Government policy of HIV/AIDS in India and South Africa

Government of India has announced a comprehensive National Policy for prevention and control of AIDS in India. The policy aims at an expanded and coordinated response to HIV/AIDS with advocacy and ownership of the programme at every level being the hallmark. Prevention strategy lays stress on targeted intervention for control of STIs and RTIs, condom use, blood safety coupled with awareness campaigns in rural areas. An enabling socio-economic environment for infected people, protection of their human rights and provision of clinical care are other important aspects. NGOs and community-based organisations will be more actively involved in providing home and community-based care for AIDS patients. Multisectoral participation within Government and with UN system and bilaterals is advocated to synergise the efforts. There is greater realization that control of HIV/AIDS is a socio-economic issue and a multi-sectoral response is essential for its prevention. Control of STIs/RTIs is receiving outstanding priority in the programme, followed by blood safety. There is greater consciousness about the rights of PLWAs, greater community participation for home and community-based care.

It was only 1985 that there was any realization in India about the problem related to AIDS there had previously been a mild curiosity in scientific circle about the suddenness of its out break in the western world. And the overwhelming perception had been that it was a disease confined to the gay community. However, ICMR with considered it necessary to establish a task force on AIDS in 1985 and to start screening sera for high risk groups at the national institute of Virology, Pune at the ICMR Center of virology.

The government of India launched a National AIDS Control Programme in 1987, which concentrated on surveillance, blood safety, and information, education and communication (IEC). A comprehensive five-year
strategic plan was launched during 1992-97 with World Bank credit as the National AIDS Control Programme Phase I. The second phase of the National AIDS Control Programme (NACP-II) was formulated with the two key objectives of reduction of the spread of HN infection in the country and to strengthen India's capacity to respond to HN/AIDS on a long-term basis. Specific objectives of this phase include interventions to change behaviour, especially among high-risk groups through targeted interventions, decentralization of service delivery through State AIDS Control Societies (SACS), protection of human rights, operational research and management reform. Inter-sectoral collaboration with all government departments, elected representatives of the people, chambers of commerce and industry, community-based organisations and the civil society in general is another feature of this phase.

During the past few years the programme has witnessed a rapid expansion and decentralisation in the country. SACS have been set up in 35 states/UTs and three municipal corporations (Mumbai, Chennai and Ahmedabad). These 38 societies have adequate financial and administrative powers to identify and respond to local needs. SACS operate through the regular health infrastructure and have designated district nodal officers to carry out activities related to prevention and control of HN/AIDS. Considerable progress has been made in the past few years in implementing quality interventions. Two landmark policies, the National AIDS Prevention and Control Policy and the National Blood Policy, were adopted by the government in 2002. These are expected to be the framework on which the comprehensive national response to the epidemic will be based upon. To facilitate this response, AIDS-related legislation is also on the anvil.

Some of the specific areas of response are discussed here.

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Behavioural Surveillance

Access to quality data on sexual behaviour of the population is also essential for mounting evidence-based control programmes. A nationwide baseline behavioural surveillance survey was conducted among the general population, bridge and high-risk populations in the country. Findings from these surveys are being used for better programming. Clear differentials between states and groups on various risk practices have been brought out.

Learning for Life: School AIDS Education Programme

The school AIDS programme of NACO is a crucial intervention to address schoolgoing youth of the country. It is an innovative effort that offers flexibility to the states to follow models that best suit it in providing peer-driven life skills education to children of classes 9 and 11. It is always implemented through departments of education either directly or through NGOs. The programme focuses on: (a) raising awareness levels about HIV; (b) helping young people resist peer pressure to participate in risky behaviour; and (c) helping develop safe and responsible lifestyles, like abstinence. The programme is presently operational in about 35,000 schools.

Information Education and Communication

Under IEC activities, multimedia campaigns are being taken up. Special communication packages are developed for vulnerable groups like sex workers, IDUs, truckers and street children. Focused radio programmes are broadcast on a regular basis to provide information about prevention and control of HIV/AIDS. Field publicity units, and the song and drama division have taken extensive campaigns in rural areas. AIDS hotlines with the 1097 toll-free numbers have been established in major cities in the country.

Another example of a successful programme for the youth has been the Universities Talk AIDS (UTA) programme, which covered 3.5 million students in 4,044 institutions in the country. This programme was launched in
1991 and implemented by the National Service Scheme (NSS) with assistance from the WHO and NACO. The programme was aimed at reaching all universities and 10+2-level higher secondary schools. Along with a training manual in English (translated into various regional languages), a lot of IEC material was produced for disseminating information to students. The evaluation reports of the UTA programme by the WHO and other professional agencies indicate that the programme was successful in creating awareness about HIV/AIDS and developing a positive attitude towards sex in both boys and girls.

Family Health Awareness Campaign

The Family Health Awareness Campaign is an innovative public health initiative to create awareness and encourage health-seeking behaviour among rural populations on RTIs and STIs, and to motivate and sensitise field-level health functionaries on the importance of treating such infections. Such a campaign is being organised annually in the entire rural population and in urban slum population in the country. About 226 million target beneficiaries (15 to 49 years) had been covered during the last campaign, out of which 43 million people attended the camps. More than 3.5 million cases were referred from these camps and 1.8 million cases were treated during this campaign in the year 2000.

Initial responses in case of India has also been of denial and missed opportunities. Since the discovery of the first case among female sex workers in Tamil Nadu, Infection rates have been consistently on the rise, but most India health officials and health care establishments viewed HIV as a "foreign" disease or an "imported" infection, confined to some limited groups. Even politicians regarded the spread of HIV/AIDS as a law and order problem i.e., they believed that spread of HIV/AIDS can be managed by controlling certain high risk groups and prevent it from spreading to the general population. Stigma and misconception coupled with social norms and
conservative attitude towards sex made responding to the epidemic even more difficult.

The national response to the HIV/AIDS epidemic in India was led by the National AIDS Control Organization (NACO), a semi-autonomous organisation under the Ministry of Health and Family Welfare. NACO was established with the help of financial assistance from The World Bank, it carries out the government's National AIDS Control Program (NACP-1) established in 1987. In its second phase NACP-11 (1999-2004) it has taken steps to strengthen its focus on care, support and treatment issues alongside prevention in response to the growing number of HIV infection in the country.\(^3\)

The programme has seen rapid expansion and decentralization in the country. There are 38 SACS (belonging to 35 States and 3 Union Territories) which operate through the health infrastructure. District nodal officers are required to carry out activities for prevention of HIV/AIDS. Considerable progress has been made in past few years. NACO has even sought cooperation of NGO's for some activities (mainly in the form of Targeted Interventions) taken up for implementation of its programmes. A National AIDS Committee is composed and established to show its commitment to a multi-sectoral approach and it includes representation from the Government, NGO's persons from scientific and professional background and also persons living with AIDS (PLWHA). India's strategy for AIDS focuses first on Prevention. Prevention programme includes ensuring blood safety, Voluntary Counseling and testing centers, better surveillance, condom promotion to name a few. Treatment which includes anti-retroviral therapy gets a lower priority. The plan is to increase HIV awareness and contain the prevalence of virus. For any strategy to work, resources are a major requirement. The India Government's Health budget was roughly $160 million per year, but only a

small portion is earmarked to combat AIDS. International funding has provided the larges share of financial backup of $850 million from various funding agencies over a period of five years. Even if all commitments are disbursed in time, it would represent a modest investment in AIDS prevention and treatment in India.

Unlike South Africa, India is fortunate to have a well-developed pharmaceutical industry which can provide ARV (ART) drugs at low cost to the government. Cipla, Ranbaxy and others have also signed an agreement with Clinton Foundation to provide low-cost drugs to not only India but other affected countries including South Africa and three other countries at per capita cost of $0.37 per day. Indian Health Ministry is negotiating to obtain the ARV drug at even lower prices. In addition to a thriving pharmaceutical industry, India also has first-rate scientists and bio medical researchers who can be tapped to improve the epidemiological studies. National AIDS Research Institute, near Pune is a good example and it is funded in part by collaborative agreements with partners in the United States, such as John Hopkins University and National Institutes of Health.5

**South Africa**

The initial response to HIV/AIDS epidemic by South African Government officials had been beset by denial and ambivalence, and had lacked internal coherence. In fact, initially to South African leaders were preoccupied with the transition to democracy in the mid-1990 and with host of other issues, failed to take AIDS seriously. In 1995, AIDS still ranked 12th statistics causing deaths in South Africa. Till 1999, President Mbeki, who succeeded Nelson Mendela, doubted any connection between HIV and AIDS. It was only July 2000, when the 13th International Conference on AIDS was

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4 [MIN OF FIN-http://indiabudget.nic.in/welcome.html](http://indiabudget.nic.in/welcome.html)
hosted in South Africa, which market the beginning of world attention to AIDS in South Africa.

