African Affairs, 104/417, 591–614 doi:10.1093/afraf/adi036

Advance Access Publication 8 September 2005

SOUTH AFRICA'S HIV/AIDS POLICY, 1994–2004: HOW CAN IT BE EXPLAINED?

ANTHONY BUTLER

ABSTRACT

This article aims to explain South Africa's controversial post-1994 HIV/AIDS policy. It isolates two competing sets of policy prescriptions: a 'mobilization/biomedical' paradigm that emphasized societal mobilization, political leadership and anti-retroviral treatments; and a 'nationalist/ameliorative' paradigm that focused on poverty, palliative care, traditional medicine, and appropriate nutrition. It explains the ascendancy of the ameliorative paradigm in terms of its administrative and political viability in South African conditions. It explores how public sector institutions circumscribed the viability of biomedical interventions, while political institutions and state-society relations reduced knowledge transfer and policy learning. It then investigates the intellectual context that shaped the political viability of each paradigm. Finally it argues that the ANC accommodated proponents of each policy paradigm, and that instrumental calculation of the dangers of an inequitable and unsustainable anti-retroviral programme best explains the government's continued adherence to a cautious prevention and treatment policy.

SOUTH AFRICA'S HIV/AIDS PREVENTION AND TREATMENT POLICY has been widely criticized at home and abroad for prevarication and confusion.[1] Confronting an HIV-positive population estimated at five million, government policy has, according to one account, been 'a sorry tale of missed opportunities, inadequate analysis, bureaucratic failure and political mismanagement'.[2] This article explores South Africa's post-1994 HIV/AIDS policy, and seeks to explain the gulf of mutual incomprehension that divides African National Congress (ANC) policy-makers from their critics. Avoiding prior attributions of 'irrationality' and 'denialism' that have marked most criticisms

Anthony Butler is Associate Professor of Political Studies at the University of Cape Town. He is grateful to Howard Smith and two anonymous referees for their comments on an earlier draft of this article.

1. See E. Cameron 'The dead hand of denial', *Weekly Mail and Guardian*, (Johannesburg), 17 April 2002; A. Butler, *Contemporary South Africa* (Palgrave Macmillan, New York, 2004), pp. 128-9, 144-6; M. Crewe, 'How do we make sense of Mbeki?', *AIDS Analysis Africa* **11**, 1 (2000), pp. 10-11; K. Cullinan, 'Infected by toxic ideas', *Financial Mail*, (Johannesburg), 7 May 2004.
2. N. Nattrass, *The Moral Economy of AIDS in South Africa* (Cambridge University Press, Cambridge, 2004), p. 41.

of ANC policy, it argues that instrumental calculation has played an increasingly prominent role in government strategy.

The article first sets out just what it is that needs to be explained about HIV/AIDS prevention, treatment and care policy. While the government promoted coherent national strategic frameworks, a high level of conflict has marked the sector. Two competing complexes of policy prescription are isolated: a 'mobilization/biomedical' paradigm that emphasized society-wide mobilization, political will, and anti-retroviral (ARV) treatments; and a 'nationalist/ameliorative' paradigm that focused on poverty, individual responsibility, palliative care, traditional medicine, and appropriate nutrition. While not fundamentally inconsistent with one another, these prescriptive complexes were each underpinned by different sets of assumptions about the nature of the HIV/AIDS challenge and the government's appropriate response to it.

The article explains why the ameliorative rather than the biomedical/mobilization paradigm gained ascendancy in the middle of the decade. It recognizes the power of political leaders, but argues that they are able to promote successfully only those policies that are administratively and politically viable.[3] It explores how the institutional form of the public health bureaucracy greatly circumscribed potential policy innovations, and shows how the organization and politics of the political executive, liberation movement, and state-society mediating systems contributed to a centralization of policy-making that delimited decision-makers' knowledgeability and thus their ability to deliberate effectively. It then investigates the intellectual context in which public health policy was debated, to show how the two paradigms were competing for support among policy-makers and activists with quite different formative experiences and intellectual presumptions.

The final section argues that the ANC's broad church has accommodated strong proponents of each prescriptive complex, and that the continuing strength of the ameliorative paradigm, in the face of increasing international and domestic pressure to abandon it, is best explained as a result of strategic calculation. The limited ARV production and distribution that the government can realistically hope to achieve poses considerable economic, socio-political, and national security challenges, and instrumental calculation of these threats best explains the government's continuing caution concerning prevention and treatment policy.

HIV/AIDS policy 1994-2004

The ANC came to power in 1994 after ten years of National Party inaction with regard to AIDS. Liberation movement activists sometimes shared

3. I draw heavily on the path-breaking framework advanced by P.A. Hall, 'The politics of Keynesian ideas', in P.A. Hall (ed.), *The Political Power of Economic Ideas: Keynesianism across nations* (Princeton University Press, Princeton, NJ, 1989), pp. 361-91.

with their predecessors both a homophobia that denigrated the victims of the country's first (gay) epidemic and a xenophobia that prejudged the vectors of the second. Pre- and post-1994 political leaders in this conservative society were also united by their refusal to discuss sexuality, sexually transmitted infections, or male power.[4] The ANC nevertheless took office with a formidable strategy, on paper at least, for addressing HIV/AIDS. A National AIDS Convention of South Africa (NACOSA), first convened in 1992, brought together the ANC, the ANC-aligned United Democratic Front, and the National Party government's ministry of health, to develop a comprehensive 1994 national AIDS plan based on robust projections: 'HIV/AIDS is emerging as a major public health problem, with over 2,000 reported cases at the end of 1993, and 500,000 people infected with HIV'. By 2000, the plan noted, 'there will be between four and seven million HIV-positive cases, with about 60 per cent of total deaths due to AIDS, if HIV prevention and control measures remain unaddressed .... credible predictions indicate that by the year 2005, between 18 and 24 percent of the adult population will be infected with HIV, that the cumulative death toll will be 2.3 million, and that there will be about 1.5 million AIDS orphans.'[5]

The national AIDS plan, endorsed by incoming minister Dr Nkosazana Dlamini-Zuma, was insufficiently informed by the institutional and social realities of South Africa. Like other policy blueprints of this period, it overestimated the economic, and especially human, resources at the disposal of the incoming government.[6] Moreover, this avowedly multi-sectoral HIV/AIDS plan, designated a 'presidential lead project', was situated in a national department of health in the throes of transformation. Because health is in part a provincial prerogative, AIDS was vulnerable to further administrative obstruction in a second tier of bureaucracy, then staffed partly by entrenched 'sunset-clause' protected bureaucrats from the previous regime.[7] Competing claims on resources in the poorer provinces, the demands of administrative reconfiguration, and very uneven provincial capacity, further undermined implementation.[8]

The characteristic 'invisibility' of HIV/AIDS, and its pigeonholing as a health issue, left it marginalized by seemingly more urgent political and

4. Nattrass, *Moral Economy*, pp. 41-2.
5. African National Congress, *A National Health Plan for South Africa*, May 1994. Available at <www.sas.upenn.edu/African_Studies/Govern_Political/ANC_Health.html> [22 June 2004]. Compare the 2003 out-turn of 5.3 million people living with HIV/AIDS and 1.69 million cumulative deaths. O. Shisana, 'Taking a closer look at the national response to HIV/AIDS in South Africa'. Paper presented at the Next Decade of Democracy seminar series, August 2004. Human Sciences Research Council, Pretoria, 5 August 2004.
6. A. Whiteside and C. Sunter, *AIDS: The challenge for South Africa* (Tafelberg and Rousseau, Cape Town, 2000), p. 120.
7. J. Parkhurst and L. Lush, 'The political environment of HIV: lessons from a comparison of Uganda and South Africa', *Social Science and Medicine* **59** (2004), pp. 1913-24.
8. Whiteside and Sunter, *AIDS*, p. 121; Nattrass, *Moral Economy*, p. 43.

