THE HISTORICAL CONTEXT OF HIV/AIDS IN SOUTH AFRICA

HIV/AIDS in South Africa

Having examined the nature of HIV/AIDS and some of its potential impacts at the individual, familial and national levels, I will now provide a brief history of HIV/AIDS in South Africa. This section is not intended to serve as a complete account of South Africa’s HIV/AIDS epidemic. Rather, my aim is to highlight and concisely discuss HIV/AIDS’ emergence in South Africa and characteristics of the state response to this virus between 1986 and 2000. It is not within the scope of this inquiry to investigate factors fuelling the alarming spread of HIV/AIDS in South Africa. As such, I will ignore this issue for the remainder of this report. Nevertheless, Pelser (2002), Schneider (2001, 2002), Schneider and Fassin (2002), Whiteside and Sunter (2000) and Schneider and Stein (2001) provide a comprehensive and detailed account of the social, historical, political, and economic sources of South Africa’s HIV/AIDS epidemic.

An unrelenting tide, HIV/AIDS spread so rapidly that national prevalence in 2000 was 24.5 percent (Ibid., 2001). With approximately 5 000 000 infected individuals, over 50 percent of whom are younger than 25 years old (Pelser, 2002), South Africa possesses the world’s largest absolute number of infected adults and an eighth of the world’s HIV/AIDS affected persons (Ibid., 2002). Utilising current national rates of incidence and in the absence of a focussed and effective policy response, models of the HIV/AIDS epidemic suggest that South Africa will possess 1 000 000 annual HIV/AIDS related deaths and a 50 percent prevalence in the labour force by 2008 (Ibid., 2002). Significantly, the predicted 60 percent increase in HIV/AIDS infections between 2000 and 2008 is attributable to young women in the 15-25 age cohort and young men in the 25-35 age cohort (Ibid., 2002). Collectively, these groups represent a large portion of the South African population that traditionally occupy the most economically and socially productive roles in society.
Given these assertions of the extent of national HIV/AIDS prevalence and its potential for growth, the following contextual historical analysis examines the national government’s response to HIV/AIDS over the period 1986-2000 in terms of the conceptual framework outlined earlier. As such, this section highlights the persistence of implementation deficits in hampering policy implementation and the numerous sources of these deficits. Further, and in light of the figures presented above, this section demonstrates how an accumulation of implementation deficits created the conditions for HIV/AIDS to thrive. Accordingly, the following is an essential step to highlighting the relevance of this study to the national public sector response to HIV/AIDS. Finally, analysis of the National AIDS Plan in terms of the conceptual framework utilised in this report, offers new perspectives on the national government’s failure to implement public HIV/AIDS policy between 1994 and 2000.

Clinically defined in 1983, HIV/AIDS gained prominence in the international scientific community as a disease of homosexual men. Accordingly, the earliest data on HIV/AIDS (that is, data for the period 1983-1986) in South Africa focuses almost entirely upon homosexual men. In fact, it was only in 1990 that antenatal clinic attendees were tested for HIV/AIDS in South Africa. Thus, 1990 is the first year for which substantial and credible population level data on heterosexually transmitted HIV/AIDS exists in South Africa. Although pre 1990 data on heterosexually contracted HIV/AIDS is available, it is non-specific given that heterosexual, paediatric and haemophiliac HIV/AIDS were reported collectively until this time. As the primary agency tracking HIV/AIDS in South Africa during the early 1980s, the bias evident in state data is indicative of the apartheid state’s stance on HIV/AIDS. Building on the premature and preliminary notions of the international scientific community to justify its stance, the apartheid state targeted homosexual men as the purveyors of this deadly and at the time still mysterious disease (Phillips, 2002).

Ignoring evidence that the nature of HIV/AIDS (especially with regards to its dominant mode of transmission) in Africa was fundamentally different to that in North America and Western Europe, the apartheid state initially constructed HIV/AIDS as a disease of
promiscuous and devious homosexual men. Ignoring credible evidence that HIV/AIDS in Africa was overwhelmingly heterosexually transmitted (in contrast to North America and Western Europe where the virus was confined to homosexual sexual networks) the apartheid state dismissed HIV/AIDS as a disease acquired by homosexual men due to their deviant, hedonistic and carnal behaviour. In this way, the apartheid state permitted itself to ignore the virus thus facilitating its entry into the wider heterosexual population.