Although, a national AIDS Convention of South Africa (NACOSA) was established in 1992, the ANC (African National Congress) government accepted its strategy to fight AIDS in 1994. AIDS activists and health professionals in South Africa including many in Government took initiative at many levels and worked for national and global levels to lower drug prices, combat stigma and confront the impact of AIDS, in spite of the hostile attitude of the government in the initial stages.

Despite the earlier setbacks, the roll out is gathering momentum in terms of treatment (ART-Anti retroviral treatment), care and support, not only from social organizations, business sectors and International Donors but also from the Government. The Treasury increased the budget allocation for treatment and other planned HIV/AIDS initiatives.\(^6\) In 1999, the current president of South Africa, Thabo Mbeki, strongly questioned the scientific evidence that HIV is the sole cause of AIDS, an action for which he was condemned at home and abroad. His controversial stance on AIDS confuted an orthodoxy that contrasts state responses to AIDS in South Africa before and after the landmark 1994 democratic election. According to this view, the pre-1994 National Party (NP) apartheid regime, hidebound by puritanism and racism, ignored or at best paid lip service to the AIDS threat. African National Congress (ANC) rule, however, allegedly meant a dramatic improvement, as the party had condemned its predecessor's response to AIDS and was committed to helping the poor or marginalized, from whom most AIDS sufferers came.

Because apartheid created gross inequalities in health care, it is logical to assume that the apartheid government would pay little attention to AIDS, a disease that disproportionately affected blacks. Homophobia, racism, and

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puritanism thwarted' a timely, effective reaction, and that the state's lack of credibility among the black majority undercut its belated response. Apartheid caused poverty, overcrowding inequality, fatalism, and conflict, all of which promote the spread of HIV AIDS. The NP regime, supported primarily by conservative Afrikaners, was notoriously, prudish about issues such as sex education, and censors -routinely banned 'obscene' books, films, and objects. Frank discussion of sexually transmitted infections (STIs) such as AIDS was hugely problematic in such a society.7

This image of sharply contrasting state responses to AIDS is, however, too simplistic. From the late 1980s, official bodies, notably the Department of National Health (DOH) and the Medical Research Council (MRC), addressed AIDS, even while AIDS activists, public health experts, and opposition leaders decried state inaction and ineffectual strategies. Many lower-level civil servants and scientists in health-related public agencies seemed aware of the AIDS threat, although many senior government figures seemed blind to the problem. This remained true in the post-1994 period. The new government was relatively slow to address the disease, developing contradictory policies and sometimes questioning basic scientific findings about AIDS. Just as in the apartheid period, the AIDS policy-making process after 1994 could be characterized by a gap between rhetoric and reality, lack of political will, inadequate funding, slow policy development and implementation, and tensions between the state and civil society.

These similarities in state responses to AIDS before and after 1994 illustrate much about the economic, political, and social challenges to the South African state. The post-1994 government faced- many problems that characterize governance throughout sub-Saharan Africa. Artificial colonial and apartheid borders and institutions weakened state legitimacy and hindered the implementation of any type of policy. The post-1994 administration found
that governance proved harder than criticism; without a -tradition of political pluralism or tolerance, the former rulers' centralizing, authoritarian tendencies were alluring\(^8\). Just as other African states suffered from the economic legacy of colonialism, post-apartheid South Africa needed vast sums for education, housing, electricity, water, jobs, and public safety. These problems required resources even greater than those needed to defend apartheid; AIDS. Was only one of many problems the state faced? In the aftermath of apartheid, poverty and insecurity facilitated the spread of HIV, as they have elsewhere in Africa.

However, South Africa differs from many African states engaged in fighting AIDS in notable ways. The transition from apartheid to democracy has been time consuming and politically distracting. If negotiating a new order hampered F. W. de Klerk's government (1989-1994) from focusing on AIDS, the need to transform the state after 1994 slowed AIDS efforts. Furthermore, the end of apartheid entailed changes in government structures, such as integration of the black homelands into the previously 'white' South Africa and the devolution of some powers to nine new provinces. Apartheid-era bureaucrats, whose jobs were protected from 1994 until 1999, often clashed with new state employees. Though the struggle against AIDS has been hindered throughout Africa by an unwillingness to discuss sexual behavior, in South Africa such attitudes were compounded by many whites and blacks viewing AIDS in racial terms. Like many other African leaders, both NP and ANC politicians failed to address AIDS in a timely manner. However, unlike many of their African counterparts, some South African leaders have confused the public with their extraordinary views about the disease.

During the pre-1994 period, especially before 1990, there was much denial in official circles about AIDS. The militaristic and puritanical climate

\(^8\) Shoutall1998
under P.W. Botha (president from 1984 to 1989) made it difficult to act against AIDS, even after the disease spread into the heterosexual black majority. Once the government began to recognize the need to do more, it was distracted by other issues. Black resistance to Botha's unwillingness to end apartheid forced his successor. To focus on seeking a negotiated solution with black leaders. Reformists in the state bureaucracy also had to fight rearguard battles with conservatives who were suspicious of new initiatives, such as AIDS-education campaigns. Prudishness among both white and black South Africans hindered frank discussion about how AIDS is transmitted, and the government's lack of legitimacy among the black majority hampered the credibility of its most well-intentioned efforts to fight AIDS.

As late as 1987, the state response to AIDS displayed little urgency. Conservative white voters saw AIDS as limited to homosexual men and 'licentious' blacks. Some clergy, notably in the powerful Afrikaans Reformed churches, dismissed AIDS as punishment for sin. Scientists in the regime's secret chemical and biological warfare program showed interest in AIDS, only insofar as HIV infection among guerrillas based in neighboring states might lead to their defeat. For example, microbiologist Mike Odendaal recounted being given a vial of blood from a dying AIDS patient to use against regime opponents.

When DOH annual reports first discussed AIDS in 1985, they focused on how all 21 diagnosed cases were male; of these individuals, 20 were white, 16 were gay, and one was bisexual. The three heterosexual cases had 'some contact with Zaire'; one additional case was because of a blood transfusion. The 1986 report noted that the overwhelming majority of 13 new cases were among homosexual men. In 1987, the DOH reported a total AIDS caseload of 64 South African citizens plus 20 individuals 'from countries to the north'. While the report stated that 10 per cent) to 20 per cent of high-risk groups

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9 (Crewe 1992, 14-16)

10 DOH1987,10
(e.g., gay men) were 'definitely carriers", it claimed that HIV prevalence among the general population was low\textsuperscript{11}.

There are numerous political reasons why the South African state underrated the AIDS threat. In the 1980s, Borha's regime faced economic sanctions, foreign isolation, hostile neighbors, anarchy in urban black areas, and an ANC-Ied guerrilla campaign. In response, the government offered expensive but inadequate reforms, such as giving limited powers to new mixed race 'colored' and Indian (but not African) chambers in the previously all-white parliament. At the same' time, the state became increasingly repressive and intolerant, even of whites who rejected its notions of warrior masculinity. For instance, a 1999 MRC coauthored study alleged that some gay white military conscripts suffered electrical shock or chemical treatment intended to alter their sexual orientation; there are also claims that the military performed some 9(0) sex-change operations on gay conscripts. The state was so focused on preserving white rule that Botha's 'total strategy' left few resources for a disease that challenged regime's conservative views and seemed to strike the most marginalized groups.

By the late 1980s, the state had begun to react to AIDS. Though the authoritarian Botha regime was notoriously impervious to criticism, increasing evidence of a potentially broader epidemic led to the development of new AIDS policies. Government preoccupation at the top with containing unrest in black areas and with allaying the growing fears of whites also provided space for lesser, but more enlightened, DOH and IMRC officials to shift policy direction.

In 1987, the MRC established an AIDS research unit, which soon noted a 'disquieting increase' in heterosexual transmission, though most cases were; in the black community. That year the MRC hosted and published the

\textsuperscript{11}DOH 1988,7
proceedings of an international AIDS research symposium\textsuperscript{12}. Press reports of AIDS 'spreading among African miners and into the communities surrounding the compounds' confirmed the threat to the general population\textsuperscript{13}. The 1988 DOH report reflected greater concern about the disease and acknowledged the difficulty of AIDS education because of 'taboo subjects, such as sex, blood and death'\textsuperscript{14}. This increased awareness that AIDS could no longer be dismissed as affecting a tiny minority was apparent in the aforementioned 1988 DOH education campaign.

