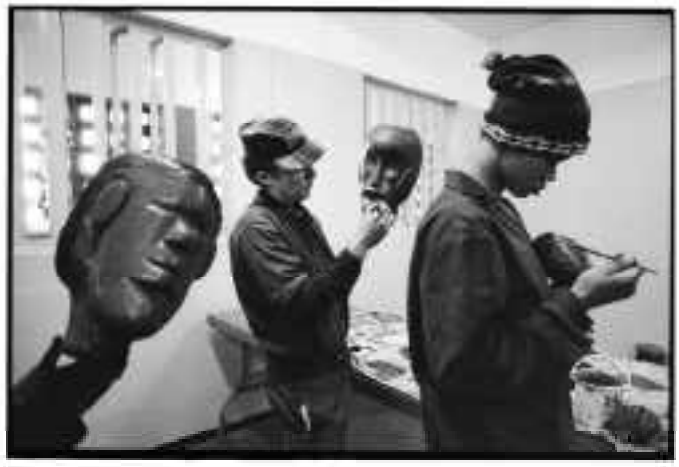
University of Pretoria

# To the edge

## AIDS Review 2000

Hein Marais



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Hein Marais

**Hein Marais** is a Johannesburg-based journalist and researcher and writer specialising in political and development issues. An updated second edition of his book *South Africa: Limits to Change – The Political Economy of Transition* (published in 1998 by Zed Books and UCT Press) will appear in mid 2000.

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# Contents

# Foreword

This is the first in a series of AIDS Reviews, to be published annually by the Centre for the Study of AIDS at the University of Pretoria. Each Review will seek to address a particular question and in answering it broaden our knowledge and understanding of HIV and AIDS as the epidemic unfolds in South Africa. In 2000 we decided to try and answer the complex question as to why, despite the comprehensive National AIDS Plan adopted in 1994, South Africa has what has been described as the fastest growing HIV epidemic in the world. We have tried to discover what forces shaped the response to the epidemic and how these have operated over time. We have woven together the many threads of the AIDS world that will be familiar to most South Africans, but have, for the first time subjected them to an integrated and critical analysis.

We have drawn on many sources – published documents and discussion articles, as well as published papers and commentaries, and the comments and observations of many people. We would like to acknowledge the following people who were prepared both to be interviewed and to have their comments published – Edwin Cameron, Morna Cornell, Mark Gevisser, Mark Heywood, Quarraisha Karim, Anthony Kinghorn, Clarence Mini and Brian Williams. We would also like to recognise the contributions of many people to the debates and discussions that are inevitably part of an undertaking of this nature. These include Gary Adler, Pierre Brouard, Peter Busse, Makie Kunene, James McIntyre, Eleanor Preston Whyte and Frans Viljoen.

The Rector of the University of Pretoria, Professor Johann van Zyl, and the Vice Rector under whose guidance the AIDS Centre falls, Professor Chris de Beer, have been generous with their support, insights and commitment. The support of the University for this project and the work of the Centre is recognised. The University of Natal shares this commitment: we value our partnership and the shared HIV/AIDS programme of the two institutions. The CSIR and the UP have developed a united response to HIV and AIDS and their commitment to this project is also appreciated.

We hope that this AIDS Review 2000, ***To the Edge***, will help to increase our understanding of HIV and AIDS in South Africa and offer new ways of responding to the multiple challenges this epidemic poses for a society like ours.

Robin Hamilton undertook the task of editing the Review and Gisèle Wulfsohn provided the photographs.

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The views expressed in this review are solely those of the author and the Centre for the Study of AIDS.

*Those of us in exile are especially in the unfortunate situation of being in the areas where the incidence of this disease is high. We cannot afford to allow the AIDS epidemic to ruin the realisation of our dreams. Existing statistics indicate that we are still at the beginning of the AIDS epidemic in our country. Unattended, however, this will result in untold damage and suffering by the end of the century.*

- Chris Hani, speaking at an AIDS conference in Maputo, Mozambique, 1990.

*Our movement and the MDM [Mass Democratic Movement] must learn to tackle these problems head on ... Some of us might regard this as a diversion from the important task of transfer of power to the people .... We have a noble task ahead of us – reconstruction of our country. We cannot afford to allow the AIDS epidemic to ruin the realisation of our dreams.*

- Chris Hani, speaking at an HIV/AIDS policy conference convened by the ANC in Lusaka, Zambia May 1991.[1]

# Introduction

South Africa has become the site of one of the fastest growing HIV epidemics in the world. On average, 1 500 citizens are being infected with HIV each day, in addition to the 3,6 million South Africans who were estimated to be living with HIV by mid-1999. The 1998 HIV/AIDS survey of the national Department of Health found that one in every eight adults was living with HIV – a 33.8% increase on the previous year's figures. Among teenage girls, infection rates rose by almost two thirds, to 21%. "It frightens the

hell out of me that the rate of increase among the young is still so high," former health minister Dr Nkosazana Zuma was quoted as saying.[2] More than 100 000 people were expected to contract AIDS in 1999.[3]

The first recorded case of HIV in South Africa was in 1982. This first phase of the epidemic (clade B virus) was linked biologically to the epidemic in North America and Western Europe (Schneider, 1998b). In the late 1980s, this converged with a second phase (clade C virus) that was linked to the epidemics in east, central and southern Africa. The South African epidemic lags roughly 5-10 years behind those in central and east Africa.

National HIV prevalence rates were calculated for the first time in 1990 via annual surveys of public sector antenatal clinic attendees. In that year, about 0.8% of the population was estimated to be HIV-positive; by 1998 the prevalence rate had passed the 22% mark.

Projections now show the country will be in the most devastating throes of the AIDS epidemic by the year 2004. A risk scenario conducted by the Metropolitan Life insurance firm estimates that more than 6 million South Africans will be infected by 2005. By the same year, 2,5 million people will have died of AIDS-related illnesses. Ominously, even "significant changes in sexual behaviour" will trim back those projections only marginally, since the forecasted casualties will occur mainly among people who have contracted HIV already.[4]

Already, statisticians have reduced estimates of South Africa's average life expectancy from 65.4 years to 55.7 years. According to Dr Alan Whiteside of the HIV/AIDS Research Unit at the University of Natal, that figure will drop to about 48 years by the year 2010. Other forecasts are even lower, citing 35-40 years.[5]

Shocking as they are, these projections are not new. In 1996, an Old Mutual Actuaries and Consultants survey forecast that the annual death rate in the workforce would rise from 5 to 30 in every 1 000 workers.[6] Hardest hit will be mineworkers, some 45% of whom are already infected with HIV, according to the deputy minister of mineral and energy affairs, Susan Shabangu.[7]

In KwaZulu-Natal, where HIV prevalence rates have edged past the 30% mark, deaths now outstrip births, according to research by University of Natal demographer Karen Michaels. If current trends persist, by 2005 only 13% of the population could live to celebrate their 40th birthdays. According to UNAIDS, more than 700 000 AIDS orphans will be created by the AIDS epidemic countrywide.

The disease is spreading unevenly across the country, with the northern and eastern provinces hardest hit. Infection rates among women attending antenatal clinics in KwaZulu-Natal had reached 32.5% in 1998 (a 20.8% rise over 1997), while the Northern Province experienced a rise in the infection rate of 40.2%. The lowest infection rate (5.2%) was recorded in the Western Cape. Overall, infection rates in 1998 rose in seven of South Africa's nine provinces. Meanwhile, large variations in infection rates occur within provinces. In Messina and Beit Bridge in the Northern Province, for example, prevalence rates exceed 60%, although the overall provincial rate was estimated at about 10%.

**Progression of HIV infection: national and provincial figures**

| Area / Province | 1995 % | 1996 % | 1997 % | 1998 % |
|---|---|---|---|---|
| **South Africa** | 10.4 | 14.1 | 16.0 | 22.8 |
| **Eastern Cape** | 6.0 | 8.1 | 12.6 | 9.9 |
| **Free State** | 11.0 | 17.5 | 19.6 | 22.8 |
| **Gauteng** | 12.0 | 15.5 | 17.1 | 22.5 |
| **KwaZulu-Natal** | 18.2 | 19.9 | 26.9 | 32.5 |
| **Mpumalanga** | 16.2 | 15.8 | 22.6 | 30.0 |
| **Northern Cape** | 5.3 | 6.5 | 8.6 | 9.9 |
| **Northern Province** | 4.9 | 8.0 | 8.2 | 11.5 |
| **North West** | 8.3 | 25.1 | 18.1 | 21.3 |
| **Western Cape** | 1.7 | 3.1 | 6.3 | 5.2 |

**Source:** Data from the Department of Health of the Republic of South Africa. Sampling and testing done with the participation of provincial co-ordinators, SA Blood Transfusion Services; SAIMR laboratories; Virology Departments of Cape Town and Natal Universities, the NIV, MEDUNSA, Makweng Provincial Laboratory of the Northern Province and MRC.

Analysts warn that "AIDS could have a more devastating effect on this country than apartheid". The question, they say, "is not whether there will be an epidemic, but how terrible it will be".[8] According to Dr Malegapuru Makgoba, president of the Medical Research Council, "there is no economic recovery without tackling AIDS. If we don't stop AIDS, there will be no African renaissance".[9] As commented by one journalist:

> By the year 2020, there is a very real possibility that within the heart of South African's workforce – people 20 to 40 years old – one in every three will be sick with HIV/AIDS. These are the people on whose backs the new South Africa should be built ... Businesses will have to spend more money to retrain workers to replace those lost to the disease, and productivity will fall due to missed workdays. Government services will slow even further as key officials (and their loved ones) get sick and die ... As people with AIDS slowly die, their families lose their incomes, medical bills pile up and family members are forced to care for the sick ...[10]

It is difficult not to conclude that South Africa thwarted its chances to stem an epidemic that has increased thirty-fold since 1990. "Despite the commitment of the democratically elected government of 1994 to the HIV epidemic by allocating substantial human and financial resources, the scale and magnitude of these efforts have not been sufficient to turn the epidemic around," said Quarraisha Karim, the first director of the Directorate HIV/AIDS & STDs.[11]

In the early 1990s South Africa was the only country in the world which had to contend with an exponential rise in HIV prevalence rates in the context of a major political transition. In 1990-1994, therefore, what was unavailable was the institutional and political stability – not to mention the political legitimacy of government – necessary to implement a coherent and co-ordinated response.

But HIV/AIDS was also drowned out by a profusion of other priorities, the immediacy and gravity of which were beyond dispute. Political violence in KwaZulu-Natal and on the Witwatersrand, fears of an impending civil war and the elaborate jousting at the political negotiations table occupied the time, energy and resources of professional politicians, political activists and policymakers alike. Moreover, despite some ominous projections, HIV seroprevalence in South Africa was still low; rising

from 0.8% in 1990 to 4.3% in 1993 when the political settlement was finally concluded. A medium-term perspective invited alarm, since prevalence was almost doubling annually (see table below). Yet the immediate priorities at the time were lodged firmly in the short term: achieving and then nursing the political settlement, preventing the possible implosion of the nation-state, ending political violence and safeguarding South Africa's tremulous passage to democracy.

**HIV prevalence in South Africa**[12]

| | |
|---|---|
| 1990 | 0.76% |
| 1991 | 1.49% |
| 1992 | 2.69% |
| 1993 | 4.69% |
| 1994 | 7.57% |
| 1995 | 10.44% |
| 1996 | 14.07% |
| 1997 | 16.01% |
| 1998 | 22.8% |

Source: UNDP & UNAIDS, *1998, HIV/AIDS and Human Development in South Africa*, p 50; South African Institute of Race Relations, 2000, *1999/2000 South African Survey*, SAIRR, Johannesburg

The table shows that HIV prevalence rose dramatically during the period when a national AIDS response was being mustered and implemented. The scale of the failure becomes clearer when one notes that the HIV prevalence rate in both Thailand and South Africa was less than 1% in 1990; eight years later it was 1.5% in Thailand compared to over 22% in South Africa.

Yet, by 1994, a potentially effective response had been designed, in the form of the National AIDS Plan. Months after the April 1994 elections, the new democratic government adopted that Plan, galvanising hopes that an epidemic could be averted. South Africa seemed to have hit the ground running in its bid to stem the spread of HIV/AIDS. But hopes that it would avoid the devastation visited on other African countries had all but dissolved by 1999, as the HIV prevalence rate rose dramatically.

In 1999, the achievements listed by government in fighting HIV/AIDS included:

- training "more than 10 000 secondary school teachers" and the launching of life-skills programmes;
- initiating the first phase of the Beyond Awareness Campaign, which "served to link affected people with the available resources";
- appointing traditional healer consultants to train traditional healers in the management of sexually transmitted diseases (STDs) and HIV;
- distributing 140-million condoms and beginning to develop a strategy to introduce the female condom; and
- starting lay counselling and mentorship programmes to strengthen counselling services.[13]

Perhaps the most successful aspect of the National AIDS Programme has been to improve the quality of STD care and increase the public's access to that care. In fact, it appears to have been a classic example of "getting the small things right", argues Helen Schneider:

> Ensuring good STD care is simpler than organising peer education or doing outreach with marginalised groupings, and points to the kinds of prevention tasks that are within the capacity of the system to implement ... If simple tasks

> are successfully managed, they will contribute to building an environment which will make more challenging interventions through government possible at a later stage.[14]

Yet it is also was impossible to dispute the tragic fact that South Africa has failed to manage and control the spread of HIV. An HIV epidemic has taken hold; an AIDS epidemic is now inevitable. Many observers and actors attribute this largely to the National Plan not being implemented as envisaged and that, as a result, a "South Africa United Against AIDS" (the theme of the 1992 conference) did not transpire. In Helen Schneider's assessment, "all are in agreement that the National AIDS Plan was not implemented as expected and has turned out to be not much more than 'a neat book on the shelf'" (1998a:5). Harsher views hold that "anything would have been better than the way it turned out".

As the Plan became submerged amid competing priorities, civil society organisations (CSOs) failed (despite their best efforts) to muster widespread pressure for its implementation. Gradually dissolving, too, was the mutual trust between government and the CSOs needed to salvage the plan, while divisions among organisations working in the HIV/AIDS field contributed to the stasis. Despite clear evidence of a looming calamity, the political will to act decisively was lacking in government in a period when concerted action was required. Lost as a result was a crucial window of opportunity for pre-emptively acting against the pandemic.

Whether lost or squandered, the five years allowed incubation of the social and economic disaster that now looms for South Africa. As we shall see, numerous attempts to make up lost ground have been made since late 1998. Much as these initiatives deserve praise, they also require monitoring and critical assessment. South Africa's margin for error and omission has become very slim.

This paper seeks to track – from a variety of angles – the key factors that shaped government's AIDS response in 1994-1999. It is widely held that most of the difficulties encountered related to questions of process rather than technical content – hence the emphasis on the contextual problems that hampered implementation.[15] In surveying those factors, this paper is also sensitive to the fact that matters of process and content do occasionally blur. Thus the decision to lodge the National Aids Plan within the Department of Health overlaps with and reinforces a particular conception of HIV/AIDS as primarily a medical/health issue. Likewise, the failure to invest the Plan with a practical multisectoral character stemmed both from that mindset and from process problems encountered in the context of a transitory state system.

The period up to early 1997 formed the subject of that year's National Review; sections dealing with the institutional, structural and what we might term the more "literal" factors at play draw on, but do not seek to repeat the comprehensiveness of that Review. Occasionally this paper also draws on the original drafts submitted to the Review team. Correspondence, essays, conference papers and notes made available by their authors form part of the research materials gathered and used, as do periodicals and interviews conducted with a range of participants or close-at-hand observers of the processes.

Importantly, we have tried to incorporate into this analysis other factors that seemed important – though in ways that were often disguised and that tended not to lend themselves to empirical, databased research. We refer here to those currents and dynamics that help shape the ideological climate of South African society – the values, ideas, assumptions, attitudes, anxieties, desires and behavioural choices that not only affect individuals but also extend through society, thereby helping to shape social relations. Some of those sections are necessarily exploratory, and are aimed at uncovering some of the overlooked facets that complicate an effective response.

# The ideological terrain

Eluding South Africa still is an answer to these questions: What might be an effective response to a disease that is, in discursive terms, as complex as AIDS in a country as divided, as wracked by contradictions and stereotypes, and as filled with silences as ours? Exactly what interventions should practically constitute that response? How can the disease be decoded in terms that prompt people to act in accordance with such a response?

Shaping AIDS in the public consciousness since its "arrival" in South Africa in the early 1980s has been a succession of chauvinistic cliches, starting with a focus on the sexual orientation of the ailing airline steward who allegedly transported the disease onto our shores. But also shadowing the disease was an almost millennial (and, therefore, desperate) optimism, rooted in the modernist faith in science. Reason would triumph and medical science, it was believed, would conjure up a vaccine or cure. Society was a patient waiting to be wheeled into the operating theatre.

Soon those hopes began to buckle before the realisation that, without effective treatment, the majority of people infected with HIV would develop AIDS and that without effective prevention, the spread of the disease would not be arrested. Massive prevention efforts were demanded. But in the opaque ideological circuits of society, other antidotes and fallacies already enjoyed stronger support. In the popular consciousness, it seemed, AIDS could be quarantined or confined to "high-risk" groups. Homophobia was wielded as an illusory shield. Fidelity and monogamy would serve as barriers to the disease. Religious faith and putative cultural traits were invoked to fashion a sense of security. Throughout, the disease was transferred onto the Other. In a society as riven by division and bigotry as South Africa, these defensive mechanisms acquired a compelling logic.

By the mid-1990s, panic seized the medical community as it encountered daily evidence of the disease's spread. The anxiety spread through the population as it suggested that the disease's virulent transmission was not limited to sexual encounters. New myths became the handmaidens of fear, fortifying social prejudice against gays, sex workers and intravenous drug users. The category of the Other was duly expanded – and legitimized by the strange sight of dentists, health workers, boxing referees and soccer physicians, on the job, donning latex gloves.

AIDS had arrived encrusted with codes of sanction and it slotted neatly into moralistic narratives of deviance, accountability and just punishment. This set the stage. Conceptually, AIDS was seen as lodged in the individual, blocking recognition of how profoundly the disease was connected to the social and yet also divorced from the social. The systemic *patterns* of its spread were obscured by the assumed *trajectories* of infection. Prejudice and stigma compounded the myopia. "Victims" became "perpetrators". Social rejection, enforced silence and pained denial flourished in the wake of the disease. AIDS became lodged in the personal, in the individual – a maneuver that, later and inadvertently, would be reproduced by AIDS activists and organisations as they sought to establish conditions in which people with HIV and their families could deal with the disease and the social reactions it triggered. From this emerged a commendable and important emphasis on human rights. But so, too, did the conviction that people living with AIDS (PWAs) had to be the focus of AIDS interventions.

Ironically, the public gaze was again concentrated on the (stigmatised) individual.

Faith in medical science did not wane, however. It was believed that salvation would still emerge from the laboratory. The social challenge, it was thought, was to try and stem the spread of the disease and to help individuals cope – "in the meantime" – with the pain and eventual death the epidemic inflicted. An obvious contradiction had arisen. AIDS was to be transported beyond the realm of medicine and converted into a social and political issue. Simultaneously, in terms of treatment, services and an ultimate cure, it was still lodged in the medical field. The one area of action was the expanse of broader society; the other was a district of specialised expertise. Straddling these two realms was the belief that rational behaviour would halt the epidemic's spread.

But, as a disease intimately tied to poverty, unemployment, migration and gender discrimination, AIDS has resisted responses that rest squarely on a faith in Reason. What still eludes us is how to merge the paradigms of the medical and the political, the scientific and the social. There have been attempts to do so, but flawed ones. Bids to situate AIDS in its social context tended to feed off, and into, populist explanations of behaviour and knowledge. But they did not create an understanding of the disease as a social phenomenon. In fact, the early forays were decidedly anti-intellectual, blanketing with scorn the light researchers and academics sought to shed on the epidemic and the society through which it spreads.

It was not as if we had to reinvent the wheel, despite the peculiarities of our society. A wealth of sophisticated social and political theory regarding HIV/AIDS has been generated in North America and Europe. Yet we have not sought to determine to what extent these theories apply in our context or what avenues of further exploration they suggest. The response of South African social theorists to AIDS has been timid. Equally lacking has been the encouragement for them to rise to their duty.

As a result, we stand deprived of cogent understandings of many of the social dynamics that help the disease's spread. We know little about how individuals move between their social terrains, the different identities they use to do so, and the transactions they perform in order to take control of their lives. Our understanding is crammed with descriptive categories, but lacks analytical ones. We relish *describing* our society and content ourselves with the false notion that we therefore *understand* it.

So we are left stranded with only the faintest grasp of what can or cannot, what does or does not work as we seek to stave off the disaster of the AIDS epidemic. We "engage" with communities, we adopt "culturally sensitive" postures, we defer to others without an authentic sense of exactly who we are engaging with, what we are sensitive about or to whom we are deferring. The alibi we resort to typically, nonetheless, is "the community" or "the people", who should tell us what they want and need – as if those expressions are neutral, unsullied by dynamics of power and untouched by flights of hope. Having stooped to populist rules of conduct, everyone is left short-changed.

Our AIDS response has been compromised by the failure to confront and critique the ways in which notions of cultural traits and community values have colluded with the epidemic and sabotaged effective interventions. We don't yet know how people culturally and socially process a phenomenon as complex and frightening as this disease.

The dominant response has been to try and understand the disease within conventional frames of understanding – leaving hidden the

many ways in which AIDS reconstructs the familiar and warps the assumptions we bring to bear on it. Thus AIDS is viewed as a reflection of the status quo, with the epidemic fuelled by poverty, migration, discrimination, powerlessness and the like. All these factors apply. But they do not complete the circle of understanding we seek. AIDS is also a disease lodged in behavioural patterns and value systems that become adapted to the presence of the disease. The people performing these shifts of conduct are not as helpless and passive as our reductionism would have us believe.

