

The Politics of AIDS Policy Development and Implementation in Postapartheid South Africa

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By outlining the political context that shaped the development of AIDS policy in South Africa and highlighting the deeply political aspects of the AIDS crisis, this paper shows why the South African government has not effectively responded to the spread of AIDS. It questions conventional factors, such as wealth, bureaucratic capacity, regime type, and political leadership as explanations for effective government responsiveness to the pandemic. A long-term, effective response to AIDS in South Africa has been hampered by institutional constraints as a result of the legacies of apartheid, democratic restructuring, inappropriate and authoritarian patterns of political leadership, and the dominance of neoliberalism, domestically and internationally.

Introduction

The HIV/AIDS pandemic poses an unprecedented challenge to communities and societies across the African continent, yet nowhere is the crisis more acute than in southern Africa, where prevalence rates are as high as 25 percent in some countries. In the worst-hit province in South Africa, Kwa-zulu-Natal, prevalence rates by 1998 were as high as 33 percent (Schneider and Stein 2001:723). Slowly we are awakening to the implications of the pandemic in Africa, not only for issues of human survival and human development, but for issues of governance and security. Indeed, for a growing number of African states, AIDS can no longer be understood or responded to as primarily a public-health issue: it is a political issue, a development issue, and a security issue, one that requires a comprehensive strategy to mobilize social and political resources against the pandemic.

In 1994, when the democratically elected government, under the leadership of the African National Congress (ANC), came to power, there was a sense that South Africa was well placed to lead a high-profile and comprehensive response to AIDS. Before 1994, a strong and diverse network had

emerged to link nongovernmental organizations, researchers, and health workers concerned with AIDS with antiapartheid political groupings, such as the ANC. In addition, the policy terrain in the two years after the installation of the ANC-led government was largely democratic and highly consultative, leading to the expectation that “enlightened forces in civil society would work together with the new government to steer the rapid implementation of a well-formulated and rights-oriented National AIDS Plan” (Schneider and Stein 2001:723).

By 2004, little of this rationalist ideal had materialized. South Africa now records one of the world’s fastest-growing HIV infection rates: national HIV-prevalence trends among antenatal clinic attendees rose from 2.2 percent in 1992 to 26.5 percent in 2002 (van der Vliet 2003). Furthermore, a series of AIDS policy blunders and public-relations nightmares have contributed to a lack of progress, and a breakdown of trust and cooperation, both within government and between government and civil society.

In this paper, by outlining the political context that shaped the development of AIDS policy in South Africa, and highlighting the deeply political aspects of the AIDS crisis, I show why the South African government has not effectively responded to the spread of AIDS. I examine the difficulties of implementing a comprehensive response to AIDS in a country undergoing restructuring at every level, and highlight the limitations imposed by certain political compromises agreed to during the negotiations preceding the transition to democratic rule. Furthermore, I explore the implications of different forms of political leadership, as well as neoliberal growth strategies for developing an effective response to the pandemic. I suggest that these factors, by narrowly defining the pandemic as a health issue (rather than a developmental or human-security issue), individualizing responses to the pandemic (rather than focusing on communities), and hindering diverse and broad sectors of society to come together around a common vision to combat AIDS, have inhibited the development of an effective response.

This paper largely focuses on AIDS policymaking in South Africa from the early 1990s to the early 2000s. Since then, several positive developments have occurred, developments that suggest that the government is increasingly willing and able to mount a more effective response to the epidemic. For example, in late 2003, the South African government announced the adoption of its HIV and AIDS Care, Management, and Treatment Plan, one that includes the world’s largest public sector antiretroviral rollout program. In addition, many prevention efforts, especially to encourage young South Africans to abstain from sex, use condoms, or be faithful, are working (Shisana and Simbayi 2002). Thus, improvements have been made, especially in tackling some of the institutional constraints discussed in this paper.

AIDS and Politics

Throughout sub-Saharan Africa, AIDS is as much a political as a health issue, as evidenced by variations in African states' responses to the pandemic, the engagement between African governments and civil society organizations, and AIDS-spurred tensions between the developed world and the developing world. Social scientists, especially political scientists, have been slow to consider the broader implications of the AIDS pandemic and to examine the macropolitical and institutional factors that may be shaping the dynamics of the crisis and governmental responses, despite the implications for the issues that preoccupy political scientists, issues such as the state and governance, institutional reform and development, democratization, civil society, globalization, and international security. While some scholars have considered why AIDS and politics, especially in Africa, have drawn little interest from political scientists (Lanegran and Hyden 1993), others have begun to frame some research agendas that examine the dynamics of how the two intertwine (Boone and Batsell 2001). Indeed, there are compelling reasons to suggest that the expertise and theoretical concerns of political scientists can play a constructive role in grappling with the deeply political aspects of the AIDS crisis in Africa.

