AN EVALUATION OF GOVERNMENTAL HEALTH AND WELFARE INTERVENTIONS IN RESPONSE TO HIV/AIDS IN SOUTH AFRICA: 1997–2005

by

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DECLARATION

I, Lejone Jonas Mphou declare that

AN EVALUATION OF GOVERNMENTAL HEALTH AND WELAFARE INTERVENTIONS IN RESPONSE TO HIV/AIDS IN SOUTH AFRICA: 1997–2005

is my own work and that all the sources that I have used or quoted have been indicated and acknowledged by means of complete references.

Signature:

Date:

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SUMMARY

The point of departure in this study was to find a logical structure to answer the research question. In order to do this, the central concept *adequate* was defined, clarified and linked to the research question while on the same score, concepts related to it were also defined and clarified. The objectives of the study and the conceptual instruments were combined and thereafter linked to HIV/AIDS as a real life phenomenon. The literature reviewed assisted in accessing sources relevant to the topic, in setting the theoretical framework for the study and selecting appropriate tools to measure and evaluate the adequacy of governmental health and welfare interventions. The theoretical framework of the study is informed by the idea that the Government has obligations in terms of a social contract with society. On this basis, a conceptual instrument was built, bearing in mind section 2 of the 1996 Constitution. The evaluation criteria used involves collection and sifting through information and data while on the same score, making judgements about the validity of information obtained and deriving inferences from such information.

Keywords: accountability; adequate; ethics; governmental health and welfare interventions; inter-sectoral collaboration; inter-disciplinary approach; morality; HIV/AIDS policy and programmes implementation; rationality; social development; developmental social work.

LIST OF ACRONYMS

AIDS	=	Acquired Immune Deficiency Syndrome
ASSA	=	Actuarial Society of South Africa
ACHPR	=	African Charter on Human and People' Rights
CBOs	=	Community-based organisations
CHBC	=	Community home-based care
DoH	=	Department of Health
DoSD	=	Department of Social Development
ECD	=	Early childhood development
FBOs	=	Faith-based organisations
GAAP	=	Government AIDS Action Plan for South Africa
HIV	=	Human Immune Deficiency Syndrome
HST	=	Heath Systems Trust
ICESCR	=	International Covenant on Economic, Social and Cultural Rights
IDT	=	Independent Development Trust
IMC	=	Inter-ministerial Committee
MCC	=	Medical Control Council
MRC	=	Medical Research Council
MTCT	=	Mother-to-child-transmission
MTEF	=	Medium Term Expenditure Framework
NACOSA	=	National AIDS Convention of South Africa
NHLS	=	National Health Laboratory Services

NACP	=	National AIDS Control Programme
NAP	=	National AIDS Plan
NCFWC	=	National Child and Family Welfare Council
NDA	=	National Development Agency
NIP	=	National Integrated Plan
NPO	=	Nonprofit organisation
NWOs	=	National Welfare Organisations
OAU	=	Organisation of African Union
OVC	=	Orphaned and vulnerable children
PLWHA	=	People living with AIDS
PHC	=	Primary Health Care
PHRC	=	Provincial Health Restructuring Committee
PMTCT	=	Prevention of mother-to-child transmission
RDP	=	Reconstruction and Development Programme
RSA	=	Republic of South Africa
SAAVI	=	South African AIDS Vaccine Initiative
SANABS	=	South African National Blood Service
SANAC	=	South African National AIDS Council
STI	=	Sexually transmitted infection
TAC	=	Treatment Action Campaign
UNCRC	=	United Nations Convention on the Rights of the Child
VCT	=	Voluntary Counselling and Testing
WPAAF	=	Women in Partnership against AIDS Forum

WPoSW	=	White Paper on Social Welfare
WPToHS	=	White Paper for Transformation of Health Systems

LIST OF TERMINOLOGY

In order to assist the reader or user of this dissertation to know and understand concepts repeatedly used in the study, the researcher felt it necessary to define and explain them. The researcher found some of the concepts difficult to define and clarify on his own without the use of existing literature. The same could be the case with the reader and user of this study, hence the need to make provision for the following list of terminology.

a. Acquired Immune Deficiency Syndrome

According to Mvoko (1999:7), "AIDS is strictly speaking not a specific disease, but a complex syndrome of diseases resulting from the deterioration of a person's immune system. The definition of AIDS is based on the clinical and biological symptoms that are basically secondary in the disease process". Also, as AIDS progresses, opportunistic infections gain access to the body and that often become uncontrollable to the extent that the immune system become unable to ward off such infections (Skosana 2001:11).

b. CD4

The Oxford Concise Medical Dictionary (2003:116) explains CD4 as a surface antigen on helper T-cells that is particularly important for immune resistance to viruses. For adult persons infected by HIV/AIDS, the CD4 must be below 2000 to be considered for the disability grant.

c. Conditional Grants

Generally, conditional grants refer to grant transferred to a province or municipality that may only be used under the conditions stipulated in the specific legislation. In this study, conditional grants are funds specifically designated for priority HIV/AIDS interventions such as public awareness campaigns, condoms distribution, PMTCT programmes, and more recently, ARV treatment programmes (Hickey, Ndlovu and Guthrie 2004:118).

d. Health and welfare interventions

Health and welfare interventions mean legislative and policy interventions, strategies, programmes, projects including all inter-sectoral and inter-disciplinary collaborative efforts in the mitigation of the effects of the HIV/AIDS pandemic in South Africa.

e. HIV/AIDS civil society

By HIV/AIDS civil society the researcher refers to identified persons infected with HIV/AIDS, the TAC and all other HIV/AIDS NGOs and activists involved in HIV/AIDS work.

f. Human Immune Deficiency Syndrome

HIV is, according to Van Dyk (2000:2-3), "a chronic viral infection that may enter the human body through an ulcer or a lesion. The infection may occur in the presence of sexually transmitted infections, vaginal secretion or semen, blood products like plasma, breast-feeding, or unscreened blood. After contracting the virus, the immune system becomes destroyed and eventually, indefensible against the virus and opportunistic diseases. The virus progresses to AIDS in a period of two to seven years in African countries and in a period of eight to ten years in countries such as the United States of America and Europe.

g. Inter-disciplinary approach

Van Dyk (2000:13) explains inter-disciplinary approach as "a collective sharing of diverse range of academic knowledge, skills, insights, and expertise". In this study, inter-disciplinary approach means collective sharing of diverse range of HIV/AIDS knowledge generated in relevant academic fields, skills, insights and expertise developed through information sharing and scientific research.

h. Inter-sectoral collaboration

In this study, inter-sectoral collaboration refers to mutually planned and formulated HIV/AIDS policies, and programmatic responses jointly implemented by two or more of the following: (a) health and welfare departments; (b) the private sector; (c) NCFWC, CBOs, NGOs; and (d) local communities.

i. Moralistic discourse

For the purpose of this study, the term shall not be confined to the difference between right and wrong as in "moralist", but is construed to mean morally narrow beliefs and judgements emanating from the condemnation and punishment of PLWHA, commercial sex workers, homosexuals and individuals deemed to have led lives characterised by promiscuity versus those deemed to have acquired the virus though mother-to-child transmission and blood transfusion and that are therefore innocent.

j. Provincial equitable shares

For the purposes of this study, provincial equitable shares shall mean discretionary funds raised nationally and allocated equitably among provinces.

k. Seroprevalence

The term seroprevalence is made out of two words, namely; 'serology' and 'prevalence'. In the Oxford Medical Dictionary (2002:557 and 625); the word serology is explained as the study of blood serum and its constituents, particularly their contribution to the protection of the body. The word prevalence is explained as a measure of morbidity based on current sickness in a population. According to the Oxford Medical Dictionary (2002:442), by morbidity it is meant the state of being deceased. Since in this study morbidity is about HIV/AIDS, the word seroprevalence shall be construed to mean the measure of all HIV-positive cases tested and confirmed through individual blood sampling in blood transfusions by the South Africa National Blood Services (SANABS) or at Voluntary Counselling and Testing (VCT) sites between 1997 and 2005.

l. Social Assistance

Social Assistance means all social welfare grants administered in terms of the *Social Assistance Act, 1992, (Act 59* of *1992)* and made available to all deserving PLWHA, OVCs, destitute families and vulnerable communities.

m. Social Relief

Social relief of distress is actually not a social welfare grant but, a short-term measure by a State organ or private entity aimed at alleviating the crises situations or circumstances of individuals or communities unable to meet their most basic needs. For example, social relief of distress is made available when a specific area is subjected to a disaster, when the family affected has no means of survival and when acting in the best interests of and destitute OVC. The DoSD intervenes by way of issuing food vouchers or transport in terms of the *Social Assistance Act, 1992, (Act 59 of 1992).* Private entities may render assistance in terms of the *Non-profit Organization Amendment Act, 2000, (Act 17 of 2000).*

n. Social Security

According to Olivier (2003:24), there is no consistent approach to "social security" as a concept, which is construed that there is no universal meaning to the concept, but for the

purposes of this study, social security shall be explained as an umbrella concept meaning all health related and welfare interventions encapsulating, among others, social assistance embodying social relief of distress and grants-in-aid.

CHAPTER 1

INVESTIGATING AND EVALUATING THE ADEQUACY OF INTERVENTIONS IN THE FIELD OF HIVAIDS

Concepts, like individuals, have their histories.
Søren Kierkegaard

1.1 INTRODUCTION

The first chapter of this dissertation sets out the motivation, the historical background, the nature and scope, as well as related aspects of the research project. The responses by Government to HIV/AIDS and motivational factors that stimulated the researcher's curiosity and generated interest to investigate and evaluate health and welfare interventions are discussed under the background. In order to build a logical structure to address the problem, the central concept *adequate,* which is embedded in the research question and concepts related to it is defined and clarified. The central concept is linked to the research problem and related concepts are linked to the central concept while conceptual instruments are linked to HIV/AIDS as a real life phenomenon in South Africa. Basically, the aim of this study is to investigate the adequacy of governmental responses to one of the worst pandemics in history. This includes the investigation and the evaluation of whether programmes and projects were appropriate and accessible between 2000 and 2005 or not.

The information and data on Human Immune Deficiency Syndrome (HIV) and Acquired Immune Deficiency Syndrome (AIDS) governmental interventions were obtained through the review of literature and official documents. The literature review is organised in such a manner that the objectives of the study are linked to conceptual instruments developed in order to measure and evaluate the adequacy of governmental responses to HIV/AIDS. To collect evidence relating to responses, the researcher made use of libraries, the internet and official data from the national Department of Health (DOH) and the national Department of Social Development (DoSD), National Treasury, as well as media reports. However, the researcher avoided the use of media reports during the literature review because such reports are not

necessarily scientific. The inevitability of involving more than one department and discipline is influenced by a plethora of HIV/AIDS problems that are multidimensional and that cut across social classes and age groups. It is in this context that inter-sectoral and inter-disciplinary approaches in response to HIV/AIDS are investigated and evaluated in this study. The choice of the period between 1997 and 2005 was mainly influenced by the fact that the 1996 Constitution of the Republic South Africa, 1996 (hereafter referred to as (*the 1996 Constitution*), and the White Papers on Transformation of Health Systems and Social Welfare were all adopted in 1997. The national HIV/AIDS and Sexually Transmitted Infections (STIs) Strategic Plan covered the period between 2000 and 2005. To help the reader or user of this study get a sense as to why there was a need to investigate and to evaluate responses to HIV/AIDS in this specific period, the researcher considered it essential to start by providing a historical background in relation to responses to HIV/AIDS.

1.2 HISTORICAL BACKGROUND

The formal review of the African National Congress's (ANC's) National Health Plan of May 1994 gave birth to the National AIDS Coordinating Committee of South Africa (NACOSA) in 1998. The Plan came ten years after the first two AIDS cases were officially confirmed (Torkington 2000:170). When NACOSA and the South African National AIDS Council (SANAC) were being formed, HIV/AIDS was being defined as a moral problem requiring bio-medical attention. The unwritten moralistic presuppositions underlying debates permeated the political arena and had an influence on HIV/AIDS policy-making and implementation (Fourie 2006:175). According to Fourie, one of the concerns during human rights debates was the continued invective against antiretrovirals (ARVs) and mother-to-child transmission (MTCT), in connection with which NACOSA and SANAC failed to provide guidance. This is despite the objectives of NACOSA and SANAC being, among others: (a) to guide government departments in implementing the National AIDS Plan (NAP) and the National Integrated Plan (NIP); (b) to co-ordinate HIV/AIDS service-delivery nationwide; and (c) to democratise HIV/AIDS policy-making process in South Africa.

In order to be able to translate the objectives of NACOSA into action, the National AIDS Plan (NAP) was conceived in order to, among others, produce climate conducive to the coherent and coordinated prevention and care for HIV/AIDS infected and affected individuals. In the opinion of Fourie, one of the reasons for the failure of the NAP and NIP to deliver effective and efficient HIV/AIDS services was lack of accountability by both NACOSA and SANAC. This was influenced by the fact that the NAP was accepted by the African National Congress (ANC) caucus during the existence of the Government of National Unity and as a result, the ANC did not take full ownership and responsibility of the NAP (Fourie 2006:110–119). The demise of the NAP in 1996 led to the development and the implementation of the NIP under the auspices of SANAC.

The NIP was jointly implemented by the DoH, the Department of Education and the DoSD as lead agencies. SANAC was, among others, tasked by Government to: (a) provide advice on HIV/AIDS policies; (b) create and strengthen partnerships for an expanded response among all sectors; (c) mobilise resources for the implementation of AIDS programmes; and (d) to provide recommendations for appropriate research. The NIP called for joint delivery of HIV/AIDS services such as, among others, VCT, as well as community home-based care (CHBC). However, SANAC struggled to implement the broad HIV/AIDS policy objectives and also lacked the required capacity to make appropriate and effective budgetary allocations (Fourie 2006 152:170).

Whereas influenced by the personal and social effects of HIV/AIDS to conduct this study, the report of Dorrington and Johnson (2002:52) that estimated that 40% of deaths of people aged between 15 and 49 years of age were due to HIV/AIDS in 2001, also generated interest to conduct this study. Many adults within this age group were sexually active and were at child-bearing age. Their deaths have led to the proliferation of more AIDS-orphans and child-headed families in need of care (Hunter & Williams 2000:7) and (Miller & Charlton (1988:554). The burden of looking after people living with HIV/AIDS (PLWHA) after family disintegration fell on young girls while the extent of vulnerability faced by AIDS-orphans depended on whether they were infected themselves. The degree of psycho-social trauma suffered and care needed by AIDS-orphans and child-headed families (Subbarao, Mattimore & Plangemann 2000:4) has

been one of the causes for concern in this study. The background provided in this section and the motivation to conduct this study led to the following question being asked.

1.3 RESEARCH QUESTION

On the basis of NACOSA and SANAC having had to struggle to implement both the NAP and the NIP against the backdrop of: (a) moralistic, bio-medical and human rights discourses; (b) the lack of accountability on the part of NACOSA and SANAC and: (c) the continued invective against ARVs and MTCT at highest echelons of political power, the big question was: **Have the national Departments of Health and Social Development in South Africa responded adequately to the HIV/AIDS epidemic between 1997 and 2005?** The aim and the objectives of the study are therefore intended to respond to this question.

1.4 THE AIM OF THE STUDY

The aim of the study is to measure the adequacy of governmental health and welfare response to HIV/AIDS by pursuing the following objectives:

- to find criteria in terms of which the adequacy of State interventions in the field of HIV/AIDS pandemic can be evaluated;

- to investigate and evaluate whether the State, the national DoH and the DoSD adhered to international agreements, constitutional obligations and legislative mandates in responding to HIV/AIDS;

- to investigate and evaluate whether HIV/AIDS policies were developed and implemented and whether other measures were taken within available resources, to achieve the progressive realisation of health and welfare rights; and

- to explore and evaluate how PLWHA, affected poor families and vulnerable communities were reached and supported by Government;

- to explore the use of public money in fighting the HIV/AIDS pandemic in South Africa.

By the time the research proposal was submitted international agreements were already signed and ratified between 03 October 1994 and June 1995. They are therefore not viewed as direct responses to HIV/AIDS in this study because their signing and ratification was not prompted by HIV/AIDS, but was a gesture by the State showing commitment to be part of the international community. The 1996 Constitution was also not specifically adopted in response to HIV/AIDS, but as supreme law to guide the Country. It is in this context that the nature and scope of this study should be understood.

It should be noted that although this dissertation contains a literature review, it is not an aim of this dissertation to do a literature review. Chapter two is a means to an end and not an end in itself.

1.5 NATURE AND SCOPE OF STUDY

In terms of the classification by Mouton (2001: 143), the historical and the textual approaches are listed under empirical studies. However, this dissertation is not necessarily empirical in the positivist sense of the term in that no surveys, interviews or questionnaires are used to measure and evaluate the adequacy of responses to HIV/AIDS. Instead, the conceptual instruments are developed, and official documents, as well as literature are reviewed in order to set the theoretical framework and select appropriate measurement tools. The study is historical and textual because health and welfare interventions between 1997 and 2005 are investigated and evaluated by navigating available textual and official information and data. As a beginning researcher at master's level, it could have been difficult to clarify and define concepts and develop operational definitions without consulting existing textual information. According to Singleton, Straits and Straits (1993:101), it is important for a beginning researcher to rely on existing theoretical definitions when developing or clarifying concepts embedded in one's hypothesis or research question. The use of the internet to source information from the

University of South Africa (UNISA) and visits to municipal libraries economized greatly on travelling costs and time.

As pointed out by Peil (1995:3) and Mouton (1998:119–125), a concept is an idea used to explain and describe events and situations, which eventually inform the framework of a scientific study. Meanwhile, in the opinion of Singleton *et al* (1993:124–125), the meaning of any scientific concept can be implied by statements of its relations to other concepts. In this study, the central concept *adequate* is defined and clarified and concepts related to it are also defined and clarified. Furthermore, conceptual instruments are developed to measure the adequacy of health and welfare interventions between 1997 and 2005. According to categorisation provided by Mouton (2001:158), the study of this nature is evaluative.