The result of all this is a society that is trapped between two misfortunes. On the one hand, there is the health and medical establishments' failure to deal with the disease (in the form of services, treatment and counselling). On the other, there is the ideological failure of politicians, intellectuals and AIDS workers to decipher the social, economic and political mechanics of the disease. Instead of remedying these failings, the moralistic overtones of prevention messages and AIDS workers' rhetoric have an alienating effect, allowing people to deflect the disease onto the Other. Consequently, we see a population that is manifestly *aware* of AIDS – to the point of being bored, dismissive and fatalistic – but that lacks the conceptual tools for effective behavioural and attitudinal changes.

For all its shortcomings and failings, the National AIDS Plan did try to forge some links between these different dimensions of the disease. But it couldn't merge – or reconcile – them within an overall response. What had to be done was clear. But the Plan was prevented from attaining its goals by incomplete understandings of the social, cultural and ideological terrains on which it had to work.

# Origins and outline of the National Plan

The South African Strategy and Implementation Plan (referred to as the Plan from here on) emerged in a period of rich but perilous flux early in the 1990s. Efforts to secure a negotiated political settlement seemed to founder one month, revive the next, only then to encounter new hurdles. Political violence was endemic in townships on the Witwatersrand and across KwaZulu-Natal, while the prospect of organised right-wing reaction hung over the negotiations like Damocles' sword.

But amid fears of a possible cataclysm that might lead to the break-up of South Africa, a bewildering array of networks and consultative forums beavered away at new policy frameworks for a democratic government. One such initiative was the NACOSA process which, through wide-ranging consultation, formulated an AIDS policy between late 1992 and early 1994.

Spearheaded by the NGO sector, progressive health care networks and sections of the mass democratic movement, the process of devising a national AIDS response led to a national conference in 1992 (with the theme "South Africa United Against AIDS"). It was there that the National AIDS Co-ordinating Committee of South Africa (NACOSA) was launched. The conference was attended by

representatives of political parties, as well as HIV/AIDS, health care, human rights and religious organisations. It had been convened by the ANC and the former Department of Health, and served as a catalyst for a fertile period of policy development that eventually would yield the National AIDS Plan.

Both the process and character of inputs into the Plan bear highlighting. Occurring in the midst of a major political transition, the Plan "was not managed by a government department, but by a coalition of forces largely outside of government".[16] In line with the spirit of the time, the design of the Plan was marked by wide-ranging consultation and guided by the ethos of consensus making. According to Helen Schneider, the process drew heavily on perspectives and proposals generated "in AIDS prevention, care and support work in the 1980s and early 1990s from both industrialised and other African countries".[17] However, the transitional context of the time lent them some distinctive features.

The Plan, Schneider continues:

> was drawn up during a time when the National Bill of Rights was being formulated and debates on human rights in the new South Africa were at their maximum. The Plan thus combined the technical with the political and was comprehensive, practical and carefully costed. It was explicit in rejecting what Kirp and Bayer (1992) refer to as "containment-and-control" in favour of "co-operation-and-inclusion". It went further than the generation of WHO-inspired medium-term AIDS plans of the time to embrace the sexual rights of women as a cross-cutting theme and to accord people living with AIDS a key role in AIDS policy development and implementation. (1998:5)

Indeed, the 1997 South African STD/HIV/AIDS Review described the Plan as:

> an effective and democratic way of developing a representative and united response to the HIV and AIDS epidemic, and a mechanism for the people to signal to the government how they wished the HIV/AIDS epidemic to be tackled and the services and programmes they wished to be involved in and provided.[18]

The National Plan entailed an integrated response to HIV/AIDS and comprised six key elements:

- education and prevention;
- counselling;
- health care;
- human rights and law reform;
- welfare; and
- research.

Key among the principles adopted was that people with HIV and AIDS would be involved in all prevention, intervention and care strategies; that the Plan would be guided by recognition of women's vulnerable position; and that confidentiality would be protected. Importantly, the Plan did not view the epidemic primarily as a medical issue but couched HIV/AIDS education, prevention and care in broader, social terms. All sectors of government were to be enlisted in the fight against HIV/AIDS. Thus, the Plan's goal and objectives were to:

- prevent the transmission of HIV;
- provide care for people infected with and affected by HIV/AIDS;
- alleviate the impact of HIV/AIDS on communities;
- support people not infected by HIV in their efforts to retain that status;
- provide a forum for all South Africans to become involved in efforts to combat the spread of HIV/AIDS;
- identify resources that could be deployed in the fight against HIV/AIDS; and

- ensure that communities were fully involved in all stages of the development, planning and implementation of the Plan.

Implementation would be guided by the pursuit of three, overriding objectives:

- preventing the spread of HIV;
- reducing the personal and social impact of HIV and AIDS; and
- mobilising and unifying national, provincial, international and local resources.

The timing of the venture was important. In the context of an incipient political transition, consensus was more easily marshalled; across the board, debates were polarised into support for the new or support for the old. Few people were keen to be seen to be opting for the old order. Meanwhile, the influence of organisations and individuals with progressive credentials and histories was strong. In addition, the Plan was drafted more or less in an institutional and fiscal vacuum, unrestrained by the practicalities of governance. (In this sense, it was analogous to the ANC's adoption of the Reconstruction and Development Programme.) Together, these factors enabled the formulation of an 'ideal' or 'model' response.

Warnings about practical difficulties in implementing the Plan came mostly from officials who had worked in or with the apartheid state, and so such warnings were largely unheeded.[19] These officials were familiar with the byzantine tendering, financing and organisational procedures that had to be traversed to implement the Plan. But rather than offer routes around these obstacles, they tended to emphasise the impossibility of implementation. At the same time, the implementation strategy of the Plan paid too little heed to existing posts, preferring to base it on wishlists of new posts and structures. Inevitably, "lack of capacity" later became a recurrent complaint.

Although the process was overshadowed by the unfolding political dramas of the early 1990s, some top ANC officials seemed to grasp its importance. Chief among them were Dr Nkosazana Zuma (soon to be minister of health) and Manto Tshabalala-Msimang (the then chair of the parliamentary portfolio committee on health, and later minister of health). Dr Zuma, in fact, served as chair of the NACOSA strategy subcommittee.

According to her:

> As NACOSA, it was obvious that AIDS was going to be one of this country's greatest crises – in terms of health and the economy – and that the government was not going to get around to doing anything unless prompted. So we felt that we needed to present it with a plan they could use as the basis for strategy.[20]

Political support for the Plan seemed clear. After the 1994 elections, Dr Zuma (as minister of health) endorsed the plan as the national framework for action. The national AIDS programme was located in the Department of Health under the Directorate HIV/AIDS & STDs. An AIDS programme director was appointed in December 1994. The directorate was given the task of facilitating and co-ordinating the implementation of the Plan through provincial structures. The AIDS budget was promptly doubled, while government raised further funds from the European Union and other foreign donors. HIV/AIDS also received special status by being ranked as one of the 20 social priorities identified by government, potentially earning the programme privileged access to resources. Almost R50 million in foreign funding was raised to finance it.

In one of its early decisions, the new Cabinet endorsed and gave its formal support to the Plan. This seemed to mean that all government departments were committed to implementing the Plan

through their structures and that they would support the Department of Health in its specific ventures. The need for high-profile political leadership also seemed to have been met. However, such hope soon evaporated.

The guiding principles of the NACOSA process were later incorporated into the Government White Paper on Health System Transformation, adopted by Parliament in April 1997:

- civil society and government would be involved mutually in containing the spread and impact of HIV/AIDS;
- people living with HIV/AIDS would be involved in all prevention, control and care strategies;
- there would be no discrimination against people infected with HIV/AIDS and their legal rights would be protected; and
- emphasis would be placed on adequate capacity-building at all levels to accelerate HIV/AIDS prevention and control measures.

The Plan had laid great emphasis on co-operation and inclusion, while a vibrant synergy was envisaged between the state and civil society. Crucially, implementation of the Plan was envisaged as multi-sectoral, with its management apex located in the President's Office. This, it was hoped, would provide the authority and prominence needed to propel implementation horizontally across various government departments and vertically through the tiers of government.

# From the drawing board to the coalface

Government's national plan emphasised AIDS prevention and education (involving 53% of the HIV/AIDS budget), and counselling, care and support for people with HIV and AIDS. But, as Mark Gevisser reported at the time:

> most of this funding – about R100-million – will go towards improving the primary health care system. Despite a high HIV-infection rate (550 000), there is not yet an undue strain on health-care services: currently, there are only 10 000 people with AIDS needing medical treatment, as opposed, for example, to 11 000 killed on the roads each year. But, notes [Clive] Evian, 'the crunch will come in five to seven years' time'.[21]

Concerns were already being voiced at this stage about the degree of political commitment that would need to accompany the programme. "We have a major ally in Zuma," one of the participants in the NACOSA process, Clive Evian, was quoted as saying, "[but] there hasn't been any real demonstration of political will from the other heavies up there, except for Mandela, who has highlighted the issue from time to time".[22] Similar concerns would multiply in the ensuing years.

The Plan assigned to government the central role of funding, organising, propagating and executing an effective response. This was supposed to occur in coordinated fashion, via

> a network of technically competent and progressive cadres at national level and the nine new provinces, who together would form the core infrastructure of the government AIDS programme.[23]

Highlighted, too, was the need to base the AIDS programme in the President's Office, with regional authorities working out of the nine provincial premiers' offices. The aim was to locate it as close as possible to the pinnacle of executive power, a move that could add great symbolic weight to the programme, as well as increase the institutional power needed to implement the Plan's various provisions.

However, soon after the formation of the new government, it became clear that this prescription would not be heeded. Dr Zuma believed that the government's AIDS programme should be a function of the Department of Health.

There is no evidence that Dr. Zuma did not support the Plan or was not keen to see it implemented. Nevertheless the location of the Plan in the Department of Health highlighted the tension between the medical and social understandings of HIV/AIDS. The emphasis would be on the biomedical, behaviourist model of health intervention. This model hinges on aiding and persuading individuals to make certain behavioural choices *despite* the constraints created by social status. It is an approach that avoids looking at the complex social transactions people perform in order to position themselves as advantageously as possible in society. Essentially, it is a rationalist approach that sees behaviour as the outcome of transparent, predictable and consistent decisions that can be altered by new, equally rational, inputs. Applied to HIV/AIDS it runs into two problems: HIV/AIDS is a disease that seems to defy rationality, and the approach shows a profound lack of knowledge and understanding of stressed social behaviour.

The government's AIDS programme was thus based on the following foundations[24]:

- a national programme (the National HIV/AIDS and STD Directorate), set up in 1994 and located in the national Department of Health. By 1998 it could draw on 18 staff members and 7 short-term consultants;
- nine provincial programmes, mainly linked to communicable disease control. The bulk of the responsibility for policy implementation was vested at this level;
- emerging district level AIDS or communicable disease coordinators. According to Schneider (1998b), staffing levels were (and remained) very low: a total of six to 24 professionals, depending on the province, with most appointees also saddled with a range of other, more "traditional" tasks; and
- fifteen AIDS Training, Information and Counselling Centres (ATICCs) in eight provinces. These had been created prior to 1994. Most are in urban areas and are based with local government authorities. Staffing is low (one to eight people per ATICC).

With respect to HIV/AIDS, South Africa's good fortune – a successful transition to democracy – was also its misfortune. Having been adopted by the new democratic government, the Plan had to be translated into practice through a public sector that soon after found itself in the throes of restructuring. In Mark Gevisser's opinion:

> the tragedy of South Africa and the AIDS epidemic is that the time at which something could be done was also the time of the transition. So, despite the warnings and the incredible research contained in the 1994 document, the Plan effectively went onto the backburner.[25]

Amalgamating and rationalising the various apartheid administrations was an absolute necessity. Under the apartheid system, 18 racially and ethnically divided bureaucracies had been created.

These had to be merged into a national bureaucracy and nine provincial bureaucracies. At the same time, planning and management systems, the operating ethos and the staffing profiles of departments had to be overhauled in line with the overarching reconstruction and development objectives pursued by the new government. The difficulties encountered were legion. There were also examples of obstruction from some apartheid-era civil servants, confusion about the location of responsibility and lines of accountability, and a climate of disorientation and distrust in which the newcomers had to operate.

By 1995 the resulting constraints were manifest. A year after the NACOSA Plan had been adopted, the National Directorate HIV/AIDS & STDs had appointed only five staff members: a director (who had taken up the position full-time only five months after her appointment), two professional and two support staff. The staff structure of the directorate was only finalised in the 1996/97 financial year, although staffing levels had been boosted by the end of 1995 thanks to the use of short-term contract staff (a route used by several government departments in order temporarily to circumvent painstaking bureaucratic procedures). The Directorate was also able to use people who had been seconded from other tiers of government in order to develop and implement certain specific tasks.

Having staff members on the job did not, however, mean that the task was eased. A lack of familiarity with bureaucratic procedure was endemic. The situation was attributable to a rules- and regulations-bound bureaucracy, as well as to the mood of insecurity and, occasionally, outright intransigence from old-style bureaucrats.

There was also some resentment by new bureaucrats of the need to adhere to regulatory and procedural systems – driven by a tendency to associate these systems with illegitimate "apartheid state rules". A sometimes flippant attitude toward the need for checks and balances ensued (when the priority, after all, was to carry out mammoth tasks quickly). Delays became endemic, as inadequately prepared documents and submissions were returned time and time again for correction. Certainly, incumbent bureaucrats could and should have offered better training and support to the new staff. By the same token, the new staff should have demanded this. Instead, a kind of obstinate stalemate occurred. The "old guard" used their knowledge and experience to humiliate the newcomers (and defend their jobs by showing that they were indispensable), while pride and disdain prevented the "new guard" from enlisting the help of their "foes" when it lost its way in the bureaucratic maze.

The first director of the Directorate HIV/AIDS and STDs, Quarraisha Karim, lamented early on that "you are operating in a vacuum, you know what to do but not how ... The most qualified person at the moment, with regard to procedure, is the senior clerk".[26] By mid-1997, however, matters appeared to be stabilising. The directorate had appointed 18 full-time staff and hired seven part-time consultants. But in Gary Adler's view the directorate remained encumbered by problems that filtered down to provincial level:

> The malaise in the National AIDS Directorate has meant that provinces have not been able to identify with a national vision of what needs to be done. It also means that provincial MEC's for health have been let off the hook and not been pressured into taking bold steps to do something about AIDS in their provinces.[27]

According to the Plan, the engine room of the HIV/AIDS response would be located at provincial level. But the architects of the Plan had not reckoned with the quasi-federal system that was agreed upon at the political negotiating table. With the exception of the housing sector, national government was to allocate to the provinces lump sum budgets that provincial governments then had to divide up between different departments. Strictly speaking, national government could not decree the amount of funding any provincial government had to spend on, for example, health, let alone the amount it wished to see destined for HIV/AIDS work. To be sure, provincial decision-makers had to operate within a framework of nationally determined policy priorities and frameworks, but their subsequent decisions about actual spending were insulated from national "interference". This has meant that provincial health departments are tasked with implementing health policies and programmes that are often devised at national level. However, the provinces have discretion about actual allocation of budgets and thus about the practical implementation of such policies.

Yet the spending liberties vested with provincial governments should not be exaggerated. Provincial budgeting decisions are circumscribed by, among other factors, a policy of fiscal constraint and have been accompanied by explicit injunctions that provincial fiscal deficits rapidly be reduced and reversed. As well, the setting of provincial spending priorities has had to occur within a hotly contested context of competing demands and perspectives.

That noted, within an overall fiscal frame determined at national level, provincial governments since 1997 have been able to decide on their own health, and HIV/AIDS, spending levels. With respect to HIV/AIDS spending, this allocative power has resulted in widely divergent levels of funding – ranging in the 1998/99 financial year from a mere R2.5 million in one province to as much as R55 million in another.[28]

In some provinces, there was unhappiness about budget allocations and even the policies developed at national level. Many provinces also regarded the National Directorate with suspicion and were reluctant to accept joint programmes and decision-making. On occasion, materials provided by the National Directorate were rejected because "proper consultation" allegedly had not occurred. Often muted and disguised, this feuding allowed a process of mutual blame to occur – with the national department accusing provinces of failing to deliver and the latter retorting that lack of consultation and unrealistic directives stymied their work. Similar feuds raged between the provinces and local authorities. At play, it seemed, were fascinating but debilitating struggles for legitimacy, influence and power.

A range of problems have retarded provincial departments' efforts to carry out their mandates effectively. Achievements have been highly uneven and correlate strongly with the degree of political will demonstrated and applied in different provinces. In several provinces, HIV/AIDS work has been sustained largely by NGOs and CBOs.

**Provincial level staffing for HIV/AIDS & STD programmes (1998)**

| Province | Professional / technical staff | No. of regions & STDs | Regional staff for HIV/AIDS | No. of districts & STDs | District staff for HIV/AIDS | Provincial budget for HIV/AIDS & STD programme activities |
|---|---|---|---|---|---|---|
| **Western Cape** | 2 | 4 | 4 | 0 | - | Nil |
| **Free State** | 2 | 6 | 6 | 4 | 4 | R2.5m |
| **Northern Province** | 1 | 7 | 7 | 25 | 7 | R4m |
| **Mpumalanga** | 3 | 0 | - | 16 | 20 | Nil (CDC integrated) |
| **Eastern Cape** | 0 (2 CDC) | 5 | 5 | 21 | 4 | Nil (integrated into health promotion) |
| **Gauteng** | 6 | 5 | 8 | 25 | 11 | R2m + R47m allocated across Depts. + R4m for NGOs |
| **North-West** | 6 | 0 | - | 18 | 18 | R1.5m |
| **KwaZulu-Natal** | 2 | 8 | 8 | 21 | ? | R6.9m |
| **Northern Cape** | 3 | 6 | 3 | 0 | - | R3.9m |

**Notes:** 1. Budget figures to do not reflect funds allocated to regions or districts.
2. "CDC" refers to Communicable Disease Control.
3. Eight of the nine provinces have ATICCs, which receive funding from the province through other channels. The same number of provinces also support NGOs.
4. The five provinces with the highest prevalence of HIV are shaded in the table above.

**Source:** Schneider, H., 1998, *The AIDS Policy Process in South Africa* (Annex C: Results of Questionnaire distributed to provincial HIV/AIDS programme co-ordinators, May 1998), Background document (June), Johannesburg, p 14.

Whereas a degree of capacity and stability was being achieved in the national directorate by mid-1997, a much more desultory state of affairs continued at provincial level. Eighteen months after their formation in 1994, only two of the nine provincial health departments had set up formal AIDS programmes. That figure grew in the next two years, but provincial co-ordinators appointed to these programmes generally lacked the institutional clout they needed to get their work off the ground. Very few had direct experience of running HIV/AIDS services.

While some co-ordinators held the rank of director, others were accorded much less authority; their job descriptions ranged from

deputy and assistant director to the lowly community liaison officer. The upshot was that the efficacy of their efforts came to hinge on the commitment shown by their respective MEC for health. This, however, varied hugely. The importance of this variable was confirmed also in the fiscal realm. For example despite having the second-highest HIV prevalence rate in the country, Mpumalanga in the 1996/97 financial year had an AIDS budget of only R2 million (of which only a quarter was spent).[29]

As a result, AIDS programmes existed in name only in several provinces. A paper submitted to the South African STD/HIV/AIDS Review noted in mid-1997 that:

> [a]lthough provincial programmes are beginning to emerge and take shape, they simply do not have the capacity at present to achieve the ambitious aims set out for them in the National AIDS Plan. Provincial AIDS Programme structures all fall within health departments where they exist in a support function to district structures, which are supposed to implement health programmes in an integrated fashion ("vertical support for horizontal implementation"). In many provinces the district level is still limited in capacity ... The still evolving process of decentralisation with inadequately developed mechanisms of co-ordination between the various actors, had made it difficult to fast-track AIDS activities through provincial and district structures.[30]

What was highlighted was the fact that the implementation section of the Plan did not reflect the realities that pertained in the various regions. This did not mean that the provinces were bereft of capacity – just that the resources that existed were not necessarily those identified in the Plan. Most provinces hid behind this issue, instead of harnessing existing capacity to help achieve the six key strategies of the Plan. It is by no means certain that the priorities identified in the six key strategies could not have been implemented – even in resource-strained departments. Few provincial co-ordinators, for example, are known to have used national government's endorsement of the Plan to goad their provincial health departments and provincial governments into providing more support for their programmes. Instead, there was a kind of "comradely" submissiveness.

Almost eighteen months later, the 1998 report entitled *HIV/AIDS and Human Development: South Africa* still found political commitment and public leadership lacking in most provinces, with the Free State the main (albeit qualified) exception.[31] It noted that the Gauteng provincial government's response "seems to have been largely health-sector driven with minimal involvement of other sectors", despite the fact that Gauteng's budget allocation for HIV/AIDS work almost matched that of the National Directorate. Public leadership was provided mainly and effectively by the NGO sector. In KwaZulu-Natal, the Eastern Cape and the North-West, political commitment was found to be weak. The report accused the Eastern Cape government of mustering "an indifferent response" that was mitigated only by "serious commitment and hard work at grassroots and community levels". The latter activities, though, were "constrained by few resources and little official support".[32]

To its credit, the KwaZulu-Natal government in late 1998 mounted a special HIV/AIDS programme and launched an interdepartmental forum on HIV/AIDS and STDs. Mpumalanga's response was restricted to the health and welfare sectors, with the education department performing some work through the life-skills programme. In the Northern Province, stronger political commitment was undermined by a lack of structures and capacity, while a more concerted response took root in the Northern Cape, where it was propelled by stronger commitment (thanks largely to the advocacy and lobbying of the regional NACOSA structures).

In most provinces the provincial co-ordinators were assigned minimal staffing resources. Again, bureaucratic wrangles were largely responsible; gaining approval for new appointments in terms of civil service regulations proved difficult. By 1997, only Gauteng province had a total staff complement of more than *three* in its AIDS programme. But the hindrances were surmountable, as Gauteng showed: temporary or contract posts could be created (in Gauteng they accounted for seven of the nine staff positions). The bureaucratic letter of the law could be sidestepped by using short-term consultants. Among the other disjunctures plaguing implementation at the provincial coalface was the fact that provincial co-ordinators did not have line authority over district staff, yet important parts of the programme had to be implemented through those staff.