Adopting this approach and ignoring credible evidence to the contrary (especially with regards to the presence of generalised\textsuperscript{13} and mature heterosexual epidemics elsewhere in Africa during the mid 1980s), the apartheid state condemned HIV/AIDS as a disease of homosexuals. In this way, due to their perceived sexual depravity and their strong association with this relatively new, sinister and lethal disease of suffering and death, the stigma of homosexuality intensified and homosexuals doubly shunned and ostracised. Adopting a denialist attitude that condemned HIV/AIDS sufferers for their perceived deviance, the apartheid state abandoned the infected to their suffering. Taking this unproductive attitude towards HIV/AIDS, the apartheid state ignored fundamental issues surrounding this disease. As such, and again ignoring the experience of other African countries, the apartheid state ignored the nature of the virus and made no attempt to predict its future course or impact on the South African population. Responding in this manner the apartheid state contributed to the stigma of HIV/AIDS and facilitated its entry into the general heterosexual population.

I do not wish to single out homosexuals as the earliest source of HIV/AIDS in South Africa. Rather, and as evidenced by available data and research, I wish to reaffirm that HIV/AIDS first gained attention in South Africa as a disease of homosexual men. Complemented by the apartheid state’s apathy to the health and welfare of non-white populations, this early emphasis on homosexuality and HIV/AIDS allowed the (apartheid) state to appropriate HIV/AIDS to homosexual men with the ability to travel overseas and/or in sexual contact with those that did. This early association between HIV/AIDS and homosexuality ensured that early responses to the HI virus and AIDS were

\textsuperscript{13} That is, a rate of prevalence greater than or equal to 5 percent of the total population.
overwhelmingly restricted to and directed against homosexual men, thus enabling the virus to stealthily enter and inhabit the majority heterosexual population. To reiterate, due to the association between HIV/AIDS and homosexuality in the infancy of what is now an unprecedented pandemic, the apartheid state’s phobia of homosexuals and a general apathy to the health and welfare of non-whites, HIV/AIDS was immediately dismissed as a disease of hedonistic homosexuals by the apartheid state. As such, the apartheid state neither paid attention to the nature of the virus, nor its potential to spread amongst the majority black heterosexual population during its infancy in South Africa.

The rapid spread of HIV/AIDS from less than 50 confirmed cases in 1985 to a national prevalence of 1.7 percent in 1992\(^{14}\) points to a significantly more complicated epidemiology than that advocated by the apartheid state in the period 1983 to 1990. The sheer number of new infections during this time indicates that it is unlikely that (predominantly white) homosexual men were the sole purveyors of HIV/AIDS in South Africa in the early to mid 1980s. Although only clinically defined in the West in 1982, eastern and central African countries already possessed relatively mature and generalised HIV/AIDS epidemics by the mid to late 1980s. The example of Uganda, which possessed a national prevalence of approximately 7.1 percent in 1985 (the first year in which HIV/AIDS data is available for Uganda), is a testament to this assertion. Previously known to Ugandans as ‘Slim’, the disease now defined as HIV/AIDS was already established in the Ugandan population as a predominantly heterosexually transmitted STI before its emergence as a disease of homosexuals in the West (Kamanzi, 2005)

Given these assertions, it is thus most likely that HIV/AIDS entered South Africa simultaneously through homosexual and heterosexual populations (Wilkinson and Abdool-Karim, 1997 in Schneider and Stein, 2001). The apartheid state’s initial dogmatic, ignorant and impractical response to HIV/AIDS thus facilitated the virus’ sustained spread through the majority heterosexual population. Unnoticed and unchallenged,

\(^{14}\) This figure is based on the number of HIV/AIDS infected individuals at antenatal clinics in South Africa in 1992. Although there is some controversy regarding the accuracy of these data, they have been demonstrated to serve as an accurate and precise proxy for the national rate of prevalence (Whiteside and Sunter, 2000 in Pelser, 2002)
HIV/AIDS was thus allowed to grow in silence within the heterosexual population during the mid to late 1980s.

To reiterate, the apartheid state’s apathy towards homosexuals and ‘their’ disease ensured that there were no serious or comprehensive (that is, targeting the heterosexual population) public efforts to contain the disease during its infancy in South Africa. Rather, the apartheid state chose to respond by stipulating that all homosexuals be tested for HIV/AIDS, further ostracising and condemning homosexual communities, and amplifying the stigma and fear surrounding this disease. Insufficient to contain the spread of the virus, the apartheid state’s initial response to HIV/AIDS allowed the virus to rapidly establish itself within the heterosexual population. Introduced into a high risk environment complimented by the high risk behaviour of the general population, HIV/AIDS crossed numerous social boundaries that initially restricted the virus to migrant worker and homosexual sexual networks. In this way HIV/AIDS was permitted unchallenged and unmonitored access to the general heterosexual population.

