and* ***Datura strammonium****.* (Joubert, J Tox Clin Tox 1990; 28(1))

Professor P Joubert, head of the Dept of Pharmacology and Therapeutics at the Medical University of SA (Medunsa), an internationally recognised authority on South African indigenous medical toxicity, in his earliest published work on the subject, undertook a retrospective comparative epidemiological study of acute poisonings at **teaching hospitals of the University of the Orange Free State, Bloemfontein**, 1970-1976, which revealed that *"****among whites, medical drug poisonings predominated****"*, but ***"among the black developing community****, was responsible for few poisonings****, priorities being prevention of pesticide, paraffin, carbon monoxide*** (indoor fires) ***and traditional medicine poisonings."*** (Joubert P, "Toxicology units in developing countries: different priorities?" J Toxicol Clin Toxicol 1982 Jul; 19(5))

In a subsequent project covering 1981-1982 at **Ga-Rankuwa Hospital, Pretoria**, **Joubert** determined that ***"whilst 18 % of all acute poisonings were due to traditional medicines, most (86.58 %) of all deaths from acute poisoning were as a result of poisoning with traditional medicines",*** concluding: *"**toxicology services, primarily geared towards the management of cases of drug poisoning, are inappropriate to the needs of developing communities**."* (Joubert P, Sebata B, "The role of prospective epidemiology in the establishment of a toxicology service for a developing community." S Afr Med J 1982 Nov 27; 62(23))

In a continuing project covering 1981-1985, also at **Ga-Rankuwa Hospital**, **Joubert** once again determined that *"the main poisoning causes were paraffin (59 %), but with low mortality (2.1 %), whilst **poisoning with traditional medicine resulted in a high mortality of 15.2 % and accounted for 51.7% of all deaths, always accidental".*** Furthermore, ***"Vomiting, diarrhoea, and abdominal pains** were the most frequently encountered symptoms, while **lungs, liver and central nervous system were commonly affected. The traditional healer was the main source, 83.4 %, while 11.3 % was bought from African medicine shops. Questioning patients and traditional healers facilitated the identification of a number of etiological agents"***. (Venter C, Joubert P, "Aspects of poisoning with traditional medicines in southern Africa". Biomed Environ Sci 1988 Dec; 1(4))

Joubert's study described ***"traditional medicines"*** as ***"a particularly important and interesting aspect of the local poisoning pattern"*** and stated: ***"the major cause of fatal poisoning pattern at Ga-Rankuwa appears to be very similar to that reported from Bloemfontein"***, and also ***"is similar to mortality reported from Zimbabwe".*** (Joubert P, J Toxicol Clin Toxicol 1990; 28(1)) & also (Nyazema NZ, Trans R Soc Trop Med Hyg 1986; 80) & (Chitsike I, Cent Afr J Med 1994 Nov; 40(11)) Researchers at the University of Zimbabwe have reported that: ***"poisoning by traditional medicines are the biggest single group of all cases."*** (**Kasilo** O, Nhachi C, S Afr Med J 1992 Sep; 82(3) ***"The main agents associated with acute poisoning were traditional medicines."*** (Nhachi C, Kasilo O, J Appl Toxicol 1992 Dec; 12(6) ***"Zimbabwe has a big poisoning problem, especially with regard to treatments recommended by the traditional healer."*** Conclusion: ***"Education and information dissemination on toxic agents are vital and much remains to be done. The report confirms the importance of toxicology information to the Southern African (SADCC) region as a whole".*** (Kasilo O, Froese E, A 10-year review of the Teaching Hospital-Based National Drug and Toxicology Information Service. Clin Pharm Ther 1989 Oct; 14(5))

Joubert's successors and the medical press have played down this problem, eg. Dr. D.H **Brand** is mentioned in an article referring to follow-up work at **Medunsaf**, 1987-1993, but both the title of the article, "Accidental poisonings rare in herbals" and the theme, contrary to the facts, suggested a small percentage of overdose or poisoning from traditional medicine, whereas **Dr Brand's research had actually determined that *"while only a small number of plant species were involved, these resulted in high mortality".*** (Medical Chronicle, Nov / Dec 1993); **Brand** also reported that *"toxicity levels of* **Urginea sanguinea** *and some* **Drimia** species *are currently being investigated at* ***Medunsaf****, following the observation of* ***toxic symptoms*** *in patients who had taken herbal medicines". (Brand pers comm with Anne Hutchings)*; Dr E **Osuch**, Joubert's current successor, in a recent thesis, confirmed that ***"The same traditional medicines (24 different plants) tended to recur as causes of hospital admissions…responsible for more than half of all acute poisoning deaths".*** (Osuch, Thesis Summary)

Noteworthy is that this work continues at **Medunsaf** (Department of Pharmacology and Therapeutics), but now in **determining the toxicity of traditional medicines in the "scientific marketplace".** (S Afr J Sci 1997 Nov-Dec; 93(11/12)) The current department head, Prof W **du Plooy** plays down the Joubert and his successor's **Medunsaf** statistics by deliberately interpreting them in the most misleadingly favourable light, in an effort to trivialise and side-line the problem. Urgent telephonic and e-mail requests years ago for specific research documents lodged in Du Plooy's Dept at Medunsaf, to focus priority attention on this unacknowledged problem, have gone largely unheeded. (Personal comm 16 Feb 1998)

Significantly, **Du Plooy** is a member of the **NRC**♣ and a **MRC** ¯ funding recipient for "Traditional medicines as part of the national drug policy" and " Toxicology of traditional medicines", so neither he nor the authorities can claim ignorance or obscure research. In a recent presentation, he volunteers one additional botanical name: **Boophane disticha,** and hypocritically concludes: ***"The public should be protected against compounds that have harmful properties***. *How? It is impossible for medicines."* Even more hypocritically: ***"AT LEAST THE PUBLIC SHOULD BE WARNED! ie awareness."*** ("Analysing the Epidemiology of Traditional Medicine Poisoning", presentation delivered at "Complementary Health Care Summit, 25 August 1998) This event was advertised as "Determine how your organisation can **capitalise** from this unique opportunity **in the market**". Entrance fee: R2000+ per day for a 3-day event.

Further vindicating Prof. Joubert's concerns, in spite of attempted down-playing propaganda, are the summary conclusions of Joubert's current successor, **Dr. E Osuch**, who extended his work as a **thesis** covering the subsequent period 1987-1992. Dr **Osuch** concluded that: ***"Traditional medicine ingestion was responsible for more than half of all acute poisoning deaths."*** Also of interest is that *"**Eight remedies** have been identified which were **associated with haematuria and renal failure**. **One of the most common causes of acute poisoning** admission to the Ga-Rankua hospital **was ingestion of the watery extract of Urginea sanguinea."*** Even more recently **Osuch et al** stated: ***"A large percentage of acute poisonings in black South Africans is due to traditional medicines."*** (**Foukardis** G, Munting G, Osuch E, Toxicological aspects of some traditional medicines used by patients admitted to Ga-Rankuwa Hospital. J Ethnopharmacol 1994 Feb; 41(3)); ***"Used as a blood purifier, clinical symptoms affect the gastro-intestinal & urinary tract, central nervous system, or the splanchnic system."*** (**Foukaridis** G, Osuch E, Mathibe L, Tsipa P, J Ethnopharmacol 1995 Dec; 49(2))

Du Plooy confirms our position in summarising the work of **Joubert, Brand, Osuch and Foukaridis** as follows: *"A solid is less harmful. **Extractions are more harmful**. It could be life saving if the material is identified, which may take too long. **Clinically, longer than 6-24 hours after poisoning is too long**. **Typical clinical features include kidney failure (haemolytic anaemia), heart failure, arrhythmia** and a **variety of infections**. **In children** the most common problem is dehydration and **eventual kidney failure**. **The incidence of poisoning is high in patients who are old and go for blood purification; patients with fertility problems (male and female); for abortion; and for male STDs"*. ("Analysing the Epidemiology of Traditional Medicine Poisoning", Compl Health Care Summit. 25 Aug 1998)

We have identified what is **probably the major traditional African medicine "killer plant", namely Callilepsis laureola,** known as **"Impila", which ironically means "health"** in Zulu. (Hutchings A, Terblanche S. S Afr Med J 1998; 75)

IMPILA: Byrant A, Zulu Medicine and Medicine Men, Centaur, 1966 – *"without doubt **a virulent poison**"*; •Seedat Y, Hitchcock P, S Afr Med J Jul 31; 45(30) – ***"acute renal failure"***; •Wainwright J, et al, S Afr J Med 1977 Aug 13; 52(8) – *"found to cause **fatal liver necrosis**, widely used as a herbal medicine; **nephrotoxic, hypoglycaemic, hepatoxic"***; •Watson A, et al, S Afr Med J 1979 Feb 24; 55(8) – *"administration of Impila is common, the practice can and does cause **poisoning, hepatic and renal tubular necrosis, hypoglycaemia, alteration of consciousness, hepatic and renal dysfunction"***; •Veale D, S Afr Pharm J 1987;(54) – ***"**rootstock is **toxic and can be fatal if ingested in small quantities; confusion, vomiting, diarrhoea, convulsions, hypoglycaemia and liver and kidney failure"***; •Savage A, Hutchings A, "Poisoned by herbs". Br Med J 1987; 295 – *"clinical symptoms of Impila intoxication are **abdominal pain, jaundice, hypoglycaemia, disturbed hepatic and renal function"***; •Dehrmann F et al, J Ethnopharmacol 1991 Sep; 34(2-3) – *"used extensively as a medicament, **nephrotoxic"***; •Bye S, Dutton M, In: Oliver J, ed. Forensic Toxicology. Scottish Academic Press, 1992 – *"**hepatoxic, nephrotoxic, hypoglycaemic"***; •Steenkamp V, et al, Hum Exp Toxicol 1999 Oct; 18(10)) –*"Poisoning with impila is a recurring phenomenon in South Africa and since it **leads to rapid death from renal and/or hepatic failure, it is suspected that many cases are undiagnosed; patients may die without reaching hospital and do not often admit to ingestion of a traditional remedy.***

What would the relative risk/benefit ratios be for Impila? (which would have to be comparatively higher for the latter than for the former for such a toxic drug to be tolerated by any self-respecting regulatory authority) *"With approximately 50% of the population using* ***Impila*** *in* ***Natal****, it is* ***the second most widely used*** *and has been reported on extensively."* (Ellis M. Medicinal Plant Use-A Survey, Veld and Flora 1986 Sept) ***"In Umlazi, one of the largest "townships" in the Durban area, 30% of a random sample of residents had used the highly toxic medicinal plant impila."*** (Wainwright J, et al, The toxicity of **Callilepis laureola**. S Afr J Med 1977 Aug 13; 52(8)) Since there are no approved uses, we have to assess popular uses against the above-mentioned risks, and **clearly this plant would never be acceptable for and on the basis of these**: a) *"Roots are taken as tonics by young girls in the early stages of menstruation."* (Doke C, Vilakazi B, Zulu-English Dictionary, 2nd edn. Witwatersrand Univ Press 1972); b) *"Ground roots taken for snakebite and administered as enemas and in baths to protect the children of parents who have already lost many children."* (Valley Trust *[***HST W***]*, Personal comm Hutchings)

Even more dangerous is Impila's traditional use during pregnancy and childbirth, likely the biggest killer of all, eg: *"Roots are sometimes an ingredient in* ***"inembe"****, taken regularly during pregnancy to ensure an easy childbirth, and to make an infusion for fertility."* (Gerstner J, Bantu Stud 15 (3) (4), 1941); *"They are sometimes included in medicines known as* ***"isihlambezo"****, which are used by traditional birth attendants to ensure the health of both mother and baby during pregnancy."* (Gumede M, Traditional Healers, Skotaville Publishers 1990) Dr Mike **Stewart**, Dept Chemical Pathology, **SAIMR**, has focused on Impila, yet his annual budget for all his analytical work is a mere R50000 with not a cent from the **MRC** (Pers comm, 31 Mar 99)**.** Stewart et al have developed a method for the detection of impila constituents in urine and recently described the clinical symptoms and the application of the screening method to diagnosis in the case of a mother and child, who both showed symptoms of impila poisoning. The child survived, but the mother died. (**Steenkamp** V, et al, Hum Exp Toxicol 1999 Oct; 18(10))

"Many black South African women use traditional African herbal remedies as antenatal medications or to induce or augment labour. Very little is known about the pharmacology and potential toxicity of plants used in these herbal remedies. Several of these plants are poisonous." (**Veale**, et al, J Ethnopharmacol 1992 Jun; 36(3)) *"****Some of the herbs are toxic in large doses****. According to Joy Veale, a lecturer in pharmacology at the University of Witwatersrand,* ***there are about 36 plants in South Africa used to induce labour, of which 15 are toxic****."* (**Pantanowitz** D, Alternative Medicine: A Doctor's, Perspective. Southern Book Publishers, 1994) ***"African traditional herbal medication*** *is commonly* ***used in pregnancy*** *by women attending King Edward VIII Hospital, Durban. Its use* ***may lead to fetal distress effecting pregnancy outcome."*** (**Mabina** M, et al, *[***MRC**, Univ Natal, Dept Obstetrics and Gynaecology*]* S Afr Med J 1997; 87(8)) ***"Though some evidence exists suggesting negative effects of its ingestion, the maternal-fetal health impact and toxicity of isihlambezo have not been adequately studied. Pharmacological analysis suggested*** *both therapeutic and* ***harmful consequences*** *of isihlambezo."* (**Varga** C, Veale D, Soc Sci Med, 1997 Apr, 44(7))

Paediatric use is also seriously problematic. (**Bodenstein** J, S Afr Med J 1977 Nov 5; 5; 52(20)) More specifically eg at **Habisa Hospital, Kwazulu Natal**: ***"We have observed a distinct clinical syndrome amongst acutely unwell children frequently associated with the administration of a traditional medicine enema. Admission was frequently prompted by sudden, marked clinical deterioration following enema administration (68% within 24 h). Clinico-pathological features of this enema syndrome:- respiratory distress/insufficiency with tachypnoea, abdominal distension, hypotonia and loss of consciousness occurred frequently. In-hospital mortality was 28% and higher in those receiving herbal (43%) rather than chemical (21%) enemas. Hyperkalaemia, leucocytosis (> 15,000 mm3) and respiratory distress/insufficiency occurred more frequently in those who died."*** (**Moore** D, Moore N, Ann Trop Paediatr, 1998 Jun, 18(2)) **Pediatric enemata are a problem in other provinces, eg: "*****herbal intoxication regularly occurs, with high mortality in infants, especially under 1 year of age*****."** (Personal comm, Dr Debbie **Baker**, ICU, **Livingstone Hospital, Port Elizabeth**, 26 Mar 1999)