The relevance of the influence of the adoption of the 1996 Constitution, the involvement of the DoH and the DoSD as lead agencies, as well as the multifaceted ramifications of the personal and social impact of HIV/AIDS, led to the consultation of literature on constitutional law, public administration, statutory interpretation, healthcare, epidemiology and social work in chapter 2. In this study, health and welfare interventions are investigated and evaluated as units of analysis while the national DoH and the DoSD are treated as the locus of study and not necessarily the focus. What is noteworthy is that units of analysis are inclusive of budgetary allocations and expenditure. In a nutshell, they are treated as integral parts of a broader strategy aimed at combating HIV/AIDS in South Africa. Much as budgets, expenditure, statistics and targets are not analysed extensively, focus is also not much on health and welfare policy-making in this study, but on the implementation of HIV/AIDS policies and the appropriateness and the accessibility of programmes between 1997 and 2005. The reason the researcher to focus on the period between 1997 and 2005 is influenced by the fact that the 1996 Constitution and the White Papers on the Transformation of Health System and Social Welfare were adopted in 1997. The following were delimitations and limitations of the study noted.

1.6 DELIMITATIONS AND LIMITATIONS OF THE STUDY

This study investigates governmental responses with specific reference to the DoSD and the DoH in South Africa. Although other national government departments were required to collaborate with the national DoH and the DoSD in the fight against HIV/AIDS, they were not, in terms of their own responsibilities, constitutionally and legislatively accountable. To be more precise, the DoH and the DoSD were lead agencies in the fight against HIV/AIDS. The DoH was directly responsible to develop and implement preventative strategies while the DoSD was more involved in the fight against the personal and social impacts. That is why other government departments are not forming part of this study. Much as literature on responses to HIV/AIDS at national level was not in abundance, it could have been more problematic to obtain such literature for responses at provincial levels. As shall be noted in chapter 2, literature was obtained mainly from international books and journal articles that are not necessarily focussing on provincial responses in South Africa.

Furthermore, the time limitation involved the impossibility to obtain the estimated total number of PLWHA, orphaned and vulnerable children (OVCs) and families reached through social security catchnets between 1997 and 2005 because the social pensions system (socpen) was not designed to separate HIV/AIDS beneficiaries from the rest. HIV/AIDS allocations were twined with TB under the Strategic Health Programme between 1997/98 and 2001/02 while also being allocated together with community home-based care (CHBC) under the Development Implementation Programme between 2001/02 and 2004/05. It was therefore difficult to establish expenditure with specific reference to HIV/AIDS in the period. Furthermore, the actual budgetary allocations and expenditure for HIV/AIDS treatment between 1997/98 and 2001/2 could not be traced because ARVs were not distributed from public hospitals and clinics during the period. However, these limitations did not deter the researcher to design the study because appropriate methodology to implement the study was decided on.

1.7 RESEARCH DESIGN AND METHODOLOGY

According to Singleton *et al* (1993:103–115), it is natural to use more than one means to solve a problem. They point out that multiple measures to respond to the hypothesis or research question are in most cases available, and can be used in social research for as long as there is a relationship between units of analysis, concepts, indicators or measures. For the purpose of implementing this study, it was imperative to explain the relationship between the units of analysis (health and welfare interventions), the central concept *adequate* and related ones and evaluation criteria used in the following sections.

1.7.1 CLARIFYING AND LINKING CONCEPTS TO THE RESEARCH QUESTION

In order to build a logical structure that will answer the research question, the researcher had to start by defining and clarifying the central concept *adequate* and concepts related to it. According to Mouton (1998:109), this kind of technique is called conceptualisation and is synonymous to "conceptual analysis". In this study, the central concept, namely *adequate* is firstly construed to mean the *political morality* and *governmental will* to adhere to international agreements, constitutional obligations, and legislative mandates; and further how these obligations and mandates were translated into real action by the State and national DoH and the DoSD. The central concept is not only used to refer to responses in terms of quality of service, but also in quantified terms. The approach of treating quality and quantity as the two sides of the same coin is the idea of Afanasyev (1980:97), who points out that both quality and quantity may be treated as a unity inasmuch as two sides of the same coin.

Secondly, the central concept is construed to mean the extent of *moral* commitment on the part of the State and its representatives to implement *rational* HIV/AIDS policies and abide by *ethical principles* as required by the 1996 Constitution. The concept *morality* will be used to refer to the political conduct of political office-bearers while the concept *ethics* shall be used to refer to the conduct of Government representatives and structures of response as required in section 195 (a) of the 1996 Constitution. The concepts *moral* and *ethics* are therefore not used synonymously and interchangeably as propounded by (Afanasyev 1980:374). As pointed out

by Afanasyef, morality or ethics influences all aspects of life in society and has a direct bearing on politics. Afanasyev further points out that *morality* or *ethics* are the aggregate of standards or rules of behaviours in society, reflecting people's ideas of justice and injustice, good and evil, honour and dishonour, etc.

The central concept *adequate* is in the third place related to the concept *rationality*, which according to Pauw & Wessels (2003:4) is an issue in Public Administration and Theory of Science. Pauw & Wessels point out that rationality is a worthwhile ideal that can be used in science for as long as expectations prompting the use thereof are realistic and the meaning of the term is made clear (Pauw & Wessels 2003:16). In the fourth place, according to Fox and Meyer (1996:1), the concept *accountability* can be viewed from different points of view. Firstly, it can be viewed as the responsibility of government and its agents towards the public to realise previously set objectives and to account for them in public. Secondly, the concept can be viewed as commitment required from a public official to accept public responsibility for his or her actions or inactions. Thirdly, the concept can be viewed as the obligation that a subordinate has to keep his or her superior informed of the execution of responsibilities. The definition of the related concepts linked to the central concept *adequate*, were all appropriate and relevant in building the logical structure of the study. They also assisted in building the following conceptual instruments because they could be linked to HIV/AIDS and responses to it as a real life phenomenon.

Based on these definitions of related concepts and for the purposes of this study, the term *adequate* shall mean *The extent of political commitment and governmental will to implement rational policies informed by relevant articles of international agreements, constitutional obligations and legislative mandates in an accountable manner through programmes that recognise quality and quantity as two sides of the same coin.*

1.7.2 LINKING CONCEPTUAL INSTRUMENTS TO HIV-AIDS AS A REAL LIFE PHENOMENON

According to Hughes (1993:11), research instruments cannot be divorced from theory/concepts while in the words of Pauw & Wessels (2003:3), a theory is a unified complex of conceptual instruments and facts that increase our understanding of a phenomenon. In order to be able to measure and evaluate the adequacy of responses to HIV/AIDS, bearing in mind the central concept and related concepts discussed above, the following conceptual instruments that are categorised into legal, implementation and care criteria were developed by the researcher:

- The extent of commitment on the part of the State and national DoH and the DoSD to adhere to relevant articles of international agreements and the 1996 Constitution in responding to HIV/AIDS in South Africa;

- The influence of HIV/AIDS debates on governmental responses and the extent of commitment to implement HIV/AIDS health and welfare policies and programmes in accordance with constitutional obligations; and

- The extent of commitment by government to respond to the personal and socio-economic needs of PLWHA, and how OVCs, pregnant mothers and their infants, as well as affected families and vulnerable communities were reached within a developmental social work paradigm.

By defining and clarifying concepts in the previous section and by linking conceptual instruments to HIV/AIDS as a real life phenomenon in this section, the researcher was preparing theoretical framework of the study while at the same time setting relevant tools of measurement, bearing in mind that information and data relating to health and welfare interventions had to be collected.

1.7.3 INFORMATION GATHERING

According to Mouton (1998:110) and Peil (1995:9), research design is inclusive of how data was collected. It was after numerous visits to municipal libraries and UNISA that the researcher became aware that literature on health and welfare interventions was not in abundance on library shelves. In view of this, the researcher resorted to the global and the South African internet, as well as government sites. The researcher agrees with Mouton (2001:35–36) that the internet and websites should not be allowed to substitute the use of traditional media such as books and journal articles. This is why only information from books is used during literature review as discussed in chapter 7 and not information from the internet. However, by the time the research proposal was submitted, the internet was already a powerful tool used to access government policy documents, discussion papers, speeches and media statements as referenced under the list of sources. This information was useful in identifying HIV/AIDS legislation, policies and strategies discussed from chapter 7. As is appropriate in Public Administration, the most important source of information was official documents. Much as it is acknowledged that worthwhile ideas were obtained from relevant media reports consulted, it would have been problematic to use information from them because they were more often than not influenced by editorial policies and the political orientation of individual journalists. However, the researcher gained new insights and knowledge from the media statements and that assisted in determining the logic of the study.

1.7.4 DETERMINING LOGIC OF RESEARCH

According to Mouton (1998:171), the basic logic of all research is informed by the relationship between research problem, knowledge gained, evidence unearthed and conclusions arrived at. In this study, the relationship between the research question, the central and related concepts, as well as criteria to measure and evaluate responses to HIV/AIDS as a real life phenomenon is discussed under sections 1.7.1 and 1.7.2. In Trochim (2006:1) and Mouton (1998:69) evaluation is construed as a process of collecting evidence, deriving inferences and making judgements about an object. In this study, evidence on whether responses to HIV/AIDS were

adequate between 1997 and 2005 is presented in each chapter while inferences drawn and judgements made appear at the end of each chapter as part of conclusions.

It would have been tantamount to the presentation of an unfinished story and failure to fulfil responsibility if feedback was not provided. It would have been what Peil (1995:157) refers to as “drop and run”. For the purposes of this study, the evaluation criteria under section 1.7.2, the methodology identified by Trochim as cited above, as well as the logic of reasoning called PEC (Problem, Evidence and Conclusion) framework by Mouton are used when conclusions are made at the end of each chapter.

1.8 OVERVIEW OF CHAPTERS

What the researcher sets out to do in the first chapter is to provide the background, motivation, nature and scope of the study as well as related aspects. The central concept *adequate* embedded in the research question is defined and clarified in order to build the logical structure that responds to the research question. Also, related concepts are all defined and clarified and thereafter linked to the central concept. Furthermore, the conceptual instruments are developed in preparation of chapter 3. In an effort to set the theoretical framework and measurement criteria, the researcher interacts with other scholars in the second chapter through the process of a literature review. The problems encountered during the literature review and how the literature was organised is discussed while at the same time linking the objectives of the study with conceptual instruments in the chapter.

The third chapter links to chapter 2 in the sense that it sets the theoretical framework of the study and selects appropriate tools of measurement, based on literature reviewed. In this chapter, the researcher explores relevant articles of international agreements and links them to constitutional obligations and legislative mandates relevant to the study. The need for the implementation of the goals of social development, indicators of quality of health care, principles of care, as well as the relevant standards and norms of developmental social work are also discussed as measurement tools. The fourth chapter outlines the role played by the courts of law, forums and tribunals, as well as responsibilities of national structures of response

such as NACOSA and SANAC. Also discussed are the directorates, subdirectorates and committees involved in the fight against HIV/AIDS.

Chapter 5 is focussed on the implementation of the principles of the NACP from 1997 to 2000 and all efforts aimed at achieving the progressive realisation of health and welfare rights through policy development and implementation. The roles that social workers played, the imperativeness of NGOs support at PHC as well as community levels are discussed and explained. Further, the use of existing health and welfare prevention services and efforts to reduce the personal and social impact of HIV/AIDS are mentioned while obstacles to effective and efficient response to HIV/AIDS are also dealt with.

The sixth chapter outlines some of the developments during the implementation of the priority areas of the national HIV/AIDS and STIs Strategic Plan for 2000–2005. The influence of policy developments on programme responses between 1997/98 and 2000/01 and how destitute PLWHA, OVCs, poor families and vulnerable communities were reached are also discussed in the chapter. In chapter 7, budgets and expenditure are discussed as integral part of broader strategy aimed at combating HIV/AIDS and the impact of policy and programme developments in HIV/AIDS work is also explained. Chapter 8 provides an overview of governmental responses to HIV/AIDS and evaluates their adequacy with specific reference to the periods between 1997/2002 and 2002/2005. The politicisation of HIV/AIDS and interference in research are evaluated as primary causes of delayed response, while budgetary constraints and organisational factors are evaluated as secondary causes.

1.9 SUMMARY

What the researcher set out to do in this chapter was to set the motivation, the nature and scope, the methodology and related aspects of the dissertation. The main point was to find a logical structure to answer the research question by, among others, defining and clarifying concepts. The central concept *adequate*, which is linked to the research question and concepts related to it are defined and clarified and linked to HIV/AIDS as a real life phenomenon. Again, the conceptual instruments are developed in order to be able to measure and evaluate

the adequacy of health and welfare interventions in response to HIV/AIDS. Now that all of these are achieved, the researcher will start interacting with other scholars in the field of HIV/AIDS and health and welfare interventions. By so doing, the theoretical framework of the study will be prepared while tools of measurement are set at the same time.

CHAPTER 2

LITERATURE REVIEW

A sense of curiosity is nature's original school of education. Dr Smilley Blanton.

2.1 INTRODUCTION

Now that curiosity generating interest in the study, scope, methodology and related aspects of the research projects are made known, it becomes imperative to review existing literature in preparation of the theoretical framework and setting tools of measurement. This chapter is an essential part of the study by means of which the researcher starts interacting with other scholars in the field of HIV/AIDS and health and welfare interventions. Thus, it is important to first explain how access was gained to literature and how it was organised, as well as problems encountered. It must however be stated that while a massive corpus of literature on HIV/AIDS could be obtained, the amount of public administration literature directly linked to HIV/AIDS was less extensive.

2.2 PURPOSE OF LITERATURE REVIEW

In order to be able to access the relevant accumulated body of knowledge, ideas and evidence emanating from previous (empirical) research findings, visits were paid to libraries and the internet. The purpose was firstly to establish what other scholars are saying about HIV/AIDS, its impact on destitute PLWHA, OVCs, poor families, pregnant mothers and their infants, vulnerable groups and communities. Secondly, the purpose was to investigate empirical findings on responses to HIV/AIDS and the relevance of collaboration in mitigating the impact of HIV/AIDS. Lastly, the purpose was to ensure that no previous research is unnecessarily duplicated by this study.

2.3 PROCESS FOLLOWED IN LITERATURE REVIEW

According to Mouton (1998:121), the process of a literature review is an essential component of any study because it is the main point of access to the relevant body of knowledge. In Mouton (2001:87), it is pointed out that a good review of previous studies not only assists in avoiding duplication of previous research, but also helps in providing clues and suggestions about what avenues to follow.

It would have been dangerous for the researcher to rely on sensational media reporting and unscientific data as well as unproven assumptions by political and public office-bearers. Mouton (2001:91) compares the literature review to an interactive and a cyclical process whereby the review process itself is not simply driven by the research question, but is also a process that can lead to a change in the formulation of the research question. The researcher concurs with Mouton (2001:112–117) that, to put together a coherent, logical, clear and persuasive research usually involves repeated practice and drafts that may lead to frustration.

In this study, the focus and the locus were initially on one province, but were later elevated to national DoH and the DoSD as the researcher continued to interact with the supervisor. This broadened the scope and timeframe of the study because relevant articles of international agreements had to be consulted and be juxtaposed with constitutional provisions. It would have been impractical**,** let alone time-consuming for the researcher to read each and every article or book on HIV/AIDS in-depth, even though irrelevant to the study. As a result, the researcher started by first reading forewords or prefaces of books and abstracts or summaries of journal articles obtained from libraries and the internet first. This assisted in deciding on whether to read the source in-depth or discontinue reading. In some instances, it was enough to read the research reports only without in-depth reading, because clues could immediately be identified. In the process, problems were however encountered.

2.4. LIMITATIONS OF THE REVIEW OF LITERATURE

Most of literature consulted covering the period between 1982 and 2002 was international and not specifically focussing on South Africa. To start with, the book by Epstein (2007) contains statistical information mainly based on the United Nations documents and the United States of American Democratic Health Surveys. The statistical information cited in the book is based on designated HIV/AIDS sites in selected hospitals that excluded rural areas. It was therefore not unreasonable to suspect that the statistical information was not accurate. In essence, it could have been dangerous for the researcher to construct debates based on estimates varying so widely and statistics regarded with such scepticism. The book by De Waal (2006) is also an international book which discusses responses to HIV/AIDS in which, De Waal (2006:9) examines the nature of civil society and activist mobilisation regarding AIDS in Africa, and not with specific reference to South Africa.

Again, the book edited by Guthrie and Hickey (2004) is an international book which examines how governments in four African and five Latin American countries were funded. In the chapter dedicated to South Africa, Hickey, Ndlovu and Guthrie (2003:129–150), examine budgetary allocations and expenditure. The enumerated amounts for equitable shares derived from provincial research and calculations are set. However, calculations might have been done prior to 2003, because the article was only published in 2004. The observation was that the tables are mainly providing medium-term expenditure allocations and not necessarily the actual and updated expenditure until 2004. Nevertheless, the article provided the researcher with scientific knowledge and insight regarding governmental health and welfare HIV/AIDS interventions and structures of response involved. Budgets, statistics and targets are not analysed in this study, and the same goes for HIV/AIDS policy-making. The focus is on contextual factors that influenced the development and implementation of HIV/AIDS policy and how those were translated into real action through programmes.

The book by Fourie (2006) provided the researcher with new knowledge and insights pertaining to the problem identification in the field of HIV/AIDS. While Fourie provides an AIDS timeline from 1982 when the first two HIV/AIDS deaths were confirmed (Fourie

2006:189–196), Hickey *et al* (2004:105) outline a chronological overview of responses to HIV/AIDS between 1992 and 2003. These authors are unfortunately not covering the year 2005.

The book by Guest (2003) was consulted. The book gives an account of experiences of orphans, foster parents, charity organisations, carecentres and social workers in South Africa, Zambia, and Uganda, and not necessarily an account of health and welfare interventions with specific reference to South Africa (Guest 2003:57–96). However, the book provided the researcher with new knowledge and insight regarding the psycho-social impact of HIV/AIDS on OVCs and child-headed families. Against the backdrop of factors mentioned above, the researcher was also faced with the problem of organising the literature review, which was finally addressed as in the following section.