Witness to the disastrous impact of HIV/AIDS throughout Africa, and further motivated by the high rates of infection amongst its members (especially those within Umkhonto we Sizwe – the ANC’s military wing), the ANC took a proactive approach to HIV/AIDS. Beginning with the 1990 Maputo Declaration on HIV/AIDS in Southern Africa and in partnership with various non-state organisations and the internal anti-apartheid movement, the ANC acknowledged and began to address the issue of HIV/AIDS. Recognising the urgency of prevention in order to forestall those consequences of widespread epidemics observed and experienced elsewhere in Africa, the newly unbanned ANC met with the apartheid era national Department of Health in 1991 in order to formulate the framework for a prevention oriented, human rights based response to HIV/AIDS in South Africa (Schneider and Stein, 2001). Cooperation between these two parties led to the formulation of the National AIDS Committee of South Africa (NACOSA) in 1992, an unusual show of solidarity and concern given the: (i) apartheid state’s historical apathy and disregard toward HIV/AIDS and the country’s majority black population and (ii) the
sensitive and precarious state of negotiations for a transition to democracy at the time (Ibid., 2002).

The National AIDS Plan

Mandated with the task of producing a broad based (that is, addressing all sectors of society) and inclusive (that is, incorporating a wide range of actors in policy making and implementation) framework to guide the public response to HIV/AIDS, the National AIDS Committee of South Africa quickly produced the National AIDS Plan (NAP). The NAP is significant in two regards. In the first instance, it was created with the input of a wide range of actors including members of the activist and research community, CBOs, FBOs, the ANC and the apartheid state. In addition, the National AIDS Plan was formulated with the experience gained from eastern and central African countries in the 1980s. Formed from a highly consultative process and drawing from a wide range of expertise, the National AIDS Plan was a specific plan that covered all aspects of HIV/AIDS including prevention, treatment and care, monitoring and research. Further, and due to the involvement of the variety of bodies that were part of NACOSA the NAP was widely regarded as a far reaching, imaginative, coherent and potentially effective response to HIV/AIDS that although based on international guidelines was the most progressive plan of its kind in the world.

Based in numerous of features of the National AIDS Plan, the high regard for its potential and foresight is most evident in its rights based approach to HIV/AIDS and incorporation of persons living with HIV/AIDS in policy development and implementation (Ibid., 2002). Essentially, the NAP’s emphasis on ‘cooperation and inclusion’ as opposed to ‘containment and control’ in conjunction with its crafty synthesis of political forces and technical proficiency characterised it as a radical departure from accepted international norms and guidelines on appropriate and optimal responses to HIV/AIDS.

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15 Since its success necessarily depended upon its full implementation.
The second striking feature of the National AIDS Plan is that it was the first wide spread and far reaching response to HIV/AIDS developed for the public sector in South Africa. This is especially significant given that the NAP was only adopted in 1994, almost a decade after HIV/AIDS first gained attention in South Africa and during which time it was afforded carte blanche to spread its tentacles of misery, fear, death and destruction. Building on the political optimism of the time, the formulation of such an inspiring plan as the National AIDS Plan fostered hope that a new and legitimate government led by the ANC was in the position to lead a comprehensive and high profile reply to HIV/AIDS. This response was viewed with the potential to finally come to grips with HIV/AIDS and mitigate its impact upon the social, economic and political development of a new South Africa (Ibid., 2002). The potential magnitude and impact of the epidemic and the seriousness with which it was understood by senior politicians is succinctly reflected in the words of the late Chris Hani who in 1991 commented that HIV/AIDS cannot be allowed to ruin us from realising the noble tasks of empowering the people of South Africa and enabling us to reconstruct our country (Marais 2000 in Schneider, 2001).