Besides the above-mentioned subsets, the following represent further confirmation of this enormous problem. *"Toxic plants are used for medicinal purposes by the Zulu population."* (**Foukardis** G, Joubert P, Forte M, Clin Toxicol 1992; 30) *"In the treatment of measles, a variety of **indigenous medications are** used, some of which are **potentially dangerous**."* (Ijsselmuiden C, S Afr Med J 1983 Mar 5; 63(10)) *"Although widely recognised by physicians, the **acute renal failure** **resulting from the use of herbal preparations obtained from witch-doctors** has not been fully described."* (Gold C. Clin Nephrol 1980 Sep; 14(3)) ***"In cancer of the oesophagus, traditional medicines are a significant risk factor."*** (Sammon A, Cancer 1992 Feb 15; 69(4)) ***"The potent effects of their herbal medicines can result in damage to any part of the gastro-intestinal tract, and may be fatal. Diseases caused by witch-doctors constitute an important facet of the disease spectrum of blacks."*** (Segal I, Tim L, S Afr Med J 1979 Aug 25; 56(8)) ***"The inappropriate use of traditional medicines results in numerous fatalities, invariably in children."*** (Bye S, Dutton M, J Ethnopharmacol 1991 Sep; 34(2-3))

Traditional African medicines also have **psychiatric usage**. Dr Thomas **Lambo**, a champion of traditional African medicine, a Nigerian psychiatrist, dean of the Medical School, vice chancellor of the University of Idadan, and **Deputy Director-General of the WHO** for many years, in response to a question as to whether the **traditional African** healers sometimes harm their patients, answered ***"They have an extensive pharmacopoeia of herbal psychotropic drugs. A lot of damage has been done, there is no doubt".*** (Bass T, Reinventing the Future: "Conversations with the World's Leading Scientists". Addison-Wesley Publishers, 1994) **Prof D Oberholzer**, Department of Psychiatry, **Pretoria University**, had **traditional healer's psychiatric herbs** analysed at the university laboratories and determined that ***"many potentially harmful agents were discovered in the therapeutic plant material".*** (Oberholzer D, J S Afr Institute of Psycotherapy, 1985, Mar, Issue 36)

*"**Traditional medicines** can be beneficial, dangerous or useless in a pharmacological or psychological capacity, their **dangers being mainly as direct irritants or as hepatic or renal toxins. Mild to moderate toxicity from short or long term use is difficult to separate from the original illness. Greater absorption from enemas coupled with irritant proctitis and perforation indicate that enemata have a high mortality".*** (Ellis G, Medicinal Plant Use, Veld & Flora, Sept 1986) ***"Traditional medicines (or mutis) are usually administered orally or as an enema by a traditional healer . Gastro-intestinal irritation was the most common syndrome (54%) experienced after traditional medicine administration. Cardiac glycosides are often found (44%) in autopsies [Johannesburg Forensic Chem Lab] where death was presumed to be caused by herbal medicine. It is concluded that in patients with gastro-intestinal symptoms, traditional medicine cardiac glycosides should be suspected."*** (Mc Vann A, Havlik I, **Joubert** P, Monteagudo F, S Afr Med J 1992 Feb 1; 81(3))

"Herbal medicine may be directly responsible for harmful or fatal results, and frequently cause especially gastro-intestinal disorders, which may certainly be ascribed to the witch-doctor and his medication." (Van Rensburg H, Mans A, Profiles of Disease and Health Care in South Africa, Academica 1982) **Dr Desmond Pantanowitz**, Professor of Surgery, **University of Witwatersrand** writes: ***"Many dangerous substances have been isolated from nyanga concoctions, including the orange crystals** of **potassium dichromate, which can cause liver failure. Cantharides** (Spanish fly) is often used to treat impotence; **the side-effects of this poison are irritation of the gut and urethral mucosa, as well as kidney failure.** Some nyangas even add **battery acid** to their concoctions to give them some 'body'. The concoctions are administered via various routes: oral, anal, and through the skin. **Damage may occur along the entire gut, from the oesophagus all the way through to the anus**. Ritual enemas are a favourite method used. **Infants** receive up to 100 enemas before age two. Enemas may be prescribed for ritual purposes and for the treatment of complaints as diverse as impotence, dysmenorrhoea, fever, diarrhoea, constipation, abdominal pain and headache. **The traditional healer can be a danger to society**". (Pantanowitz D, Alternative Medicine: A Doctor's Perspective. Southern Book Publ 1994)

"In the rural setting, ***a truncated cow horn is often used to dispense the enema; this may mechanically damage the rectum, causing anorectal laceration or rectal perforation. Complications are seen regularly at academic hospitals****, particularly Baragwanath.* ***Conditions that are repeatedly diagnosed are gut necrosis with perforation, peritonitis, gram negative endotoxic shock, disseminated intravascular coagulation, adult respiratory distress syndrome and hepatorenal failure, which can all result in the death of the patient****. While the rural individual is given mainly herbal enemas, such as the poisonous milkweed species* **Aesclepsias physocarpa***, the sophisticated urban dweller is given additional exotics such as* ***Dettol, vinegar, copper sulphate, potassium permanganate, hydrochloric acid, sodium hydroxide****, and the favourite,* ***battery acid****. To my knowledge* ***patient's families have never charged murder against a traditional healer in this country. No evidence can be obtained in a court of law. There is a code of secrecy and silence governed by a fear of retribution****."* (Pantanowitz D, Alternative Medicine: A Doctor's, Perspective. Southern Book Publishers, 1994)

Besides poisonous plants, **other toxic agents controversially used by traditional healers** are: **battery acid, chloroxylenol, potassium permanganate / dichromate, and copper sulfate.** (Ellenhorn's Medical Toxicity: Diagnosis and Treatment of Human Poisoning, Williams & Wilkins, 2nd Edn.1997) *"****Renal failure*** ***may occur with potassium dichromate****"*. (Wood et al, S Afr Med J, 1990 Jun 16; 77(12), (Michie et al, Hum Exp Toxicol, 1991; 10) Potassium dichromate is used primarily for its colouring rather than disinfection action. (Bye S, Dutton M. Proc Int Assoc Forensic Toxicol, Scottish Academic Press, 1992) Du Plooy has recorded the use of **neon colourants**. (Du Plooy W, Analysing the Epidemiology of Traditional Medicine Poisoning, Compl Health Care Summit. 25 Aug 1998)

Dr Steven Toovey, Director of Medinfo, says: *"We know, from experience, that* ***some traditional medicines are toxic****"*. The reporter continues: *"Dr Toovey ran independent tests in two laboratories on a traditional mud remedy to strengthen the blood, eaten mainly by pregnant women with anaemia. Both laboratories found* ***arsenic*** *and* ***mercury*** *in the samples. Among the test tubes filled with indigenous roots and herbs at Groote Schuur Hospital's department of pharmacology* (Folb-Ed)*, researchers have encountered problems that move beyond the diseases and ailments they set out to cure.* ***Toxic chemicals in muti remedies have raised alarm in the scientific community****."* The photo caption: *"TRADITIONAL WEAPON"* (Emily Osinoff, " Indigenous plants could provide real muti", Sunday Argus, May 30 1999)

"Toxicity related to traditional African medicines is becoming more widely recognised. Accidental herbal toxicity occurs not only as a result of a lack of pharmaceutic quality in harvesting and preparation, but also because these remedies are believed to be harmless. Treatment in most cases of plant poisoning remains symptomatic, with few antidotes available." (Stewart M et al, "The toxicology of African herbal medicines." Ther Drug Monit, 1998, Oct, 20(5)) "An analysis of the Johannesburg forensic database revealed that in cases of poisoning with an unknown substance, *(pharmaceutical and agri-chemicals were found in 20% and 33% of cases respectively and)* ***herbal materials were found in 43% of cases where a traditional remedy was either stated to be the cause of death or was found to be present."*** Their conclusion: *"Since there are as yet no standard methods for the detection of many herbal remedies or their metabolites,* ***careful analysis is*** **(should be)** ***mandatory for the correct identification of the true cause in cases of poisoning****."* (Stewart, M et al, *Forensic Sci Int* 1999 May 17; 101(3))

The Department of Health initiated a project on the safe use of hazardous pesticides with the aim of increasing community awareness. (Health - Government Yearbook Government Communications GCIS 1998) Why no corresponding programme for more widely used traditional medicines? **Additional problems not being adequately addressed for awkward political conside rations** are eg, *"traditional healer's may cause* ***dangerous delays****."* (Smyth A, et al, South Africa's Health, Letter, BMJ 1995; 47(3)); ***"a potential route*** **(incisions)** ***for viral disease transmission****." (Hepatitis, HIV?)* (Jolles S & F, Letter, African Traditional Medicine, Lancet, 1998 Jul 4, 352(9121)) ***"Ritual or muti murders by a traditional healer are a form of human sacrifice. The murder is carried out after body parts are removed while the victim is still alive."*** (Scholtz H, et al, Forensic Sci Int, 1997 Jun 6, 87(2)) **Education now! Please!**

AFRICAN MEDICINE "ETHNOPIRACY" BY THE STATE, UNIVERSITIES & PHARMA-INDUSTRY

We have mentioned the openly identified poisonous species implicated in the Ga-Rankuwa sub-sets, but these are only 5 out of 24, and **neither du Plooy, as custodian of** Joubert, Brand, and Osuch's **Medunsaf toxicological data, nor Folb, as custodian of the UCT TramedF data, have complied with our repeated requests for comprehensive information access to compile and release an urgent educational African botanical toxics list.** Access to the Tramed database was again denied us on 24 May 1999 by professor **Folb**, claiming that this aspect still had to be developed, yet he declined our offer to undertake this work. (Personal comm, T/Dr A Rees) In the meantime, the following remain the only detailed but very limited sources of such information, none of which are readily accessible or meaningful to the traditional healer / medicine fraternity, the former national source being out of print, with copies selling in excess of R1000 and the latter regional source, dealing only with Zulu medicine: a) **Watt J and Breyer-Brandwijk M, The Medicinal and Poisonous Plants of Southern and Eastern Africa**, E & S Livingstone Ltd, 1962; b) **Hutchings A**, Zulu Medicinal Plants, Univ of Natal Press, 1996.

It is interesting to note that Watt, like Folb, was a Professor of Pharmacology (Univ of Witwatersrand), but unlike the latter, cared enough about the African people to use the institution at his disposal to laboriously collate the existing toxicological information and make it widely available, including to all hospitals for the treatment of herbal poisonings. On the other hand, **Folb, leader of the Traditional Medicines Programme F who was handed public custodianship of an electronic database 20 years under development, cannot 8 years later provide a toxics list, nor is he willing to grant access to those volunteering to undertake this priority work. Folb, as Chair of the MCC for 18 years, had a mandate to ensure the protection of the public from toxic medicines, yet instead of using the database to identify and alert healers to the risks, only lucrative new drug leads were sought.**

None of the above-mentioned identified toxics are at all covered in the South African Traditional Healer's Primary Health Care Handbook, based on the TramedΦ database and produced by the **Medical Research Council (MRC)**¯ and the Traditional Medicines Research Group (TMRG)♠ of the Universities of Cape Town and of the Western Cape. Prof Eagles, Head of the Pharmacy School, UWC, as one of three tiers of the TMRG and who was and is again the vice-Chairperson of the MCCΨ/MRA, is also, with du Plooy, an influential member of the Traditional Medicines Working Group, National Reference Centre (NRC)♣.

We have to protest, that the forgoing facts having been determined, and the regulatory authorities repeatedly exposed thereto, as well as to that which follows, they who were/are mandated to protect the public from toxic medicines were/are presented with a golden opportunity to educate prescribers, suppliers and consumers regarding which plants were/are most seriously implicated, as well as dose, contra-indications, precautionaries, early and advanced poisoning symptoms etc, a golden opportunity squandered by all concerned, especially the MCCψ, via access to the Traditional Medicines Programme (TRAMED)Φ/TMRG♠ with Folb / Schlebusch / Bruchner, and now Eagles / Rees / Matsoso at the helm.

Shockingly little or nothing has been done about this unacceptable situation, least of all by those who over the period that this information has been directly available to them and who have been directing MCCψ policy under the shallow guise, repeated ad nauseam, of being the custodians of public safety from toxic medicines and insisting that they have been empowered to control all medicines. The previous, transitional and new authority bear legal responsibility. We are presently engaged in ongoing culpability investigations for "**gross dereliction of public duty" and genocide** against Professors **Schlebusch** and especially **Folb** and in the latter's case, a further enquiry into ethnopiracy, since Folb has directorship at the University of Cape Town of the Dept. of Pharmacology, the **World Health Organisation Collaborating Centre for Drug Policy (WHOCCDP)**; and the Tramed ProgrammeΦ and so was better positioned than anyone to be aware of these shocking circumstances and especially as chairman of the MCCψ, to have been doing something meaningful about them. **Eagles** faces similar investigation, now approximating the position previously held by Folb, especially regarding his role in the NRC (TAM).