The ANC later claimed that it and its alliance partners had developed 'NACOSA. Yet the state was very involved. On the other hand, while Nelson Mandela addressed the convention, neither the health minister, Rina Venter, nor any other minister attended\textsuperscript{15}. This puts in question NP leaders' (as opposed to DOH professionals') commitment to fight AIDS, although the cabinet perhaps feared alienating more white voters by prioritizing the disease. Bitter disagreements marred the convention. There were more divisions between civil society groups and the political parties (both the ANC and NP) than there were between the ANC and the apartheid regime. A major issue was the omission from the convention steering committee of the community-based National Progressive Primary Health Care Network mandated in 1989 by the ANC to handle AIDS work\textsuperscript{16}. Even the 11 ATICCs were criticized because they were located where they served almost exclusively whites; only in mid-1993 was one for Soweto approved. In hindsight, these disagreements between political authorities and civil society foreshadowed future tensions.

In theory, the government had begun to embrace a more progressive general health policy. Minister Venter announced in her 1990 budget speech a

\textsuperscript{12} Ibid
\textsuperscript{13} Van Niekerk 1988
\textsuperscript{14} Opcit DOH ,P17
\textsuperscript{15} Fleming 1998
\textsuperscript{16} Gevisser and Stober 1992
plan to 'reconstruct' health services, with less racial or ethnic fragmentation, more equity in funds, and access for all. The plan did not necessarily mean an improved response to AIDS, but it recognized that the apartheid approach of segregated health agencies was inefficient and unfair, and any reform that reached out to all South Africans might improve the state's ability to fight AIDS. Venter warned, however, that economic constraints made dramatic adjustments in her budget impossible for many years. The liberal Business Day derided her 1991 announcement of a huge AIDS education program, arguing that even doubling spending on AIDS was not enough. Though the state AIDS budget quadrupled between the 1991/92 and 1992/93 fiscal years (SAIRR 1993, 285), it dropped slightly from 1992/93 to 1993/94. Much of the budget shifted from direct education to research and surveillance or the aforementioned ATCCs and nongovernmental organizations (NGOs), which were thought to be more credible than state agencies.

The state's lack of financial resources hampered its AIDS efforts. The MRC complained that funding remained inadequate for behavioral and epidemiological AIDS research. In fact, there were no reliable statistics on the number of AIDS deaths in the country. While official reports showed 26 AIDS deaths in the first nine months of 1992, 153 people had died of AIDS in just one hospital in Natal. As was true after 1994, financial constraints also were used to justify state reluctance to offer AIDS drugs; AZT, then the one registered drug proven to slow the progression of AIDS, was provided free only to hemophiliacs infected by blood transfusions and to health-care workers infected on the job by contaminated needles.

Divisions in the AIDS bureaucracy complicated the state's AIDS efforts. In a period of great flux in the state apparatus, conservative, usually male Afrikaners who had dominated the senior levels of the bureaucracy increasingly diverged from de Klerk's reformist NP. English-speaking whites,

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17 MRC1991 3-4
18 Greviser 1992b
somewhat more liberal than either faction, now filled key, positions in the DOH AIDS unit, a possible sign of de Klerk's efforts at more inclusiveness. However, these individuals often lacked their bosses' political clout or connections. For example, bureaucratic infighting may have been behind orders by the DOH to investigate alleged irregularities in running the AIDS unit and alleged complaints about the acting unit head, Manda Holmshaw. Holmshaw countered these charges by noting that she and her deputy had complained that their advice on AIDS prevention often was ignored, and that they had opposed efforts to transfer a third of the AIDS budget to the state immunization program. One casualty of the lack of a unified, well-coordinated DOH effort was a new AIDS educational kit geared especially to schools. Its early withdrawal may have been as much because of bureaucratic infighting as because of the irrelevance of this educational material to poor black.

There were undoubtedly some notable changes after April 1994. AIDS awareness was one of 22 presidential priorities in the Reconstruction and Development Program (RDP), the centerpiece of the ANC's 1994 election platform. Grassroots organizations such as the Congress of South African Trade Unions (COSATU) had drafted much of the RDP, which illustrates the ANC's initial support from civil society. Although the pattern of health-care expenditure by the end of the de Klerk era was progressive by African standards, after 1994 state budgets shifted significantly more money from affluent to poor communities. Since poverty and soaring HIV rates are closely linked in Africa such changes were essential to combat AIDS. At the end of 1994, Mandela's government of national unity (composed of ministers from the ANC, NP, and the Inkatha Freedom Party) accepted a national AIDS plan. This plan included key MRC recommendations for greater control of STIs and educational programs for in- and out-of-school youth.

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19 SAIRR1993,286
20 Ibid
In July 1994, the health minister, Nkosazana Zuma, announced plans to double the AIDS budget by reallocating other DOH funds to AIDS\textsuperscript{21}. The 1995 AIDS budget was doubled yet again, with a quarter of it going to NGOs. The government wanted to mandate sex education for school children, run media information campaigns, improve STI treatment, develop care and support programs for infected persons, and ban discrimination against those with the disease. In the 1995/96 fiscal year, the state distributed over 97 million free condoms. Zuma promised hardnosed pragmatism; 'In the long-term perhaps we do need to change the values of this society, so that it can be more acceptable for young people not to be sexually active. But in the short term, let's face it, condoms are useful'.

In 1997, the government formed an interministerial committee to coordinate AIDS efforts, complemented in 1998 by the Partnership Against AIDS, a program to reach out to civil society to implement an AIDS action plan. By 2000, the South African National AIDS Council (SANAC) promoted a multicultural HIV/AIDS strategic plan. As a demonstration of high-level attention to AIDS\textsuperscript{1}, Deputy President Jacob Zuma chaired SANAC. By 2000 the DOH could list many further AIDS initiatives: national implementation of 'life skills and HIV/AIDS education' in high schools and parallel pilot programs in primary schools; training of key trade unionists to lobby for workplace AIDS programs; training of 270 traditional healers in HIV/AIDS counseling and care; and pilot programs of home based care to reduce the burden on hospitals. State support for MRC research increased dramatically. From 1999 the MRC coordinated the ambitious new South African AIDS Vaccine Initiative, a collaborative state-industry-NGO-academe project\textsuperscript{22}. MRC-funded scientists also developed a system designed to reduce HIV transmission to infants by heating infected mothers' breast milk to kill HIV\textsuperscript{23}. By 2001, the state was distributing 250 million condoms per year; it had

\textsuperscript{21} Gevisser 1994 a
\textsuperscript{22} MRC 1999,8
\textsuperscript{23} MRC.2000,35
expanded sites for a rapid HIV test, established 18 research and training sites for prevention of mother-to-child transmission (PMTCT), and set up 256 outlets to distribute Diflucan, a drug for AIDS-related infections. And, most notably, in late 2003, the state agreed to provide antiretroviral (ARV) treatment to all South Africans needing it.

Despite these successes, the post-apartheid state has been slow to engage AIDS, often developing contradictory policies and sending confusing messages. Several overarching themes characterize state responses to AIDS during the Mandela and Mbeki presidencies. The continued lack of political will and a tendency to view AIDS solely as a health issue are reflected in the Mandela-era responses. AIDS policies in this period were further complicated by the move from a distributive economic plan to a neoliberal agenda, tensions between societal attitudes and the new liberal constitution, and a tendency to centralize policy making. Several of these themes continued in the Mbeki period, but AIDS policies became even more problematic, due to the denial of established science on HIV/AIDS, increased tension between the state and civil society, and controversy over providing treatment for those with AIDS.

In June 1994, Clive Evian, Johannesburg AIDS chief-and an architect of the NACOSA AIDS plan, hailed the appointment of Nkosazana Zuma as health minister. Zuma was an outspoken critic of the NP government's AIDS policies and a former chair of NACOSA's strategy subcommittee. Evian warned, however, that apart from Zuma there had been 'no real demonstration of political will from the heavies up there, except for Mandela, who has highlighted the issue from time to time.' This pattern of limited 'political attention to AIDS was apparent at the 1997 ANC national conference, when President Mandela, in a long final speech as ANC leader, mentioned AIDS just once.' In his closing comments, Mandela referred-to 'the intensification of

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24 DOH2001a
25 Gevisser1994a
the struggle against HIV I AIDS' in a list of 12 'important issues'\textsuperscript{26}. Similarly, an ANC-commissioned 1999 audit of the RDP only mentioned AIDS in a footnote\textsuperscript{27}.