2.5 ORGANISATION OF THE LITERATURE REVIEW

In Mouton (2001:123), it is shown that the review of literature can be combined with theoretical framework. However, that is not the case in this study because the research is designed in such a manner that the theoretical framework is prepared in the next chapter, while the facts pointing to governmental response are discussed from chapter 4. Furthermore, the technique discussed by Mouton (2001:92), which allows the use of the chronological structure together with other methods, is used in this chapter. It is not unusual, according to Mouton (2001:94), to find the chronological structure organised with other methods.

2.5.1 LINKING THE LITERATURE WITH OBJECTIVES OF THE STUDY AND CONCEPTUAL INSTRUMENTS

In order to be able to translate the objectives of this dissertation into a scientific study using the legal criterion developed under section 1.7.2, the article in chapter 21, of the book edited by Olivier, Smit and Kalula (2003), in which Jansen van Rensburg and Olivier (2003:626–645) discuss the scope and content of international agreements, was consulted. The purpose was not to use international agreements as direct responses to HIV/AIDS, but merely to explore as to

whether they were adhered to in the process of policy-making and implementation. Rautenbach and Malherbe (1996) and Botha (1996) were also consulted. On the one hand, Rautenbach and Malherbe (1996:20), discuss the Constitution of 1993 as the first interim supreme law of the country which, for the first time in the history of constitutional developments in South Africa, contained the Bill of Rights. On the other hand, Botha (1996:36) points out that the same 1993 Constitution changed the face of statutory interpretation in South Africa. As explained by Botha, the courts, tribunals and forums were for the first time in the history of constitutional developments in South Africa, bound to take into cognisance internationally agreed documents as legal instruments.

The knowledge and insight gained in reading Rautenbach and Malherbe (1996:6–8) and Botes (1996:26) is that the State was bound to protect the general community and to give direction to how rules of law should be applied. Furthermore, the development and the implementation of welfare, housing, public healthcare and social security, were deemed the most important duties of the government.

In terms of the second criterion developed in section 1.7.2, it was essential to first find an appropriate definition for the term *implementation*. Looking at the definition of the term "implementation" by Brynard (2000); it became evident that the implementation of HIV/AIDS responses requires public/private partnerships that include the wider community. It was therefore inevitable and of cardinal importance to review the literature on the role played by the NGOs, CBOs and the extent of community participation.

In reading Schaay (1997:9), Crewe (1997:20) and Adegoroye (1989:14–20) it became apparent that NGOs and CBOs have been in the forefront of the care of the PLWHA, OVCs and affected families, as well as vulnerable communities. In the opinion of Adegoroye, PHC is capable of bringing healthcare services close to where people live and work, and constitutes the first element of a continuum of care. As shall be shown in chapter 5 and 6, this approach was inevitable in dealing with the past imbalances of apartheid. The policy responses to HIV/AIDS outlined in Fourie (2006:50–172), and how moralistic, bio-medical and human rights debates influenced governmental responses, as well as a chronological overview of HIV/AIDS policy

developments discussed in Hickey *et al* (2004:105), provided information of how PLWHA were viewed and treated, as well as how Government intervened.

2.5.2 THE IMPACT OF MORALISTIC DEBATES ON HIV/AIDS LITERATURE

What became evident when reading Fourie (2006:58–64), is that moralistic judgements that hinged on the condemnation of commercial sex workers, homosexuals, gays and PLWHA permeated the political arena, state institutions, the media, religious institutions and traditional societies. It is also pointed out by Fourie that minimal responses to HIV/AIDS during the moralistic phase were evoked by the misconceptions and moral judgements levelled at gays and homosexuals. After the official confirmation of the first two AIDS deaths in 1982, the national radio and the television network were still government-owned and no meaningful and positive AIDS awareness messages were transmitted by political and public office-bearers through their departments. In the opinion of the researcher, the time spent on HIV/AIDS debates denied space for the promotion of robust debates on how to mitigate the spread of HIV/AIDS. Out of these debates, scientific literature on health and welfare interventions could have been developed.

The moralistic discourses did not only impact on the availability of HIV/AIDS literature and interventions, but also on the ability of the DoH and the DoSD to respond adequately to HIV/AIDS. The situation was compounded by, among others, the politicisation of HIV/AIDS as discussed by (Heywood 2005:378) and the prolonged denial that HIV does not cause AIDS (Joseph 2003:1146). On the one hand, children and those exposed to HIV/AIDS through blood transfusion and MTCT were deemed innocent victims. On the other hand, the HIV infection and how it was acquired became the focus and not necessarily the impact of the virus itself. In reading Fourie, what became evident was that HIV/AIDS was seen by the National Party-led government and its institutions, some churches and traditional societies as a behavioural problem that could only be tackled by the bio-medical community.

2.5.3 LITERATURE LINKING BIO-MEDICAL DEBATES WITH POLITICS

While the literature indicated that the bio-medical community had an influence in the policy environment (Fourie 2006:66–76) between 1982 and 1994, the very same community was divided in the beginning. In the opinion of the researcher, this division was not only caused by some members of the bio-medical community who continued to condemn homosexuals, gays and commercial sex workers, but also by confusion over whether HIV causes AIDS or not and the politicisation thereof. It would not be inappropriate to suggest that moralistic beliefs and the denial that HIV does not cause AIDS delayed the implementation of appropriate health and welfare interventions. In Fourie (2006:189), it is pointed out that blood tests to identify HIV-antibodies became available for the first time in South Africa in 1986, while the finding that HIV had jumped to the heterosexual community was only made known in 1988. By that time, narrow political agendas and pseudo-scientific arguments were threatening the autonomy of scientists (Deane 2005:538–540). As pointed out by Collins, Thomas and Coates (2000:1389–1390), debates in health and welfare research were politically interfered with to the extent that medical tests were administered to study subjects in the absence of peer review processes. Bearing in mind that, according to Rautenbach and Malherbe (1996:6–8) and Botes, Brynard and Roux (1996:26), the State was bound to protect the general community and to give direction as to how rules of law should be applied, the researcher felt the need to explore *systems* and *structures* that may have been established and *organised* to protect and promote the legal and human rights of PLWHA.

2.5.4 LINKING SYSTEMIC, STRUCTURAL AND ORGANISATIONAL FACTORS

Every state has a particular *legal system* (Rautenbach & Malherbe 1996:2) and these systems are continuous interventions in the social world. During the moralistic and the bio-medical discourses as discussed under sections 2.5.2 and 2.5.3 and before the TAC could start coaxing the government to distribute ARVs, any member of the civil society was, according to Botes *et al* (1996:26), at liberty to challenge the conduct of the State or its representatives not consistent with the rights entrenched in the Constitution of 1993. The right of access to courts of law and independent and impartial forums and tribunals was further entrenched under section 34 of the

Constitution when it was adopted in 1997. When the latter was adopted, the interpretation of international agreements by the courts of law, forums and tribunals as legal instruments was recognised as discussed under section 3.3 of the next chapter.

In reading the book by Cloete (2000:11), with the research article by Trochim (2006:1–2), the researcher found out that the concept “ethics” can be explained in the public administration and research settings. While on the one hand, Cloete discusses the concept *ethics* as one of the basic values and principles governing public administration in South Africa, Trochim discusses *research ethics* as a system of ethical protection aimed at protecting the rights of research participants and that ensures that they are fully informed about the procedures and risks involved in research. The exploration of the influence of systemic and structural factors prompted the need to also investigate organisational factors that influenced the ability of the DoH and the DoSD to develop and implement HIV/AIDS legislation, policies and programmes.

However, extensive HIV/AIDS literature consulted do not discuss “public administration” as a victim. The literature on public administration with specific reference to HIV/AIDS was less extensive. It was less extensive on the impact of HIV/AIDS on governance and development with specific reference to, among others: (a) impact on public sector skills; (b) cost implications on recruitment and training; (c) influence on increased costs of service provision; and (d) public sector budget. As a result of the scarcity of HIV/AIDS literature dealing with “public administration” as a locus and victim, the researcher had to resort to official documents and records of departments in implementing the study. In conclusion, the researcher was able to trace the study by Van den Berg of the University of Pretoria (2008). However, the study is about the life experiences of teachers and the responsibility of schools in terms of implementing HIV/AIDS programmes and not about interventions.

2.6 CONCLUSION

While it was a desire on the part of the researcher to be exhaustive in covering available scientific publications in the field of HIV/AIDS interventions, most of the literature consulted

was developed at international level and not necessarily specific to health and welfare interventions in South Africa. So far the literature consulted suggest that the causes to inadequate responses to HIV/AIDS were not prompted by systemic factors only, but also by structural and organisational factors. Facts to this effect will be provided from the next chapter and evidence will be assessed in the final chapter. Although some literature on HIV/AIDS locally published could be traced, it was not necessarily focussed on HIV/AIDS health and welfare interventions between 1997 and 2005, but on political interventions and policy discourses. However, literature consulted assisted in developing the theoretical framework and in setting tools of measurement in the next chapter.

CHAPTER 3

THE THEORETICAL FRAMEWORK OF THE STUDY AND TOOLS TO MEASURE THE ADEQUACY OF RESPONSES

If we can't measure it, we can't manage it. F Mohamed. (Senior implementation strategies: New Horizons).

3.1 INTRODUCTION

The literature review dealt with in the previous chapter not only assisted the researcher to identify related empirical research findings in the field of HIV/AIDS and interventions, but also assisted in preparing the conceptual instruments listed under section 1.7.2 and in selecting appropriate tools of measurement in this chapter. As pointed out by Mouton (1998:109), the theoretical framework provides guidance and gives direction to the research. The primary aim in this chapter is therefore to set the theoretical framework for the study and to select measurement tools that will enable the researcher to answer the research question.

3.2 THEORETICAL FRAMEWORK

The point of departure of this dissertation is the idea that Government has obligations in terms of a social contract with society (see section 2 of the Constitution; Rawls 1973:11 et seq). On this basis, a conceptual instrument was built consisting of three aspects, namely legal obligations, implementation and care obligations.

The first aspect of the study is to establish whether international agreements and constitutional obligations were adhered to when HIV/AIDS was responded to by the Government between 1997 and 2005. Secondly, it was important, after establishing the latter, to explore the extent of political commitment and governmental will to develop and implement HIV/AIDS policies and programmes. Thirdly, it would have been impractical for the Government to respond to HIV/AIDS without taking into cognisance its capacity in relation to, among others: (a)

management of service delivery and integration of primary healthcare; (b) health facility staffing and recruitment; (c) infrastructural capacity and public budget availability; and (d) development and retention of available skills. Fourthly, the White Papers on the Transformation of Health Systems and Social Welfare were adopted in 1997. The researcher felt it important to explore as to whether social development goals and developmental social work norms and standards were advocated in the White Papers and linked to HIV/AIDS work. In order to be able to measure the adequacy of the governmental response to HIV/AIDS between 1997 and 2005, the following *legal*, *implementation* and *care* measurement criteria were developed.

3.3 MEASUREMENT CRITERIA

The legal criterion is not only used to investigate the extent of adherence to international agreements by the Government when HIV/AIDS legislation and policies were developed and implemented, but also to explore how case law influenced HIV/AIDS work. Against the backdrop of HIV/AIDS discourses, what must be borne in mind are the McGeary case of 1991 and the Hansen case of 1992 wherein the rights of privacy and the provision of free medication were respectively curtailed by the courts of law (Fourie 2006:92). The inclusion of case law in the study will assist in determining whether the Government acted on its own volition or not in as far as the nationwide distribution of ARVs is concerned. In investigating obligations in terms of the social contract, the point of departure was section 2 of the Constitution which stipulates that any law or conduct not consistent with it shall be invalid and that obligations imposed by it must be fulfilled.

Since focus is on the implementation of HIV/AIDS policies through programmes and projects, the definition of policy implementation by Brynard (2000:166) was accepted by the researcher for the purposes of the second criterion. According to Brynard (2000:166) "Policy implementation encompasses those actions by public or private individuals (groups) that are directed at the achievement of objectives set forth in prior policy decisions". The need to investigate the development and the implementation of policies and programmes in terms of their appropriateness and accessibility as responses, stem from the fact they were used as

vehicles to implement constitutional obligations and legislative mandates. The policies and the programmes were aimed at mitigating the increasing HIV infection rate and the impact of contextual factors associated with poverty, vulnerability and lack of information.

The third and the fourth criteria are used to investigate how destitute PLWHA, OVCs and child-headed families were diverted to care programmes. The OVCs were sometimes forced to drop out of school to supplement or generate family income. Likewise, they were forced by circumstances to care for their sick parents and sometimes relatives who were unable to fend for themselves (Subbarao *et al* 2000:4). It was felt important to first investigate whether the Government was constitutionally obliged to intervene through policies and programmes before investigating whether a continuum of care was provided for PLWHA, OVCs, destitute families and vulnerable communities.

3.3.1 WAS THE GOVERNMENT CONSTITUTIONALLY OBLIGED TO ADHERE TO INTERNATIONAL AGREEMENTS?

The first thing that the researcher did was to investigate as to whether the State, as a geo-political entity and subject of international law, was bound by the following international agreements and the African Charter to respond to HIV/AIDS as a real life phenomenon:

a. Article 19 and 20 of the *Convention on the rights of the child* (UNCRC) signed in June 1995, provided that States shall take all appropriate legislative and administrative measures to protect the child by establishing social programmes aimed at providing necessary care and support, be it treatment when sick, or foster placement when circumstances call for intervention. Article 24 (b) further provides that States must ensure the provision of medical healthcare and assistance to all children, with emphasis on the development (United Nations 1990:7–9)

b. Article 16 of the *African charter on human and people's rights* (ACHPR) which got approval from the Organization of African Unity (OAU) in 1981, and which gained legal status in 1986, states that every individual shall have the right to enjoy the best

attainable state of physical and mental health and that governments shall introduce measures to protect the health of their people by ensuring that they receive medical attention when sick (Organization of African Unity 1986:4)

c. Article 12 (2) (c) and (d) of the *International covenant on economic, social and cultural rights* (ICESCR) commits States to promote, protect, and fulfil socio-economic rights of their subjects. According to the article, States shall recognise the right of everyone to enjoy the highest attainable standard of physical and mental health. This right includes: (i) prevention, treatment and control of epidemic, endemic, occupational and other diseases; and (ii) the creation of conditions which would assure to all medical services and medical attention (United Nations 1976:5).

The signing and the ratification of above-mentioned agreements between 1994 and 1995, as well as the adoption of the 1996 Constitution, heralded a paradigm shift in HIV/AIDS work as shall be shown below. As pointed out by Burns (1999:2), the adoption of the Constitution ushered in a new era whereby the supremacy of Parliament was replaced with the supremacy of the Constitution. In terms of section 39 (1) (b) of the Constitution the courts of law, forums and tribunals are required to interpret these international agreements as shall be shown under section 6.4.

Although the separation of powers is recognised in the Constitution, that does not preclude the courts from making orders that have an impact on social policy. For example, according to Klinck (2003:334), the issuing of the court order in the case of the TAC versus the State, as discussed under section 6.4, was no intrusion into the domain of the executive because that was an intervention mandated by the Constitutional Court. What became evident when looking at articles of international agreements above is that they are related to constitutional provisions relevant to this study in terms of purposes to be served. For example, article 19 of the UNCRC links with section 28 (1) (b) of the Constitution, which stipulates that "every child has the right to family care or parental care, or to appropriate alternative care when removed from family environment while article 24 of the same agreement links with section 27 (3), which stipulates that no one may be refused emergency treatment. Some of the constitutional provisions are

mentioned under section 6.4 where the relevance of the TAC case to this study is discussed. The Constitution did not only influence the face of statutory interpretation, but also the implementation of social development programmes as shown in section 3.3.2 below.

3.3.2 THE EXTENT OF COMMITMENT TO IMPLEMENT NATIONAL PROGRAMMES, STRATEGIES AND SOCIAL DEVELOPMENT GOALS

The White Paper on Social Welfare (WPoSW) and the White Paper on Transformation of Health Systems (WPoTHS) were adopted in 1997 to redress the past imbalances of apartheid and to address issues of transformation by, among other things, promoting: (a) public/private partnership; (b) comprehensive community development; and (c) individual and collective empowerment communities and NGOs. The WPoSW advocated a range of services for PLWHA, OVCs, families and vulnerable communities while the WPoTHS contained the principles of the NACP such as: (a) the prevention of the spread of the epidemic through the promotion of safer sexual behaviour, adequate provision of condoms and control of STIs; (b) the protection and promotion of the rights of the PLWHA by ensuring that discrimination against such people is outlawed; (c) usage of the mass media to popularise key prevention concepts and development of life skills education for youth in and out of school; (d) reduction of the personal and social impact of HIV/AIDS through the provision of counselling, care and social support, including social welfare services for the PLWHA , their families and vulnerable communities; and (e) mobilisation of and unification of local, provincial and national resources to prevent and reduce the impact of HIV/AIDS (South Africa 1997(b):36). By the time the NAP of NACOSA was finalised in 1998 and when the NIP was being developed between 1999 and 2000, ARVs were not being distributed from public hospitals and clinics.

In the words of Sewpaul and Rollins (1999:250–252), for a country which suffered political and socio-economic imbalances like South Africa, social development must be construed as a macro policy framework and must be designed to impact on those most marginalised in society. On the same score Patel (1992:146), points out that the developmental approach discards paternalism by putting people in the centre of development programmes. The goals of social development aimed at redressing the imbalances of apartheid that required the

transformation of the entire health and welfare systems were: (a) the improvement of the material conditions of the lives of the people; (b) the maximisation of the development of human capacity in order to create productive members of society; (c) the promotion of individual and collective reliance in an enabling social, economic, and political environment in order to promote social and emotional well-being, worth, dignity and self-reliance and; (d) the assistance of individuals and groups at various stages of their development and in different circumstances, and those in need of protection, care, support, as well as material assistance to achieve their optimal development (Sewpaul & Rollins 1999:250–252). It would have been impractical, let alone impossible to implement these goals in the absence of budgetary allocations. It is against that backdrop that in chapter 7, the budgets are investigated as an integral part of broader strategy aimed at combating the effects of HIV/AIDS between 1997 and 2005.