Instead of using the 60,000 entry TRAMED F database available to the WHOCCDP to *"monitor all adverse reactions to medicines in South Africa, investigate national problems of drug toxicity, recommend policy in this regard and encourage the rational and safe use of medicines, including traditional medicines, to address an important and comparatively neglected scientific research and public health field, and to establish the rational and safe use of traditional medicines",* the facilities are *"presently engaged in large amounts of research based upon the extraction and isolation of active compounds from plants used by traditional healers in the treatment of disease."* (Homepage: University of Cape Town, Dept of Pharmacology) Some students from indigenous backgrounds are reportedly now pushing for proper codes of conduct. (Sunday Times, 2/2/99)

Ethnopiracy projects at TramedF include: "*Natalie **Brine** – anti-malarial compounds from plants; Sandra **de Klerk** anti-malarial activity present in plant mixtures used by traditional healers; Motalepula Gilbert **Matsabisa** – ethno-pharmacology in drug development; investigation of the anti-malarial activity of indigenous Southern African plants; Siyabulela Calvin **Ntutela** – efficacy of plants used in traditional treatment of tuberculosis; Portia **Rachaka** - potentiation of immune response by traditional herbal remedies* (Homepage: University of Cape Town, Dept of Pharmacology); also "*Malaria is the focus of research UCT's Pharmacology Department, where Dr Pete **Smith** has **examined plants used by traditional healers** for treating fever."* (Diana Streak, Fair Lady, Sept 1995); ***Matsabisa** is testing plants discovered by traditional healers in KwaZulu–Natal in treating malaria."* (Sunday Times, 21 March 1991) More recently: *"the **Traditional Medicines Research Group** at UCT sent a Masters student to a hi-tech laboratory in **Barcelona** that can analyse plant material much faster than in SA. One was obtained from the **Durban herb market** and the other is widely used throughout South Africa."* (Claire Bisseker, Financial Mail, 19 Mar 1999) *Dr Karen **Barnes**, a clinical pharmacologist supervised clinical trials of the drug in a high-risk area in KZN and Sibongile **Pefile**'s area of research involves the use of plants to treat viral skin disorders"*. (Laurice Taitz, Sunday Times, 2 May 1999)

The **Traditional Medicines Programme (Tramed)F** is based on a **database** donated by **Noristan** Laboratories to the University of Cape Town's Pharmacology Department to be incorporated into a **national database to which all interested parties can have access**. (Lindy Hughson, editor, Pharmaceutical and Cosmetic Review, July/August 1995); The project has since 1995 been assisted by Dr T Felhaber, supported by a **Fellowship from SA Druggists**, and since 1991, **Isaac Mayeng**, supported by a grant from the **Medical Research Council (MRC)**. This project had its genesis at a the **28th Annual Congress of the South African Pharmacology Society** on the **24 September, 1994**, at which most of the ethnopirates mentioned here were present. (Nigel Gericke, Tramed, Indigenous Plant Use Newsletter, November, 1994) **Noristan Laboratories, who originally donated the local database to UCT have subsequently been acquired by Hoechst, giving the global drugs cartel right of access to the vastly expanded database comprising South African proprietary indigenous intellectual property.**

The database has had added, a substantial collection of information on traditional medicine donated by the Hans Snyckers Institute of the Medical School, Univ Pretoria. Further collaboration exists with Dr Anne **Hutchings** (ex-Univ Zululand), Prof Wimpie **du Plooy**'s Dept of Pharmacology at Medunsa, Dr Carl **Albrecht** at the Dept of Pharmacology and Dr Michael **Becker** at the Dept of Virology, both at the Medical School, Univ Stellenbosch. Dr David **Gammon, Dept of Chemistry, UCT**, is "collaborating with the Dept of Pharmacology in the investigation of the biological activity of **medicinal plants** found in the southern African region, **identified through traditional medicine."** (Homepage: UCT Dept of Chemistry) Central to the TramedΦ programme from an early stage has been **T/Drs Solomon Mahlaba and Isaac Mayeng. Both are major sell-outs to their profession, benefiting only themselves, as the ancestral knowledge of the nation is raped by commercial interests, whilst scientific feedback to the traditional healers as a whole has been negligible. As reward, both enjoy virtually proprietary access to the Tramed database for their respective traditional African medicines businesses.**

The statutory **Medical Research Council (MRC)** are the logistical and funding backbone for these ventures, thereby directly implicating the State in these suspect ethnopiracy activities. Further projects are: ***"MRC-supported researchers at the Department of Pharmacology and Therapeutics* (du Plooy's Department) *at Medunsaf have analysed Devil's Claw, and compared its anti-inflammatory properties*** *to fluticazone, a powerful cortisone-based anti-inflammatory."* (MRC Annual Report, June 1998); Professor Olivier and colleagues are involved in an indigenous medicine database at the **University of the North** and especially the **Rand Afrikaans and Free State Universities are networking closely with the TMRG. More recently a consortium has been formed, comprising the CSIR** (specifically the Division of Food Science and Technology – Foodtek)**, MRC, and the Universities of Cape Town, Western Cape and the North.** Eddie Koch writes: *"Almost every university now has research relating to traditional medicines in the pharmacy or other departments."* (Electronic Mail&Guardian, undated)

Nigel Gericke, founder of **TRAMED F** whilst working as phytomedicines development manager for **SA Druggists**, states in his CV that he continues to serve as **consultant to TRAMED**, including ***"ongoing research into side-effects"*** and ***"to encourage the safe use of indigenous medicinal plants, and the development of a database, including toxicology."*** In late 1995, at the request of **Folb**, as the **MCCY**, a study and recommendations were made by **Gericke** for the development of a South African approach, yet **no urgent regulatory action is being imposed on this sector, which by far represents the major, if not sole risk to public safety from natural health substances against which the MCCY/MRA claim to act when witch-hunting the international natural health substance traditions.**

Dr. Gericke in the meantime developed his own commercial range of ethnopirated indigenous medicines (**Healer's Choice** brand) and with his senior at SAD, Bosch van Oudtshoorn, co-authored a recent book (**Medicinal Plants of South Africa**, Briza, 1997), (to promote their products?) developed from the **TRAMED F** database, to which it gives no acknowledgement, nor to the traditional healers. **Most irresponsibly this book does not even begin to address the above-mentioned vast toxicological problem, since for the majority of the 132 plants featured, in spite of significant toxicities,** (besides the obligatory publisher's indemnity) the book treats these as if they did not exist, except for occasionally mentioning that this or that isolate has toxicological potential, but largely from a commercial perspective.

A shockingly similar situation inexplicably exists with the recently published South African **Traditional Healer's Primary Healthcare Handbook** (UCT, 1997), also a product of the **TRAMED F** Programme, which, although it provides short token precautionaries for those toxics among the 55 plants featured, **simply does not do justice in addressing the enormous problem of acute poisonings and fatalities arising from traditional African medicines. We have to question and protest the deliberate exclusion of an educational Toxics List**, especially considering Folb's above-mentioned statements regarding toxicity, and more recently, those of **Eagles**: *"In favour of muti is that the cost is lower than that of allopathic medicines.* ***Against it stands the risk of poisons, toxicity****, counterfeits and chemical pollutants. If people aren't enlightened about the dangers of mixing a handful of leaves together, the results can be uncontrollable"*. (Lee P, undated, Independent Online)

Some 3000 plants are in use, 10 % in major use, and of which **the most toxic or those responsible for most of the serious poisonings and fatalities are not even featured or identified in these two publications, especially curious considering that they both have their genesis from within TRAMED F, and against the claimed public safety interest,** much of which is hypocritically regurgitated by **Folb** in the first paragraph of his forward to the manual. **The authorities have no excuse to plead ignorance in defence of their callous inaction in the face of so much innocent human suffering and loss of life, since this is the primary responsibility of the Medicines Control Council, and the traditional African healers and vendors are not directly to blame. The MCCy/MRA / DOH upper hierarchy must bear legal responsibility for every preventable death, for gross dereliction of duty, amounting to genocide by inaction.**

In addition to **TRAMED F** , is a **Traditional Medicines Research Group (TMRG)** [a] which is a broader joint venture between the **Medical Research Council** [¨], the **Dept of Pharmacology at the University of CapeTown** and the **School of Pharmacy of the University of the Western Cape**, which is **also engaged in ethnopiracy testing of plant extracts at UCT, according to Dan Ncayiyana, Deputy Chancellor of UCT:** ***"to isolate active compounds to develop new drugs."*** (Electronic Mail & Guardian, 19 Oct 1997) ***"The University of the Western Cape is testing plants for anti-tuberculosis properties".*** Dr Leng, chairperson of the Department of Pharmaceutical Chemistry says: ***"The plants we have selected for screening are ones already used by traditional healers."*** (Diana Streak, Back to our roots, Fair Lady, Sept 1995); It is no surprise that the person who was preferred by the **MCC Y** to take over as Chairman in June 1998 was vice chairman, **Professor P. Eagles, head of the UWC School of Pharmacy**, who **is currently expanding on Folb's ethnopiracy operation**, and has taken over his role as a major influence (vice chair) on the Council. **Professor Eagles is also the influential chairperson of the NRC♣.**

The Traditional Medicines Research Group (TMRG) [a] was formed in 1997, after PHARMAPACT embarked on a concerted expose' of Folb's MCC regulatory double-standard in the light of his piracy TramedF Programme, at which point center stage was shifted to UWC, with the strategic transfer of Mayeng to Eagle's School of Pharmacy. The promotional media propaganda borders on the obsequious, but reading between the lines again reveals the phoney social rhetoric and cheap window-dressing, behind which the blatant ethnopiracy still festers, eg: *"The TMRG [a] intends to glean information for the health benefit of all South Africans."* The plot: *"The group will use modern scientific and biomedical knowledge* ***to investigate medicinal plant extracts and isolate bioactive compounds for developing more effective drugs****."* (The Monday Paper, UCT, February 24, 1997); The lie: *"Researchers hope to collect information on Southern African medicinal plants and to use this knowledge to set safety standards regarding herbal remedies."* (Electronic Mail & Guardian, March 4, 1997)

"Traditional healers seek recognition and scientific verification of their remedies. We want to gain their trust. What we will not do is use their intellectual property to make profits which do not benefit them. An important objective will be to create a comprehensive ***traditional medicines database for use by traditional healers, policy makers, drug regulatory authorities, the pharmaceutical industry and the public****."* **(See the lie!) "*We are committed to making the database universally accessible*."** (MRC Press Release, 6 February 1997) Both the author, as a representative of the Western Cape Traditional Healers and Herbalists Association, and his research associate, T Dr **Anthony Rees**, as chairman of the South African Herbalists Association, and PHARMAPACT have been denied access to the database. **Dr Phillip Kubukeli**, **President of the Western Cape Traditional Healers and Herbalists Association** is recorded on a televised documentary (SABC, Options, 1998), as having never had access to the **TramedF** database to which he and his colleagues have so freely contributed. Why?

Kubukeli has naively been collaborating with **TramedF** for years, handing over indigenous knowledge for an occasional hand-out and in the hope of recognition for the healer's work. Kubukeli has stated that he *"**support(s) the idea of published research, since some herbs can be a hazard, so researching them will make us more sure that our medicine is safe**, and our medicine will be acknowledged by the government, but **fear(s) that by exposing too much, healers will be made redundant**"* (Diana Streak, Back to our roots, Fair Lady, Sept 1995) Sadly the **Tramed** collaboration has contributed more to the latter aspect, yet the naivety persists: *"In my collaboration, we are working closely with Pharmacology departments in the study of the safety of our traditional medicines."* (Presentation to PHARMAPACT's Health Freedom SA Indaba, Knysna, June 1998) It is not possible to reconcile the false promotional rhetoric with the unequivocal facts: **Professor Eagles:** *"Our brief* (National Drug Policy) *was to **investigate traditional medicines for toxicity, efficacy, safety and quality** to incorporate them in the health care system, **and be able to register and control them**."* It is quite clear that the MCC (**TramedF** via Folb, and now Eagles) and in particular in their *"brief to establish a **Complementary Medicines Committee (CMC)**, including all experts"* for the aforementioned purpose have not succeeded, not in spite of, but because of the domination on this committee by the likes of Gericke, Mayeng and Mahlaba.

Neither Mayeng, nor Mahlaba have true representative mandate by the majority of traditional healers, nor should they, because of their obvious financial vested interests be qualified for any policy or decision-making process, yet nevertheless both hold influential positions on the Traditional African Medicines Committee of the CMC and the Traditional Medicines Working Group of the National Reference Centre (NRC) § , Dept of Health. Mayeng furthermore, since late 1998, is Senior Medicines Control Officer, Medicines Registration, and heads the transitional Complementary Medicines Section at MCCy /MRA.

T/Dr Solomon Mahlaba manufactures and markets his own extensive range of "finished, labelled and marketed" traditional African medicines, branded "UMUTI AMANDLA", which is known to the MCCy , this matter and that of traditional medicines manufactured by "Guideline Products" having been brought to the attention of the Registrar, Precious Matsoso and the Inspectorate. T/Dr Isaac Mayeng, in a recent book confirms his vested interest as follows: *"I also have my own private herbal medicines production and supply business."* Proof of his two-facedness is in his own words: *"Some healers think that if they cooperate with the medicinal side, the* ***government*** *will pay them a* ***salary****. That can* ***never*** *happen. There needs to be* (bank?) *checks* (cheques?) *and balances.* ***At the national level, the element of power and greed comes into play quickly****."* (Susan Schuster Campbell, "Called to Heal", Zebra Press, 1998)

Earlier self-prophetic truisms from **Mayeng**: *"The companies are positioning themselves with the healers. These groups are interested in the markets the healer's represent, not necessarily the healers themselves. Traditional healers have become sceptical of sharing their information, experience and data. Some healers have found their work published in journals under the name of their medical colleagues. Many healers feel, and rightly so, that* ***their work has been stolen****. Whenever there is a natural plant growing freely, which improves a given disease, the pharmaceutical and scientific industries will prevent this herb from being widely distributed. The rules of the game demand that the active ingredients be isolated, synthesised, then packaged in such a way to sell to a mass market at great cost for the very medicine that was given in nature."* (Schuster Campbell, 1998) As Eagles has stated: *"A stumbling block in moving forward is apprehension among traditional healers about the benefits."* (Gustav Theil, "Harvesting the curing power of plants". Mail&Guardian, March 4, 1997)

Hypocritically in February 1998, **Mayeng advised the Parliamentary Portfolio Committee on Health that *"traditional medicine had to be regulated to ensure standardisation of herbal medicine, a code of conduct and ethics, the passing on of invaluable knowledge, and patenting"*** (Vuyo Mvoko, News, Business Day, 19 February, 1998), and in February 1999, **Mayeng presented the fruits of this stolen heritage, the "TramedF Monographs" to the WHO in Geneva for the rest of the pharma-world to plunder, while South African consumer's are poisoned to death in their thousands for lack of toxicological information.** Mayeng now heads the section of the **MCCy /MRA** which aims to engage in both this and all the preceding activities he so hypocritically warned readers about in the preceding interview. (Susan Schuster Campbell, 1998); **Mayeng** was recently exposed as a fraud, when in response to a query whether the ICC∅ had been informed of the pending 26 February meeting, he claimed that the traditional healer's were not interested, and that he had no contacts for them (a lie), only to pretend the next day to be taking the initiative in informing the ICC∅ of a critical meeting.