Immediately upon assuming power in 1994, the new ANC led state adopted the National AIDS Plan as the basis for South Africa’s first comprehensive public sector response to HIV/AIDS. Taking their cue from their rigorous involvement in NACOSA and the formulation of the NAP the strong, technically proficient and widely experienced body of NGOs, anti-apartheid political groupings, academics and health professionals dealing with HIV/AIDS all expected to work cooperatively with the government in order to rapidly implement South Africa’s new AIDS plan (Schneider and Stein, 2001). Such expectations were factored into the National AIDS Plan, which recommended that national government take a leadership and managerial role in implementation and that provinces work cooperatively with the network of established non-state actors in order to realise speedy implementation of the bulk of this broad-based response to HIV/AIDS. Accordingly, the NAP recommended that the presidency lead and administer a multisectoral coordinating body with direct authority over those actors involved in its implementation. This body was to be assisted by a similar multisectoral coordinating structure contained within the office of the Premier at provincial level.
Unfortunately, and to the dismay of all those nonstate actors involved in its formulation, those recommendations within the National AIDS Plan concerning the formulation of a multisectoral oversight authority and the inclusion of nonstate actors in implementation were spurned by the state. Thus, and in direct opposition to general expectation, the first public sector response to HIV/AIDS in South Africa was placed under the ambit of the DOH (Schneider, 2002). Accordingly, and although declared a Presidential Lead Project in 1994 (thereby gaining early access to the resources necessary for comprehensive implementation), the state’s decision to delegate the NAP as the sole responsibility of the Department of Health created numerous complimentary obstacles to implementation. This approach created significant barriers to implementation and ultimately barred comprehensive implementation of the National AIDS Plan.

Beginning with the Sarafina II debacle in 1995, problems of exclusion were exacerbated by an emerging environment of conflict and contention between state and non-state (especially HIV/AIDS related NGOs, academic, research and activist organisations) actors. An HIV/AIDS themed musical, the national department of health commissioned Sarafina II using funds donated by the European Union (Schneider and Stein, 2001). Once the existence of the project became public knowledge (a full 6 months after the musical was commissioned for R14 million), considerable opposition arose from a variety of stakeholders including the government’s own AIDS Advisory Committee and provincial AIDS programmes who had not been consulted in the decision making process. Taken up with vigour by the media and opposition parliamentarians an investigation was launched and the contract ultimately cancelled (Ibid., 2001).

In combination with the controversy surrounding Sarafina II the state’s support of the ‘miracle’ HIV/AIDS cure Virodene, further corroded relations within the state and between state and non-state actors. The outfall of these two events resulted in irreparable damage to the state’s HIV/AIDS programme, and its relationship with non-state actors involved in HIV/AIDS prevention, treatment, care and support. To be sure, the Virodene scandal was so serious that it led to the state influenced removal of the director of
Medicines Control Council and the premature departure of the first national AIDS programme director. In essence, the conflictual relationship between state and non-state actors, tension between political leaders and the bureaucracy, and other emerging and pressing issues of the time (for instance, restructuring of the health care sector) allowed attention to be diverted the urgent issue of implementation of the National AIDS Plan (Ibid., 2001).

The ANC led state’s first failure in realising implementation of the National AIDS Plan was the appointment of a National AIDS Programme Director under the ambit of the DOH and not within the intersectoral capacity suggested by NACOSA and recommended in the National AIDS Plan. Placing the NAP under the ambit of the Department of Health, the national government created a precedent for the provinces. Newly formed, unsure of their jurisdiction within the new South Africa¹⁶ and uncertain about their own capacity and abilities, provincial governments followed the example of the national government by placing responsibility for the implementation of the NAP within their respective departments of health. Adopting this approach, both the national (whose AIDS Programme Director held a managerial and leadership role) and provincial (whose AIDS Programme Directors held a more active role in and thus greater responsibility for implementation) governments committed the grave error of placing responsibility for such a mammoth plan as the NAP within a single group of state institutions. Mimicking the national approach, provincial governments eliminated the possibility of a multisectoral response to HIV/AIDS under the ownership of a multisectoral body at all levels (that is, national and provincial). As such, the broad basis of the National AIDS Plan was diluted such that those innovations which facilitated inclusion, cooperation and diversity were lost to a narrower, biomedically premised view of HIV/AIDS.

At the risk of redundancy I would like to reiterate the above assertion. Failing to create a multisectoral body with direct authority over the numerous and diverse actors tasked with the implementation of the National AIDS Plan, the national government diluted the scope of this bold plan. Assigning responsibility for implementation to the Department of

¹⁶ This is especially so in the period 1994-1996 during which a provisional constitution was in effect.
Health (a move copied by the provinces) the national government created obstacles to implementation of those aspects of the NAP that fell outside of the realm of health (for instance, prevention through awareness and education campaigns in schools). In this way, failure to create the recommended multisectoral oversight authority confused: (i) the roles and responsibility of, and (ii) lines of accountability between those state departments\textsuperscript{17} (at the national and provincial levels) at the forefront of implementation.

