

PUBLIC POLICY AND HIV/AIDS IN SOUTH AFRICA

An Overview

Tom Lodge and Vuyiseka Dubula

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Introduction

This paper brings together key research findings that help us to understand the role of South African politicians, officials and public administration in efforts to manage and curtail the HIV/AIDS epidemic. After providing basic biomedical information about HIV/AIDS, the paper opens with a section that details the epidemic's history and spread. This is followed by a discussion of its impact. Policy responses and the implementation of policy then both receive detailed consideration. The paper then examines responses to HIV/AIDS outside the public sector and the difficulties that have accompanied efforts to develop partnerships between official agencies and other bodies. Shorter concluding sections of the paper identify successes, failures, and questions that still wait systematic investigation. South African experiences are compared to those of other African countries. A final section on future trends will follow after feedback and commentary.

Basic information

AIDS – Acquired Immunity Deficiency Syndrome – is a condition in which particular cells within the immune system, CD4 lymphocytes, drop in number to below 200 per millilitre of blood, a point at which those who are affected cannot produce an adequate immune response to infectious diseases such as TB or pneumonia. Since the early 1980s, most medical scientists have understood AIDS to be the consequence of infection by the human immunodeficiency virus, HIV, which damages CD4 cells. HIV is transmitted through sexual fluids, blood and breast-feeding. About a third of children born to HIV-positive mothers are infected at birth. The speed with which people who are infected with HIV develop AIDS, and their relative susceptibility thereafter to “opportunistic infections” such as tuberculosis, can be affected by environmental conditions such as poverty. The appearance of the virus is believed to be fairly recent. Other diseases are able to destroy the immune system but not in the same way and not as commonly nor to the same extent as AIDS.

A very small minority of doctors and scientists have contested the significance of HIV as a necessary cause of AIDS or have even denied its existence. An extreme version of this “dissident” argument suggests that AIDS itself represents merely the effects of diseases such as tuberculosis that are primarily the consequence of poverty. More generally, AIDS dissidents dispute the validity of HIV testing, contest the statistics derived from such testing and maintain that the “anti-retroviral drugs” used to defend the immune systems among HIV-positive patients and to prevent transmission from them are highly toxic and can indeed promote the symptoms or illnesses associated with AIDS. These views find no endorsement within mainstream medical science but in certain countries, including South Africa, as we shall see, they have influenced the evolution of public policy.

To date, there is no cure for AIDS. In 1996 anti-retroviral drugs became available that can prevent the replication of the HIV virus though they cannot eliminate it entirely. ARV treatment normally begins when HIV infection is at an advanced stage, when it has brought the CD4 count in blood to below 200 cells per millilitre, or when the patient has contracted one of the “opportunistic infections” to which HIV-positive people are susceptible, shingles, tuberculosis, pneumonia and meningitis are common examples. Normally healthy people have a CD4 count of 1000 or so. At these stages a twice-daily dosage of anti-retroviral drugs will help allow the immune system to reconstitute itself so that CD4 counts rises to stabilise at the level the patient’s immunity at the point they became infected and the patient becomes healthy again. Usually the various ARV drugs are used in a triple combination – this prevents drug resistance developing – this is called Highly Active Antiretroviral therapy or HAART (Abdullah, 2004: 306-208). Once the patient has started an ARV regimen they must remain on it permanently. Initially the drugs can have side effects including sharp headaches and vomiting.

One of the complicating effects of HIV/AIDS is that initial infection does not usually cause any discernible deterioration in health – it can take a decade for the virus to degrade the immunity system to a point at which the person affected becomes seriously ill, and then they will be ill from one of the diseases or conditions to which AIDS makes people susceptible. This gradualness of the progress of the illness’s progresses has influenced both individual and collective responses to it (Phillips, 2004: 41). The presence of the virus is confirmed by a simple blood test: the patient can learn the result within minutes of being tested. CD4 testing is undertaken separately. Testing should be accompanied by counselling, both before and after the test is administered.

History, extent and trends in the spread of the epidemic.

HIV/AIDS was first diagnosed in South Africa in 1982 in the cases of two gay white men, flight attendants who had returned from the United States (Ras, 1983: 64; Dhlomo, 2000: 51). As has been the case elsewhere, initially infection rates expanded quite slowly: the number of known cases of people ill with AIDS in 1990 was 305 (Schurinck, 1990: 1). Early reports suggested a significant level of infection within Johannesburg’s gay community (Sher, 1989: 76). The first reports of HIV-infected heterosexuals were in 1987 and concerned Malawian workers on the goldmines, a development that prompted the then ruling National Party to call for deportations of infected workers (Phillips, 2004, 32-35). Increased migration as South African borders opened up during the 1990-1994 democratic transition probably helped to accelerate infection rates. Especially high rates of prevalence were located near lorry routes leading into Swaziland and Mozambique (Liffe, 2006). By 1991, reports of AIDS transmission among heterosexuals began to exceed the number of cases known amongst South African gay men (Whiteside and Sunter, 2000). Prevalence rose especially quickly in the mid-1990s. Between 1993 and 1994, HIV prevalence among pregnant women attending ante-natal clinics nearly doubled, from 4% to 7.6%. By 2001 HIV prevalence among such women was at 24.8 per cent (Lewis, 2004: 100). By December 2003 according to UNAIDS statistics cited by Fourie, 5.3 million people were HIV-positive and of these 5.1 million were among the economically active age group, between 15 and 49 years old. That year 370,000 people had died of AIDS-related illnesses, making it the first cause of death in South Africa (Fourie, 2006: 1).

The number of deaths caused by AIDS in South Africa has been the subject of political controversy and is also a contested issue because so many AIDS deaths are misclassified

through being attributed to other illnesses either as a consequence of genuine ignorance or because of deliberate under-reporting (Birnbaum et al, 2011: 278-285). Given the median length of the period between the beginning of HIV infection and the time of death (for patients without access to medication) as calculated by UNAIDS, 10,5 years for men and 11,5 years for women, most AIDS-related deaths would have occurred after 2000; by that year it is estimated that the total death toll was 500,000 (Arndt and Lewis, 2000: 1). Precise tallies of the cumulative South African death toll attributable to AIDS are impossible but annual estimates suggest that to date the disease has killed close to 4.5 million people.

Prevalence estimates based upon pregnant women's attendance at ante-natal clinics remain the chief source of data on infection rates. What these figures indicate is that the HIV-infected population has grown from 4 million in 2002 to 5.26 million today, in 2013, and the proportion of HIV infection as a proportion of the whole adult population has risen from 8.7 per cent in 2002 to 10 per cent in 2013 – among the 15-49 age group, 16.6 per cent, a prevalence rate that makes South Africa HIVAIDS epidemic the largest in the world, absolutely and proportionately (Statistics South Africa, 2013: 4). South Africa's HIV-positive population constitutes about 17 per cent of the global total of HIV infections. There are differences about the extent of prevalence reflecting different bases for their calculation or estimation – for example UNAIDS statistics are often different from the statistics used in by Statistics South Africa, usually rather higher. Different methodologies of calculation include extrapolations from reports of HIV infection at ante-natal clinics, survey-based HIV testing among nationally representative samples and analysis of officially recorded mortality causes. Differences do not represent sharp disagreements about the prevalence of the epidemic or trends in its development (for such disagreements see Setswe, 2004: 183-208) though estimates of deaths do vary quite considerably (for further commentary about the statistical variations see Rian Malan, 2009).

Annual estimated totals of deaths attributable to AIDS-related illnesses became lower towards the end of the decade, down to 270,000 in 2011 (UNAIDS, 2012: A27), partly a consequence of the expanded provision of anti-retroviral medication after 2003. Provision of medication also impacted upon life expectancy which in 2006 was estimated at 50, rather longer than earlier estimations in the mid 40's (Dorrington et al, 2006: i). The proportion of HIV-positive patients receiving anti-retroviral treatment increased from 1% to 21% between 2003 and 2008. The impact of such prescriptions was evident in TB case fatalities: these remained constant for TB patients who were not HIV positive but fell sharply amongst those who were (Middlekoop et al, 2011: 263-269). New infections peaked in 1999 at 600,000 and in 2012 were down to around 300,000. Epidemiologists attribute this decline to increased condom usage among vulnerable groups and to the impact of awareness programmes. Incidence rates, that is the percentage of people newly infected during a year as a proportion of the uninfected population at the beginning of the year, began declining in 2006; in 2013 the rate is 0.85% compared to 1.32% in 2005 (Statistics South Africa, 2013: 4). However the proportion of HIV-prevalence among women who attend clinics has stabilised and has now remained level for several years at 29.5 per cent, a reflection of the effect of longer survival of the rising number of patients who can now obtain medication, two million in 2013. In South Africa women are more likely to be infected than men: Statistics South Africa assumes a ratio of female to male prevalence for those aged between 15 and 49 of 1,5. This ratio rises among very young women, aged between 15 and 25: twice as many women as men in this age group are likely to be affected. As long as annual new infections continue at numbers above annual death rates as is still the case the overall HIV-positive population will continue to grow.

Early forecasts suggested very high future death tolls, 10 million deaths by 2015 and life expectancy down to 40 from a pre-epidemic age of 65 (Arndt and Lewis, 2000: 1). Demographic forecasting is an uncertain science, though, especially in settings in which existing population statistics are unreliable (for the methodological complexities of predicting the impact of HIV/AIDS on South African demography see: Anderson and van Zyl, 2004). In 2006, modelling undertaken for the Actuarial Society of South Africa suggested that by 2015 cumulative deaths caused by AIDS would reach 5.35 million with a total population living with HIV of 6 million, 12 per cent of a total population of 50 million. By then annual population growth would have reduced to 0.4 per cent down from 2.7 per cent in 1992. The overall number of HIV-positive people would still be growing but at a decreasing rate (Dorrington, et al, 2006: 22).

In 2011, the prevalence of HIV infection within the 15-to 49 year age group in South Africa at 18.10% was the fourth most severe in Africa, exceeded only by the rates in neighbouring Lesotho (24.30), Botswana (24.60) and Swaziland (27.20). Prevalence in Sub-Saharan Africa as a whole was 4.9 per cent, making it globally the region most affected by HIV/AIDS (UNAIDS, 2012). Why has the scale of the epidemic been so severe in South Africa even when compared to most other African countries? One widely used explanatory model, the Jaipur paradigm, suggests that two key variables determine the likelihood that an HIV epidemic will develop and that it will have a severe social and economic impact. In this scheme wealth inequalities and lack of social cohesion makes societies susceptible and vulnerable to HIV/AIDS (Fourie, 2006: 32). With respect to the Jaipur Paradigm, with its extreme social inequality as well as its politically polarised racial divisions South Africa would be exceptionally vulnerable to the epidemic. Unusually high levels of internal and foreign labour migration into South African urban labour markets help explain risky patterns of sexual behaviour that facilitate the spread of HIV/AIDS as well as its rapid transmission from other parts of the continent: with respect to this consideration South Africa's good transport infrastructure has been a facilitating factor (Natrass, 2004: 26-29). Migrant labour in which men mostly live apart from their families encourages multiple sexual partnerships that proliferate the infection. As we shall see, HIV infection rates are likely to be affected by sexual violence; with 12.5 reported rapes per 10,000 people South Africa has one of the highest incidences of rape in the world (Kaufmann, 2004: 22). Localised cultural variations help to explain differences in HIV prevalence across South Africa. Very high rates of infection in KwaZulu Natal compared to other provinces is attributed to Zulus not practising circumcision, in contrast to Xhosas for example, who are similarly engaged in labour migration (Kaufmann, 2004: 22-23).

A final distinguishing consideration that helps explain the acceleration of the epidemic in South Africa is the way in which during its early stages it was ignored or ineffectually addressed by policy-makers. In the 1980s this was because a white minority government was disinclined to accord priority to dealing with an illness that seemed mainly to affect marginalised groups: gay men and foreign migrants. In the early 1990s policy makers were preoccupied with regime transition. Subsequently, as we shall see, ideological considerations further delayed effective policy responses. Arguably policy neglect and ineffectualness in South Africa may be a result of racial division and the social and political 'boundaries' created by such divisions. Gauri and Lieberman's revealing comparison of Brazilian and South African government responses to AIDS makes it very evident that vigorous or 'aggressive' policy addressing the effort evolved in Brazil much earlier with decisive effect on checking incidence. The explanation for this is that despite comparable racial diversity and correlations between race and power, policies and politics are less racially configured. In South Africa even after apartheid, public disagreement about the disease's nature and its

scope meant there was weak support for effective policy: as late as 2000 for ‘most South Africans , AIDS (was)... not seen as a central policy problem’ (Gauri and Lieberman, 2006: 66).

Impact of the epidemic since its inception.