Regime type, political leadership, and incentives facing politicians, levels of economic development, and bureaucratic capacity are all variables in explaining the scope and effectiveness of state responses to crisis (Boone and Batsell 2001:6); however, the AIDS crisis challenges conventional indicators and frameworks, and compels us clearly to define and specify the variables we use to explain variations in government responses to AIDS. In explaining differences in government responses to AIDS, the conventional indicators of levels of economic development and bureaucratic capacity are unsatisfactory. Throughout sub-Saharan Africa, the wealthiest and best institutionalized states in general have not been the ones to respond most successfully to the fight against AIDS, as witnessed in the case of Kenya, Botswana, and South Africa. In contrast, countries such as Senegal, one of the continent's poorer countries, and Uganda, which has known state decay and civil war for much of its postcolonial history, have been at the forefront of Africa's fight against AIDS. As I show with the South African case, the highly unequal distribution of wealth and the legacies of apartheid and discrimination that persist in the bureaucracy have been important factors that have impacted the government's ability to respond effectively.

Similarly, regime type has served as a useful indicator in explaining government responsiveness to crises, with democratic governments considered the most responsive and dictatorships considered the least (Sen 2000). A focus on regime type highlights the need to understand the politics of AIDS as central in combating the disease, yet it has not been a useful indicator in explaining African governments' responses to the AIDS crisis. Kenya and Zimbabwe have politically closed and bureaucratically entrenched regimes, and have failed to respond constructively to the AIDS

challenge; Uganda and Senegal, however, countries not usually counted as democracies in typologies of African states by regime type, have been most successful at mounting an effective response to AIDS. In contrast, South Africa and Botswana, two democratic regimes, have two of the highest infection rates in the world.

Boone and Batsell (2001) point to political openness and legitimacy, and productive partnerships with civil society organizations and foreign NGOs, as factors that help produce forceful government responsiveness to the issue of AIDS in Uganda and Senegal, responsiveness that has in turn led to a decline in HIV infection rates in those countries. Political leadership has been a factor often cited as contributing to constructive public policy responses to AIDS (Caron 1999:30;UNAIDS/WHO 2000:25). Mary Caron, of the Worldwatch Institute, argues that “where politicians have lifted their heads from the sand [and become involved in battling HIV-AIDS], millions of lives have been saved” (quoted in Boone and Batsell 2001:5). Conversely, it is consistently argued that in countries, such as South Africa, that have been ineffective at battling the AIDS crisis, a lack of political will and leadership is to blame:

At first glance the idea that beating a virus has anything to do with getting politics right and handling people well seems odd. But a second look will show that we are losing the battle against AIDS *solely* because the government is getting the politics wrong. (Friedman 2000)

But political leadership, too, as a variable proves to be too broad and ill-defined to explain government responsiveness to AIDS. The South African experience suggests that it is not simply the presence or absence of political leadership that contributes toward constructive public policy responses to AIDS, but political leadership of a particular sort. In South Africa, the government’s response to AIDS has been marred, not by a lack of political leadership, but by patterns of technocratic, authoritarian, and controlling political leadership, which has sought to impose its decisions on people, rather than facilitate cooperation among people to realize society’s goals. Such patterns of political leadership have deterred people from working together to tackle the epidemic.

Global and Institutional Factors and HIV/AIDS in South Africa

Several factors contribute to the inadequacy of the South African government’s response to HIV/AIDS: (1) the adoption of neoliberal macroeconomic strategies to conform to the dictates of capitalist globalization, (2) administrative/bureaucratic restructuring that accompanied the transition to democracy, (3) the retention of apartheid-era civil servants, and the quasi-federal system that places social-service provision in the hands of provincial

authorities, and (4) the nonparticipatory and secretive leadership style of the ANC, a legacy of militant opposition while in exile. These factors highlight the institutional environment and the global climate in which AIDS policymaking in South Africa has been taking place.

The introduction of neoliberal macroeconomic reforms, designed to attract foreign investment and conform to the dictates of capitalist globalization, has had a profound impact on the social policies adopted by the postapartheid state. While the current era of globalization has curtailed state autonomy and sovereignty globally, with the introduction of structural-adjustment programs and the impact of Bretton Woods institutions, there have been strategic efforts to reduce the role of the developmentalist state in Africa. At the same time, neoliberal capitalism is posited as the only developmental path for developing countries.

During the first half of the 1990s, the ANC's economic-development and social-transformation strategy was guided by the Reconstruction and Development Program (RDP), the result of a highly participatory and democratic process, which emphasized the need for people-driven development, with a strong role for a neo-Keynesian state to facilitate social transformation. The RDP set out to establish a new social contract by breaking down the adversarial relationship between the state and society and binding the state to redistributive policies aimed at meeting the basic needs of South Africa's majority.