Despite the fact that the National AIDS Plan was formulated through a highly consultative process involving numerous sectors of society, its implementation (against the recommendations of the NAP) was devolved to a single group of state institutions. These institutions were ill equipped to manage and drive implementation of a plan as broad and comprehensive as the National AIDS Plan. Intersectoral cooperation was a feat achieved only in thought and those aspects of the NAP falling outside of the scope of the provincial departments of health failed to be implemented in a coherent, complimentary and sustained manner. Further, and given innumerable other challenges faced by the Department of Health and provincial departments of health alike (most especially, the racially and geographically skewed distribution of public health resources within provinces), the issue of HIV/AIDS lost its ‘special’ status at the bureaucratic level. Thus, the eminent position of HIV/AIDS on the political agenda was not matched within the bureaucracy - that body responsible for implementation of the NAP.

Errors in judgement over the location of the National AIDS Plan within the state were complimented by a number of political and other factors at the provincial level. In the first instance, provincial lethargy in appointing Provincial AIDS Programme Directors resulted in a significant period of stagnation in the process of implementing the NAP. In fact, and despite the fact that national government moved swiftly to ensure that its managerial obligations within the NAP and role as a leader were fulfilled (by appointing a National AIDS Programme Director in 1994 and declaring the NAP a Presidential Lead Project in the same year), provincial governments failed to appoint Provincial AIDS Programme Directors until 1996. In essence, this lack of initiative created a serious

\textsuperscript{17} Namely Health, Education and Social Development.
human resource deficit that stalled implementation of the NAP even though funding for this plan was available and waiting to be utilised. This lack of urgency is particularly significant given that implementation of the National AIDS Plan was to be most actively pursued at the provincial level. Ultimately, the lack of an agency driving implementation in each province and to whom members of the task network were accountable allowed for implementation to proceed in a piece meal and incoherent manner between 1994 and 1996.

The appointment of Provincial AIDS Programme Directors in 1996 raised hopes for progress in the implementation of the National AIDS Plan. Unfortunately, and once again to the substantial detriment of all South Africans, the post 1996 period saw no significant progress in this regard. Building on the errors of previous years, provincial governments contributed to the confusion, lack of accountability for and narrowing of the scope of implementation of the NAP through their choice of individuals to fill the role of Provincial AIDS Programme Directors. In the main, these individuals were drawn from the apartheid era civil service, making it very difficult for them to command the authority and allegiance necessary to realise full scale implementation of the National AIDS Plan in their provinces. This argument is extended by individuals who argue that those civil servants retained from the apartheid era civil service by dint of the Sunset Clauses agreed to in pre 1994 negotiations, lacked the motivation and interest to fulfil their new responsibilities and facilitate implementation of the NAP (Schneider, 2001). As such, they regard the inherited administration as an expensive, inefficient and authoritarian body with an aptitude for corruption over service delivery (Human and Strachan, 1996 in Schneider and Stein, 2001).

Although this is an contentious argument that is difficult to prove or disprove, it is certainly likely that Provincial AIDS Programme Directors operated in a tense environment characterised by a dearth of trust and lack of cooperation. Placed within the ambit of provincial departments of health, tension between provincial AIDS Programme Directors, their colleagues in the provincial departments of health and colleagues in other provincial departments (most especially Education and Social Development) certainly
contributed to the lack of progress in implementation of the National AIDS Plan. In addition, this tension and lack of cooperation was compounded by conflict between those members of the task network outside of the provincial departments of health, and who were not directly accountable to these departments over ownership of the NAP and the roles and responsibilities of the range of departments and individuals tasked with its implementation. To clarify, the environment surrounding provincial AIDS coordinators and the confused and hotly contested lines of accountability (resulting from contestation over the ownership of the National AIDS Plan and the rightful jurisdiction of each provincial department) within the task network were significant factors undermining implementation of the NAP in the post 1996 period.