A national survey based on a representative sample of around 23,000 households and conducted by HSRC fieldworkers in 2008 remains one of the most reliable indicators of the varying impacts HIV/AIDS infections have across South Africa’s population. The survey found 10.9% of the population infected. As noted above, women were more likely than men to be HIV positive, 13.6% of the national population of women as against 7.9% of South African men. Younger women were especially likely to HIV infected – up to the age of 34, much more likely than men. Amongst these women those who had significantly older sexual partners were most at risk of being infected. The vulnerability of women is accentuated by other gendered power inequalities as Gilbert explains (2002: 1093-1110). For example a Medical Research Council sponsored survey found 20 per cent of women in Soweto survey exchanging sex for money or services. Research confirmed that women frightened of violence were unlikely to negotiate safe sex and hence women who were routinely beaten by their husbands were 50 per cent more likely to HIV-positive (Msimang and Ekambaram, 2004: 75-76).

Young adults generally were most at risk, though encouragingly researchers concluded from comparisons from earlier surveys that prevalence in the 15-24 age group had declined significantly since 2005 – from 10.3% to 8/2% - as a result of the doubling of condom usage within this cohort. Africans had the heaviest prevalence rates – 13.6%. Within the other race groups used in South African demography, rates of infection were much lower: 0.3% for whites, 1.7% for coloureds, and 0.3% for Indians. Whites and Indians were significantly less likely to participate in surveys, fieldworkers found, but the authors of the report did not believe that this reluctance distorted findings significantly. Disinclination to participate was partly a consequence of a widespread belief among both whites and Indians that their groups were not vulnerable to HIV/AIDS, a misconception that the authors of the report found alarming (Shisana et al, 2009: 71). South African research is often silent on the issue of variations in HIV prevalence across race groups and in the past estimates have varied widely. An earlier household survey conducted in 2002 suggested that 6% of coloureds and 6% of whites were HIV positive (McCoy et al, 2006: 246).

Geographically, as noted above, prevalence varies across South Africa’s provinces, with infection rates as most severe in KwaZulu and Mpumalanga and lowest in Western and Northern Cape. People inhabiting urban informal settlements or shanty towns were most likely to be HIV positive, the 2002 household survey discovered. HIV-AIDS prevalence rates correlate negatively with rising educational qualifications, more skilled occupations and better pay – in other words better educated, more skilled and better paid workers are relatively less likely to be HIV positive (Nattrass, 2004: 30-31). This may make the South Africa experience distinctive compared to other African countries in which research has suggested that “HIV infection does not disproportionately affect the poorer” (Mishra et al, 2007: 17-28). Migrant workers and their partners are much more likely to contract HIV than non-migrants and their partners, a comparative study between otherwise similar groups of men and their partners whose main homes were in rural KwaZulu discovered; nearly 26% of the migrants in the sample were HIV-positive compared to 12.7 per cent of the non-migrants

(Lurie et al, 2003: 149-156). However proportions of the population groups who have acquired skills and better paid jobs and who are HIV-positive are probably also quite high. For example, estimations of the share of undergraduate students who are HIV-positive deduced from the results of voluntary testing suggest worryingly high proportions – 22 per cent in one such investigation in 2000 (Volks, 2004: 161). The 2002 national survey cited above indicated that 16.3% of public health workers – a relatively well educated occupational category – were HIV-positive (McCoy et al, 2006: 247). Twenty two per cent of South African teachers were HIV-positive in 2006, according to UNAIDS (Pennap et al, 2001: 165). Various efforts in 2000-2001 to model the impact of HIV/AIDS on the South African workforce predicted prevalence rates of 13% among highly skilled workers, 20-22% among skilled workers and between 22.8-32.8% by 2005. Actual reported rates of HIV prevalence in companies that survey their own workforces have tended to be lower than these rates, though still fairly high even in the very skilled or managerial sectors (Booyesen et al, 2003: 12).

In 2002 the investment firm ING Barings undertook a systematic study of HIV/AIDS' likely economic impact. The study suggested that AIDS would accentuate an existing skills shortage, lower labour productivity, increase costs for companies, and through increasing expenditure on health services it would reduce significantly public sector capital investment. However labour shortages would prompt companies to replace unskilled workers with more capital intensive production methods, shrinking formal sector employment in the long term. Overall the pandemic would result in lower growth rates, lower on average by 0.3 to 0.4 percentage points a year and it would discourage foreign investment (Fourie, 2006: 2). Certain forecasts did suggest that despite overall GDP contractions, proportionately larger population losses and increasing productivity attributable to more capitalisation might conceivably lead to rises in per-capita GDP (for example, Bureau of Economic Research, 2000: 16). Detailed studies of actual costs incurred by individual firms as a consequence of the epidemic suggest they can be very high. For example in the case of a KwaZulu Natal Sugar Mill investigated in 2000, the mill would lose from its severely sick employees 27 working days a year due to sick leave and hospital visits. The value of such lost days, together with the costs of hiring replacement workers and medical costs undertaken by the firm would normally amount to three times a year's wages (Morris and Cheevers, 2000). As Nicoli Nattrass has argued, expenditure on anti-retroviral medication would in the long run reduce such costs significantly as infected workers are restored to their normal vigour and of course such provision would curtail the projected consequences of the pandemic as predicted in the ING Barings study. Most of the forecasting of the economic impact of HIV/AIDS was undertaken at a time when the available medication was extremely expensive and hence did not include the possibility of mass prescriptions in their calculations (Nattrass, 2004: 166-167). And many employers remained relatively unconcerned about the costs that would arise from HIV infections among their workers. As Dickenson notes "when the sums were finally calculated, they didn't amount to a compelling bottom line argument" for many company managers (Dickenson, 2010: 70).

Research that details historical macro-economic impacts of the pandemic still remains unusual, though: most investigation of the macro-economic consequences of HIV/AIDS has been directed at modelling future impact. One especially bleak assessment suggested in 2004 that HIV/AIDS had already halved economic growth; this however was based on a growth regression estimate using comparative cross country analysis (Lewis, 2004: 114-115). An ILO report in 2004 concluded that South Africa's annual GDP loss between 1992 and 2002 was 1.3%, about \$7 billion a year (cited by O'Grady, 2004: 40). Estimates of GDP growth loss vary considerably, though: one review identified a range of estimated forecasts between

0.3% and 1.6% (Ford et al, 2002:11). In 2003 a business coalition commissioned a survey of 1006 companies that found that 39 per cent of its respondents believed that HIV/AIDS was already significantly reducing labour productivity – this was especially the case with respect to larger manufacturers. About a third reported reduced profitability because of AIDS and a third were incurring significant extra costs (Bureau of Economic Research, 2004). Despite costs associated with replacing and “shadowing” sick workers, though, only a very small minority of firms were planning to become less labour reliant and more capital intensive, a finding that runs against the prediction in the ING Barings model. However a more systematic study of the impact of HIV/AIDS on the labour market between 2001 and 2007, based on sampling data from Statistics South Africa’s Labour Force Survey finds that the epidemic may well have reduced wages for workers from “high mortality populations”, that is Africans undertaking unskilled labour, both as a consequence of “firms and individuals investing less in productivity leading to falling wages” or as a result of firms passing on part of the cost of ARV treatment through reduced wages. The same study also discerned that employment of Africans without secondary school matriculation was falling as a consequence of firms avoiding hiring from high risk groups (Chicione, 2011).

Research on the micro-economic consequences of HIV/AIDS, at the level of the household, is quite well developed in South Africa. In 2002 a study commissioned by the Henry Kaiser Foundation showed that two-thirds of households with members sick with HIV/AIDS had experienced sharp falls in income, many of these were poor in any case. In these cases a third of household income were directed at medical expenses (O’Grady, 2004: 28). In 2003 a study compared over six months the economic status of 200 HIV/AIDS-affected households in the Free State with 200 of the nearest neighbours to each of the affected households. The study found that on average each affected household had per capita incomes and expenditure over the six months half that of unaffected households. Adult members of affected households were more likely to be unemployed (Bachman and Booyesen, 2003). A follow up study two years later found significant decreases in monthly expenditure in affected households, a clear indication of the progressive impoverishing impact of the illness on households (Bachman and Booyesen, 2004). Similar research conducted in Limpopo province in 2001, this time among more than 600 households with a quarter of them affected by HIV/AIDS, discovered that affected households had an average annual income of around R13,000 compared to unaffected household average income of just over R20,000. In many cases the disparity was a consequence of income earners giving up jobs to undertake care of sick family members. Patterns of expenditure between the two groups of households differed significantly with affected households spending more on transport, medical costs and funerals and half as much on education – the latter a result of withdrawing children from school, also to provide care support. Unaffected households had much higher mean savings, R575 per household, compared to mean savings of R367 in affected households, which, as one might expect, were usually more indebted (Oni et al, 2002). Funeral costs are an especially serious item of expenditure; one research investigation suggested that for poor households affected by HIV/AIDS, funerals can cost around seven times their monthly income and nearly two thirds of such households are unable to insure for the full costs (Collins and Leibrandt, 2007: 75-81). In short, HIV/AIDS, which in South Africa particularly affects poorer people, can make such people considerably poorer still and is likely to have a long term effect on the life chances of children of affected families.

Among the effects of the epidemic on family structure especially frequently explored by researchers is the growing numbers of South African children orphaned by HIV/AIDS deaths. In 1998, the researchers working for the Department of Health reckoned that between 197,000 and 250,000 children were orphaned that year in KwaZulu Natal province.

Estimated projections for the insurance industry suggested that by 2010 2 million children would be orphaned by 2010, half a million in KwaZulu Natal (Michael, 2000: 23). A UNAIDS projection in 2004 calculated that in 2010, the number of AIDS orphans in South Africa would exceed 3 million (O'Grady, 2004: 37). An estimation by the Actuarial Society of South Africa concluded that by 2007 there were 1,201,675 children who had lost their mothers through AIDS (Budlender et al, 2008: 64). Alongside these projections were forecasts that swelling numbers of children would live outside normal homes joining the already sizeable population of delinquent street children growing up outside the structures and institutions that nurture sociable behaviour. Such projections need to be treated cautiously, though (for sceptical commentary on these predictions see Bray, 2003: 39-55). The definitions of orphanhood they use extend the term to any child who has lost a parent - estimates for "double orphans" are much smaller. One study based on national household data found that 85 per cent of "orphans" using the broader definition still lived with the surviving parent (Meintjes and Giese, 2006: 407-422). Researchers encounter a small minority of child headed households that are a consequence of AIDS orphanhood - 0.47% of total households in one study in 2006 - and these do not seem to be increasing (Meintjes et al, 2010). Moreover in South Africa, local cultures often resist the conceptions of orphanhood used by AID agencies. Indeed, Meintjes and Giese, argue, institutionalising special provisions for AIDS orphans risks these children becoming more vulnerable to local stigmatisation. So, the more excitable predictions of AIDS orphans constituting rapidly growing armies of disaffected street children may have been overly alarmist. Even so, AIDS orphans may still be additionally vulnerable compared to other children living in comparably impoverished settings. A Cape Town based on interviews with orphaned children found plenty of evidence of emotional distress as a consequence of the children experiencing multiple moves between households, abuse from purported care-givers and from a sense of "not belonging" (Cluver and Gardner, 2007: 318-325). However an examination of a cohort of children that included AIDS orphans and other children in the same households in a rural KwaZulu Natal community with high infection rates found no significant differences in health, school attendance or other symptoms of well-being between the children except that paternal AIDS orphans tended to be rather behindhand at school (Parikh, 2007: 95-105).

What about the political consequences of the pandemic? Ten years ago Alex de Waal painted an apocalyptic picture in which African governments become progressively destabilised by the epidemic. He suggested that the sudden changes in adult life expectancy resulting from the epidemic would have profound changes on the behaviour of governments and citizens. Diminished life expectancy as well as actual AIDS inflicted mortalities would degrade government skills as echelons of skilled people become invalid or dead. Confronted with uncertainties about the long-term life expectancy of entrant level staff, governments will reduce investment in long term managerial training. In an overall economic setting in which because of HIV/AIDS there is a move towards informal sector economics as companies abandon capital investment, patrimonial politics will proliferate. Unable to afford the increases in health expenditure required to manage the pandemic, governments will experience progressive losses in legitimacy as they confine the provision of healthcare to the politically powerful, relying on increasingly badly disciplined police and soldiers to maintain public order against millenarian protest movements (de Waal, 2003). A South African focused study undertaken in 2000 suggested that as the next generation of political and economic leaders were eroded by the illness democracy would weaken. The government's tax base would shrink and ballooning health expenditure would cut into other areas of government "delivery". Meanwhile civic life would be eviscerated through the decimation of

activists and their increasing pre-occupation with private concerns (Willan, 2000; see also Manning, 2002).