policy imperatives. Dlamini-Zuma's tenure was plagued by a financial mismanagement scandal concerning the government-sponsored AIDS play *Sarafina II*, and by increasingly strained relations with the non-governmental sector and health professionals. High-level support in 1996 for quack AIDS remedy Virodene set politicians against the Medicines' Control Council (MCC) and the Medical Research Council (MRC). Nevertheless, a wide-ranging 1997 review of HIV/AIDS policy[9] led in the following year to a re-invigorated government AIDS action plan, loudly championed by president-in-waiting Thabo Mbeki, promising greater public awareness and new institutional mechanisms to address the cross-sectoral challenges of the pandemic. The operational plan transferred financial and human resources into a scaled-up syndromic management intervention that successfully reduced the sexually transmitted infections (STIs) that create vulnerability to HIV infection.[10] However, high-level political support was replaced by equivocation, new institutions designed to drive forward national strategy remained unstaffed, and a coherent behaviour-change strategy — involving life skills teaching, condom promotion and a renewed communications strategy — lacked the required intensity of safe sex messages and diversity of community mobilizations. While HIV/AIDS awareness grew, stigmatization continued largely unabated.[11] New treatment options, moreover, were resisted, with the government determined to avoid publicly funded ARV therapies, primarily, or so it appeared, on affordability grounds.

In 1999 incoming health minister Manto Tshabalala-Msimang – like Dlamini-Zuma a medical doctor and member of the drafting committee for the 1994 AIDS plan – seemed initially to support wider use of ARVs to prevent mother-to-child transmission (MTCT) of HIV. It was in this context that Thabo Mbeki, now president, launched broadsides in 2000 against the conventional intellectual foundations of AIDS health policy, questioning the causal relationship between HIV and AIDS, and positing the potential toxicity of antiretroviral AZT. He convened a presidential advisory panel to scrutinize further the scientific orthodoxy, and wrote a letter to fellow world leaders asking for the socio-economic, as opposed to purely viral, causes of AIDS to be investigated. His scepticism was also reflected in the composition of the National AIDS Committee (SANAC), which excluded leading researchers, the MRC, and the MCC, while including voices considered 'dissident' by mainstream biomedical researchers.

9. Department of Health, *National STD/HIV/AIDS Review Report* (Department of Health, Directorate HIV/AIDS and STDs, Pretoria, 1997).
10. Parkhurst and Lush, 'Political environment', pp. 1914, 1921.
11. *Ibid.*, p. 1921.

The government nevertheless launched the *HIV/AIDS/STD Strategic Plan for South Africa 2000-2005*,[12] premised, according to Tshabalala-Msimang, on the view that HIV/AIDS 'is not just a health problem that can be contained by adopting a few medical or health-centred interventions'.[13] The national plan, she argued, 'emphasises a multi-sectoral approach, pulling together resources of all sectors in fighting this developmental challenge'.[14] While the plan drew upon the strategic plan template provided by the United Nations,[15] it lacked concrete commitments and timeframes, and created controversy by evading analysis of ARV options. Discourses of 'affordability' took centre stage in the face of court challenges from the Treatment Action Campaign (TAC) and growing international censure. 'Dissident' or 'denialist' opinion moved underground, but political leaders signally failed to renounce it. Under intense political pressure, from inside as well as outside the ANC, the government in late 2002 set up a joint treasury and health department task team to look at 'resource implications for various treatment options including anti-retroviral treatment', covering not only procurement and dispensing costs but also 'factors such as the health infrastructural base required for the safe and effective administration of anti-retroviral drugs'.[16] This process culminated in 2003 in a commitment radically to scale up the provision of ARVs. Critics argued, however, that the opportunity to divert a major epidemic had already been missed. They point, moreover, to what they see as a continuing lack of political commitment to the treatment programme, which they believe lies behind the hitherto slow implementation of the national ARV plan.

Two paradigms

HIV/AIDS policy deliberation in South Africa has been characterized over the past ten years by a variety of shifting alliances and schools of thought, even within the liberation movement itself. Some ANC activists have been at the forefront of campaigns against government policy and in support of public ARV provision, and the movement's own health policy committee has at times been at odds with the ANC in government. In 2000 and 2001, the Treatment Action Campaign and the government even joined forces, in order to bring legal action against the international pharmaceutical companies. HIV/AIDS prevention and care planning, moreover, was often highly

12. National Department of Health, *HIV/AIDS/STD Strategic Plan for South Africa, 2000-2005* (Department of Health, Pretoria, 2000).
13. M. Tshabalala-Msimang, 'The state has an Aids [sic] plan', *Weekly Mail and Guardian*, (Johannesburg), 28 February 2003.
14. *Ibid.*
15. UNAIDS, *Guide to the Strategic Planning Process for a National Response to HIV/AIDS* (Joint United Nations Programme on HIV/AIDS, Geneva, 1998).
16. Tshabalala-Msimang, 'The state'.

consensual, marked only by differences of emphasis over communication strategy, condom marketing, voluntary counselling and testing, outreach programmes to focus on sex workers, and life-skills education.

While there was much agreement over the necessary elements for an effective response to HIV/AIDS, however, it is possible analytically to distinguish two competing policy models. A social mobilization and biomedical paradigm, advanced by the medical establishment and campaign groups, argued for more declarative and clear national political leadership, the mobilization of all social resourses to combat the epidemic, the introduction of publicly funded post-exposure prophylaxis for rape survivors and health professionals, and the use of ARVs to prevent mother-to-child-transmission as a centrepiece of prevention policy. Supporters of this paradigm were later at the forefront of demands for a drastically scaled-up public ARV treatment programme. A second model, ascendant within government after 2000, focused on sexually transmitted infections (STI) treatment, behaviour change, condom marketing, a mass communications strategy, and life-skills education. The emphasis within this paradigm was on prevention and palliative care, with nutrition, traditional medicine, massive social grants provision, and anti-poverty programmes prioritized, while bolstered traditional leaders were given responsibility for reinforcing the cohesion of rural communities.

Biomedical treatments such as ARVs were entirely absent from the ameliorative model, and critics argued increasingly vociferously that its proponents failed to respect biomedical science, were engaged in 'denialism', supported 'dissident' research, and refused to provide the national leadership, strategic vision, and societal mobilization that they believed the pandemic demanded. Thabo Mbeki in particular, as president from 1999, took up and advanced the ameliorative paradigm, while his supporters conceptualized it in African nationalist terms. Critics have focused on three aspects of his leadership. Firstly, while liberals usually denigrate the leadership rhetoric of the ancient democracies as demagoguery,[17] and fear the power of the irrational mob and its hypnotic leader,[18] they claim the moral dimension of HIV/AIDS makes vital the authority and symbolic power of leaders, and their ability to shape popular conceptions of the acceptable. The hypnotic leader, they claim, can turn the crowd to otherwise unattainable ends.[19] While Mbeki's record has for this reason been unfavourably contrasted with that of Uganda's Yoweri Museveni, the effectiveness of such moral leadership in fact remains highly contested.[20] While national

17. On Plato's malign attack on rhetoric, see B. Vickers, *In Defence of Rhetoric* (Clarendon Press, Oxford, 1988), pp. 83-147.
18. J.S. McClelland, *A History of Western Political Thought* (Routledge, London, 1995), pp. 659-82.
19. A.M. Butler, 'Unpopular leaders: the British case', *Political Studies* **43**, 1 (1995), pp.48-65.
20. Parkhurst and Lush, 'Political environment', p. 1914.

political leaders may help to create an environment within which behaviour change can occur, the informal institutions through which young people learn about HIV/AIDS are largely impervious to their rhetoric.[21]

Leaders' injunctions will not reshape gender preconceptions that leave women vulnerable to survival sex or prostitution, ignorant about the routes of HIV transmission, and subject to implicit sexual rules that limit their discretion about the use of condoms. They cannot unilaterally criticize polygamy, rituals of initiation, or the xenophobia that licenses the sexual abuse and exploitation of immigrants and refugees. Neither can they reduce intolerance of homosexuality. Religious values and traditions, rather than political leaders, obstruct condom distribution and inhibit learning about how HIV is spread. South Africa's intellectual, labour and commercial leaders, as much as her political figureheads, have been unable to bring their followers with them when it comes to such culturally sensitive practices and beliefs. While churches have been at the forefront of palliative care for those living with AIDS, religious leaders have, with very few exceptions, baulked at the attempt to change their followers' behaviour.