# Explaining the stasis

The disappointing fate of the Plan appears to have been shaped strongly by structural and organisational impediments. Less clear and more hotly debated is the extent to which subjective factors contributed – the absence of commitment and leadership from politicians and other persons in authority, and a general failure to appreciate the complexities of the epidemic.

Doubtless, the transformation processes unleashed within the state after the 1994 elections made the adoption and application of a co-ordinated, multisectoral approach difficult. Difficulties were encountered that had an acute impact – all the more so when the National AIDS Plan pivoted on government's central role as the chief funding, mobilising, implementing and co-ordinating force, and called for "a co-ordinated network of technically competent and progressive cadres at national level and the nine new provinces, who together would form the core infrastructure" of government's AIDS programme.[33] The new government had no previous governing experience. In a complex and potentially unstable environment, it was literally "learning on the hoof" as it sought to dismantle the legislative edifice that had supported the apartheid system and to modify state institutions to perform tasks they had been explicitly designed to prevent previously. At the same time, it was trying to dispense the socio-economic benefits pledged during the election. Calm reflection was a luxury few, if any, government departments enjoyed.

Yet government did not have to reinvent the wheel in all respects. At its disposal was an impressive pool of experience and expertise that had accumulated in the 18 district-level AIDS Training, Information and Counselling Centres (ATICCs). These had been created before 1994 by the AIDS unit of the Department of Health and Population Development. Funded from national level via the provincial departments, they were located in local authorities. For a considerable period, they had been the cutting-edge of grassroots HIV/AIDS work. In this sense, capacity did exist – at least for short-term interventions regarding counselling, testing and training. The ATICC structures could also have been developed and transformed further. There was however, a perception that ATICCs belonged to the "old order". Support diminished, understaffing became a problem and some of the structures were allowed to shut down. Thus, functioning service units disappeared.

This comment is not intended to romanticise the role of ATICCs. They varied greatly and operated differently. Their urban concentration was duly criticised. Some were stricken with problems. But they did provide testing, counselling and training services that, otherwise, would have been unavailable. A more sensible route would have been to develop services where they did *not* exist, while improving those that were being provided, rather than attack ATICCs. Instead, they were vilified by some provincial departments and accused of "empire-building".

The 1998 UNDP and UNAIDS report noted that the "capacity of ATICCs to engage in outreach and skills training is critical to the strengthening of resource bases at community level". ATICCs staff had already developed and tested a rich array of methodologies and programmes. Yet these resources were scarcely tapped by provincial governments even as their AIDS programmes languished without sufficient staff. Instead, ATICC staff offering services and assistance to provincial programmes often encountered lack of interest and even resistance.

Part of the problem was the view that ATICCs (which were located in local government) were duplicating services that should be provided by provincial departments. Such qualms seemed out of place in a period when most provincial AIDS programmes manifestly were unable to get off the ground, and when more, not less services were required.

The 1997 National Review document also dismissed those objections, reminding that "there is sufficient AIDS work for a wide diversity and it makes sense for the provincial programmes to recognise where work is happening, to collaborate with and strengthen this ..."[34]

Perhaps more potent was the perception that ATICCs, having been created by the apartheid regime, lacked legitimacy and could not be trusted. In retrospect these prejudices seem trite. ATICCs had in many regions sustained NACOSA, and later NAPWA structures and were particularly active in submitting proposals and comments to the constitutional process, the Human Rights and Gender Commissions, as well as the Law Commission. Yet, the consequences of those sentiments were amplified by the fact that ATICC funding after 1994 was decided at the discretion of provincial AIDS co-ordinators (rather than devolving from the national level). In some cases their decisions appeared influenced by the view that ATICCs were over-resourced and that staff salaries were too high. These notions, too, were largely erroneous, as the 1997 National Review document noted:

> With the exception of the KZN ATICCs and Johannesburg, the ATICCs operate on a staff of less than ten. The budgets of most ATICCs in terms of their allocation from the provincial governments is between R400 000 and R600 000. When one considers this in the light of the pace of the epidemic, the failure on the part of most provincial health departments to kickstart a vigorous and dynamic AIDS programme and the lack of leadership and programme development from the Department of National Health, it is clear that ATICCs are seriously under-resourced and underfunded. Yet, it remains that they are carrying the bulk of HIV and AIDS work in the country.[35]

Some ATICS have received no increase in funding allocation since 1994, despite the demonstrable increase in infection rates, care needs, training requirements and requests for support.

Such missed opportunities compounded the inertia characterising provincial AIDS programmes. To some extent, ATICCs became ensnared in a generalised problem encountered by government: that of effectively defining and assigning the responsibilities and authority needed to co-ordinate a programme through the three

main tiers of government (national, provincial and local). Late in the day, many local authorities were still balking at the need to match provincial support for structures like ATICCs and AIDS Service Organisations (ASOs). In Johannesburg, where HIV infection rates were widely known, the Egoli 2002 structural adjustment plan was unveiled without mentioning HIV/AIDS and its potential impact on the city. Detailed reports had been submitted to the authorities, yet requests for urgent meetings to discuss the issue seemed to fall on deaf ears.

# Change of emphasis

Subsequently, the National AIDS Programme shifted its emphasis from implementation to devising guidelines, developing capacity and improving co-ordination. In mid-1998, Helen Schneider could still note that "a disjuncture exists between national planning/ expectations and implementation realities within provinces" (1998a:7). The infrastructure for implementation was increasingly in place but it still fell short of what was needed to achieve the objectives of the Plan.

The sidelining of ATICCs is an example of how the factors of structure and agency often overlapped to shape the fate of the Plan. A further example is the ongoing debate over where the government's AIDS Programme should be located.

There was significant pressure from NACOSA to locate the AIDS unit in the President's Office or at least in (then) deputy president Thabo Mbeki's office. Involved in this bid (in late 1994 and early 1995) was Clarence Mini, who co-chaired NACOSA between 1994 and 1998:

> With Edwin [Cameron] as co-chair of NACOSA, we decided to pursue the "Uganda approach" – of having the AIDS unit in the President's Office. We were handed over to the Rev [Frank] Chikane to pursue this with him ... We pushed with Chikane, said we don't want a whole office with the President – let the secretariat stay with the health department, but let the main person, the leader of the unit, be with the President, even if it's just a desk behind the door. We just wanted the person to take advantage of the stature of the office.[36]

By mid-1995, it was clear that the bid had failed. Frank Chikane informed the NACOSA heads that the proposal had been discussed with the health minister and that the decision was to keep the directorate in the Department of Health. As AIDS Consortium director Morna Cornell recalls, the argument was that the AIDS programme would become just one of many projects if it was located in the President's Office, whereas it could be more effectively prioritised and managed out of the Department of Health.

The initial plan to situate the AIDS unit at the apex of executive power was dead. So, too, was the fall-back position – boosting the authority and profile of the unit by locating the unit's head in the President's Office. The effect was triply profound. The unit's prominence was scaled back, it lacked access to executive power and its work was to be couched firmly in a biomedical framework.

Compounding this was the fact that the head of the unit – the National Directorate: HIV/AIDS & STDs – was appointed at the level of director and not that of chief director. Her authority, therefore, was nominal. Set back was a central premise of the NACOSA Plan: that of linking the AIDS programme with other, co-ordinated efforts aimed at socio-economic transformation.

The notion of interdepartmental co-ordination was not, however, abandoned. But Nkosazana Zuma believed this would best be achieved and managed from within the health ministry. Indeed, some successes were notched up on this front: putting life-skills on the Education Department's agenda and bringing the Correctional Services Department around to recognising the importance of HIV/AIDS. But government had structured the AIDS programme in such a way that it risked being elbowed aside by the many other, competing priorities that loomed. In health consultant Anthony Kinghorn's view, a lot of the other sectors didn't buy into AIDS and didn't see it as a core business. Even in health, people were preoccupied with other priorities.

Would the National Plan have been more effective if it had been managed out of the President's Office? According to Quarraisha Karim, it would not have worked better:

> There were enormous challenges that government had to face. ... Everything was new. It didn't really matter where it was going to be based. If I had a choice and a say, I'd say its establishment in the Department of Health was the right decision ... at least there was a nascent programme (whatever its limitations), and the minister's commitment was clear.[38]

Helen Schneider has aired a similar view, arguing that the RDP experience suggested that projects placed in line departments tended to be more successful than those located in co-ordinating units or in the President's Office (1998a:6). On the other hand, it could be argued that situating the AIDS programme in the new RDP Office could have enabled the creation of a more dynamic programme, unfettered by the old bureaucracy and loosened from the health paradigm. In Mary Crewe's view, "it could have been more experimental, introduced new ideas, sought new allies and created new response options".

Clarence Mini acknowledges the many other challenges that confronted government and the problems encountered by the RDP ministry, but contends that "anything would have been better than the way it [the Plan] turned out".[40] In the view of Mark Heywood of the AIDS Law Project the decision to locate the government's AIDS programme in the Department of Health was a decisive factor in the Plan's fate:

> The Plan explicitly stated that responsibility for HIV and AIDS should not be vested in the Department of Health but this was ignored. Once lodged with the health department, it fed into the denial and unwillingness of other departments to take responsibility for AIDS. It enabled them to say: Don't worry, Zuma's dealing with it ... In a sense, everything was stymied from that point onwards.[41]

Whether NACOSA could have done more after 1994 to influence the government's decision is moot. The Plan was unequivocal about where an AIDS unit should be sited and NACOSA made every effort to convince government to heed this proposal. Yet the Plan and the subsequent lobbying that flowed from it pivoted on a central assumption: that there would be a united and emphatic recognition in government that the AIDS programme should be a national priority. Shadowing this was the (perhaps understandable) lack of appreciation for the range of other priorities that would emerge and the danger that the programme could fall by the wayside.

There were early signs that Cabinet supported the "idea" of a National AIDS Plan, but was less convinced about the specific recommendations of the Plan. The upshot, it seems, is that the awareness existed that something had to be done, but the determination to stand and deliver was not there.

To be sure, inter-sectoral co-ordination was not a hallmark of the government's first term. The RDP Office was the salient, attempted exception. However, its efforts to oversee and co-ordinate an overall development strategy stirred both resentment and confusion in the various ministries and departments which themselves were in the throes of drastic restructuring. In early 1996 this experiment was abandoned. Henceforth RDP objectives would be incorporated into the line functions of the various departments. In such a context, the case for a Ugandan-type AIDS Commission seemed frail. At the same time, HIV/AIDS did not rank among the developmental priorities delegated to departments after the closure of the RDP Office. Except for the Life-skills education programme undertaken jointly by the Departments of Health and Education, there was scant evidence of the inter-sectoral approach mapped in the National Plan.

Even the Life-skills programme was not conceived by top leadership. It was drafted and planned by a seconded staff member and a relatively junior (but highly experienced) health department official. It was driven by lower-ranking officials and only later was it approved and supported by the respective ministers and directors-general. It turned out to be a relatively successful programme and has highlighted the possibilities for action even without the initial impetus of strong political will.

It is worth noting here an important power shift that has occurred in government. Typical of countries undergoing economic restructuring along neoliberal lines is the inflated power that accrues to the finance ministry. South Africa has been no exception. Since 1996, Trevor Manuel's finance ministry has matured into a *de facto* super-ministry in government. By diligently setting and patrolling the fiscal perimeters of government, the finance ministry effectively establishes the limits within which other departments' policies and activities occur.[42] This affects not only the resources which the Department of Health can devote to HIV and AIDS programmes, but also the extent, speed and character of restructuring in the health system broadly. Thus, health department officials could (in late 1998) buttress Nkosazana Zuma's decision not to fund free AZT-treatment for pregnant women (citing budget constraints) by adding that, even if the finances were made available, primary health infrastructure in the country remained inadequate to guarantee the success of such a programme.

# A crisis of will?

AIDS activists have grown more openly critical of government leaders' alleged failure to more forthrightly take up the cudgel of the HIV/AIDS campaign. During the first four years of Nelson Mandela's presidency, for example, he is believed to have made only one major AIDS speech – in Switzerland, in 1997. There, he told a foreign audience that:

> the vision which fuelled our struggle for freedom; the deployment of energies and resources; the unity and commitment to common goals – all these are needed if we are to bring AIDS under control. Future generations will judge us on the adequacy of our response.[43]

There was a pervasive tendency for politicians to shift the issue to the outer limits of their attention fields. When NACOSA staged a special briefing on HIV/AIDS for parliamentarians in September 1996, only 14 MPs attended.[44] Two years later, the Poverty and Inequality in South Africa report would still deem it necessary to call for "greater political, bureaucratic and financial commitment to the Plan". Such admonition has become commonplace. But the assumptions that underpin it deserve critical reflection.

# Bureaucratic commitment

We have already sketched how the dysfunction that plagued the Plan's implementation needs to be located within the broader, disorientating context of intra-state restructuring. Equally important, however, was the epistemological framework in which HIV/AIDS programmes operated at the provincial level. As Helen Schneider (1998:6) has noted, provincial AIDS managers worked within a traditional biomedical framework. Many were not recruited from the network of AIDS activism but were drawn from pre-1994 state structures. Their frames of reference and operational ethos offered them few connecting points with the contrary experiences and approaches nurtured in the progressive opposition movements. While it is tempting to criticise these reassigned incumbents from the "old order"[45], such a posture obscures the fact that there was little overlap between the Plan's paradigm and those paradigms used by the provincial implementers.

The structure of provincial-level AIDS programmes conflicted with the model envisaged in the Plan. These programmes were lodged within the emerging health system, thereby institutionalising a conceptualisation of HIV/AIDS as, first and foremost, a medical/health challenge and pushing the socio-economic dimensions of the disease into the background. (Thus, for example, the managerial positions created were slotted into an evolving network of communicable disease officers in district structures.) This development seemed driven by several, mutually reinforcing dynamics: conscious choices made by provincial policy makers, concerns that fiscal and institutional constraints made difficult the creation of "a separate vertical programme" devoted to HIV/AIDS work (Schneider, 1998), and a desire to utilise as best possible the inherited personnel resources.

# Financial commitment

Funds allocated to AIDS programmes and various other preventive activities were hardly of startling proportions. Indeed, budgetary constraints would be cited in late 1998 as the main reason for not funding a programme aimed at dispensing free AZT treatment to HIV-positive pregnant women.

Health care budgets devoted to HIV/AIDS activities can be divided into three categories. The first was devoted to education, information, counselling and care-giving[46]:

| | |
|---|---|
| 1994/95 | No budget line (budget approved in 1993) |
| 1995/96 | R13.9 million |
| 1996/97 | R60 million |
| 1997/98 | R35.4 million |
| 1998/99 | R47.6 million |

The second category provided financial assistance to institutions engaged in research and surveillance, and organisations combating HIV/AIDS[47]:

| | |
|---|---|
| 1994/95 | No budget line |
| 1995/96 | R6.7 million |
| 1996/97 | R20 million |
| 1997/98 | R6.5 million |
| 1998/99 | R3.5 million |

The third category supported efforts to develop and co-ordinate national policy and services for a variety of defined groups, among them people with HIV/AIDS[48]:

| | |
|---|---|
| 1995/96 | No budget line |
| 1996/97 | R100, 000 |
| 1997/98 | R167, 000 |
| 1998/99 | R1 million |

More substantial were the funds provided to the National AIDS Programme. These included R41.9 million allocated by the national Department of Health, R40 million from RDP funds (spread over two years) and R59 million in donor funds (from the European Union and the Belgian government, also spread over two years).[49]

Yet the poor and faltering implementation of the National Plan appears not to be linked *directly* to government funding. From 1994 to 1997, Schneider notes, "the AIDS programme consistently underspent on its allocated budget" (1998:5). At least until 1998, there was consistent *underspending* of budget allocations for AIDS-related activities:

> Three quarters of the way into the 1996/97 financial year, only 14% of [the National AIDS Programme's] allocated R80 million budget had been spent and R14.6 million was rolled over into the 1997/98 financial year. Less than one third of the original R53 million EU [European Union] grant had been committed by the end of 1996, and the contract has been extended to December 1997.[50]

A cautious approach was adopted regarding funding. Small sums could be applied for relatively easily, but large amounts had to pass through the time-consuming tender process. As a result, there was a surfeit of small projects, often pilot projects. These projects tended

not to add up to a programmed response. Even more harmful, however, were cuts in government funding to AIDS service organisations (ASOs). In the 1998/99 financial year that funding fell by half to R12 million; some ASOs closed, allegedly as a result.

While the parsimony imposed by national government's fiscal austerity drive certainly limited the funds devoted to AIDS work, it is not clear that more money would necessarily have translated into greater impact. On the other hand, those fiscal constraints have hindered the pace, extent and quality at which South Africa's primary health care system has been developing. The consequences on HIV/AIDS work have been profound, says Morna Cornell: "The primary health system is still very weak. Yet, we know that 60-70% of HIV/AIDS work has to happen at the primary level."[51]

# Political commitment

One of the most commonly voiced criticisms of the government's AIDS programme is that it was not buttressed by sufficient political commitment. In its executive summary, the National Review highlighted:

> the ability to mobilise the range of actors around a common vision and engage and communicate across the divides [as] probably the key aspects required, rather than control through a bureaucratic structure. AIDS policy implementation is dependent on achieving co-operation across sectors and organisations, where no-one is formally in charge of everyone else. The process of mobilising and organising the AIDS response is therefore critical.[52]

Nelson Mandela's muted responses have been noted. The National Review cited a "senior government official" who admitted to the lack of visible commitment beyond the ministry of health and suggested that the commitment more or less befell Dr Zuma since it fitted her job description (1997:2). As deputy president, Thabo Mbeki gave a major, nationally televised speech on AIDS in October 1998, launching the Partnership Against AIDS. Since then cabinet ministers have made more frequent, public reference to AIDS and many now routinely wear a red ribbon in public. Yet, in the ANC's annual Anniversary Statement in January 1999, HIV/AIDS earned a mere two-line reference in a 17-page speech, as it did in the organisation's January 2000 statement.[53] In Mbeki's June 1999 State of the Nation address it earned only seven lines (and no announcement of concrete, new measures).

Assuming that sufficient political commitment, indeed, was lacking (at least until late 1998), one can then ask whether adequate commitment would have translated into an effective AIDS programme. The query resists a definitive answer. It has been argued that, given the myriad institutional complications that plagued government's AIDS activities, political will was not *the singular* factor shaping the efficacy of the post-1994 response. Indeed, excessive emphasis on political commitment leads one to the idea that anything becomes possible as long as it is impelled by sufficient will. A more troubling question should be posed: Would a constant stream of pronouncements and exhortations have pierced the shroud of invisibility surrounding HIV/AIDS? As we discuss in more detail below, not only does social discourse usher the disease into the shadows with vehement determination, but it is by the nature of its transmission "invisible". Would this be breached by routinely speaking its name?

Perhaps the answer is revealed by posing an inverse but rhetorical question: Has the disease been combated anywhere effectively without steadfast and persistently expressed political commitment? The response has to be "no". Political commitment seems to be an essential, but in itself insufficient, factor in an effective bid to manage the disease. Particularly in a transition context, the presence or absence of commitment tends to amplify consequences. Amid disharmonious agendas, unsettled working conditions, disrupted management functions and a surfeit of competing demands (ranging from tasks of institutional restructuring and strategic planning to the more customary "business" of a given department), any one specific priority risks slipping through the cracks. Constantly reaffirmed political commitment then becomes a crucial variable. It cannot spawn miracles, but it can help prevent a particular priority from sinking beneath the maelstrom and becoming, as some middle-level managers in Gauteng's provincial health department have described AIDS work, an "add-on".

The most obvious exception to this trend of absent or weak commitment occurred in the national Department of Health. There, the issue's prominence was hugely (though perversely) boosted by a series of AIDS scandals that led to widespread media coverage and public discussion. Helen Schneider has suggested that these scandals, in fact, showed that politicians were "already under pressure to act on AIDS and [were] searching for short-term solutions" (1998:8). In that reading, they betrayed misapplied or miscalculated political will.

In Edwin Cameron's view:

> The conventional explanation that minister Zuma and her Department were overladen and thus incapacitated by the burdens of new incumbency in office is demonstrably simplistic. In the case of tobacco she single-mindedly and speedily achieved most commendable breakthroughs in the face of concerted corporate and international opposition. The answer must therefore be sought in the more complex realm of ineptitude and even personal and political denial. This necessitated recourse to callow, injurious, and politically disastrous "quick fixes", instead of addressing the more complex task of finding appropriately directed solutions in the realm of prevention, treatment and legal protection against discrimination.[54]

In his profile of Dr Zuma, Mark Gevisser wrote:

> At the end of our time together, I ask Dr Zuma ... why she has chosen to be so high-profile about anti-tobacco legislation and yet so silent on AIDS. She disputes the premise of my question strenuously: she speaks much more about AIDS than she does about smoking; it's just that 'everyone thinks about me every time they have a cigarette, because of the warnings on the packets and the ads'. I josh that she should institute a campaign of similar intensity promoting condoms – then people would think about her every time they have sex too. She lets loose a deep ripple of laughter ...[55]

Indeed, an anti-smoking campaign is much more easily executed than an HIV/AIDS campaign. The former targets a particular activity – smoking – and through a range of largely punitive measures (non-smoking areas, advertisement bans, loading heavier taxes on cigarettes[56], etc.), it makes pariahs of those who continue to indulge in and promote that activity. An HIV/AIDS campaign does not have the luxury of this ostracising option, nor can it be built on the basis of such proscriptions. Moreover, one can see who smokes; you cannot see who has HIV. It was therefore easier for Dr Zuma to act against smoking than against HIV/AIDS. The fact that she did the former with apparently effective zeal does not mean that she lacked enthusiasm or commitment for the latter.

Moreover, given all the hindrances encountered, there was no guarantee that robust political commitment at the national level would automatically filter down to the provincial tier. On the other hand, this literal reality should not annul the potential impact of sufficient political will on the part of national politicians. That commitment could be expressed and imposed through several other channels. One was (and remains) the regular MinMec meetings between national ministers and all nine provincial MECs in a given sector. To be sure, the sheer might of intent could not brush aside the structural difficulties encountered at the provincial level. But in some areas creative detours were possible – by appointing short-term contract staff to provincial AIDS programmes as Gauteng had done, for instance.