It is true that in South Africa an increased share of public resources are being directed at public health: UNDP figures, for instance indicate that as a proportion of GDP, South African public healthcare rose from 3.4% in 2000 to 3.9% in 2010. Within overall health expenditure the proportion directed at providing treatment and care for people affected by HIV/AIDS has been rising, especially after the expansion of ARV prescriptions in 2005. This falls well short, though, of the doubling of health care expenditure predicted by in certain forecasts premised upon assumptions about the rising cost of hospitalisation of AIDS patients (Lewis, 2004: 113). It is also true that AIDS-related expenditure is not confined to health budgets. For instance, accelerating public spending on social welfare is partly a consequence of rising numbers of AIDS patients receiving disability grants (Booyesen, 2004). Whether these developments represent partial confirmations of the political destabilisation trajectory outlined above is questionable, though. Taken by themselves they may be signalling improvements in state capacity. This would not be an unprecedented outcome. Research in wealthy and developed countries has shown how the challenge of the epidemic has prompted institutional reinvigoration: the revival of public health law in the United States is a case in point (Burriss and Gostin, 2003: 96-117). The long term effect on political life of the HIV/AIDS pandemic in South Africa remains comparatively under-researched. The next sections of this paper will first review public policy and other political responses to AIDS as well as considering the implementation of policy before attempting an overall assessment of the political impact of HIV/AIDS in South Africa.

Public policy responses.

To date, Pieter Fourie's study is the most detailed history of the formation of national policies addressing the HIV/AIDS pandemic (Fourie, 2006). His analysis suggests that this history falls into phases or periods that coincide with the duration of different administrations. The outline below draws substantially on Fourie's chronology.

Under National Party governments up to 1990, South African policy actors, as Fourie observes, "had very little incentive to mobilise public resources" to address HIV/AIDS vigorously (Fourie, 2006: 52). South Africa's lack of social cohesion supplied a moral environment in which infected people were easily stigmatised as deviants themselves to blame for their infection. Early government approaches to the illness were especially shaped by perceptions that HIV/AIDS especially affected gay white men. White politicians were disinclined to discuss sexual behaviour in public forums let alone conduct mass education on safe sex, a reluctance that matched attitudes among "traditional" African notables. In any case, very high levels of violent political conflict through most of the decade ensured that there were more pressing policy concerns. Hence official measures that addressed the illness were influenced by a "narrowly medical" understanding of it as a "clinical entity, delinked from the rest of Apartheid society" (Fourie, 2006: 68). Taking their cue from government, medical bodies also tended to address virological rather than social issues, as was evident from the initial preoccupations of the Medical Research Council's AIDS Virus Research Unit. What limited public education was undertaken supplied basic facts about transmission without any effort to address the cultural beliefs that shape sexual behaviour.

The most assertive political actions taken to counter the spread of AIDS were restrictive and coercive. In 1983 HIV-positive people were prohibited from donating blood. Legislation in

1987 accorded powers to medical officers to test people they suspected of being infected and to test any foreigners, an approach that took its cues from the Chamber of Mines that had the previous year begun enforcing testing and rejecting of HIV-positive foreign migrant workers before recruitment. The Chamber, though, joined forces with trade unions in opposing the government's call to repatriate HIV positive workers already in employment (Campbell and Williams, 1999: 1629). Though initially proposed in 1987, government refrained from making HIV/AIDS a notifiable disease and the first efforts to investigate prevalence through testing at ante-natal clinics began only in 1990. The first modelling of AIDS' likely future impact began in 1989, sponsored by an insurance company. Trade union opposition as well as litigation against the discriminatory legislation and exclusionary responses by employers and the medical insurance industry mounted towards the close of the decade and in 1991, the laws allowing repatriation and enforcing testing were repealed. In 1990 a network of AIDS Training, Information and Counselling Centres was established in white local authorities. Van der Vliet, though, believes that these and other officials educational efforts were usually dismissed by black South Africans as apartheid propaganda exercises (Van der Vliet, 2004: 49). By this stage civil society agitation had organisational expression in an AIDS Consortium that adopted a Charter of Rights for HIV/AIDS patients.

Fourie represents the 1991-1994 period, a time when most South African politicians were engaged in the political dynamics of negotiating a new political order, as a phase during which AIDS policy making became democratised. A general political setting in which government was divided and distracted allowed room for "policy entrepreneurs" that included human rights activists, trade unionists, ANC leaders, members of the medical establishment and even enlightened officials to begin developing a comprehensive strategy. A major conference in 1992 established a National AIDS Coordinating Committee of South Africa (NACOSA). Assisted by the inception of national surveys of prevalence at ante-natal clinics that began in 1992, the preliminary work for drafting a National AIDS Plan could begin. A draft of this Plan was ready at the time of the elections in April 1994 and a version was accepted as government policy in October.

So, at the inception of Nelson Mandela's government, the administration already had a well developed and widely supported national policy for addressing HIV/AIDS, a policy that was "normatively underpinned" by human rights precepts and which contrasted sharply with earlier more restricted and punitive approaches. Indeed, as Fourie notes rather sardonically, "a more politically correct and seemingly socially appropriate policy could hardly be imagined" (Fourie, 2006: 109). The National AIDS Plan acknowledged the expansion of the epidemic as a unique crisis that required the coordinated mobilisation of resources across government rather than being simply a health issue that should be addressed by specialised bodies. Government approaches should focus on preventative public education that should address both sexual behaviour and the stigmatisation of HIV positive patients. Meanwhile patients should have all possible access to treatment and care and every other kind of support.

Good policy was no guarantee of effective action, though; as we know in the first few years of Nelson Mandela's government, HIV infection rates accelerated. In fact despite the adoption of efforts to counter the epidemic as a "lead programme" in the new government's Reconstruction and Development plan, Mandela himself paid the issue perfunctory attention. The NAP committed the government to engage communities in the direction and implementation of the plan, but the location and confinement of its management in the Ministry of Health coupled with the new Minister, Nkosazana Zuma's disinclination to consult, helped this not to happen. Making HIV/AIDS primarily a concern of medical professionals rather than of all government, as Fourie notes, was a serious mistake. This

bureaucratic assignment of responsibility for the plan's implementation to one department undermined one of its key intentions, "to change the conception of HIV/AIDS as being a public health issue and establish it as a broader developmental and human rights concern" (Fourie, 2006: 118). At the same time, the NGO sector was losing experienced activists to government and parliament which also helped to weaken public pressure for effective implementation. The new officials now in command positions disdained existing expertise – they ignored, for example, the AIDS Training and Information Centres, bodies that were set up by the authorities mainly in white areas to train public educators during the 1980s.

In 1996, the government's embrace of its monetarist Growth, Employment and Redistribution (GEAR) blueprint meant in practice a reallocation of priorities in which countering AIDS lost its status as a "lead" project. As Schneider and Stein suggests, this was a period when "good policy (was) obstructed by 'quick fix' interference by senior politicians" (Schneider and Stein, 2001: 723). A series of scandals helped to discredit government actions, including the Ministry's sponsorship in 1997 of a bogus pharmaceutical cure for AIDS, Virodene, concocted from dry cleaning solvent and its illicit use of R14 million European Union funding for a poorly conceived musical entertainment, "Sarafina", intended as a vehicle for public education. Confronted with criticisms of her unwillingness to seek advice after the outcry that followed the commissioning of Sarafina. Minister Zuma was quite unrepentant: "The Department could not be expected to consult every NGO", she said, "AIDS doesn't consult, it infects people" (Johnson, 2004: 122). In its promotion of Virodene, the Ministry by-passed the Medical Research Council, the body that normally registers drugs for prescription. This was the first of a series of acrimonious conflicts between ANC cabinets and medical professionals.

A more constructive pharmaceutical initiative, the Medicines and Related Substance Control Amendment Act of 1997 provided for the importation of cheap generic versions of anti-retroviral medication but in 1998 the government ruled out the generalised prescription of such drugs to prevent mother to child transmission. Even with the new availability on cheap Indian and Brazilian imports, the costs would be prohibitive, officials argued. Arguments about cost reached their nadir with the proposition, voiced by a presidential spokesman in 2000, that treating very sick pregnant mothers with ARVS to prevent transmission would result in a new group that the state would need to care for: "That mother is going to die and that HIV-negative child will be an orphan. That child must be brought up. Who is going to bring the child up? It's the state, the state. That's resources, you see" (Johnson, 2004: 124). In fact in 1998, a new Child Support Grant was introduced that replaced an old racially discriminatory Apartheid era provision that would provide R100 a month for children in families affected by loss of livelihoods; this resource has become widely available to AIDS orphans as a consequence of civil society efforts to help poor households access such grants (Budlender et al, 2008: 64).

In 1997, the government disbanded the increasingly critical AIDS Advisory Group, the body it has established in 1994 to guide Plan implementation (Johnson, 2004: 121). In response to this decision a new activist organisation, the Treatment Action Campaign, established itself at the end of 1998. Confronted with increasing criticism about the argument on costs, Departmental officials began instead expressing concerns about the "toxic" side effects of Azidothymide (AZT), the anti-retroviral drug than used to stop mother to child transmission. In April 1999, the government gazetted plans for making AIDS a notifiable illness, a reversal of a key aspect of the NAP which stressed patient rights to confidentiality; according to the Department of Health's Director-General, opposition to notifiability stemmed from a Western "gay-centric" culture. Two years later, in 2001, the decision was reversed with officials

citing concerns about the risk of stigma and administrative incapacity to enforce notifiability, but the 1999 announcement underlined the gulf that now existed between government and civil society on HIV/AIDS policy formation. By the end of the Mandela administration, in countering HIV/AIDS, top political leadership was firmly committed to prioritising prevention over treatment, entrenching a policy predisposition to view the two ways of addressing the epidemic as antithetical rather than complementary.

As with Mandela's government, Mbeki's administration would begin its HIV/AIDS focused undertakings with a reasonable articulation of policy. A five-year "Strategic Plan" was announced in January 2000. Essentially a restatement of the principles contained in the earlier NAP, this Plan also committed the government to address the epidemic in a "holistic" manner, so that every department would have dedicated HIV/AIDS personnel, operations and resources to support them. A new body would be set up, the South African National AIDS Council, and various committees would be constituted to regularly assemble departmental heads and relevant officials from provincial administrations. The Strategic Plan itself did not include any detailed provision for ARC treatment, though. A National Integrated Plan that was drawn up for provincial governments in December 1999 concerned itself mainly with the building of a Life Skills educational programme in schools, mass distribution of free condoms, as well as support for voluntary counselling and testing and community and home-based care and support activity. The AIDS Council was in fact set up but those of its members that were supposed to be drawn from civil society excluded the key concerned groups as well as the scientific establishment and it would take no independent initiatives: essentially it was a body managed by the Department of Health to rubber stamp official decisions. In their first year, the budgets allocated to provincial governments for expenditure on HIV/AIDS related expenditure remained largely unspent. But whatever the merits of official emphasis on preventative public education its effects were in any case countered by President Mbeki's own challenges to the presumptions that underlay public policy. In effect, during Mbeki's presidency, government would be "opposing its own policy" and hence policy making became fractured and pluralist (Fourie, 2006: 171). For at this juncture the main barriers that prevented policymakers addressing AIDS effectively were once again located in the "problem identification" phase in the policy making cycle.

Shortly after the publication of the government's strategic plan, Thabo Mbeki's office announced the formation of a Presidential AIDS Panel. As Mbeki explained in his invitation to a leading "dissident scientist", David Rasnick, to join this body, the Panel would review the "hypothesis" that HIV caused AIDS. From this date on for the next few years, official pronouncements on AIDS' causes would refer to the causal link between AIDS and HIV as a "thesis". President Mbeki began publicly expressing doubts about the scientific status of the disease in late 1999 and in particular questioned the generally accepted link between HIV and AIDS. He believed that conventional scientific explanations about the disease's causes stemmed from racial prejudice. In 2001, Mbeki publically referred to the "insulting" theory that AIDS originated in Africa. In reality, Mbeki contended, South Africans who were dying of the illnesses that immune deficiency exposed them to (tuberculosis for example) were not victims of a virus; they were instead the casualties of poverty. In any case, the calculations projected by epidemiologists on AIDS' incidence were "hysterical". The President's Panel reported in April 2001. It was itself a deeply divided body and its report included two parallel sets of findings reflecting the views of both dissident and more conventional science. One suggestion from the dissidents was that blood donations should no longer be screened for HIV, a proposal that fortunately the Minister of Health dismissed.

Doubt about AIDS origins was not new within the ANC. In 1988, the ANC's exile journal, *Sechaba*, published two articles on HIV/AIDS, both by Jabulani Nxumalo, writing under the pen name "Mzala". Nxumalo drew upon East German scientific authorities to suggest that the AIDS virus was imported into Africa through an American military conspiracy. Moreover the notion that the disease originated in the continent was the expression of racist prejudice. The East German sources Nxumalo cited claimed that HIV/AIDS' prevalence was exaggerated by western drugs companies and that the vast majority of HIV testing resulted in false positives. Mbeki's doubts about the causes or even existence of HIV/AIDS were not unprecedented and ANC activists may well have been very receptive to his views. And predispositions to believe Mbeki may well have extended beyond his partisan followers. When visiting Mpondoland villages in 2005 Jonny Steinberg encountered widespread beliefs about AIDS having been maliciously introduced into Africa (Steinberg, 2008: 146-148). NGO activists quickly discovered that the president's views had profound effects on public behaviour. As Nxululeko Nxesi, director of the National Association of people Living With HIV and AIDs noted in 2000, his organisation encountered rejection of the message that HIV caused AIDS "on a daily basis" and that "it (was) affecting what we are doing" with respect to the advocacy of safe sex (Altenroxel, 2000).