The second criticism of Mbeki has been that he has failed to mobilize resources, human and financial, behind the government's response. Critics of AIDS policy, however, tend to construct wish-lists — as de Waal notes, they first concern themselves 'with the bio-medical, public health, education and care requirements of effective response, and then conclude with an appeal for "political will" or "leadership" to make these policy requirements a reality'[22] — and the medium-term expenditure framework is invulnerable to heavy-handed presidential manipulation. A third and more penetrating criticism concerns Mbeki's silences more than his words, and the attributions of 'irrational' and 'denialist' beliefs that can be made about them. Prominent judge Edwin Cameron, for example, argues that 'the president's [denialist] stand has caused predictable confusion and dismay among ordinary South Africans — with unavoidably devastating consequences in an epidemic where public education about self-protection and the necessity for behaviour change is a life-saving centrality'.[23] Senior politicians, including the president, remain unwilling to attack the stigmatization that AIDS brings, while transmitting opaque messages about how HIV is transmitted, the use of condoms, and the safety of ARVs. In these ways they undermine behaviour change and drug adherence strategies, and perpetuate intolerance. The delay, obfuscation, and tardy implementation of ARV treatment, these critics claim, result from this persistent strain of denialism.

21. A. de Waal, 'AIDS: Africa's greatest leadership challenge', *Justice Africa*, October (2000), available at <www.justiceafrica.org/aidspaper.htm> (6 June 2003).
22. *Ibid.*
23. Cameron, 'Dead hand of denial'.

Attributions of 'irrationality' or 'denial', however, no matter how many people hold them to be true, do not constitute adequate explanations of human collective behaviour. Beginning with the presumption that South African policy-makers are 'other persons who are persons in much the same sense as we are ourselves',[24] this article explains the ascendancy of the ameliorative paradigm without resort to such devices. It argues that the trajectory of South Africa's HIV/AIDS policy can be understood primarily by exploring the administrative and political viability of the two paradigms in South African conditions.

Institutional frameworks

This section explores how the institutional context favoured the ascendancy of the ameliorative paradigm over its mobilization competitor. It begins with an analysis of how the state bureaucracy lent administrative viability to the ameliorative but not the biomedical prescription. It then goes on to explore how the organization of the liberation movement, the central executive, and state-society mediating institutions reduced productive policy contestation, and denied policy-makers access to the knowledge bases they needed to engage in order to deliberate effectively on their policy dilemmas.

The structure of the public health bureaucracy lent administrative viability to the syndromic treatment of sexually transmitted infections but not to a public ARV programme. In syndromic treatment, health workers apply standardized algorithms to address sets of symptoms, rather than drawing upon expensive and scarce clinical diagnostic resources, thus permitting the treatment of large numbers at limited cost.[25] As Parkhurst and Lush have noted in their comparative study, such techniques were viable, given the country's organized health bureaucracy, whereas in Uganda such interventions were not conceivable.

Moreover, while affordability discourses played a prominent role in government equivocation about ARVs, South Africa, unlike other African states, was not constrained by its inability to afford the ARVs themselves, or by a need to mobilize donor support in order to procure drugs. The most important institutional constraint confronting South African policy-makers was a dramatic and worsening shortage of human resources in the public health sector, a shortfall that has been the Achilles' heel of the biomedical paradigm. Between 1989 and 1997, 80,000 health workers emigrated, and health professionals have been drifting steadily from public

24. J. Dunn, 'Practising history and social science on "realist" assumptions', in C. Hookway and P. Pettit (eds), *Action and Interpretation: Studies in the philosophy of the social sciences* (Cambridge University Press, Cambridge, 1978), p.174.
25. Parkhurst and Lush, 'Political environment'.

to private sectors, and from rural to urban areas. By the end of the last century, only around a quarter of rural physicians were South African citizens, with the remainder drawn primarily from other southern African health systems. While the current national AIDS treatment plan proposes to create 12,000 new posts, there are already 30,000 unfilled vacancies in the public health sector.[26] Despite proposals to train health professionals, to recruit from overseas, and to re-deploy existing resources, the capacity gap has always seemed too great to be closed, making it harder for proponents of the biomedical paradigm to establish its credibility.

There has also been a shift in debate on policy. Regulated contestation within a policy community improves policy because it allows miscalculations to be identified, expert knowledge to be mobilized and transferred, policy learning to develop, and leadership oversight and error to be corrected. However, the national leadership of the ANC has become increasingly intolerant of dissent in areas, such as HIV/AIDS, that it has identified as its own prerogatives. Under Mbeki, democratic centralism has been applied dogmatically as an instrument of party management, and the centre has cowed the national executive committee.[27] Leftist critics of declining ANC internal deliberation sometimes explain centralization as a reaction to 'careerism' and factionalism, or in terms of the natural professionalization of party management. Greater hierarchy and discipline within the movement, and the entrenchment of deference to the leadership, are also products of the ANC's history in exile and its ideology of liberation.[28] The ideology of liberation 'prioritizes the past over the present' while 'national liberation experience marks out dominant parties as legitimate heirs to liberation'.[29] Popular election victories merely reinforce a liberation movement's perceived entitlement to rule, a historically derived right that cannot be overturned by electoral defeat. Where the centre decides to enforce 'the line', it does so strictly, dismissing transgressors as racist, unpatriotic, ultra-leftist or counter-revolutionary.

The organization of the state also influences how advice and information are channelled, which officials or experts possess special authority, and whether or not a particular policy is recognized as administratively viable.

26. See A. Padarath, C. Chamberlain, D. McCoy, A. Ntuli, M. Rowson, and R. Loewenson, *Health Personnel in Southern Africa: Confronting maldistribution and brain drain*. Equinet Discussion Paper Series 3 (Health Systems Trust, Durban, 2003); South African Department of Health, *Operational Plan for Comprehensive HIV and AIDS Care, Management and Treatment for South Africa* (Department of Health, Pretoria, 19 November 2003).

27. T. Lodge, 'The ANC and the development of party politics in modern South Africa', *Journal of Modern African Studies* **42**, 2 (2004), pp. 189-219; J. Cronin, Interview with Helena Sheehan in Cape Town on 24 January, 2002, available at <http://www.comms.dcu.ie/sheehanh/za/cronin02.htm>(17 August 2004).

28. Cronin, Interview; R. Suttner, 'Culture(s) of the African National Congress of South Africa: imprint of exile experiences', in H. Melber (ed)., *Limits to Liberation in Southern Africa* (Human Sciences Research Council, Pretoria, 2003), pp. 178-99.

29. R. Southall, 'Post-colonial legitimacy in Lesotho', in Melber, *Limits to Liberation*, p. 129.

A variety of institutional factors help explain the force of the ameliorative/nationalist paradigm. Firstly, while HIV/AIDS was explicitly recognized as a cross-sectoral challenge, power over AIDS policy-making was in fact concentrated in the department of health and the treasury, and later the presidency, rather than in cabinet. The national and provincial departments of health were unsuited to the inter-sectoral challenges thrown up by HIV/AIDS, while the treasury was preoccupied with medium-term fiscal discipline. Under Mandela's disorganized presidency, his staff shared authority with the deputy president's office. In South Africa's cabinet government system, the president and cabinet govern together, and the cabinet is collectively responsible to parliament.[30] Under Mbeki, however, the treasury continued to dominate resource allocation, while a 'new integrated presidency' instituted a system of departmental coordination that located policy planning in clusters coordinated by the presidency, thus usurping the cabinet's ability to mobilize knowledge across government and to mediate conflict.