At the structural level this problem was compounded by the fact that provincial AIDS coordinators in the majority of provinces were placed in mid to low level managerial positions. As such, even when these individuals adopted the goals of the newly elected multiparty and multiracial state, they often lacked the institutional resources to initiate and sustain wide scale implementation. Further, and by dint of their low level status, these individuals lacked the power to hold institutions within the task network accountable for a lack of progress in meeting their assigned objectives. Missing the necessary level of power and influence, provincial AIDS coordinators lacked the authority for quick and wide scale implementation of the National AIDS Plan. Interestingly, the low institutional status of provincial AIDS coordinators is another example of the deprioritisation of HIV/AIDS within the bureaucracy(ies) tasked with combating its spread and mitigating its impact through the implementation of the NAP. Finally, it must be noted that the decision to draw provincial AIDS coordinators from the ranks of the apartheid era civil service and not the established and vastly experienced network of HIV/AIDS activists and researchers played a vital role in further derailing implementation of the NAP. Lacking the connections with nonstate HIV/AIDS actors that would enable them to draw on their vast expertise and tackle obstacles to implementation, provincial AIDS coordinators were completely ill equipped to realise any meaningful implementation of the NAP.
Organisational and structural problems in the implementation of the National AIDS Plan were exacerbated by the rapid redistribution of health care finances at the provincial level. Driven by a strong willed minister, the Department of Health oversaw a 30 percent redistribution of financial health care resources between provinces in 1995 alone. In conjunction with the emphasis on health care restructuring in the 1994-1997 period, the system of fiscal federalism introduced in 1997 further deprioritised the issue of HIV/AIDS at the provincial level. With provinces now receiving non-specific ‘global’ budgets, provincial departments in each province had to compete with each other for a share of their province’s respective allowances from the national treasury. Consequently, and although some funds for HIV/AIDS programmes were obtained through alternative sources, departments at the provincial level tended to receive only those funds proportional to their lobbying ability and not those reflecting their need. This problem was compounded by the fact that alternate intergovernmental transfers (that is, from the national to provincial level) were difficult to obtain in the environment created by fiscal federalism (Schneider, 2001).

In combination with fiscal federalism, the effect of redistribution of health care financial resources saw real per capita spending on health fall in the Western Cape, Gauteng\textsuperscript{18}, Mpumalanga and Eastern Cape in the period 1996-1999 (Ibid., 2001). So we see, although they were assigned responsibility for the full implementation of the National AIDS Plan, many provincial departments of health found themselves lacking the resources to implement a multiplicity of HIV/AIDS interventions, and simultaneously cope with the pressures of health sector restructuring. For those provinces wishing to cede responsibility for the issue of HIV/AIDS back to the national level, fiscal federalism provided the opportunity to further ignore the National AIDS Plan and HIV/AIDS. This is so, even though a significant proportion of funds for HIV/AIDS programmes are granted on condition of the exclusivity of their use. Financial constraints hampering implementation of the NAP were further augmented by the emphasis on devolving

\textsuperscript{18} For Gauteng, per capita health spending rose between 1996 and 1997 but fell between 1997 and 1999 (Schneider, 2001).
(decentralising) primary state functions\(^{19}\) to the provincial, local and district levels. In the main, decentralisation of state functions made it: (i) difficult to assign practical and achievable roles to institutions within the National AIDS Plan implementation network, (ii) create realistic responsibilities for each institution in the task network, and (iii) hold these institutions accountable in practice (Schneider and Stein, 2001).

In addition to these problems, Schneider and Stein (2001) and Key Informant B (KI B, 2005) reveal how the persistent inability of national and provincial governments to spend all the funds allocated to them in each financial year further hampered implementation of the National AIDS Plan in the post 1996 period. The sources of persistent underspending are complex and varied and according to Whelan (2001 in Schneider, 2001) and Penn-Kekana et al (2001 in Schneider, 2001) include uncoordinated planning within and across spheres of government, weak financial information systems, a severe lack of managerial skills within provincial governments and a culture of fiscal restraint introduced with fiscal federalism and reinforced by the adoption of the neoliberal Growth, Employment and Redistribution strategy at the national level. To reiterate, health sector restructuring, fiscal federalism and decentralisation allowed played a pivotal role in deprioritising the issue of HIV/AIDS at the provincial level. Given the slow pace of implementation of the National AIDS Plan in the period 1994-1996 and in conjunction with obstacles to the implementation of the NAP during this period, the financial and political obstacles to implementation encountered between 1996 and 1999 stalled all attempts to comprehensively implement the NAP.