"Almost every African city, town and village has a thriving market for the tools of the (traditional) healer's trade. In 1978, a United Nations-sponsored conference called for governments to look at incorporating traditional medicines into national health plans for the poor. Almost two decades later, growing awareness of benefits from traditional knowledge has affected the ***global pharmaceutical industry****. New realities and a global shift toward natural remedies are bringing increased attention.* *cont..*

Sometimes the "cure" is worse than the ailment. Throughout Africa, health officials and healers cite accidental poisoning as the biggest problem with traditional remedies*. Governments seek to register and regulate their medicines. "All those words for (healers) are wrong", said* ***Folb****, chairman of the South African Medicines Control Council. A history of failed deals and unkept promises make African healers wary of foreigners promising big money for their secrets. Obstacles abound in getting the herbal remedies out of the African bush. Western pharmaceutical companies seek to test every known healing plant."* (Tom Cohen, nando.net, Associated Press, October 18, 1997)

Traditional healers have accused the pharmaceutical industry of trying to muscle in on their lucrative natural herbal market. Witness Nigel Gericke: *"The potential for* (industry in?) *this country is enormous."* (Diane Streak, Fair Lady, September, 1995); **Pharmacare**, alias **South African Druggists**, was told by the Medicines Control Council (MCC) to stop making four cure-all herbal remedies sold as "**Healers Choice**" because of legislative constraints. The company refused. Meanwhile the MCC admits it has reached an impasse with SAD, which had failed to register the ingredients used in Healers Choice, as required by the national drug policy. *"The natural-remedy market is worth some $16,5-billion world-wide and is growing at a phenomenal rate," says Rodney Hesketh-Mare, general manager of* ***Pharmacare****. "Local healers do not have a monopoly on these remedies. It may be that some healers will feel threatened, but we are approaching the market from a different angle, complementary to what is sold on the streets."* (Angella Johnson, Electronic Mail&Guardian, May 11, 1998)

This did not satisfy Sipho Mndaweni, president of the **Interim Co-ordinating Committee of Traditional Practitioners in South Africa (ICC)Æ** who **complained that** *"**traditional healers and vendors may end up being squeezed out of the market"*** and who **insisted that *"South African Druggists is just testing the water before marketing more traditional medicines to be sold over the counter".*** *Mndaweni says, "We won't see a cent of the vast profits they will make, even though* ***people will buy these goods thinking it's the same as what we do****."* His committee has made submissions to Parliament for *"some control over the trademark 'traditional medicines' and to stop this kind of abuse."* (Angella Johnson, **"**Inyanga rage as drug groups muscle in!" Electronic Mail&Guardian, May 11, 1998); PHARMAPACT are in strategic alliance with the **ICCÆ**, monitoring, recording and reporting developments to our best ability with the documentation at our disposal.

"In the last few months at least four pharmaceutical companies have visited the downtown Johannesburg offices of the Traditional Doctor's Association to ask for help in identifying plants that can be used to manufacture new drugs and medicines. This sudden interest in the pharmacopeia that South Africa's healer's have gathered over the centuries is part of a multi-billion dollar research drive by drug companies to learn the secrets of traditional healers around the world." (Eddie Koch, undated electronic Mail&Guardian article, "The allure of the traditional cure: Multinational pharmaceutical companies scrambling to tap wisdom") This is nothing new. The process having been started by the multinational companies, (including Noristan) some 20 years ago. (Safowora A, Medicinal Plants and Traditional Medicine in Africa, John Wiley & Sons, 1982)

Worst of all is that this ethnopiracy is happening in our own back yard, with State support via the Dept of Health and Medical Research Council♦. Witness the following report-back from one of these meetings and then an example of the rape of the traditional African medicine heritage by a consortium of most of the above-mentioned names and institutions, **spearheaded by the statutory Council for Scientific and Industrial Research (CSIR)Ã**, **headed by Dr M Horak**, team-leader of the **Database Working Group of the Traditional Medicine Working Group of the NRC§**, with the full co-operation of **Eagles, Matsoso, Makhambene, de Wet** and **Mayeng,** all of the **MCCy, Walters** of the **MRC♦**, **Bannenberg** and **Peteni** of the **DoH**, and **du Plooy** of **Medunsaf**, plus **Mahlaba** and others. **Nothing is being done about the tens of thousands of fatal poisonings and untold morbidities, fearing non-co-operation by healers on the "claims for cures" scam, not to mention political potential political fallout should the Government upset the sangomas, who are highly influential in their communities.**

NATIONAL REFERENCE CENTRE (NRC):- EVIDENCE OF "ETHNOPIRACY" BY THE STATE

The first three meeting's events are reported on as follows: At the founding meeting it was decided that *"Different rules and regulations would apply or be needed to address differences in the supply of traditional medicines to patients. 1) Traditional medicines commercially available (manufactured, and packaged to be sold in retail outlets); 2) Traditional medicines prepared by a healer for a specific patient on an individual name basis."* At the next meeting, *"the involvement of the MCCy centred on claims of a cure for some conditions.* ***The moment a plant is claimed to cure a disease it can be legislated as a medicine.*** *Current definitions of* ***safety*** *and efficacy will be revisited.* ***Safety*** *and some efficacy have partially been addressed by the fact that it has been given to patients for years. The major difference is between the* ***individual use*** *of a product and the bulk distribution and* ***sale*** *thereof.* ***Safety*** *needs to be addressed if a product is sold in bulk."* (NRC 4 June 1997) *"****The MCCy is concerned with medicines of plant origin being pre-packed and sold in shops and not with one-on-one treatment of a patient. It also concerns the issue of herbs being sold on the pavement in certain cities****."* (NRC 11 Sept 1997)

REPORT-BACK REGARDING THE LEGAL ISSUES WORKING GROUP OF THE NATIONAL REFERENCE CENTRE FOR TRADITIONAL MEDICINES, NATIONAL DRUGS POLICY, HALLMARK BUILDING, DEPT OF HEALTH, PRETORIA. 2 JUNE 1998. By Stuart Thomson.

(This report was prepared for PHARMAPACT, the Interim Co-ordinating Committee of Traditional Medical Practitioners of South Africa (ICC)Æ, and the Western Cape Traditional Healers and Herbalists Association)

The National Reference Centre (NRC)§ for Traditional Medicines is a facilitating initiative of the Department of Health, arising out of the National Drug Policy for South Africa. The stated aim is to *"investigate the use of effective and safe traditional medicines at primary level."* As per the WHO, ***"traditional medicines will be investigated for efficacy, safety and quality with a view to incorporate their use in the health care system"*****.** Quite clearly, **the traditional healers are not central to the plan in the long term; only their medicines are of real interest.** Most revealing of all is the unequivocal statement *that* ***"Marketed medicines will be registered and controlled"***. A further insight is obtained from the outline of the functions of the reference centre which these working group meetings are busy establishing and which will include: *"development of a national database of indigenous plants screened for efficacy and toxicity; testing for efficacy and toxicity."*

Who exactly is running the show? Certainly not the traditional healers, though there are a fair share of non-representative opportunists and naïve stooges providing the obligatory window dressing, including in this instance: T/Drs. Simon **Mhlaba** (Natal Nyanga's Assoc.), Seth **Seroka** (African National Healer's Assoc.), and Isaac **Mayeng** (Tramso - Trad Med Syst Org), **Prof. Folb's stooge as strategic liaison person for the traditional healers. Significantly all are on the equally non-representative and non-democratic African Traditional Medicine Sub-Committee of the Complementary Medicines Committee of the MCCy. This concentration of influence on both forums illustrates either the deliberate selective nature of the canvassing for participants, or lack of support by the majority.** There are otherwise only a handful of collaborating traditional healer opportunists, all in all, in about 20% minority to the academics and others.

Having lined-up the window dressing, the remainder of non-traditional healer Europeans at the meeting ensured that the group-leader would be Dr. Nico Walters of the Medical Research Council¯, Cape Town (speciality: indigenous technology), who acknowledged to me prior to the meeting that he was part of Professor Folb's team (and one of the tiers in the Traditional Medicines Research Group (TMRG)ª, including Folb's UCT Pharmacology Dept. and Prof. Eagles UWC Pharmacy Dept.). The MRC¯ are closely involved with the WHO Collaborating Centres for Drug Policy and actively support the ethnopiracy operations of Professors Folb, Eagles and du Plooy by way of financial grants. The MRC¯ pride the TMRGª with *"using modern scientific and biomedical knowledge to investigate medicinal plant extracts and to isolate boiactive compounds for developing safer and more effective drugs"*.

Also prominently involved was the Council for Scientific and Industrial Research's (CSIR) Ā Dr. R. Marthinus Horak, who quite frustrated, informatively pointedly reminded all that: *"the focus was not intended to be traditional healers, but rather traditional medicines"*. Dr. Horak is the Manager of the Chemical and Microbial Products (CMP) Programme of Foodtek at the CSIR Ā. *"The CMP Programme* (in their own words) ***recently launched a major bioprospecting project that is aimed at investigating most of the 23,000 South African indigenous plants for pharmaceutically active compounds, which plant extracts are to be tested by the CMP Programme."*** (Bulletin of the Plant Protection Research Institute. Autumn1998).

Seeing this hopeless trend following that of the selective CMC nominations debacle, **I, for the record, formally protested that the proceedings constituted a sham of representativeness and democracy and a set-up favouring vested interests**, since those accepting nomination to a steering committee to decide the fate of millions were not public representatives, **nor did they have a mandate to represent all, or most traditional healers**. The convening Chairperson, Lulu **Peteni**, **Deputy Director, Essential Drugs Programme, ruled me out of order, claiming that the only "mandate" given this group by the earlier group meeting was to elect the steering committee** and to establish terms of reference for the future work of that committee which would meet frequently and the present work group which would meet infrequently, the usual autocratic top-down approach.

I protested that none of the meetings were truly representative, or democratic, since they were not called by public notice. Peteni replied that the 1996 National Drug Policy publication represented public notice, which I protested was absurd and **was left no alternative other than to withdraw from the unconstitutional proceedings and merely observe. Before the close of the meeting, I protested the fact that the toxicity issues were being ignored, and requesting that my written submission be officially entered into the record and next agenda**, to which I was **advised that** I should take up my objections with the Dept. of Health and that **since my submission did not bear a signature, (just my name), it did not constitute a legal document**.

Similar objections were recorded in the minutes of the June 97 Reference Centre meeting. At the recent meeting, members of Chief Gcaleka's group in particular, expressed concerns that their ancestor's gifts would be exploited, if not suppressed by the medical institutions, and T/Dr. Simon Mhlaba expressed his wariness of the database. Mayeng, Folb and Eagle's main collaborator, who has unique proprietary access, simply dismisses these issues with unsubstantiated assurances that ***"all the healer's fears will be taken care of"***. **Most of the healers are naïve as to the money driven ruthlessness of the academic and pharmaceutical interests which are herding them and their ancestoral wisdom and knowledge into a system established to prostitute these and expropriate their collective 2 billion Rand crude market in indigenous herbs.**

The plan is clearly not to serve the healer, contrary to common belief. The minutes of the initial meeting state that ***"the Centre will concern itself with the study of plants with medicinal properties"*** and *that* ***"other issues concerning traditional healers do not fall within the mission of the Centre"***. It is generally not appreciated that **these initiatives were conceived and instigated by the old regime in precisely the way which would cause the least suspicion, and were strategically implemented at the time of political transition, so that when the process started, it would appear to be a trustworthy initiative of the people's government.**

The aim is to trick the traditional healers to willingly part with their knowledge, previously via "database collaboration", and now via the new trap of "registering claims for cures". There is nebulous talk of protecting intellectual property rights, non-disclosure documents, and contracts to deal with claims, but these are rendered clearer by the necessary talk of ***"financial incentives for drug leads given to companies", "contracts between companies and healers"*** *and* ***"claims at universities to constitute claims"***. Peteni revealed that: ***"the function of the Centre was to acquire good quality information and to act as a clearing-house, leaving the rest up to the institutions"***. Besides the MCC, MRC and CSIR, virtually every university has representation, usually their pharmacology and / or pharmacy departments.

The further aim is to expropriate and pharmaceuticalise the local market and exploit the active principles internationally via patented synthesised derivatives, with little or no return for the rightful owners, the African people. The June 1997 minutes acknowledge that: *"traditional medicines are of economic importance and are seen as an important source of drug leads for pharmaceutical companies"*. The key to understanding the take-over is contained in statements such as *"only widely accepted plants will be accepted into the formulary"*, *"safety needs to be addressed if a product is sold in bulk"*, *"once the chemical research is done, new intellectual property rights can be registered"*, *"discoveries need to be patented to ensure that the discoverer benefits from further development by pharmaceutical companies"*, and *"patenting is a costly process"*. These issues raise the hurdles to the extent that only pharmaceutical interests with their resources and not the healers / vendors can legally participate in prospering from their ancestoral legacy.

Also from the minutes of an earlier meeting of the **Traditional Medicines Working Group of the National Reference Centre** is a direct reference to **"vested interests": *"The centre will not only encompass the MCCY but other organisations like the CSIR Ä and MRC¨ will be included as partners. The CSIR Ä is currently in a consortium with other institutes, busy with "bioprospecting". In 10 years the group wants to scrutinise 80% of indigenous medicinal plants. There was a concern that the CSIR Ä has a financial interest and could take over the market. The CSIR Ä is a national research institute, owned by the government and is as such not profit orientated."*** (NRC 11 September 1997)

Let us briefly investigate this totally fraudulent concept and claim of "non-profit bioprospecting":

The **CSIRÃ's Bioprospecting project** aims to *"investigate most of SA's indigenous plants for **commercially valuable properties**. We will strive **to add value to indigenous knowledge through scientific investigation of eg traditional medicines derived from plants**, in close collaboration with traditional healers, legal advisors and policy-makers, to develop equitable collaboration, subject to agreements which define confidentiality, intellectual property rights and reciprocity"*. Please bear in mind that **traditional ancestral knowledge belongs to no one individual or group of individuals, but to whole communities! To claim such information for oneself and sell it is clearly theft and fraud and should be punishable by both civil and traditional court. Legitimately only a unanimous community can make such a decision. Foodtek,** the **CSIRÃ** department where the **Bioprospecting project** is resident, claims that *"throughout this process, we will ensure the equitable sharing of benefits between all parties involved, the intellectual property of participants, in particular sharers of indigenous knowledge, is respected and safeguarded"*. (Foodtek Homepage 1998) Clearly however, **if the true owner's are not participants, the thief (healer) is not only paid for stolen property, but has their identity and knowledge of their crime safeguarded by the receiving accomplice (CSIRÃ).**

Claims to "take account of the rights and interests of indigenous peoples and provide partnerships which will permit communities to benefit from their indigenous knowledge" (Foodtek Homepage 1998), are clearly just false public relations rhetoric, being as they are, irreconcilable with the facts, eg: "The discovery, development, **world-wide patenting and licensing of an 'appetite suppressant' derived from an indigenous plant by Horak** at **CSIR Ã**-Foodtek gave impetus to the establishment of the Bioprospecting consortium. **The product is to be commercialised as a prescription medicine. (Is this a priority African need?) A licensing agreement for development and commercialisation has been signed between the CSIR and the UK-based company, Phytopharm. Pfizer**, is funding the construction of a FDA-approved clinical supplies unit at CSIR for the manufacture of **P57**, to be used in clinical trials". ("Bioprospecting breakthrough", Pharmaceutical & Cosmetic Review – Nov/Dec 1998)

*"**Under the agreement, Pfizer has acquired an exclusive world-wide licence to develop and market P57. Phytopharm will receive up to 32 million Dollars in license fees** and **milestone payments** based upon the achievement of specific objectives. In addition, Pfizer will make at least 7 million Dollars in contributions in an early development programme to be carried out by **Phytopharm**, who **will also receive royalties on sales of P57 by Pfizer**. Financial Advisors: NM Rothchilds & Sons Ltd."* (Press release, Phytopharm Homepage, Aug 1998) *"**The company did not name the plant to protect "its" intellectual property**. Financial terms of the deal with the CSIR were also not disclosed"*. (Cape Times, Business Times, 24 Jun 1997); *"**CSIRÃ scientists refused to divulge the species of the miracle indigenous plant** code-named P57. **American drug company, Pfizer, bought exclusive rights to market P57 in an estimated R240 million deal**"*. (A Baleta, Sunday Argus 3/4 Oct 1998) "***Neither company was prepared to name the herb**, dubbed P57*. Stuart Thomson commented to the press as follows: "***These companies come here, flash their money around, and for a few measly bucks, convince traditional healers to hand over ancestral knowledge."*** (L Taitz, "SA flower power for Viagra giant: Accusations of 'ethno-piracy' as Northern Cape plant is targeted for use in weight-loss drug", Sunday Times, Aug 1998)

This herb, "ghaap", Hoodia spp, previously Trichocaulon spp, has for centuries been used by the African, Bushman, Hottentot, Nama, settler and colonist for diverse medicinal purposes and *"for the assuage of hunger and thirst"*, as recorded 70 years ago by Rudolph Marloth in The Flora of South Africa, Cape Town, 1932. (Quoted by Smith C, Common Names of South African Plants, Dept Agric Tech Serv, 1966) Note that Horak claims that ***"When we deal with the 'custodians' of this information we see them as peers and we respect their knowledge"***. Note the double-speak as Horak cannot resist grabbing all the glory for himself, when he goes on to state: "*In South Africa you are at the top of your field in science when you publish 25 journal articles and a few books. In Europe the top scientists have frames on the wall with the drugs 'they' discovered behind glass. That's what I am looking forward to."* (Laurice Taitz, Sunday Times, 2 May 1999) Horak is an intellectual property plagiarist, fraud and thief.