The centre's priority of political control, enforced by functionaries such as information service and policy unit head Joel Netshitenzhe and Minister without Portfolio Essop Pahad, has resulted in the stifling of policy contestation. Often under the guise of gender balance, Mbeki has appointed cabinet ministers — and after the 2004 elections a new array of deputy ministers — who lack the political weight and personal constituencies that would permit them to rebut presidential control. Meanwhile, senior officials, who are on contract to the presidency, have acquired greater control over ministerial agendas. The positions of provincial ANC chair and provincial premier have now been uncoupled, thus reducing quasi-federal policy experimentation.

Institutions created to encourage respect for socio-economic rights, to promote open and democratic politics, and to facilitate appropriate contestation of policy, remain fragile in this new democracy. The liberation movement's popularity and hierarchical culture have helped to undermine the separation of powers between executive and legislature, resulting in compliance and upward accountability in parliamentary oversight committees. Opposition parties have not achieved legitimate voice for critical interventions against the government. The independent offices designed to engender accountability have been colonized increasingly aggressively by the centre's loyalists.[31]

30. Republic of South Africa, *Constitution of the Republic of South Africa*, Act 108 of 1996 (Government Printer, Pretoria, 1996), S85(2).
31. Cronin, Interview.

State-society relations

State-society relations structure the flow of information between state and society, the exercise of pressure by citizens and organized interests upon government, and the allocation of resources.[32] Producer interests, however, have been ineffective lobbies for policy change in this area. Business interests are fragmented, and dominated by large resources groups keen for government to pay for workforce rather than public ARV treatments. Many businesses have taken no steps to address the impact of HIV/AIDS on productivity and skills. Writing in the country's leading business newspaper, one well-known commentator argued that 'deaths will occur overwhelmingly among people (of all races) who have less than a matric education. . . . the lost workers will be quite readily replaceable from the millions of unemployed, and society will adjust in a myriad of ways to labour shortages. For example, a million domestic workers constitute a reserve pool of labour that can be drawn into industry.'[33] The government faces a strategic conflict with big business and the medical insurance industry over who is to pay for ARVs, with all sides having an incentive to persuade others to shoulder costs.[34] The tripartite alliance of the ANC, the Congress of South African Trade Unions (COSATU) and the South African Communist Party (SACP), still allows the testing of many ideas through conflict. While COSATU has periodically indicated that it is very much behind the TAC's campaign for ARVs, however, it has been obliged to maintain a troubled silence on AIDS in the public sphere as part of tripartite alliance compromise. The SACP, as we shall see, perpetuates Marxist discourses which have undermined coherent policy deliberation.

Relationships with knowledge-generating institutions and expert groups deteriorated steadily across the decade. Biomedical researchers in the universities failed to establish productive and stable relations with the government. While power became concentrated, the presidency became less open to outside sources of expert advice, and biomedical and epidemiological experts were unable to command the attention of decision-makers. Health sector institutions such as the MCC and the MRC, viewed as havens for apartheid-era officials despite senior appointments by government after 1994, lacked lines of communication to the centre and the authority to demand a hearing from senior officials and ministers. Growing suspicion characterized interactions between the state and civil society organizations, which were struggling to retain influence in a harsher donor environment, and mostly hesitated to criticize the liberation movement. Collaboration

32. Hall, 'Politics of Keynesian ideas', pp. 378-80.
33. K. Owen, 'Quality education the only hope', *Business Day*, 27 May 2002.
34. P. Bond, 'Corporate cost-benefit analysis and culpable homicide', *ZNet*, 25 June 2002. Available at http://www.zmag.org/content/showarticle.cfm?SectionID=2&ItemID=2023 (6 September 2004)

was possible only on the government's terms, while those supporting the biomedical/mobilization paradigm were increasingly viewed as opponents. While campaign groups have mostly been unable to find any sustainable middle ground between deference and confrontation, the Treatment Action Campaign combined constructive with critical engagement in its campaign for the public provision of ARVs. It used public protest, constitutional challenges, and a mass programme of non-violent civil disobedience to press its policy critique, its campaigning and advocacy tactics including marshalling scientific evidence to rebut government disinformation about ARVs, and international campaigning to encourage foreign pressure. TAC's greatest successes were in persuading its own activists that it was legitimate to use the courts against the government, and in enhancing the media's limited inclination and capacity for investigative journalism.[35]

This institutional and political context militated against decision-makers' adoption of the biomedical/mobilization paradigm, and reduced their capacity to reflect knowledgeably on the relative merits of the two prescriptive paradigms. The structure of the political executive, liberation movement centralization, and the nature of state-society relations hampered communication between state and society and circumscribed the generation of reliable knowledge. Liberation movement centralization reduced policy contestation. The hierarchical state bureaucracy and poor relations with the voluntary sector increased the viability of syndromic STI approaches and palliative care, but militated against wider community-based prevention and treatment interventions.

Intellectual frameworks

This section explores the lenses through which ANC activists and political leaders viewed the emerging epidemic, and unpacks the notion of 'denialism' that has been directed by critics at the liberation movement and its leadership. As Hall has noted, 'the nature of the prevailing political discourse can work to the advantage or disadvantage of new policy proposals. In terms of prevailing discourse, some new proposals will be immediately plausible, and others will be barely comprehensible.'[36] I argue here that South Africa's political history created two relatively distinct worlds of discourse, one in the public sphere that was hospitable to the biomedical/mobilization paradigm, and the other internal to the liberation movement that favoured the nationalist/ameliorative paradigm. These worlds provided two separate languages for analyzing HIV/AIDS as a policy problem. Each set of discourses made its own assumptions about the nature of society, and the appropriate role of government in public

35. A. Butler, 'The negative and positive impacts of HIV/AIDS on democracy in South Africa', *Journal of Contemporary African Studies* **23**, 1 (2005), pp. 1-24.
36. Hall, 'Politics of Keynesian ideas', p. 383.

policy. Each appealed to a different set of purportedly common ideals and collective memories. By exploring these worlds of discourse, we can help to explain why one set of ideas, the nationalist paradigm, had more force for many ANC leaders and activists than the biomedical paradigm, and why it remains difficult for the mobilization strategy to carry the day.[37]

Thabo Mbeki's purportedly 'denialist' reflections — on the unreliability of biomedical science, the unscrupulous profit-mongering of international drug companies, and the racial denigration that lies behind attributions of African HIV-prevalence to sexual excess or perversity — have been the object of much scrutiny.[38] Since he greatly curtailed his direct public comment on HIV/AIDS in 2000, his silences and tangential asides have been equally closely scrutinized. We know that 'denial' occurs at the level of individual behaviour even among those communities most knowledgeable about AIDS. Research into the 'safe sex' practices of men who have sex with men in gay New York and San Francisco highlights prevalent strategies of self-deceit and rationalization.[39] 'Micro-denial' persists in refusing to admit AIDS as the cause of death, persistence with unsafe sex, and the redefinition of risk using 'folk models' of safe behaviour.[40] Fearing rejection, individuals may not disclose their HIV status to their partners, and they may rationalize their denial of responsibility for high-risk behaviour.[41]

It is far more difficult, and controversial, to establish what denial might mean at the social and cultural levels. 'Biomedical denialism', questioning the causal link between HIV and AIDS, is a label applied equally to those citing poverty as AIDS' primary cause, those positing whether AIDS might not be caused by ARVs themselves, or those accused of misrepresenting medical science and abusing orthodox scientists as dupes of capitalist forces or participants in a racist conspiracy. HIV/AIDS 'denial' purportedly also takes the form of 'othering',[42] in which AIDS is 'not our problem'