By 1996, however, the RDP had largely been sidelined as the guiding framework for ANC development policy, and was replaced by the Growth, Employment and Redistribution Strategy (GEAR). Developed by a group of conservative economists with no consultation with groups outside government, Parliament, or governmental departments other than the Department of Finance, GEAR seeks to spur economic growth by reducing state expenditure and promoting fiscal responsibility. With the introduction of GEAR, ANC adopted much of the neoliberal logic of global capitalism. The introduction of GEAR represents a significant shift in the process of policy formulation in South Africa:

It has ushered in a new pattern of exclusive decision-making with limited input by "technical experts" from civil society. It marks the decline of broad consultation on issues of social transformation and the exclusion of poor, particularly rural, interests from the policy and decision-making arena. (Johnson 2000:26)

Indeed, neoliberal macroeconomic policies have impacted AIDS policymaking and implementation in South Africa in several important ways. It has exacerbated and encouraged the tendency within the ANC toward more closed, centralized, and hierarchical political leadership and policy processes. In the South African context, a hierarchical political leadership style ran contrary to the expectations of participatory democracy held by

the majority of South Africans. Furthermore, given the increasingly closed nature of policy processes, when the postapartheid state was confronted by a weak and ineffective bureaucracy, it was unable and unwilling to mobilize resources and expertise within society to drive an effective campaign against HIV/AIDS.

Neoliberal reforms have reduced the amount of state resources available to spend on AIDS programs. More importantly, they slowed the pace of transformation in the health sector, thus continuing apartheid-era institutional and economic legacies and prolonging bureaucratic incapacity to implement AIDS programs effectively. AIDS policy—indeed, all social policy—now had to comply with the restrictions of government expenditure according to the new macroeconomic framework. In the health sector, and especially with a ballooning AIDS epidemic, dramatic effects have occurred, especially with regard to policy implementation. For example, after 1994, the new Department of Health developed a rather radical approach to social transformation, one that included the allocation of scarce resources away from first-world curative facilities to new primary healthcare (PHC) clinics, and the provision of free primary care to pregnant women and children under six; yet such transformations have been retarded, primarily because of fiscal constraints imposed by GEAR, and neoliberal, market-oriented precepts demanded by world trade.

The slowness of transformation in the health sector was compounded by the process of administrative restructuring, the retention of apartheid-era civil servants and the quasi-federal system of government. The challenge for the new government in 1994 was not so much that it had inherited a weak bureaucracy with weak institutions, but that it had inherited a bloated and largely inefficient one, geared toward serving the needs of a small, white minority while policing the black majority. The process of administrative restructuring in the first few years of democracy took time and energies away from program implementation.

International “best practice” suggests that effective institutional responses to HIV/AIDS are best achieved through a multisectoral and multilevel approach (Strode 2003). This suggestion is based on an acceptance that HIV/AIDS is not simply a health issue, but is a developmental problem with profound socioeconomic implications. The International Guidelines on HIV/AIDS and Human Rights articulates an international standard for a multisectoral response:

States should establish an effective national framework for their response to HIV/AIDS which ensures a co-ordinated, participatory, transparent and accountable approach, integrating HIV/AIDS policy and programme responsibilities, across all branches of government. (Quoted in Strode 2003:7)

Like other countries in southern Africa, South Africa adopted a multisectoral approach to HIV/AIDS and developed a variety of HIV/AIDS

institutions, strategies, and policies; however, largely because of the pressures of bureaucratic restructuring, the limited understanding of the term *multisectoral*, and a lack of knowledge on the most appropriate ways to coordinate a national response to HIV/AIDS, AIDS programs became mainstreamed within the department of health. In addition, conflicts between apartheid-era civil servants and the “new guard,” as well as among various levels of government as a result of decentralization, prompted a lack of consensus and concerted effort, and unclear and confusing messages that have characterized the government’s response to the epidemic.

Thus, in 1994, although the new government inherited a highly developed health infrastructure (highly developed by African standards), it was not set up to meet the majority’s needs. In the first few years, the process of administrative restructuring took time and resources away from program implementation. The retaining of apartheid-era civil servants and the quasi-federal political system further complicated the process of bureaucratic restructuring and constrained social transformation efforts. At the same time, neoliberal economic reforms shaped the context in which bureaucratic restructuring and social transformation could take place. Government policies were driven largely by fiscal considerations, which slowed the pace of transformation and encouraged secretive and centralized decision-making processes.

Apartheid Legacies, State Restructuring, and AIDS Implementation

South Africa, compared to most of its neighbors, is a relatively wealthy and well-resourced country, with a population of more than 40 million and a per-capita GNP of about \$2500 (SA Health Review 1996); however, the distribution of wealth and resources within South Africa is unequal, reflecting the legacies of the system of apartheid and white, minority exploitation for more than 100 years. The country conceivably has the financial-resource potential to provide universally accessible HIV prevention, care, and support, but access to health and social services remains sharply unequal, causing South Africa to have one of the highest infant-mortality rates in the region (McIntyre and Kirigia 1997).

In the apartheid era, despite the increasing prevalence of HIV/AIDS, especially in the gay white community, there was no national HIV/AIDS strategy, and no HIV/AIDS institutions were created. The first attempts to establish a national AIDS strategy came from outside of government.