The president's scepticism about AIDS certainly undermined official attempts to combat the pandemic through treatment. Between 1998 and 2001, public hospitals were prevented from using antiretroviral drugs, including Nevirapine, a much cheaper alternative to AZT, even for treating rape victims. In fact, several provinces, including two rebel ANC administrations in the Eastern Cape and Gauteng, resumed using Nevirapine quite widely during 2001 but elsewhere provincial health ministers loyally maintained the ban for several years more, firing doctors who questioned such policy. For example the provincial Executive Member for Health in Mpumalanga, Sibongile Manana, charged that black women were being used as guinea pigs to test anti-retrovirals, and, moreover, she added as an aside, HIV/AIDS had nothing to do with AIDS. Fortified by support from the national Minister, Manana then proceeded to evict from its official premises the Greater Nelspruit Rape Intervention project, a body that prescribed Nevirapine to rape victims (Jeter, 2001). Taking their cue from the president, cabinet ministers including Health Minister Manto Tshabala-Msimang, began questioning AIDS statistics and projections, suggesting these were derived from faulty sampling procedures. HIV was best treated with nutritional supplements, Msimang insisted, garlic and lemon juice were especially efficacious in building up immunity, she advised. When Nelson Mandela expressed his disquiet at an ANC National Executive meeting over the government's refusal to support the prescription of Nevirapine he was shouted down by a derisive majority of those present (Gumede, 2008: 209). After the Treatment Action Campaign successfully obtained a Supreme Court judgment on 14 December 2001 compelling the government to use Nevirapine in hospitals, government nominees on the Medical Control Council began warning that the drug might need to be deregistered on grounds of toxicity. The TAC, Mbeki insisted to the ANC's parliamentary caucus, was an agent of multinational pharmaceutical companies, it was from these that it derived its funding. The government decided to appeal against the judgment in the Constitutional Court.

The human costs of the government's refusal to prescribe anti-retrovirals have been calculated. One such exercise is based on the assumption that a programme that began in 2000 would succeed in treating 5 per cent of those in need of the therapy in its first year and would have good prospects of expanding its scope so that by 2005 it might reach half the HIV-positive population by then in need of ARVs. Such a progression is comparable to experience of Botswana and Namibia. Such a rate of prescription would have prevented 330,000 deaths and the infection through mother to child transmission of 35,000 babies

(Chigwedere et al, 2008: 412). As well as aggravating the death rates attributable to HIV/AIDS through refusal to medicate the serious ill, another serious consequence of government support for “dissident” positions was the absence of any serious planning to cope with the longer term consequences of the pandemic. At the very least, it would have been reasonable to expect from government a comprehensive overhaul of social security and medical insurance. Although in August 2002, after the Constitutional Court judgment on 5th July 2002 dismissed the Minister’s appeal, and in response to internal pressures within the ANC, the Cabinet appeared to commit itself to provision of antiretroviral treatment by adopting an HIV/AIDS Care, Management and Treatment Plan (Johnson, 2004: 108), through the health ministry’s resistance to treatment continued. The Treatment Action Campaign in conjunction with trade unions organized a civil disobedience campaign during 2003 to protest against the delay. Meanwhile COSATU brought a plan for anti-retroviral provision for pregnant women to the official corporate bargaining forum, NEDLAC, but government negotiators refused to accede to it. It would take a second Constitutional Court judgement in November 2004 before any official policy change on treatment but really full-hearted compliance with the Court’s decision only began after the ANC’s leadership change in 2008. Despite ostensible policy change in 2003 Minister Manto Tshabalala-Msimang continued to insist that most public expenditure should be directed at prevention not treatment (Nattrass, 2004: 57). By 2009, with a new health minister in charge, 850,000 patients were receiving medication, still well short of what was needed but a substantial advance all the same, when compared to the 14,000 on publically dispensed prescriptions in June 2004. In October that year, the government committed increased funding to drug purchases. Now the major challenges were administrative rather than political: by itself the health system simply could not manage the scale of the treatment required. But with President Jacob Zuma himself publically undergoing an AIDs test, leadership’s support for an effective programme to counter the pandemic was no longer in doubt.

One key consequence of the Mbeki government’s “obfuscation of the policy problem” (Fourie, 2006: 165) in questioning AIDS’ causes is that effective policy increasingly had to be engendered and shaped through civil society mobilisation and litigation. Indeed, the unintended effect of Mbeki’s resistance to treating AIDS effectively was the mobilisation of a social movement which in the long term would prove to be an important source of support in extending the embrace of the government’s own treatment and patient support programmes. This movement, in Fourie’s words, helped counter the government’s own inclination to “monopolise implementation” of any efforts to counter HIV/AIDS in favour of more “bottom up” or participatory policy delivery (Fourie, 2006: 179). Another effect was that during the Mbeki presidency policy both academic analysis and media commentaries remained largely focused on whether or not biomedical treatment should be provided: much less analytical attention was directed at the detail of implementing treatment and prevention undertakings.

Of the two major book-length studies of South African HIV/AIDS policy, Pieter Fourie’s volume, is developed within a framework of academic policy analysis. His contentions are that for more than two decades, South African policy making became stalled at the “problem identification” stage and this opened up room for actors outside government to exercise decisive weight in the fight against aids, a situation in which key developments have even sometimes “bypassed” government. His book closes on a note of qualified optimism; by 2003, he suggests the essential constituents of a corporatist approach to AIDS were present, evident in the thrashing out of a treatment strategy at NEDLAC by government, business, labour and civil society (Fourie, 2006: 173-182).

The other important book about South African policy, Nicoli Nattrass's *Moral Economy*, takes as its key question whether the authorities should supply universal medication to all who are affected by HIV/AIDS. Anti-retroviral treatment she notes has an important preventative dimension for it makes HIV-positive people less infectious and greater numbers are likely to undergo testing and counselling, the corollaries of ART administration if the medication is freely available as an inducement. Much of Nattrass's argument is directed at a demolition of the government's case that universal ART coverage was unaffordable, still quite an influential view in 2004, the date of her book's publication. Her evidence that a full treatment programme would in fact be cost effective begins by identifying inefficiencies and wastage in the current budgetary management including the failure to roll over unspent designated funding. With respect to supplying medicine to pregnant mothers she points out that ante-natal clinical provision in South Africa is very high comparatively. Most women use such centres and they embody infrastructure that could be used for an effective programme to stop mother to child transmission. This in itself would save around 350,000 children from infection by 2015. If ART coverage could be expanded to other groups, the reduction in numbers of very sick people would of course result in savings on hospital care and other kinds of support, savings that represent evidence that challenges official arguments about the relative cheapness of prevention as opposed to treatment. Other savings would include less take-up of disability grants, though here Nattrass concedes that the possibility of accessing such grants may serve as an incentive for people to remain sick – grants are available only to patients with very low levels of immunity. Conversely, though, providing treatment might incentivise disclosure and lessen the social stigma directed at infected people, Nattrass suggests. Moreover, expanding coverage would not necessarily require an enormous expansion of health facilities to administer a complex drugs regime, an argument then used by government to justify the limitation of ART prescription.

The possibilities of expanding treatment coverage in poorly resourced communities were first explored in a pioneering programme launched in 2001 in Khayelitsha, a township outside Cape Town, by a partnership between the provincial health authorities, then under an administration led by the Democratic Alliance, not the ANC, and Medicins Sans Frontieres (MSF). The lessons from this experience were then applied by MSF in the more challenging environment of the district around Lusikisiki in the Transkei between 2003 and 2006. The main features of these ventures, those that made them pioneering, were the assignment of prescription responsibility to community nurses and the recruitment of a network of lay counsellors from local residents to provide preparation and psycho-social support and peer pressure for patients taking the medicine. In the case of the Lusikisiki project would-be recipients of the medicine would actually be chosen by the community network (Beresford, 2004b: 279) and they would then undergo several weeks of preparation, including the renunciation of alcohol and tobacco. Community based support was the key factor in maintaining adherence after the inception of medication (Abdullah, 2004: 262), something that even the government began to recognise in 2003 when it started paying lay counsellors who supplied such support to patients a monthly "allowance" of R500. With this kind of support the Lusikisiki clinic based programme had vastly superior rates of keeping patients in treatment to the ARV dispensation managed through the local hospital (Steinberg, 2008: 266; Ford et al, 2006: 17). Moreover, evaluators of the Lusikisiki programme reckoned that by 2005 it was prescribing ARV's to 95 per cent of those in need of treatment (Ford et al, 2006: 18).

Though, not without problems what these programmes confirmed was that impressive rates of disciplined long term maintenance of treatment regime was possible in very poor communities that had only the most basic public health facilities. At the beginning of 2007

prompted by the evidence accumulating from these efforts government rescinded its rule that only doctors could prescribe ARV treatment. This was a rule that provincial health departments in the Western and Eastern Cape had set aside when they sanctioned the MSF programmes but which was generally observed elsewhere, but from 2007, in theory at least, nurses working in primary health care clinics could dispense ARV drugs. Up until then, though, bottle necks in the testing and dispensing procedure because of excessive demands imposed upon hospitals was a major reason for the slow pace of expanded prescription of ARVs even in hospitals in the main centres (Ford et al, 2006: 19; Beresford, 2004a: 270-273). The larger tertiary hospitals were in fact especially likely to be stressed by the demands imposed by ARV prescription given the erosion of their facilities and resources in ten years after 2004, a consequence of reallocations in favour of primary health care by successive ANC administrations as well as their functioning as hospices for terminally ill AIDS patients (Benatar, 2004: 81-92).

The emphasis in the analytical studies that address government policies has been on treatment. South African state sponsored efforts to prevent and restrict HIV infections through trying to modify sexual behaviour have received less attention. There has been a proliferation of such programmes and many of them have been conducted independently of national initiatives. Provincial and local governments have often supplied public funding to civil society initiatives (Campbell, 2003: 159). Evaluations of public education programmes that have been undertaken suggest that preventative public education undertakings have enjoyed a fair measure of success. As suggested in the previous section of this paper, since 2006 they probably have helped to slow down HIV incidence rates.

Of the national and exchequer-funded prevention initiatives, LoveLife has been the most conspicuous and ambitious. Lovelife was launched September 1999. Its long term purpose was to change sexual behaviour and the beliefs prompting such behaviour among teenagers, and through this by 2005 to halve new infection rates among young people. It would seek to achieve these aims through a “brand-driven” campaign. This would begin with Media programmes including bill boards, TV and radio and printed publicity. Thus material would supply information and promote discussion around issues such as condom usage, multiple partners and gender norms. Advertising would be followed up by interactive educational programmes undertaken by community based peer educators, the so-called groundBREAKERS. LoveLife would elicit participation through its Y-Centres (Youth Centres), franchises (youth-serving community organisations affiliated to loveLife) and National Adolescent-Friendly Clinic Initiative (NAFCI) clinics. These bodies would draw young people into “positive” recreational activities and, in the case of the clinics, provide friendly and accessible sexual health support. Theta Junction, a telephone counselling centre and a TV series supplied additional channels for communicating loveLife messages. One aim would be to foster more relaxed communication about sex and sexuality; this, programme leaders believed to be an essential precondition for any behavioural change. By 2004 there were over 235 NAFCI clinics, 16 Y Centres, 532 schools implementing loveLife programmes, 908 groundBREAKERS, and 153,543 young people had actively participated in loveLife programmes nationally.

Early investigations indicated that loveLife may well have engendered behavioural changes within its targeted community. Market research commissioned by the programme in 2001 suggested favourable reception of messages though focus groups indicated poor recall of content and the unintended projection of misleading messages, for example that HIV was only a black people’s disease. A survey undertaken for the organisation in 2001 did indicate that as result of exposure to programmer young people were more likely to speak to parents

about sex and AIDS. This survey also showed that exposure had promoted changes in sexual behaviour – in particular among girls who had become, they claimed in interviews assertive about condom usage and reductions in numbers of sexual partners. The candid and liberal approach of loveLife to sexual issues was evidently popular and was not perceived as encouraging sexual experimentation, one of the early criticisms directed at its publicity. The clinics and the centres were well used within the communities in which they were located (Stadler and Longwa, 2002: 373).

A more stringent independent evaluation of loveLife was undertaken in 2003. Pettifor et al's research surveyed youngsters living near loveLife centres (Y-Centres and NAFCI clinics) and, as a control, a group living in districts with only standard public sector clinics (Pettifor et al, 2007: 172). A survey showed that 85% of youth interviewed reported awareness of loveLife – including 65% in farming areas. More than a third of the respondents reported participation in programmes. Youth who had participated in two or more programmes were significantly less likely to be HIV positive and more likely to use condoms safely than those who had not (Pettifor, et al, 2007: 73). A more critical view of loveLife, though, focuses not so much on its outcomes but rather on the biases in its content. Here the argument is that upbeat and encouragingly “positive” treatments of sexuality tend to downplay and obscure the risks associated with behaviour that spreads infection: sexual violence and transactional sex, for instance (Thomas, 2004).