37. *Ibid.*
38. See, for example, Nattrass, *Moral Economy*, pp. 49-50; P. Sidley, 'Clouding the AIDS issue', *British Medical Journal* **320** (2000), p. 1016; M. Makgoba, 'HIV/AIDS: the perils of pseudoscience', *Science* **288** (2000), p. 1171; H. Schneider, 'On the fault-line: the politics of AIDS policy in contemporary South Africa', *African Studies* **61** (2002), pp. 45-67; D. Forrest and B. Streek, 'Mbeki in bizarre Aids [sic] outburst', *Weekly Mail and Guardian* (Johannesburg), 26 October 2001.
39. N. Sheon and M. Crosby, 'Ambivalent tales of HIV disclosure in San Francisco', *Social Science and Medicine* **58**, 11 (2004), pp. 2105-18; R.J. Wolitski, R. Valdiserri, P. Denning and W. Levine, 'Are we heading for a resurgence of the HIV epidemic among men who have sex with men?', *American Journal of Public Health* **91** (2001), pp. 883-6.
40. S. Cohen, *States of Denial: Knowing about atrocities and suffering* (Polity Press, Cambridge, 2001), pp. 56-7; E. Lowy and M. Ross, ' "It'll never happen to me": gay men's beliefs, perception and folk constructions of sexual risk', *AIDS Education and Prevention* **6**, 6 (1994), pp. 467-82.
41. Sheon and Crosby, 'Ambivalent tales'; R.S. Gold, 'AIDS education for gay men: towards a more cognitive approach', *AIDS Care* **12**, 3 (2000), pp. 267-72.
42. C. Campbell, *Letting Them Die: How HIV/AIDS programmes often fail* (Double Storey, Cape Town, 2003), pp. 188-95.

or 'can't happen here'. Africans have in this way attributed AIDS to Western homosexuals, Europeans and Americans to Africans, whites to blacks, and rich to poor. HIV/AIDS, on one account, is vulnerable to such cultural denial because 'the syndrome's menacing and mysterious emergence, the finality of the diagnosis, the association with stigmatised groups and sexual practices, [and] the potent metaphor of depravity' make complete acknowledgement difficult.[43]

Yet such attributions of denial make all too easy assumptions about the intrinsic authority of biomedical claims to know. Orthodox biomedical characterizations of the epidemic have been widely interpreted as the instruments of a continuing racist conspiracy. From the passage of the first public health legislation in the late nineteenth century to the forced removals of the 1960s and 1970s, public health has been used in South Africa as a justification for racial segregation.[44] From the scientific racism of the late Victorian period to the bizarre official anthropologies of high apartheid, the social sciences have served as the instruments of racial oppression. South Africa's white medical professionals, it should be remembered, created and enforced apartheid's ruthlessly segregated health system without the need for any legislative framework.

Scientific population policy in South Africa focused on the control of black reproduction and the expansion of the white population.[45] Some apartheid–era politicians celebrated AIDS as a disease that would decimate the black population, while scientists developed chemical and biological weapons for use on black political leaders. Others 'were researching contraceptive methods to induce sterility in the African population, and were allegedly attempting to spread HIV through a network of infected prostitutes'.[46] Social and medical sciences denigrated Africans, albeit mostly inadvertently, as promiscuous or animalistic in their sexuality. Mbeki famously alluded to such prejudices in his characterization of theories of the African or Haitian origins of HIV as 'insulting'. In a broadside against campaigners for antiretroviral treatment, moreover, he claimed that 'others who consider themselves to be our leaders take to the streets carrying their placards, to demand that because we are germ carriers, and human beings of a lower order that cannot subject [our] passions to reason, we must perforce adopt strange opinions, to save a depraved and diseased people from perishing from self-inflicted disease'. These protesters,

43. Cohen, *States of Denial*, p. 56.
44. M. Swanson, 'The sanitation syndrome: bubonic plague and urban native policy in the Cape Colony: 1900-1909', *Journal of African History* **18**, 3 (1977), pp. 387-410.
45. C. Kaufman, *Reproductive Control in South Africa* (The Population Council, New York, 1977); O. Chimere-Dan, 'Population policy in South Africa', *Studies in Family Planning* **24**, 1 (1993), pp. 31-9.
46. D. Fassin and H. Schneider, 'The politics of AIDS in South Africa: beyond the controversies', *British Medical Journal* **326** (2003), pp. 495-8. This section draws heavily on this illuminating article.

he claimed, 'proclaim that our continent is doomed to an inevitable mortal end because of our unconquerable devotion to the sin of lust'.[47] Western cultural identity, on this reading, counter-poses the civilized European to the degenerate African, and by extension Western civilization to African social corruption. An informal discussion document, *Castro Hlongwane*, circulated to the national executive committee of the ANC by Peter Mokaba in March 2002, reiterated that the 'HIV/AIDS thesis' is 'informed by deeply entrenched and centuries-old white racist beliefs and concepts about Africans and black people . . . it makes a powerful contribution to the further entrenchment and popularisation of racism'.[48]

African nationalist critics of the biomedical paradigm noted that colonialism and poverty lie at the heart of the second HIV/AIDS epidemic in South Africa. The poor and the unemployed are more likely to have unsafe sex and the sexually transmitted infections that predispose them to HIV infection. They have less access to information, primary health care and HIV-diagnostic facilities. Poverty and gender oppression together facilitate transmission and undermine prevention.[49] A century of mass population movements to the mines and industries of apartheid, a sub-continental migrant labour system, and more recently political exile and war refugee movements, have accelerated rates of transmission. Furthermore, the sexual violence and survival sex that labour migration promoted predisposed poor women to high levels of infection. All three sets of factors — inequality, violence, and particularly mobility — are therefore products of the continent's colonial and segregationist history, and apartheid bequeathed a legacy of racialized HIV prevalence.[50]

The initially defensive reaction to what was received as a denigrating and racist biomedical epidemiology of HIV turned to hostility in part because of the failure of scientists in the early 1990s to present any coherent socio-historical alternative.[51] Health professionals have also been slow to establish trust by frankly admitting their historical role in the apartheid system, leaving them vulnerable to the allegation that it is they who are in denial. If cultural denial can be found in the liberation movement, it may result from the ANC's conception of the national democratic revolution as the culmination of a century of anti-colonial struggle on the continent. The historical significance of the liberation movement in the eyes of some of its leaders lies in its role as the locomotive of continental renaissance, a long

47. Forrest and Streek, 'Mbeki'.
48. P. Mokaba and anonymous others, 'Castro Hlongwane, caravans, cats, geese, foot and mouth and statistics: HIV/AIDS and the struggle for the humanisation of the African', 2002, p. 5. Available at <www.chico.mweb.co.za/doc/aid.Castro.Hlongwane.doc> (8 September 2004).
49. Campbell, *Letting Them Die*, p. 195.
50. Fassin and Schneider, 'Politics of AIDS', p.496.
51. *Ibid.*, p.495.

awaited and historical triumph that has now collided intolerably (and thus inconceivably?) with the reality of an AIDS catastrophe. Moreover, determined to prove that Africans can run a sophisticated society as Africans and not merely as partners of well-meaning whites, liberation movement leaders have been unwilling to defer to claims from others to know better. Ironically, in seeking an 'African solution', many of them turned to 'dissident' scientific opinion in the United States. Ultimately, however, international opinion — notably Canadian Premier Jean Chrétien's reported threat to exclude discussion of Mbeki's New Partnership for Africa's Development from the G8 agenda unless government policy on HIV/AIDS was turned around — was to prove significant in forcing the government to engage publicly with the biomedical paradigm.