3.3.3 LINKING INDICATORS OF QUALITY OF HEALTH CARE WITH PRINCIPLES OF CARE

The researcher decided to bring the indicators of *quality of healthcare* and *principles of care and support* together because they both deal with the need for the integration of primary health care (PHC) and the promotion of community participation. The indicators of quality of healthcare such as: (a) infrastructural capacity for primary health care (PHC); (b) health facility staffing and PHC training; (c) integration of PHC services; (d) in-service training; and (e) management of service delivery, were identified by the DoH researchers in consultation with stakeholders, including the staff (South Africa 1998:1–2).

According to Crombie and Davies (1996:156–157), inadequacies and deficiencies in healthcare come in many ways and may include a lack of the following: (a) communication and interaction between people, political and public office-bearers; (b) adequate space; and (c) skilled manpower. In terms of reaching beneficiaries and mitigating the personal and social impact of HIV/AIDS, the principles required that: (a) care be inclusive of early diagnosis of diseases and reduction in the frequency and severity of illness; (b) appropriate minimum standards of care be made available throughout the country, with the same standards of care for

HIV-positive and negative people; (c) the greatest volume of care be provided at primary care level with integration of AIDS into PHC services; (d) the continuum of care between home, primary care centre and hospital be provided; (e) counselling services be integrated into healthcare services, bearing in mind that AIDS care requires teamwork among all carers; (f) evaluation of existing innovative care approaches; and (g) support for complimentary therapies (*AIDS Bulletin* 1994:6). The problems identified in relation to the indicators of quality of healthcare are dealt with under section 4.5 and 6.6 while the implementation of principles of care are dealt with under section 5.2 and 5.3, as well as section 6.2 to 6.5. The principles of care and support were implemented by social workers of the DoH and the DoSD in recognition of the standards and norms of developmental social work dealt with in section 3.3.4 below.

3.3.4 LINKING STANDARDS AND NORMS OF DEVELOPMENTAL SOCIAL WORK WITH SOCIAL DEVELOPMENT GOALS

It was important to link the standards and norms of developmental social work with social development goals in order to determine whether individuals at various stages of their development and different circumstances benefited spiritually and materially to achieve their optimal development. The two relevant developmental social work standards used to measure and evaluate the adequacy of responses in this study required that: (a) social workers must assist with the arrangement of legal assistance (eg wills), applications for relevant social welfare grants, such as, foster care for orphaned children, care-dependency for children born infected and affected, disability grants for persons profoundly infected with and affected by HIV/AIDS, and other forms of support, such as social relief of distress; and (b) social workers must ensure that community care of AIDS patients involves a continuum of care which links all available resources in a community. This care starts from initial counselling to include care of psycho-social needs, medical and nursing needs, as well as family needs such as the care of children, legal advice and assistance.

Social workers were expected to identify PLWHA, OVCs, destitute and poor families deserving of assistance and divert them to appropriate catchnets, bearing in mind that the communities and PHC staff were expected to adhere to the fact that: (a) every community had

to provide some home-based care and access through partnership of community-based care; and that: (b) all clinics serving communities in their catchments had to identify home-based care coordinators for formal and informal sector activities (South Africa 2003a:1–2). The role of social workers in collaboration with healthcare workers and officials of the DoSD in implementing social development goals and developmental social work in HIV/AIDS is dealt with in sections 5.2.1, 5.2.2, 5.3.2, 5.3.3, 6.2.2, as well as section 6.3.

Based on the theoretical framework set and the tools of measurement selected, the following can be concluded.

3.4 CONCLUSION

The set theoretical framework and appropriate selected tools of measurement will assist the researcher in measuring and evaluating the adequacy of governmental response to HIV/AIDS, bearing in mind that the legal criterion was merely aimed at exploring whether there was adherence to international agreements. The criterion should not necessarily be construed as direct response to HIV/AIDS because the signing and the ratification of international agreements by the Government of the Republic of South Africa was a gesture to merely commit the State to be the part of the international community. What is most relevant to the study is the fact that the courts, tribunals and forums were bound by section 39 (1) (b) of the Constitution to consult international agreements when interpreting statutes, including legislation in the field of HIV/AIDS. Therefore, it would have been inappropriate to investigate the adequacy of responses in isolation of case law. In the coming chapters, the appropriateness and the extent of commitment to make health and welfare care programmes accessible are investigated. Further, the evidence on whether standards and principles of care were provided adequately through developmental programmes will be presented. In the next chapter, the researcher starts to present factual evidence on the need for the courts, tribunals and forums to interpret international agreements as influenced by the supremacy of the Constitution.

CHAPTER 4

THE ROLE OF THE COURTS, FORUMS, TRIBUNALS, NATIONAL STRUCTURES AND DIRECTORATES IN RESPONSE TO HIV/AIDS

The achievement of your goal is assured the moment you commit yourself to it. Mack R Douglas.

4.1 INTRODUCTION

Basically, the signing and the ratification of international agreements and the *African charter on human and people's rights* as discussed in the previous chapter is not necessarily construed as integral part of broader strategy aimed at combating HIV/AIDS, but as mere political commitment by the State to be part of the international community. The articles of international agreements identified in the previous chapter are used to measure the extent of adherence to them when HIV/AIDS was responded to. As quoted in the previous chapter, section 27(2) of the Constitution compelled the State to take reasonable legislative and other measures, within its available resources, to achieve the progressive realisation of health and welfare rights entrenched in section 27(1). It is against the backdrop of the latter that the researcher investigates whether the DoH and the DoSD carried out their legislative mandates adequately in response to HIV/AIDS. But before that, it is imperative indicate why international agreements and the *Charter on human and people's rights* were also consulted.

4.2 THE ROLE OF THE COURTS, FORUMS AND TRIBUNALS IN HIV/AIDS WORK

According to Olivier and Kaluka (2003:126), the State signed and ratified international agreements, which according to section 39 (1)(b) of the Constitution, must be interpreted contextually by the courts of law, tribunals, and forums in order to arrive at appropriate decisions and rulings. This new approach of moving away from the old textual to the new contextual approach in interpreting statutes was influenced by the advent of the political

dispensation gained in 1994 and the subsequent adoption of the first democratic Constitution in 1997 (Botha 1996:98–99). Olivier and Kaluka (2003) as well as Botha (1996) appear to share the same view because they all point out that international agreements are sources of international law and that they must be interpreted contextually as legal instruments. As shall be shown under section 6.4, the interpretation of international agreements in conjunction with constitutional obligations, which later led to the distribution of ARVs from public hospitals and clinics, was enforced by the High Court in 2002 in the landmark case of the TAC versus the State.

4.3 CONSTITUTIONAL OBLIGATIONS PLACED ON THE PRESIDENT OF THE COUNTRY AND MINISTERS

With the inception of the new democracy in 1994 the doctrine of parliamentary supremacy was replaced by the supremacy of the Constitution, in other words, the legislature, the executive and the judiciary were bound to comply with the Constitution (Burns 1999:2–15). In Botes *et al* (1996:26), it is mentioned that the Constitution is generally accepted as an expression of the will and wishes of the people and is the supreme law encapsulating, among others, enforceable guarantees for individual rights. The enforceability of the rights in the Constitution puts any member of civil society at liberty to approach the courts, the Human Rights Commission, and even the Constitutional Court to enforce such rights (Cloete 1996:83–86). Section 27 of the Constitution, which guarantees everyone the right to healthcare and welfare, including social security is enforceable as shall be shown under section 6.4.

Despite the existence of constitutional obligations imposed on the President and Ministers in terms of schedule 2 of chapter 14 to obey, observe, uphold, and maintain the Constitution, narrow personal and political interests were entertained as discussed in section 5.2.4. Although the principle in section 41 (1) (b) requires all levels of government to secure the well-being of the people of the Republic of South Africa, the national Government could not provide the motivation for not distributing ARVs from all public hospitals and clinics between 1997 and 2002. In the words of Cameron and Stone (1995:13), the right existed for citizens to know the motivation for the decision of the Government. In terms of the basic values and principles

governing public administration under section 195 of the Constitution, political and public office-bearers were expected to be accountable, transparent and to maintain a high standard of professional ethics. Furthermore, in terms of section 12 (2) (c), everyone has the right not to be subjected to medical or scientific experiments without their consent The duty to protect PLWHA and OVCs is according to the strategic plan concerning HIV/AIDS and STIs (South Africa 2000a:5) the responsibility of all government departments, the private sector, NCFWC, NGOs and all stakeholders involved in HIV/AIDS work. That is why it was essential to explore the roles of the national structures of response within the DoH and the DoSD.

4.4 THE ROLE OF NATIONAL STRUCTURES OF HIV/AIDS RESPONSE COMMITTEES AND DIRECTORATES

As a result of the need for collaboration at governmental level, the Inter-departmental Committee (IDC) was established in 1998 at national level to lead and to develop the Government AIDS Action Plan for South Africa (GAAP). The two main objectives of GAAP, which was spearheaded by the IDC, were to expand the response to HIV/AIDS and to mobilise government departments and the civil society against the pandemic. The action plan of GAAP comprised three phases, namely; (a) mass mobilisation in 1998; (b) mass action in 1999; and (c) rolling mass action in 2000 (South Africa 1999:8).

The mass mobilisation phase was aimed at promoting partnership between government, business, trade unions, and the civil society by earmarking calendar dates for awareness and life skills education. The mass action phase focused on communities through rallies, while the rolling mass action was about fostering ownership of mobilisation efforts. The need to foster partnership to meet the plight of those infected and affected was highlighted in the rallies, particularly on 1 December 1998 in Durban on World AIDS Day (South Africa 1999:7–8). In order to foster the ownership of mobilisation efforts, the activities that were promoted were, among others: (a) government’s commitment to the leadership of an inter-sectoral programme; (b) capacity development of NGOs and community groups and the; (c) advocacy for a broad response and sufficient resource (Floyed 1997:7). According to a discussion document of the Department of Social Services and Population Development (South Africa 2001:6), as part of

mobilisation efforts, collaboration was likely to cushion the devastating effects of HIV/AIDS. Collaborative efforts required of social workers to be involved in ensuring that the "best interests of the child" principle is served and that cooperation with PHC workers, ECD and CHBC facilities, as well as childcare forums within communities take place. Basically, community participation at PHC level was central. According to Levendal, Lapinsky and Mametja (1997:1), "... community involvement in service delivery entailed partnership between individuals, groups, organizations, and healthcare professionals in which all parties examine the root causes of ill-health and together agree on approaches to address them". The importance of community participation in HIV/AIDS work was already recognised when the WPoTHS and the WPoSW were adopted in 1997. The responsibility in terms of building public/private partnership and mobilising government departments lay with NACOSA and SANAC.

4.4.1 THE ESTABLISHMENT OF THE NATIONAL AIDS COORDINATING COMMITTEE OF SOUTH AFRICA

The NAP of NACOSA, as the first blueprint by the new political dispensation, was accepted by the Minister of Health, Dr Nkosazana Dlamini-Zuma in 1998 (Smart 2002:200). The NAP recognised the crucial role and responsibility regarding provision of care and HIV treatment by the Government. Although the goals of the NAP were, among other things: (a) to prevent the transmission of HIV; (b) to provide care for HIV/AIDS; and (c) to ensure community involvement; it was ineffective in achieving these objectives, based on, among others, the following factors identified by Fourie (2006:119).

a. The State was undergoing restructuring at all levels and was unable to prioritise HIV/AIDS because of the implementation of Reconstruction and Development Programmes (RDP).

b. The culture of non-delivery inherited from officials of the old order and the lack of experienced new cadre of developmental policy implementers had an influence.

c. Delayed development of programme infrastructure at both national and provincial levels impacted negatively on the establishment of VCT sites throughout the country.

d. Implementation of the NAP, which was narrowly focused on health issues, was located within the health department instead of the Presidency.

e. NGOs were weakened by the exit of experienced leadership, who got appointed to government structures.

As further pointed out by Fourie (2006:20), the programmes of the NAP were eventually reviewed with a view to taking stock of their strengths, gaps and weaknesses. The review of programmes showed that there was a need for political leadership and public commitment to address human and legal rights abuses and to reduce stigma and discrimination. Although the NAP called on sectors of the society, including faith-based organisations (FBOs) to stand together against the pandemic, it was ineffective in translating this objective into real action. The main problem with NACOSA was that it comprised of unelected representatives who turned a blind eye on the importance of involving PLWHA. Consequently, SANAC was established to replace the defunct NACOSA.

4.4.2 THE ESTABLISHMENT OF THE SOUTH AFRICAN NATIONAL AIDS COUNCIL

SANAC was launched in the year 2000 to formalise multi-sectoral collaboration and to enhance cooperation between government and civil society. According to Fourie (2006:144), SANAC also replaced the AIDS Advisory Council (AAC), which was not a multi-sectoral body capable of addressing all moralistic, biomedical, and human rights-related discourses because it was mainly made up of technical experts. SANAC was tasked to advise the country on HIV/AIDS policies and to create and strengthen partnership for expanded response among all sectors. SANAC was composed of the Deputy President of the country, who was a chairperson, 16 Government representatives, and 17 representatives from various sectors of the civil society. It was tasked by Government to mobilise resources for the implementation of HIV/AIDS programmes and research. The entity was duplicated in each province, and by the

end of 2005, was continuing to guide the implementation of the HIV/AIDS and STIs Strategic Plan for 2000–2005. Between the period of the demise of NACOSA and the birth of SANAC, there was no formal programme that could address issues pertaining to CHBC, MTCT and VCT.

Like many other developmental institutions, SANAC was not spared criticism. One of the criticisms levelled at SANAC was that it consisted of a majority of officials appointed by Government. They were neither HIV/AIDS scientists nor representatives of the AIDS Consortium. According to Fourie (2006:145–147), SANAC was subsequently reviewed independently; and emanating from the process, it was found to not have been effective in advising the Government concerning the following:

a. SANAC was unable to bring political commitment to the HIV/AIDS response in South Africa and was unable to influence the outcome of key decisions.

b. The meetings of SANAC were held behind closed doors, thereby making it impossible to hold the entity accountable through normal democratic channels and processes.

c. The structure of SANAC did not allow interaction with other stakeholders or any non-member and yet it was established to promote public/private partnership.

d. SANAC lacked effectiveness in advising the Government on matters of great policy significance and also lacked capacity to monitor the implementation of the NIP.

NACOSA and SANAC mainly comprised non-elected officials and their meetings were held behind closed doors as if they were not public entities. This conflicted with the constitutional obligation to promote accessibility, openness and accountability as entrenched in section 195 (1) of the Constitution. Lastly, against the backdrop of heated political debate over the causal link between HIV and AIDS and the failure by Government to distribute ARVs, the researcher concurs with Fourie (2006:120) that NACOSA and SANAC were not effective in bringing political commitment required in HIV/AIDS work.

Be that as it may, SANAC was instrumental in ensuring that NGOs and CBOs understand what was expected of them in as far as the implementation of HIV/AIDS policies was concerned. Its technical task teams were charged with, among others, the responsibility to address social mobilisation as one of priority areas (South African 2000/2001a:422).

4.4.3 THE ESTABLISHMENT OF HIV/AIDS COMMITTEES AND ROLES THEY PLAYED

According South Africa (2000a:28) the IDC comprised of all representatives who coordinated HIV/AIDS activities in all government departments. They met on a monthly basis to review government programmes. The entity was tasked to facilitate the development of HIV/AIDS workplace policies and to also develop HIV/AIDS programmes for all departments of government. It was duplicated in all provinces, taking into cognisance different dynamics and unique circumstances and the needs of each province. In order to ensure community participation and collaboration at district level, district HIV/AIDS committees were established. Furthermore, non-HIV/AIDS issues such as transport, job creation and poverty alleviation that had a bearing on the livelihood of PLWHA and OVCs were taken into cognisance by the entity. It was expected of all stakeholders to collaborate with the DoSD and the DoH in order to ensure efficiency and effectiveness in all provinces and in order to set realistic goals and objectives committed to the standards pertaining to: (a) the distribution of funds according to the HIV/AIDS and STIs Strategic Plan; (b) the prioritisation of the process of HIV/AIDS spending within the provinces; and (c) the commitment to ongoing national and provincial HIV/AIDS communication.

Unlike the IDC meetings, the Inter-ministerial Committee (IMC), which was established in 1997, was attended by political office-bearers at national level and was chaired by the Deputy President of the Republic of South Africa. The committee met on a monthly basis and its main function was to review the country's response to HIV/AIDS. In order to ensure national and provincial cooperation, the Committee of Ministers and Members of Executive Councils (MinMec) for health and welfare were established. In the meetings, the ministers and provincial counterparts shared the opportunity to discuss issues pertaining to HIV/AIDS and to

approve national policies and guidelines. Resolutions on deliberations and articulated matters in the meetings were brought to the attention of the national executive and the legislature. In order to provide an opportunity for all Heads of Provincial Health to come together and discuss national and provincial strategic issues of importance, the Provincial Health Restructuring Committee (PHRC) was established. The reports of the IMC and the NIP were discussed in these meetings (South Africa 2000a:14–15).

The committee was also responsible to advocate for, among other things, the management and coordination of activities and the implementation of programmes pertaining to poverty alleviation. It was expected of committees to liaise with other sectors in promoting inter-sectoral response. Each committee had a technical AIDS team whose functions were: (a) the preparation and submission of quarterly reports; (b) the documentation and sharing of best practices arising from the sector as well as the identification of obstacles to the response within the sector; (c) the mobilisation of resources for appropriate interventions and the identification of strengths, gaps and weaknesses in relation to HIV/AIDS work; (d) the formulation of specific HIV/AIDS sectoral plans and budgeting for the implementation of those; and (e) the integration of HIV/AIDS and STIs activities in their yearly plans and the identification of determinants of the spread of HIV/AIDS and STIs specific to the sector (South Africa 2000a:28–31).

The quarterly activity reports submitted by the abovementioned committees were based on priorities and objectives of the NACP and the NIP (South Africa 2000a:31). Apart from committees discussed above, there were also HIV/AIDS structures in the form of directorates and subdirectorates established to advise the Government and to review responses in line with the NACP and the NIP. Furthermore, apart from the establishment of abovementioned committees, directorates and subdirectorates were created to achieve the progressive realisation of section 27 (1) and 27 (3) of the Constitution.