Let us examine the State's health mandate, from their own principal official guidance documents:

While *"Act 101/1965 provides for the establishment of the Medicines Control Council for the control of medicines"* (Medicines and Related Substances Control Act No.101 of 1965), the specific parameters are internationally established as: *"The Council is mandated to serve the public interest in the regulation and control of the quality, safety and efficacy of medicines. Because most of South Africa's population lives in conditions more akin to the developing world, it is important to examine whether the country is optimally served by the established system"*. (Folb P et al, "Drug regulation in South Africa", J Clin Phamacol, 1988 Sep; 28(9)); ***"The Council was created by Parliament for the purpose of ensuring the quality, efficacy and safety of medicines available to the public."*** (Folb P, Schlebusch J, "The regulation of medicines in South Africa", SAMJ 1989, 16 Dec; 76); ***"In terms of the Act, the Council has the mandate to ensure that the medicines available to the South African public are safe and in the public interest. The Council may take into account only the scientific data available."*** (Folb P, "The registration and control of medicines in SA", Med Law 1991; 0(6))

The ruling African National Congress party's National Health Plan states: *"Guiding Principles: Every person has the right to achieve optimum health, and it is the responsibility of the state to provide the conditions to achieve this. The ANC is committed to the promotion of health through prevention and education. All racial and ethnic discrimination will be eradicated. There will be a (priority) focus on the prevention and control of major risk factors and diseases."* *Drugs Policy: Only drugs shown by analysis to be safe and of acceptable quality and efficacy will be marketed. A special committee will investigate the safety of traditional drugs. A regulatory body for traditional medicine will be established."* (A National Health Plan for South Africa, ANC, Johannesburg, May 1994)

*"The **National Drug Policy (NDP)** is the South African Government's plan for the rational and economic use of drugs in the country."* (National Drug Policy for South Africa 1996) ***The South African Drug Action Programme (SADAP) was envisaged to ensure the implementation of the NDP, (including)*** *major changes to legislation such as to* ***the Medicines and Related Substances Control Act*** (**Summers** R, Suleman F. Drug Policy and Pharmaceuticals, in South African Health Review 1996, HST, 1996); ***"The NDP aims to promote rational prescribing, dispensing and use of drugs by all health workers and the public. Emphasis is on education, training, and the provision of drug information and appropriate prescribing and dispensing."*** *Dr W* ***Bannenberg*** *was appointed* ***SADAP*** *Director from 1997. The* ***WHO Collaborating Centre on Drug Policy, Information and Safety Monitoring at the UCT*** *(Department of Pharmacology)* ***and UWC*** *(School of Pharmacy) run courses promoting Rational Drug Use."* (Gray A, **Eagles** P, CH 10, "Drug Policy", in The South African Health Review 1997, Health Systems Trust, 1997)

The National Drug Policy has as it's *"Health Objectives: To ensure the safety, efficacy and quality of drugs. 'Marketed' traditional medicines will be investigated for safety and quality. 'Marketed' traditional medicines will be registered and controlled. Rational use of Drugs: To promote rational prescribing, dispensing and use of drugs by personnel and to support the informed and appropriate use of drugs by the community".* (National Drug Policy for South Africa, Department of Health, January 1996) **Oxford Dictionary definition of the word "market": *n. Be offered for sale; v. Buy or sell in market; v.t. Sell (goods) in market or elsewhere.*** (Oxford Dictionary)

The supply of "unlabelled" traditional medicines is by any definition still "marketed". The Act itself defines "sell" as: "retail, wholesale, import, offer, advertise, keep, expose, transmit, consign, convey or deliver for sale or authorize, direct or allow a sale or prepare or possess for purposes of sale, and barter or exchange or supply or dispose of to any person whether for a consideration or otherwise" It is indisputable that: *"Trade in traditional medicines is a multi-million Rand "hidden economy" in southern Africa, where a high level of urbanisation generates high demand for traditional medicines, particularly to mining towns or large urban centres."* (Cunningham, A.B. 1993. Imithi isi Zulu: the traditional medicine trade in Natal/KwaZulu. MSc. thesis, University of Natal.) (Williams, V.L. 1996. The Witwatersrand muti trade. Veld and Flora 82: 12-14.)

The **Medicines Regulatory Review** (Dukes)**,** rather than strengthening the public safety mandate in it's recommended overhaul of the regulatory system, actually further erodes the "public interest" component by not stating strongly enough the problem of traditional African medicines toxicity, in spite of its recognition that ***"South Africa is faced with many purely national issues, including the massive challenge of African traditional drugs"*****,** which awareness arose solely as a result of my direct consultation with the team and the presentation of a rudimentary version of this report. (The Medicines Regulatory System in South Africa: Review and proposals for reform. Dept of Health, 24 March 1998)

Significantly, the Review never recommended that only "marketed" medicines be regulated, but it appears that this rather weakly stated aspect has been deliberately capitalised on by the **Medicines Regulatory Authority Transformation Task Team** who, too timid to exercise bold responsibility, **continue to promote the culturally and demographically inappropriate Listing System**, and which team included, not surprisingly, **Summers** and **Eagles**, but also **Rees, Matsoso and Makhambene**. (Report of the Medicines Regulatory Authority Transformation Task Team, 17 July / 23 September 1998); **Even the SAMMDRA Act itself makes no distinction on the basis of the concept of only "marketed" medicines being subject to regulation** (RSA. South African Medicines and Medical Devices Regulatory Authority Bill, B 114-98), **so the distinction appears to be merely a cop-out by the regulatory authorities to avoid having to handle this political hot potato.**

Professors Folb and Eagles, the most informed and influential educators and policy makers as far as medicines regulation and toxicity of traditional African medicines are concerned, are leading these genocide / ethnopiracy operations. Educational courses for traditional healers? No way. They are not interested in the thousands of annual deaths and morbidities from medicines under their jurisdiction, they **are focussed on the academic prestige and millions to be made from ethnopirated traditional African medicinal substances for the patent and synthesis of mass-market First World drugs.**

Ethical scientists however, share our concerns: *"It would seem to be a good idea to record toxic traditional medicines so that traditional healers might be persuaded to substitute safer plants or reduce quantities administered. Although universities, public and private institutions are involved in traditional medicines research, progress has been very slow in achieving the above goal."* (Cunningham A, Review of Ethnobotanical literature from eastern and southern Africa, People and Plants Online Marrakech, Morocco, undated) **Dr Lydia Makhuba** PhD, professor of chemistry at the Universities of Botswana and Swaziland, collaborating with the UN WHO states that: *"Our general approach is two-fold: to find out if there are useful ingredients, and also to try and discourage the use of any toxic mixtures"*. **Dr Robert Bannerman** (too many qualifications to list), retired Manager, WHO Programme for Traditional and Indigenous Systems of Medicine, has stated it even more strongly: *"to promote the useful practices and 'equally' to discourage the harmful ones"*. (Science in Africa, Interviews, Voice of America, 1982)

Consider the conclusions reached in the recent paper titled "The toxicology of African herbal medicines": ***"There is a need to explode the myth that all of these are safe. In South Africa there exists a window of opportunity for a serious examination and publication of the facts concerning the risks of using traditional herbal remedies. In addition, there needs to be a coming together of those interested in the toxic, as opposed to the beneficial aspects of traditional medicines."*** (Stewart M et al, Ther Drug Monit, 1998, Oct, 20(5)) More recently: ***"In the light of statistics that most people in Africa use traditional herbal treatments, there is an urgent need for more research into the efficacy and safety of the medicines being used by the majority".*** (Traditional Medicine & HIV/AIDS in Africa. A Report From The International Conference, Nairobi, May 2000) **Whilst PHARMAPACT have clearly taken the initiative regarding the former aspects, it is now up to the State to facilitate the remaining obligations of this recommendation, heretofore so shamefully neglected. With some 10000 to possibly 20000 annual preventable deaths and several million morbidities from traditional African medicines in South Africa, why have these often "fatally poisonous medicines" not been given toxicological precautionaries at every opportunity and "called-up" to protect consumers?**

 # Many of these substances cross our borders from as far afield as Mozambique, Malawi, Swaziland and Tanzania. Why are the MCCy /MRA not similarly instructing the Customs officials to embargo these medicinal drugs at point of entry as with the relatively innocuous international health substances? # Why are MCCy / MRA inspectors not exercising their functions within the arena of the traditional African healers, herbal / muti shops and markets? Toxic medicines used by other practitioners, even on an individual basis are scheduled and/or registerable. Why should Act 101/1965 and the SAMMDRA complementary medicine regulations exempt and thereby perpetuate the biggest killer category of all, ie. Traditional African Medicines ? Are our African citizens not entitled to equal legislative protection, or is genocide via deliberate inaction really evidence of a sinister apartheid era plot to allow the poisoning/reproductive manipulation of the unsuspecting African traditionalist, (possibly even contemporarily perceived by some to be a nuisance drain on State resources), **now awkwardly exposed, yet allegiance to a New World Order agenda and international pharmaceutical ideology / control still taking preference over the ANC slogan of "health for all"?**

The bottom line is that for the Listing System to be implemented, it will have to include the African traditional medicines, or face constitutional challenges and criminal charges against the enforcing authority. If on the other hand, the African traditionals are forced into such an oppressive system, it would involve the expropriation of a **2 billion Rand market** from thousands of people who have traditionally earned their sustenance this way, severely restrict free public access to and escalate the cost of these substances to the very people who rely on them most and who the current authorities purport to serve.

CONVENTION ON THE PREVENTION AND PUNISHMENT OF THE CRIME OF GENOCIDE

Adopted by Resolution 260 (III) A of the United Nations General Assembly on 9 December 1948.

Genocide is a crime under international law, contrary to the spirit and aims of the United Nations.

Article 1. ----- Genocide is a crime under international law, which we undertake to prevent and to punish.

Article 2. ----- **Genocide means any of the following acts committed with intent to destroy, in whole or in part, a national, ethnical, racial or religious group, as such:**

- (a) **Killing members of the group;**
- (b) **Causing serious bodily or mental harm to members of the group**;
- (c) **Deliberately inflicting on the group conditions of life calculated to bring about … its physical destruction in whole or in part**;
- (d) **Imposing measures intended to prevent births within the group**;

Article 3. ----- The following acts shall be **punishable**:

- (a) **Genocide**;
- (b) Conspiracy to commit genocide;
- (c) Direct and public incitement to commit genocide;
- (d) Attempt to commit genocide;
- (e) **Complicity in genocide .**

Article 4. ----- **Persons committing genocide or any of the other acts in Article 3 shall be punished, whether constitutionally responsible rulers, public officials or private individuals.**

CULTURAL NOTES CENTRAL TO THE AFRICAN CONCEPT OF TRADITIONAL HEALING

"In Bantu "Theory of Causation"- ie their entire body of ideas on the causes of illness, death, and adversity; the spirits of the departed, the ancestors, hold a prominent and central place, the supreme arbiters of good and evil. The Bantu peoples therefore do not worry about physical disease, however painful, but are deeply concerned about its origin. Their treatment, ie the rituals, traditional practices and ceremonials are mainly directed towards the reconciliation with the ancestors and towards neutralising the magical and malevolent influences which have caused the illness. Their use of herbal remedies is based on the same premise, of disposing of the evil at work in the body of the afflicted person, which is the cause of the trouble."

"The term witchdoctor means the doctor who renders witches harmless, not the doctor who is a witch. The isangoma is thus the exposer of evil and the diviner of causes. The second influence used against evil is the inyanga or herbalist. He does not traditionally divine the source of evil, but treats it with herbs and various rituals and ceremonies. In the setting of these belief-systems, Western medicine is merely the painkiller, the analgesic as it were. The untutored person cannot conceive that the body is subject to disease processes which can progress unbeknown to them. It is not only the untutored among the Bantu who hold these views, the half-educated and even some educated people are often influenced by their age-old beliefs." (Walker M, in Aspects of Community Health in South Africa, Searle C, Ed. The South African Nursing Association, 1973)

"Africans believe that certain of their illnesses can only be cured by their own inyanga, that it is useless to go to the hospital if a person has contracted one of these. About half of the illnesses diagnosed by the inyanga today are attributed to witchcraft. The inyanga gives medicine to protect the patient and the family from a person's evil intentions. It is believed that the inyanga can prevent almost any adversity in life. Since they do not relate disease to organs, they cannot understand, recognise or treat disease by scientific observations. Thus ***treatment is mystical and herbs are prescribed haphazardly.****"* (Geland M, "An African Culture in relation to Medicine", in Mankind and Medicine in the Third Millennium, Tygerberg Hosp/Univ Stellenbosch, Sept 1976)

"There are two principal types of Zulu Traditional practitioners. The Isangoma, usually female is a diviner and is said to be chosen by her ancestors who bestow upon her a clairvoyant diagnostic powers. The "doctor" or Inyanga is usually male and has a comprehensive knowledge of Zulu medicines, usually passed from father to son. The medicines employed are often ground from a variety of leaves, barks, stems, bulbs, fruits, flowers, seeds and parts of animals. They may be given as purgatives, enemas, rubbed into t he skin, breathed in, administered via small cuts in the skin etc. Traditionally in cases of diarrhoea, for example, purgatives were given in the belief that it was essential to clean out the cause of diarrhoea from the system."