Schools-based programmes with similar aims have been a second emphasis in national government preventive measures against HIV/AIDS. The Lifeskills programme was instituted by the Departments of Health and Education in 1998. By 2004 840 master trainers had trained 13,609 teachers. Researchers conducted follow-up interviews with learners, though in schools affected, showed that the programme had succeeded in making them more aware of HIV/AIDS but that it did not impact positively on condom usage – teachers tended to concentrate on biomedical facts about HIV and “did not address the group norms and meaning that maintain high risk behaviour”. For example girls remained unsure about their rights and whether they could say no to unwanted sex. In most schools no time was allocated specifically for the programme and the trained teachers did not undertake training of other teachers. Guidance periods were used but generally principals and teachers did not regard HIV/AIDS as a priority. In any case Lifeskills tended to be taught didactically as a body of academic knowledge rather than discursively in a fashion that could engage student emotions (Visser, Schoeman and Perold, 2004: 273-276). Diffidence amongst teachers and the tendency for the conventional academic syllabus to crowd out schools-based HIV education has been a general difficulty. A survey of five school-based programmes organised encountered “serious implementation problems” in four of them, mainly to do with scheduling as well as teacher reluctance or teacher inability to employ participatory learning problems (Harrison, et al, 2010: 10). Further criticisms of Lifeskills suggest that it failed to “access learners who needed it most” and that trained teachers were often confronted with “the silence and stigma around the disease that pervades schools, teachers and students” (Hickey, 2002: 46). The criticism that South African HIV-AIDS education is often too narrowly focused on medical facts and fails to address directly the cultural beliefs that prompt risky sexual behaviour is a quite widely generalised observation, not just of class-room based programmes. Another general criticism is the absence of programmes that specifically target older people, especially men over the age of 40 as well as the failure to incorporate whites (Van Zyl, 2012: 3-5).

The tendency for programme organisers and instigators to “cling to bio-medical understandings of disease and disease prevention” (Campbell, 2003: 188) rather than

acknowledging and working through local beliefs systems that shape sexual behaviour and communal understandings of HIV/AIDS may be one consequence of the distancing effects of social incohesion. In this sort of argument, as Gauri and Liebermann argue, South Africa's racially constituted economic inequalities not only determine the social location of the epidemic but also shape government responses to it, helping to ensure that policymakers and policy actors address the epidemic as a problem that affects "them" rather than "us". Historic inequalities helped to constrain black leaders from taking the biomedical evidence about the epidemic seriously and historic social divisions restricted social empathy and the kind of cultural awareness that is needed if beliefs systems are going to be addressed in educational programmes (Gauri and Lieberman, 2006: 64-65). Anthony Butler has also suggested that South Africa's political history has helped to create a particularly fertile climate for AIDS denialism. He contrasts conventional bio-medical HIV/AIDS epidemiology with what he calls the "nationalist/ameliorative" paradigm favoured by Thabo Mbeki and other ANC leaders that questioned HIV as the main cause of immune deficiency and which focused its prescriptions on poverty alleviation, palliative care and nutrition. These kinds of measures had especial appeal in a setting in which the health care system was leaching personnel – 80,000 doctors and nurses migrated between 1989 and 1997 - and in which the treasury was ascendant in policy making. But more especially, black politicians' rejection of bio-medical orthodoxy was facilitated by a local history of medical science reinforcing racial segregation as a disease control measure and lending itself to efforts to limit specifically black population growth and control black sexuality. Additionally, Marxist trained leaders were willing enough to accept conspiracy-based narratives about the behaviour of multi-national pharmaceutical corporations and eager to attribute to poverty the status of the prime cause of the deaths that medical orthodoxy attributed to AIDS (Butler, 2005: 401-405).

Policy implementation.

To what extent have national policies been implemented in the way they were designed to be? Notwithstanding ostensible general agreement by 1994 about the severity of the threat posed by the epidemic and the need for concerted efforts to prevent its proliferation and despite the availability of financial resources, generalised administrative action against HIV/AIDS was very slow. As one authoritative commentary notes, by 1998, few of the plans adopted in 1994 were actually in operation and, to quote one activist, the National AIDS Plan remained a "neat book on the shelf". As we have seen, the first major public-sector efforts to promote public education about AIDS began only that year. This was four years after AIDS NGO's had pioneered the projection of messages about AIDS avoidance through a television soap opera, *Soul City*. Viewer statistics attested to *Soul City*'s popularity and its own self evaluation in 1997 did indicate that it had helped to expand condom usage (Schneider and Stein, 2001: 724).

Part of the explanation for this inertia is to do with bureaucratic inefficiencies. Like most other kinds of social expenditures, the direct responsibility for starting up and managing any HIV/AIDS programmes, both preventative and treatment-oriented, was assigned to the nine provincial governments. These were new entities bringing together separate groups of officials who had worked under different racially and ethnically constituted authorities during Apartheid. Under the new constitutional dispensation the new provincial governments acquired considerable financial autonomy: they received allocations from the national budget calculated according to their population size and developmental characteristics but they were free to decide how they should divide expenditure of these budgets. One effect of this was

that allocations to HIV/AIDS varied hugely within a range of 2.5 million (Mpumalanga) to R50 million (Gauteng) – a variation way out of any proportion to differences in size of overall budget (Schneider and Stein, 2001: 725). Secondly, in any case, even those provinces that chose to allocate very small budgets to addressing HIV/AIDS failed to spend the larger share of the sums they budgeted – in 1996, for example, Mpumalanga only spent a quarter of its AIDS budget (Johnson, 2004: 19). Overall, half the national AIDS budget was spent that year (Schneider and Stein, 2001: 726). In reaction, the National Department of Finance decreed from 1997 that unspent provincial budgets could not be rolled over for the following year.

One key choice by cabinet was to locate the National AIDS Programme Director in the Department of Health rather than making it a cross-sectoral appointment as recommended in Plan; in effect this meant that the main responsibility for executing the Plan was with health officials. Each province was intended to appoint a coordinator who would also have the power and authority to work across departments. But most provinces had to postpone these appointments until 1996 – this was a reflection of inherited procedural obstacles and when coordinators were chosen they were normally drawn from existing civil servants, usually people who had worked on communicable disease control, rather than from the echelons of AID activism. Coordinators usually held middle management level civil service rank and hence lacked necessary authority and indeed the scope of their jobs was left undefined. They tended to confine their activities to within the boundaries of the Department of Health, working “within a narrow medical framework” (Schneider and Stein, 2001: 726). As traditional administrators they often had “minimal” connections with community AIDS networks and the NGO sector they were supposed to work with and were disinclined to engage with them anyway (Johnson, 2004: 118).

Administrative difficulties were not simply attributable to the confusion and muddle that accompanied the process of reconstructing inherited bureaucracy. In 2000, the Department of Health, responding to public pressure, took the decision to begin a pilot programme of dispensing ARVs to halt mother-to-child transmission. In each province there were to be two locations for this pilot scheme, 18 altogether. Here mothers-to-be would have access to initial counselling, rapid testing for HIV, free prescriptions of Nevirapine for themselves and their children, advice and training about formula feeding and free supplies of the formula milk itself. Two years later the schemes were evaluated. One key distinction that was immediately evident was big differences between the proportions of people attending clinics who agreed to undergo testing: KwaZulu could report that the majority of clinic users consented to tests but elsewhere the proportions who underwent testing were much smaller, a reflection of KwaZulu employing an “opt out” approach to testing in contrast to other provinces deciding to make testing a procedure that patients would have to request. But the real problems followed decisions about testing. Several provinces struggled or failed to train and recruit adequate numbers of lay counsellors, despite the availability of funds to pay them. In three of the provinces, testing was held up because of protracted and frequent disruptions in the supply of testing kits. Poor record keeping helped to explain why less than half the women who did test positive subsequently received medication. Several provinces failed to undertake follow-up monitoring required to make sure that women were using the formula milk correctly and almost all the sites failed to replenish their formula milk supplies. Finally large proportions of new-born children were left untested for their HIV status (Doherty, 2005: 213-217). These sorts of problems persisted. Writing in October 2003, the year before the major effort to scale up treatment programmes, Samatha Willan noted many clinics did not have drugs to administer prevention of mother-to-child transmission or the medicine for opportunistic infections (Willan, 2004: 110). In this year the South African government

reported 52,574 unfilled posts in its public health sector, a 31% vacancy rate (Schneider, et al, 2006: 18).

In these circumstances to scale up the provision of treatment, the methods employed by *Medecins Sans Frontieres* (MSF) in its Lusikisiki would certainly have represented a plausible model to follow. This was in a setting in which at the inception of the programme the local primary health care clinics were grievously short of people, equipment and medicine (Steinberg, 2008: 93-94). Even so, here MSF's provision of free anti-retroviral medication through primary health care clinics with its shifting of key tasks normally undertaken by nurses to lay workers enabled a doubling of clinic usage without any additions to the numbers of nurses employed. In Lusikisiki district nurse to patient ratios rose from 1:29 in 2003 – the national average - to 1: 47 in 2006. However, despite notional acknowledgement of the role that could be played by community based carers and counsellors – by 2002 the Department of Health had budgeted for the part-time payment of 30,000 lay workers – in actual practice their role would remain constrained. In September 2006 a meeting organised by MSF and the Nelson Mandela Foundation brought together health workers from six provinces to report on the issues that had arisen in the roll-out of mass prescription of ARVs. Most of the sites represented at the meeting reported on nurses struggling with overwhelming case-loads as well as severe staff shortages resulting from unfilled doctors' posts and nurses resigning. In many locations the engagement of lay workers was limited by administrative insistence that only nurses could undertake the initial counselling and the testing. Another key bottleneck was caused by the refusal of certain provinces to allow nurses to initiate prescription: retaining this as a doctor's prerogative creates obvious barriers to expanding treatment in those districts in which doctors posts are often unfilled for months (Ford, 2006: 19-22). Another critical bottleneck was badly staffed and malfunctioning pharmacy services: this emerged as a major issue even in the comparatively well administered Western Cape health department in 2001 when the province embarked on a prevention of mother to child transmission through prescribing ARV at 300 of its clinics (Abdullah, 2004: 255)

Even where staff and facilities did exist it was often the case that the key people were poorly prepared and facilities were inadequately organised for the tasks that they were intended to undertake. The National AIDS Plan called for the mass provision of free condoms – this would accompany the provision of education about their reliable use as well as information about safe sex and the avoidance of sexually-transmitted diseases. This was one public programme that did proceed quite quickly: in 1995 98 million condoms were distributed through primary health clinics as well as at taxi ranks, hospitals, colleges, nightclubs, and other social facilities. By 2004 condom distribution had exceeded half a billion (Guari and Lieberman, 2006: 53). We know from survey data that by this stage amongst younger people condom usage had increased, so this effort may have been effective. Even so, research undertaken amongst teenagers in Cape Town and Kimberly suggests that any successes were despite and perhaps were limited by shortcomings in the ways in which clinic staff managed their part of the programme. Youngsters told researchers that they were worried that if they went to clinics to ask for advice about sexual issues their problems wouldn't be treated confidentially. Even if such assurances were given when the health workers were known members of the community any claims about confidentiality might not always be believed. Those that had attended clinics said they the nurses were often “unhelpful, hostile and judgemental”. It was often embarrassing to obtain condoms, especially if they were placed in a box in a busy waiting room (Bermudes and da Cruz, 2004: 144-147).

More generally there is evidence to suggest that in their meetings with “front line health professionals” people who are anxious about their HIV status encountered “harsh and

unsympathetic” attitudes, authoritarian predispositions that may have been inherited from the apartheid bureaucracy, researchers believe (Schneider and Stein, 2001: 724). Traditional bureaucratic work-styles also inhibited collaboration between public sector officials and health professionals and community based lay workers who support AIDS patients.

KwaZulu Natal-based researchers have reported on efforts to secure public sector support for palliative care workers in Etabeni in rural KwaZulu Natal, a voluntary network that supplied a range of services to people in the later stages of AIDS illnesses: fetching food and water, washing patients and helping them travel to hospital. The HIV/AIDS Networking NGO, HIVAN, had undertaken in 2005 to help this network create partnerships with district officers of the health and welfare departments and the local municipality so that they could access services, skills, training and grants more easily. The researchers found that though senior health projects were aware of the Etabeni network and approved of its aims, senior managers could never find time to attend meetings and sent junior people instead who could take no decisions. The district’s AIDS office did pay a small stipend to the network leader but otherwise paid it no attention; his attempts to visit the office elicited a reprimand and a reduction in the stipend. A Municipal official began attending partnership meetings but councillors refused to support his plan to support the network’s activities. Meanwhile the Department of Welfare’s local social worker refused to leave his office to meet potentially eligible grant recipients who could not travel. The researchers concluded that the volunteers were “constrained by a public sector context that actively hampers effective grass-roots empowerment” and that even when civil servants were personally predisposed to be helpful hierarchical administrative protocols barred their engagement in the project. “Most importantly”, they found, “the institutional culture” limited “opportunities for new ideas to move up the power hierarchy” (Nair and Campbell, 2008: 48-49).