4.4.4 THE ROLES OF HIV/AIDS DIRECTORATES AND SUBDIRECTORATES

The Directorate HIV/AIDS and TB within the DoH was still being headed by Dr Nono Simelela by the end of 2005. The Directorate made representations in all meetings and provided further information that was useful for decision-making by the national committees (South Africa 2000a:12–15). According to Simelela (1999:22–23), the Directorate comprised the following subdirectorates:

a. **Subdirectorate Care and Support**: The Subdirectorate was involved with, among other things, the development of adult care, paediatric care, home-based care, and palliative care. The Directorate, in tandem with the DoSD, Education portfolio, NGOs, CBOs, FBOs, and other stakeholders, were active in co-coordinating an effective strategy for the care of OVCs.
b. **Subdirectorate Counselling**: The Directorate consulted with professional bodies on the development of minimum standards for lay counsellors. The development of mentorship programmes, accreditation issues and processes were also handled by the Subdirectorate.
c. **Subdirectorate Medical Interventions and Barrier Methods**: The Directorate was responsible for the distribution of condoms, syndromic management of sexually transmitted diseases, and the provision of a comprehensive package of care to HIV and TB patients.
d. **Subdirectorate Partnership and Support**: The Directorate rendered support to all sectors and assisted in the development of workplace programmes, advocacy training, and capacity building.

The role that the directorates and subdirectorates played in implementing the NACP is discussed in the next chapter while the role they played in implementing the national HIV/AIDS and STIs Strategic Plan for 2000–2005 is discussed in chapter 6. Abovementioned directorates and subdirectorates were located within the DoH and not the DoSD.

The work of the following directorates and subdirectorates of the DoSD was guided by the Ten Point Plan introduced by the Minister of Social Development, Dr Zola Skweyiya with the aim to prioritise poverty alleviation and to mitigate the effects of HIV/AIDS. The Directorates of the DoSD were allocated budgets discussed in chapter 7 and they linked with HIV/AIDS in the following manner:

a. **Directorate Development Implementation and Support**: The Directorate was responsible for HIV/AIDS, poverty alleviation, community development and the promotion of public/private partnership. Between 1997 and 2000 the Directorate was busy developing policies on children suffering from the HIV/AIDS pandemic and to promote collaboration with all stakeholders.

b. **The Directorate Social Security Policy and Planning:** This Directorate was responsible for the administration and payment of social security grants. The grants payable to persons infected and affected by HIV/AIDS are discussed under section 5.3.

c. **The Directorate Welfare Services and Transformation**: The Directorate was responsible for rights advocacy in relation to children and the youth, as well as older persons and persons with disabilities.

Apart from the directorates mentioned above, the Directors-General Forum was established in order for directors-general to promote the spirit of collaboration at all times in HIV/AIDS work, which is why the HIV/AIDS pandemic remained a standing item in all meetings of the forum (South Africa 2000a:15). It was felt not necessary to discuss the composition of committees, directorates and the forum in detail because they were basically not the locus of study. The establishment of those is not necessarily deemed an adequate response to HIV/AIDS, but the actual role they played was of importance. However, it cannot be suggested emphatically in this section that the response was adequate because the problems experienced by the national structures of response in the budget process and related problems encountered are still to be investigated.

4.4.5 STRUCTURES COORDINATING AND INTEGRATING HIV/AIDS BUDGETARY ACTIVITIES AT NATIONAL LEVEL

For the purposes of this study, key relevant players discussed by Hickey *et al* (2004:113), were identified by the researcher and only those involved in the budget process were visited. At the national level of Government, the Budget Forum was constituted as a consultative body responsible for the examination of fiscal and financial matters. There was consultation between the Budget Forum and the MinMec, which met throughout the year to identify trends, to set priorities, and to discuss budgetary implications impacting on national policies. While the MinMec meetings could set priorities and articulate budget implications, the Ministers Committee on the Budget (MinComBud) remained prominent in coordinating activities that involved the drafting of budgets and the overseeing thereof.

4.5 ORGANISATIONAL PROBLEMS ENCOUNTERED

The implementation of services advocated in the WPoSW and the principles of care and support contained in the WPoTHS required organisational resources and capacity building programmes driven by the national Government. According to Gildenhuys and Knipe (2000:290) the organisational resources include, among others, skilled manpower, infrastructure, space and financial resources. The problem in implementing HIV/AIDS services in the White Papers hinged on the fact that more than 80% of households in South Africa were relying on the disproportionately underfunded public sector which increased by less than 1% per year. In the midst of budgetary crisis, a political moral crisis was caused between 1999 and 2001 when the Minister of Health, Dr Nkosazana Dlamini-Zuma was alleged to have failed to justify the R14,2 million awarded to the play Sarafina 2. As quoted from the criticism by Kitching in Fourie (2006:123), the money awarded to Sarafina 2 outstripped provincial budgets and this led to a political crisis of morality. One of the negative developments in budgeting for the response to HIV/AIDS was the politicisation of HIV/AIDS and unnecessary interference in HIV/AIDS research between 1997 and 2002. During this period, there was a shortage of trained healthcare professionals (Wilson & Fairall 2005:478).

The distribution of healthcare professionals between urban and rural areas was not balanced and it was problematic to attract the necessary staff to underserved jurisdictions (Tshabalala-Msimang 2005:6–7). While the Minister of Health recognised that the quality of health care service depended critically on a sufficient number of professionals with relevant and appropriate knowledge and skills (Tshabalala-Msimang 2003:4), there were, as reported in the media, no retention strategies to discourage skilled and experienced health professionals to emigrate overseas. One of the most effective retention strategies would have been to pay health care professionals competitive salaries.

According to South Africa (2003a:2), care and prevention education required capacity building through the training of all healthcare professionals and officials in the DoSD. The training strategies required the inclusion of, among other things, the following aspects:

a. Pre-test and post-test counselling
b. Prevention of mother-to-child HIV transmission
c. Ethical considerations for HIV/AIDS clinical and epidemiological research
d. Management of infection in children

In order to ensure that the new cadre of employees, including social workers and coordinators, understand the work in the field of HIV/AIDS, and to ensure that a diverse range of skills and expertise are shared, a training manual was compiled by UNISA (Van Dyk 2000:13). The manual called for collective effort by different sectors and a variety of disciplines as well as the need for complex insight in dealing with HIV/AIDS. Furthermore, the manual emphasised that skills were required in terms of communication, and financial and project management in order to enhance interaction between and within the State and the private sector.

According to South Africa (2000a:29) it was essential to come up with the agreed upon standard of one (1) dedicated employee per one hundred thousand (100 000) HIV/AIDS beneficiaries. By the end of 1997, eleven thousand (11 000) healthcare workers were already trained in managing opportunistic infections such as tuberculosis (TB) and STIs by the DoH.

However, there were problems inherited from the old order that impeded the implementation of the standard.

The standard was finally implemented after the auditing of human resources that existed at national, provincial, regional and district levels in 1999. However, the implementation thereof between 2000 and 2003 was dealt a blow by the implementation of the moratorium on the filling of vacant posts issued in terms of the resolution 7 of 2000 of the Department of Public Service and Administration. The moratorium, which was implemented in the year in which the NIP was finalised, plus the emigration of health professionals overseas, as reported in the media, makes it difficult to suggest that the response to HIV/AIDS in South Africa was adequate.

4.6 INTERPRETATION

In this chapter, the researcher has set out to investigate the role of the courts, forums, tribunals, national and provincial structures of response and directorates in response to HIV/AIDS. What should be borne in mind is that all interventions by the courts of law, forums and tribunals are regarded as external and are not attributed to the DoH or the DoSD. Therefore, in the event where the court intervened, such an intervention shall be deemed to have been imposed because it was not implemented on own volition by the department concerned.

4.7 CONCLUSION

While commendable that the State acted rationally by recognising international agreements and the *Charter on human and people's rights* when the Constitution was developed, NACOSA and SANAC failed to achieve the progressive realisation of health and welfare rights entrenched in section 27 (2). Again, while commendable that these rational structures were created with good intentions of leading the government and civil society in response to HIV/AIDS, they failed to respond adequately to HIV/AIDS between 1997 and 2002. They failed to effectively build public/private partnerships, to guide government departments and to mobilise communities because their meetings were held behind closed doors. As a result of

disallowed interaction with other stakeholders against the backdrop of the politicisation and the invective against HIV/AIDS, it suffices to suggest that they were influenced in a political way. Lack of interaction with national directorates, committees and the AIDS Consortium disadvantaged both NACOSA and SANAC in as far as information from the ground was concerned. As a result, they both failed to advise the government on matters of great policy significance in the field of HIV/AIDS.

The political influence on the work of NACOSA and SANAC permeated the national HIV/AIDS and TB Directorates located within the DoH, which was headed by Minister Manto Tshabalala-Msimang, who supported the invective against ARVs. By her own admission, the Minister emphasised that the quality of healthcare service depended critically on a sufficient number of professionals with relevant and appropriate knowledge and skills. As indicated under section 4.5, the response to HIV/AIDS was rendered inadequate by, among others, a lack of a trained cadre of healthcare professionals and infrastructure development. These problems were compounded by the non-availability of retention strategies that could have discouraged skilled and experienced healthcare professionals from emigrating overseas. The most effective and decisive retention strategy would have been to pay them competitive salaries as discussed under section 4.5. Again, the response to HIV/AIDS was dealt a blow between 2000 and 2003 by the implementation of the moratorium on the filling of vacant posts issued in terms of resolution number 7 of 2000 by the Department of Public Service and Administration. In the next chapter, the researcher investigates the adequacy of responses to HIV/AIDS in relation to the implementation of the NACP.

CHAPTER 5

THE IMPLEMENTATION OF THE PRINCIPLES OF THE NATIONAL AIDS CONTROL PROGRAMME BETWEEN 1997 AND 2000

Let us train our minds to desire what the situation demands
Marcus Annaeus Seneca.

5.1 INTRODUCTION

In the previous chapter, the constitutional obligations and legislative mandates in relation to health and welfare interventions are discussed. Furthermore, budgetary constraints and other organisational impediments emanating from the emigration of health and welfare professionals and social workers, as well as the implementation of the resolution 7 of 2000 on the filling of vacant posts are discussed. In the backdrop of these problems, the DoH and the DoSD were faced with the challenges of implementing the principles of the NACP contained in the WPoTHS. Mainly, the implementation of policies and programmes that were in accordance with the NACP are investigated in this chapter to determine as to whether that was adequate or not.

5.2 PREVENTION OF THE SPREAD OF HIV/AIDS AND MITIGATING ITS EFFECTS

According to South Africa (2003/2004:19), there were no significant developments regarding the establishment of sites for VCT and PMTCT between 1997 and 2000. However, mass mobilisation, mass action and rolling mass action campaigns were conducted between 1998 and 2000 as indicated under section 4.4. During the period, much focus was on the promotion of safe sexual behaviour and factors associated with it. According to Matthews (2005:47–150), the main driver of HIV in South Africa was sexual behaviour and practices influenced by personal, interpersonal, environmental, and cultural factors. In many communities, personal factors such as low self-esteem were associated with among other things, an irrational keenness

to engage in an earlier sexual debut, of having more sexual partners and having a negative attitude towards the use of condoms. Due to their low levels of self-esteem, these persons were often easily coerced into sexual activities as material items were sometimes exchanged.

Furthermore, the increased infection rate was attributable, according to a discussion document of the Department of Social Services and Population Development (South Africa 2001:6–7), to interpersonal factors, such as peer pressure to be sexually active and male-dominated sexual relationships. Coercive sexual activities and male-dominated sexual relationships, as well as some cultural practices compromised women's assertiveness and their position in society. The social workers and counsellors of the DoH and the DoSD were required to strengthen family fabric by, among others: (a) encouraging healthy family relationships and enrichment thereof, (b) implementing parenting programmes and promoting intergenerational positive parenting cultural practices in households with HIV/AIDS victims and (c) countering the impact of learned compromised behaviours and the negative cultural practices. In an effort to mitigate the effects of HIV/AIDS on OVCs, problems were linked to the NCFWC, childcare forums, CHBC and ECD facilities, as well as schools. This linkage meant the beginning of the integration of HIV/AIDS service delivery at community and PHC levels. In further preventing the spread of HIV/AIDS and its effects, the following strategy was also implemented.

5.2.1 LINKING EARLY CHILDHOOD DEVELOPMENT FACILITIES TO HIV/AIDS WORK

It was at the levels of communities and PHC where NCFWC, childcare forums, CHBC and ECD facilities, as well as HIV/AIDS community groups were able to identify OVCs with complicated emotions. It was also at those levels that VCTs and HIV/AIDS community groups could identify adult persons with complicated emotions and in dire need. That is why it was essential to capacitate all these facilities and HIV/AIDS community groups on referral systems capable of tracking PLWHA and OVCs from hospitals, clinics, schools, religious institutions and the wider community (Hepburn 2001:28). As mentioned in section 3.3.2 and 3.3.3, the developmental social work norm required social workers of the DoH and the DoSD to assist with the arrangement of legal assistance (eg wills), applications for relevant social welfare

grants and other forms of support, such as social relief of distress. These social workers ensured that community care of AIDS patients were linked to a continuum of care which included counselling and care of psycho-social, medical and nursing needs of OVCs. Legal advice and assistance was provided where necessary to PLWHA, OVCs and affected families. The fact that various disciplines were involved meant that an interdisciplinary approach and collaboration in the fight against HIV/AIDS was a prerequisite.

Between 1997 and 2000, formal awareness programmes on a harmful lifestyle and sexual practices were introduced and one of the aims was the early identification of OVCs and families at risk. The ECD facilities were not only used to identify OVCs and families at risk for diversion to appropriate interventions, but could also be used to teach OVCs and families how to protect themselves from abuse and HIV/AIDS, as part of the prevention strategy. In order to ensure collaboration at the level of the community, ECD facilities were required to link with social workers, PHC, FBOs, and CHBC formations to reinforce stages of development in childhood through cultural and religious practices. This was aimed at ensuring that ordinary children who do not attend formal/informal pre-school programmes also have access to prevention and welfare programmes (South Africa 2001:6–7).

5.2.2 USING VOLUNTARY COUNSELLING AND TESTING SITES AND FAMILIES TO PROMOTE HIV/AIDS PREVENTION

In Frohlich (2005:355), VCT sites are described as the first line of defence against HIV while the family is described as the second line of defence and also an entry point for all preventative interventions. Although the VCT sites and families were seen as the gateway to health and welfare goods and services, their effectiveness as preventative interventions, was obscured by unwillingness on the side of the people and families to know and disclose their HIV/AIDS status. In the opinion of the researcher, most individuals were hiding behind the principles of confidentiality and privacy as discussed under section 5.2.4. As mentioned under section 4.4.1, development in terms of the establishment of VCT sites was not significant between 1997 and 2000 and it was problematic to attract medical healthcare professionals to rural and farming communities.

Families, like VCT facilities, were useful in preventing the spread of HIV/AIDS, which is why it was important to include them in the popularisation of key prevention concepts by the media. Families and VCT sites were used by social workers in collaboration with community leaders, FBOs and teachers to fight coercive sexual activities, male-dominated sexual relations and cultural factors discussed in the introduction to this section. Through this interaction, life skills education for youth in and out of school was developed, while at the same time the values of the family were being strengthened. This was a mammoth task that both the DoH and the DoSD could not implement and manage on their own, hence the need to build the capacity of service providers, such as, NCFWCs, NGOs and childcare forums. Apart from the role of providing life skills education for youth and the strengthening of family values, the capacity building of NCFWCs and NGOs was also aimed at capacitating them to identify OVCs in need of adoption and foster care placement. Furthermore, national councils and NGOs were able to assist the DoH, the DoSD, families at risk and vulnerable communities with referrals to income-generating and poverty alleviation programmes and projects. The roles that social workers were expected to play in diverting families and prospective beneficiaries to social work services were emphasised in workshops and official meetings (South Africa 2001:6–7).

5.2.3 USING MASS MEDIA TO PROMOTE PREVENTION EFFORTS

The DoH contracted an NGO named Lifeline to run AIDS Helpline in order to provide individualised information and counselling (South Africa 2001/2002b:33–35). The introduction of the Helpline was intended to help people disclose their HIV status as most of them were scared to do so. According to Frohlich (2005:355), people who disclosed their HIV/AIDS status were often treated as outcasts. In workplaces, they were sometimes marginalised, discriminated against, and often fired. At community levels, people who chose to disclose their HIV/AIDS status were sometimes isolated, killed, or beaten to death as it once happened with the AIDS activist Gugu Dlamini of KwaZulu-Natal in 1998 (Fourie 2006:193).

In the year 2000, the two consortia, Johnnic Communications and Meropa Communications, which were a mix of formal/private sector and NGOs, won tenders for continuity announcements and print-advertising. The purpose of the campaign was to promote safe and

healthy behaviour among the youth. The younger audience was encouraged to delay sexual activity and those in later teens were encouraged to practice safe sex. Many lives were lost to HIV/AIDS due to lack of information, which is why it was important to use effective prevention strategies such as the television, the radio, and the print advertising to promote safe sexual behaviour. The use of this communication mix assisted in linking and diverting the PLWHA and OVCs, as well as affected families to service providers and NGOs willing to help (South Africa 2003a:16). While HIV/AIDS information was imparted nationally and prevention strategies promoted through mass mobilisation campaigns, the HIV vaccine suitable for the South African situation was supposedly being developed.

5.2.4 THE DEVELOPMENT OF THE HIV VACCINE AND POLITICAL INTERFERENCE IN RESEARCH

Although section 195 (1) of the Constitution requires that the high standard of professional ethics be promoted, the drug called Virodene was developed and was supported by Government and politicians, despite being developed by scientists who did not posses expert knowledge of HIV and virology or microbiology. The purported anti-AIDS drug called Virodene PO58 was construed a miracle cure for HIV/AIDS by politicians while its efficacy and toxicity were not questioned publicly as was the case with AZT and Nevirapine. The political crisis of morality was, according to Heywood (2005:378) and Joseph (2003:1146) characterised by a unique form of denialism in the highest echelons of political power.