Like the preceding government, the Mandela administration tended to define AIDS narrowly as a health issue. The 1994 ANC election platform mentioned AIDS as part of a promise to direct 'major resources' to combat tuberculosis, AIDS and other STIs, cancer, and 'other plagues'. The RDP mentioned AIDS only once, in the document's health section. It advocated active and early treatment, mass education, especially in rural areas, and an end to discrimination against people with the disease. Despite this brief recognition of the need to address AIDS, the DOH rather than the RDP fund paid for AIDS programs. Major policy documents, such as those on housing, rural development, welfare, and population, minimized AIDS (Thomas and Howard 1998, 100). In the secretary general's report on the 1994 ANC national conference, apart from a claim by the youth league to have initiated a local and regional AIDS campaign, AIDS appeared only in Zuma's report on the health ministry ANC.

Though the politically popular RDP remained the official policy framework of the ANC-COSATU-Communist Party alliance, President Mandela closed the RDP office in March 1996; instead, regular government departments were now to implement the RDP \textsuperscript{28}. That year the ANC replaced the RDP' with the Growth, Employment and Redistribution Strategy (GEAR), despite COSATU and Communist Party criticism. GEAR sought to marry democratic transformation with the fiscally cautious, market-oriented reforms favored by the International Monetary Fund and the World Bank. The adoption of GEAR shows that, as before 1994, the state would not ignore the concerns of domestic or overseas investors and financiers. The move from the

\textsuperscript{26} ANC 1997
\textsuperscript{27} Bond and Khosa 1999,101
\textsuperscript{28} Terreblanche 2002,96-112
RDP to the GEAR hampered funding prospects for a costly AIDS campaign. GEAR did not mention HIY but, reminiscent of the Venter era aimed to 'limit additional state expenditure on social needs'.

The Mandela government's shift to neoliberalism paradoxically coincided with a shift in the nature of international assistance in the fight against AIDS. Once the South African state was no longer tainted by apartheid, foreign donors increasingly switched support from NGOs to the state. Yet, because the donors insisted on fiscal prudence, the state was less willing to fund needed AIDS programs. This shift especially hurt private initiatives that had hitherto depended on international efforts. instance, despite longstanding political alignment with the ANC, in April 1995 lack of funding halted the National Progressive Primary Health Care Network's AIDS program, which provided nationwide community-based counseling and support. Funding constraints also hurt public sector programs; for example, overcrowding and limited staff caused Johannesburg Hospital to turn away patients with AIDS. As the DOH estimated 3.6 million HIV-positive South Africans by the end of 1998, future costs of the epidemic seemed daunting.

Another problem bedeviling AIDS policies during the Mandela presidency was the difficulty of merging the ANC's liberal position on human rights with the societal prudishness about sexual behavior that had constrained policy reforming the de Klerk era. This tension was particularly evident in the controversy over AIDS among prisoners. After the 1994 election, the University of the Witwatersrand's AIDS Law Project began fighting the nonconsensual HIV testing of prisoners and the continued isolation of HIV-positive prisoners. Such discriminatory policies recalled the Botha regime's efforts to expel Malawian miners with AIDS. Moreover, given the window period between HIV infection and the appearance of HIV antibodies in blood tests, testing or isolation could not prevent newly infected convicts from...

29 Thomas. and Howard 1998. 100-101
30 Whiteside and Sunter 2000, 125
spreading HIV. In July 1995, Lawyers for Human Rights also petitioned the minister of correctional services to end the segregation of HIV-positive prisoners and to distribute condoms in prisons. The ministry refused to hand out condoms on the ground that apartheid-era statutes prohibiting sexual activity between those of the same gender still existed.

These prison practices contradicted the ANC position on discrimination. The ANC sought 'nondiscrimination against infected individuals' as early as 1993. The ANC had been the first major South African political party to support including sexual orientation in a bill of rights, though there had been some opposition inside the ANC to recognizing gay and lesbian rights. A ban on discrimination on grounds of sexual orientation was included in the 1993 and 1996 Bills of Rights. Nevertheless, it was only on 17 May 1996 that the corrections minister announced the end of HIV-positive prisoner segregation and the start of condom distribution in prisons.

The prison cases illustrate not only that the government was reticent about engaging the difficult topic of sexual behavior despite the liberal constitution, but also that neither the ANC president nor the ANC-dominated legislature was willing to use its power to end discriminatory policies. As chief executive, President Mandela could have ordered changes in prison policies as early as 1994. It took the correctional services committee of the National Assembly two years to make the changes sought by the AIDS Law Project. Likewise, it took a high court ruling in 1998, rather than ANC-sponsored legislation, to overturn laws criminalizing intimate homosexual behavior. One reason for the aging president's seeming lack of leadership may have been that he was turning over many day-to-day tasks to his deputy, Thabo Mbeki, who lacked his authority and 'charisma. For example, when Mandela was scheduled to give a nationally broadcast speech on AIDS entitled 'Ten Minutes to Save the Nation', audiences discovered that he had delegated the task to Mbeki at the last minute.
Without strong political leadership on the AIDS issue, competing critic priorities and centralizing tendencies undercut post” 1994 AIDS efforts. Old and new bureaucrats squabbled, while national, provincial, and local authorities battled over funding allocations, program design; and policy decisions. In June 1996, DOH AIDS project chief Quarraisha Karim complained of waiting nearly eight months for contract approval for a STI program, during which she could not hire permanent. In May 1997 complaints arose that of R65 million allotted for HIV education only half had been used. None of the R4.4 million intended for research on ear and support had been spent and the R 18 million designated for the provinces was bogged down in bureaucratic red tape. AIDS training for high school educators was only scheduled to start that same month.

Despite the new democratic, quasi-federal constitution, the pre-1994 tendency to centralize AIDS programs at the national level and to limit dialogue with civil society groups remained. Though NACOSA's AIDS plan had advocated a national manager in the president's office and regional authorities in the provincial premiers' offices, Zuma preferred to manage AIDS programs from the DOH. This propensity for centralization was apparent in a second disastrous state AIDS intervention. Facing growing numbers of desperate AIDS patients-and the high cost of ARVs, the government appeared to back an experimental drug, violence, developed by three Afrikaner scientists. Though American researchers had shown that viridian, which contains a toxic industrial solvent causing liver damage; actually activates HIV.31

Zuma and Mbeki arranged a meeting between the scientists and the cabinet. When the Medicines Control Council (MCC) repeatedly denied applications for human virodene trials, Zuma, Mbeki, and the ANC secretary general attacked the MCC for blocking the drug while so many faced death. In

31 Gevisser 1994a).31
response, Zuma announced she would replace the MCC with a reformed body. This decision, as well as Zuma's move to reform the HIV/AIDS and Sexually Transmitted Diseases Advisory Committee after it opposed her scheme to make AIDS a modifiable disease, demonstrated Zuma's desire to control AIDS policies. The High Court in Pretoria later struck down Zuma's decision on the MCC and in December 1998, the MCC rejected an application for virodene clinical trials. Nevertheless, the politicization of science in order to achieve central control over policy making hurt the fight against AIDS during the first years after apartheid, much as politicization of health policy had hurt AIDS efforts in the apartheid era.

When Mbeki became president in 1999, he replaced Zuma with Manthe Tshabalala-Msimang. The new president, 110 was strongly supported by his minister, became controversial for his AIDS policies. He was soon criticized for questioning the link between HIV and AIDS. In 2000, Mbeki appointed an expert commission to investigate several aspects of HIV and AIDS, such as, the causes of the immunodeficiency that makes AIDS fatal, appropriate responses to these causes, and why AIDS in sub-Saharan Africa is 'heterosexually transmitted while in the western world it is said to be largely homosexually transmitted'. This framework reflected Mbeki's 'sincerest in the views of 'dissident' scientists on the panel.