Whose denial? The Marxist diversion

ANC intellectual life is also marked by its historical penetration by the SACP, and by the communist education in exile of government ministers. While the ANC is by no means a Marxist organization, it speaks a quasi-Leninist language, and its established members are familiar with the central concepts of Marxist political economy. The quasi-Marxism of the movement both helps the leadership to justify its authoritarian party management as 'democratic centralism', and assists a declining SACP leadership to bolster, self-servingly, its fast-eroding authority. Persisting cod-Marxism provided fertile ground for two kinds of beliefs about HIV/AIDS within the liberation movement: that there is a conspiracy by international capital to profit at the expense of Africans; and that it is the poverty caused by the international economic order that is the primary cause of what the biomedical orthodoxy wants to label 'AIDS deaths'.

Malign international drug companies are widespread in ANC rhetoric. The Youth League asks this question of the high court: 'We wonder why does the court reduces [sic] itself to become an agent to drum profit for multinational pharmaceutical companies whose only interest is to make money out of sick people.'[52] *Castro Hlongwane* details the operations of an 'omnipotent apparatus' designed to advance the hegemonic interests of capital. There are 'many people and institutions across the world that have a vested interest in the propagation of the HIV/AIDS thesis… these include the pharmaceutical companies, which are marketing anti-retroviral drugs that can only be sold, and therefore generate profits, on the basis of the universal acceptance of the assumption that "HIV causes AIDS"'.[53] If

52. African National Congress Youth League, 'Statement on the order to provide Nevirapine', issued by the League on 26 March 2002, available <www.anc.org.za/youth/docs/pr/2002/pr0326.html> (4 May 2004)
53. Mokaba, *Castro Hlongwane*, p. 4.

AIDS is a conspiracy engineered by ruthless pharmaceutical companies to supply ARVs at a profit, the conspiracy may also involve depopulation by means of ARV poisoning, or at least the use of Africans as guinea-pigs. Vested interests such as Western governments, inter-governmental organizations, scientists, academics, the media and non-governmental organizations may all support this conspiracy.[54]

Given the evident injustice of the international economic order, nationalists claim, apologists for the pharmaceutical companies are merely engaged in a different kind of denial. It is poverty, and not HIV, that is *primarily* responsible for deaths attributed to weakened immunity. Poverty, according to Mbeki, is 'the world's biggest killer', and 'the greatest cause of ill health and suffering across the globe, including South Africa, is extreme poverty'.[55] Debt, malnourishment, unclean water, low levels of education, and poor health infrastructure are primarily responsible for vulnerability to malaria, diarrhoeal diseases, tuberculosis, and diseases of immune deficiency. As Tshabalala-Msimang more mildly puts it:

> our challenges are compounded by conditions of poverty and underdevelopment that undermine the overall health status of our population. . . . Hunger still discourages people from completing their six months' treatment for tuberculosis — a disease that remains the biggest killer of people with Aids despite being curable even in the presence of HIV . . . The fact that this government places the challenge of poverty squarely on the Aids agenda is not an indication that we are reluctant to tackle the issues of treatment. Quite the opposite: poverty eradication and medical interventions are mutually reinforcing and we would be selling our people short if we did not attend to both.[56]

Political and economic calculation

The ANC is a broad church and it is no surprise to find that both biomedical/mobilization and nationalist paradigms could be found within it, with neither able to secure complete ascendancy. As the liberation movement began to accommodate aspects of the orthodox biomedical position, so the cautious approach of the government to treatment and prevention was underpinned by calculation of the economic, social and political dangers of scaling up the government's response.

Economists are divided over the potential economic impacts of AIDS. While broadly in agreement about the factors likely to reduce growth — a higher death rate among the economically active, a decrease in the capital and human resources available for production and investment, a fall in the rate of saving, declining disposable incomes, and reduced domestic

54. *Ibid.*
55. Thabo Mbeki, quoted in *ibid.*, p. 107.
56. Tshabalala-Msimang, 'The state'; see also R. Hecht, O. Adeyi and I. Semini, 'Making AIDS part of the global development agenda', *Finance and Development* **39**, 1 (2002), pp. 36-9.

consumption — economists do not agree about the likely magnitudes.[57] There is no consensus over appropriate methodologies, robust data are limited, and policy and behaviour changes can substantially alter the epidemic's trajectory.[58] One influential study applies heroic assumptions about labour surplus and investment planning to predict a mere 5.7 percent overall GDP shortfall by 2015.[59]

Some analysts speculate that HIV/AIDS will reduce tax revenues by undermining the administrative capacity of the national revenue service or by encouraging evasion. Expenditure demands, on the health and social welfare budgets initially, but later across the board, are likely as planners mobilize resources to minimize the spread and impact of the virus. Yet the calculations are everywhere contestable, with some departments possibly landing such 'windfall gains' as a decline in children at school or old people claiming pensions.[60] The dangers of amateur calculation in a context marked by uncertainty can be seen in the case made by presidential spokesman Parks Mankahlana against the use of ARVs to prevent mother-to-child transmission of HIV. ARVs might save a child's life, but the child's 'mother is going to die, and that HIV-negative child will be an orphan. That child must be brought up. Who's going to bring the child up? It's the state, the state. That's resources, you see?'[61]

Scholars increasingly focus on how AIDS will affect the structure and organization of the economy if ARVs are not made more widely available. It kills people in their twenties and thirties, reducing savings and undermining the transmission of human capital across generations. By reducing incentives to invest in education and training, and by lowering school attendance, it may radically undercut the skill and knowledge base of the economy.[62] In such circumstances, extending life spans may bring greater benefits than economists have hitherto supposed. While the government reacted with hostility to such studies, they may have increasingly influenced

57. C. Ford, G. Lewis, and B. Bates, 'The macroeconomic impact of HIV/AIDS in South Africa', in K. Kelly, W. Parker and S. Gelb (eds.), *HIV/AIDS, Economics and Governance in South Africa: Key issues in understanding response: a literature review* (Centre for AIDS Development, Research, and Evaluation, Johannesburg, 2002), pp. 10-20.
58. ING Barings, *Economic Impact of AIDS in South Africa* (ING Barings, Johannesburg, 2000); J. Stover and L. Bollinger, *Economic Impacts of AIDS in South Africa*, (Futures Group International, Connecticut, 1999). Available at <http://www.iaen.org/impact/stovboll.pdf> (4 March 2004); C. Arndt and J. Lewis, 'The macro-economic implications of HIV/AIDS in South Africa: A preliminary assessment', *Journal of South African Economics* **68**, 5 (2000), pp. 856-87.
59. Bureau for Economic Research, *Macro-Economic Impact of HIV/AIDS in South Africa* (Bureau for Economic Research, Stellenbosch, 2001).
60. Ford, et al., 'Macroeconomic impact'.
61. J. Cohen, 'South Africa's new enemy', *Science* **288**, 5474 (2000), pp. 2168-70.
62. C. Bell, S. Devarajan, and H. Gersback, *Long-run Economic Costs of AIDS: Theory and an application to South Africa*, Policy Research Working Paper WPS 3152 (World Bank, Washington, DC, 2003); A. De Waal, 'How will HIV/AIDS transform African governance?', *African Affairs* **102**, 406 (2003), pp. 1-23.

its appraisal of the potential benefits of ARV intervention. Analysis of the climate for investment in South Africa, however, may have had the opposite effect. The past two decades have seen ongoing business uncertainty about the long-term stability of the society.[63] Tribalism, civil war, crime, 'Zanu-fication', and now AIDS, have all shown the potential to create a negative herd mentality among investors, while fixed private-sector investment remains disappointingly low. In this context, it may be prudent for government to treat HIV/AIDS as a series of manageable poverty-related problems in the 'second economy', in order to reduce its impacts upon business confidence. Foreign direct investors and financial markets might otherwise be only too willing to treat AIDS as an overarching threat to policy certainty and political stability.