Much of the early commentary on failures in effective policy implementation focused on political shortcomings; Nelson Mandela’s failure to pay more than perfunctory attention to the issue during his presidency; ministerial preferences for “quick-fix” approaches such as the “discovery” of Virodene; and Thabo Mbeki’s reluctance to accord recognition to HIV/AIDS as an epidemic that required special measures. As noted in an earlier section of this paper, this resulted in the policy process becoming stalled or distracted by problem-definition issues. Following on from this, as we have just observed, there have been the difficulties of translating possibly good policy into universally effective practice, with policy implementation hampered by bureaucratic obstructions, resource constraints and mismatches between policy prescriptions and the actual adopted operational procedures.

This second set of issues does suggest that even if leadership had maintained a more consistent determination to accord priority to the aims and recommendations of the 1994 National Plan, the government’s performance might not have been so very different. In particular, analysts have questioned the extent to which Mbeki’s role in questioning conventional medical knowledge about AIDS etiology has really obstructed South African efforts to prevent the spread of the disease (Doubt, 2013: 228). In any case, as Helen Schneider has observed, many administrative actions against AIDS have been conducted by sub-national entities “relatively autonomously and sometimes in contradiction to central political stances” (Schneider. 2002: 153). And leadership questioning of medical orthodoxies about AIDS did not always affect policies which though they may have benefitted AIDS patients and their dependants did not have addressing AIDS as their main concern. The provision of social welfare is a case in point and in any case the Department of Social Development in fact explicitly maintained a policy of acknowledging the epidemic’s severity and encouraging applications for Child Support and Foster Care Grants for AIDS orphans (Budlender, et al, 2008: 62 and 67). In much of the recent analysis, though, about medicine’s

failures in the struggle against AIDS, the focus is not so much upon high politics or upon bureaucratic configurations. Rather the emphasis is on the practices of everyday life that too often confront prevention and treatment efforts particularly when these are designed without any reference to the cultural settings in which they are instituted and which condition the behaviour that such efforts often seek to change. A substantial body of research has demonstrated the pervasiveness of AIDS related stigmas and beliefs about supernatural explanations for AIDS among urban as well as rural South Africans (see for example Kalichman and Simbayi, 2004). As Steinberg's anecdotal evidence as well extensive survey evidence demonstrates the fear of stigmatization affects people's willingness to undergo HIV testing (Kalichman and Simbayi, 2003; Meiberg et al, 2008).

Jonni Steinberg's *Three Letter Plague* supplies a richly detailed account of the reception of the MSF programme in Ithanga, one of the outlying villages in Lusikisiki district. Here the first tests were held in 2005. By the time the day of the test ended, Steinberg is told, "the whole village knew who had tested HIV positive", for the testing venue was that day subjected to close collective scrutiny. This was a small community of several hundred people in which everybody knew everybody else. Those people who tested negative received only brief post-test counselling – the identities of HIV positive villagers whose counselling sessions were much longer were duly noted by vigilant onlookers. So, testing itself could expose people to subsequent recriminations and abuse. The testing procedure could subject HIV positive villagers to an investigative communal scrutiny. In the case of one village visited by MSF earlier not all who tested positive were able to obtain medicine – their CD4 counts were too high. These people were then told by local Zionist preachers that they did not need medicine: prayer should be sufficient. For the community this group would function as an investigative control:

For now, those whose HIV-positive status is public knowledge are divided into two groups. The first have AIDS and are on ARV treatment. The second are asymptomatic, and most have, for the moment, denounced ARV treatment. And for the rest of the village, they are not sure. They will watch both groups keenly. They will observe who lives and falls ill and dies. The outed are unfortunate subjects of an empirical experiment (Steinberg, 2008: 192).

Steinberg's picture of Ithanga is of a community that is deeply divided generationally and in other ways and in which factional gangs constituted by young men exercise coercive power without any restraint. In this setting MSF interventions embodied a disruptive dynamic in existing relationships of power. But there were other considerations that affected villagers' willingness to engage with MSF's programme either as patients or as lay workers. Modern medical knowledge about the epidemic had to compete with culturally entrenched beliefs about illness as a symptom of social disorder – manifestation of witchcraft - that could be addressed most effectively through recourse to indigenous medical authority. As one of the ANC municipal councillors in Lusikisiki confided, "I don't trust these ARVs because they are not ours" (Steinberg, 2008: 153). Other studies have demonstrated that scepticism about biomedical approaches to AIDS extends well beyond rural villagers; a survey commissioned by loveLife in 2002 discovered that 7% off its respondents were certain that "sex with a virgin could cure aids" (Van der Vliet, 2004: 81). Another investigation encountered a similar proportion of students at the University of Venda who doubted AIDS' existence (Volks, 2004: 163).

Ithanga residents' attitudes to the testing and the prescriptions that followed it were also shaped by historical precedent. Steinberg repeatedly encountered the belief that when people were tested the hypodermic needles actually transmitted the virus – that the virus was a malicious plague intentionally brought from outside by white people. There were historical

precedents for this belief: comparable fears stymied the progress of influenza inoculations in 1918 and blood testing for various illnesses in the 1930s (Steinberg, 2008: 149-151). In this setting, acceptance of the rationale underpinning MSF's programme required the embrace of a fresh cosmology. As Sizwe, Steinberg's friend and key informant, tells him, the MSF counsellors when they arrived at his village, "they reminded (him) of those religious cults... of the prophet who comes to the village and says he has seen the light and you must follow him" (Steinberg, 2008: 32). This may have been the only way they could have functioned with any effect for as Steinberg himself notes, treatment – and the communal support it required - could only work "if animated by a social movement" (Steinberg, 2008: 85). In this movement recruitment and engagement would have a morally redemptive character, the medically unnecessary embargoes on drinking and smoking were corollaries to this, Steinberg thinks (2008: 180-181).

Such a movement might well be exclusionary, though, and it may well engender its own adversaries. As Catherine Campbell notes from her similarly locally focused study of HIV prevention efforts in KwaZulu Natal, what is needed is community mobilization that can create the "social context" that will enable safer sexual behaviour and other desired outcomes (Campbell, 2003: 189). But within local communities, inequalities in "economic, cultural and symbolic" capitals can make mobilization very difficult, affecting as they do the predispositions to participate of different groups. Such inequalities are best acknowledged and understood before mobilization begins (Campbell, 2003: 191). For example, Steinberg has suggested that the "feminisation" of AIDS activism may have inhibited young men from participating in action against AIDS (cited in Doubt, 2013: 232). As already noted public education has tended to focus on young people's experience and this too might limit its effectiveness in societies in which moral authority is still invested in older men and women, a consideration that often limits the impact of musical performances undertaken in Venda by young women selected as "peer educators". These women attracted censure from elders as "vectors of the virus" (McNeill, 2011: 3). In short, mobilising communities is a politically complex task, and it may require hard choices about which groups to enlist and in what order to recruit them, complexities, which as Campbell reminds us are too often "masked by inappropriately bland development jargon such as partnerships and stakeholders" (Campbell, 2003: 191).

Responses to HIV/AIDS outside the public sector and the development of partnerships between official bodies and other agencies

Notwithstanding the difficulties that accompany efforts in building community based action that addresses the needs posed by the epidemic there is widespread agreement, though, that to be effective official policy initiatives need to be undertaken in active collaboration with groups outside the state. The evidence surveyed in the previous section of this paper has highlighted the bureaucratic weaknesses of public agencies – simply to reach the people they seek to influence or provide for they need to engage with those organised social groups and more informal networks with which historically they have had very little interaction.

South African partnerships between public sector and non-state entities are generally viewed as essential for the success of the HIV/AIDS policy implementation. Peris Jones cites a range of authorities that maintain that co-ordinated multi-sectoral governance responses are regarded as critical in mitigating the impact of HIV/AIDS. And by the mid 1990's in South Africa there was a very extensive network of organised activities addressing the epidemic. In

1996, 661 independent agencies concerned with AIDS appeared on a national AIDS data base (Schneider and Stein, 2001: 728). As we have seen, NGO's played a pioneering role in developing public education about AIDS and until 2006 development agencies, social movements and the private sector supported and provided the major share of ARV treatment made available in South Africa. Private sector-sponsored schemes proliferated after 2002 (Dickinson, 2004: 627), though within them enrolment, uptake and adherence to ARV regimes was uneven. Within those companies that financed and delivered care about a third of the workers who were likely to have needed it had enrolled, the evidence from a survey conducted in 2004 indicated (Connelly and Rosen, 2006: 130). As well as treatment, the main burden of caring for those who were very sick was carried by community, non-governmental organisation, churches and some of the private sector companies.

So, there was no shortage of potential partners for a multi-sectoral approach by the government. Jones suggests that the disappointing way HIV/AIDS policy interactions and coordinations turned out in South Africa has to be understood in a setting in which since 1994 the ruling party has become increasingly predisposed to discourage mobilisation of any kind. This tendency, Jones suggests has had adverse implications for civil society-state relations (Jones, 2005: 419-447). So well before political leaders began disputing the scientific validity of biomedical understandings of HIV/AIDS, government was becoming increasingly aloof from the AIDS NGO community. But Thabo Mbeki's apparent embrace of AIDS denialism closed down any possibility of a national level partnership developing on the basis established by the 1992 National AIDS convention notwithstanding the continued willingness of certain provincial administrations and officials to work with NGO's in the provision of ARVs.

In 2000 national governments' unwillingness to collaborate with the key non state actors was affirmed during the launch of the South African National AIDS council. Schneider argues that the exclusion a number of key civil society organisations like Treatment Action Campaign (TAC), National Association of People Living with HIV/AIDS (NAPWA), the AIDS consortium and major medical researchers was a clear indication of closing down participation of those opposed the presidential views on HIV/AIDS. Heywood maintains that political leadership's "denialism" was the key consideration in blocking the formation of any nationally coordinated partnership between government and civil society organisations. By 1998 the evidence from countries in the North that antiretroviral treatment was effective and affordable would help prompt the first popularly based protest activism focused on HIV/AIDS. (Heywood, 2004:93-122).

The Treatment Action Campaign remains one of the most successful of South Africa's new social movements. It was formed in 1998 in Cape Town by a group of HIV-positive activists, including several members of the ANC, to persuade or compel the government to provide wider access to treatment for HIV-positive patients. The TAC drew upon the tactical methods of the 1980s civil disobedience movements, to which many of its leading participants belonged. It also used litigation to challenge government policy. The TAC has good relations with COSATU, the ANC's trade union ally, with whom they co-drafted a national AIDS plan. The TAC was effective partly because of lessons that its leading officials learned from their anti-apartheid activist experience, but also because these officials eventually became socially mobile. The TAC prides itself on being media friendly in packaging its message. It is able to ensure the visibility of "a nicely photogenic crowd" clad in T-shirts proclaiming "HIV-positive" in its protests. Not all TAC activities target the government, though. In 2000, a TAC Defiance Campaign organized pickets and demonstrations against high prices charged

by the drug companies that hold patents on the main antiretroviral medicines. The TAC began recruiting a network of doctors and pharmacists who were willing to prescribe generic substitutes for such drugs, and the TAC officials travelled to Brazil and Thailand to buy initial supplies of these medicines. The organization subsequently, with some justification, claimed credit for price reductions announced by the pharmaceutical companies Pfizer and Glaxo Wellcome. TAC protests also elicited sympathetic responses from ANC notables. Nelson Mandela lent his personal support to the campaign when, in July 2001, he visited Zackie Achmat, the TAC's president. Achmat had announced that he would refuse antiretroviral medication until the government was willing to make such drugs readily and freely available. As noted above TAC litigation to compel the government to do this ended up in the Constitutional Court after the authorities appealed earlier high court judgments in favor of the TAC.

From its establishment the TAC also sought to organise people living with HIV, scientists, health professionals, civil society to challenge stigma and discrimination and to empower communities with knowledge about HIV treatment. The death of a young HIV positive woman from KwaZulu-Natal who was stoned to death after publicly disclosing her HIV status shocked the country by highlighting the effects of prejudice. The TAC's strategy was to use an HIV POSITIVE branded T-shirt to make HIV visible in society and to encouraging speaking to honour of those who fall prey to discrimination. Robins has suggested that it is the near-death experience from both AIDS and its stigma that produces survivors whose commitment to social activism is reinforced because they have a sense of new life, a comment that resonates with the parallel between AIDS activism and prophetic religious movements noted by one of Steinberg's informants. This experience life after near -death contributed to the construction of a "HIV positive" social identity that couples itself with understanding of what it means to be citizens the concurrent obligations of membership of a social movement (Robins, 2006: 312-323). As Heywood has noted:

The murder of Gugu Dlamini was perhaps an act of denial, illustrating that it was intricately mixed with stigma but a fact many observers omit is that fighting stigma is not just about eliminating prejudice – it is about putting something in its place. Expanding access to real information about HIV/AIDS and its treatment to poor communities – rather than just the 'ABCs' of HIV prevention – equips people to make decisions. Thus it was that a campaign for access to treatment came to generate an organisation.