The MRC president Malegapuru Makgoba, himself an ardent black nationalist like Mbeki, criticized this approach in the American journal Science. He noted that, despite Mbeki's rejection of imposing 'Western experience on African reality,' his views on AIDS came from 'dissident' Western scientists, and that other 'politically driven decisions' on AIDS included his enthusiastic support for virodene, the refusal to give ARV s to pregnant women, and the 'politically motivated suggestion' that malnutrition and poverty caused AIDS in Africa. He concluded that South Africa could

32 (SAIRR 2000, 236, 242).
become fertile ground for the 'pseudoscience often embraced by politicians' (Makgoba 2000). In some ways, Mbeki's politicization of science and his fascination with its fringes recalled the fantastic schemes of the apartheid biological and chemical warfare program. 33

Mbeki's ideas led to increased state-civil society tensions over AIDS policies. The opposition Democratic Alliance, the liberal media, COSATU, and AIDS NGOs such as the Treatment Action Committee (TAC) increasingly criticized the government. In the de Klerk era,: NP reforms pitted Afrikaner modernizers against conservatives, but most NP hardliners had joined the Fly Right. In contrast, the ANC's critics were often its political allies and supporters. For example, in 2000 COSATU blamed GEAR for the state's 'lack of a comprehensive and coherent response to the demands for access to effective treatment of HIV' and. for 'inadequate social infrastructural resources' to combat AIDS. COSATU asked the government to 'end its scientific speculation' and .expand its efforts 'on the basis that HTY is the medical cause of AIDS: COSATU insisted that ARVs be given to pregnant women and rape victims (COSATU 2000). Openly gay high court judge Edwin Cameron, an appointee of the post-apartheid regime, denounced the president for creating confusion, while Nelson Mandela urged a more rapid response to AIDS. When SANAC was launched in 2000, it included several cabinet ministers and government official, two traditional healers, and a little known American to represent NGOs; there were no scientists, physician's nurses, or MRC or MCC representatives on the council. 34

The state responded to criticism from civil society in several ways, First, Mbeki claimed that the AIDS threat had been exaggerated; though he based this conclusion on 1995 data. In August 2001, he asked minister Tshabalala-Msimang to review health spending in light of the 1995 estimates, Meanwhile, the MRC reported a marked increase in AIDS mortality figures, 33 (Burger and Gould 2002, 24, 31-33). 33

34 Powell 2000.
but the government blocked release of the MRC report until the end of 2001 and commissioned Statistics South Africa, a state agency, to develop a new report. The latter method makes more sense, as HIV status is often unknown and families may pressure doctors to report other, less-stigmatized causes of death.

State response to criticism from traditional supporters was the cabinet's dramatic recommitment on 17 April 2002 to fighting AIDS. This included massively expanding the AIDS budget from R350 million in 2001/12 to R1 billion in 2002/03 (DOH 2002d). As part of this renewed interest in AIDS, the state defensively heralded recent successes. In October 2002, the cabinet claimed a 90 per cent AIDS awareness level, use of, nontraditional outlets for condom distribution such as informal shops and bars in black townships, and rapid progress toward a vaccine.

If providing ARVs for PMTCT has proven difficult, the issue of universal access to ARVS for the broader HIV-positive population is even more complex. In October 2002, the cabinet announced that a joint DOH-treasury task team would investigate the costs and benefits of a free universal ARV program. At this point, the TAC agreed to delay a civil disobedience campaign, given signs of possible adoption of a national AIDS treatment plan (Thorn 2002). Yet, when the report was finished in February 2003, the cabinet delayed its consideration and the health minister and president's office subsequently sent it back to its drafters, In response, the TAC leaked the report to the press (TAC 2003a). In February 2003, approximately 20,000 people marched in Cape Town to demand treatment. Speakers included the COSATU president Willie Madisha, the Anglican archbishop Njongonkulu Ndungane, and the radical opposition member of parliament Patricia de Lille (Galloway 2003).

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35 DOH 2002d).
In the face of this public outrage and TAC civil disobedience, some ANC party leaders began to view the issue of universal treatment as a political concern. Though most ANC leaders had been reluctant to differ openly with Mbeki (Lodge 2002, 262-63), concern about fallout in the 2004 election encouraged a shift in the positions of some ANC members. Education minister Kader Asmal, ex-DOH director-general Olive Shisana, ANC elections chief Manne Dipico, and party chief strategist Joel Netshitenze reportedly labored behind the scenes to support access to ARVs. Against Mbeki and Tshabalala-Msimang's opposition, in August 2003 they persuaded the cabinet to endorse the report favoring universal rollout and to request the DOH to urgently develop an operational plan (Kindra 2003). On 19 November, the cabinet announced it had approved a plan to provide at least one service point with free ARVs in each DOH district within one year and one service point in every municipality in five years (TAC 2003b).

The MCC's objections in July 2003 about the testing of nevirapine PMTCT further bolstered state opponents to ARVs. If the MCC withdrew its approval of nevirapine, a national treatment plan would be threatened (Economist 2003b). Cabinet approval of a general ARV treatment program, like that for PMTCT, was predicated on using the cheaper drug nevirapine, not its more costly alternative AZT. In September, the MCC allowed the manufacturer of nevirapine more time to provide more data to allay the council's concerns and reassured the public that nevirapine could still be used for PMTCT or for broader treatment of HIV and AIDS. These MCC quibbles may threaten more than PMTCT by reopening the debate about the toxicity of ARs.

The Mbeki government has, despite its belated agreement to offer treatment to the vast majority of South African AIDS patients, seriously damaged its reputation. The administration focused on fears of toxicity and practical difficulties in implementation to block provision of ARVs even
When the claim of impossible costs was rendered hollow by drug companies' offer of heavily discounted or even free drugs and by Mbeki's authorization spending billions of rends on arms. However, do not explain Mbeki's response to providing ARVs, any more than they explain his recent assertion that he does not know anybody who has died of AIDS or his silence on World AIDS Day in 2003.

The Mbeki government's seemingly baffling AIDS policies reflect arguer contradictions inside the post-apartheid regime. Despite his administration's public commitment to democracy, transparency, and accountability, behind the scenes the government has become entangled in a close if sometimes strained alliance with big business advocates of neoliberal economic policies. These links increased with the emergence of a small but growing black bourgeoisie; the shift away from idealistic redistributive policies that had begun under Mandela helps explain Mbeki's reluctance to embrace expensive programs to fight AIDS. Yet, while Mbeki has denounced international capitalists (such as drug companies) as exploiters, he also has shown little enthusiasm for importing or manufacturing cheap generic versions of ARVs. He has attacked white liberal critics of his policies as 'racists,' while he has denounced socialist critics as 'ultra-leftists' or dupes of white 'enemies of transformation'.

There is nevertheless clear evidence of pediatric seroconversion and, in addition, a higher observed infant mortality rate among babies born HIV-positive mothers. The model uses a 35 per cent mother-to-child transmission rate.

**POLICIES FOR LARGE ORPHAN POPULATIONS**

Techniques can be used as an indicator of the epidemic. Together with other more detailed studies it demonstrates that there is an orphan problem.

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36 (Economist 2003a).
37 Calland and Jacobs 2003; Lodge 2002, 162-65
Case material collected in the course of our own research suggests that certain key policy areas need to be addressed in relation to orphans, and these will be examined next.

**Education**

Those dealing directly with orphans and their problems see education as a priority. The young children need to start school and the older ones must be kept in school. The associated costs of doing this are considerable for poor households.

Of some importance is the content and quality of the education which these orphans receive. A case could be made that it should be predominantly agricultural or vocational, for all of these children will have to earn their own living from an early age. In Uganda some vocational schools run by the religious orders are accepting a limited number of orphans because they believe that the future of orphans will depend upon their having marketable skills, as all of them will not wish to live by agriculture. However, such a view effectively excludes a very large number of people from other, more academic, types of education, and insofar as Uganda may lose many of its skills and trained people to AIDS and these will have to be replaced, it can be argued that the orphans created by the epidemic should not be doubly penalised by exclusion from the best education available.

**Nutrition, Shelter and Clothing**

In the great majority of cases these fundamental needs are met. Insofar as rapid appraisal can in any way be a reliable guide, there were few orphans, except at one or two unsatisfactory orphanages, who showed obvious signs of failing to have these needs satisfied. In addition, some of the older children appeared underfed and ragged. These children were not neglected, but were simply receiving inadequate nutrition, particularly those who were living in poor households. Their condition was a result to being orphans in a poor society, rather than of simply being orphans. In some cases there was not
enough food, particularly during the dry season. The special nutritional and care problems of these children need special attention.

**Legal Protection of Orphans' Property**

Some of the disputes before the local courts in Rakai district involved orphans. These cases concerned the rights of orphans to inherit their deceased parents' tenure of the farm. It would be a worrying precedent if landlords won any of these cases. Clearly these children are vulnerable to pressures from the unscrupulous. Minors are always vulnerable to relatives, who may try to cheat them out of their inheritance, or who may divert their wealth to educating their own children; orphans will be no exception. In Rakai a few landlords had started dispossessing the orphans of the rights in land which their parents had enjoyed, and which are widely treated in these communities as heritable. Such widespread insecurity is an additional burden for households already suffering stress through death and illness.