According to Collins *et al* (2000:1389–1390), debates in health and welfare research findings can invigorate political process and ultimately lead to significant policy changes. Instead of allowing robust debates in research in South Africa, President Thabo Mbeki established the international AIDS Advisory Panel comprising 16 denialists and 16 orthodox scientists, to advise the country on the most appropriate response to HIV. Instead of paying heed to the scientifically proven evidence of the orthodox scientists that suggested that HIV causes AIDS, he chose to follow the assumption by denialists that there is no causal link between HIV and AIDS (Heywood 2005:378–379). Heywood and Joseph further maintained that failure by

Government to provide ARVs and Nevirapine was basically not a matter of budgetary constraints, but a matter of suspected political interests and delaying tactics.

Another political setback in response to HIV/AIDS was when President Thabo Mbeki publicly pushed for the Medical Control Council (MCC) fast-tracking of the approval of the drug's efficacy for public use (Fourie 2006:122). Again, the DoH announced that it would not provide AZT and Nevirapine, despite proven efficacy of the drugs in Thailand and Uganda. Again, the touting of Virodene happened before the drug could pass MCC clinical trials. As if the political moral compass was lost at the highest echelons of political power, international embarrassment was caused in 2002 when the efficacy of Virodene got political backing from President Thabo Mbeki and the Minister of Health, Dr Manto Tshabalala-Msimang before scientific peer reviews could even be conducted (Deane 2005:538).

Despite political interference in HIV research, partnership between the South African AIDS Vaccine Initiative (SAAVI), the Medical Research Council (MRC), and the traditional healers was developed in 1999 with a view to developing a preventative and effective vaccine for HIV/AIDS. In preparation of the clinical testing of candidate AIDS vaccine, a testing site was established at the Chris Hani Baragwanath Hospital in Gauteng (South Africa 2000/2001a:421). It was required of SAAVI to ensure that the HIV/AIDS medical trials were conducted in compliance with the guidelines of government on ethical research. In partnership with SAAVI, the MRC prepared communities for vaccine trials. The guidelines referred to here were released in October 2000 and they called for adherence to the highest ethical standards in research (South Africa 2003b:10). The MRC and SAAVI further partnered with the private sector and other research bodies in South Africa and the United States to develop and test an effective and affordable vaccine relevant to South African conditions within 10 (ten) years (South Africa 2001/2002b:41).

5.2.5 INTRODUCING THE AIDS NOTIFICATION LEGISLATION

In a quest to prevent the spread of HIV/AIDS, the then Minister of Health, Dr Nkosazana Dlamini-Zuma published the draft AIDS notification legislation in terms of sections 32 and 34

of the Health Act 9 of 1977 on 23 April 1999. The draft legislation required that AIDS and AIDS-related deaths be classified as notifiable diseases, which meant that AIDS and AIDS-deaths would be reported to the Government, family members, caregivers, municipalities and funeral undertakers. The development of the draft legislation was prompted by, among other things, the need for the Government to combat HIV/AIDS and to protect caregivers and family members from further infection (*AIDS Legal Quarterly* 1999:17). However, the legislation was not only deemed clashing with human rights by Mpedi, Kuppan, and Olivier (2003:216) and Fourie (2006:151), but with certain constitutional and legislative prescripts, for example, the constitutional right to privacy as entrenched in section 14 (d) of the Constitution and section 7 of the Employment Equity Act 55 of 1998, which promoted the principle of non-disclosure.

According to Heywood (1998:9), the right to privacy is a constitutional and a common law right entrenched in international law. As a matter of ethical principle, healthcare professionals, nurses, social workers, and careworkers involved in HIV/AIDS were required to be mindful of the patient's right to privacy. According to Peil (1995:16), experiments inconsiderate of research ethics might have caused permanent damage to the subject's health, which is why, according to Deane (2005:539–540), scientists were expected to maintain autonomy and comply with ethical guidelines. While HIV/AIDS was being politicised and research interfered with, the DoSD continued with programmes aimed at mitigating the personal and social impact associated with HIV/AIDS.

5.3 REDUCING THE PERSONAL AND SOCIAL IMPACT OF HIV/AIDS

While the DoH was addressing nursing, medical and health care needs of PLWHA and OVCs, the DoSD was developing appropriate social development policies and providing social welfare services to needy South Africans, who were unable to provide for themselves (Mpedi *et al* 2003:216). More often than not, some families disintegrated simply because one spouse tested positive for HIV. This resulted in children being displaced. According to Malherbe (2003:384–392), it was sometimes unavoidable that children were removed from their families and placed in the care of other persons or institutions. As it was not practical to restrict the payment of social welfare benefits to immediate family and legal parents, any caregiver or

prospective foster parent could apply for benefits. In the case of child-headed families, the eldest of the OVCs could receive social welfare goods and services from the DoSD on behalf of their siblings. The following social welfare grants and financial awards were administered and paid out in terms of the Social Assistance Act 59 of 1992.

5.3.1 EXTENDING THE DISABILITY AND THE CARE-DEPENDANCY GRANTS TO VICTIMS OF HIV/AIDS

The medical and the social models of disability discussed by Klinck (2003:314) are considered for the purposes of this study. Owing to the extent of severity of HIV/AIDS as a medical condition, a disability grant was made available to destitute adults whose CD4 count was less than 200. The eligibility to apply for the disability grant was also owing to physical or mental effects that caused inability to obtain employment or inability to provide for their dependents (Klinck 2003:311). The roll out of ARVs complicated access to disability grants because, as people gained access to ARVs, their CD4 count rose, thereby removing them from the social security catchnet. The WPoSW did not limit HIV/AIDS services to adults only, but to deserving OVCs as well. For example, a care-dependency grant application was considered for OVCs on the basis of the extent of substantial effects of HIV/AIDS on the child (Malherbe 2003:385). In the event where the child was taken care of by a state institution on a 24 hour basis, the caregiver or foster parent was not eligible to apply for the grant.

5.3.2 FOSTER CARE PLACEMENT FOR ORPHANED AND VULNERABLE CHILDREN

The most preferred intervention models of placement for OVCs displaced as a result of HIV/AIDS were the immediate family, extended family, surrogate parents, foster care, adoption, and neighbourhood or community catchnets, as opposed to institutional catchnets. The “surrogate parent” and the “cluster foster” models were interventions in which a surrogate parent was hired by the Government or a national welfare organisation to care for OVCs in a home (Frohlich 2005:351). These models allowed the child to be in a familiar environment rather than being in strange ones. Institutional models were used only in times of emergency

and were basically expensive, let alone difficult to sustain and to familiarise children with (Sewpaul 2001:6).

Under a normal foster care placement, the child was placed under the care of the foster parent/s in terms of the Child Care Act 74 of 1983, as amended. The order of placement was issued by the competent children's court, based on the investigation already conducted by the social worker of the DoH, the DoSD, NCFWC or the NGO. The foster care placement and payment was a constitutional right entrenched in the Constitution of the Land. For example, section 28 (1) (b) of the Constitution stipulates that *every child has the right to family care or parental care, or to appropriate alternative care when removed from family environment.* In the event where the situation demanded intervention prior to the finalisation of the order of foster care placement, or where children were displaced as a result of a crisis and where the family or the community was not able to meet basic needs, short term measures and financial awards were issued for PLWHA, OVCs and affected families.

5.3.3 PROVIDING ASSISTANCE TO CAREGIVERS, FAMILIES AND COMMUNITIES IN DISTRESS

The DoSD was mandated to provide goods and services to indigent persons taking care of those not able to fend for themselves due to the mental or physical severity of their illness. For example, grant-in-aid was applied for in terms of regulation 30 of the Social Assistance Act 59 of 1992. The mental and physical condition of the child or an adult person being taken care of had to demand regular attention by that person. Further to that, social relief was made available as a short term measure undertaken by a state organ during individual or community crisis. The crisis had to be of such a nature that the affected person, the destitute family or community was unable to provide or meet basic needs. The aid and the social relief of distress was extended to people taking care of PLWHA and infected OVCs in need of CHBC (Frohlich 2005:358–366).

5.4 MONITORING HIV/AIDS INFECTION RATE AND PROGRAMMES IMPLEMENTATION

Basically, the introduction of the AIDS notification legislation discussed under section 5.2.5 was aimed at monitoring the infection rate and the impact of HIV/AIDS in South Africa. However, according to Mark (1999:4), the AIDS notification mechanism was not a viable method of information gathering and could not be recommended for the improvement of surveillance. Over and above that, the mechanism was expensive and probably not feasible as it was capable of increasing the number of tests done, rather than a real increase in the number of cases. Mark points out that surveillance conducted at representative sentinel sites would be the best and the most viable method to monitor the clinical features of AIDS and to determine its impact on the healthcare system (Mark 1999:5). The view was also held by Smith (1999:6), who also saw the draft AIDS notification legislation as inappropriate and irrelevant in AIDS research. Although the AIDS notification legislation was not accepted on legal and ethical grounds, the mechanism could have assisted the Government in planning and developing appropriate programmes to mitigate the personal and social impact of HIV/AIDS.

According to Cloete (2000:215), it is essential to keep track of, among other things, spending on programmes and progress towards implementation when monitoring compliance to legislation and policy requirements. As shown above, while NACOSA and SANAC were charged with the responsibility to: (a) monitor the implementation of principles of care and support in the NACP; (b) implement services advocated in the WPoSW and; (c) funds channelled to HIV/AIDS activities in the country, they operated in the veil of secrecy and their organisational structures were weak and they lacked effective policies and strategies. Furthermore, failure by NACOSA and SANAC to monitor properly was caused by the fact that their secretariats were located within the DoH, thereby limiting the performance of multi-sectoral coordination. Again, the PHC services in South Africa were fragmented between the provincial and the local levels of governance. It is not inappropriate therefore to suggest that NACOSA and SANAC did not monitor responses to HIV/AIDS properly, bearing in mind that non-members and the general public were not allowed to interact with NACOSA and SANAC (Hickey *et al* 2004:109).This resulted in progress towards mitigating the impact of HIV/AIDS

in accordance with principles of HIV/AIDS care and support contained in the NACP of the WPoTHS (South Africa 1997a:61) and HIV/AIDS goods and services advocated in the WPoSW (South Africa 1997(b):61) being delayed.

5.5 INTERPRETATION

While appreciated that there were attempts to develop the HIV vaccine as discussed under section 5.2.4 and introduce the AIDS notification legislation in terms of section 32 and 34 of the Health Act 9 of 1977 as discussed under section 5.2.5, the invective against ARVs and MTCT at the highest echelons of political power continued as discussed under 1.2. Furthermore, the inappropriateness and irrelevance of the AIDS notification legislation and the absence of effective HIV surveillance mechanism at representative sentinel sites suggest that the mitigation of the spread of HIV in the period 1997 to 2000 was a dismal failure leading to the following being concluded.

5.6 CONCLUSION

The evidence presented under sections 5.2.4 and 5.2.5 suggest that there was a political morality crisis in the period 1997 to 2000 because, apart from the politicisation of the work of NACOSA and SANAC, which led to ineffective monitoring of programmes implementation and funds channelled to provinces, the work of research institutions such as the MRC, MCC, SAAVI and the University of Pretoria were also politically interfered with. The denial by the political and public office-bearers that there was no causal link between HIV and AIDS led to little focus on the virus and discouraged robust debates on its impact. What further led to political morality crisis between 1997 and 2000 was the continued invective against ARVs and MTCT on the one hand, while on the other hand pushing for the MCC fact-tracking of the approval of the efficacy of Virodene P058, which was a purported AIDS drug developed by the University of Pretoria scientists who did not have expert knowledge of HIV, virology or microbiology also led to delayed response.

CHAPTER 6

THE IMPLEMENTATION OF PRIORITY AREAS OF THE NATIONAL HIV/AIDS AND STIs STRATEGIC PLAN FOR 2000 to 2005

No Strategic Plan can anticipate every bump in the road, every thunderstorm, or every eventuality. F Mohammed.

6.1 INTRODUCTION

In the previous chapter, the researcher discussed the implementation of the principles of the NACP contained in the WPoTHS and goods and services advocated in the WPoSW. The Plan discussed in this chapter was initiated by the Minister of Health, Dr Manto Tshabalala-Msimang in accordance with the WPoTHS and the WPoSW. This was done in July 1999 in a meeting attended by, among others, academic institutions, human rights organisations, political parties, media, and relevant government departments. The final draft of the Plan was completed in 1999 and was subsequently approved by Cabinet in January 2000. The priority areas of the Plan discussed in this chapter are, among others (a) prevention; (b) treatment; care and support; (c) human and legal rights, as well as research. Developments pertaining to research monitoring and surveillance are already discussed under sections 5.2.4 and 5.2.5 respectively. They are therefore not going to be part of the discussion in this chapter. The responses commencing with the Plan are investigated with a view to finding out whether they were occasioned by the High Court decision or whether the Government acted of own volition. In essence, the purpose in this chapter is to measure the extent of the commitment to implement the priority areas of the Plan, the first priority area being prevention.

6.2 THE CONTINUATION OF PREVENTION EFFORTS

Whereas the DoH continued to distribute condoms for HIV prevention, refusal to distribute ARVs continued between 2000 and 2002. Despite that, the DoSD continued to provide welfare goods and services to reduce the personal and social impact of HIV/AIDS. In terms of the selected strategies of the national HIV/AIDS and STIs Strategic Plan for 2000–2005, the DoH

was expected to take a lead in providing HIV/AIDS treatment while the implementation of care and support efforts was a joint responsibility of government departments, NCFWC, NGOs, CBOs, FBOs and communities (South Africa 2003a:10). In the field of HIV prevention, the DoH did well in making sure that condoms were distributed free of charge through government departments. The implementation of barrier methods such as the use of condoms, maintenance of safe blood transfusion services, as well as VCT and PMTCT were essential in mitigating the spread and the high prevalence of HIV/AIDS.

6.2.1 PROMOTING THE USE OF CONDOMS AS A BARRIER METHOD

According to South Africa (2003b:4), the goal for the use of condoms as a consistent barrier method was encapsulated in the national HIV/AIDS and STIs Strategic Plan for 2000–2005. In terms of table 6.1 below, the distribution of male condoms increased by 69 million between 1999 and 2002 and female condoms increased by 0,7 million in the same period. The distribution of male and female condoms in 2003/2004 was virtually doubled as compared to 1999/2000. However, no study providing reasons to the disproportionate correlation between condoms distributed to males and their female counterparts as set out in table 6.1 could be found.

TABLE 6.1

DISTRIBUTION OF CONDOMS

TYPE	1999/2000	2000/2001	2001/2002	2002/2003
Male	198 million	254 million	267 million	302 million
Female	0,6 million	0,6 million	1,3 million	194 million
Total	198,6 million	250,6 million	268,3 million	496 million

SOURCE: DEPARTMENT OF HEALTH ANNUAL REPORT 2001/2002b:34

Apart from making use of public health outlets to distribute condoms, non-traditional outlets such as, brothels, taverns, hair salons and shebeens were utilised to display and to distribute condoms (South Africa 2003/2004:19). Much as the use of condoms was an effective method

of HIV prevention, the personal, interpersonal and cultural factors discussed in section 5.2 were challenges, especially in rural areas. There were also challenges in relation to MTCT in the areas.

6.2.2 MITIGATING MOTHER-TO-CHILD TRANSMISSION

The observation indicating that HIV is transmittable from mother to child revealed that whether the viral load is high or low, chances of transmission are always high. The goal of PMTCT was to integrate VCT into maternal and child healthcare services by, among others, identifying HIV positive women and reducing the transmission of HIV from parent to child. As a result, the PMTCT Programme was launched in the beginning of 2001. In the same year, the operational research project on the PMTCT, which included the investigation of administration of Nevirapine to the mother and the baby within a comprehensive package of treatment, was implemented. The research project ran for a period of two years at 250 health facilities clustered as 18 research sites. It was confirmed through that research that the risk of a HIV positive mother transmitting the virus to the child was high during the course of birth and that transmission could also occur later on through breastfeeding. The impact of the programme became clear in 2002/2003 and the lessons learned from the research were the following (South Africa 2003(b):7):

a. A strong VCT service was key to good uptake of the PMTCT as an intervention.

b. Community involvement could reduce stigma and create an environment for women to exercise their choices.

c. The quality of PMTCT Programme depended on the quality of PHC service on which it was built.

d. The resources of service user's access to transport, clean water and electricity did impact on the programme.

Due to the increased number of VCT sites at the end of 2003, more than 80 000 pregnant women received PMTCT, of which 60% consented to being tested. In all, 28% (13 000) of the 46 000 who tested, tested HIV-positive. Seven thousand (7 000) of women who tested positive received Nevirapine. The 6 947 babies whose parents were tested, received Nevirapine while 5 135 of women who tested received replacement feeding for their babies for a period of six months. The difference between those who tested positive and the recipients of Nevirapine was influenced by the fact that tests were sometimes taken early in pregnancy while the supply of Nevirapine was only close to the date of giving birth. In order to fast-track growth pertaining to the Treatment Programme, the DoH produced guidelines aimed at expanding the programme. The expansion of the programme led to the development of training packages for frontline healthcare providers. As a result of pressure emanating from the distribution of ARVs, an estimate of 1 200 doctors and nurses were subjected to training (South Africa 2002/2003:16). What remained a national problem in the area of prevention was ensuring that blood transfusion was safe and free of discrimination.

6.2.3 ENSURING A SAFE BLOOD TRANSFUSION SERVICE

The HIV/AIDS pandemic is one of diseases that can be passed from the blood donor to the recipient. According to Tanner (2006:1), the World Health Organization (WHO) estimated that 10% of HIV infections globally were acquired from blood transfusions. In South Africa alone, research evidence suggested that 24 HIV infected units of blood entered national blood supply in 1999. Due to the racial profiling of donors, poor funding and high HIV seroprevalence in South Africa, blood donations declined from 0,17% in 1999 to 0,08% in 2002. By that time, there was a suggestion that gay men and blacks were risks of donating HIV-tainted blood to the extent that the donated blood of President Thabo Mbeki was discarded in 2004. The latter caused public outcry and the policy of the South African National Blood Service (SANABS) of using race in rating the risk of blood donations was criticised (South Africa 2003a:7).