The AIDS-policy terrain in the early 1990s provided hopeful indications that HIV prevention may be a national priority, and that the policy process would be inclusive and well coordinated, and provide a human rights and holistic response to the pandemic. As early as 1990, the recently unbanned African National Congress (ANC), along with large numbers of people from the nongovernmental and health and welfare sectors, began

debating the principles and content of an appropriate national response to AIDS. Major South African health organizations committed themselves to establishing a national AIDS program through nongovernmental channels, primarily the National Progressive Primary Health Care Network. In June 1990, the National AIDS Task Force was established, at the instigation of the ANC (Heywood and Cornell 1998:62).

In October 1992, in an unusual show of national unity, the ANC and the Department of Health jointly convened a conference on AIDS in South Africa, a conference that brought together all the players critical for an effective HIV prevention campaign. At that time, South Africa was still in the throes of a particularly complex and volatile political transition, and a date for the first democratic elections had yet to be decided, yet the conference was attended by nearly 450 people, representing a wide range of actors across sectors, and led to the formation of the National AIDS Committee of South Africa (NACOSA) to coordinate a process of policy development, and to the writing of an AIDS plan. The AIDS plan proposed a holistic and multisectoral response, including education and prevention, counseling, healthcare, welfare, and research. It assigned a central role to government in leading, funding, and implementing a coordinated response to AIDS, and proposed in the office of the president a national coordinating structure, which would have final authority (NACOSA 1994).

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. (Schneider and Stein 2001:725)

With the transition to democracy in 1994, the NACOSA plan was adopted as policy by the Department of Health. The HIV/AIDS Directorate within the Department of Health was strengthened in order to drive the implementation process, and a National AIDS Program Director was appointed. AIDS and twenty other social priorities were declared “presidential lead projects,” giving AIDS special status and early access to resources designated for reconstruction and development. In addition, two institutions were created to guide the response to the epidemic. The first was the AIDS Advisory Group, a body of largely nongovernmental experts and representatives set up to advise the HIV/AIDS Directorate on policy matters. The second group was the Inter-Departmental Committee on HIV and AIDS (IDC), a forum for government departments to interact and network around HIV and AIDS in the workplace (Strode 2003:9).

In 1997, a national review of South Africa’s response to HIV/AIDS concluded that there was a lack of commitment outside of the Department of Health to a multisectoral approach to the epidemic. Although the institutional mechanisms to harness political commitment were in place, they had been ineffective. The review criticized the slow implementation of the

NACOSA plan, and concluded that implementation focused too narrowly on the health sector. A further concern was that the lack of coordination between sectors and various levels of government had generated conflict between sectors.

Thus while the postapartheid government had largely put in place the necessary institutions and strategies for a multisectoral and holistic response to the HIV/AIDS epidemic, it was on the implementation side where challenges occurred. Implementation of a multisectoral AIDS strategy became the task of a public sector that was itself in the throes of restructuring, and a new political elite that was understandably consumed with the challenges of ensuring democratic consolidation and political stability:

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. (Mark Gevisser, quoted in Marais 2000:15)

Two conditions agreed to in the negotiations preceding the handover of power significantly shaped social policy implementation: the establishment of a quasi-federal political system to satisfy minority political interests, and the clause that protected the jobs of the white civil servants for five years after 1994 (Schneider and Stein 2001:724). The quasi-federal system established by the new constitution and the process of decentralization that occurred after 1994 presented ongoing difficulties for the new government and the AIDS infrastructure.¹ There was the challenge of having to define responsibilities and coordinate actions between spheres of government, but in effect the institutional arrangements meant that the national government was largely not in control of AIDS programs. Under the new constitution, the national government is responsible for certain strategic functions (military, penal, tertiary education), for collecting and distributing revenue in an equitable way between the provinces, for setting broad policy frameworks, and for defining norms and standards for service provision; however, it has little control over social spending and implementation, including the provision of health services and the implementation of AIDS programs. That responsibility for these public functions lies at the provincial level has resulted in enormous variation in AIDS budgets across the provinces.²

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. . . .

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. (Marais 2000:17)

Thus, despite some attempts at the national level to commit to multisectoral action on AIDS, it rapidly became incorporated into mainstream health-sector restructuring at the provincial implementation level after 1994 (Schneider and Stein 2001).

Furthermore, in practice the roles and relationships within the spheres of government have been unclear. Some provinces resent national interference, and have regarded the National HIV/AIDS Directorate with suspicion. Other, weaker provinces would prefer to abdicate responsibility to the national level. Friction over roles and responsibilities went all the way down to the local or district level.