The former may create privileged households and encourage corruption and even orphan-farming; the latter may be seen at best as an inefficient use of scarce resources, and at worst as a threat to the welfare of these children. In general we are talking about very poor people and very poor communities, their poverty made worse by the past traumas they have suffered and the current trauma of AIDS. The choice of how to pass between the Scylla of targeting and the Charybdis of non-targeting must surely be one of the curellest which this society could have to face, and it is in the care of orphans that it is faced in an acute form. For some women, especially young women, a third strategy may involve finding one or more sponsors or 'sugar daddies'. In his South African study of this practice, differentiates what he terms 'transactional sex' from prostitution in two ways: first, partners are constructed as 'girlfriend' and 'boyfriend' (as opposed to 'prostitute' and 'client'); and second, the gifts received for sex are part of a broader set of obligations that may not be predetermined. He sees three major contribution factors that lead
to these arrangements. First, there is the privileged economic position of men; second, the high societal value for men having multiple sexual partners; and finally, the agency of women themselves, in that they consciously use these arrangements to access power and resources. Hunter looks at the dynamics of these relationships in an informal setting and a township and finds that in the first case, women's extreme poverty and vulnerability caused them to use these relationships to meet basic subsistence needs. But in the township, cultural premiums on fashion and consumption goods (such as cell phones) fueled the propensity of young women to take on sugar daddies. In both cases, it may take more than one man to provide for the women's material needs: 'a comment often made in [the informal settlement], reflecting the concern with subsistence, is that women goma (choose a man) "one for rent, one for food, one for clothes".'

Two of the other most successful AIDS activist movements in the world, those of Brazil and South Africa, also adopted this strategy of relying heavily on the talent, leadership, and expertise of individuals who are from highly vulnerable and/or HIV-positive communities. In the case of Brazil, which is often pointed out as an outstanding success story for the state’s accomplishments in both the prevention and treatment arenas, the gay communities, which suffered the first heavy losses from AIDS, led the fight to make AIDS a political priority. South Africa has seen the development of a world famous treatment activist movement, the Treatment Action Campaign, which started in 1998. Its most famous leader, Zackie Achmat, is HIV positive, as are many other leaders and participants in the organization, which now numbers in the thousands. Working to lobby a government that until late 2003 was openly, opposed to the provision of antiretroviral treatment, it has had major successes in, for example, pushing for the administration of the drug nevirapine to prevent mother-to-child transmission. As highlighted in

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38 Hunter 2002, 100)
other chapters in this volume, the organization has also taken on the global pharmaceutical industry in court. In August 2002, it was a key actor in launching a Pan-African HIV/AIDS Treatment Access Movement.\textsuperscript{40}

On 1 December 1994, 42 national governments formally accepted the Denver Principles by signing the Declaration of the Paris AIDS Summit. These governments committed to support 'greater involvement of people living with or affected by HIV/AIDS' in participating at all levels in 'the creation supportive political, legal and social environments'.\textsuperscript{41} UNAIDS also has strongly endorsed GIPA and has sponsored consultations and provided materials to demonstrate best practices and ideas of how GIPA can be implemented. As UNAIDS explains, GIPA, is not the tokenism that occurs when programs and organizations allow people living with HIV/AIDS (PLHAs) to participate marginally as speakers or symbols. Even involving PLHAs at the policy-implementation stage to work as peer educators, caregivers, or outreach workers may not fully, utilize GIPA, if the implementers do not have a say in program design and decision making. Rather, GIPA is realized when PLHAs are called on as experts and decision makers in addition to their roles as implementers and speakers.

AIDS is situated within the context of a profoundly changing South Africa, in which the official end of apartheid led to the implosion of society into violence (Benita 3001).\textsuperscript{42} Fifty years of apartheid divided society, created distrust among citizens, and led to grossly unequal economic development. The spread of HIV/AIDS challenges a country searching for direction and power in the face of social and economic shock and the 'disenchantment of freedom'. AIDS is merely one of the many competing priorities the country faces. Initiated by Nelson Mandela and continued by Thabo Mbeki, the process of political change has been coupled with the ideology of 'African

\textsuperscript{40} Achmat 2003, xi-xvi).
\textsuperscript{41} UNAIDS 1999, 1).
\textsuperscript{42} (Benita 3001).
renaissance'. President Mbeki seeks to impose this ideology on his country and the world, and he has actively sought to advance this ideology through the regional and continental recognition of his country's power. The much-publicized international clashes between HIV and AIDS indicate the challenges of fighting AIDS in a country whose reconstruction is dependent on finding new social references. AIDS seems to be a reflection of South Africa's social change and a window by which the country can become both a leader on the continent and a leader from Africa on the world stage.

In a society full of damaging contradictions that are the legacy of apartheid, AIDS policies also seem contradictory. For example, though the government has challenged drug producers, high-level political leaders have questioned the effectiveness or even the usefulness of antiretroviral (ARV) therapies. Additionally, South Africa's international tussle with pharmaceutical companies is emblematic of the symbolic willingness of the president to put South Africa among the countries 'to be reckoned with'. In 1997, the country passed the Medicines Act, which allowed domestic production of generic medicines for those with HIV/AIDS. Coupled with Brazil's action to produce its own generic drugs, the South African legislation challenged the control that Western pharmaceutical companies have over AIDS medications. After suing the South African government for breech of international trade laws, 39 drug companies then dropped the suit in 2001. The legislation and legal victory seemed to illustrate Mbeki's desire to stand against Western science, corporations, and ideology.

Yet, while the Mbeki government has challenged Western institutions, his government has been criticized by civic associations for its complacency in developing AIDS policies, especially for universal access to ARVs. The anti AIDS organizations in South Africa are pioneers when it comes to collective mobilization in Africa. They were a crucial link in the international mobilization that caused the pharmaceutical companies to back down from the
aforementioned lawsuit. These organizations have also opposed Mbeki and his minister of health's questioning of the efficacy and safety of ARVs, and they deem such official statements on AIDS and ARVs to be counterproductive. These organizations are involved in both South African and international civil society; on both levels, these groups in other African countries, particularly in French-speaking Africa, that have merely followed the lead of nongovernmental organizations from industrialized countries on the issued of access to ARVs.  

President Mbeki's famous letter of 3 April 2000 to world leaders provides insight into how the country's reactions to AIDS reflect a participatory political culture and a political culture that rejects international injections. Covered extensively in the international press, he letter asserted that the nature of the HIV/AIDS epidemic in Africa required uniquely African solutions to the crisis. The letter raised vehement outcries concerning its public health ideas. But its political meaning needs further analysis. From the perspective of political sociology, and analysis of the South African president's discourse falls between an analysis of political culture and a cognitive approach to public policy making. Mbeki's controversial attitude must be viewed in a wider context of a political culture that is being reformulated, a process that represents a vehicle for Mbeki's ideological objectives.

The letter appeared a few months before the first-ever global AIDS conference held in Africa, the International AIDS Conference hosted from 9 to 14 July 2000 in Durban. Given the timing of the letter, Mbeki's contractory reasoning seemed surprising. To understand the political and ideological stakes in the letter, one must go back to apartheid and its abolition, to Mandela's accession to power in 1994, and to his succession by Mbeki. The apartheid system was built on a model of racial separation supported by the

43 Fassin 2002).
ideology of the superiority of the white minority over the black and colored populations. The apartheid regime founded its segregationist practices on differences believed to be insuperable; that is, on the belief in the absolute inferiority of all nonwhites, especially the black majority. From 1948 until roughly 1990, the ethical struggle of the black majority clashed with the silence of some democratic Western powers toward the regime of Pretoria. In fact, the South African white elite regarded that passive response to 'white power' as tacit support for the ideology of apartheid. This historical experience sheds light on the possible resentment of South African officials to the dominant position of Western opinions on health issues in debates among political personalities who are supposed to be on equal footing.

Because of the long liberation battle against apartheid, the political culture of post-apartheid leaders, including those of the African National Congress, is shaped by the concepts of refusal and struggle. The contemporary history of divisions in South Africa, in which the black community was defined by skin color and its 'Africans,' represents a fundamental element for understanding the president's letter. Mbeki positions his own country as part of the international community. Far from being a paradox, Mbeki's protests are consistent with a historical attempt to secure a 'place' for those previously lacking representation and to demand some evenhandedness in the treatment of different points of views. Mbeki asserts that even the most extreme scientific ideas about HIV/AIDS must have a place in the discourse, and the president himself admits that even his letter might be extreme: 'It may be that these comments are extravagant'.