"The pharmacopoeia is extensive and contains powerful chemical substances with both potentially useful as well as toxic properties. *In addition to the pharmacological properties, it is also believed that the colour of a medicine is related to its power, which therefore act at a metaphysical as well as a physical level. Treatment modalities, however, are not restricted to the use of medicines. The support and advice of protective ancestors can be elicited through adherence to complex rituals including animal slaughter. Scarification is a common treatment, analogous to immunization."* (Friedman I, Healthlink, Issue No. 37, October 1998)

-------End of Cultural Notes-------

Postscript (Added to the updated April 2000 Report)

Historical rebuttal note. The original report (as presented to the Secretariat of the Medicines Control Council in Pretoria on 14 June 1999 and to the full Council on 23 July 1999 by the author, with senior members of the PHARMAPACT allied statutory **Interim Co-ordinating Committee of Traditional Medical Practitioners (ICC)**, who enjoyed invited observer status, in attendance) **contained the invitation:** ***"Comments are elicited for corrections and/or additions to the final report, the publication form/fate of which will be determined by the MCC/MRA's committed response or absence thereof".***

Non-Responses. As of October 2000, the following respondents of the registered letters below, had not replied several months to a year after their respective due dates and thereby have tacitly by default, specifically accepted as factual, the content of the the above Report and the serious charges made in these letters about their active, perpetuating and/or cover-up roles: the Chairman, Parliamentary Health Portfolio Committee, Dr Abe Nkomo; the Director-General, Dept of Health, Dr Ayanda Ntsaluba; the Chairperson, Medicines Control Council (MCC), Dr Helen Rees; the Registrar, MCC, Ms Precious Matsoso; the Chairman, Complementary Medicines Committee, MCC, Dr Peter Makhambene; Senior Medicines Control Officer and Head of Complementary Medicines Section, MCC, Mr T/Dr Issac Mayeng; and past MCC Chairman and still public custodian of the Tramed database, University of Cape Town Head of Dept of Pharmacology, Professor Peter Folb. To do otherwise would have served to implicate them all even further in this heinous "crime by inaction" and its cover-up. The matter will now be referred to the honourable Minister of Health and Public Protector for action against the State criminals and all accomplices.

(All letters are abbreviated to restrict their content only to that pertinent to the matter at hand)

Also, as of October 2000, only one of the ANC officials listed at <http://www.life-link.org.za/contacts/anc.htm> had responded (negatively) to a pre-release report despatched for constructive comment a fortnight previously.

---This first item is an extract of the introduction to the banned Parliamentary submission---

The Chairperson and Honourable Members, 26 October 1998

Parliamentary Portfolio Committee on Health

Thank you for granting us our request to make a direct presentation to the Committee.

We have gone to great lengths to prepare a synoptic selection of documents for your information.

- **The tragic ethnopiracy of the traditional African health substances by pharmaceutical companies, universities and the State machinery itself (MRC and CSIR)** is of great concern to us, since it parallels the take-over of the international traditionals, but only more despicably so, since this sector is even more vulnerable to capitalistic economic pillage, which will be officially authorised by SAMMDRA enabling regulations.

- **The shocking history of double-standard MCC activity, ethnopiracy and genocide against the African traditionist.** In closing we wish to thank the honourable Committee members in anticipation of their best attention to the numerous issues legally served on them here as public and Parliamentary record. As always we are at your service in the interests of Truth.

Yours faithfully,

Stuart Thomson,

Director, the Gaia Research Institute,

National Co-ordinator, PHARMAPACT. Full document <http://www.angelfire.com/biz/pharmapact/setup.html>

-------(The above item leads into the next item)-------

Dr Abe Nkomo **By Registered Mail**

Chairperson, Health Portfolio Committee 15 November 1999

Dear Dr Nkomo

PARLIAMENTARY EVICTION: GROSS DENIAL OF CONSTITUTIONAL RIGHTS

I write to you on this first anniversary of your unforgettable 26 October 1998 eviction of myself from the Health Portfolio Committee public hearing on the SAMMDRA bill where you used the utterly false excuse of un-parliamentary behaviour and of my "swearing at and denigrating people" to not only evict me, but also falsely accused me of "slander and libel" so as to strike our 62-page printed submission from the parliamentary record, and furthermore thereafter resorted to the unusual, but highly illustrative extreme action, of actually confiscating said submission from every single recipient thereof in the committee chamber.

You should be ashamed of your despicable disregard of the fundamental rights of others in pursuit of your own spin-control agenda. Evidence for this role as a puppet of the New World Order, in addition to strategically striking our 62-page submission from the parliamentary record and confiscating all copies in the committee chamber, is **your fraudulent assertion** in an interview in the Nov/Dec 1998 issue of the Health Independent, just a few weeks after our eviction, **that *"Traditional African Medicines have never killed anyone",*** the very antithesis of at least 8-pages of documentary proof to the contrary forming an integral part of our suppressed submission (in addition to serious claims of genocide, ethnopiracy, State mal-administration, fraud, and false parliamentary testimony by vested interests).

I am extending to you to an opportunity to acknowledge your ignorance in this latter regard to me in writing and to publish a notice of correction in said publication, failing which I shall personally see to it that you face appropriate public charges of fraud. Any aspect of this communication and accompanying annexes not specifically denied and convincingly refuted shall by simple default be tacitly construed to be a complete submission thereto by all co-respondents to which such aspects might conceivably have application. We trust that this well-intentioned documentation will serve to bring this unfortunate matter to an amicable conclusion with an eventual equally satisfactory solution to the circumstances forming the intellectual and ethical subject matter equally violated by said criticised administration and so serve to keep our Constitution and Parliament from discredit.

Yours sincerely

Stuart Thomson

Director, Gaia Research Institute.

National Co-ordinator, PHARMAPACT. Full document: <http://www.angelfire.com/biz/pharmapact/nkomo.html>

An open formal letter served on: 26 February 1999

(By hand to bolded recipients) **By Registered Mail**

Dr Ayanda Ntsaluba, Director-General, Dept. of Health;

Dr Helen Rees, Chairperson, Medicines Control Council;

Mrs Precious Matsoso, Registrar, Medicines Control Council;

Dr Peter Makhambene, Chairman, Compementary Medicine Committee, MCC;

Dr Abe Nkomo, Chairman, Parliamentary Portfolio Committee on Health.

Dear Sir/Madam

PROPOSED REGULATION OF ALL NATURAL HEALTH SUBSTANCES AS MEDICINES:

Why has virtually nothing been done to prevent the thousands of annual mortalities and the hundreds of thousands of morbidities caused by not only MCC approved or registered drugs, but also by a handful of traditional African drugs, which latter deaths are largely avoidable and have been known and legally under the MCC's jurisdiction since 1965, and we believe ignored for evil political expedience during the wicked apartheid era, and ignored by the new regime, certainly since we published our African Traditional Medicine MCC Genocide reports in January, March and June 1998, and which were served on the Minister of Health, Director-General of Health, MCC, Dukes Review Team and the Parliamentary Portfolio Committee on Health and was furthermore televised nation-wide on the Options programme, with a repeat.

What has been done by the MCC and their illustrious Complementary Medicines Committee, eg in response to the honourable Minister of Health's 23 April 1998 referral of the "Medicines Control Council Genocide Against The African People" report to the MCC/CMC (Ministerial Ref 3/6/2/2) and what progress has been made even generally in this regard?

Yours faithfully

Stuart Thomson

National Co-ordinator, PHARMAPACT

Full document: <http://www.angelfire.com/biz/pharmapact/Pubmeet.html>

……..

Ms Precious Matsoso **By Fax and Registered Mail**

Registrar, Medicines Control Council 11 October 1999

Dear Ms Matsoso

MEDICINES CONTROL COUNCIL TYRANNY, CORRUPTION AND SUPPORTED GENOCIDE

It is with a sense of utter disgust that I write to you on this occasion. Not only has Council apparently failed to take seriously our presentations and their shocking documented facts, but you yourself have shown total disregard for our extended goodwill under what for us are extremely difficult circumstances (appealing to thugs and criminals) by not providing us with the requested minutes of the meeting where the Genocide Report was tabled and furthermore also the minutes of the next 23 July Council meeting where I did a presentation to Council on the aforementioned topic.

I specifically requested in writing on the 25 June 1999 that you "put this letter and the two reports before Council (as per our constitutional right)" and further clearly stated that: "We look forward to evaluating their comments thereon via the minutes thereto which we request now in advance." Moreover at the full Council meeting of 23 July 1999, I specifically repeated our request to both yourself and Chairperson Dr Helen Rees that the minutes of the previous meeting and the meeting in session be made available to us without delay. I have repeatedly done so and I once again invoke our constitutional "right of access to any information held by the State; and any other person that is required for the protection of any rights".

You are requested within 7 days, to provide us with the minutes of the relevant meeting of the CMC to which this matter was referred in July, as well as that of the two Council meetings in question (23 July 1999 and the prior meeting). These are our immediate priority requirements. Please note that failure to provide all of the above requested information will not only have the effect of further denying us our constitutional rights under Section 32(1) of the Constitution, but will furthermore have both the effect of and reinforce our perception of your intention to deliberately subvert the course of justice.

Regarding the genocide and ethnopiracy aspects of our dispute with Council, whilst we would expect this treatment and total disregard for the welfare of the African people at large from the apartheid regime Council remnant still entrenched in office, the active supportive participation of Mayeng, Mohoto and yourself in their callous agenda is quite frankly a sickening shock.

Yours sincerely

Stuart Thomson

Director, Gaia Research Institute

National Co-ordinator, PHARMAPACT

Mr Isaac Mayeng 3 December 1999

Senior Medicines Control Officer **By Fax & Registered Mail**

Medicines Control Council

Department of Health YOUR REF. 26/6/2/1(CML/114)

Mr Mayeng

QUERIES RE PHARMAPACT PRESENTATION TO COUNCIL: 23 JULY 1999

I am in receipt of your letter of 7 September 1999, requesting me to "provide the Secretariat of the Medicines Control Council (with) information on products ***'allegedly'*** responsible for the deaths among the South African Population, or of the manufacturing sites where such medicines are compounded". You state that "the products are ***'alluded to'*** in your (my) document on 'Regulatory Proposals for Natural Health and Therapeutic Substances (section (f), p.1), which you (I) presented to Council on 23 July 99".

Never mind how selective your choice of semantics, the bottom line is that **my statements are factual and several senior members of the MCC and Dept of Health are guilty of and are compounding a serious ongoing crime against the innocent and ignorant indigenous peoples of South Africa whom both institutions are mandated to protect.** The priority activities of said personnel and institutions are patently absurd as these relate to so-called "complementary medicines", in that they cowardly, but with disproportional fervour, address the extremely petty, whilst totally ignoring the extremely serious issues which I have raised with several institutions and officials over the past few years, namely in this instance, **the death of several thousand individuals every year as a result of exposure to traditional African medicines.**

If you had but taken the care to read the submission, you would have noted that the section read:

"(f) The logistical inability of the indigenous African medicines to be equally and urgently included in the process, let alone the process enforced on this significantly high-risk sector. The gross moral, legal and constitutional implications of ignoring or exempting this sector, directly responsible for an estimated 10-20 thousand tragically unnecessary deaths per annum has been detailed in our recent 15,500-word report titled 'MCC / DoH Traditional African Medicine Genocide and Ethnopiracy Against the African People'."

How can 15,000 words be inadequate, especially when they lead the reader directly to the sources of both the problem and the personnel and institutions perpetuating it, as well as to the only comprehensive sources of the existing data…the very same personnel and institutions, either directly part of, sponsored by, or otherwise allied to the State in this disgraceful scandal? If said personnel and institutions were forthcoming with the repeatedly requested and eventually demanded access to the Tramed Database, I would have presented a 1,500-page report on the specifics by way of an essential (Traditional African Medicine) "Toxics List". Without access to this data, I am unable to assist the authorities any further, yet this deliberate limitation does not diminish the accuracy of my report, nor its shocking conclusions.

The above-mentioned report is not the first occasion on which I have raised this issue at the highest non-judicial level. An earlier version, raised with the Minister of Health in January 1998, elicited the following response from Dr Zuma: "I wish to advise you that the Medicines Control Council, the Complementary Committee and a cross section of experts representative of the different disciplines and philosophies of complementary medicines and traditional herbal medicines are working hard towards a solution that will be in the interest of all South Africans. I believe that these legal structures and the experts supporting them, are capable of finding solutions that will in time, serve to control all natural health substances in an appropriate manner". Clearly Zuma was deceived. She should have sacked all these pseudo-experts along with the others. Sadly, the replacement MCC and Secretariat personnel have proved to be equally incapable of responsibility.

Our earlier report "PHARMAPACT EXPOSE': MEDICINES CONTROL COUNCIL APARTHEID GENOCIDE AGAINST THE AFRICAN PEOPLE" (Paragraphs 29-56), dated 3 March 1998, was presented to and discussed with the **Dukes Review Task Team**, of which Dr Ian Roberts, Dr Wilbert Bannenberg, Dr Bada Pharasi and Director–General Dr Ayanda, are all senior officials of the Department of Health. Our October 1998 submission, including yet further expanded documentation was presented to Parliament in October 1998, only to be illegally strategically struck from the Parliamentary Record, implicating yet another institution and its officials in this ongoing scandal, destined for the courts.

Regarding your request that I provide the Secretariat of the MCC with information (which is your job, not mine), this is an especially an odd request, given that my 15,000 word report which identified the precise custodians of this information, was not only presented to the Exco of the MCC on 23 July 1999, but was earlier presented in draft form to those present at the Secretariat meeting with the Registrar on 14 June, yourself included. That you should have the gall to subsequently request from me, on behalf of Council, the very information which you and they know is almost exclusively held by Eagles, Mahlaba and yourself, and has been repeatedly denied to my colleague T/Dr Anthony Rees and myself, illustrates the absurdity of your and their appointments to the Secretariat and Council, a sure case of "the foxes in charge of the hen-house".