Other channels existed within the ruling party, the African National Congress (ANC), specifically through meetings of its most powerful body, the National Working Committee (NWC), and its National Executive Committee (NEC), as well as the Women's Committee and the Youth Desk. These were important sites in which an AIDS response could have been established as a political priority.

Political commitment is not only important within government and the state, but also across society. It is on that terrain that the sidelining of HIV/AIDS in the government's dialogues with the broader public proved most damaging – all the more so when its comparative silence on the issue has been broken most forthrightly and vociferously when scandals erupted regarding its AIDS programme. At no point have government pronouncements on, and media coverage of, HIV/AIDS been more sustained or prominent than around the Sarafina II and Virodene scandals. But at the hub of the attention was neither proactive awareness-raising nor, indeed, an emphasis on HIV/AIDS. As the controversies developed, the focal point became the government's handling of the scandals. Pushed aside were not only the HIV/AIDS response but even the substance of the scandals. Public attention came to focus on the dramaturgy of the debacles: the language and tone of the health minister's statements, the to-and-fro of wounding criticisms and peevish reactions, and the steady entry of new voices and views into the fray, turning it into a kind of brawl-by-media. The details of those scandals are discussed below.

Despite the post-1998 efforts of politicians to put HIV/AIDS on the map in more proactive ways, these expressions of newfound commitment lacked imagination. To the best of our knowledge, no South African politician explicitly has linked the disease to the expansive idealism of an African renaissance. Yet, the devastating consequences of this disease are the antipathy of those ideals: the distortion and weakening of social structures, the collapse of social services, the scuttling of human endeavour and the spread of tragedy. "If we don't stop AIDS, there will be no `African renaissance'," Dr Malegapuru Makgoba, president of the Medical Research Council, has said.[57] The link is not merely a negative or opportunistic one. Containing the disease requires activating the kind of ethos that underpins an African renaissance:

> HIV/AIDS, in its competition for resources and potential to evoke fear and loathing, could become one of the most deeply fracturing elements in our process of transformation. But precisely because of the personal and economic imperatives that inform the need to "be well", it could equally emerge as an issue around which we can unite. It transcends the imperatives of party politics, points to our shared interests and proclaims deep kinship in terms of shared vulnerabilities and responsibilities.[58]

# State & civil society – a marriage on the rocks?

As the National Plan made clear, an effective response hinged on a programme of activities mounted by the state, but their effectiveness would depend on how well they could be co-ordinated and harmonised with the endeavours of civil society. Blame for the Plan's unhappy fate therefore cannot be assigned only to the state and, more specifically, government.

Civil society groups initially succeeded in devising and then persuading the new government to adopt the multifaceted HIV/AIDS plan. But by 1996, it was clear that the anticipated synergy between the state and civil society[59] was not emerging. The reasons for this failure were varied.

With respect to business, harmonised intentions and action regarding HIV/AIDS was entirely absent. To a large extent, this was caused by organised business' tendency to lodge responsibility for broad, socio-economic issues with the state, reserving for itself the task of getting on with the "business of business". In addition, the sector most severely affected by the epidemic – mining – had historically failed to regard the health of black workers among its highest priorities. In a racist society where, black (especially poorly skilled or unskilled) workers were regarded as replaceable supernumeraries, business' impulse to act decisively regarding HIV/AIDS was likely to be feeble.

An early response of some in the mining sector was to suggest repatriating foreign workers who were deemed to be "introducing" HIV into the country and the industry. By expelling the outsider, one could expel the virus. The approach fitted with the perceptions surrounding the disease – coupling the fear of a virus "invading" from beyond the country's borders with the reality of HIV transmission as an invasion of the body.

The first (and for some time, only significant) exception to this trend was the parastatal electricity utility ESKOM. A 1995 actuarial study forecasted that HIV/AIDS would add 15% in direct costs to the payroll by the year 2005. ESKOM soon declared the epidemic a strategic priority. Gradually, other major corporations began displaying greater concern, among them Anglo-American, Telkom, Tongaat-Hulett and Afrox. Several other large firms have launched workplace HIV/AIDS programmes. One of the longest-running initiatives is the Lesedi Project, started in 1996 by Harmony Gold Mine, which claims to have reduced HIV infection by 46% among mineworkers.[60]

As the asymptomatic phase of the epidemic began drawing to a close in 1999, many larger firms initiated responses. But, according to Dr Clive Evian, the responses still tended to be short-lived, unsustained and inadequate.[61] Few corporations have extended their horizons of concern and action beyond their immediate workforces. ESKOM, along with Anglo-American, remains a rare exception on this front. In Mpumalanga, they have joined forces with the provincial health department and local government structures to launch the Kriel Peer Education Project. The only other instance of significant state-business collaboration regarding the epidemic is the South African AIDS Vaccination Initiative.

Responses from the trade union movement were equally desultory. As far back as 1989, the Congress of South African trade Unions (COSATU) had passed a resolution calling for a trade union campaign regarding AIDS. Two years later it staged a special conference on AIDS in the workplace and, in 1995, it identified AIDS as a priority issue at its health, safety and environment conference. But these, largely symbolic gestures did not translate into consistent, programmatic action. The 1997 *South African STD/HIV/AIDS Review* described the trade union response as "largely non-existent".[62] A year earlier, a survey of trade union activities conducted by the Directorate HIV/AIDS & STDs elicited only 12 responses from the 150 questionnaires sent to union offices. Not a single COSATU affiliate responded.[63]

However, the new National AIDS Council does include strong representation from the labour movement. Likewise, the Treatment Action Campaign has forged strong links with labour organisations – a potentially powerful move that can ensure the involvement of the trade union movement in an important campaign to improve treatment access for people with HIV and AIDS.

More active were more than 650 NGOs "with an interest in AIDS".[64] They included organisations working specifically on AIDS, along with many workplace, community-based, health, religious, legal, media, academic and other groups. Indeed, great expectations of state-civil society collaboration circulated among these organisations, especially those classified as AIDS service organisations (ASOs). These hopes were buoyed by the origins of, and their involvement in, the NACOSA Plan, government's adoption of it in 1994 and the expectation that the state would draw AIDS activists, experts and workers into the new structures. Indeed, no other issue seemed to offer as much potential for marshalling the resources, expertise and commitment accumulated among ASOs into a co-ordinated, state-led campaign.

That optimism had begun ebbing by 1996. The slow, uneven and often unenthusiastic implementation of the Plan caused growing concern and disenchantment. Rather than being encouraged or merely welcomed, efforts to engage the top echelons of the health ministry around these concerns seemed to elicit suspicion and defensiveness.

In reality, the relationship ASOs had hoped for (and in some instances seemed to believe was being nurtured) had never been consummated. Instead, it rested on assumptions and hopes that shared progressive credentials and even "struggle histories" naturally would translate smoothly into commonmindedness, camaraderie and trust when individuals after 1994 dispersed into government, state institutions or stayed on in ASOs.

By the end of 1996 those hopes had been smashed. Much has been written about the funding difficulties, organisational travails, staff exoduses and strategic confusion encountered by NGOs and CBOs from the early 1990s onwards.[65] These developments certainly hampered voluntary sector organisations' abilities to forge with the state the kind of co-operation that seemed both necessary and feasible. NACOSA did not escape this trend. In late 1996, it was described as "battling for a reason for existence", with Helen Schneider and Jo Stein later noting that:

> its ability to mobilise large numbers of people across sectors has become increasingly limited. Trade union and business representatives no longer attend meetings and attempts by NACOSA to bring AIDS on to the agenda at Nedlac [the National Economic, Development and Labour Council] have not met with major successes.[66]

NACOSA'S initial role as a body that would co-ordinate AIDS activities in concert with government had all but dissolved. Subsequently, it refashioned itself as "an independent NGO,

focused on lobbying, advocacy, networking and NGO capacity-building".[67]

Compounding these difficulties was the failure to anticipate and, later, fully appreciate the complexities and hardships that marked efforts to transform state institutions. In the opinion of the AIDS Law Project's Mark Heywood:

> There was an assumption that there would be immediate recognition that AIDS would be a national priority – but it wasn't. We never worked out what the entry point would be to turn this around. Until the last 12 months or so, ASOs had a tunnel vision about how to deal with AIDS. We talked about a broad response but we also talked about AIDS as if it's the only thing government had to deal with and this contributed to our failure to find an entry point.[68]

Helen Schneider agrees:

> In retrospect, one of the problems with the NACOSA process was that it loaded too much on government's shoulders – there was a belief that things would just happen much more effectively than they did. In a way we couldn't have done better at the time, but there should have been a rapid process of reviewing, a constant process of assessing and asking questions. That didn't really happen, not even within government (at least not until the 1997 National Review process). [69]

Still, the need to create a two-way flow of information was recognised – from the government, via NACOSA to communities, and back again. But when this exchange began to include concerns about procedures and calls for greater accountability, the legitimacy of the model was queried. Also questioned (not just by government, but also by some NGOs) was NACOSA's "right" to act as such a powerful critic.

At the heart of the Plan lay the assumption that united and co-ordinated action within government as well as between it and the voluntary sector would be achieved quite easily. It wasn't. Not only did HIV/AIDS quickly recede among the government's priorities, but even those sections of government given the task of mounting a response seemed to shun the stock of skills and experiences that had been accumulated in and around ASOs. In mid-1998, Helen Schneider would reflect that with the exception of one provincial AIDS co-ordinator, the core members of the task teams who had drafted the Plan did not lead its implementation post 1994. Seven of the nine provincial co-ordinators had not been involved in the process at all.[70]

An additional problem lay in the way NGOs were funded after 1994. Most of the money for NGO AIDS work was channelled through the Department of Health, as donors were discouraged from directly funding NGOs. This raised the spectre of state interference and the erosion of autonomy.

Together, these factors certainly contributed to the deterioration of state-ASO relations. But the watershed events came in the form of a series of debacles and controversies that continue. First to erupt, in early 1996, was the Sarafina II scandal.

# Sarafina II: a special kind of drama

The Sarafina II controversy was fuelled by three factors: the fact that a large portion (R14.27 million) of the national Department of Health's AIDS budget was spent on the Mbongeni Ngema-produced musical, that proper tendering procedures had not been adhered to, and criticism about the awareness-building merit of the musical's content.[71]

By early 1996 the word Sarafina seemed synonymous with blundering. Newspapers milked the debacle for new, sometimes spurious "revelations", while opposition parties relished the opportunity to lambaste the new government. ASOs ventured into the fray, at first in circumspect and non-judgmental fashion, focusing on the content of the play rather than the attendant controversies. Indeed, the AIDS Consortium tried to engage the minister in lengthy and detailed correspondence that centered on the messages conveyed by the musical.

Those efforts had little impact. Criticisms were dismissed: the department, Dr Zuma told journalists, could not be expected to consult every NGO. "AIDS doesn't consult, it infects people," she reportedly said, adding the suggestion that the uproar might have been linked to the fact that the tender had gone to a black person.[72] "We are not apologetic about what we have done", said the director-general of health, Dr Olive Shisana. Top ministry and departmental officials adopted a siege mentality that would remain in place for another three years. To the press and opposition parties, it was an invitation to harry continuously and to create regular headlines. Still mainly owned, managed and edited by white men, much of the South African press discovered a convenient way to demonstrate its newfound determination to uphold propriety and the rule of law. Dr Zuma's martial demeanor only reinforced that zeal.

The scandal offered a telling glimpse of the headstrong manner in which the government's AIDS campaign was being executed. Journalist Mark Gevisser's view was confirmed that Dr Zuma's *modus operandi* was "to commit her sector to reform, and deal with the problems it creates later". A kind of combat mode was adopted: advance now, count the casualties later:

> [R]ather than acknowledging that there might have been irregularities and instituting an immediate inquiry, she rushed, hackishly, to the defence of a department that seems to have acted indefensibly; and then demanded of the ANC that it rush, as hackishly, to her own defence. Of the several canards she pulled out of her hat, the most ill-advised was the race card (her critics were whites who just wanted to pull black people down): it has been effectively trumped ... by the anger and derision of many ordinary black men and women.[73]

"The minister rarely takes advice from anyone," a state health official would later tell journalists.[74] In late 1998, Ayanda Ntsaluba, the new director-general of health, would admit that Sarafina II had put the department "in a defensive position ... it's bad being in a defensive position when one needs to make progressive decisions".[75]

Other views were more strident. The executive director of the Aids Foundation, Gary Adler said that the Sarafina II scandal, "threw the national AIDS directorate into disarray, and with it came the demise of a shared vision for AIDS in this country". He also believes that the funding cuts suffered by ASOs (from R19 million to R2 million in 1998) were partly motivated by spite directed at a sector that had tried to extract accountability from the department.[76]

It can also be argued that the money should not have been allowed to become the central issue. R14 million (or about R2-R3 for each pupil who would have seen the play) was not an exorbitant amount. The preoccupation with the cost of the play had an unfortunate effect, fuelling the myth that the AIDS programme was awash in funding. Ultimately, the scandal was not about the funds allocated to the play, but about the circumvention of bureaucratic procedures.

Ironically, some ASOs decided after the Sarafina debacle to soften their criticism of the Department of Health. They seemed reluctant to be associated in the public mind with the opposition parties (especially the Democratic Party) that were belabouring the issue. This attempt to distance themselves from the frenzy of criticism, however, appeared to go largely unnoticed in the health ministry.

"Maybe, if Zuma wasn't so visibly under pressure from the Sarafina scandal, then perhaps it could have just slipped away and we could have got on with things," Helen Schneider believes.[77] "Sarafina II has been damaging to the AIDS programme, but I believe that there is sufficient goodwill to put it behind us and move forward on the important issue of tackling the epidemic," Rose Smart said when she took over as director of the AIDS programme in December 1996.[78] But the scandal did not fade away. Instead it was supplemented by a steady stream of other debacles. Next to hit the headlines was the Virodene scandal. A pattern of behaviour had been established, and criticism only reinforced it. "I've never received good press; everything I touch is attacked," Dr Zuma grumbled in March 1996.[79]

# Virodene: search for the holy grail

The drug Virodene P058 triggered a scandal in early 1997 when it emerged that Dr Zuma had tried to fast-track its development despite warnings from the Medicines Control Council (MCC) that the drug was dangerous. She reportedly helped direct a funding appeal from the researchers to Cabinet, without first investigating the substance of their alleged findings.

Indeed, when the Virodene team received an ovation at the end of their audience with the Cabinet, their research had not been submitted for peer review. Thus a standard practice in the medical community was violated. The debacle quickly exhibited all the features of a tabloid scandal. Accusations and counter-allegations flew thick and fast. Amid this, one fact stood out: the three Pretoria scientists spearheading the Virodene project had run roughshod over established ethical and procedural guidelines for medicines development.

When confronted, the researchers argued that violation of procedures had been necessary because they had been "blocked" by an AIDS research "establishment" which allegedly was smarting at the researchers' refusal to share their patent rights.[80] However, the research had not proceeded beyond a Phase One trial, a stage

which "[doesn't] give the correct answers [and doesn't] give the side-effects, which only become known after a few years," according to then Medical Research Council president Walter Prozesky.[81] In the view of Medicines Control Council head Peter Folb, whose integrity and honesty is internationally respected, no researcher was "in a position to even suggest it is effective. No patient is going to be exposed to this chemical until we know if it could be acceptable," he declared.[82] Government responded by shutting down the MCC in 1998 and replacing it with a new control body. Curiously, the same Cabinet that threw its weight behind a discredited vaccine initiative would later challenge a tried and tested drug treatment like AZT – not only by disputing its effectiveness, but by claiming that it was dangerous.

Virodene was discounted when its active agent was identified as an industrial solvent called dimethylformamide (DMF). According to one medical expert, DMF was likely to damage human DNA, as well as the DNA of the HIV virus. Despite this, Virodene brought a glimmer of hope to some people living with AIDS. At the Sparrow's Nest Home for People with AIDS, patients pleaded to be used as human guinea pigs and signed away their rights in order to take part in clinical trials for Virodene.

Measured support for the researchers also came from unexpected quarters. In an editorial headlined "Give Virodene and the minister a break!", *South African Medical Journal* editor Daniel Ncayiyana admitted that the researchers' work had breached the peer review process, but continued:

> The minister's support and enthusiasm for the Virodene research are perfectly understandable. There is no doubt that the rigid conventions of medical research which the medical establishment (particularly editors) hold so dear can, on occasion, serve to stifle the kind of originality that may be necessary to address unconventional situations.[83]

A year later, passion still overshadowed reason. When the Democratic Party aired allegations that the ANC had a financial stake in the research, Dr Zuma reacted by accusing the party of racism. "The DP hates ANC supporters," she reportedly told journalists. "If they had it their way we would all die of AIDS".[84]

The accusations of nefarious intent seemed misplaced. Instead, the government's support for, and promotion of Virodene exemplified the mismanaged and misdirected manner of its efforts to contain the epidemic. Determined to head off a pandemic, it now staked great hopes on the rapid discovery of a cheap drug that could be made available through the public health system.

The reality of an impending calamity had sunk in, thanks to several doomsday forecasts, one of them an actuarial study by the insurance giant Old Mutual. But, rather than bolster a holistic response and abandon the defensive and divisive conduct embodied in the health ministry, it served only to embolden the quest to discover a miracle cure. If nothing else, Cabinet's initial enthusiasm for a ramshackle research initiative (at least partly conducted "underground"[85]) confirmed government's increasing hope that a quick fix could be found.

Dr Zuma, in particular, seemed locked into combative pose. The upshot was a mudslinging contest that had the effect of ruling out as nitpicking or unpatriotic behaviour any critical scrutiny of the ways in which the HIV/AIDS epidemic was being combated. The scope for substantive and earnest engagements with the Department of Health around HIV/AIDS narrowed considerably. Quarraisha Karim still sees "a general problem in government about criticism being taking personally rather than regarding taking it as constructive". But in the view of some, ASOs were also culpable in the animosities that emerged – by being "too critical and not working closely enough with government."[86] As noted, however, ASOs initially had not engaged in the sensationalism surrounding

Sarafina II, preferring to try and raise directly with the health minister their concerns about the pedagogic merits of the play. After Sarafina, some ASOs also consciously muted their criticism of the Virodene affair.

Nevertheless, the sum effects of these debacles were to distract both the public and politicians from the real dilemmas at hand. NACOSA and the AIDS Consortium had warned in early 1997 that "AIDS education and prevention work have been sidelined by the sensational presentation to Cabinet [of the Virodene research] and the accompanying media coverage".[87] Politicians adopted belligerent stances as they tried to douse the flames of criticism, with the health minister especially retreating into a defensive shell from where declamations would be issued. As a result, the skirmishes "polarised those who should have been allies, and turned valuable 'social' capital into 'sour' capital" (Schneider, 1998a).

The epidemic was certainly placed in the spotlight, but not in its own right. Instead public concern was refracted through these controversies and focused on the government's conduct. The overall effect was to deflect responsibility for HIV/AIDS action onto the government, at the expense of efforts to lodge that responsibility within society broadly, at the individual and collective levels. According to Helen Schneider, the debacles:

> diverted energies from facing the real challenges of implementation. AIDS in South Africa has come to symbolise the need to extract public accountability from senior government officials, allowing the society to externalise the problem as belonging to bumbling politicians rather than the nation as a whole.[88]

Equally damaging was the manner in which relations between government (particularly the health ministry) and ASOs became mediated by press reports during the Sarafina II and Virodene controversies. In terms of both ownership and editorial control, the South African press remained firmly in white hands. The quest for evidence of government "incompetence" or venality was enthusiastic – and the debacles seemed godsent. Not only did they answer to the perennial journalistic search for headline-grabbing conflict and drama, but they seemed to carry portentous intimations of misjudgement and, even, misconduct.

Inevitably, AIDS activists were drawn into fray. However circumspect their intentions, they found themselves positioned as critics and antagonists in the ensuing "debates" that were waged in the press. Accusatory quotes that heightened the drama featured prominently and were often divorced from the qualifications that had preceded or followed them.[89] To be sure, this is standard journalistic practice in a market-driven media environment. But, coupled with the siege mentality adopted by government in general (and the health ministry in particular), it had the effect of further eroding the scope for substantive and more considered engagement between the ministry and ASOs.

Again, race featured prominently. Most of the ASO leadership consulted was white. Their progressive credentials were often beyond reproach. But as the gloves were shed, this counted for little; they found themselves lumped with what was perceived to be a generalised onslaught on the integrity of the democratically elected government.

As Mark Gevisser puts it:

> There is a lot of prickliness about criticism in government/media relations, especially if it comes from white, liberal journalists who might also have their own agendas. When this happens in a country with a socio-political history like South Africa and you feed AIDS and its stigmas into this, you can see how the reaction would be even more severe. It seems quite clear that there would be even more resistance to white (sometimes gay) AIDS activists criticising govern-

> ment. This is partly because of this history of whites telling blacks what to do with their health. You saw this in the notifiability debate. I remember hearing Olive Shisana at a conference saying basically that confidentiality was a white, gay, male thing, that Africans have a different take on it.[90]

The upshot was that public and media attention was refracted through scandals and came to focus not on the efficacy of government's overall response but on specific controversies and abberative conduct. Not only was HIV/AIDS being seen as "government's problem", it also stood as an emblem of "the problems of government". Such a gaze pushed the epidemic itself to the margins.

This was an opportune time to embed government's HIV/AIDS response in a more consultative frame of operation and to subject it to a critical review process. To the health ministry's credit, the latter did occur in mid-1997. Indeed, the National Review was no head-nodding exercise; it bristled with substantive criticism and detailed proposals.

But the terms of engagement were clear: *primus inter pares*, government would, on the balance of evidence and research, determine its own course and brook little contention once it had chosen its path. This was in line with the centralised and hermetic character of the actions that had precipitated the debacles: none stemmed from consultation with other AIDS actors (in some instances, even the Directorate HIV/AIDS & STDs was left out of the loop), nor were the subsequent criticisms kindly received.