Provincial AIDS coordinators have the additional task of implementing a programme through district structures that are still weak and over which they have no line authority. (Schneider and Stein 2001:726)

Indeed, AIDS policy has also been the victim of power struggles between different spheres of government who have to negotiate the responsibilities and relationships between various government departments and branches:

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. (Marais 2000:17)

In 1994, the government also found itself in the position of having to transform the institutions of the state to make them responsive to the needs of the majority, rather than a minority, using the manpower of the old civil service, schooled in undemocratic and technocratic practices and hostile toward the ANC's goals for transformation or often reluctant to commit to ambitious targets and strategies. The new government inherited an intact apartheid administration that

was concerned much less with social delivery than with maintaining a political system of divide and rule. It was chaotic—organized along racial and ethnic lines into 18 different bureaucracies. Financial and information systems were poor and many managers in responsible positions lacked basic skills such as planning, budgeting and evaluation. It was an expensive, inefficient and authoritarian system that

encouraged corruption rather than delivery. (Schneider and Stein 2001:724)

This had detrimental effects on the implementation of numerous social-policy initiatives, including AIDS policy, by creating a gap between intentions and implementation. In 1998, the Presidential Review Commission, an independent review of the public service commissioned by the government, documented the institutional logjam that was created in reorienting the South African public service toward new social goals (Presidential Review Commission 1998).

With regard to AIDS policy, the effects were clear. At the national level, the HIV/AIDS Directorate was slow to appoint new, full-time staff, relying instead on the use of short-term contract staff and people seconded from other tiers of government. Gaining approval through the government bureaucracy for new appointments in terms of civil-service regulations proved quite difficult. Even with new staff, a lack of familiarity with bureaucratic procedure and bureaucratic delays became endemic (Marais 2000:16). Quarraisha Karim, the first director of the HIV/AIDS Directorate, bemoaned during the 1997 National HIV/AIDS Review 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” (Schneider and Stein 1997:41). Hein Marais describes the “obstinate stalemate” that occurred between the old guard and the new:

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. (Marais 2000:16)

The institutional and bureaucratic problems that plagued the national government filtered down to the provincial level. Gary Adler, of the AIDS Foundation, argued:

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. (*Mail and Guardian* 1999)

On the implementation side at the provincial level, expertise and political will were often lacking. Most provincial AIDS coordinators were appointed only from 1996 on, were in mid- to low-level managerial positions, and

were generally associated with communicable-disease control (Schneider and Stein 2001:726). These positions were largely filled by public servants from the old structures, with low levels of power and influence, instead of individuals from the network of AIDS activists.

The efficacy of provincial AIDS programs often hinged on the commitment of the provincial MEC for health, as the provincial AIDS coordinators rarely had the institutional clout to get their work off the ground. Again, this contributed to widely divergent responses at the provincial level. A paper submitted to the 1997 *South African STD/HIV/AIDS Review* noted that:

although 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 department 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 decentralization with inadequately developed mechanisms of coordination between the various actors, had made it difficult to fast-track AIDS activities through provincial and district structures. (Schneider and Stein 1997:4).

Variable provincial commitments placed the task of implementation in the hands of old civil servants with little authority and limited vision to roll out a comprehensive AIDS program quickly and effectively. These civil servants had minimal connections with nongovernmental and community AIDS networks—connections that could have greatly facilitated the implementation of an AIDS program, and would have introduced a more democratic, consultative and participatory form of policymaking and implementation. Instead, the AIDS infrastructure was narrowly conceived within a health and biomedical framework, and characterized by complex and cumbersome bureaucratic structures, which hindered effective implementation.

As late as 1998, a report entitled *HIV/AIDS and Human Development: South Africa* found that political commitment and public leadership was still lacking in most provinces. 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 (Marais 2000:19). But other provinces fared far worse. Mpumalanga province, for example, has the second-highest HIV prevalence rate in the country, yet in 1996–1997, it had an AIDS budget of only R2 million,

of which only a quarter was spent (Schneider and Stein 1997:4). Indeed, in common with other government departments, AIDS programs consistently underspent on their allocated budgets.

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 (Schneider and Stein 1997:3).

The pattern of underspending can in part be traced to the national government's fiscal austerity, which early on limited funds devoted to AIDS work, but more importantly hindered the pace and extent to which South Africa's primary healthcare system has been developing and transforming. The slowness of transformation in the health sector, coupled with bureaucratic constraints caused largely by restructuring, contributed to a lack of capacity at the provincial level to manage and administer large projects, as well as a cautious approach that was generally adopted regarding funding. Small projects, requiring small sums of money, could be applied for and administered relatively easily; however, larger projects, requiring large amounts of money, had to pass through the time-consuming tender process. As a result small, pilot projects proliferated, but they did not add up to a programmed response (Marais 2000:26).

To address the problem of underspending at the provincial level, the national department of finance instituted a policy whereby unused funds could not be rolled over into the next year's budget. If the provincial departments did not spend the money, they would lose it. At the same time, the amount of funding allocated for AIDS programs has been steadily increasing over the past several years. Despite this, a 2003 study by the Institute for Democracy in South Africa (IDASA) concluded that the biggest challenge facing government in its response to HIV/AIDS is not the lack of financial resources, but the capacity to spend (Kahn 2003). The study showed that R8 million or 23 percent of the 2001–2002 budget for HIV/AIDS conditional grants³ had not been spent. Provincial officials gave conflicting explanations for the underspending. Provincial treasury staff said the problem was lack of management skills in provincial health, education, and social-welfare departments; however, department officials said it was the rigidity of the conditional grants themselves that made spending difficult (Kahn 2003).