In combination with the (new) state’s inexperience in dealing with HIV/AIDS and governance in general, the political turbulence and lack of decisive leadership on HIV/AIDS between 1994 and 1999, as well as the vast number of other issues competing for state attention (for instance, health sector restructuring due to geographical inequalities in the distribution of state infrastructure, inequality in levels of care between the private and public sectors and maldistribution of resources between the levels of

\(^{19}\) For instance, responsibility for the provision of education and health care.
care\textsuperscript{20}) allowed for HIV/AIDS to drop off the bureaucracy’s implementation radar (Schneider and Stein, 2001). As such and despite great promise and optimism at its inception, comprehensive implementation of the National AIDS Plan was an unrealised goal in the period 1994-1999. The public sector response to HIV/AIDS in the period 1994-1999 was essentially characterised by lethargy, and parallel and unconnected spheres of activity that did little to curtail the spread and impact of the HIV virus. This is most evident in the tremendous acceleration of national HIV/AIDS prevalence from 7.6 percent in 1994 to 22.4 percent (and climbing) in 1999 (Schneider, 2001). Gauteng faces a similar situation to the one described in national figures, with a 12 percent rate of provincial prevalence rising to 29.4 percent in 2000 (Pelser, 2002). Left unchecked, HIV/AIDS grew into a developmental threat that was only reconsidered with the formulation of the National HIV/AIDS/STI Strategic Plan for South Africa: 2000-2005.

I would like to reiterate and clarify the above assertions. The National AIDS Plan, as developed by the National AIDS Committee of South Africa, represents South Africa’s first legislated national response to the HIV/AIDS epidemic. Formulated through a highly participatory and inclusive manner, responsibility for the implementation of the NAP was unexpectedly and quiet suddenly ceded to the Department of Health by the (newly elected) ANC in 1994. This approach was completely unexpected and excluded significant players (namely, nonstate and civil society organisations) involved in the formation of NACOSA and formulation of the National AIDS Plan from the policy implementation process. Emerging from a period of strong cooperation between 1990 and 1994, as manifest in the strength of the anti-apartheid movement and the formulation of a multisectoral and multifaceted response to HIV/AIDS, state and nonstate organisations entered into a period of increasing tension and conflict. Increasingly ostracised and scorned by the state, the nonstate HIV/AIDS community was ultimately unable to contribute its skills, technical expertise and experience to the implementation of the NAP.

Adopting a conventional approach to the implementation of a radical plan, the state’s approach to implementation was the most significant obstacle to implementation of the

\textsuperscript{20} Schneider, 2001.
National AIDS Plan. Failing to heed the advise of NACOSA and create a multisectoral authority to oversee and pursue implementation at all levels, the state instead chose to assert its newly acquired authority and place responsibility for the implementation of the NAP with the DOH. Unfortunately, and to the demise of the NAP, this approach was emulated at the provincial level. In this way, a biomedical bias toward HIV/AIDS emerged that nominally discredited more social aspects of the NAP. As such, the unconventional though potentially effective and highly lauded National AIDS Plan was discarded in favour of a more conventional biomedical approach to HIV/AIDS. In addition to these problems, the method of implementation adopted by the national and provincial governments created confusion and tension between various government departments over ownership of, priorities within, and their respective roles and responsibilities in the process of implementation of the NAP. Stemming from a lack of accountability and leadership within the task network, the deprioritisation of HIV/AIDS within the provincial bureaucracy, and its incorporation into the public health system, neither HIV/AIDS nor the National AIDS Plan were made a special case with vertical authority structures at the provincial level (Schneider and Stein, 2001). In conjunction with the breakdown of cooperation between national government and NGOs and within the government itself, the resultant breakdown of cooperation and trust initiated by these forces ultimately undermined implementation of the NAP (Ibid., 2001).

These organisational and structural problems in the implementation of the National AIDS Plan were complimented and compounded by the financial constraints faced by members of the NAP implementation task network between 1994 and 1999. Consequently, neither the virus itself nor the NAP were afforded the attention and resources (both human and financial) necessary for the quick and comprehensive implementation of a national response to HIV/AIDS. Ultimately, and even though significant progress and innovation occurred at the national level these achievements in policy development were not recreated in policy implementation at the provincial level.