According to Alcorn (2007:1), a turning point was reached in 2004 when SANABS backed down on its racial profiling policy. The latter came to being as a result of the intervention by the Minister of Health, Dr Manto Tshabalala-Msimang. The intervention by the Minister also

led to South Africa being the first country in the world to introduce the nucleic acid testing in October 2005. It is further pointed out that the Medical Director of SANABS, Dr Sam Gulube confirmed that the introduction of the method meant that every unit of blood was tested not based on skin colour. Furthermore, Alcorn points out that approximately 3 000 units of blood were tested every day at the cost of R344 000 a day.

In further ensuring safe blood transfusion in 2003/2004, the National Health Laboratory Services (NHLS) was established in 2000. The 250 established laboratories employed 3 500 employees in 2003/2004. By the end of 2005 two thousand and eight (2008) posts of medical technologists were filled while 24 CD4 operating sites and nine viral load laboratories were established. The laboratories were established in rural areas previously under-serviced in the Eastern Cape. According to South Africa (2006:345), the short-messaging system (SMS) project assisted in transmitting laboratory results in rural under-serviced areas of the Cape. The project was concluded and was expanded nationally from 2005/2006.

6.3 PROVIDING CARE AND SUPPORT

Due to the need to increase access to services and to enhance service delivery in the field of HIV/AIDS, the Minister of Welfare, Dr Zola Skweyiya prioritised financial assistance for the care of PLWHA, OVCs and needy families through support to NCFWC and NGOs in partnership with other departments from 1999 (South Africa 2000/2001b:41–55).Most goods and services pertaining to care were still being provided by the DoSD through a continuum of care between families and schools, ECD, VCT, NGO and CHBC facilities as discussed in chapter 5. During 2001/2002, six hundred and ninety one (691) VCT sites were established and by the end of 2004, the number of established sites increased to 2 582. The majority of the sites were located in public health facilities and only 130 sites were located in non-medical facilities.

On 19 November 2003, the Cabinet approved the implementation of the Operational Plan for Comprehensive HIV/AIDS Care, Management and Treatment in South Africa. The Plan recognised the need to improve management of the care and treatment for PLWHA by, among

others, providing ARVs at public health facilities. However, the provision of ARVs required accreditation of public health facilities and this process was started late in 2004 at 113 facilities identified by provinces. This intervention was implemented towards the end of the implementation of the Plan and that in itself is a cause for concern in this study. As follow-on to the progress made, the first and second round visits by National Health Portfolio identified challenges pertaining to, among others, inadequate staff, poor information management, inadequate patient transport, insufficient space and uncoordinated referral system in the very same year (South Africa 2003/2004:18).

However, things improved in 2005 because 169 882 OVCs were identified and were receiving appropriate care and support services. As follow-ons, twenty five thousand four hundred and sixty five (25 465) visit interventions were conducted to child-headed families to render counselling and support services. The total number of families that received support was 247 792 while 6 976 caregivers and families received training. The training included parenting skills, trauma management, child and youth care work, psycho-social support, HIV/AIDS counselling and peer education, among others. Psychosocial support and counselling was provided to 54 964 PLWHA and 621 support groups were strengthened while 9967 individuals were referred for social welfare grants (South Africa 2005b:129). What must be borne in mind though is that the beneficiaries referred for social grants did not automatically qualify for eligibility to apply because the means test was put in place to gate keep those who had sufficient and acceptable means of survival.

6.3.1 ENSURING INDIVIDUAL AND COLLECTIVE CAPACITY BUILDING

As a result of increased number of VCT sites, the number of accredited counsellors increased to 4 466 by the end of 2001/2002. It is estimated that more than 300 000 people received services from these sites (South Africa 2002/2003:17). In order to be able to deal with an increasing workload, 1000 healthcare workers were re-trained in regard the use of ARVs in the long-term management of AIDS, while 50 000 copies on treatment and care manuals were distributed in the year 2000. The manuals provided public healthcare workers and NGOs with guidelines relating to sound nutrition for PLWHA. In order to make policy-makers in

government understand the impact of the pandemic and how to apply this understanding in their planning processes, the HIV/AIDS Primary Capacity Development Course for Government Planners was effected from July 2001 (South Africa 2001/2002:99). When the latter was implemented, the DoH had already started to conduct treatment literacy workshops and programmes. Participants to the workshop were inclusive of healthcare workers and PLWHA. The Life Line counsellors were also provided with the same kind of training between 2002 and 2003 (South Africa 2003a:8).

While refusal to provide ARV treatment was being contested through the High Court by the TAC, the DoSD targeted to train 8 395 volunteers and community workers to provide social protection to OVCs. However, the actual output was 6 976. The training included, among others, volunteers and community workers and was in psycho-social support, trauma management, child and youth care work, as well as HIV/AIDS counselling. In line with priority area two of the national HIV/AIDS and STIs Strategic Plan, the DoSD also targeted to provide technical and financial support to 450 CHBC care projects targeting children and poor households. The actual output was 352. The implementation of the training programme led to the establishment of 200 child care forums. The desired output of 200 child forums countrywide was exceeded because 1 071 child care forums were established. Furthermore, 60% of rural CBOs were targeted for collective training by the DoSD through workshops. The impressive actual output of 90% was achieved, which exceeded the target by 30%. In strengthening responses further, the National Action Committee for Children Affected by HIV/AIDS was established with the aim of ensuring that the Government meets its constitutional obligations to provide treatment, care and support to children through linkages between HIV/AIDS programme and Poverty Relief Programme (South Africa 2005/2006:545).

6.4 CREATING APPROPRIATE HUMAN AND LEGAL RIGHTS ENVIRONMENT

A turning point was reached in July 2002 when the High Court handed down a ruling that ARVs and Nevirapine were to be provided nationwide from all public hospitals and clinics (Kevin 2003:1). The DoH was given a deadline of the end of September 2003 to come up with

a draft plan to roll out the distribution of ARVs from all public hospitals and clinics. The plan was subsequently released by the DoH on 19 November 2003 (Deane 2005:545). The decision for the rollout emanated from the case of the Treatment Action Campaign (TAC) versus the Minister of Health, wherein reference was made to international agreements and the Constitution. After being coaxed by the TAC in meetings with Government and being forced through the High Court to distribute ARVs, the State cited the following reasons for not implementing HIV/AIDS treatment (Annas 2003:750):

a. The efficacy of drugs would be compromised in sites where comprehensive package of services, including breastmilk substitutes, was of no avail

b. The administration of the drug might produce a drug-resistant form of HIV

c. The use of Nevirapine prior to the demonstration of its safety was not procedural

d. The health system was not capacitated to deliver the "full package of services"

The High Court interpreted articles of international agreements mentioned in section 3.2 as legal instruments and read them in conjunction with section 27 (1) of the Constitution, which states that: *Everyone has the right to have access to* (a) *health care services, including reproductive health care*; (b) *sufficient food and water; and* (c) *social security*. Again, section 27(2), which states that: *The state must take reasonable legislative and other measures, within its available resources; to achieve the progressive realization of each of these rights* was referred to. Also referred to was section 28 (1) (b) which provides that: *Every child has a right to family care or parental care or, to appropriate alternative care when removed from the family environment, has the right to basic nutrition, shelter, basic health care services and social services*. It was emphasised that the child's best interests are of paramount importance in every matter concerning the child. The court responded to reasons not to provide Nevirapine and the restriction of the distribution thereof in the following manner:

a. In disposing of the safety issue, the court referred to the WHO recommendation that the drug was safe. The determination by the South African Medical Control that the drug was safe was also referred to.

b. In dealing with the capacity issue, the court held that resources are relevant to the universal delivery of the full "package", but are not relevant to the question of whether Nevirapine should be used to reduce mother-to-child transmission of HIV at those public hospitals and clinics outside the research sites where facilities existed for testing and counselling.

The High Court ordered the Government to formulate and to also implement the decision, bearing in mind available resources, a comprehensive and coordinated programme in realisation of the pregnant woman's rights and her child. The court then ordered the Government to implement the following as a matter of urgency (Annas 2003:750–75):

a. The removal of restrictions that prevent provision of Nevirapine at all public hospitals and clinics that were not research and training sites at that point in time

b. Distribution of and the use of Nevirapine at public hospitals and clinics as long as medically indicated

c. To ensure that counsellors are trained and made available at public hospitals and clinics

A few months before the sitting of the High Court, it surfaced in the meeting of MinMec in 2002 that five provinces broke ranks with the ANC due to its policy on HIV/AIDS. These provinces stood firm on expanding restricted PMTCT facilities beyond pilot sites allocated (Haffajee & Bisseker 2002:26). Such provinces were the Western Cape, KwaZulu-Natal, Free State, North West and Gauteng. According to Wilson and Fairall (2005:478), the delayed response also held the provision of palliative care to ransom. Due to the fact that the Government failed to secure victory in the case, the court order compelling the State to

distribute ARVs from public hospitals and clinics created pressure on the DoH to enhance and strengthen responses in other priority areas of the national HIV/AIDS and STIs Strategic Plan.

6.5 THE STRENGTHENING OF THE HIV/AIDS RESPONSE

In further strengthening the response to combat HIV/AIDS, the operational Comprehensive HIV Plan for the Care, Management and Treatment of HIV/AIDS Care was announced by the Cabinet on 20 November 2003 (Cardiello, Dong, Marlin, Rodriguez, Trevor & Walker 2003:1). This Plan was the last component of the HIV/AIDS and STIs Strategic Plan and was produced by the Health National Task Team in tandem with the Clinton Foundation. The Plan was aimed at addressing the country's critical needs for the distribution of ARV treatment and a variety of aspects of HIV/AIDS including:

a. Accessibility to antiretroviral treatment for PLWHA within five years, through the establishment of local integrated care centres providing community care and support services in every health district

b. Systematic scale-up and integration of healthcare infrastructure to support all prevention and treatment programmes and services with cultivation, recruitment, and retention of local and international health care professionals specialising in HIV/AIDS care and STIs prevention

c. Creation of effective public education campaigns aimed at the prevention, tolerance, and community awareness to reform the social stigmas and discrimination associated with HIV/AIDS

d. Expansion of strategic partnership with NGOs, CBOs, media and international organisations to support the goals of the plan

Whereas the researcher appreciates that the DoH and the DoSD were able to develop the HIV/AIDS and STIs Strategic Plan and the operational Comprehensive HIV Plan for the Care,

Management and Treatment of HIV/AIDS Care in a collaborative manner, the implementation of the former was marred by political interference and invective against ARVs and PMTCT, while the latter was announced late in November 2003. It was therefore difficult to suggest that the DoH and the DoSD responded adequately to the impact of HIV/AIDS. The other factors that that impeded the effective implementation of the national HIV/AIDS and STIs Strategic Plan and the operational Comprehensive HIV Plan were identified.

6.6 PRIMARY AND SECONDARY FACTORS CAUSING INADEQUATE RESPONSES TO HIV/AIDS

As pointed out by Cloete (2000:215), it is essential to keep track of, among other things, spending on programmes, timeframes, progress towards objectives, and quality and quantity of outputs when monitoring compliance to legislative and policy requirements. During the implementation of the national HIV/AIDS and STISs Strategic Plan and the operational Comprehensive HIV Plan, programmes monitoring was not effective as confirmed in South Africa (2003/2004:64), where it is pointed out that the most serious challenge that faced the DoH and the DoSD before 2003/2004 was the poor level of performance monitoring, implementation and spending. As a result of problems identified in terms of implementation of monitoring and funding, the DoSD outsourced activities pertaining to monitoring of funding, capacity building, policy and research, policy dialogue and impact assessment to the National Development Agency, which was established in terms of the National Development Agency Act 108 of 1998. The key strategic objective of the National Development Agency was to collaborate with local community development trusts, foundations, government clusters and civil society organisations (South Africa 2005b:11).

Based on evidence provided and for the purposes of this study, the factors that stood in the way of effective implementation of priority areas of the national HIV/AIDS and STIs Strategic Plan are divided into two categories, namely, primary factors and secondary factors. The primary factors identified are: (a) the politicisation of HIV/AIDS; (b) continued invective against ARVs; (c) and MTCT that permeated national structures of response such as NACOSA, SANAC and the MCC as outlined under section 1.2 and the research institutions as discussed

under sections 4.41, 4.4.2 and 5.2.4. All other factors identified as structural and organisational are dealt with in section 4.5 and they were: (a) budgetary constraints; (b) the lack of skills in financial management and project management and; (c) the scarcity of healthcare professionals knowledgeable in HIV/AIDS, microbiology and/or virology. The implementation failures were compounded by various problems. For example: (a) the absence of an effective retention strategy for healthcare professionals and social workers; (b) the implementation of the moratorium on filling of posts issued in terms of resolution 7 of 200 by the Department of Public Administration; (c) poor information management as discussed under 6.3; (d) inadequate patient transport; (e) insufficient space and; (e) uncoordinated referral systems. From the foregoing, the following interpretation is coined.

6.7 INTERPRETATION

Based on the influence of systemic, structural and various organisational factors identified and presented again in this chapter, it became very difficult, as suggested below, for the researcher to suggest or conclude that the DoH and the DoSD were able to respond adequately to the impact of HIV/AIDS between 2000 and 2005 in South Africa.

6.8 CONCLUSION

Taking into cognisance the politicisation of HIV/AIDS and the invective against ARVs and MTCT that permeated national structures of response and their work, it became difficult and inappropriate to suggest that the Government had a political will to comply with relevant articles of international agreements and constitutional obligations. Furthermore, based on evidence presented under section 6.4, had the TAC not forced the Government to distribute ARVs through the High Court in 2002, the Government would never have done that in 2002. In view of this, it is not inappropriate to suggest that the government did not act on own volition and that the implementation of the distribution of ARVs, as an intervention, was basically external.

While appreciated that the intervention by the Health Minister led to South Africa being the first country in the world to introduce the nucleic acid testing in October 2005 as discussed under 6.2.3, this remarkable developments was carried out in the last year of the implementation of the national HIV/AIDS and STIs Strategic Plan for 2000–2005.

The DoSD was able to: (a) provide training to caregivers and families; (b) identify PLWHA, OVCs and support groups for appropriate care and support; and (c) refer individuals for social welfare grants as discussed under section 6.3. However, information on the effectiveness of training provided, the quality of care and support provided, as well as the total number of beneficiaries who did in fact receive grants was not obtainable for the year in question. Again, these comment-worthy developments were implemented and recorded only in the final year of the implementation of the national HIV/AIDS and STIs Strategic Plan for 2000–2005.

In the absence of the financing of all priority areas of the national HIV/AIDS and STIs Strategic Plan, programmes implementation could have been impractical. It was therefore felt necessary to investigate the impact of budgetary allocations and expenditure in the field of HIV/AIDS.

CHAPTER 7

INVESTIGATING THE INFLUENCE OF POLICY DEVELOPMENTS ON HIV/AIDS PROGRAMMES AND EXPENDITURE BETWEEN 1997/1998 AND 2005/2006

Outlook determines outcome; attitude determines action
Warren W Wiersbe.

7.1 INTRODUCTION

The investigation of how the national HIV/AIDS and STIs Strategic Plan for 2000–2005 was conducted and some inadequacies are identified in the previous chapter. On the one hand, the purpose in this chapter is to explore how policies and programme responses impacted on HIV/AIDS budgets and expenditure and on the other hand, how budgets and expenditure influenced programmes implementation. The budgets are discussed, among others, as tools of coordination and integration and the new financing policy as a launching pad to redress the past imbalances of apartheid while implementing the goals of social development. In essence, the overarching goal in this chapter is to investigate how budgets and the new financing policy were used to implement programmes pertaining to HIV/AIDS. The central concept "adequate", which is embedded in the research question is defined and clarified in both qualitative and quantitative terms in chapter 1. This resulted in this chapter being discussed in both narrative and enumerative terms. The researcher did to not only use official documents of departments in investigating allocated HIV/AIDS budgets and expenditure, but also made use of the national expenditure estimates of the National Treasury. The researcher saw it fit to start by discussing budgets as tools of control, coordination and integration.

7.2 EXPLORING BUDGETS AS TOOLS OF CONTROL, COORDINATION, AND INTEGRATION

According to Hickey *et al* (2004:100), demographic and socio-economic indicators were taken into cognisance when budgetary allocations to combat HIV/AIDS were done. For the first time, budgets began to be used as performance-based tools that gave a framework within which

HIV/AIDS policy implementation and programmes were allocated funds. As a matter of principle, the DoH and the DoSD were required to monitor expenditure in terms of implementing the NACP between 1997 and 2000 and the national HIV/AIDS and STIs Strategic Plan for 2000–2005. Apart from being used as tools of control, budgets can, according to Gildenhuys (1997:130), be used to coordinate activities and integrate services. Gildenhuys further points out that coordinated efforts should be aimed at keeping everyone abreast of programme developments.

The harmonisation of coordinated efforts targeting PLWHA, affected women, vulnerable youth, and OVCs were aimed at implementing social development goals discussed under section 3.3.2. Again, the principles of care and norms, as well as standards of developmental social work discussed under section 3.3.3 and 3.3.4 were integrated at PHC and community levels because those were levels at which social interactions could be used to maximise the efficiency and the effectiveness of HIV/AIDS work. Common sense dictates that it could have been impractical to maximise efficiency and effectiveness of VCT, ECD and CHBC sites to promote implementation of interaction in the absence of the allocation of budgets.

7.3 ALLOCATION OF BUDGETS TO NON-GOVERNMENTAL ORGANISATIONS AND COMMUNITY INITIATIVES

On the one hand, many emerging service organisations and those already rendering legitimate HIV/AIDS services were still financially excluded from funding in 1997/1998, while on the other hand more coalitions to promote a more coherent response was required to identify and expedite the diversion of deserving PLWHA, OVCs, families and vulnerable groups to appropriate health and welfare catchnets. To implement a more coherent response from 1999, the Minister of Social Development, Dr Zola Skweyiya reviewed the financing policy with the aim to, among other things; transform the way the NCFWC and NGOs were subsidised and to also promote social integration and to promote the development of communities. The flaws identified during the review processes were that: (a) in some instances financing continued, virtually ad infinitum, in the absence of appreciable performance, (b) payment to service providers was linked to unit cost and social work posts, instead of the need, targeted group, and

cost of the service; and (c) sets of services were predetermined, usually, with a single purpose. As opposed to the situation in the former political dispensation, the new financing policy was not based on entitlement, but on the appropriateness and the progressiveness of services rendered (South Africa 2000:1–2).