State or Society Relations and Popular Participation

Clearly, the process of state restructuring created complexities and challenges that were difficult to anticipate and overcome. Institutional constraints hampered a quick and coordinated response around which all sectors of society could be mobilized:

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). (Helen Schneider, quoted in Marais 2000:32).

It has been suggested that the AIDS plan overestimated the new government's implementation capacity (Schneider and Stein 2001); however, the importance of the plan lay in the participatory manner in which it was developed, involving large numbers of people over several years, thus establishing an expectation of future participation in AIDS policy. In addition, the plan effectively outlined a human-rights response by highlighting the relationship between human rights and public health, and formalizing a set of principles based on the protection of human rights.

Typical of the experimentations with new forms of participatory democratic politics that characterized certain aspects of the political processes at the time,⁴ through NACOSA, AIDS-policy development drew heavily on the participatory and consultative tradition of the political movement that had by this time been largely consumed under the "ANC's dominating presence" (Greenstein, et al. 1998). During this period, AIDS policymaking reflected the continued interdependence between the ANC and popular organizations, but it also reflected the contradictions inherent in this relationship. The incorporation of the internal democratic movement into the ANC brought together two forms of political leadership: on the one hand, the ANC leadership in exile had waged a struggle that facilitated an authoritarian, hierarchal, and largely secretive leadership style; on the other, the internal democratic movement had established a highly decentralized, open, and responsive style of political leadership that resulted from a tradition of mass political mobilization.

On coming to power in 1994, the new government not only adopted the NACOSA plan, but also recognized the need to create a two-way flow of information between government and civil society. The AIDS Advisory Group, one of the first institutions created to guide the response to the epidemic, was comprised largely of extragovernmental representatives and

experts. But as institutional constraints delayed governmental action, the exchange between the government and extragovernmental groups⁵ began to sour.

The AIDS policymaking process quickly began to shift away from consultative policy practices. There was little discussion or contact with the range of nongovernmental AIDS actors regarding the implementation of an AIDS policy. Nongovernmental groups began to raise concerns about procedures and called for greater accountability. In response, the government began to close ranks, and allowed for less and less consultation. The AIDS Advisory Group was disbanded in 1997, after it had sharply criticized the government and had adopted policy positions contrary to those of the government. Even within government, the interdepartmental committee on AIDS ended up being a rather ineffective body, as decisions on AIDS policy were already being made at the political level and by the top echelons of government.⁶

In part, the decline of popular participation in policymaking was a result of the weakening of popular democratic organizations that accompanied political enfranchisement in 1994. Many key NGO personnel previously aligned with the ANC went into the new government, creating a serious brain drain from civil society. In addition, most foreign funding channeled through the popular democratic groups during the antiapartheid struggle was now given directly to the new government. Thus, the popular democratic organizations no longer had their prior ability to engage in and influence the policy process.

In addition, many commentators, within and outside the ANC, have argued that the boundaries for opposition and debate within the government and the ANC and the tripartite alliance have narrowed (McKinley 1996, 2000, 2001). The ANC leaders, most of whom are former exiles and were trained in the radical Leninist school of thought, which gives primacy to the role of the vanguard party and revolutionary intellectuals, continues to use vanguardist and top-down practices and concepts of organization, such as democratic centralism, tight internal discipline, and strong central coordination (Johnson 2003). The continuation of such practices has shaped the restructuring of state–society relations in postapartheid South Africa, by asserting the primacy of the state over civil society and ascribing to the state the role of knowledge producer, able to develop policy and set the agenda for social transformation (Johnson 2002).

These patterns of authoritarian leadership and strained state–society relations in the AIDS policy arena came to the fore in a series of blunders and public-relations nightmares beginning with the scandal of *Sarafina II*, a musical about AIDS, commissioned by the Department of Health. The play was meant to popularize messages about HIV prevention, especially among South African youth; however, the apparent secrecy of the process, irregularities in the underwriting process, the R14 million (approximately \$3 million) that was awarded, and the play's confusing content led to a

huge outcry from a range of stakeholders inside and outside of government, including the AIDS Advisory Committee, the provincial AIDS programs that had not been consulted, and the European Union, whose funds financed the project.

Responding to the scandal, Minister of Health Zuma stated, “the department could not be expected to consult every NGO. AIDS doesn’t consult, it infects people” (*Mail and Guardian* 1996). The scandal offered a telling glimpse of the headstrong manner in which the government’s AIDS campaign was being executed (Marais 2000). Criticisms of the project were dismissed by the Department of Health, and the department was put on the defensive. Journalist Mark Gevisser describes the siege mentality adopted by top officials within the department:

[R]ather than acknowledging that there might have been irregularities and instituting an immediate inquiry, [the Minister] 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. (quoted in Marais 2000:33)

A second scandal erupted in 1997, when the Department of Health announced its support for the drug Virodene, which was claimed to be a South African treatment for AIDS. Virodene had been developed and tested by a group of researchers from a local university, but had raised serious concerns on the part of other medical experts, including the university ethics committee and the Medicines Control Council, who turned down applications for further testing on humans. Despite these allegations, the Minister of Health, in a unilateral and publicly unaccountable manner, endorsed the drug, creating renewed conflict with NGOs, and chaos and confusion over how to address AIDS prevention and care. Virodene was ultimately recognized as toxic and unusable, having “turned out to be little more, chemically, than an industrial solvent” (Mbali 2002:2). But this scandal further solidified the patterns of criticism of the Department of Health by the media, opposition parties, and some civil-society groups, and increasing defensiveness and hostility in response by the department.