The calculus of social and political stability

It would be too cynical to attribute the slow move towards ARV treatments from 1998 to 2003, and the announcement of a scaling-up in 2003, to an electoral calculation. However, the ANC's actions have not been irrational in such terms. As Hall has noted in his analysis of the entrenchment of Keynesian economics, 'science has no purchase over politics unless it also speaks to the interest of those who operate in that realm', primarily by providing solutions to prevailing political problems.[64] The ANC's electoral calculation in 1999, when Peter Mokaba was campaign director, would have militated against the ANC adopting as its political priority a crusade against AIDS that the government, given the marginal overall impact of treatment on mortality, would inevitably have been seen as having lost. By 2002, in contrast, public opinion surveys began to reveal that the public was placing HIV/AIDS much higher up its agenda, suggesting that the electoral costs of delay might finally be greater than the costs of action.[65]

Analysts around the world have been speculating about the potentially catastrophic impacts of HIV/AIDS on democratic consolidation, economic growth and social stability.[66] After all, AIDS threatens to attack the state's coercive and security capacity, its ability to collect taxes and deliver public services, and the new middle classes whose commitment to democracy is

63. A. Butler, 'Considerations on the promotion of Foreign Direct Investment in South Africa', unpublished paper, 2001, Department of Political Studies, University of Cape Town, Political and Policy Uncertainty in South Africa Project.
64. Hall, 'Politics of Keynesian ideas', p. 391.
65. Idasa, 'Democratic governance in South Africa: the people's view', *Afrobarometer* 11 December 2002, archived at <www.idasa.org.za> (7 February 2003)
66. United States National Intelligence Council, 'The global infectious disease threat and its implications for the United States.' National Intelligence Estimate 99-17D (NIC, Washington, DC, January, 2000), available on CIA website at http://www.cia.gov/cia/reports/nie/report/nie99-17d.html; Bell et al, *Long Range Economic Costs*; De Waal, 'How will HIV/AIDS transform African governance?'.

so vital to its entrenchment. We can presume that the government has considered the possible implications of the pandemic for political and social stability. While an accelerated ARV programme has struck many analysts as self-evidently rational, the government may have registered potentially explosive negative consequences. Treatments are expensive in part because of the numbers of infected people, and because they turn HIV/AIDS into a chronic disease. The more successfully ARVs reduce deaths, the faster the overall cost of providing treatment escalates. The problem of sustainability is not primarily financial, however, but rather infrastructural.[67] With ARVs now costing little more than US$150 per patient per year, and notwithstanding still considerable costs associated with ancillary testing, the 'affordability' debate about comprehensive treatment has abated. The World Health Organization has launched an initiative to place three million people on antiretroviral treatment by the end of 2005,[68] with even Swaziland and Malawi proposing immediate seven-fold and twenty-fold increases in ARV treatment respectively. Pretoria in 2003 planned a fifty-fold increase in two years — from less than 3,500 people on ARVs in the public sector in 2003 to 190,000 by April 2005 — and a further scaling-up to 1,400,000 people by April 2009.[69] As Kober and Van Damme note, however, these national treatment plans are to be realized in countries where policy-makers see the lack of health workers, and not financial resources, as 'the single biggest constraint'.[70]

The cabinet has acknowledged the need to recruit and train health professionals on a large scale, and to increase the availability of necessary non-health resources such as clean water. Unprecedented clinical, social, psycho-social and nutritional expertise, however, must be created at a time of declining human resources and growing HIV prevalence among health workers. The tuberculosis control programme is failing, as are the simplest public health measures like childhood immunizations in poor provinces. According to one blunt 2001 assessment, 'widespread use of anti-retroviral therapy for AIDS-sick persons does not offer a realistic solution'.[71] In such conditions, the public promise to scale up from a few thousand to more than a million ARV recipients poses an evident political hazard. *De facto* rationing of treatment will be inequitable, and will bring political risks that the government must be concerned to minimize. A discriminatory and rationed antiretroviral programme might arouse public discontent and

67. Tshabalala-Msimang, 'The state'.
68. K. Kober and W. Van Damme, 'Scaling up access to antiretroviral treatment in southern Africa: who will do the job?', *The Lancet* **364**, 9428 (2004), pp. 6-8; World Health Organization, *Treating 3 Million By 2005: The WHO strategy* (WHO, Geneva, 2003).
69. Kober and Van Damme, 'Scaling up'.
70. *Ibid.*
71. Abt Associates, *Impending Catastrophe Revisited: An update on the HIV/AIDS epidemic in South Africa*, a report commissioned by Henry J. Kaiser Family Foundation and Lovelife (Lovelife, Parklands, 2001).

generate further 'new social movement' protest, currently confined to the water, electricity, land reform, and housing sectors. Substantial population movement to the cities, moreover, might follow failure to deliver on the ARV promise in rural areas, overwhelming urban health facilities and overloading other public service providers.

The careful calculation of such potential consequences is quite consistent with the government's words and actions. The cabinet carefully but evasively noted that 'those who are infected but have not as yet progressed to an advanced stage of AIDS [can] lead a normal life through proper nutrition, healthy lifestyles and treatment of opportunistic infections . . . not everyone who is infected with HIV would need antiretroviral treatment.'[72] The government has forged new political alliances with traditional leaders, presumably in part with the intention of reinforcing social institutions in the areas hardest hit by the epidemic. It has legislated a new role for the traditional healers who will provide rural palliative care, and has prioritized nutrition programmes and social grants that create incentives to die in rural areas. Its failure to address stigmatization can also be explained in this way, as an attempt to control open defiance and the search for treatment in urban areas.

Stigmatization is closely related to personal responsibility. A 2004 opinion survey in 15 high-prevalence countries found that poor people 'demote AIDS to a low priority problem behind more immediately pressing concerns like jobs or hunger' and remain 'undecided about whether their governments should divert scarce resources…' to fight AIDS.[73] Yet in other African countries the government has never provided much health care, whereas South Africa's more extensive social welfare system may create greater expectations of assistance and obligation upon government.[74] Ministers have been keen to attribute responsibility to other social actors, including business and the voluntary sector, dubbing the national strategic plan a 'living document' produced by and for the society as a whole, 'so that all our initiatives as a country… can be harmonised to maximise efficiency and effectiveness'.[75] *Castro Hlongwane*, however, goes further in rejecting 'as fundamentally incorrect and anti-democratic the attempts to transfer the responsibility to look after oneself to the state… Each one of

72. Government Communication and Information Service, 'Special cabinet meeting statement: enhanced programme against HIV and AIDS', 8 August 2003, Pretoria. Available <www.gcis.gov.za/media/cabinet/030808.htm> (8 September 2004).
73. Afrobarometer, 'Public opinion and HIV/AIDS: facing up to the future?', Afrobarometer Briefing Paper No. 12, April 2004. Available <http://www.idasa.org.za/gbOutputFiles.asp?WriteContent = Y&RID = 457> (10 September 2004).
74. Whiteside and Sunter, *AIDS*, p. 67.
75. National Department of Health, *HIV/AIDS/STD Strategic Plan for South Africa, 2000-2005* (Department of Health, Pretoria, 2000), section 1.1. This document, produced under the auspices of the department, has no attributed authors and is not acknowledged by the department as an official document.

our citizens has a responsibility to take all necessary measures to protect his or her health.'[76] This transfer of responsibility for AIDS from the state to those suffering from it may promote shame, thus helping to limit open conflict with the state, protest against the injustice of selective treatment, and refusal to pay for public services.

Conclusion

South African HIV/AIDS policy can be explained without appeals to leadership irrationality or wider cultural denialism. Purportedly denialist statements often exhibit exceptional semantic precision, for example contesting the view that 'immune deficiency is acquired *solely* from the HI virus' while accepting 'that HIV may be *one* of the causes of this immune deficiency'.[77] Policy changes over the decade, and shifts in the political coalitions supporting and contesting them, demonstrate that we do not face a fundamental epistemological divide between the proponents of two incommensurable paradigms.