Indeed, a consistent lack of consultation marked government's AIDS campaign in the 1994-1998 period. Even the Directorate HIV/AIDS & STDs was subjected to highly centralised decision-making in the health ministry. Consultation with directorate staff (and even the director herself) about high-profile, controversial issues was rare. Virodene and the confidentiality debate, as we shall see, were prime examples. Indeed, the 1997 National Review cited one provincial co-ordinator complaining that "national government is prescriptive and patronising while much of the work lies with provinces", while another protested that "national is top-down and vertical ... National level has implemented eight projects [in this province] without discussing it".[91] Schneider and Stein concluded from their research that:

> here was a general perception that in the past, parts of both the directorate and the Department of Health had not fully understood the central importance of 'good process, had 'turned in on' themselves, were uncommunicative ('not transparent') and authoritarian in their approach, and had lost the non-discriminatory, human rights vision of the National AIDS Plan.[92]

Yet, the STD and TB components of government's national AIDS programme confirmed that alternative, more consultative and better co-ordinated activities were possible. In STD work, roles and responsibilities were properly elucidated and managed across different levels of government. ASOs and other NGOs were successfully harnessed into this work. Similar, happier outcomes occurred in counselling and sex-worker initiatives.

This suggests that the overarching problems described here could not be attributed strictly to structural complications. Perhaps more illuminating is an explanation that incorporates the ways in which conflict, dissent and heterodoxy were managed by ministerial and departmental leadership. For the most part, STD work and counselling initiatives were not controversial, nor did they involve divergent perspectives. In such instances, plans did survive beyond the drawing board and yielded some of the key successes of the government's AIDS programme.

In stark contrast were initiatives that bristled with differences of opinion. Confidentiality and the search for a vaccine were prime examples. The determination to act decisively combined with a reluctance to indulge dissent and produced actions by fiat. Demurral and contestation were either pre-emptively nullified (by foregoing consultation) or aggressively dismissed. In the experience of one ASO activist, "the community and those in the field were trying to be supportive, not to shoot down the Department of Health, but attempts to intervene were ignored and then there was hostility and defensiveness and threats as a response to criticism."[94] This mode of conduct extended into 1998. In a report as NACOSA co-chair, Mary Crewe noted that "the reaction to criticism has bordered on the paranoid and defensive".[94] Some analysts subsequently have detected a similar pattern of behaviour across government, noting that:

> a discourse has been maturing that pivots on notions of loyalty and patriotism, contrasted with notions of betrayal and deviance. The subtext is a noxious affirmation that 'if you are not with us, you are against us'.[95]

Indeed, the health ministry's decision-making about HIV/AIDS would remain insulated and yield directives that occasionally seemed to conflict with the enveloping commitment to combat the epidemic as effectively as possible.

The Sarafina II and Virodene episodes could be attributed to misapplied zeal. But the late-1998 decision to withhold funding from a proposed programme to provide AZT treatment to HIV-positive pregnant mothers defied such explanation. In fact, the reasons proffered by the government for this decision would shift several times as the controversy dragged on and provided clues that the motivations behind both the Virodene and AZT stances might have been less "innocent" than generally assumed. The latter two "scandals" are as a result perhaps understandable as the fall-out or by-products of other, more expansive policy priorities being pursued by government. Confronted by the scale of the looming calamity, government action increasingly seemed to be guided by the principle that the end justifies the means.

# The mystery of the AZT decision

The 1998 decision to withhold government funding for azidothymidine (AZT) treatment of pregnant, HIV-positive women seemed to highlight the impact of a tight fiscal policy managed out of the finance ministry. Indeed, the health minister's initial explanations attributed the decision to "budget constraints". According to Dr Zuma, the cost-benefit scenario did not favour funding the programme.

Without AZT treatment, 30 out of every 100 babies born to HIV-positive mothers would themselves be HIV-positive; AZT could reduce that number to 15 out of every 100. "But I have to look at the whole picture," Dr Zuma said. "If you have limited resources, you may decide to put your resources into preventing mothers getting infected in the first place. These are difficult issues we have to face." Apparently more attractive to Dr Zuma at the time were efforts to develop an AIDS vaccine, an initiative she "really wanted to encourage", according to one press report.[96] (Later, during a debate on her budget vote in Parliament in March 1999, Dr Zuma said she did not want to be put in a situation of having to choose who should benefit.[97]) In fact, her and Cabinet's decision not to approve funding amounted to deciding that *no-one* should benefit.

A public outcry ensued, with some critics noting that government had spent roughly the same amount hosting the twelfth summit of the Non-Aligned Movement in Durban in September. Further fuelling the anger was government's decision to spend R30 billion over the next decade in order to modernise the South African National Defence Force.

Partly in response to the AZT debacle, the Treatment Action Campaign (TAC) was formed. Its main objectives were to ensure access to affordable and quality treatment for people with HIV and AIDS, to prevent and eliminate new infections, and to improve the affordability and quality of health-care access for all.

The TAC would go on to lay strong emphasis on activism and consciously couch its HIV/AIDS-related demands in a broader socio-economic and political context. Thus it set about building a mass membership base and forging links with unions, employers, religious bodies, women and youth organisations, lesbian and gay organisations, and other sectors. Importantly, it sought to force pharmaceutical companies to lower the costs of HIV/AIDS medications, while at the same time pressuring government to act more forthrightly on the disease. Although it has helped move treatment issues into the spotlight (and popularised questions regarding drug multinationals' roles in stemming the disease), its efforts to influence government practices regarding HIV/AIDS, by its own admission, have been uneven.

Economists joined the fray, among them Nicoli Nattrass, who argued that "it is economically illiterate and shockingly ill-informed to argue that we cannot afford to give pregnant women AZT ... This is apparent from the most basic cost-benefit analysis."[98] Her calculations bear repeating:

> Taking the narrowest possible approach, the government simply has to ask whether the cost of administering AZT is more or less than the costs of treating children with AIDS over their short lives. AZT costs about R500 a month, and a pregnant woman needs to be treated during the last three months of pregnancy to reduce the risks of passing HIV on to the child from about 63% to 13%. So, if the state treats 100 women in order to save an additional 50 children, this will cost R3 000 per saved child.
>
> The average cost per patient per day in the Red Cross Children's Hospital is about R900. Poor patients are charged R44 per 30 days, so practically the entire cost of treating most African children with AIDS falls on the state. Any child that spends more than four days in hospital with AIDS-related problems has cost the state more than it would have done to save that child through the use of AZT.
>
> According to sources in the Red Cross Children's Hospital, children with AIDS live for about five years, and they are likely to spend at least five weeks a year in hospital. If so, each child will cost the state R54 000 – that is, 18 times the cost which would have been incurred had the state administered AZT to enough pregnant women to save that child.[99]

As soon as a medium-term perspective was adopted, the budget constraints cited by Dr Zuma seemed unconvincing as an explanation. Moreover, the government has justified its policy of fiscal austerity by adopting a medium- to long-term outlook. It forms part of a package of economic adjustments needed, it claims, to achieve the developmental objectives outlined in the Reconstruction and Development Programme. Still left begging, therefore, is the question: What (other) calculations could have accounted for Dr Zuma's decision?

Health ministry officials, meanwhile, continued to issue divergent explanations for the decision. According to the health minister's

spokesperson, Vincent Hlongwane, the issue was not cost-effectiveness – "it is that the government does not have the budget for this kind of treatment." Referring to claims that AZT treatment could spare 15 out of 100 babies vulnerable to HIV infection, Hlongwane said "We don't doubt these findings, but are not influenced by them."[100] In other words, lowering the price of AZT would not have changed government's decision, nor would the availability of another, cheaper treatment of equal or better efficacy. Yet, simultaneously, there were reports that the Department of Health had *underspent* its budget by R90 million and that this money would be used to introduce the haemophilus influenza which prevents meningitis in children.[101] According to Dr Glenda Gray, director of the Perinatal HIV Research Unit at Chris Hani Baragwanath Hospital, the anti-meningitis vaccine would "save 51 out of every 100 000 children," compared to AZT which would "save 15 000 out of every 100 000".[102]

Other health officials continued to cite the manufacturer's price for AZT treatment as the main problem. "If they [AZT manufacturer Glaxo Wellcome] really want to benefit South Africa and show they are concerned about the AIDS crisis they should give it to us as cheaply as is possible. After all, they have made their money on this drug already," said Ian Roberts, an adviser to the health ministry. The fact that Glaxo Wellcome – possibly also politicking – had already announced it would slash the AZT price by about 70% (to around R400 for a month's treatment) and hold the discount for five years only compounded the confusion.[103] Government's fiscal constraints argument would later fray further when the Medical Research Council's Salim Abdool-Karim claimed that the discount meant AZT could be distributed in clinics at an annual cost of about R20 million – a figure, he believed, which was "well within the government's means".[104]

Subsequently, Dr Zuma also disputed the effectiveness of AZT in preventing mother-child transmission of HIV. Her demurral had some basis, though not in relation to the "intrinsic" effectiveness of the drug. Tests have shown that the success rate of the AZT treatment programme is considerably higher when babies are formula-fed, as opposed to breast-fed (as most are in South Africa). The potency of an AZT programme therefore would be enhanced if combined with extensive promotion of formula-feeding.

A relatively smooth-functioning primary health infrastructure nationwide was also required. The health system, however, has lagged on this front – so much so that a health ministry official was quoted saying it would not immediately be able to implement a free AZT programme countrywide "even if it was offered to us free tomorrow". "If AZT was affordable then we could work out systems and structures to roll out the rest of the treatment," Ian Roberts explained in early 1999.[105] An effective, universal treatment programme required a relatively well-functioning public health system – an achievement that, unfortunately, still eludes the state. Yet, this should not have precluded a first-phase programme built around targeted pilot projects. Every child due to be born from an HIV-positive mother would not benefit. But thousands, indubitably, would. The tangle of official explanations for the AZT decision did not make sense.

In October 1999, president Thabo Mbeki controversially stepped into the fray. Addressing the National Council of Provinces, he alleged that AZT was too dangerous to be administered:

> Concerned to respond appropriately to this threat, many in our country have called on government to make the drug AZT available in our public health system. Two matters in this regard have to be brought to our attention. One of these is that there are legal cases pending in this country, the UK and the US against AZT, on the basis that this drug is harmful to health. There also exists a large volume of scientific literature alleging that, among other things, the toxicity of this drug is such that it is in fact a danger to

> health. These are matters of great concern to government, as it would be irresponsible for us not to heed the dire warnings which medical researchers have been making.[106]

Interestingly, Mbeki's concern about alleged health risks had not weighed as heavily when he supported the Virodene research earlier. In late November 1999, the new health minister, Manto Tshbalala-Msimang, lined up behind Mbeki. "The fact is that some of the mice [tested with AZT] have contracted cancer. It attacks bone marrow. It is very toxic," she claimed, adding: "Could you, with a clear conscience, introduce those toxic drugs to a woman and her child? I say no."[107]

The claims, though, did not survive scrutiny. Mbeki apparently had gleaned his information from unspecified websites on the Internet.[108] Side-effects do accompany long-term use of AZT and include dizziness, nausea, insomnia, vague headaches, muscle pains and anaemia. But, as Salim Abdool Karim, head of AIDS research for the Medical Research Council, pointed out, "public health is based on the principle [of benefit versus risk]. If [the minister] doesn't agree with that principle, she might as well shut down the health department and go home."[109]

According to Glaxo Wellcome's medical director for sub-Saharan Africa, Dr Peter Moore, there were no cases anywhere in the world in which AZT was the subject of litigation on safety grounds.[110] Newspaper reports quoted health specialists as saying that AZT was recommended by the World Health Organisation as well as the US Centre for Disease Control. Peter Cooper, head of paediatrics at Johannesburg Hospital and the University of the Witwatersrand, described Tshabalala-Msimang's statement as "complete nonsense".

It is difficult not to conclude that the AZT decision was propelled less by immediate budget constraints or concerns about its side-effects than by other considerations – some practical (the lack or inadequacy of health systems and structures), some political/economic (the ongoing battle with transnational pharmaceutical corporations). This suggests that the government's AIDS campaign has on occasion been subsumed under other, overarching processes, priorities and agendas.

It seems that a political/economic agenda was paramount: the government stand-off with transnational pharmaceutical companies over parallel drug and medicine imports, a battle spearheaded and valiantly waged by Dr Zuma. Paying the going-rate demanded by AZT manufacturer Glaxo Wellcome conceivably would have signalled a lack of fortitude in government's bid to win the right to source patented drugs at cut-price rates from other developing countries or manufacture them locally. In April 1999, then deputy president Mbeki highlighted this facet of the AZT decision when he told reporters: "The problem lies not with government. The problem lies with pharmaceutical companies' exorbitant prices on the [AZT] drug, thus making it impossible for government to make it available."

The need to gain cheaper access to drugs and medicines is not at issue here; indeed, the importance of this quest is self-evident. But this cannot preclude examining the possible effects of that overarching endeavour on specific decisions such as the government's refusal to make AZT available to pregnant women.

The stakes in this stand-off are high. The advantages to health care in South Africa are obvious. Less evident were the ways in which the confrontation fed into the South African government's stern bid to cement its status as a (if not *the*) paramount champion on the world stage of the interests of the South. At stake were not only the specific health benefits that would accrue, but also the chance to boost South Africa's desired stature as a state that did not buckle under the combined onslaught of transnational corporations and the US government.[111] Cast against this back-

drop, the sequence of justifications offered for the AZT decision appear less confusing and contradictory. This aspect of the AIDS response became instrumentalised and subordinated to wider imperatives. [112]

By 1998 South Africa's window of opportunity to prevent an AIDS epidemic had all but shut. With HIV prevalence rates running higher than 20% in some provinces (including the most populous – KwaZulu-Natal – where it was edging past 30%), the country had reached the brink of a full-blown pandemic: an AIDS crisis was now a mere three to five years away.

# Notifiability: clash of "cultures"?

One of the hallmarks of the Plan was its insistence on imbedding HIV/AIDS work within a human rights framework. Confidentiality was one important aspect of this stance.

The reasoning behind that stance had been succinctly captured in the judgement at the end of the 1993 Appeal Court case of Barry McGeary:

> In the long run, preservation of confidentiality is the only way of securing public health; otherwise doctors will be discredited as a source of education, for future patients will not come forward if doctors are going to inform on them. Consequently, confidentiality is vital to secure public health as well as private health, for unless the infected come forward they cannot be counselled ... Disclosure of the condition [HIV/AIDS] has serious personal and social consequences for the patient. He is often isolated or rejected by others which may lead to increased anxiety, depression and psychological conditions that tend to hasten the onset of so-called full-blown AIDS. [113]

But the NACOSA Plan's commitment to confidentiality never seemed to make a significant impression on the health ministry. Early in her tenure as health minister, Dr Zuma had linked confidentiality to the kinds of stigmas that seemed to fuel discrimination. In July 1994, she remarked that:

> the most important thing is to counter the stigma of AIDS. If people deal with it secretively, it just reinforces the culture of fear and ignorance, and makes it impossible to control. People need to see AIDS as a disease like any other, to demystify it. We have to outlaw discrimination against people with AIDS. [114]

The remark seemed to suggest a two-pronged approach: outlawing discrimination while at the same time taking measures that would push HIV/AIDS into the "open". This was in line with the contrary position that complete confidentiality reinforces the climate of secrecy and fear. In the view of NAPWA's Peter Busse it is a Catch 22:

> [U]ntil people start talking about their experiences of living with HIV there is going to be a general disbelief on the part of the population. And on the other hand, because of the discrimination and stigma which people face, which can be very real and very hard, it's very difficult for people who are infected to get up and talk about the fact that they are HIV positive. [115]

A view also circulated that an unequivocal emphasis on individual rights and liberties might have the perverse effect of abetting a mind set that associate the disease with individuals, rather than with society. On the one hand, there is the message that HIV/AIDS threatens everyone. On the other hand, confidentiality seems to cloak it in secrecy – thereby lodging the disease with *those who are infected*, who remain faceless ciphers onto whom popular prejudices and stereotypes can be projected. Confidentiality, in such a reading, functions as a barrier against the social "ownership" of HIV/AIDS which some activists advocate.

In November 1996, health director-general Dr Olive Shisana told an interviewer that she was "not convinced that we are doing the right thing in keeping HIV/AIDS such a secret". Comparing HIV to the Ebola virus, she stressed the need to contain it immediately and suggested: "We should ask the average South African whether we do the right thing in our fight against HIV/AIDS with our attitude towards the whole issue of confidentiality of HIV."[116]

ANC and AIDS activists immediately criticised the remarks. More telling was the response of Rose Smart, then the newly appointed head of the Directorate HIV/AIDS & STDs, who felt the department lacked a clear policy on the issue. Two and a half years later, her concern was still valid, but by then the department had declared AIDS a notifiable illness. The declaration was in line with departmental style, it seemed: headstrong but sometimes misguided policy changes regarding HIV/AIDS without proper consultation and policymaking processes.

However, Dr Shisana's comparison of HIV/AIDS to the Ebola virus was misleading. Ebola is a highly contagious disease that threatens anyone who comes into contact with an infected person. Public health therefore demands that infected people be separated from the rest of the population. HIV/AIDS is infectious only under very specific circumstances.

The 1997 National Review explicitly came out in favour of confidentiality. Yet, even at the launch of the document, Dr Zuma reportedly opposed that stance by reaffirming the need to make AIDS a notifiable disease. In April 1999 the health ministry followed this up by announcing plans to make AIDS (not HIV) a notifiable disease, with Dr Zuma shrugging aside objections with this caustic declaration:

> We can't afford to be dictated to by human rights or AIDS activists. We need to do what is right. We want to know who is dying of AIDS, and relatives and partners must be notified. It is time we treated AIDS as a public health issue like TB. We don't go about treating that with secrecy.[117]

The animosity with which the health ministry viewed ASOs was affirmed, an attitude that also seemed coloured with notions of race and "culture". In Helen Schneider's view, "there is also an assertion of an African perspective – the idea that we have to find solutions ourselves and part of this might mean rejecting the 'Western, gay' kind of approach."[118]

Dr Zuma argued that notification would help prevent further infection and enable the epidemic to be traced more accurately. Critics have disputed the claim, saying data collection would remain unreliable since "even specialists dispute the pathology justifying AIDS diagnosis".[119] The AIDS Consortium's Morna Cornell contended that the move "would offer no positive benefits to people living with HIV/AIDS, and that it could prevent openness about HIV/AIDS''. NAPWAs Peter Busse called the proposal "an outrageous suggestion":

> One can't argue that HIV/AIDS is the same as any other disease. With other diseases you are not denied employment, you are not evicted from your family home or killed for revealing you are infected.[120]

The AIDS Advisory Group, a small committee of recognised HIV/AIDS experts rejected notifiability and repeatedly requested meetings with Dr Zuma and Dr Shisana to discuss the matter. They were answered with a cold shoulder. Soon afterwards, the group was disbanded. The official reason given in a letter in a letter from Dr Shisana was that European Union funding for hosting the group's meetings had run out. The notifiability proposals were subsequently gazetted, though their fate under Dr Zuma's successor as health minister, Manto Tshabalala-Msimang, is uncertain. Once again, the urgency of generating an effective response to the epidemic seems to have generated a misguided response. Unfortunately, relations between the ministry and ASOs had soured so badly that a mutually respectful engagement with the controversy seemed impossible.

# The political domain

It is by no means clear that institutional and structural factors fully explain why an HIV/AIDS response became submerged amid other governmental priorities. The decisions, actions and omissions that shaped the government's HIV/AIDS response were also influenced by a mix of other factors, among them political concerns, the inevitable imprints of the society's history of racism (and ongoing racism) and the personal sensitivities of high-ranking politicians. An enquiry into the fate of the 1994 Plan, therefore, has to also venture into the thicket of intersections between the political, social and personal domains.

In the view of Mark Gevisser, the shifting of HIV/AIDS onto the backburner

> was also a political manifestation of certain psychological attitudes about AIDS. At the personal level there appears to have been a predisposition not to deal with AIDS head-on, and that attitude was made easier by the fact that there was, obviously, so much else to tackle as priorities.[121]

Feeding this reluctance were a variety of factors that pre-dated 1994. One was the sensitivity toward and anger about a right-wing campaign that sought to associate AIDS with exiles returning from other countries in the region. The ANC resisted calls for testing of returnees from countries with a high HIV prevalence rate (such as Uganda, Angola, Tanzania and Zambia), a stance it later attributed to its "relative unclarity about the disease". That explanation remains unconvincing.

It was perfectly clear at the ANC AIDS conference held in exile in Lusaka in the early nineties, that the organisation was acutely aware of the epidemic, its nature and transmission, its effects and its likely impact on the country. In ANC leader Chris Hani's comments this understanding was manifest. Both Zuma and Tshabalala were present throughout that meeting. Representatives of the National Progressive Primary Health Care Network (NPPHCN) spoke about what was happening in South Africa and expressed some of the concerns felt by that organisation.

According to some accounts, the ANC leadership had been privy to a study that revealed a high HIV prevalence rate among exiled cadres that had been stationed elsewhere in the region. Certainly, ANC cadres stationed in Africa had been confronted with the effects of the epidemic. At a conference staged in Maputo in early 1990, ANC officials met with progressive health workers and AIDS activists from South Africa; the outcome was the *Maputo Statement on HIV and AIDS*. In the same period, the belatedly remembered warning of Chris Hani was issued:

> Those of us in exile are especially in the unfortunate situation of being in the areas where the incidence of this disease is high. We cannot afford to allow the AIDS epidemic to ruin the realisation of our dreams. Existing statistics indicate that we are still at the beginning of the AIDS epidemic in our country. Unattended, however, this will result in untold damage and suffering by the end of the century.[122]

On the same day that Chris Hani spoke those works, an ANC health desk document was released, in which the gravity of the impending epidemic seemed clearly recognised.

The disease marked one of the few areas in which the ANC decided to work with an apartheid government department in the early 1990s while negotiations proceeded. All this indicates that key figures in the ANC had pinpointed HIV/AIDS as a priority for the organisation.