The effects of these scandals on AIDS policymaking and implementation were quite damaging. Rose Smart, Director of the HIV/AIDS Directorate at the time remarked on how these political scandals took time away from program-implementation efforts. She stated that where there once were opportunities to advise the minister on policy matters, this all changed with the blowout from the scandals.⁷ Another civil servant working in the HIV/AIDS Directorate at the time stated that a gag order was effectively issued for the directorate, and that no one was allowed to talk to the media or outsiders regarding government AIDS policies.⁸ Saadiq Kariem, a member of the ANC Health Committee, confirmed that the

ANC, drawing on its history as a military liberation movement, in effect “closed ranks” against what it perceived to be an outside threat. Decisions around AIDS were first taken politically, within the ANC, and without involvement from civil servants.⁹

These scandals effectively signaled the “demise of a shared vision for AIDS in the country” (Marais 2000:34), and precipitated a cycle of conflict between the state and other AIDS players in South Africa. At issue has been not so much the government’s unwillingness to act, but that the centralized and closed manner of its actions have often led to quick-fix initiatives, which have done little to further AIDS prevention or care:

Ultimately, policy contestation around AIDS in South Africa can be understood as a series of attempts by the state to legitimately define who has the right to speak about AIDS, to determine the response to AIDS and even to define the problem itself. (Schneider 2001:21)

In other words, the AIDS-policy debates have been central in the reconstruction of the terms of relations between civil-society organizations and the state in a hierarchical and highly institutionalized fashion, where the state is ascribed the role of knowledge producer, able to develop policy and set the agenda for social transformation. Political leaders have sought to establish who will legitimately be accepted as civil-society partners with the new state and the extent to which nonstate actors can define government policy:

High[-]level state interventions in the AIDS field have thus perhaps less to do with the differences in the content of policy than with a discomfort, and at time active exclusion of, social movements that express certain styles of activism and that fall outside of the immediate networks of political patronage and influence within the tripartite alliance. (Schneider 2002:153)¹⁰

This pattern of vanguardist leadership prevalent within the government, more than a lack of political commitment, is an important factor in understanding the difficulties of implementing AIDS policy in South Africa, and has been at the root of much of the contestation around AIDS. This centralized and closed leadership style has rendered the bureaucracy largely unable and unwilling to mobilize and coordinate around a common vision a range of actors inside and outside of government, and across social and sectoral divides. Furthermore, since the bureaucracy was a weak player because of institutional constraints, its unwillingness or inability to harness other energies and expertise outside of government became an important factor inhibiting an effective response to the AIDS epidemic.

Antiretroviral Therapy and the Political Economy of AIDS

Patterns of closed policy and decision-making were also provoked by the introduction of unpopular neoliberal economic reforms and the adoption of GEAR as the new macroeconomic framework in 1996. Policymakers were compelled to push through controversial policies that were driven largely by fiscal concerns with limited consultation from outside stakeholders. This is one of the ways in which the broad macroeconomic framework has shaped the postapartheid state's response to AIDS.

More broadly, neoliberal reforms affected the limits within which health and AIDS policy was developed, defining what is and what is not possible, and removing certain issues from debate. The inflated power given to the finance ministry and to fiscal concerns is typical of countries undergoing economic restructuring:

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. 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. (Marais 2000:24)

When controversy regarding the provision of antiretroviral therapy (ARV), especially to prevent mother-to-child transmission, began to mount, in 1998, and when health minister Nkosazana Zuma canceled plans for government-funded pilot programs, the department of health cited budget constraints, but added that even if the finances were made available, primary health infrastructure in the country remained inadequate to guarantee the success of such a program.

The government stuck to its unaffordability argument, even though no real costing for such a program was done by the Department of Health until 2003.¹¹ In March 2000, President Mbeki's key spokesperson, Parks Mankahlana, offhandedly justified to *Science* magazine why the Department of Health refused to provide ARV treatment to pregnant, HIV positive women.