Any complex policy cannot be just the creation of leaders, but must be understood in the context of the institutions and intellectual discourses that allow it political and administrative viability. South Africa's public and political institutions predisposed many policy-makers to support an ameliorative/nationalist paradigm and to reject a mobilizing/biomedical alternative. The intellectual discourses of the liberation movement created an inhospitable environment for a biomedical science that lacked an appealing social epidemiology of the virus. A history of apartheid division, exile, and racist science predisposed numerous powerful and rational decision-makers to doubt the benevolence and coherence of the biomedical/mobilization paradigm. Political and economic calculation, in the face of the government's cruel inability to muster human resources for a universal ARV programme, may have further predisposed the government towards delay and obfuscation, and encouraged it to disperse responsibility for the epidemic across society as a whole.

It is beyond the scope of this article to evaluate the performance of the government. While we have been able to explain government HIV/AIDS policy, we are not able to excuse or to celebrate it. It is notable, however, that the ANC was unable to mobilize the knowledge resources of the movement, and of the wider society, in pursuit of its complex social and political goals. The ANC's dialectical conception of knowledge-creation left it unable to respect the epistemic specialization that is intrinsic to biomedical science. The quasi-Marxism propagated by the leadership and

76. Mokaba, *Castro Hlongwane*, p. 8.
77. *Ibid*, quotes respectively on pp. 107, 106, my emphasis.

self-serving intellectuals was a genuine impediment to practical judgement. The centre was unable to engage creatively with knowledge creators, health professionals and the voluntary sector, through either state or liberation movement mechanisms, and it was insufficiently obliged to contest and defend the ameliorative paradigm it embraced.

Representative constitutional democracy can be understood as a fallible but historically informed attempt to reduce the vulnerability of human populations to the dangers of concentrated authority. More complete engagement of the liberation movement with judicial and legislative bodies, with vehicles for participation and contestation, and with knowledge-creating institutions in the wider society, would militate against the inadvertent destruction that concentrated power can sometimes bring. In its HIV/AIDS policy, the movement at times came close to withdrawing into its own centre, talking to itself in insular tongues about a reality, in part biomedical, over which it had very limited intellectual control.

Bibliography of books and articles

References to other sources, including interviews, archives, newspaper articles, websites and grey publications, are contained in relevant footnotes.

Afrobarometer, *Public Opinion and HIV/AIDS: facing up to the future?* Afrobarometer Briefing Paper No. 12 (April 2004). <http://www.idasa.org.za/gbOutputFiles.asp?WriteContent=Y&RID=457> (10 September 2004).

Arndt, C. and J. Lewis, 'The macro-economic implications of HIV/AIDS in South Africa: a preliminary assessment', *Journal of South African Economics* **68**, 5 (2000), pp. 856-87.

Butler, A.M., 'Unpopular leaders: the British case', *Political Studies* **43**, 1 (1995), pp.48-65.

Butler, A.M., 'South Africa's political futures', *Government and Opposition* **38**, 1 (2003), pp. 93-112.

Butler, A.M., *Contemporary South Africa* (Palgrave Macmillan, New York and Basingstoke, 2004).

Butler, A.M., 'The negative and positive impacts of HIV/AIDS on democracy in South Africa', *Journal of Contemporary African Studies* **23**, 1 (2005), pp. 3-25.

Campbell, C., *Letting Them Die: How HIV/AIDS programmes often fail* (Double Storey, Cape Town, 2003).

Chimere-Dan, O., 'Population policy in South Africa', *Studies in Family Planning* 24, 1 (1993), pp. 31-9.

Cohen, J., 'South Africa's new enemy', *Science* **288**, 5474 (2000), pp. 2168-70.

Cohen, S., *States of Denial: Knowing about atrocities and suffering* (Polity Press, Cambridge, 2001).

Crewe, M., 'How do we make sense of Mbeki?', *AIDS Analysis Africa* **11**, 1 (2000), pp.10-11.

De Waal, A., 'How will HIV/AIDS transform African governance?', *African Affairs* **102**, 406 (2003), pp. 1-23.

Dunn, J., 'Practising history and social science on "realist" assumptions', in C. Hookway and P. Pettit (eds), *Action and Interpretation: Studies in the*

philosophy of the social sciences (Cambridge University Press, Cambridge, 1978), pp.145-75.
Fassin D., and H. Schneider, 'The politics of AIDS in South Africa: beyond the controversies', *British Medical Journal* **326**, (2003), pp. 495-8.
Gold, R.S., 'AIDS education for gay men: towards a more cognitive approach', *AIDS Care* **12**, 3 (2000), pp. 267-72.
Hall, P.A., 'The politics of Keynesian ideas', in P.A. Hall (ed), *The Political Power of Economic Ideas: Keynesianism across nations* (Princeton University Press, Princeton NJ, 1989), pp. 361-91.
Hecht, R., O. Adeyi and I. Semini, 'Making AIDS part of the global development agenda', *Finance and Development* **39**, 1 (2002), pp. 36-9.
Kober, K. and W. Van Damme, 'Scaling up access to antiretroviral treatment in southern Africa: who will do the job?', *The Lancet* **364**, 9428 (2004), pp. 6-8.
Lodge, T., 'The ANC and the development of party politics in modern South Africa', *Journal of Modern African Studies* **42**, 2 (2004), pp. 189-219.
Lowy E., and M. Ross, ' "It'll never happen to me": gay men's beliefs, perception and folk constructions of sexual risk', *AIDS Education and Prevention* **6**, 6 (1994), pp. 467-82.
Makgoba, M., 'HIV/AIDS: the perils of pseudoscience', *Science* **288** (2000), p. 1171.
McClelland, J.S., *A History of Western Political Thought* (Routledge, London, 1995).
Melber, H. (ed.), *Limits to Liberation in Southern Africa* (Human Sciences Research Council, Cape Town, 2003).
Nattrass, N., *The Moral Economy of AIDS in South Africa* (Cambridge University Press, Cambridge, 2004).
Padarath, A., C. Chamberlain, D. McCoy, A. Ntuli, M. Rowson and R. Loewenson, *Health Personnel in Southern Africa: Confronting maldistribution and brain drain*. Equinet Discussion Paper Series, 3 (Health Systems Trust, Durban, 2003).
Parkhurst J. and L. Lush, 'The political environment of HIV: Lessons from a comparison of Uganda and South Africa', *Social Science and Medicine* **59** (2004), pp. 1913-24.
Republic of South Africa (RSA), *Constitution of the Republic of South Africa*, Act 108 of 1996 (Government Printer, Pretoria, 1996).
Schneider, H., 'On the fault-line: the politics of AIDS policy in contemporary South Africa', *African Studies* **61** (2002), pp. 45-67.
Sheon N., and M. Crosby, 'Ambivalent tales of HIV disclosure in San Francisco', *Social Science and Medicine* **58**, 11 (2004), pp. 2105-18.
Sidley, P., 'Clouding the AIDS issue', *British Medical Journal.* **320**, 7240 (2000), p. 1016
Southall, R., 'Post-colonial legitimacy in Lesotho', in Melber (ed.), *Limits to Liberation*, pp.115-33.
Suttner, R., 'Culture(s) of the African National Congress of South Africa: Imprint of exile experiences', in Melber (ed.), *Limits to Liberation*, pp. 178-99.
Swanson, M., 'The sanitation syndrome: bubonic plague and urban native policy in the Cape Colony: 1900-1909', *Journal of African History* **18**, 3 (1977), pp. 387-410.
Vickers, B., *In Defence of Rhetoric* (Clarendon Press, Oxford, 1988).
Whiteside A. and C. Sunter, *AIDS: The challenge for South Africa* (Tafelberg and Rousseau, Cape Town, 2000).
Wolitski, R.J., R. Valdiserri, P. Denning and W. Levine, 'Are we heading for a resurgence of the HIV epidemic among men who have sex with men?', *American Journal of Public Health* **91**, 6 (2001), pp. 883-8.