In the letter, Mbeki sets forth two elements in his questions on the science about HIV/AIDS in Africa. First, he uses the following syllogism: the major modes of HIV transmission are homosexual and masculine in the West, while they are heterosexual in Africa. He argues that responses to AIDS in

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44 Mbeki 2000
Africa should be different than those used in the West because the epidemiological dynamics of the two epidemics are dissimilar. Second, Mbeki deals with the scientific studies of the harmful nature of ART. He compares the 'casting aside' of some scientists whose views Mbeki embraces to the worst human tragedies, using rhetoric and daring analogies that go far beyond the framework of the scientific debate on HIV/AIDS. He writes: 'It is suggested, for instance, that there are some scientists who are "dangerous and discredited" with whom nobody, including ourselves, should communicate or interact. In an earlier period of human history, these would be heretics that would be burnt at the stake.\footnote{Ibid}

Mbeki's intention seems to be to affirm that Africans are entitled to hold different views and to have different experiences from those of the former champions of apartheid. Since these champions were wrong during apartheid, why would they not be now? By sending the letter to global leaders, Mbeki implicates not only former apartheid leaders in South Africa, but also their direct and indirect defenders in Western, industrialized countries. He asserts: 'Not long ago, in our country, people were killed, tortured, imprisoned and prohibited from being quoted in private and in public because the established authority believed that their view were dangerous and discredited. We are now being asked to do precisely the same thing that the racist apartheid tyranny we opposed did, because, it is said, there exists a scientific view that is supported by the majority, against which dissent is prohibited'.

The president's rationale is primarily ideological and aims to reject everything that may nurture a 'single thought' system that excludes those who do not agree with what he calls 'the established authority'. The letter's political thought and discourse are inspired by the anti-apartheid struggle to which he clearly refers: 'We are now being asked to do precisely the same thing that the racist apartheid tyranny we opposed did.' The president shifts the focus from
the scientific opponents of those who question established findings on HIV/AIDS to the historical enemies of the freedom of the African people. This shift supports the president's incrimination, vehement, aggressive, and witty discourse. Some agitate for these extraordinary propositions with a religious favor born by a degree of fanaticism which is truly frightening.46

Beyond the letter's official purpose, Mbeki invites his readers to join a struggle that is redolent of past fights for freedom of thought and expression. In the dynamic, the president expands the struggle beyond South Africa to the global realm, so that Africans can from an alliance with Westerners to refuse the imposition of a (Western) worldview on Africa. Do the issues raised in Mbeki's letter relate solely to scientific debates about HIV/AIDS or are they about the formation of a broader identity-based opposition? That question stands out in the last sentence of the letter: I am greatly encouraged that all of us, as Africans, can count on your unwavering support in the common fight to save our continent and its people from deaths from AIDS.

Some aspects of Mbeki's biography help explain his desire to move the debate from more than a narrow focus on AIDS in South Africa to an international focus. Fassin (2002, 16) writes: "Thabo Mbeki is, unwillingly, a product of transnationalism which is, sociologically speaking, viewed as the most characteristic feature of globalization. After spending a short time in prison, he left South Africa to get his' training in Great Britain, in the Soviet Union and particularly in the leadership. Circles of the exiled ANC throughout Africa. By turning some discussions on AIDS in South Africa into a "global controversy," he is less naive than some aspects of his rhetoric might suggest.'

Mbeki's letter is situated in a dissident political culture inherited from the past struggle against apartheid. The current AIDS situation on the continent revitalizes the notion of dissidence to the potential benefit of South

46Ibid
Africa, which can gain recognition as a sub-regional economic and political power. Since South Africa's power could not be expressed in the ideological terms of the abolished regime, a new slogan with the advantage of a new political meaning has been coined to reclaim the economic status of South African power. 'The topic of the "African renaissance" identifies and legitimizes different forms of international "power" ... It is to be reviewed within the particular context of a tradition of blaming that the countries of the region assimilate to the internal oppression or the external aggression. Therefore, taking into account the imbalances of power, the South African leaders hesitate to explicitly summon up a repertoire of legitimacy founded on that power'.

In this context, AIDS is an element and an indication of the dynamics of social change in Africa, as well as in the global arena. The prominence of a media-covered event such as the 2000 Durban conference on AIDS was an opportunity for the South African president not only to connect AIDS and poverty, but also to remind the world about the indirect and direct involvement of external actors in Africa's underdevelopment. The AIDS epidemic in South Africa highlights a political culture that simultaneously expresses powerlessness in the global arena and that desires a renaissance. The political model of active dissidence suggests more than state reactions to international policies and opinions on AIDS; it also reflects a larger definition of South Africa's role on the global stage. Different parts of the world, including from countries of the former Soviet bloc, indicate that long periods of social and political contention end with some drastic changes in the societies and an accrued sensitivity to epidemic situations. This is apparent in M. Mbeki's letter when he writes about the memory of apartheid in recalling the epidemiological specificity of the infection in southern Africa.'

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47 Sindjoum and Venesson 2000, 917
48 Raynau and Muhongayire 1993)
In the same token, one needs to be cautious enough to draw the line between the provocation and the political meaning of Mbeki letter. Fassin provides important insights: 'More than a protest against globalization per se, it is the way that the rules are imposed to the nations and peoples under domination that he questions. The resentment ... of those who notice the world political disorder and the hegemony of the western world view represent a powerful leverage for heterodoxy. The controversy about AIDS in South Africa indicates that the perception of injustice can undermine the construction of the truth and blur the poorly-thought-through distinction between the global and the universal'.

In summary, it is difficult to measure the cost of the controversy triggered by Mbeki's letter, as well as his other statements on AIDS. It is important to remember that Mbeki is not the only actor in the fight against AIDS in South Africa. As other chapters in this volume illustrate, active civic organizations have challenged government policies and developed their own AIDS programs. Additionally, Mbeki has to some extent tempered his rhetoric and, in late 2003, his administration agreed to provide universal access to ARVs for South Africans. AIDS has been a means for Mbeki to voice a different and original African view on the world stage. But, the controversy surrounding Mbeki's words also indicates the powerlessness that state officials feel toward the AIDS tragedy in southern Africa.

Behavioural surveillance surveys (BSS) show that awareness levels on HIV/AIDS also vary widely among these states. Generally awareness levels are higher in high-prevalence states and lower in low-prevalence states that form a belt across central India, with rural women in these states the most disadvantaged in terms of awareness. Incidence of casual or multi-partner sex in the country was 5.1 percent. It is the industrially and commercially
advanced states in peninsular India that presently show highest rates of infraction and risky sexual behaviour.49

**South African Government**

- As it was being un-banned, the African National Congress (ANC) played a major role in development of national HIV/AIDS policies. In October 1992, the ANC and the apartheid government's National Department of Health jointly convened a conference on AIDS, which led to creation of the National AIDS Committee of South Africa (NACOSA).

- After a peaceful transition, the ANC won the country's first fully democratic elections. Numerous initiatives aimed at redressing inequalities were launched in the immediate post apartheid period under the Reconstruction and Development Program, the ANC's election platform.

- The ANC adopted NACOSA's AIDS plan. Along with 20 other social priorities, AIDS was declared a "Presidential Lead Project," giving it special status and early access to resources set aside for reconstruction and development.

- The AIDS plan, however, greatly overestimated the implementation capacity of the new government, not least because of the numerous challenges the ANC faced upon assuming office and the enormity of post apartheid reconstruction.

- In 1994, President Nelson Mandela inherited intact the apartheid administration. The legacy of the apartheid civil service, coupled with the transition period, led to uncoordinated planning within and across government, weak financial and information systems, and lack of managerial skills. Consequently, coordination of a national response was constrained.

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49 NACO 2001a
Given public sector capacity constraints, multiple sources of special AIDS allocations, and complex disbursement procedures, the national government under spent AIDS funds. Some of the projects on which funds were spent and lack of transparency in granting them were heavily criticized. As in many countries, the national AIDS program was housed in the Department of Health, thereby impeding a multi-sector oral response.

In 1997, the Department of Health commissioned the MRC to undertake a review of the 1994 AIDS plan, which led to a reformulation of policy priorities at the national level.

In January 2000, the National Department of Health launched the HIV/AIDS and STD Strategic Plan for South Africa 2000-2005. However, the plan has been deemed vague in terms of action and resource prioritization as well as provision of ART.

In January 2000, the South African National AIDS Council (SANAC) was formed, bringing together government and civil society, although medical researchers and key were excluded from SANAC.

In the late 1990s, South Africa's Health Minister announced that she would not permit T nor NVP to be provided to pregnant, HIV-positive women nor rape survivors in public health facilities, citing "cost, toxicity, and efficacy, particularly for the 'African' setting."