At said earlier meeting, I specifically drew your attention to the fact that you personally were heavily implicated in said report as an integral part of the problem and that I was extending an opportunity to you to rebut any aspects which you were able to, prior to my publishing the full report, an opportunity which you indicated you would avail yourself of. That you have still not met this challenge is indicative of your being unable to deny the facts.

Sincerely,

Stuart Thomson

Director, Gaia Research Institute.

National Co-ordinator, PHARMAPACT

Professor Peter Folb **By Registered Mail**

Dept of Pharmacology 13 January 2000

University of Cape Town Medical School

Sir

REQUEST FOR ACCESS TO TRAMED DATABASE FOR TOXICS LIST COMPILATION PURPOSES:

FINAL OPPORTUNITY TO REFUTE ALLEGATIONS OF COMPLICITY IN GENOCIDE / ETHNOPIRACY

You are referred to numerous verbal requests and also to several documentational challenges to grant members of this organisation, including my colleague, T/Dr Anthony Rees, past Chairman of the SA Herbalists Association and myself, access to the Tramed database for the purpose of compiling a toxics list.

On all occasions you have ignored the documentary challenges and made petty excuses on direct approach. It is for this reason that I now resort to written request by registered mail. The last verbal excuse was that the toxics aspect of the database has not yet been developed, which to my logic is even more reason to oblige.

As you well know, I have accused Prof Peter Eagles, yourself and others of complicity in genocide and ethnopiracy for the consistent inaction in using your custodianship of the Traditional Medicines database and influence on drug policy and regulation to reduce the appalling number of unnecessary deaths.

I attach for your information, my 15,000 word report, "Medicines Regulatory Authority / Department of Health Traditional African Medicine Genocide and Ethnopiracy Against the African People", which was previously informally sent to you as an e-mail attachment after presentation to the MCC, 23 July 1999.

Besides the challenge for database access, you are now formally challenged to refute, in writing by return registered mail within 30 days, aspects of said report with which you do not agree and are able to counter with explanation and supportive documentation, the remainder being tacit acceptance thereof.

Yours sincerely

Stuart Thomson

Director, Gaia Research Institute

National Co-ordinator, PHARMAPACT

(For an outline of our Traditional African Medicine accommodating Regulatory Proposals, we include the following)

PHARMAPACT PROPOSALS FOR THE REGULATION OF NATURAL HEALTH & THERAPEUTIC SUBSTANCES

(ST/PP-22/7/99)

--MAIN PRINCIPLES—

(For a MS Word version of our detailed Regulatory Schematic, please contact the author)

1) Foods, their nutrients and related constituents are rarely, if ever, truly classifiable as medicines.

2) If these factors positively influence conditions, then their action is food corrective, not medicinal.

3) Dietary supplements and traditional "remedies" interface between foods and medicines.

4) Traditional and complementary "medicines" cross the interface into the paradigm of medicines.

Mandate. Should the consumer self-medicate or become a patient by relinquishing responsibility to the practitioner, he or she becomes vulnerable and in need of protection, which is the mandate of the medicines control authority, subject to risk - benefit analysis. This mandate is **irrespective of culture** .

--INTRODUCTION--

a) First World medicinal regulatory systems are generally inappropriate for South Africa, whose demographics, for all practical purposes, places the country between the First and Third World, with the majority of its health care resources firmly in a Third World classification and highly likely to remain so.

b) Only two categories of medicine represent a significant threat to consumers, namely Orthodox and Traditional African. Potential risks may occasionally arise from Traditional Chinese, Ayurvedic, Western Herbal, and Homoeopathic as well as Nutritional Supplements and Health Foods, in decreasing order.

c) Foods, their nutrients, and related constituents are not medicines and accordingly should not be regulated as such. If these factors positively influence conditions, then their action is food corrective, not medicinal in action. Only non-food remedies to which resistant conditions alone will yield are medicinal.

c) Orthodox medicines are best regulated by the current First World model, which evolved with problems of high toxic potential in mind. Traditional African medicines, least evaluated of all, are best dealt with via accelerated research, concurrent with educational programmes to minimise use of harmful substances.

d) The remaining potential risk categories are best dealt with primarily on the basis of their toxicological potential, secondarily according to claims and indications and thirdly, according to quality criteria. In all instances, complementary medicine criteria cannot legally exceed that for Traditional African medicines.

e) The essential difference between orthodox and complementary medicines are the synthesised and novel and hence possibly toxic nature of the former, without natural correlate and widespread traditional use capable of confidently rendering them reasonably safe, based on existing epidemiological data.

f) Arising from the orthodox model, as far as products evaluated on the basis of Randomised Controlled Trials are concerned, are specific safety and efficacy data. These medicines accordingly will generally be true to manufacturer's established claims for pharmacological effects, side-effects and contraindications.

g) Complementary, (incl traditional) medicines, on the basis of their existing in nature and including the possibility of already being in the public domain, are not patentable and hence are not financially viable to undergo the five to ten year and R3000 million drug development, evaluation and registration process.

h) Complementary medicines accordingly require different evaluation / regulatory criteria. On one hand, whilst they are less likely to be toxic, their efficacy may, on the other hand, not have been definitively proven. The most practical means of regulating these is on the basis of their epidemiological and chemical safety data and indications/claims. Where no significant data exists, its prior generation is mandatory.

i) Complementary and traditional medicines, dietary supplements, health foods and miscellaneous natural health substances are acknowledged as being valuable in contributing to the health of consumers, if subject to reasonable controls in terms of quality, safety and efficacy, appropriate to their classification.

j) Regulations are for the protection and benefit of the consumer but must not unduly restrict public access so as to be in accordance with their constitutional rights to: "security in and control over their body and not to be deprived of freedom arbitrarily, without just cause" and "to receive information and ideas".

k) Regulations affecting mainly service providers, must be in accordance with their constitutional rights "not to be discriminated against on the basis of ethnic origin, conscience, belief or culture", "not to have possessions seized", and "to freedom of expression and of the media, to impart information and ideas".

l) The purpose of these proposals are three-fold: 1) to ensure appropriate food or pharmaceutical GMP Quality Criteria; 2) to ensure appropriate food or medicines Safety Criteria; and 3) to ensure appropriate Information, Promotional Claim Criteria and Efficacy, based on their respective consistent classifications.

Legislative Postscript

SAMMDRA act repealed by high court

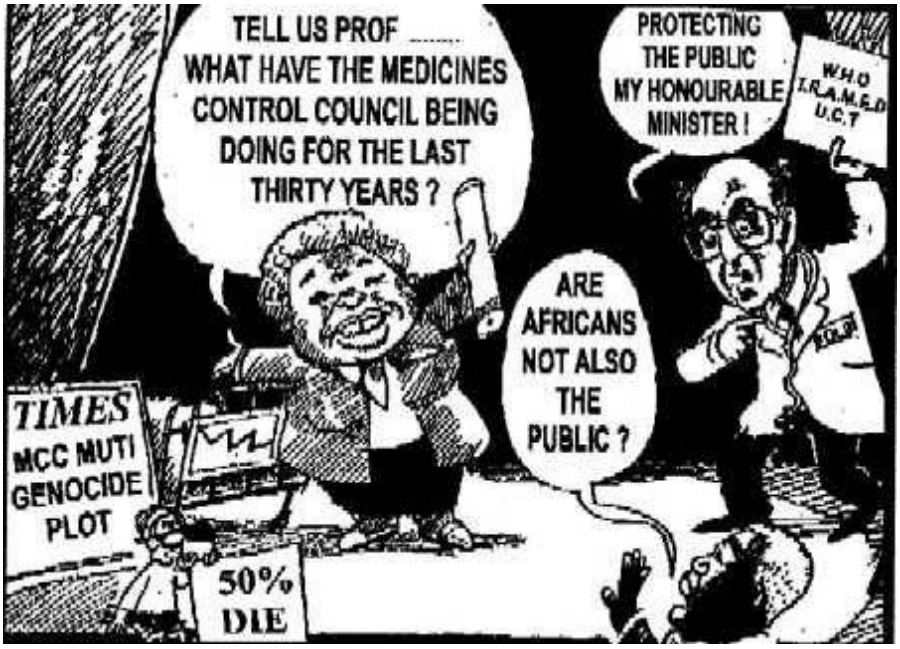
A full bench of the Transvaal High Court yesterday upheld an appeal by the Pharmaceutical Manufacturer's Association (PMA) and declared the SA Medicines and Medical Devices Regulatory Authority Act (SAMMDRA) null and void, reinstating Act 101 of 1965 in its entirety. This brings to an end the absence of an effective regulatory environment for medicine that has prevailed since the premature promulgation of the act on April 30. The court based its judgement on the finding that former president Nelson Mandela had operated outside of the authority given to him by Parliament to promulgate legislation only when that legislation is ready for promulgation. (Source: Citizen, The Star, 23.07.1999)

Loopholes in drug laws tightened

The Constitutional Court ruled that the high court decision should be upheld. There have been indications that the Act would be redrafted in June. Passing judgment on Friday, Justice Chaskalson said this case was important as it dealt with issues related to the role of the courts in controlling public power. "What the Constitution requires is that public power vested in the executive and other functionaries be exercised in an objectively rational manner. This, the president, though through no fault of his own, failed to do. A decision that is objectively irrational is likely to be made only rarely but if this does occur, a court has the power to intervene and set aside the irrational decision." (Source: SAPA, 26.02. 2000)

Another Round of Battle?

God works in mysterious ways. In the light of the above it looks like we may have yet another opportunity to challenge the foregoing in Parliament rather than having to resort directly to the Constitutional Court.



For 18 years Prof Folb chaired the SA Medicines Control Council.

There is evidence that Folb initially concerned himself with some of the toxicological aspects raised in this Report, but sadly it appears that the ethnopiracy aspects of his Tramed and Pharmacology projects took preference over the humanitarian concerns raised here. For a look at the nauseating double -speak, visit his Dept of Pharmacology website and internal links at: <http://www.uct.ac.za/depts/pha/text/index.htm>

THE GAIA RESEARCH INSTITUTE

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Margie Peden
Specialist Scientist
Trauma Research

Medical Research Council

By Electronic Mail
30 March 2000

Dear Margie

SOUTH AFRICAN GOVERNMENT GENOCIDE AND ETHNOPIRACY

Thanks for your e-mail communication. I am pleased to correspond with you on this topic. You wrote:

You message was forwarded to me by Dr Bradshaw for comment. Unfortunately the report did not come with the email. I am interested to know where you get your figures from. I am the project leader of national injury surveillance system. We only see about 60 000 non-natural deaths a year and no ways are one-sixth or one-third of these related to traditional medicines. Is this in essence what you are saying? Where do you get these data from? since I have the database on non-natural deaths in SA. Please could you let me know your source.

I assume that this is the beginning of the government spin control, based on your immediate rejection of my hypothesis without having even read the report. I am however pleased that dialogue is at last opening up, even if it is only a challenge rather than attempt to establish the facts, which clearly no-one yet fully knows. The latest addition of the Report is attached hereto.

The data that I have used is in fact that which Dr Bradshaw provided me with in April last year as "the only information available", primarily: (Bradshaw D, Estimated Cause of Death Profiles, Based on 1990 Data, CERSA, MRC, 1991), based in turn on data supplied by Stats SA; (Bradshaw, Health and Related Indicators, SA Health Review 1997); (Recorded deaths, 1994. CSS Report No. 03-09-01 (1994) Pretoria: Central Statistical Services), The figures used for comparisons are those of the Dept of Health, which as you can see, confirm the figures which I used in the extrapolations.

Whilst you may be tempted to reject my estimates, I am equally at liberty to reject your scanty data. Your figure of 60,000 non-natural deaths furthermore is clearly out-dated, ultra-conservative and has not been adjusted to take into account the extra few million souls discovered in the last census, both factors of which, even if conservatively adjusted, would together leave the figure more in the region of 80,000 -100,000, excluding homicide, violence, accidents and self-afflicted.

[Postscript: There is no data for rural Africans who compromise about half of the total population of the country. It has been estimated that at least 50,000 deaths among black people annually are not registered. (Westcott G et al, Health Statistics, and Bourne D & Dick B, Mortality In South Africa. In Perspectives on the Health System: ed. Gill Westcott & Francis Wilson, SALDRU/SAMST, Raven Press, 1979)]

It is no secret that the national database is incomplete and inadequate for your purpose, eg. "*Data on mortality and morbidity in South Africa are inadequate. The absence of a comprehensive national health information system poses problems for an analysis of mortality*." (White Paper on Population Policy, RSA, March 1998) Based on this fact, it is impossible to refute my estimations without first collecting the critical data needed to perform the analysis necessary to decide either way. Currently however, the considerable circumstantial evidence clearly positively favours my disturbing position.

Dr Bradshaw conceded the dilemma, stating: "*Estimating specific causes of death in South Africa is difficult, the last detailed information being almost a decade old, since the law was changed at that time to exclude the necessity of recording the details of the actual cause of death. The data collection system makes no provision for gathering the type of data needed to determine how many deaths might be attributable to traditional medicines. The overall figures must all be considered to be vast underestimates. There are major problems with the data. Not all deaths in rural areas are registered and many are in the ill-defined category where it was not specified on the certificate*." (Pers comm, Dr D Bradshaw, Centre for Epidemiological Research in Southern Africa, MRC, 6 April 1999)

My simple extrapolation is based on the official figures: 13.71% ill-defined, 4.24% undetermined & 1.61% other external, totalling 19.56%. For ease of calculation I used 20% of 40 million to arrive at a rough estimate of 80,000 deaths from unnatural causes, excluding homicide, violence, accidents and self-afflicted. I would not split hairs over the figure in either direction, since I am not trying to calculate, which is impossible without precise data, which simply does not exist, since it still has to be collected. I am merely estimating the possible magnitude of the problem of traditional African medicine (TAM) mortality and trying to bring a solution to bear on these tragic preventable deaths.

Based on the extensive and convincing other diverse data collated in my report, I wrote as follows:

THE ESTIMATED MORTALITY BURDEN FROM TRADITIONAL AFRICAN MEDICINES

"The crude death rate in South Africa is 8.9 per 1 000 (1995 United Nations estimates, & RSA Stats in Brief, Aug 1996; 9.4/1000 according to DoH), meaning that approximately 400,000 of 40 million South African's die each year. In the RSA 20% of all deaths are of unknown causes, (according to Stats South Africa: 13.71 ill-defined (15.2, DoH), 4.24 undetermined, and 1.61 other external = 19.56%). (Bradshaw D, Estimated Cause of Death Profiles SA, Based on 1990 Data, CERSA, MRC, 1991)"

"Deaths from traditional African medicines "could" constitute a large portion of this 80,000 estimate and it is not unrealistic to assume that traditional medicine poisoning deaths are responsible for at least 10% of the 80,000 annual deaths from unnatural causes, (excluding homicide, violence, accidents and self-inflicted), ie 8,000 traditional medicine mortalities.