Robins argues that the TAC's approach has made a fundamental contribution to the democratisation of science and public health (Robins, 2004: 651-672). Its engagement in coordinating community-based support functions with MSF's activities in Lusikisiki (Steinberg, 2008: 199-200) is a good example of how it can play this particular function of democratising medical concerns, a role that illustrates Nair and Campbell's contention that grassroots involvement is key in the effective HIV/AIDS care in poor communities (Nair and Campbell, 2008: 45-53). For Schneider (2002), the TAC's successes demonstrate the limitations of state power as well as the possibility for AIDS rights movements to transform public sector institutions. Friedman and Mottiar are more cautious. They agree that the TAC offers a case study for successful kinds of collective action by a social movement. However its success was the outcome of its adroit exploitation of an unusual political opportunity structure which included the possibility of allies within government and support across society as well as international backing (Friedman and Mottiar, 2005: 511-565). In Jones' assessment, the TAC's main success was in opening up political space and to challenge government policy decision-making in order to improve the conditions for people living with AIDS and in its ability to provide a political channel to more formal political participation

and engagement with the state by excluded individuals and groups, through social mobilisation conjoined with rights-based argumentation. Such an interpretation of rights-based approaches to development is a necessary corrective to overly legalistic, state-centred and depoliticised NGO programming approaches. However although the TAC succeeded in shifting policy, organisational difficulties still restrict service delivery. Organisations like TAC must always be careful not to be reconstituted and be co-opted into the political mainstream, Jones cautions (2005: 419-447).

The TAC's particularly assertive kind of activism has been exceptional, though; much of the community based support for people who are HIV-positive or community based preventive work is less politically confrontational. But even in the cases of those groups that have worked within the scope of officially approved initiatives, public support has a record of being hesitant or fitful or qualified.

A good example of this is the way in which the government has tried to address South Africa's historic shortage of health care workers. The progress of the HIV/AIDS epidemic accentuated an existing shortage. Following its declaration of 2002 as a "Year of the Volunteer" as we have noted the government started paying stipends to lay counsellors and home care workers in exchange for a minimum commitment of 20 hours work a week.. By 2004, the 40,000 so called Community Health Workers were a key group within the Government's Expanded Public Works Programme, a poverty alleviation initiative. Their numbers then were about the same as the number of professional nurses; by 2006 there were more than 60,000 community care givers. These workers are not considered to be public sector employees – the stipends are paid to them through NGO's. From 2006 four qualifications were registered for these workers with the necessary training supplied by NGO's, provisions that implied the future possibility of career pathways. Most of the paid and trained CHW's or caregivers would begin as pure volunteers before undergoing selection for stipends. More than ninety per cent of them were women and an increasing proportion of the CHW's were going to be recruited from HIV positive patients who themselves had regained health after entering ARV treatment regimes.

Clearly these workers play an indispensable role in both treatment and preventative programmes. As Schneider, Hlophe and van Rensburg conclude from their observation of a group of these workers over a two year period in the Free State, between 2004 and 2006, the CHWs were "increasingly relied upon to fulfil the communication tasks linked to HIV and TB" (2008: 183). In this region, there seems to have been much readier and closer engagement between public sector clinic staff and lay-workers than was evident when Nair and Campbell conducted their investigation in the same period in Etabeni, KwaZulu Natal (see the discussion in the preceding section of this paper). Among the tasks that the Free State clinic nurses began to delegate to CHW's after 2004 were the main responsibilities for tracking drop-outs from ARV prescription courses as well as drug readiness training. However the research also showed that despite – or perhaps because of – the CHW's growing confidence in their "self-efficacy", they were often very disaffected. Many of their complaints related to the ambiguities in their employment status, in which though paid by an NGO, the workers were usually managed by public officials. Despite the stipend, slightly more than the disability grant which any of the HIV-positive workers had received previously, the workers still tended to view and call themselves volunteers, and this understanding of their status seems to have been shared by clinic managers. "People look down on you when you are a volunteer" researchers were told. Moreover their employment as "volunteers" was uncertain; they were vulnerable to instant dismissal. On the other hand

officials tended to view the NGO's who paid the stipends as conduits, they themselves exercised the kind of direct authority that would normally be the function of an employer, but without any real sense of responsibility. Workers were limited by various restrictions and embargoes that underlined their outsider status: "we are treated as if we don't belong here". Patients on the other hand found it difficult to distinguish the roles of the workers and proper nurses, calling the volunteers "Nurse", usage that often made nurses angry. On the whole, though, the workers got on well with front line staff, their main complaints were about managers. The deeper cause of their dissatisfaction, though, arose from the motives prompted their original decisions to volunteer, for in desperately poor communities, lay counselling appeared to offer the prospect of eventual full time employment as civil servants. At this stage such prospects in reality were very limited and many workers felt that the selection procedures that enabled some of them to undergo "learnerships" to qualify as nursing assistants were administered unfairly: "they take somebody with standard 2 or 8 sitting in the township doing nothing and you find out that his/her mother is head or something in the Department of Health" (Schneider, Hlophe and van Rensburg, 2008: 184-185).

What about government's interaction with the private sector in addressing AIDS treatment and prevention? In ten years after 1995 an official regulatory framework evolved that would govern employer responses to HIV/AIDS. The 1995 Labour Relations Act protected HIV-positive employees from dismissal because of their condition and stipulated that they should be provided with alternative work if they were disabled by the illness. Further legislation in 1998 stopped mandatory testing and the withdrawal of benefits to HIV-Positive employees and in 2005 all medical aid schemes were compelled to support HIV testing, care and treatment including ARV. Meanwhile in 2003 the Department of Labour in consultation with trade unions developed a Code of Good Practice on HIV/AIDS and Guidelines that provided advice on workplace HIV policy and prevention programmes (Mahajan, et al, 2007: 33).

Research on actual implementation of prevention programmes (education, condom promotion and voluntary testing) indicates that while larger firms had by 2006 established such schemes they were rare elsewhere (Mahajan et al, 2007: 33-35). Mining companies were in the vanguard of such efforts beginning education and condom distribution in the early 1990s (Campbell and Williams, 1999: 1627). Beyond prescribing rules and codes of conduct, the research indicates very little private sector/ government cooperation over HIV/AIDS. On the whole, corporate responses to HIV/AIDS for better or for worse evolved separately and independently of government. Most company responses to HIV/AIDS that extended beyond the initial efforts during the 1980s and early 1990's to exclude HIV-positive people from their workforces only started developing two decades after the epidemic's inception. As Dickenson notes this delay in their response to AIDS can partly be attributed to political leadership's failure to offer clear strategic leadership and multi-sector coordination though he also believes that effective action by companies also engenders "morally based resistance" within their workforces (Dickenson, 2004: 636-637). But even in those enterprises in which company prevention programmes were well established, too often they constructed their messages around a bio-medical approach which failed to take into account "the complex chain of factors which make mineworkers vulnerable to HIV/AIDS" (Campbell and Williams, 1999: 1635). This began to change in the early 2000s with the adoption of peer education by companies, one of the measures advocated in the Code of Good Practice. Peer education is undertaken by people who share a range of identities with those whom they educate; using their "linguistic and sociocultural access" (Dickenson, 2010: 84) they can interpret or translate the information into language that is accessible and resonates with the

experience of the people they work with. But their real effectiveness is a consequence of their ability to undertake educational activity informally, in taking advantages of opportunities to steer casual conversations for example (Dickenson, 2010: 86-87). Despite their evident effectiveness, an authoritative study by David Dickenson's indicates that frequently the efforts of peer educators are ignored or stymied by middle level managers and undervalued or disregarded by trade union leaders (Dickenson, 2010: 185-189). Peer educators are often organised by human resource divisions or health and safety officials and poorly articulated into other dimensions of the company's HIV/AIDS programming, Dickenson found (2010: 75). Dickenson's research on peer education is largely directed at addressing questions about its efficacy: he presents a strong case for viewing it as a powerful way to change the conversations and norms that influence sexual behaviour. His study suggests that at the time of its publication, the most systematic efforts to establish and support workplace-based peer education have been in the private sector not in public administration

If the government was to develop a stronger real commitment to partnering HIV/AIDS prevention and treatment undertakings with community-based networks there is a growing body of research findings that indicate which networks might be especially powerful and adaptable to such functions. In a study undertaken in Khutsong Township, in a gold mining district near Johannesburg, Catherine Campbell and her colleagues have illuminated the links between social capital, sexual health and HIV infection. Here community networks can present both positive and negative effects on people's sexual health. For example people who belonged to church, burial, sport or youth groups were less likely to have casual partners and used condoms more. This group therefore was less likely to be HIV positive compared to members of a group whose social life was animated especially by membership of stokvels (rotating savings associations). While stokvels are important in enabling poor people to obtain access to large cash sums their meetings are often followed by increased alcohol consumption and casual sexual partnerships. Yet in the South African developmental literature stokvels are often perceived uncritically to embody strong incubators of social capital (Campbell et al: 2002: 41-54).

Robert Garner's work (2000) suggests that the identification of benign networks in this context might be a very complex task indeed. He considered active affiliations to a range of Christian churches as variables that might correlate with safe sexual behaviour. In Edendale, KwaZulu-Natal, he found the absence of social networks such as church youth groups or choirs reduced opportunities to engage young people helpful conversations about sexual conduct. Churches with youth groups tended to have high levels of religious socialisations and young people monitored each other's behaviour. He argues that Pentecostals particularly experienced lower levels of HIV infections because they tend to have active bible study groups and choirs. Pentacostal sects maintain regimes of socialisation through religious indoctrination and sanctions such as exclusion that seems to especially effective in modifying behaviour. Whether such a moral regime can be created without the underpinning spiritual beliefs is open to question, though Steinberg's observations of the Treatment Action Campaign activities in Lusikisiki does suggest that a secular movement can also discipline and animate its following through peer pressure and a sense of belonging to a community of the saved.

Successes and failures.

What have been the main successes of South Africa's official efforts to restrict the spread of the epidemic and limit the damage it has caused?

As we have seen, there are indications that preventative measures including public education and condom distribution have been quite effective in changing sexual behaviour and in turn reducing HIV incidence. Research on the effectiveness of LoveLife in 2001 and 2003 suggested that participation in its programmes had the effect of promoting condom usage and that those people who were regular participants in LoveLife sponsored activities were less likely to engage in unsafe sexual behaviour (Stadler and Longwe, 2003; Pettifor et al, 2007). In general, though, there is a need for more research on the effectiveness of prevention through public education; a review in 2002 lamented the absence in South Africa of "randomised control trials" of prevention programmes (Kelly, 2002: 101). The impact of such preventative measures may be reflected in declining HIV incidence (fresh infections) that Statistics South Africa began to record from 2006. Schools-based programmes seem to have been less successful, though, largely because of failures of implementation.

The eventual establishment and delivery of the world's largest programme of free prescriptions of ARV medication through public facilities, mainly after 2007, has to rate as a success. An indispensable requirement in the government's ability to achieve this delivery was very extensive recruitment of a very large cohort of laypeople as carers and counsellors, though it took the authorities a protracted period to acknowledge just how necessary were the functions supplied by these people. The return to relative health of huge numbers of very sick people as a consequence of this roll-out of treatment certainly constitutes a success. The ability of activist groups to shift government policy in 2003 over the main issue of prescription and subsequently, more incrementally, over methods of implementation, between 2003 and 2007, is a democratic achievement that attests to the vigour of institutional checks on executive authority.

Observers of the Lusikisiki programme suggest that the building of communal support networks for people on treatment regimes, networks in which patients themselves play an assertive role has the effect of reducing the stigma that surrounds HIV infection (Beresford, 2004: 280), though the opposite may be the case as well. Knowledge about the effectiveness of mass media educational efforts to reduce the incidence of stigma is at an early stage of development. Writing in 2008, Mahajan et al noted that there were then only a small number of published studies on measures to reduce HIV/AIDS stigma, though one investigation of the effects of a two year HIV story line in the TV soap opera, *Bold and the Beautiful* found that viewers in Botswana showed significantly less stigma than non viewers (Mahajan et al, 2008: 76).