But there were wrangles. One was the conundrum of translating this commitment into practice without jeopardising the attempts to assimilate returning exiles back into society and, importantly, inflaming the internal/external tensions and suspicions that marked the early 1990s. In Mark Gevisser's view:

> there was a fear of further stigmatising returning exiles and this had a lot to do with the reluctance to deal with the disease head-on. Perhaps it was also personal matter for some – a number of senior people were trying to deal (or not deal) with the disease themselves. A lot of this occurred at the unconscious or subconscious level. There was a kind of internal resistance to confronting it head-on. Add in the other factors – the negotiations time-frames, the possibility of a civil war, re-establishing the ANC organisationally inside the country – and you see a whole range of factors that allowed the disease to slip off the list of top priorities in the pre-1994 period.[123]

It is perhaps not surprising, therefore, that the disease did not receive much public prominence from the ANC leadership in 1990-1994. One of the only top leaders to have addressed the issue at length and with passion during this period was Chris Hani, then general-secretary of the South African Communist Party and head of Umkhonto we Sizwe. (Nevertheless, other ANC figures – notably the first two health ministers appointed after the 1994 elections – were very active in the processes that led to the launch of NACOSA in October 1992.)

Another important factor was the way in which the disease was stigmatised under the apartheid regime, argues Mark Gevisser:

> What makes South Africa unique epidemiologically is that there were, in a sense, two epidemics – a "western gay" epidemic and then a heterosexual African one. The first people to get sick were gay, white men. But around 1986-87 (and you can actually track the shift), the Gay Plague becomes the Black Death. The shift is quite apparent when you look back at the press stories of the period. So, in South Africa, AIDS was doubly stigmatised – which made it very difficult to deal with AIDS soberly as a matter of public policy. Uganda, for example, even Zambia, did not have to deal with the gay stigma, nor with the racist constructions that were applied to it.[124]

AIDS awareness campaigns did little to shift those perceptions. Early on prominent messages advised people to "know your partner", "stick to one partner" or reduce the numbers of partners. The effect was to confuse and deceive. It is perfectly possible to stick to one partner, love wisely, know one's partner *and still become infected*. Implicitly, some messages also contradicted themselves. The ironic sting in the tail of the plea to "support people with AIDS" was a tacit acknowledgment that people with AIDS could not automatically expect support. These safe, "sensible" messages became the educational equivalent of muzak, a kind of background drone that was easy to ignore. They were the product of a reluctance to offend ordinary South Africans – a curious reluctance, given the fate that awaited millions of people.

From the mid-1980s onwards, HIV/AIDS was shadowed by both a gay stigma (extrapolated further as a Western, alien "perversion") and a racist stigma involving white myths and anxieties about black sexuality, the population control forays of the apartheid government and whites' generalised terror of the Other. This description of the HIV/AIDS information campaigns by the (apartheid) Department of National Health and Population Development in the early 1990s captures some of the ways in which the disease was constructed in racist terms:

> ... AIDS education for the majority of the people meant the notorious "yellow hand campaign" which further discredited any efforts on the part of the government. The large illustration of a yellow hand outline, accepted because of its supposed cultural neutrality, was actually associated with the rubber washing gloves of the "madams", and was regarded with contempt from the outset by black South Africans. Posters produced were culturally illiterate, featuring white characters with the faces coloured in, and only rarely in the appropriate language. Pamphlets educating about AIDS were printed in English and Afrikaans only.[125]

Interestingly, when the advertising agency presented initial outline of the campaign, representatives of the progressive movement seemed impressed (not least by the yellow hand imagery). Some suggested that if government did not adopt the campaign, funds should be raised so that it could turned into a "people's campaign".[126] The National Party government did accept the campaign, but immediately snared the agency in restrictions. As a result, the campaign did not run in its original form. But, rather than honour their earlier enthusiasm by insisting that the original campaign be run as envisaged, progressive figures set about flatly discrediting it.

The net effect was to reinforce the tendency to sidestep the disease through denial – a tendency that characterised South African society generally but also top policymakers and politicians. Moreover, the stigmas about the disease made it an intensely divisive issue. This meant that HIV/AIDS fitted very awkwardly (if at all) into a dominant discourse directed at forging unity, fostering conciliation and generating a new basis of national consent.

At the helm of this conciliatory project was Nelson Mandela. According to the former co-chair of NACOSA, Clarence Mini, an official letter from that organisation lay on his desk when Mandela assumed office in 1994. The contents advised him of the urgency of acting quickly and decisively on HIV/AIDS and urged him to elevate the issue to a national priority. Several requests for a meeting then followed, at which NACOSA could present the 1994 Plan and impress on the president the need to locate an HIV/AIDS unit in his office. The meeting occurred months later (in November, 1994), but Mandela did not attend. His replacements were deputy presidents Thabo Mbeki and FW de Klerk, who offered the presentation courteous and apparently serious attention. In 1998 Mandela was scheduled to present a nationally televised address on HIV/AIDS; this time, Mbeki served as his stand-in. Indeed, if

measured minute-by-minute, during his presidency Mandela probably spent more time with the Spice Girls and Michael Jackson than he did raising the AIDS issue with the South African public.

It is difficult, perhaps impossible, to explain this remarkable pattern of silence and evasion without the benefit of Nelson Mandela's own account.[127] But, as noted, that silence was pervasive in government where (with the exception of the health ministry) there occurred at best rhetorical acknowledgment of the importance of the issue without actively placing it at the centre of activities, pronouncements and demands. Equally puzzling is the fact that the government has seldom linked the disease to the deprivation caused by the apartheid system – a link as valid as that routinely and correctly made between apartheid and a variety of other social and economic ills that continue to plague South Africa. For their part, AIDS activists have drawn these links for many years.

# Framing AIDS as an individual health issue

In October 1999, Dr Zuma reiterated: "The main thrust of the government's strategy is prevention through better education and information ... *The government's strategy is focused on the prevention of the spread of the virus, care for those who are affected and no discrimination against people living with AIDS.*" (Dr Nkosazana Zuma, "Awareness is the only cure for the spread of AIDS", *Sunday Times*, 18 October 1999. Emphasis added.)

Prefiguring the many technical, structural and fiscal complications that have inhibited the introduction and activation of effective HIV/AIDS programmes is the manner in which the disease has been conceptualised. Here, we encounter a fundamental ideological problem – in Brian William's view, a failure to "understand the difference between public and individual health".[128] A public health view should compel one to conceptualise the disease, and the responses, in social terms.

But the individual/social dichotomy doesn't always hold. In some respects, the gaze has focused on individuals, but without effectively finding ways to get individuals to act on public health advice. At the same time, the expansive hopes pinned on the discovery of an effective vaccine – the so-called "magic bullet" approach – shield the individual from the need to act and change behaviour. The vaccine drive "socialises" the disease in a highly distorted manner – not by lodging it in the social, but by relieving the individual from responsibility.

In mid-1994, Malcolm Steinberg, then the head of the Medical Research Council's AIDS programme, had already noted that many in government were "looking for a quick fix".[129] Later, this mindset would again be revealed in the Virodene debacle and it would feature prominently in government's defence of its decision not to fund the provision of AZT treatment to pregnant, HIV-positive women.

This thinking was not limited to government. Asked whether he considered a vaccine to be the only solution to the AIDS problem, former MRC head Dr Walter Prozesky in September 1999 told an interviewer:

> Yes, indeed I do. It is the considered opinion of medical virologists internationally as well as in South Africa that the only practical, affordable means to control our AIDS epidemic over the long term, is by mass vaccination of our population ... The South African AIDS Vaccine Initiative's dream is to give each and every baby born a present: life-long immunity against AIDS. Even if we can only prevent 50% of cases at first, we will be able to bring the disease under control, while continually improving the vaccine.[130]

In Dr Prozesky's view, that "dream" is not fanciful. Earlier, he declared that "we in this country have the expertise to deal with every stage of development of an HIV/AIDS vaccine. We have the epidemiologists, the virologists, the molecular biologists, the immunologists and the clinicians." [131]

"We've reached the panic stage," Alan Whiteside has said, "and now everyone is looking for a quick fix. In reality, there is no quick fix." It is essential that South Africa's determination to discover a vaccine is exercised in ways that do not jeopardise the other crucial elements of an effective response.

ESKOM has pledged R30 million to the vaccine research initiative and the work has begun to prepare the country for the possible introduction of a vaccine. The aim of this MRC-driven response is to ensure that the country is aware of both the possibility as well as the complexity of vaccines and to understand the nature of trials.

No doubt, the search for a vaccine is an important facet of an effective response. That quest should not be the preserve of the pharmaceutical conglomerates of the industrialised world. Indeed, according to a pharmaceutical "industry insider" quoted in one media report, the search for an AIDS vaccine has slipped far down the rungs of research priorities of transnational corporations:

> The first company to find a really effective AIDS drug will go bankrupt ... Why? Look where the majority of AIDS cases are – South-East Asia and sub-Saharan Africa. Not too many people living in those parts of the world can afford expensive drug treatments. [132]

The optimism surrounding a vaccine fits neatly with the expectancy and voluntarism of African renaissance discourse. In Mark Gevisser's view, it is also in line with a determination speedily to bring about visible improvements and changes:

> One of the things that motivates the Mbeki regime is a need for tangible results. It's all about doing things that will produce visible outcomes. The flipside is that there seems to be a block when it comes to doing things where the results seem less tangible and certain.[133]

In January 2000, the head of the Medical Research Council predicted that South Africa would be testing a vaccine by 2004. The hope proffered is false. Testing does not equal availability, which could, even if a vaccine is discovered, take until 2010. In the meantime, millions of South Africans will have succumbed to the disease and millions more will have been at risk of infection. There also is no guarantee that the vaccine would work – or be cost-effective. In fact, the loud propagation of the idea of a vaccine is at variance with the educational, safe sex campaigns that, finally, have gathered momentum. If a panacea is in the works, why take precautions and alter sexual behaviour?

At the moment an AIDS vaccine does not exist. Indeed, it is possible that a vaccine may never be discovered. If it is discovered its effective introduction will ultimately depend on the other components of an HIV/AIDS campaign – not only the six elements highlighted in the NACOSA Plan (education and prevention, counselling, health care, human rights and law reform, welfare, and research) but also a properly functioning health care system. We do not know, for example, whether a future vaccine would require repeated and sustained doses. As health workers know all too well, successful treatment of tuberculosis is possible – the drugs exist and are available through the public health system. Yet, treatment completion rates are woefully low. A vaccine, in other words, is not in itself a panacea.

# Failure to change behaviour

One of the myths about AIDS work has been the notion that South Africans are not AIDS-aware. In fact, government and civil society campaigns have created a largely AIDS-aware population. What the publicity and information campaigns have failed to do is to alter behaviour.

There are many reasons for this. Among them is the fact that much of the information disseminated through media campaigns has sought to change behaviour by inducing fear. Statements and headlines like the following (from newspaper reports) have been commonplace: "Contracting AIDS is a death sentence and the sufferer becomes a potentially lethal sex partner"[134]; "No brakes on AIDS holocaust"[135], "The new South Africa's silent killer"[136].

Understandably, the emphasis has been on alerting South Africans to the impending calamity. There is no shortage of statistics and estimates (prevalence rates, daily infections, the number of HIV-positive South Africans, lower life expectancy rates, projections of AIDS deaths, AIDS orphans, the impact on the economy, etc.) with which to inform and alarm. The accuracy of the projections and data is not the issue; indeed, the estimate that almost one in ten (3.6 million) South Africans is living with HIV is "probably an underestimation".[137] But the route of persuasion has tended to rely on fear and anxiety as the main catalysts for behaviour change. Even attempts to construct "positive" messages have lapsed into negative registers – the slogan "Don't kill love" being one current example.

There has been a lot of criticism of the negativity, the fatalism and sense of doom that defines many of these messages. Rightly, it is pointed out that infection with HIV is not a "death sentence" and that even the onset of AIDS does not mean imminent death. The erasure of hope is neither accurate, nor is it guaranteed to elicit proactive responses (as opposed to fatalistic resignation).

Much can be said in support of this criticism. In her books *Illness as Metaphor* and *AIDS and its Metaphors*, Susan Sontag, for instance, has critiqued the equation of certain illnesses with degrading suffering and inevitable death. Yet, it seems equally true that in South African society those equations are more accurate. The obscene discrepancies between the public and private health systems (that mirror huge inequalities of income and wealth), and the extent of poverty and deprivation mean that the more sanguine

attitudes advocated by Sontag are unlikely to find purchase in the lives of millions of people with AIDS. More to the point, in our context, is Mary Crewe's question: "Can there be a positive image of suffering?"[138] For, however dignified, suffering is and will be the fate of most South Africans who succumb to AIDS and of those friends and family who, in many cases, survive them. Crewe's question bears heavily on the perceptions and representations of AIDS. And it invites the perhaps heretical suggestion that hope has to be discovered not in the AIDS discourse but *in spite of it*.

When directed at specific target groups (for example, sex workers), the message of calamity might be successful. But its across-the-board efficacy is open to question, as shown by focus groups and surveys conducted in Carletonville, west of Johannesburg, where 40% of women and 30% of men are estimated to be HIV-positive.

According to Brian Williams,

> what is clear is that everybody knows about AIDS – 98% know that it's sexually transmitted and incurable. We ask about the risk factors (in other words, how the disease is transmitted) and we get about 85% correct answers, many of them showing detailed knowledge. Then, when we ask, "Do you think you're at risk?", about 40% of the respondents say they're not at risk personally. Of that 40%, one fifth are already infected.[139]

This example illustrates that awareness of the threat posed by the disease, and knowledge about transmission and preventive measures do not necessarily translate into a personal perception of risk, not to mention appropriate changes in behaviour.

This is partly due to several wrong assumptions. One is that fear or anxiety automatically triggers a rational series of reactions that can be refined and channelled into particular behaviour (safe sex, treating STDs, etc.), and that once awareness and concern is established, a "logical", predictable train of reactions can be set in motion. The error is fundamental and pivots on the notion that a powerful message, if repeated vehemently and consistently enough, will penetrate human consciousness and alter a hugely varied range of behaviour. This fallacy is discussed in more detail below. For now, the following remarks suffice.

Because newly-acquired knowledge (e.g. "AIDS kills", "Safe Sex Stops AIDS"), is filtered through other sets of signification, outcomes frequently occur which are contradictory to those sought or anticipated by AIDS workers. One is so-called "denial" (perhaps supplemented by behavioural change that has nothing to do with protection against infection). Sam Nxumalo, director of the Tugela AIDS Programme, offers this example where a person resorts to an entrenched system of signification in his community to create an alibi that carries powerful meaning:

> [I]n this area, there's a fashion where people, when they are diagnosed positive, refer to themselves as *amadlozi*. He will say he is becoming a sangoma and his ancestors are with him. So that will reduce his weight and account for all the symptoms of AIDS.[140]

The core awareness message is thereby assimilated into other, existing systems of knowledge – enabling persons to deflect the intended meaning of the information. Denial, for instance, can be achieved by invoking a particular set of cultural beliefs.

Even more morbid are instances where AIDS awareness links into and reinforces a fatalistic worldview, particularly among South Africans living in settings that seem to foreclose on the future. In

communities experiencing high levels of violence, for example, AIDS is appended to an assemblage of other, more immediately threatening daily realities. Often it ranks low against these contending (and more imminent) perils:

> [I]n this region the history of violence means that families have been decimated and so people live a kind of kamikaze existence. You know, it's "Don't tell me this disease is going to kill me in 15 years' time, that person over there wants to kill me tomorrow". You know people are living on the edge, and add that to poverty and you have an ideal breeding ground for the virus.[141]

Interviews and focus groups with miners in the Carletonville area have revealed similar attitudes. The main threats to life cited tended to be underground rockfalls and the constant inhalation of dust and other particles (that lead to breathing disorders and lung disease), while traffic accidents rank high among the list of perceived threats above ground. According to Brian Williams:

> We tell mineworkers if they don't use a condom they'll get AIDS and die in ten years. They say, quite rightly, "Well, the dust and the rocks will kill us beforehand". We have to then say, well, we'll help you with the dust and rocks. We have to be meaningful to their lives, their realities. It takes time, patience, commitment and dedication.[142]

One feels compelled to ask whether the miners' reaction amounts to a "rational" response or rather a surrender to fatalism. Clearly, a miner's chances of contracting AIDS in Carletonville are considerably higher than the chances of dying in a rockfall. On the one hand, victims of rockfalls are indisputably just that – victims of rockfalls – whereas colleagues dying of AIDS are disguised and "renamed" in a multitude of ways. On the other hand, the prevalence rates in that community are so high that these forms of denial are contradicted by reality. Perhaps the response is both fatalistic *and* rational – in the sense that fatalism becomes a rational way of coping with oppressive realities that seem to defy the intervening hand of human endeavour, enabling a person to expend his/her energies on activities that seem less resistant to intention and choice.

This example may also highlight the failure of intervention strategies to understand the complex process of learning – how adults sift new information through other layers of knowledge, how contesting narratives of understanding are shed or become legitimated, and how identity constructions allow people to move between different categories of knowledge. In other words, when a miner assimilates news of a rockfall, his identity as a *miner* is to the fore. That's not necessarily the case when he encounters an AIDS educational message. His identity as an adult male, as a migrant worker or as a father might then move centre-stage. The attempt to establish an "educational" link between the threat of death in a rockfall to potential HIV infection therefore can fail – because the two messages are refracted through different identity constructions.

However, what is also emphasised is the need for an effective approach that resonates in the life experiences of the target group – not only rhetorically (which is difficult enough) but also palpably. Therefore, AIDS awareness work needs to slot into more expansive and holistic, community-level activities that address the already perceived perils and difficulties that people face. This is not merely a matter of "building trust" and encouraging people to "take ownership" of the issue, but of recognising the reality that in a violent community, for instance, AIDS is seen to be (and, indeed, can be) outranked by other threats to life. Adding to an already traumatising roster of hazards an epidemic that spreads invisibly and that can take a decade to manifest terminally in a person is unlikely to trigger decisive changes in behaviour, especially when those changes require dramatically altering social transactions and conduct.

The fact that HIV transmission occurs predominantly through sexual intercourse immeasurably complicates matters. When awareness work ends up propagating the abandonment, rationing or radical altering of a life-affirming activity like consensual sex, the message disintegrates. To be sure, most official AIDS information efforts have long abandoned the abstinence message. (However, in his 1998 televised speech on AIDS, then-deputy president Thabo Mbeki pointedly called on young South Africans to abstain from sex.) But the success of these information campaigns hinges on subsequent non-official, organic forms of information-sharing and education – within households and families, among friends and partners, in schools and social circles, etc. The integrity of the original message survives only if, subsequently, relatively explicit discussions about sexual activity are socially sanctioned. In many settings, this is not the case. Again, the message is deflected through a series of discursive filters. As a result, a sophisticated message which requires breaching rules of permissible discourse is refashioned to fit that discourse. "Safe Sex Saves Lives" becomes "Staying Away from Sex Saves Lives" or, worse, "Promiscuity Kills" (both of which have the effect of deflecting responsibility and culpability onto the person that gets AIDS).

All this occurs in settings that are defined and regulated by severe power imbalances. Gender discrimination ranks high on this front and overlaps with skewed economic power (in terms of skills and education levels, job opportunities, income patterns) and what might be termed "generational power" (where age acts as an index of authority and submission).

The violent maldistribution of power in gender relations constitutes perhaps the single biggest obstacle to effective responses to the epidemic in South Africa. Many efforts have been mounted to trace the factors and dynamics creating this state of affairs. These have dredged the realms of economic relations, "culture" and "tradition", apartheid history, the sociology of violence and the formation of masculine identity, to mention a few. But typically overlooked are the ways in which the national liberation movements were also complicit in what has been called South Africa's "gender question". In the context of the national liberation struggle, women's struggles were roundly subordinated:

> Feminist debate may not have been openly suppressed, but it was sublimated to the intrinsic logic of the strategy for liberation: the first struggle was for the liberation of the nation, the second for the liberation of the working class, and, at best, third down the line might come the struggle for the liberation of women.[143]

In another assessment:

> Steered into the slipstream of nationalism, and waged in profoundly different political and material conditions, South African women's struggles were fought in isolation from the upsurge of feminism in the industrialised world. Whether bearing the label or not, feminism was scoffed at as an irritant in the lubricated workings of the national liberation struggle. So much so that in the 1990s, in perhaps its most opportune time in the country, it is peppered with the calumny of being elitist, unAfrican and purely "intellectual".[144]

Typically, gender imbalances become explicit when condom use is advocated.[145] In many instances, the skewed power relations make it difficult for women to protect themselves against the epidemic, let alone act as catalysts of behaviour change. These realities are rightly bemoaned and condemned. But less well understood are the kinds of judgement calls and subjective *choices* that, perforce, occur in their shadow. Here, development theorists' emphasis on community survival strategies becomes pertinent. This alerts us to the manifold ways in which people negotiate or traverse threats and opportunities in order to establish a kind of equilibrium in their lives.

This "stability" or "balance" is seldom settled, since the lives of the poor are subject to constant disruption, upheaval and adjustment. A matrix of accommodations, truces, challenges and revolts is therefore constructed and constantly revised in order to achieve a platform for survival and fulfillment within an expansive frame of constraints. At the core of this are transactions with power – gendered, economic, generational etc. We refer to them as transactions because they involve calculations and trade-offs. Submission on one front can be "traded" for an advantage on another. Retreat and submission – resented as they may be – therefore slot into a larger frame of calculated adaptation. What both history and experience has taught is that what seems "rational" from afar might well appear "irrational" to a person in a particular life-setting. The notions of "rational" and "irrational", in other words, are relative ones.

Efforts to change behaviour in spite of gender discrimination therefore have to contend with the complex ways in which oppressed persons engage in transactions of submission and assertion in order to achieve the comparative equilibrium and security that allows for the pursuit of certain priorities. The necessary denunciation of gender discrimination, however, tends to obscure an appreciation of these "cost-benefit" judgements that enable women to survive and achieve certain, chosen goals. Thus, condom use with a partner has to be weighed against the sanctions this might incur, e.g. violence or abandonment and loss of financial support needed to put children through school, or distrust that could scupper a relationship that provides a sense of necessary psychological and social security. The message of "safe sex" is refracted through these, other calculations – it does not automatically pierce them. It is essential to mount initiatives that can help redress these power imbalances or enable women to position themselves more advantageously despite them. But these efforts are more likely to meet with success if they also take account of the ambiguous and sometimes contradictory ways in which people negotiate strategies of survival.