I did go on to speculate that *this could be*: *""possibly" doubled to 15,000 and taking into account a percentage of deaths attributed to "natural" causes such as eg cardiac failure, 5000 additional of which may be traditional medicine induced, 20,000 is a fairly conservative "maximum" estimate for the number of annual preventable deaths from traditional medicines."* The "eg" could include any of a number of symptoms and other established "natural" causes of death, categorised separately from the "unnatural causes", and hence I wrote: *"Significantly, the symptoms and causes of death from traditional medicines closely mirror the major causes of death among the black population in South Africa: diarrhoea, fetal distress, renal failure, hepatic failure, respiratory distress and cardiac failure.* The additional 5000 estimate from "natural" causes is likewise conservative, because no-one is significantly, let alone consistently, capable of determining the true causal agent in all cases.

My point is borne out by other scientists, eg locally: "*Amongst black South Africans, the poisoning category is the second in order of importance in the five main causes of death (second only to contagious and parasitic diseases), whereas it is only the third and fourth category amongst the other groups.*" (Van Rensburg H & Mans A, Profiles of Disease and Health Care in South Africa, R&H Academica, 1982) Also, internationally, Prof Pieter Joubert, ex Dept. of Pharmacology & Therapeutics, Medunsa, opinioned: *"Toxicology services, primarily geared towards the management of cases of drug poisoning, are inappropriate to the needs of developing communities"*, (Joubert P & Sebata B, S Afr Med J 1982 Nov 27; 62(23)) and: *"in developing countries (South Africa), besides infectious conditions, acute poisonings with pesticides, paraffin (kerosene) and traditional medicines are the main causes of morbidity, whilst acute poisonings with traditional medicines is the main cause of mortality."* (Joubert P & Mathibe L, Adverse Drug React Acute Poisoning Rev 1989;8(3))

Joubert reported that in South Africa: "*Among whites, medical drug poisonings predominated but among the black developing community, it is traditional medicine poisonings*." (Joubert P, J Toxicol Clin Toxicol 1982 Jul; 19(5)) Whilst researching an earlier report, I assumed that the morbidity and mortality incidence for South Africans using indigenous medicines would be minuscule, but I was stunned to uncover the shocking scientifically recorded and published clinical observation that: *"In South Africa, the major cause of death among black South Africans are traditional medicines*." To reassure the reader that this was not a typographical error, the editor, a Clinical Professor of Medical Toxicology, added in brackets *"(about 50 % of deaths)"*. (Ellenhorn's Medical Toxicity: Diagnosis and Treatment of Human Poisoning, Williams & Wilkins, 2nd Edn. 1997)

The main paper referenced in the above-mentioned textbook is Prof. Joubert's "Poisoning admissions of black South Africans", dealing with acute poisoning admissions to Ga-Rankuwa Hospital, Pretoria, which determined that: "*The major cause of fatal poisoning pattern at Ga-Rankuwa appears to be very similar to that reported from Bloemfontein (and is similar to mortality reported from Zimbabwe). Overall, the major causes of mortality were traditional medicines, responsible for 51.7 % of the deaths. Of the patients who died, 62 % were poisoning by traditional medicines. None were deliberate self-poisoning. The main issues were the extremely high mortality and the prevention of poisoning by traditional medicines merits high priority in the health care of the indigenous population of South Africa. The traditional African medicine mortality is extremely high. If poisoning due to these substances can be eliminated, the overall mortality will decrease by about 50%*". (Joubert P, J Toxicol Clin Toxicol 1990; 28(1)) Joubert was an exceptionally dedicated investigator.

Other scientists have however also observed that; "*The probability of dying from a "non-communicable disease" is higher in sub-Saharan Africa than in other market economies. The paradox of higher non-communicable death rates in the adults of the developing world must be attributable to other major determinants of mortality that are more common in these regions. The estimates that are most uncertain are those for sub-Saharan Africa, particularly for the exact composition of non-communicable and injury mortality. As more regions undergo epidemiological transition, particularly premature death among adults will increasingly become a major public-health concern. Surveillance and research to measure and monitor mortality must anticipate this trend.*" (Murray C, Lopez A, Mortality by cause for 8 regions of the world: Global Burden of Disease Study, Lancet 1997; 349)

Dr M Stewart, Department of Chemical Pathology, SA Institute for Medical Research has stated: "*There is an urgent requirement for development of diagnostic methods in order to reduce the number of cases in which the death certificate refers only to the final pathology and not the causative agent.*" (Stewart M et al, Ther Drug Monit, 1998, Oct, 20(5)) Also: "*Since there are as yet no standard methods for the detection of many herbal remedies or their metabolites, careful analysis is* (should be) *mandatory for the correct identification of the true cause in cases of poisoning.*" (Stewart, M et al, *Forensic Sci Int* 1999 May 17; 101(3)) Further: "*It is suspected that many cases are undiagnosed, especially so in South Africa, where patients may die without reaching hospital and do not often admit to ingestion of a traditional remedy.*" (Steenkamp V, et al, Hum Exp Toxicol 1999 Oct; 18(10))

Stewart recently conducted an analysis of the Johannesburg forensic database over the years **1991-1995**, which interestingly **revealed only 206 cases** in which a traditional remedy was stated to be the cause of death or was found to be present in a case of poisoning with an unknown substance. **(Stewart, M et al, Forensic Sci Int, 1999 May 17; 101(3))** Illustrating just how **incomplete** the **databases** are, is his **recent prior observation: "*70 traditonal African medicine deaths in 8 months at Coronation Hospital, Johannesburg, and this just the few that made it to the hospital alive, only to die there, not to mention those who were/are extremely close to death*." (Dr M Stewart, Personal comm, 31 March, 1999)**

It would appear that Dr Stewart is the only sober humanitarian scientist working in this neglected field, having recently written: "*In South Africa there exists a window of opportunity for a serious examination and publication of the facts concerning the risks of using traditional herbal remedies. In addition, there needs to be a coming together of those interested in the toxic, as opposed to the beneficial aspects of traditional medicines*." (Stewart M et al, Ther Drug Monit, 1998, Oct, 20(5)) Dr Stewart and colleagues have developed a method for the detection of "Impila" constituents in urine. (Steenkamp V, et al, Hum Exp Toxicol 1999 Oct; 18(10)) Dr Stewart, has focused on "Impila" (Callilepsis laureola) ("health" in Zulu), probably the biggest single killer, yet his annual budget for all his analytical work was a mere R50000, with not a cent from the MRC (Pers comm, 31 Mar 99). Perhaps this is why the MRC don't appear to also have him silently muzzled and on a short lead.

A look at Impila will illustrate how easily its toxic effects might be confused with other pathologies: *IMPILA:* Byrant A, Zulu Medicine and Medicine Men, Centaur, 1966 – *"without doubt* ***a virulent poison*****"**; •Seedat Y, Hitchcock P, S Afr Med J Jul 31; 45(30) – **"*acute renal failure*"**; • Wainwright J, et al, S Afr J Med 1977 Aug 13; 52(8) – *"found to cause* ***fatal liver necrosis****, widely used as a herbal medicine*; ***nephrotoxic, hypoglycaemic, hepatoxic*****"**; •Watson A, Coovadia H, Bhoola K, S Afr Med J 1979 Feb 24; 55(8) – *"administration of Impila is common, the practice can and does cause* ***poisoning, hepatic and renal tubular necrosis, hypoglycaemia, alteration of consciousness, hepatic and renal dysfunction*****"**; •Veale D, S Afr Pharm J 1987;(54) – **"***rootstock is* ***toxic and can be fatal if ingested in small quantities,*** the main features: ***confusion, vomiting, diarrhoea, convulsions, hypoglycaemia and liver and kidney failure*****"**; •Savage A, Hutchings A, "Poisoned by herbs". Br Med J 1987; 295 – *"clinical symptoms of Impila intoxication are* ***abdominal pain, jaundice, hypoglycaemia, disturbed hepatic and renal function*****"**; •Dehrmann F et al, J Ethnopharmacol 1991 Sep; 34(2-3) – *"used extensively as a medicament,* ***nephrotoxic*****"**; •Bye S, Dutton M, In: Oliver J, ed. Forensic Toxicology. Scottish Academic Press, 1992 – "***hepatoxic, nephrotoxic, hypoglycaemic*****"**; •Steenkamp V, et al, Hum Exp Toxicol 1999 Oct; 18(10) **–"*Poisoning with impila is a recurring phenomenon in South Africa and since it leads to rapid death from renal and/or hepatic failure, it is suspected that many cases are undiagnosed; patients may die without reaching hospital and do not often admit to ingestion of a traditional remedy*."**

Since there are no approved uses, we have to assess its most popular uses against the above-mentioned risks: a) *"Roots as a cough remedy"* (Watt J & Breyer-Brandwijk M, The Medicinal and Poisonous Plants of Southern and Eastern Africa, 2nd edn. Livingstone, 1962) b) *"Roots as tonics by young girls in the early stages of menstruation."* (Doke C, Vilakazi B, Zulu-English Dictionary, 2nd edn. Witwatersrand Univ Press 1972); c) *"Roots for snakebite and administered as enemas and in baths to protect the children of parents who have already lost many children."* (Valley Trust, Personal comm Hutchings) Even more dangerous is Impila's traditional use during pregnancy and childbirth, likely the biggest killer of all, eg: d) *"Roots are sometimes an ingredient in "inembe", taken regularly during pregnancy to ensure an easy childbirth, and to make an infusion for fertility."* (Gerstner J, Bantu Stud 15 (3) (4), 1941); e) *"They are sometimes included in medicines known as "isihlambezo", which are used by traditional birth attendants to ensure the health of both mother and baby during pregnancy."* (Gumede M, Traditional Healers, Skotaville Publ 1990) Consider the widespread usage of Impila and you ought to grasp the import and urgency of my thesis: *"In Umlazi, one of the largest townships in the Durban area, 30% of a random sample of residents had used the highly toxic medicinal plant impila."* (Wainwright J, et al, S Afr J Med 1977 Aug 13; 52(8)) *"With approximately 50% of the population using Impila in Natal, it is the second most widely used traditional medicine."* (Ellis M. Medicinal Plant Use - A Survey, Veld and Flora 1986 Sept)

So as not to re-write the entire 20,000 word document, I shall close with a few concepts which may help to put the likelihood of a significant mortality figure for traditional African medicine into perspective.

If one looks at the iatrogenic / nosocomial mortalities for the USA, which has the best-computerised data internationally, we see quite clearly that nosocomial adverse drug reaction (ADR) mortalities exceed 100,000 anually. (Lazarou B, et al, Incidence of Adverse drug reactions in hospitalised patients: A meta-analysis of prospective studies. Journal of the American Medical Association, 1998; 279: 1200-5) In South Africa, allopathics are in a 20-40% minority to 60-80% for traditionals.

A simple calculation based on the (1990) US population of 260 million compared to SA's 40 million, reveals a figure of 15,000+, based on a direct extrapolation, which is perfectly within my ballpark figure of 10-20,000. However, the US figures reflect actual captured data, the real figure being estimated to be double that in real terms. (Holland E & Degruy F, American Home Physician, 1997, Nov 1; 56(7): 1781-1788) Either way, locally, 15-30,000 deaths are distributed between the two types and never-mind how one allocates ratios, one type will inevitably gain by the other type's loss. [Postscript: According to a government botanist, there seems to be more poisonings and over-dosings with traditional than with allopathic medicine. (Green E, AIDS and STDs in Africa, Bridging the Gap Between Traditional Healing and Modern Medicine, Univ of Natal Press, 1994)]

The US figures are for advanced First World scientific medical drug related hospital deaths, where the ADR's rank from the 4th to 6th leading cause of death. (Editorial, Bandolier, UK NHS, June 1998: 52-3) (White T, et al, Pharmacoeconomics, 1999 May; 15(5): 445-58) Compare our predominantly Third World facilities which most traditional African medicine patients would not even reach before or after death, and my figure of 10-2000 deaths gain ever-increased credibility. It is highly unlikely that South Africa would somehow escape its averaged extrapolated burden.

The percentage of the abovementioned deaths that are considered avoidable / preventable is either near side of a full 50%. (The above references apply, as do the following) (Johnson J & Bootman J, Archives of Internal Medicine, 1995 Oct; 155(18): 19) (Bates D, et al, Journal of the American Medical Association, 1995 Jul; 247(1): 29-34) (Nelson K & Talbert R, Pharmacotherapy, 1996 Jul; 16(4): 701-707) (Bootman J et al, Archives of Internal Medicine, 1997, Oct; 157(18): 2082-2096)

The South African figure would minimally be 15,000 "preventable" deaths annually from all adverse drug reactions. If the allopathic category accounts for 5,000 (even this percentage will be denied by those responsible)**, then traditional African medicines would have to account for 10,000. The total figure (both preventable and non-preventable) deaths for each category would then accordingly be 10,000 and 20,000 for allopathic and traditional African medicines respectively. I am content to let the authorities argue amongst themselves as to precisely who is responsible for what.**

That's it in a nutshell. I look forward to your information-based response. I do however suspect that you will be under pressure to counter my embarrassing expose' at all costs due to the fact that the **MRC** are so intimately involved in the ethnopiracy and cover-up of the essence of what I have uncovered. I am however hoping that you will surprise me, by honestly appraising the situation in the light of current data (or rather lack of it) and motivating the generation of the data necessary to scientifically quantify the facts and so facilitate the urgent policy setting and implementation of appropriate solutions.

Yours sincerely

Stuart Thomson

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cc Dr D Bradshaw

[Note: As of October 2000, no reply or rebuttal had yet been received in response to the document above.]

CONCLUSION

The issue is not what order of magnitude of a thousand deaths occurs, but what is to be done about them.

1000 - 20,000 annual deaths are 1000 - 20,000 more than from the substances now earmarked for regulation.

Neither Act 101 nor SAMMDRA, when it replaces 101, are going to address the serious issues raised above.

This is obvious, given the recorded inaction despite my efforts to highlight this crisis, far greater than AIDS.

Whilst anually thousands die, millions are rendered unreproductive and suffer untold agonies...genocide.

The author swears not to rest until justice is served on all participants in this heinous crime and its cover-up.

The author appeals to all recipients to use whatever influence / resources you may have to assist this cause.

May God bless you if you find it in your heart to respond constructively to this appeal for humane justice.

This 23,305- word report has been researched,

developed and prepared over the past 3 years by:

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