During 2000, President Thabo Mbeki, who had succeeded Nelson Mandela as South Africa's president in 1999, had begun to publicly question the link between HIV and AIDS. In May 2000, he convened a panel of international AIDS experts including AIDS dissidents charged with reexamining the causes of AIDS and determining African solutions to the pandemic. South African and international scientists met the panel and its report with widespread criticism.
Prior to the XIII International AIDS Conference, held in Durban in July 2000, there was growing international discussion of access to ARVs and PMTCT. Data from a South African study of NVP, which highlighted its ease of administration and greater cost-effectiveness, were presented at the Durban conference.

The Durban meeting marked the first time that the international AIDS conference had been held in the South. This, coupled with the increasing international coverage of President Mbeki and Minister Tshabalala-Msimang's HIV/AIDS policies, brought enormous attention to South Africa, much of it highly critical. The controversies had reached a point such that over 5,000 scientists world-wide signed the Durban Declaration, in which they reaffirmed that HIV was the cause of AIDS.18

The South African Government on HIV/AIDS

The spread of HIV/AIDS throughout the world necessitated a dramatic, escalated response to the epidemic. The Government of South Africa have also been responsive to the high HIV prevalence and TB burden. Some of the significant developments in the response to HIV/AIDS in South Africa were:

The creation of the Inter-Ministerial Committee on HIV/AIDS (IMC) in 1997 chaired by then Deputy President Thabo Mbeki.

- The launch of the Partnership Against AIDS in 1998 by Deputy President Mbeki.

- The launch in January 2000 of the South African National AIDS Council to replace the IMC (chaired by Deputy President Jacob Zuma).

- The launch of the HIV/AIDS/STI Strategic Plan for South Africa, 2000-2005. The strategy focuses on 4 main areas, namely:
  
  • Prevention
  • Treatment, Care and Support
  • Legal and Human Rights, and o Research, Monitoring and Surveillance
The implementation of the Strategic Plan entails several interventions, but within the context of this article, only selected interventions will be highlighted.

**Prevention Programmes**

It is internationally acknowledged that prevention efforts need to be the first line of defense against the further spread of the HIV/AIDS epidemic. The prevention programme in Government focuses mainly on the following areas:

- Procurement of high quality male and female condoms
- STI management
- Life skills and HIV/AIDS education
- TB Control and integration with HIV/AIDS
- Prevention of Mother-to-Child HIV transmission (PMTCT)
- Vaccine development
- Blood safety

The Department of Health has a long-standing commitment to the provision of preventive **barrier methods**. In 2000 the Department distributed approximately 250 million free male condoms in the public sector. In terms of female condoms the Department in 2001 expanded the number of sites where female condoms are available from 27 to 114.

It has been shown that the effective **management of STIs**, using the syndromic management approach, plays a central role in reducing the risk of HIV transmission. This programme is driven through the development and distribution of resource materials to healthcare workers, and the training of healthcare workers on the syndromic management of STIs. One of the outcomes of this emphasis is the steady decline in syphilis amongst pregnant women attending our public sector clinics (from 11.5% in 1997 to 4.9% in 2000).
Ensuring that the youth of South Africa have as much information available to enable them to make informed choices regarding their sexuality and sexual behaviour is an important prevention strategy. This is achieved mainly through the life skills and HIV/AIDS education programme in primary and secondary schools. This programme is managed primarily by the Department of Education.

An important arm of the prevention programme is the prevention of mother-to-child HIV transmission (PMTCT) programme. Following research studies presented at the 13th International AIDS Conference in 2000 (SAINT and HIVNET 012), the Department of Health conceived and implemented operational research to study the extent to which the HIVNET 012 findings could be replicated in real life situations. This included the study of adherence to chosen feeding practices and follow up on mother's resistance profile as well as the well-being of the infant-mother pairs over time.

Implementation started in the first of the 18 national sites and its 260 access points (clinics and hospitals) in May of 2001. (The number of access points increased from 153 in July 2001 to 260 in December 2001.) Since implementation started approximately 66 000 women have presented for antenatal care at these access points, of which approximately 36 000 agreed to voluntary and confidential HIV counselling and testing. At last count more than 3 000 babies had been provided with Nevirapine.

Already the information obtained from the various sites highlights some of the challenges in implementing such as programme, and the implications for wide-scale rollout. The main challenges relate to:

- The lack of adequate space to ensure confidential HIV counselling and testing
- Inadequate staffing levels to provide the HIV counselling and testing
- The need for support groups, especially for women who choose to formula feed

- The impact of lack of access to water, electricity and transport on the efficacy of the intervention

- The strong correlation between success and robustness of primary care services

These lessons are valuable in assessing the health infrastructure and making the necessary adjustments to ensure greater access over time.

Another prevention activity to highlight is the support of Government for the South African AIDS Vaccine Initiative (SAAVI) that was established in 1999 to develop and test an effective, affordable and locally relevant vaccine for South Africa within ten years. Since then good progress has been made. Currently SAAVI is preparing for the first clinical trial with the VEE (Venezuelan Equine Encephalitis) vaccine.

Treatment, Care and Support Programmes

The foundation of the response to HIV/AIDS is ensuring that sufficient information is available for healthcare workers to address HIV/AIDS, STIs and opportunistic infections effectively. To this end the launch of the following nine **HIV/AIDS related guidelines** in October 2000 was significant.

- Rapid HIV Tests and Testing
- Recommendations for Managing HIV Infection in Children
- Management of Occupational Exposure to the Human Immunodeficiency Virus (HIV)
- Prevention of Mother-to-Child HIV Transmission and Management of HIV Positive Pregnant Women
- Draft National Policy on Testing for HIV
- Policy Guidelines and Recommendations for Feeding of Infants of HIV Positive Mothers

- Ethical Considerations for HIV/AIDS Clinical and Epidemiological Research

- Tuberculosis and HIV/AIDS

- Recommendations for the Prevention and Treatment of Opportunistic and HIV Related Diseases in Adults

   This intervention has been followed up with the training of healthcare workers on the guidelines. In the last 3 months of 2001 approximately 1000 healthcare workers were trained on the guidelines, and this training continues in 2002.

   For Government the treatment focus has been on improving quality of life through the effective treatment and management of opportunistic infections and STIs. This treatment is available at public health care facilities, irrespective of HIV status. The release of the nutritional guidelines for people who are HIV infected is also significant.

   For people who present to public health care facilities with opportunistic infections, an important element of the public awareness and care package is the opportunity to know their status. The expansion of voluntary HIV counselling and testing is an important policy direction for Health. Since this programme started at the end of 2000, 359 VCT sites are operational of the initial 495 identified by the provinces.

   The VCT programme provides a good entry point for the other major interventions in the area of care and support, namely the establishment of home/community-based care (HBC) in South Africa. The main challenge in the establishment of home-based care within South Africa is to ensure that this is managed correctly and does not constitute an abrogation of the responsibilities of the public health care system. The Departments of Health
and Social Development have thus collaborated extensively to establish HBC, and good progress has been made (e.g. the provision of social relief to beneficiaries).

A significant effort was the agreement reached between the Ministry of Health and Pfizer in December 2000 for the provision of the drug Fluconazole (Diflucan) to the public health sector for a period of two years. Under the terms of the **Diflucan Partnership Programme**, Pfizer provides Diflucan for the treatment of two opportunistic infections, namely cryptococcal meningitis and oesophageal candidiasis (oral thrush). Since inception of the programme, more than 20 000 patients have benefited from this programme.

**Improved Surveillance**

In 1997 the Department initiated a phased programme to strengthen surveillance of HIV/AIDS. The first phase of the programme involved strengthening the methodology of the antenatal survey. The sampling procedure was refined so as to ensure that a full cluster random sample was obtained, and quality control measures were introduced. South Africa has been hailed by UNAIDS/WHO and other experts in the field as having one of the best methodologies for HIV prevalence surveillance in the world.

The second phase of the programme has entailed developing a more comprehensive "second generation" HIV/AIDS and STI Surveillance programme. The comprehensive programme includes the assessment of HIV prevalence in other sub-populations groups, HIV incidence testing, behavioural surveillance and STI incidence studies.

Until recently the response to HIV/AIDS was mainly restricted to the health sector. However, in 1998 with the launch of the Partnership Against AIDS, other government departments have come on board in the fight against HIV/AIDS. Some of the significant initiatives within the government sector include the life skills and HIV/AIDS education programme in the Department of Education, the Trucking Against AIDS initiative from the Department of
Transport, and the provision of HIV/AIDS services to prisoners (Correctional Services).

Also, through the South African National AIDS Council, civil society has become a very important partner of government in the fight against HIV/AIDS. Sectors such as youth, women, traditional leaders and people with disabilities have made tremendous strides in the last two years. However, much more effort is needed from every individual and organisation in South Africa to drive the response to HIV/AIDS. Every action counts.