Equally pronounced is the tendency of (especially) donor-driven campaigns to treat gender as an issue that applies singularly to women. Hence, we see a succession of gender workshops aimed strictly at women. The concept of gender is dialectical and involves power and other relations between *men* and *women*. Initiatives aimed at empowering women are essential components, but so too are interventions that target men – all of which somehow also have to move beyond formulations that situate women on Venus and men on Mars.

It should be no great surprise, then, that efforts to change behaviour often become ineffectual when they encounter the lived realities of their target groups. Revealed, again, is the frailty of exterior Reason once projected into specific life settings. The notion that a "rational" message, if hammered home persistently enough, will trigger singular behavioural reactions often turns out to be untrue - for that message has to contend with equally "rational" and *functional* judgements that have enabled the recipient to construct and live out a life strategy.

Much the same objection holds for attempts to effect behavioural change among youth, which is perhaps the single biggest challenge in South Africa's AIDS response. HIV prevalence charts bulge ominously in the 16-24 year age category, prefiguring mammoth social dislocation and trauma as the young parents of young children succumb to AIDS.

Yet "youth" remains one of the most poorly understood – and casually vilified – categories in our society. Condemned or bemoaned for apparently aberrant and "deviant" behaviour and warped value systems, youth are in many respects another version of the Other. The category itself blunts appreciation of difference and variety.[146] More damaging is the well-entrenched tendency to see youth as a transitional period, a kind of passage towards viable adulthood.

Youth's folly and aberrations are seen as temporary flirtations with rebellion, whereafter the imperatives of adult life will assert themselves and "normality" shall return. What results from that view, at best, is a resignation to the Otherliness of a generation (a sort of "benign" neglect of the temporarily deviant) or a tendency to infantilise youth by subjecting them to educational and disciplinary methods usually applied to children in their early stages of development. Such attitudes seem even less tenable in a society like South Africa where (mainly black) youth routinely and from young ages have to perform "adult" tasks and assume "adult" roles. The entire construct of youth thus becomes problematic.

Indeed, some social and cultural research, albeit in other settings, suggests a different frame for understanding youth behaviour. According to Erik Erikson, youth are engaged in fervent quests for "fidelity", for anchor points that can enlist trust, belonging and secular faith. Quoting Erikson, American cultural theorist Lawrence Grossberg has written that:

> youth is 'impelled to find a faith, a point of rest and defense, a touchstone by which they can accept or reject, love or hate, act or not act'. Youth involves not so much an ideological search for identity as an affective search for appropriate maps of daily life, for appropriate sites of involvement, investment and absorption.[147]

Few adults have trusted access to or understanding of these maps. The perennial lament directed at adults – "You don't understand us" – seems to ring true also for much AIDS awareness efforts directed at youth.

# A paucity of social theory

Contextualising the disease and linking it to socio-economic and socio-cultural dynamics like poverty, migrant labour, income inequalities, financial insecurity, and gender relations are crucial platforms of understanding from which an effective response can be mounted. Impressive research has been generated on these fronts.

Yet there is some controversy about the singular portrayal of HIV/AIDS as a disease of poverty. Until 1998, Barclay's Bank in Zambia reportedly saw 2% of its workforce die each year – about 10 times the mortality rate for an American bank. The casualties were mainly African white-collar workers with access to "first world" health care, through the Minbank Clinic. Yet 85% of the dying employees died of AIDS-related illnesses.[148] The reasons may not be all that mysterious. According to Donald McNeil, a 1987 Rwandan study of HIV infection at pre-natal clinics:

> showed a pregnant woman had a 9% chance of infection if her husband was a farmer, a 22% chance if he was a soldier, a 32% chance if he was a white-collar worker and a 38% chance if he was a government official ... The study's conclusion was that, in a very poor country like Rwanda, a regular paycheck meant more access to extramarital sex, raising the husband's chances of infection.[149]

This is not to say that the poor are not, on the whole, more vulnerable in South Africa, but it does remind us that the socio-economic correlates of the epidemic are complicated and are not easily flattened into formulations that fit neatly on placards.

Nevertheless, these debates have the benefit of considerable data collection and research. But much less prominent in the academic discourse around HIV/AIDS is the scrutiny and understanding of sexual behaviour, in a society where HIV is transmitted almost exclusively via penetrative sexual intercourse (although, as infection rates soar, mother-to-child transmission is also rising).

Potentially deadly as its consequences are, HIV in fact is an inefficiently transmitted virus. Scientific research has been unable to yield precise statistics, but in the medical community the following estimates are generally accepted. A male having unprotected sex with an infected female partner runs a 1/1000 risk of becoming infected; in the reversed scenario, the female partner runs a 3/1000 risk. The presence of STDs is generally believed to increase the risk factor by 10 to 20 times.

For prevalence rates to be rising as rapidly as they are (particularly among people in their late teens), it is tempting to assume that an enormous amount of sexual activity (with a variety of partners) has to be occurring.[150] The truth is that we don't know. Sex remains the most inadequately researched aspect of the epidemic. Yet, this absent knowledge is a crucial part of an effective response to the disease. "We know more about the AIDS virus than we do about any other virus in the world, yet we know virtually nothing about people's sexual activities," says Brian Williams.[151]

This is not a matter of academic voyeurism or searching for a basis for sanctions. Effectively confronting the disease requires an understanding of behaviour, influences on behaviour and motivations for behavioural change. With respect to HIV, such an approach begs two major questions: What are the motivations for sexual activity? And what are the factors determining transmission within this activity?[152] In Douglas Webb's experience, "in Southern Africa, reliable data on the extent and nature of sexual activity are scarce, with anecdotal evidence so often informing opinion without quantification".[153]

In the South African context, it's not difficult to understand why. Illuminating this blindspot would mean traversing the field of age-old white myths and anxieties about black sexuality, terrain few researchers are willing to venture onto. The quest to develop an adequate arsenal of social research about the disease runs up against South Africa's profound history (and ongoing reality) of racism, the reactions against it and the self-conscious attempts by researchers not to be seen to fall prey to it:

> The debate over the extent of promiscuity in African societies has been lively, but so often imbued with either racism or academic political correctness that the reality of the situation is so often misconstrued and invalidated ... Substantiating claims of widespread multi-partnerism is a sensitive issue to address, not only in terms of methodology but also politically.[154]

These kinds of epistemological complications render all the more difficult efforts to mount an effective response that answers to the demands of inclusivity, empowerment and "ownership".

In 1993, Edwin Cameron warned of the divisive dynamics that surround the disease:

> AIDS and HIV seem likely to replace race and skin colour over the next decade as the major criterion of discrimination and exclusion in our society. The old vectors of discrimination, the old rationales for exclusion, for demeaning treatment of fellow citizens, have become tarnished and unacceptable even to those who formerly defended them. AIDS offers a new symbol, a new focus and a new means of rationalising exclusion and deprivation; a means of insulating ourselves against other people's otherness and

> explaining to ourselves why we deny to them what we would claim for ourselves.[155]

The social and political constructions applied to HIV/AIDS are varied, depending on their sources. Worldwide, as in South Africa, the social interpretation and representation of the disease has occurred by way of metaphor. As Susan Sontag has noted, there is nothing odd about this: "Saying a thing is or is like something-it-is-not is a mental operation as old as philosophy and poetry, and the spawning ground for most kinds of understanding." Importantly, though, she adds: "Of course, one cannot think without metaphors. But that does not mean there aren't some metaphors we might well abstain from or try to retire" (1988:1).

In this vein – and anachronistically – the "alien" and "zombie" films of the Cold War era perhaps best capture the perceived relationship between HIV/AIDS, and individuals and societies: as a furtive invasion and distorting violation of the integrity of the individual body and of the community.[156] As in these films, the "victim" is unaware of the intrusion and the virus initially matures and disperses discreetly through the body and society. The fear evoked by this invisibility is compounded by the fact that transmission occurs primarily through sexual intercourse, an activity that stands at the hub of human existence. The social and psychological threat therefore extends beyond the feared outcome of illness and death; both the disease and the "rational", defensive responses that are decreed impinge on and disrupt behavioural patterns that are at the core of social being.

The most common reaction is, perhaps flippantly, termed "denial". This entails conceptually locating the disease beyond a series of perimeters in order to retain and defend spaces in which normality and "the known" reign, and where familiar social transactions can be maintained. In Helen Schneider's words:

> You're dealing with something that's invisible and postponed down the road somewhere. The premise in counselling is that you have to get people to look at the problem rather than avoid it. A colleague who has worked on alternative counselling models has found that people don't have space for HIV/AIDS in their lives and their best route is to deny it. It gives them a few more years to live a remotely ordered life. Maybe denial is, in this sense, an "appropriate" coping mechanism. People have to understand that behavioural change happened in the West in tightly knit, middle-class gay communities with very intensive support networks and intensive inputs.[157]

The disease is therefore banished out of the zones of familiarity and "normality", either by ignoring it or by lodging it with a variety of perceived aberrations (sexual preferences, social behaviours, medical-political conspiracies) or, more literally, with objects of loathing and fear (other ethnic groups or races, immigrants, even other countries). These reactions often are captured graphically in personal accounts:

> I discovered that I was HIV positive towards the end of 1996 after developing symptoms like diarrhea and loss of appetite. The doctor said I would live for not more than 14 years ... At the time I was ignorant and naive about HIV and AIDS. I perceived it as a white man's disease, or one which attacks prostitutes. I never used condoms in my life. I saw them as a strategy by the white government to reduce the black population.[158]

The vigour with which these psychological and conceptual defensive maneuvers are performed seems to bear an inverse relation to the vicarious *visibility* of the disease.[159]

The conceptual map of HIV/AIDS, therefore, is crisscrossed with dividing lines that demarcate the internal and the external, norm-

ality and deviance, the familiar and the Other, Us and Them, the individual and society. It is this representation that has made AIDS such a difficult area of social responsibility to deal with. These same partitions are erected against HIV-positive persons and, especially, PWAs. They are reinforced by the language in which HIV/AIDS responses customarily are cast: "The Battle Against AIDS", "Combating AIDS", "The Struggle Against AIDS", "Declaring War on AIDS", etc. This militarist idiom links obviously with the notion of an external, invasive enemy that has to be halted at the city gates. Thus, the very language meant to achieve inclusion and solidarity replicates the *exclusive* terms in which the disease typically is cast.

The war metaphors hold strong appeal. They refer both to the invasive nature of the virus and to representations that externalise the virus as a peril that lurks "out there" among others.[160] (An analogous spatial and social relationship lies at the heart of anxieties about crime, which generates an almost identical language in response.) Unambiguous, the metaphors signal (and are meant to summon) the steely resolve needed to overcome the epidemic. In short, they declare: "We shall beat it by any means necessary." As a call to arms, therefore, they are entirely consonant with extreme reactions. The murder of Gugu Dlamini (a KwaZulu-Natal AIDS activist killed in late 1998 by fellow community members after she had declared her HIV-positive status) fits squarely in this frame – because the war idiom links more potently with the kinds of social representations described here than with the more considered and considerate responses it is intended to elicit.[161] These "rational" inducements and strategies do not yet enjoy the *authenticity* of reactions that locate the epidemic in outsiders that have to be held at bay.[162]

Intrinsic to these responses (and augmented by militarist language) is the move from the demonisation of the illness to the attribution of fault to the PWA. The fear and loathing fuelled by the epidemic is transferred onto the "victim" – a move that has the attraction of seeming to render palpable and recognisable an unseen peril.

Another dilemma rears its head. All HIV/AIDS awareness campaigns necessarily place responsible behaviour at the centre of preventive measures.[163] By flawed but highly attractive logic, one can then deduce that someone who does become HIV-positive is *responsible* for that fate (having, presumably, violated the behavioural prescriptions) and even deserves it. Of course, that conclusion is both false and immeasurably cruel; no one deserves to get AIDS, just as no one deserves to contract cancer. But it does fit in the frame of preventive responses that, unavoidably, have to emphasise personal and collective responsible behaviour.

Yet AIDS activist discourse also singles out PWAs as a focal point for efforts to elicit compassion, concern and respect for their rights. The paradox is obvious, since the quest for inclusivity and equal treatment of PWAs ends up relying heavily on notions of difference and distinctiveness. Attempts to establish equality and counter discrimination are made by situating PWAs in a separate category and by emphasising notions of difference and distinctiveness. This occurs through a narrative of identity politics in which an oppressed or disadvantaged group assembles around a common identity that can then serve as a basis for recognition and equity demands (Crewe, 1999). The practice, of course, has been exemplified in the new social movements that emerged worldwide from the late 1960s onwards and provided a powerful basis for organising social categories that previously had been subsumed within the traditional categories favoured in progressive politics (trade unions, national liberation movements, political parties, etc.).

These approaches have been partly borrowed from the activist networks of North America and Western Europe in the 1980s. These networks hinged on well-resourced collectivities that were able to

nurture shared consciousness and close camaraderie by drawing heavily on organised gay activism which relied strongly on the politics of identity. Conversely, as Edmund White has noted, AIDS was central in the construction of the self and of the community – through the friendship and support networks mustered in the early period of the epidemic. This collective consciousness and solidarity was fostered most effectively in the self-identified and (highly) politicised social category of gay men. Assisting this was their shared experience of manifest commonalities (social discrimination experienced as gays, high vulnerability to the virus, stigmatisation, etc.):

> [A]mong the risk group in the United States most severely affected in the beginning, homosexual men, [AIDS] has been a creator of community as well as an experience that isolates the ill and exposes them to harassment and persecution.[164]

Analogously, AIDS activism in South Africa has constructed a web of representation that belongs inside rather than outside the affected groups, mirroring, as Mary Crewe notes, "the language of AIDS which at all levels is also the language of exclusion":

> People with AIDS have been and are excluded from social and medical benefits, from occupations as well as from basic rights, recognition and acceptance. But it is also true that people with AIDS seek ever increasingly to exclude people without AIDS from their structures and organisations. Activists will tell you that only people with AIDS can understand and therefore run PWA organisations.[165]

In such ways, diabolical dilemmas are compounded. We have not discovered a language of representation that can release the AIDS struggle from these kinds of ricocheting complications. Indeed, is it possible to build a genuinely inclusive consciousness around HIV/AIDS in a society where the epidemic is not concentrated around a potentially homogenous section of the population? In South Africa, it inflicts and threatens a highly diverse population that remains deeply divided by race, class and gender – and is further cleaved by matters of sexual preference, ethnicity, xenophobia, age and more. Activism that benignly tries to employ notions of difference and identity inevitably runs the huge risk of seeing those efforts appropriated into those other frames of prejudice and discrimination. In Mary Crewe's view:

> the public language of HIV/AIDS is too narrow and too tightly focused. It circulates powerfully in the AIDS community – so powerfully that outsiders can seldom find a way into it – but it does not circulate as strongly outside the boundaries of the AIDS community. The AIDS world (for it is, sometimes, a world unto itself) believes that what it says is understood by the wider community. But this is not true. What an outsider hears is AIDS people dialoguing among themselves and declaiming to everyone else. What she sees is the huge gap between people on the inside and those on the outside.[166]

These representations also seem to resonate in a more specific manner in some AIDS activist circles. The categorisation of AIDS as an illness of poverty, disadvantage and discrimination allows the "AIDS struggle" to acquire a grander and more expansive character – as a socio-economic struggle. In this approach, AIDS activism is seen to constitute a potential, new movement for broader social change. The language and experiences of the anti-apartheid movement are still fresh enough to be harnessed into this new struggle.

This representation pivots on oppositionality – Us against Them – with the enemy defined variously (for the choice of targets derive can shift) as transnational pharmaceutical corporations, or the state, or even other AIDS organisations that adopt too accommodating a line. The debilitating internecine skirmishes that rocked

several ASOs in the latter half of 1999 appeared to be linked to an approach that can be described as radical populism. It is encrypted in statements like "there is not enough outrage about AIDS in Africa" or elaborated in arguments that HIV/AIDS should serve as an axis for broad-based struggle. In Zackie Achmat's view, some ASOs have allowed themselves to be isolated from:

> the broader movement for human rights and development in southern Africa, [allowing] groups which are not committed to the non-discriminatory treatment of people with HIV/AIDS to exploit this weakness to their advantage. Throughout the world, HIV/AIDS activists have failed to consider the issues of broader health care reform: challenging insurance and drug companies on coverage of a range of illnesses, and addressing the need for food, shelter, education and broader rights protection central to the well-being of any person – not only those with HIV/AIDS. These are potential areas for a broader social alliance in defence of a greater number of socio-economic rights.[167]

Besides the attempt to insert HIV/AIDS into a social, economic and political programme of struggle and resistance, this approach is aimed at shifting the epidemic out of, and beyond the medical/health enclosure reserved for it. It is an important and valid quest. But because it pivots on oppositionality (the people versus the oppressors), it risks reproducing the binary frame of representation that plagues the HIV/AIDS response. Tragically, it does this not only across society but also within the HIV/AIDS sector which, as we write, has become riven with internal divisions. It might be that the latter development has been caused less by the approach than by its prosecution. Yet, it is also analogous to the many ways in which the epidemic is shadowed by impulses to deflect responsibility and externalise blame.

These observations are not aimed at apportioning blame but at highlighting some of the less obvious dilemmas that stand in the way of achieving a collective – and, therefore, effective and humane – AIDS response. Some of these dilemmas seem imprinted in an illness like AIDS itself, not least in the manner of transmission. Others stem from powerful socio-ideological dynamics. Yet, unlike the highly individualised experiences of malaria or cancer, that of AIDS can be collectively imagined, as demonstrated in North America.

The challenge confronting South Africa is to achieve this in a heterogeneous and severely divided society. Ultimately, it is on this ideological front that the AIDS response will fail or succeed. The most sensible premise would be to stress, as Tim Trengrove Jones has suggested:

> we are more alike than different, even if only on the basis of all being equally at risk. Dialogue around "safer sex" could provide the foundation for a truly revolutionised social ethic. Insistence on private responsibility to others is a sound basis for developing a just and caring culture.[168]

# Postscript

The first months of the new century saw a mix of apparently provident moves and more, baffling controversy. The National AIDS Council was appointed early in 2000, as part of the government's bid to step up its fight against HIV/AIDS. The council has the potential of widening the response to sectors not yet engaged in AIDS work.

Yet, the failure to appoint recognised HIV/AIDS experts and experienced campaigners to this Council is a serious omission. The HIV/AIDS crisis demands that new commitment be supported and guided by expertise and experience gained over the past 15 years.

More bewildering was government's defense of a decision to invite so-called AIDS "dissidents" to a panel that will discuss AIDS in Africa in mid-2000. The panel will be separate from the World AIDS conference, which is being staged in Durban in July. But it is expected to cast a pall over that event. And understandably so. Included among the invitees are figures who seem to have found an eager audience in government for their claims that HIV does not cause AIDS – a contention roundly dismissed by international scientific research.

The government's decision seems to defy explanation, particularly in a country on the edge of an AIDS disaster. According to presidential spokesperson, Parks Mankahlana, "this international panel must … attempt to unravel the 'mysteries' of the HIV/AIDS virus, including, and more especially, what the profit-takers cannot tell us".

Less surprising than the populist rhetoric was the presidency's claim that "we humans know very little about HIV/AIDS". The fact is that, in scientific terms, it is the most researched virus possibly in the history of illness in the world. We know as much about it as we possibly can at the moment. The effects of this flirtation with revision on an effective response remain to be seen.

Offering little comfort, too, was news that 40% of government's 1999/2000 HIV/AIDS budget went unspent and that government funding to ASOs has been cut by 43% in the 2000/2001 budget. The fact that overall HIV/AIDS spending increased by 73% begs the question why existing funds are not being spent.

South Africa has come to the brink of the scenarios painted almost a decade ago. Words and statistics cannot capture the effects HIV/AIDS will have on our country, on our attempts to rebuild it as a just and humane society, on the region and on millions of people.

# Endnotes

1 Quoted by Nikki Schaay, 1997, "The History and Development of NGO-based HIV/AIDS Work in South Africa", *South African STD/HIV/AIDS Review* Vol 4 (Appendix 21), p 30.

2. *Ibid*. The 1997 survey had estimated that 2.7 million citizens were HIV-positive.

3. "South Africa in throes of AIDS crisis", *Toronto Globe & Mail* (11 May 1999).

4. Aaron Nicodemus, "But government policy on AIDS, the 'silent killer', is disastrous", *Mail & Guardian*, 16 July 1999. The small effect of behavioural change on the projected 2005 death toll stems from the fact that those dying will be the 3,6 million people who are already infected.

5. Cited by Charlene Smith, "Planning for AIDS needs to start now", *Mail & Guardian*, 5 March 1999.

6. "Economic cost of AIDS", *Mail & Guardian*, 31 January 1997.

7. "Ministry says 45% of local mineworkers are infected with HIV", *Business Report*, 25 November 1999.

8. Dr Clive Evian, quoted in "ANC denies financial interest in AIDS drug firm", *SouthScan* Vol 13 No 5, 6 March 1998.

9. "If we don't stop AIDS, there will be no African renaissance," *Mail & Guardian*, 5 March 1999.

10. Aaron Nicodemus, "The new South Africa's silent killer", *Mail & Guardian*, 30 April 1999.

11. Aaron Nicodemus, "But government policy on AIDS, the 'silent killer', is disastrous", *Mail & Guardian*, 16 July 1999.

12. These figures are estimates based on the national antenatal surveys in which the presence of the virus or antibodies in the blood are measured.

13. Nkosazana Zuma, "Awareness is the only cure for the spread of AIDS", *Sunday Times*, 18 October 1998.

14. Schneider, H, 1998(a). " The Politics behind AIDS: The case of South Africa" a paper presented at the 12th World AIDS Conference, Geneva, p7.

15. See Schneider, H. & Stein, S, 1997, "Contextual issues affecting implementation of the Nacosa/National Aids Plan", Appendix 17 in *The South African STD/HIV/AIDS Review*.

16. Helen Schneider, 1998b, "The AIDS policy process in South Africa", background workshop document (June), Geneva, p 6.

17. Schneider (1998a:5). HIV was first detected in South Africa in the early 1980s. Prevalence was low. The first national survey of antenatal clinic patients in 1990 found a prevalence rate of 0.8%; a year later the figure had doubled to 1.5%.