The major failure in South Africa was the delay in government supplying an unambiguous commitment to the strategies that it adopted in 1994 and in failing to exploit the availability and possibilities of medication shortly after they became generally available in the late 1990s. This meant that really effective state intervention began at a comparatively late stage in the epidemic's progress. Arguably President Mbeki's questioning of AIDS etiology muddled and blunted the impact of messages the government's own preventative campaigns were trying to promote and helped reinforce the validity of local knowledge systems that resisted conventional biomedical understandings of HIV/AIDS. But even after policy turnarounds, hesitations in engaging with voluntary support networks held up implementation of treatment. More generally, a disposition by political leadership to view HIV/AIDS as an epidemic that should mainly be managed by public health workers limited the scope of official action. In

this vein, preventative efforts have too often been limited in their effect through being “framed in terms of a biomedical discourse about sexual health risk”. Such discourses neglect the difficult issues posed by “the social context of sexuality” such as the gender relationships that increase vulnerability (Campbell, 2003: 136).

Key lessons from the experience of policy implementation?

Here are seven lessons that emerge from South African efforts to limit and control the impact of HIV/AIDS.

First, confining the management of such efforts to a single sector of government, in this case, the Ministry of Health, weakened the authorities’ commitment to conceive of the epidemic as developmental challenge that confronted the whole of society not just sick people and their dependents. In effect it caused HIV/AIDS as a policy issue to lose the priority status assigned to it in 1994.

Secondly, messages that are aimed at changing people’s sexual behaviour but which focus mainly on biomedical facts are ineffective. They have to be delivered in a way that engages peoples’ values and emotions and their content has to address the reasons why people behave in the ways that the messages seek to change. Different groups of people may require different messages. Overly didactic public education, whether in schools or outside formal educational settings, is unlikely to influence behaviour.

Thirdly, the distinction between treatment and prevention is not always helpful. In South Africa, efforts directed by various agencies at promoting and undertaking treatment has important public educational effects, in altering attitudes towards testing and, possibly, in reducing stigma.

Fourthly treatment – and various kinds of preventative activity including testing and sexual advice – is most usefully supplied in primary health care settings – as Beresford has argued, “in bringing the treatment to patients, not the other way around” (Beresford, 2004: 266).

Fifthly, “task shifting” primary health care functions to lay workers has enabled a huge expansion of treatment coverage which would not have been possible if tasks had been confined to professional public health workers. Even before the expansion of anti-retroviral services, short-staffed hospitals and primary health care clinics were struggling to provide ARV’s just to pregnant women.

Sixthly, the expansion of treatment in South Africa was “animated by a social movement of lay workers and anti-retroviral users” (Steinberg, 2008: 85). This has helped to maintain levels of disciplined adherence to treatment regimes by patients without intensive supervision from scarce health professionals. More generally any policy or implementation of a plan in this country must be accompanied with grassroots social mobilisation of ordinary people living with HIV/AIDS and communities affected by it otherwise the plan will most likely be ineffective in closing the gaps between policy, implementation and the people.

Finally, much of the “best practice” in South Africa has been introduced, tested, and developed by non-state agencies. This is the case both with treatment – as in the case of MSF’s pioneering work – or with prevention, as with community and workplace based peer

education. All the more reason, then for the South African authorities to work in the kinds of collaborative arrangements in which officials are predisposed to be receptive to learning from their civil society partners.

What don't we know yet? What are the greatest uncertainties?

Firstly, with respect to the general characteristics of the epidemic, we still need clearer and better substantiated answers to the question as to why the rates of infection in South Africa are so high comparatively. There are disagreements between authorities about whether a) the extent to which infection rates and incidence are the effects of social structure and political divisions inherited from apartheid, b) whether the delays in developing and implementing an appropriate policy response are chiefly to blame, or c) whether infection rates are primarily the effect of behaviour that results from culturally entrenched beliefs that resist public educational efforts. These explanations are not mutually exclusive but sometimes they are treated as if they were. Moreover, too often, particular features of South African political and social life are used to explain the comparative severity of the South African epidemic – for example, bad policy, indecisive leadership or administrative inefficiencies – when the same features may exist elsewhere in settings in which the epidemic may have been less severe or may have been curtailed more quickly. Not enough of the analysis of the causes of the severity of the impact of HIV/AIDS in South Africa has been undertaken in a rigorously comparative fashion, though pointers on how this might be done are offered by the quantitative analysis of African countries' AIDS policies by Strand et al, Kinney and Mattes. These examine the extent to which good governance, democracy, political competitiveness correlate and may explain variations in commitment to different kinds of action that addresses AIDS (Strand et al, 2008: 80-87). A compelling hypothesis is that in the case of South Africa, inequalities and social divisions inherited from the apartheid era and perpetuated since then may have inhibited the development of empathy and social solidarity, political trust and the sense of common political identity that facilitates effective policy making and effective policy implementation (see discussion above of Gauri and Lieberman, 2006). However it needs to be confirmed with more extensive empirical investigation than has yet been undertaken.

Forecasts about the macroeconomic impact of the epidemic undertaken at the beginning of the 2000's and earlier have since been overtaken by events. Analysts still disagree about what the impact of HIV/AIDS and the costs associated with it have actually been over the last ten years and the extent to which these have been affected by mass free provision by the government of ARV's. Similarly though there is a body of research that explores the impact of HIV infection and fully blown AIDS on household incomes much of this work predates the expansion of ARV prescriptions. Whether the availability of medication has had a discernible effect on alleviating poverty in affected households still awaits confirmation from broadly-based investigations. Also on the impact of AIDS, to date there is no systematic assessment of whether the progress of the epidemic has affected political life to make it less democratic and government more coercive and patrimonial as predicted by de Waal (2003) and Willan (2000). One possibility that merits exploration is that over the long term, as government has expanded its treatment and prevention efforts, this effort may have had long term effects in strengthening state capacity.

Most academic analysis of South African policy formation is concentrated on developments before 2003, the year in which the South Africa government at least in principle committed

itself to mass prescription of anti-retroviral medication. Up to that point, as we have seen, South African policy makers struggled to progress beyond the “problem identification phase” (Fourie, 2006) of the policy cycle. Fourie’s and other studies have explored how processes of policy contestation “from below” prompted change, but from that experience we still need to draw lessons on “how best to influence policy makers” (Setswe, 2004: 186) in future, both from technocratic or expert standpoints and from the perspective of citizens. In the same vein, writing in 2002, Hickey suggested that more research was needed on “the role of parliament in dealing with HIV/AIDS”; the comment is still valid (Hickey, 2002: 53).

Since 2003, there have been two further National Strategic Plans that have addressed HIV/AIDS, one for 2007-2011 and one for 2012-2016. The 2007 plan indicated government’s much more vigorous commitment to collaboration with civil society in treatment, prevention and support for patients. The 2012 Plan included very ambitious targets including the halving of stigma associated with HIV and TB. It prompted the drafting of HIV strategies by a range of government departments, including Social Development, Basic Education, health, Women, Children and People with Disabilities as well as the Department of Correctional Services. Ostensibly these encouraging developments do suggest that policy makers no longer emphasize those narrowly medical approaches to HIV/AIDS that conceptualise it primarily as a public health issue to be tackled by mainly health professionals. However, post-2003 policy-making has yet to be assessed as carefully as the earlier policy debates. One shortcoming of several of the major academic treatments of South African policy making about HIV/AIDS is their predisposition to view policy making as an activity that is confined to the very top echelons of government. Yet major policy developments have happened as a consequence of decisions and actions made at different levels of government, as Schneider has noted (2002). It is also the case that policies that are not initially conceived with the primary aim of addressing needs arising from the epidemic may have major implications for people with AIDS, as has been the case, positively, with respect to social welfare grants (Budlender, et al, 2008).

This latter point underlines the gaps in our understanding of the range of activities that may be relevant to HIV/AIDS across the public sector. With respect to the implementation of policy, most of the analytical attention has been directed at health workers and the activists, counsellors and carers who engage with them. As with policy-making, academic assessment of the administrative effectiveness of the government “roll-out” of its treatment and prevention badly needs updating: much of the literature cited above is about experiences before 2007, before, for example, the major rise in ARV prescription. Steinberg’s observations about the takeover of the MDF initiative by the Eastern Cape provincial health authorities (2008: 276-286) suggest that notwithstanding the efficacy of the Lusikisiki model in which so many tasks are shifted to lay-counsellors, replicating or “scaling up” MSF’s work on a national scale would impose huge strain on an already stressed health service.

Finally, we need to know more about the local political and sociological effects of policy implementation. Both with respect to treatment and with regard to prevention activities, insufficient attention has been paid to the on-the-ground political dynamics that are triggered by the introduction into communities of new knowledge, additional resources (grants, stipends, etc.) and fresh kinds of social organisation. As the ethnographic work of Steinberg and Campbell reminds us, HIV programmes can empower some groups that may have been previously less powerful or indeed inhabiting secret places of shame and disgrace (Steinberg, 2008: 2) – or they may consolidate the influence of existing local elites. Similarly, programmes may appear to challenge existing power relationships to the extent to which they

engender resistance as McNeill's research on the deployment of young women as peer educators in Venda showed (McNeill, 201). After all, the knowledge promoted through AIDS education is not neutral or technical: it might challenge existing codes of behaviour and confront or challenge local hierarchies based on age or gender, for example. There is even the possibility that AIDS treatment programmes as well as public education about AIDS might have the effect of increasing or producing stigma, through creating associations that identify patient groups as groups that challenge established order or hierarchy. Finally, the relative success of certain programmes in altering the behaviour of certain groups or cohorts may have changed – or at least may be in the process of changing – the social location of the groups who are most vulnerable to infection. As Hendra van Zyl (2012) has noted, most prevention programmes have targeted young people but as young people become less likely to be infected by comparison older people in certain communities have become more vulnerable.

The general point here is that even in localised settings, HIV/AIDS treatment, support and educational activities function in communities that are sharply differentiated. They are divided by the moral beliefs people adhere to, as is evident from Garner's work on religious sects and Campbell et al's findings about helpful and malign social capital networks. They are split by people's relative access to power and material resources: as Steinberg observes, Lusikisiki "is about as unequal and diverse a place as you will find" (2008: 200). Effective action against HIV/AIDS may well be socially disruptive – to plan ways in which such disruptive effects can be managed we need to know much more about them than we do.

Comparisons between South Africa and other African countries

In South Africa, in contrast to other African countries, poor people are disproportionately vulnerable to the epidemic. This makes the South African experience distinctive compared to most of Africa (Mishra et al, 2007: 17-28). One implication of this difference is that it may explain why policy makers in South Africa were comparatively slower and more divided in their responses to the epidemic than as the case with governments north of the Limpopo.

South African leadership responses compare especially unfavourably with those of the Ugandan government. But, as Parkinson and Lush (2004) have suggested, the relative readiness of the Ugandan president to accord priority to countering the epidemic is only part of the explanation for Uganda's relative success in curtailing infection. In comparison to Uganda South Africa has a well-developed public administration and a fairly sophisticated health infrastructure which helped prompt officials and politicians to assign to the state most of the functions in caring for patients and preventing the infection's spread. In Uganda officials' awareness of bureaucratic weakness helped to foster earlier and better engagement than in South Africa between state agencies and NGO's. Indeed the main initiatives in promoting behavioural change were led by NGOs and supported by government. The behavioural emphasis in the Ugandan approach contrasts sharply with early South African focus on treatment and syndromic management. Uganda also compared favourably to South Africa in the extent to which it has engaged its local governments as frontline agencies in addressing the epidemic (Opolot, 2000).

Differences in policy emphasis between South Africa and other African countries may also reflect South Africa's relative independence from donor pressure. South Africa receives very little multilateral or bilateral development assistance. In general donors have tended to

favour supporting preventive projects rather than treatment schemes and with respect to prevention particular donors have sometimes favoured particular messages – for example US AID during the Bush presidency promoted sexual abstinence campaigning as an ingredient in any public education it funded (Jones, 2004: 168).

One final obvious way of comparing the South African experience to that of most other African countries is with reference to the differences that arise from its economic status as a partly industrialised middle income country. South Africa can afford treatment on a scale which few other African country could undertake without external assistance. The costs of provision of ARV's by 2015 are estimated to rise to 1.7% of GNP, a significant commitment but well within the WHO recommendation of feasibility for (total) health outlays (Willan, 2004: 113). Similarly the economic threat posed by AIDS to South Africa is – at least in the short to medium term, less severe than its consequences in countries in which domestic food security and export receipts still depend on household-based labour intensive peasant agriculture. Indeed De Waal and Whiteside's analysis suggests that HIV/AIDS has now become a significant aggravating cause of aggregate declines in food production in Southern African outside South Africa (de Waal and Whiteside, 2003).

Forecasting:

(To be written after South African workshop, 4 October 2013)

Given trends and dynamics in these multi-sectoral responses to AIDS is it likely that the risks and costs associated with the epidemic will expand or contract in the next ten years? Is there evidence, for example of changing behavioural patterns that may be a consequence of public education and which may lead to significant further reductions in incidence? What are the likely priorities for public resource allocation to cope with the long term impact of the disease? What kinds of public investments today would be sensible to cope with long term consequences?

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