To conclude, armed with a potentially effective plan to curtail the spread and impact of HIV/AIDS the state failed in its attempt to implement this plan. As such, the period 1994-
1999 was characterised by the enormous gap between the stated and adopted policy intent and the implementation of this policy by the state. Failing to implement the National AIDS Plan in its entirety and unable to hold to timelines for implementation, progress was slow and the coherence and complimentary nature of the plan was lost. In essence, the NAP became just another neat book on the shelf (Schneider and Stein, 2001). In retrospect, state failure to implement the NAP may be accounted for by a host of complimentary factors. In the first instance, the state lacked the machinery to implement the NAP at the provincial level. This failure of provincial governments was complimented by the general failure of the National AIDS Plan’s status as a Presidential Lead Project to ensure sustained attention and motivate direct action against capacity constraints at the provincial level. Fiscal federalism and the breakdown of cooperation between state and nonstate HIV/AIDS actors exacerbated problems created by the low level of provincial implementation capacity.

Failure to implement the National AIDS Plan provides valuable insight into the nature of HIV/AIDS policy implementation in post-apartheid South Africa. Essentially, we note that HIV/AIDS policy implementation is strongly political. As such, political leaders play a crucial role in driving implementation in a coherent, complimentary and sustained fashion. Unfortunately, and due principally to its highly political nature, progress in HIV/AIDS policy implementation is also strongly influenced by the pressures encountered by and whims of individual political elites. This is clearly demonstrated in the deputy President and Health Minister’s strong support for an untested miracle African cure for HIV/AIDS, even though the same parties were simultaneously against the use of proven and efficacious antiretrovirals. Further, the experience of the NAP highlights the ease with which HIV/AIDS policy implementation is derailed in a country experiencing complex social, economic and political change at a time when the HIV/AIDS epidemic is silently gorging itself on the South African masses.

Aware of the growing and insistent toll extracted by HIV/AIDS and implicitly accepting the failure of the National AIDS Plan, the state revised its public HIV/AIDS policy. Creating the South African National AIDS Council (SANAC) to replace the now entirely defunct NACOSA in 2000, the state revised its approach to HIV/AIDS in the newly formulated National Strategic Plan for South Africa: 2000-2005 (NSP). Adopted as national public policy in the same year, the NSP replaced the National AIDS Plan as the framework for the public sector response to HIV/AIDS. Recognising the urgency of attacking HIV/AIDS on all fronts, the National HIV/AIDS/STI Strategic Plan for South Africa: 2000-2005 outlines various strategies involving national and provincial departments of health, education and social development intended to provide a comprehensive package of prevention, treatment, care, monitoring, evaluation, research, and the maintenance of the legal and human rights of the HIV/AIDS affected (DOH, 2000). Accepting the failure of the NAP to redress South Africa’s HIV/AIDS epidemic, the NSP calls for a renewed commitment to combat HIV/AIDS from all sectors of society and states a reduction in the number of new infections as its foremost goal (Ibid., 2000).

Given the high rate of incidence amongst South Africans between 14 and 25, their vulnerability to HIV infection, and their traditional role as present and future economic and social ‘powerhouses’ of the country, youth are identified as a high priority target group within the NSP (Ibid., 2000).

Recognising the fundamental error of housing the National AIDS Plan within the department of health, the National HIV/AIDS/STI Strategic Plan for South Africa: 2000-2005 explicitly states that it is not a plan specific to the health sector, but rather a statement of intent for the entire country whose scope pervades both state and nonstate institutions. Accordingly, and significantly departing from the National AIDS Plan, the NSP recognises that no single ministry, department or organisation can single handedly combat the HIV/AIDS epidemic. Rather, the NSP is intended to serve as the framework for a wide spread national response, outlining objectives with respect to prevention, treatment, care and its other core goals, providing selected strategies for the achievement
of these goals, but leaving implementation of the selected strategies up to leading agencies appointed in each core area (Ibid., 2000).

Departing from the implementation strategy adopted for the NAP, the National HIV/AIDS/STI Strategic Plan for South Africa: 2000-2005 demands the appointment of a focal person and team responsible for developing strategies, budgeting for the said strategies, and driving and monitoring implementation of these HIV/AIDS interventions in order for each leading agency to fulfil its responsibilities within the NSP. The South Africa National AIDS Council (SANAC) is the highest body advising government on HIV/AIDS policy issues and is tasked with monitoring implementation in all sectors. So we see, the National HIV/AIDS/STI Strategic Plan for South Africa: 2000-2005 allows for vertical authority over all agencies tasked with implementation from both outside of task network (a role fulfilled by SANAC), and inside the task network (a role fulfilled by the focal person and team within each leading agency). As outlined in the NSP, SANAC is to be chaired by the Deputy President (Jacob Zuma at the time) and constituted of 16 government representatives from the various ministries and 17 representatives of civil society organisations.