18. "The Nacosa/National AIDS Plan" (Appendix 43) in *The South African STD/HIV/AIDS Review: Final Report*, p 43.

19. Indeed, correspondence from some officials on drafts of the Plan (prior to 1994) make for instructive reading. The tenor was generally conservative (at times outrageously so), but the comments occasionally included vivid counsel on some of the difficulties that could upset implementation.

20. Quoted in Mark Gevisser, "Finally the state gets serious about AIDS", *Mail & Guardian*, 22 July 1994.

21. *Ibid*.

22. *Ibid*. In hindsight, the reference to Mandela seemed informed less by fact than by political acumen. The AIDS community still hoped that Mandela would take the issue on board and hoist it to prominence as a key, national priority. Immediately after the April 1994 elections, Nacosa figures repeatedly tried to arrange a meeting with Mandela, where they hoped to present the Plan and stress its importance. As we discuss in more detail later, the meeting never happened.

23. Schneider (1998a:5).

24. This summary is drawn from Schneider (1998b:3).

25. Interview, November 1999.

26. Quoted in Schneider & Stein (1997:41).

27. "But government policy on Aids, the `silent killer', is disastrous", *Mail & Guardian*, 16 July 1999.

28. Figures cited in Schneider, H., 1998, (9:4).

29. Schneider & Stein (1997:4).

30. *Ibid*.

31. UNDP & UNAIDS, 1998, *HIV/AIDS & Human Development: South Africa*, Pretoria, pp 100-102.

32. *Op. cit.*, p 101.

33. Schneider (1998:5).

34. "AIDS Training, Information and Counselling Centres" in *The South African STD/HIV/AIDS Review* Vol 4, p 104.

35. *Op. cit.*, p 107.

36. Interview, November 1999.

37. Interview, November 1999.

38. Interview, November 1999.

39. Interview, November 1999.

40. Interview, November 1999.

41. Interview, November 1999.

42. A recent example was the redesign of the government's R30bn arms-for-investment deal. Pressure from the finance ministry led to the scheme being divided into two phases, spanning 22 years, despite the unalloyed enthusiasm for the deal from the defence and the trade and industry ministries.

43. Nelson Mandela, 1997, Address to the World Economic Forum, Davos (Switzerland), 3 February.

44. Lawson, L, 1997. HIV/AIDS and Development, SAIH and INTERFUND, Johannesburg, p59.

45. Their incumbencies were, of course, directly related to the so-called "sunset clause" in the negotiated political settlement. By refraining from a "clean-up" in the civil service, the ANC hoped to defuse the feared mobilisation of organised right-wing reaction.

46. Its official objective was "to reduce the transmission of HIV infections by communicating and promoting health-seeking behaviour through collaborative efforts with all levels of government and outside government, as well as providing appropriate care, counselling and support for people who are infected and affected". Descriptions and figures are drawn from UNDP & UNAIDS, 1998, Pretoria, 99.

47. The objective being "to provide financial assistance to institutions conducting research and disease surveillance in respect of HIV/AIDS and sexually transmitted diseases and to organisations involved in combating HIV/AIDS"; *ibid*.

48. This was a so-called "special need" category to "develop, promote and co-ordinate national policy and services in respect of people with disabilities, chronic illness, HIV/AIDS and medical social services, ageing and employee assistance programmes"; *ibid*.

49. *Ibid*.

50. Schneider & Stein (1997:3). They add, correctly, that underspending was an endemic feature of 1994-1996. As part of efforts to overcome this, the finance department later introduced a zero-based budget system. Unless exempted from this requirement, unspent funds then could not be "rolled over" into the next financial year, thus placing a high premium on spending allocated funds in each financial year.

51. Interview, November 1999.

52. (1997:1).

53. The reference occurred in a list of challenges facing South Africans and read: "These include the AIDS epidemic which, among other things, requires that we change the habits of our people with regard to issues that relate to sexual behaviour and lifestyle." See *Statement of the National Executive Committee of the African National Congress, delivered by the President, on the occasion of the 88th Anniversary of the ANC*, January 8, 2000 – at http://www.anc.org.za.

54. Interview, November 1999.

55. Mark Gevisser, "Sarafina of the health system – Dr Nkosazana Zuma, minister of health, in the Mark Gevisser Profile", *Mail & Guardian*, 22 March 1996.

56. A life-*threatening* vice then literally becomes more expensive. With dastardly irony, life-saving measures against HIV/AIDS – such as condom use – are more expensive.

57. "If we don't stop Aids, there will be no African renaissance", *Mail & Guardian*, 4 December 1998.

58. Tim Trengove Jones, "AIDS, the botched issue", *Sunday Times*, 30 May 1999.

59. In South Africa in the early 1990s, civil society acquired an almost fetishistic allure. Definitions were, at times, fanciful and civil society was endowed with magical properties. In Monty Narsoo's mischievous summary, it became "the panacea for the ills of the failed East European regimes, the decline of the welfare state, the ailing economies of the African continent and for reconstruction in South Africa". See Marais, H. 1998, *South Africa: Limits to Change – the political-economy of transformation*, UCT Press and Zed Books, Cape Town and London, pp 200-204. Employed here is a more sober definition that includes the private business sector and recognises the overarching weight of capital in civil society. This is different from the tendency in South African progressive circles to apply the concept narrowly to associational groupings active in the voluntary sector.

60. "Finding light in the tunnel of AIDS ignorance", *Sunday Times*, 10 October 1999.

61. "The corporate dilemma", *Reconstruct* supplement (*Sunday Independent*), 28 November 1999.

62. Moodley, P., 1997, "Contributions of other sectors to the HIV/AIDS epidemic" (Appendix 18) in *The South African STD/HIV/AIDS Review*, p 3.

63. *Ibid*.

64. Schneider (1998a:9), citing Griesel, R.D. & Wege, J.W., 1996, *South African AIDS Network: A Directory of the National AIDS Database*, Department of Health, Pretoria.

65. See, for example, Marais (1998:209-217), Marais (1997:93-128) and Meer (1999:109-118).

66. Quoted in Schneider, H. & Stein, S., 1997:48. Nedlac did, however, endorse an AIDS/HIV Employment Code of Conduct, produced by the National Aids Coalition, which set out criteria to prevent employment discrimination against HIV-positive individuals.

67. *Ibid*.

68. Interview, November 1999.

69. Interview, November 1999.

70. Schneider (1998b:8).

71. Performed by Ngema's company, Mbongeni Ngema and Committed Artists, the musical premiered in KwaZulu-Natal on World Aids Day, 1 December 1995.

72. "Health minister defends Aids musical", *Mail & Guardian*, 9 February 1996.

73. Mark Gevisser, "Sarafina of the health system – Dr Nkosazana Zuma, minister of health, in the Mark Gevisser Profile", *Mail & Guardian*, 22 March 1996.

74. Quoted in "Aids chief steps down", *Mail & Guardian*, July 17, 1998.

75. "Zuma's new right-hand man", *Mail & Guardian*, October 23, 1998.

76. "But government policy on Aids, the `silent killer', is disastrous", *Mail & Guardian*, 16 July 1999.

77. Interview, November 1999.

78. "New health head vows to tackle Aids crisis", *Mail & Guardian*, 20 December 1996.

79. *Op cit*.

80. "Aids `breakthrough' broke all the rules", *Mail & Guardian*, 24 October 1997.

81. *Ibid*.

82. "Aids agony over drug clampdown", *Mail & Guardian*, 14 February 1997.

83. Daniel Ncayiyana, "Give Virodene and the minister a break!" (editorial), *South African Medical Journal* Vol 87 No 3, March 1997.

84. The DP claimed to have obtained minutes from an October 1997 meeting of Cryopreservation Technologies (which was in line to manufacture the Virodene drug) which allegedly "indicated that the party [ANC] was promised a 6% stake in CPT". It also referred to an internal memo from the Virodene researchers to CPT members in which they praised the ANC government for having "gone to much effort to support us and even change laws to assist CPT". Dr Zuma had, in the previous year, been quoted as saying she wanted new legislation

which would allow her to overrule the Medicines Control Council. The ANC rejected the allegations as being "as ludicrous as they are preposterous" and denied having any financial interest in the drug's development. It said an ANC investigation had found that "the so-called 6% share allocation did not exist". See "Profit prize claimed to be ANC's AIDS drug motivation", *SouthScan* Vol 13 No 5 (6 March 1998).

85. "When we realised some people were not happy with what we are doing, we went underground and had to pay for the research ourselves," Zigi Visser, husband of one of the researchers, was quoted saying; see "Aids `break-through' broke all the rules", *Mail & Guardian*, 24 October 1997.

86. Interview, November 1999.

87. "Press statement on Virodene PO58", Nacosa and the AIDS Consortium, 27 January 1997.

88. Helen Schneider (1998a:9).

89. Several ASO representatives gave examples of this in interviews conducted for this paper.

90. Interview, November 1999.

91. Quoted in Schneider, H. & Stein, S. (1997:49)

92. *Op. cit*., p 50.

93. *Ibid*.

94. Crewe, M., 1998, "Co-chair report – Nacosa 1997-1998", 27 February.

95. Marais, H., 1999, "His masterful voice", *Leadership* (October/November), p 72.

96. "Zuma defends AZT policy", *Mail & Guardian*, October 16, 1998.

97. "Shock survey announces one in eight adults carries AIDS virus", *SouthScan* Vol 14/ No 5, 5 March 1999.

98. Nattrass, N., 1998, "We can't not afford AZT", *Mail & Guardian*, 4 December.

99. *Ibid*.

100. "Zuma stands firm on AIDS policy", *Sunday Times*, 28 February 1999.

101. *Ibid*.

102. *Ibid*. In May 1999, another about-turn occurred when government reversed its earlier decision and gave the go-ahead to the UNAIDS-funded programme to distribute AZT to pregnant HIV-infected women at the country's largest hospital, Chris Hani Baragwanath.

103. Glaxo Wellcome called it "a totally unconditional offer". The only safeguard requested, it claimed, was that the drug be marked distinctively to prevent it from being illegally resold in the West.

104. Quoted in Nicole Turner, "Pros and cons of administering anti-retroviral drugs", *Reconstruct* supplement in *Sunday Independent*, 28 November 1999.

105. These quotes are from a *Globe and Mail* article May 11, 1999.

106. Thabo Mbeki, 1999, "We cannot base our actions on untruths about rape and AZT", speech to National Council of Provinces, 5 November 1999, Cape Town.

107. Quoted in Aaron Nicodemus, "Truth and lies about AZT", *Mail & Guardian* daily news website, 1 December 1999.

108. "The president [has] got a thick set of documents. He went into many sites, including the World Health Organisation's one," presidential media liaison officer Tasneem Carrim was quoted as saying. See "Scientists reject Mbeki's claim on Aids drug", *Sunday Independent*, 31 October 1999.

109. Quoted in Aaron Nicodemus, *op. cit*.

110. *Ibid*.

111. In October 1997, the US government upped the ante by officially joining international pharmaceutical companies in expressing concern at South African draft legislation that would allow the South African health minister to override patent rights on medicines. It offended against international property rights, US ambassador James A Joseph said in a letter to the parliamentary health committee. See "US joins opposition to Zuma bill", *SouthScan* Vol 12 No 37, 10 October 1997.

112. Even if this reading is incorrect (and budget constraints were the real reason), the AZT decision constitutes more evidence that the special status envisaged for the National AIDS Plan did not materialise.

113. Lawson (1997:41)

114. Quoted by Mark Gevisser, "Finally the state gets serious about AIDS", *Mail & Guardian*, 22 July 1994.

115. Quoted in Lawson (1997:42).

116. Quoted in "Drop the secrecy around HIV/AIDS, says Shisana", *MaSAnet*, 29 November 1996.

117. "Zuma makes doctors report AIDS patients", *Sunday Times*, 18 April 1999. Dr Zuma made the statement after a two-day meeting of health ministers of the Southern African Development Community.

118. Interview, November 1999.

119. Witwatersrand University academic Tim Trengrove Jones, "Zuma may be gone, but her disastrous AIDS policy lives on", *Sunday Times*, 4 July 1999.

120. Quoted in "Zuma makes doctors report AIDS patients", *Sunday Times*, 18 April 1999.

121. Interview, November 23, 1999.

122. Quoted by Donald G McNeil Jnr, "Aw, c'mon, you don't really believe those Aids myths?", *Mail & Guardian*, 11 June 1999.

123. Interview, November 1999.

124. Interview, November 23, 1999.

125. Douglas Webb, 1997, *HIV and AIDS in Africa*, Pluto Press, p 75.

126. Interview with a participant at the presentation session, January 1999.

127. In the meantime we are left with anecdotal accounts, such as this one, offered by Donald G McNeil Jnr: "Where was President Nelson Mandela on this? I thought it was because a man who could barely bring himself to discuss dating with a young whippersnapper like Allister Sparks wouldn't touch such a tender subject, but I was recently set straight by an American UNAIDS officer who lived here back then. Mandela talked briefly then about AIDS and even condoms. The officer assumed he stopped on becoming president because it was undignified. But last month Mandela said he stopped because it upset people. From "Aw, c'mon, you don't really believe those Aids myths?", *Mail & Guardian*, 11 June 1999.

128. Interview, 5 November 1999.

129. Quoted by Mark Gevisser, "Finally the state gets serious about AIDS", *Mail & Guardian*, 22 July 1994.

130. Dr O.W. Prozesky, 1999, "SAAVI: New hope for millions?" (Interview) *MRC News* Vol 30 No 3 (September).

131. Quoted in "New hope in war against Aids", *Mail & Guardian*, September 25, 1998.

132. Interview, November 1999.

133. Quoted by Aaron Nicodemus, "Ministry refuses anti-HIV drug discount", *Mail & Guardian*, 7 May 1999.

134. "The AIDS epidemic can be controlled by protecting the public", *Sunday Times*, 31 May 1998.

135. *Mail & Guardian*, 15 May 1998.

136. *Mail & Guardian*, 30 April 1999.

137. Director of the Directorate HIV/AIDS and STDs, Dr Nono Simelela, quoted in "Cabinet approves formation of national AIDS council", *Sunday Independent*, 28 November 1999.

138. Defenders of Beneton's controversial advertisements featuring a photograph of a person living with AIDS have claimed it was an example of a "positive" or "dignified" image of suffering. More convincing, though, is the view that the photo merely iconised suffering and deflected it into an entirely different discourse (encouraging the purchase of Beneton clothing items). In British journalist Suzanne Moore's words, "what is disturbing is mostly that these pictures hang in our consciousness, disconnected and dislocated from any context in which we might make sense of them". See Moore, S, 1996, *Head over Heels*, Viking Press, London, p 32.

139. Interview, November 1999.

140. Quoted in Lawson (1997:14).

141. Michael Worsnip, director of the Association for Rural Advancement (Afra), a land rights organisation in the Midlands of KwaZulu-Natal, quoted in Lawson (1997:35).

142. Interview, November 1999.

143. Gerald Kraak & Graeme Simpson, 1998, "The illusions of sanctuary and the weight of the past: notes on violence and gender in South Africa", *Development Update* Vol 2 No 1, p 7.

144. Hein Marais (1998:223).

145. Sometimes violently explicit, as in reported cases where women have been attacked and even killed by partners who discovered condoms among their personal belongings. The condoms were interpreted as evidence that the woman was being "unfaithful". See, for instance, "Wife hacked over condoms", *Sunday Times*, 28 February 1999.

146. Except in the most backhanded fashion, whereby "youth" refers mainly to young males, leaving young women in a sociological "no-man's land", literally.

147. Grossberg, L., 1992, *We Gotta Get Out of This Place: Popular Conservatism and Postmodern Culture*, Routledge, New York, p 176. See also Erikson, E.H., 1968, *Identity: Youth and Crisis*, Norton, New York.

148. Donald G McNeil Jnr, "The absurdity of the HIV dissidents", *Mail & Guardian*, 25 June 1999.

149. *Ibid*.

150. For example, in Carletonville (a community with 370 000 people) the prevalence rate is estimated to be about 43%. Research has shown that, at age 15 years, the prevalence rate among women is close to 0%. But among 20-22 year-old women, the rate soars to about 50%, peaks at 25 years and then declines again. (Interview with Brian Williams, November 1999).

151. Interview, November 1999.

152. See Chapter 2 in Webb (1997) for a discussion of the conceptualisation of HIV epidemiology.

153. Webb (1997:138).

154. *Op. cit.*, pp 138-139. This does not suggest that no such research has been attempted, but that the instances are rare. One example is a survey of secondary school students in Mpolweni, KwaZulu-Natal, cited in Webb (1997:136-142).

155. Edwin Cameron, 1993, "Human rights, racism and AIDS", *SA Journal of Human Rights* Vol 9 No 1, p 27.

156. John Carpenter's 1982 film *The Thing* and Don Siegel's 1956 film *Invasion of the Bodysnatchers* are good examples. (Coincidentally, in the latter the "invasions" occurred in bed, while the victim slept – hence the original title of the film, *Sleep No More*.)

157. Interview, November 1999.

158. Former security policy informer Patrick Hlongwane, now a fieldworker with the National Association of People Living with AIDS (Napwa), quoted in "Killer on a mission of mercy: AIDS is his new enemy", *Sunday Times*, 24 January 1999.

159. "Vicarious" in the sense that the disease is revealed through its evisceration of health and, ultimately, through death.

160. Again, this image of the epidemic is not entirely false. Unlike cancer (which occurs when rogue cells mutate and "break out" of their strongholds inside the body), AIDS is contracted through invasion or intrusion, when the contaminated blood or sexual fluids of another person *enter* the body. Medically, it is difficult to divorce AIDS from the idea of "an infectious agent that comes from the outside" (Sontag, 1988:17).

161. Sometimes the language progresses from metaphor to (almost) literal truth – as in the headline "Residents flee as AIDS sparks war: Anger simmers after killing of victim", describing the aftermath of Dlamini's murder in KwaMancinza township near KwaMashu; *Sunday Times*, 27 December 1998.

162. The notion of disease as a weapon of war or conquest is hardly fanciful, of course. In 1347, for instance, a Tatar army laying siege to the Crimean port of Kaffa was believed to have catapulted bubonic plague-infected corpses over the city walls. Centuries later, disease played a central role in the subjugation of South American peoples by the Spanish conquistadors, as it did in the vanquishing and extermination of North American indigenous people. For these and other examples, see Arno Karlen, 1995, *Plague's Progress: A Social History of Man and Disease*, Indigo, London.

163. There is another – at the moment, chimerical – approach, increasingly favoured by the South African government: the "magic bullet" of a (still non-existent) AIDS vaccine.

164. Sontag (1988:25).

165. Mary Crewe, 1999, "AIDS: activism and the role of the universities", paper presented to the Heads of Commonwealth Universities, 8 November, Durban, p 3.

166. *Ibid*.

167. Zackie Achmat, 1998, "Another voice from the coalface", *Development Update* Vol 2 No 1, p 67. Two organizations (the AIDS Law Project and the AIDS Consortium), in fact, were named as examples of such "isolation from the broader movement" – an early reminder of the internecine squabbling primed by this approach.

168. "Zuma may be gone, but her disastrous AIDS policy lives on", *Sunday Times*, 4 July 1999. Emphasis added.

# Acronyms

| | | |
|---|---|---|
| AIDS | - | acquired immune deficiency syndrome |
| ANC | - | African National Congress |
| ASOs | - | AIDS service organisations |
| ATICCs | - | AIDS training, information and counselling centres |
| AZT | - | azidothymidine |
| CBOs | - | community-based organisations |
| CSOs | - | civil society organisations |
| COSATU | - | Congress of South African Trade Unions |
| HIV | - | human immuno-deficiency virus |
| MCC | - | Medicines Control Council |
| MEC | - | Member of the executive council (province) |
| MRC | - | Medical Research Council |
| NACOSA | - | National AIDS Co-ordinating Committee of South Africa |
| NAPWA | - | National Association of People Living with AIDS |
| NGOs | - | non-governmental organisations |
| RDP | - | Reconstruction and Development Programme |
| STDs | - | sexually transmitted diseases |
| TAC | - | Treatment Action Campaign |
| WHO | - | World Health Organisation |


FOUR STEPS TO SAFETY

# Centre for the Study of AIDS

The Centre for the Study of AIDS is located at the University of Pretoria. It is a 'stand alone' Centre which is responsible for the development and coordination of a comprehensive University wide response to AIDS. The Centre operates in collaboration with the Deans of all Faculties and through Interfaculty committees to ensure that a professional understanding of the epidemic is developed through curriculum innovation as well as through extensive research.

Support for students and staff is provided through peer based education and counselling, through support groups and through training in HIV/AIDS in the workplace. A large number of student volunteers are involved in the programme as are many community groups, ASOs and NGOs.

To create a climate of debate and critique the Centre publishes widely and hosts AIDS Forums and AIDS seminars. It has created web and email based debate and discussion forums and seeks to find new, innovative, creative and effective ways to address HIV/AIDS in South African Society.

The Annual Reviews, published each April, will each address a major aspect of the South African response to the HIV/AIDS epidemic.

Review 2001 will be addressing the complex question of Care in communities and families.

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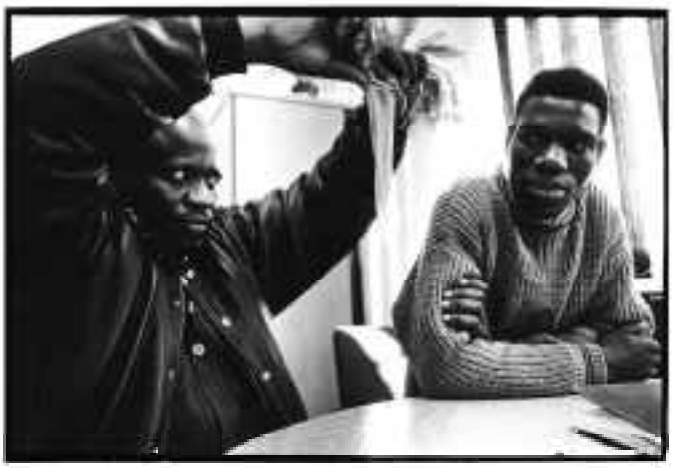

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