That mother is going to die and that HIV-negative child will be an orphan. That child must be brought up. Who is going to bring the child up? It's the state, the state. That's resources, you see. (Quoted in Bond 2001:177)

This issue has pitted the government against activist groups anxious to see more resources spent, especially on preventing HIV transmission to young children, and even resulted in a recent Constitutional Court case against the government, precisely over the issue of the government's responsibility to provide ARV drugs to prevent mother-to-child transmission of HIV. The case was brought against the government by the Treatment Action Campaign (TAC), a voluntary association of organizations and individuals who advocate for the treatment of people with HIV/AIDS and the prevention of new infections. TAC argued that the government was in breach of the Bill of Rights and its Constitutional duty to respect, protect, promote, and fulfill the socioeconomic rights enshrined in the Constitution. The government argued that its obligation to achieve the progressive realization of these rights is conditioned by available resources, and that the cost of providing all HIV-positive mothers with the antiretroviral nevirapine was prohibitive. In June 2002, the Constitutional Court ruled in favor of TAC, handing South African AIDS activists a landmark victory.

The court case successfully established a human-rights response to the AIDS pandemic that even includes the issue of socioeconomic rights, yet global and local debates continue to be shaped by the hegemonic neoliberal framework, which demands that we understand the AIDS pandemic in a particular way: as a health issue, rather than a development or human-security issue; as an individual concern, rather than a community or even a global concern. The emphasis on containment of the disease has meant that broader issues of nationalized healthcare, global public health, poverty or socioeconomic development are not discussed and debated. Furthermore, excessive individualism leads to the placement of overwhelming emphasis on antiretroviral medicines and individual treatment.

By defining the AIDS problem in a particular way, neoliberalism limits the possibilities of action, and automatically removes certain issues from debate:

By locating the AIDS policy discussion in a seemingly technical discourse of affordability and sustainability, the space for public deliberation over the appropriate size of a national treatment programme has been sharply curtailed. This has had the effect of stifling the formulation and expression of social values concerning how best to address the AIDS pandemic. (Nattrass 2004:17)

Indeed, the hegemony of neoliberal economic thinking disguises the normative basis of economic policies, thus defining the realm of the possible.

Conclusion

In South Africa, AIDS and politics have been deeply intertwined. As with other African countries, politics has played a decisive role in shaping the dynamics of the crisis. State action and leadership in this domain is critical. Despite South Africa's wealth and economic development, and the stability of its democratic political institutions, the rising rates of HIV infection in South Africa suggest that the government's response to the crisis has been ineffective.

Many AIDS-affected African countries have had to grapple with some of the issues and problems confronting South Africa. Most have undergone some form of neoliberal economic restructuring, which has shaped the context in which AIDS policymaking and implementation are taking place; however, in South Africa, given the recent enfranchisement of the majority of the population, there is a heightened expectation that the state will now provide certain social services. In the case of AIDS treatment, especially the provision of ARV drugs, the majority's expectations of government responsibilities came into conflict with the government's fiscal austerity measures. In contrast, in a country such as Uganda, the expectations and demands of delivery, especially of ARV treatment, from the people were not as great.

The challenge of bureaucratic restructuring and capacity-building are also common factors affecting South Africa and Uganda, but the types of challenges confronting each country are different. Uganda has had to deal with bureaucratic incapacity, but the presence of strong, centralized leadership beginning with President Museveni meant that broad sectors of society were galvanized around a common vision, and nongovernmental organizations could support or even prop up the government's efforts.

While strong presidential leadership and centralized coordinating structures have been enabling in Uganda, in South Africa the same characteristics have led to inappropriate political responses and the exclusion of a broad spectrum of civil society. The drive to deliver can take precedence over democratic goals, like extending representation in policymaking and implementation; however, this has spurred animosity and a sour working relationship between government and civil society actors—which remains an obstacle to policy implementation.

An analysis of AIDS policymaking and implementation in South Africa raises questions about the impact of institutional factors and global conditions on governmental responses to the pandemic. In the end, universal prescriptions on the content of AIDS policy, the role of government, intersectoral action, and political commitment have to be reinterpreted within the possibilities of local contexts and dynamics. The challenge for scholars, politicians, and social actors attempting to address AIDS in South Africa is to develop a deeper understanding of the social and political context in which the AIDS epidemic is unfolding, and to analyze and support those factors that contribute to constructive public-policy responses to AIDS.

NOTES

1. The South African government consists of one national government and nine provincial governments.
2. For the 1998–1999 financial year, provincial AIDS budgets varied from R2.5 million to R55 million (Schneider 1998).
3. To control the amount of money spent at the provincial level on HIV/AIDS, the national department has begun allocating funds to the provinces through conditional grants—which means that the money can be used only for the purpose specified in the grant.
4. South Africa's democratic transition was unique, given the degree of experimentation with new forms of participatory democratic politics. This experimentation was most visible in the establishment of consultative forums alongside the formal negotiation process, as well as the creation of the Reconstruction and Development Program (RDP).
5. After 1994, NACOSA refashioned itself as an independent nongovernmental organization.
6. Interview with Ria Schoeman, March 2004.
7. Telephone interview with Rose Smart, 8 April 2004.
8. Interview with Ria Schoeman, March 2004.
9. Interview with Saadiq Kariem, April 2004.
10. The tripartite alliance is formed of the African National Congress (ANC), the South African Communist Party, and the Congress of South African Trade Unions.
11. Interview with Ria Schoeman, March 2004.

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