Whereas required to be properly constituted and structured in terms of the new Non-profit Organisations Act 17 of 2000*,* any emerging NGO not yet registered could access financing on submission of a business plan together with other prescribed forms (South Africa 2000b:7). The process of developing norms and standards for service delivery and costing of welfare services was finalised and implemented with effect from 2003. Eventually, the poverty relief projects submitted by the DoSD in 2002/2003 were approved and funded with the aim of yielding outputs in, among other areas: (a) the promotion of social integration, diversity, and equity; (b) the use of services as a networking tool between organisations and communities; (c) the promotion of integration between social services and social security; and (d) the allocation of resources to ensure more equity (South Africa 2001/2002a:500).

According to South Africa (2000b:39), there were two financing options made available to organisations seeking financial assistance, namely, grants and service purchasing. The grant option provided an opportunity to emerging and developing NGOs to access financing from the DoSD and the DoH, even when not formerly registered. Applications were considered for approval even though lodged through an existing but different registered organisation. Organisations in this category were expected to be already rendering the service at community level to a reasonable number of people, who were actually benefiting. The service purchasing option was available for goods and services that were earmarked to meet national or provincial priorities. Here, service providers were required to submit their service plans, in which they committed and agreed to address priority needs of remote and rural communities in need. Further to that, the extent of performance and compliance in addressing priority needs of remote areas were used to determine whether the service level agreement should be discontinued or renewed.

As the name entails, the project financing, was accessed mainly at project level. This level applied in cases where certain components of services were deemed to be appropriate, affordable and meeting the requirements of developmental priorities. The differentiated services level applied where different activities and different target groups were contained in one service plan, whereas in the case of inter-sectoral financing, the contents of the service plan had to culminate into a comprehensive and fully developmental service. In a nutshell, a residential facility was expected to provide different expertise to broader community target groups, including PLWHA and OVCs in a coordinated and integrated manner. Appropriate mechanisms in terms of financing were also put in place to ensure that provincial departments and NGOs received assistance and support from 1997 to 2000. It must be clear from the foregoing that the main objective of funding public/private partnerships, NGOs and community-based initiatives was to ensure social integration while redressing the imbalances created by apartheid. As a result of the relaxation of eligibility to apply for funding, there were 466 HIV/AIDS NGOs providing CHBC to 61 663 individuals in 2001 (South Africa 2001/2002b:41) and 2868 poverty relief projects funded jointly by the DoH and the DoSD in order to strengthen partnerships (South Africa 2000/2001b:40).

7.4 THE STRENGTHENING OF STRATEGIC PARTNERSHIPS AND TRENDS IN EXPENDITURE

It is stated in sections 2.5.1 and section 4.4 that NGO and community involvement was important in planning and implementing PHC efforts aimed at mitigating the impact of HIV/AIDS. The budgets of the MTEF of 1998/1999–2001/2002 and 2002/2003–2004/2005 are now analysed as shown in table 7.1. Whereas GAAP was allocated funds as set out in table 7.1, nothing was allocated for NCFWC, NGOs and community initiatives between 1997 and 2000 as already mentioned. However, in terms of table 7.2, HIV/AIDS NGOs were allocated funds and they started spending with effect from 2001/2002. As set out in tables 7.2, 7.4 and 7.5, the financing of NGOs and CHBC was a shared responsibility between the national DoH and the DoSD as required in the NACP and the national HIV/AIDS and STIs Strategic Plan for 2000–2005. What is evident from the tables is that the medium term expenditure framework for CHBC increased more than fourfold in 2002/2003 from 2001/2002 and also tremendously

when adjusted appropriation was done in 2004/2005. While the medium term expenditure for HIV/AIDS NGOs increased six fold under the Strategic Health System as set out in table 7.2, there were no significant increases in as far as the Social Development Programme as set out in table 7.6 is concerned. This is attributed to the fact that the DoSD was busy reviewing the 1999 financing policy that was finalised in 2001.

TABLE 7.1

EXPENDITURE ESTIMATES UNDER VOTE 16: PROGRAMME 2: STRATEGIC HEALTH

Subprogramme	**Expenditure outcome**			Adjusted Appropriation 2001/2002	**MTEF Estimate**		
	R thousands						
	1998/1999	1999/2000	2000/2001		2002/2003	2003/2004	2004/2005
HIV/AIDS and TB	101 541	74 480	181 148	265 892	408 205	544 033	689 503
Maternal, child and women's health	297 518	32 195	654 706	625 301	614 540	618 322	639 499
Government AIDS Action Plan	580	4 813	14 013	22 357	-	-	-
TOTALS	**399 539**	**111 488**	**849 867**	**913 750**	**1 022 745**	**1 162355**	**1 329 002**

SOURCE: (SOUTH AFRICA, NATIONAL TREASURY. ESTIMATES OF NATIONAL EXPENDITURE 2002: 353)

As shown in table 7.1, funds were allocated for HIV/AIDS and TB, as well as for maternal, child and women's health. There were no funds for the promotion of comprehensive and holistic treatment and care. However, as shown in table 7.3, comprehensive HIV/AIDS grant allocations were made for the MTEF period 2002/2003–2004/2005 and the adjusted appropriation of R115 108 was allocated in Programme 2 of 2006.

TABLE 7.2

EXPENDITURE ESTIMATES UNDER VOTE 16: PROGRAMME 2: STRATEGIC HEALTH

Subprogramme	**Expenditure outcome**			Adjusted Appropriation 2004/2005	**Extracted year from the MTEF Estimate**
	R thousands				
	2001/2002	2002/2003	2003/2004		2005/2006
HIV/AIDS	264 820	454 588	666 230	1 235 329	1 531 165
Maternal, child and women's` health and nutrition	103 708	103 177	122 490	142 884	148 417
HIV/AIDS NGOs	5001	31 331	43 378	40 250	49 745
Government AIDS Action Plan	29 808	-	-	-	-
Poverty relief	3 487	12 370	6 500	7 138	-
South African AIDS Vaccine initiative	-	6 000	10 000	10 000	10 000
LifeLine	-	-	11 000	12 000	15 000
LoveLife	25 000	25 000	25 000	23 000	23 000
Soul City	-	-	-	5 900	8 000
South African National AIDS Council	20 000	10 000	15 000	15 000	15 000
TOTALS	**429 324**	**642 466**	**899 598**	**1 491501**	**270 858**

(SOURCE: SOUTH AFRICA, NATIONAL TREASURY. ESTIMATES OF NATIONAL EXPENDITURE 2003: 346)

The funding of HIV/AIDS NGOs was aimed at ensuring that PHC and the comprehensive community development programmes are implemented to serve the needs of vulnerable groups and affected communities. It could have been impractical for the DoH and the DoSD to mitigate the impact of HIV/AIDS on their own, which is why allocations were made available for partners like NACOSA and SANAC. However, SANAC was launched in 1998; but monies allocated to it were spent only in 2001/2002 as set out in table 7.2. According to the table, funding for HIV/AIDS increased remarkably in 2002/2003 with expenditure for HIV/AIDS NGOs increasing tremendously in the same year as set out in the same table. The main observation in relation to the study is that increased HIV/AIDS expenditure came with the handing down of the decision of the High Court on July 2002. Tables 7.3 and 7.4 below

support the notion that increases in budgetary allocations and expenditure were mainly influenced by the handing down of the High Court decision.

TABLE 7.3

EXPENDITURE ESTIMATE FROM VOTE 16: PROGRAMME 2: COMPREHENSIVE HIV/AIDS GRANT

Subprogramme	**Expenditure outcome**			**Adjusted Appropriation 2005/2006**	**Extracted year from MTEF**
	Thousands				
	2002/2003	2003/2004	2004/2005		2006/2007
Comprehensive HIV/AIDS Grant	210 209	333 556	735 381	115 108	1 567 214

SOURCE: (SOUTH AFRICA, NATIONAL TREASURY. ESTIMATES OF NATIONAL EXPENDITURE 2006: 334)

The Comprehensive HIV/AIDS Grant was introduced in 2002/2003 and expenditure outcomes were as set out in table 7.3 above. By the time the Programme was introduced, conditional grants to provinces for HIV/AIDS activities indicated in the first column of table 7.4 were already made available with effect from 2001/2002. As shown in column three of the table, conditional grant allocations increased fourfold in 2004/2005.

TABLE 7.4

NATIONAL CONDITIONAL GRANT ALLOCATIONS TO PROVINCIAL HEALTH DEPARTMENTS FOR HIV/AIDS WORK

Activities within AIDS programme.	**2001/2002**	**2002/2003**	**2003/2004**	**2004/2005**
VCT	R22-m	R49-m	R81-m	R86-m
CHBC	R12-m	R47-m	R64-m	R68-m
PMTCT	R20-m	R24-m	R53-m	R128-m
Step-down care	R0-m	R30-m	R60m	R90-m
Programme Management	R0-m	R7-m	R8-m	R8-m
TOTAL	R54-m	R157-m	R266-m	R380-m

(SOURCE: DEPARTMENT OF HEALTH ANNUAL REPORT 2001/2002b:32)

As set out in table s 7.1, 7.2, 7.3 and 7.4 above, budgetary allocations and expenditure were not adequate to mitigate the impact of HIV/AIDS between 1997 and 2000. Substantial increases in HIV/AIDS spending were only done in 2003/2004 after the State was compelled by the High Court to roll out ARVs from all public hospitals and clinics. The allocations for the MRC and the NHLS are not reflected in all tables above. Since these entities had a role to play in preventing the increased spread of HIV, they are dealt with separately below.

7.5 THE FUNDING OF THE MEDICAL RESEARCH COUNCIL AND THE NATIONAL HEALTH LABORATORY SERVICES

The MRC and the NHLS were involved in the implementation of the NACP between 1997 and 2000 and the national HIV/AIDS and STIs Strategic Plan between 2000 and 2005 as discussed in sections 5.2.4 and 6.2.3 respectively. From Programme 2: Vote 16 of the National Expenditure Estimates of 2006, the MRC obtained funding mainly from a variety of local and international sources and the DoH was also making some contributions. Allocations in support of the NHLS doubled between 1999/2000 and 2002/2003, while allocations to the MRC increased from R156,7m in 2003/2004 to R173,3m in 2005/2006 (South Africa 1998/1999–

2005/2006:343;344;357;362). The MRC undertook scientific research on clinical health issues including HIV/AIDS and prepared communities for vaccine trials on HIV/AIDS.

On the one hand, there was cooperation between the MRC and the DoH in setting research priorities, and on the other hand, the NHLS was a fully operational legislated preferred provider of laboratory services to public health facilities. Although the MRC was on the health vote, its budgeted allocations from Government were determined in the Department of Science and Technology as part of the science vote while the MRC generated about 50 per cent of its revenue from commercial research services conducted on behalf of both the public and private sector. It is stated under Vote 16 that the major source of revenue of the NHLS was the sale of analytical laboratory services to users such as provincial departments of health (South Africa 1998/1999–2005/2006:337;342;343;362). However, what should be noted is that research in terms of HIV/AIDS was not confined to health issues only, but also applicable to social development.

7.6 THE NEED TO FUND PROGRAMMES FOR THE IMPLEMENTATION OF RESEARCH IN THE FIELD OF SOCIAL DEVELOPMENT

As common sense dictates, it was going to be problematic for the DoSD to implement social welfare objectives without conducting situational analysis to establish the impact of HIV/AIDS and the appropriateness of interventions. The subprogramme applicable to the latter was the Population and Development Research Programme listed second at the bottom of table 7.5 Provision was made under the Grant Systems and Service Delivery Assurance Programme (Programme 3) for research to be initiated and implemented by the DoSD.

The initiation of research in the field of HIV/AIDS was aimed to provide an evidence base for social assistance policies that inform social welfare grants discussed in section 5.3. The funded subprogramme through which the latter was implemented was the Research, Compliance and Support Subprogramme appearing at the bottom of table 7.5. Although the MTEF allocation of R1 263 was made for 2001/2002 and 2003/2004, the adjusted appropriation increased

tremendously to R17 797 in 2004/2005. However, these increases are not attributed to policy changes only, but to the coercing of the Government to distribute ARVs by the TAC which led to the High Court's decision handed down in 2002.

TABLE 7.5

ESTIMATES OF AUDITED EXPENDITURE UNDER VOTE 18: PROGRAMME 7: SOCIAL DEVELOPMENT

Programme	**Expenditure outcome**			**Adjusted Appropriation 2004/2005**	**Extracted from MTEF Estimates**
	R thousands				
	2001/2002	2002/2003	20003/2004		2005/2006
Children, families and youth development	4 020	5 199	8 571	16 701	17 991
child and family benefits	942	1 963	2 215	4 325	4 782
HIV/AIDS	14 954	51 153	69 293	78 890	185 572
CHBC	14 954	51 153	69 293	76 015	145 176
Coordinated Action for OVCs and youth	-	-	-	436	1 422
poverty alleviation and food security	51 222	330 983	465 558	409 424	402 839
NGOs	2 231	2 677	2 852	3 833	3 892
Population and Development Research	2 141	3 273	5 003	3 800	4 346
Research, compliance and support	-	-	1 263	17 797	18 084
TOTALS	**90 464**	**446 401**	**624 048**	**6 111 221**	**784104**

SOURCE: (SOUTH AFRICA, NATIONAL TREASURY. ESTIMATES OF NATIONAL EXPENDITURE 2005/06: 405/410)

It is evident from table 7.5 above that budgetary allocation for HIV/AIDS and CHBC was doubled from 2001/2002 to 2003/2004. This was caused by allocations for HIV/AIDS and CHBC being provided for under the same vote, although falling under Programme 8 and 9 respectively. Apart from the need to provide healthcare and support at community levels through the implementation of social development goals, it was also important to ensure that

the human and legal rights of PLWHA, OVCs, youth, vulnerable families and communities were promoted and protected.

7.7 PROTECTING THE RIGHTS OF OVCs, YOUTH, FAMILIES AND VULNERABLE GROUPS THROUGH EXPENDITURE

According to priority area 4 of the national HIV/AIDS and STIs Strategic Plan for 2000–2005, it was necessary to develop intersectoral campaigns on tolerance and acceptance of PLWHA. To achieve this, budgetary allocations had to be made available. Expenditure pertaining to the promotion of the Rights Advocacy in respect of Children Programme and the Rights Advocacy in respect of Vulnerable Groups Programme was incurred consistently from 1997/1998 to 2003/2004 as set out in table 7.6 below.

TABLE 7.6

EXPENDITURE IN RESPECT OF THE PROTECTION OF CHILDREN, YOUTH AND FAMILIES UNDER VOTE 17: PROGRAMME 4: WELFARE SERVICES TRANSFORMATION

Programme	**Expenditure outcome**			**Adjusted Appropriation 2000/2001**	**MTEF estimates**		
	R thousands						
	1997/1998	1998/1999	1999/2000		2001/2002	2002/2003	2003/2004
Rights Advocacy in respect of children, youth and families	23 372	9 104	24 366	6 267	3 374	3 589	3 748
Rights Advocacy in respect of vulnerable groups	5 016	5 509	9 216	15 794	6 110	6 436	6 671
TOTALS	**28 388**	**14 613**	**33 582**	**22 061**	**9484**	**10025**	**10419**

SOURCE: SOUTH AFRICA, NATIONAL TREASURY. ESTIMATES OF NATIONAL EXPENDITURE: 2001: 365

As shown in table 7.5 above and 7.7 below, the DoSD was not only focussing on campaigning for and promoting the rights of OVCs, vulnerable youth, destitute families and vulnerable

groups, but was also tasked to address issues of poverty and community development in general.

7.8 FIGHTING POVERTY AND VULNERABILITY THROUGH PARTNERSHIPS

In chapter 5, poverty is discussed as one of the main contributors to increased HIV/AIDS infection rate in South Africa. That is why poverty programmes were implemented to reduce the personal and social impact of HIV/AIDS as discussed under section 5.3. In terms of tables 7.2, 7.5 and 7.7 poverty programmes are referred to as poverty relief by the DoH and as poverty eradication or alleviation by the DoSD as shown under Vote 16: Programme 2, Vote 17: Programme 5 and Vote 18: Programme 7. According to South Africa (2004:515) and the tables referred to above, no further allocations were made to Programme 7 in 2004/2005 to directly fight poverty. To further create an enabling environment for developmental services, funding of programmes was transferred to the NDA. The fight against poverty was and remains a mammoth task because from the researcher’s observation through socialisation and knowledge acquired from media reports, poverty was still rife among previously disadvantaged communities in most urban areas and rural areas of South Africa at the end of 2005.

TABLE 7.7

EXPENDITURE TO FIGHT POVERTY, TO BUILD PUBLIC/PRIVATE PARTNERSHIP AND TO DEVELOP COMMUNITIES UNDER VOTE 17: PROGRAMME 5: DEVELOPMENT IMPLEMENTATION SUPPORT PROGRAMME

Subprogramme	**Expenditure outcome**			**Adjusted Appropriation**	**MTEF estimates**		
	R thousands						
	1997/1998	1998/1999	1999/2000		2001/2002	2002/2003	2003/2004
Poverty eradication	50 900	1685	205 997	160 266	51 154	101 134	72 180
HIV/AIDS	-	-	-	-	14 900	1 693	1 538
Community development	3 278	1429	493	845	1014	1060	1 111
Public/private partnership	5 945	6347	5 048	5 293	4 661	4 701	4 905
Administration	546	693	667	632	649	668	696
TOTAL	**60 669**	**10 154**	**212 205**	**167 036**	**72 378**	**109 256**	**80 430**

(SOURCE: SOUTH AFRICA, NATIONAL TREASURY. ESTIMATES OF NATIONAL EXPENDITURE 2001: 368)

Despite the fact that allocations for the Subprogramme Maternal, Child and Women's Health were made as set out in tables 7.1, and 7.2 and though budgetary allocations were made for the rights advocacy in respect of children, youth, families and vulnerable groups as set out in table 7.6 above, it cannot be suggested that budgetary allocations and expenditure were adequate based on evidence presented. Evidence provided in this chapter points to it that budgets were not allocated adequately in support of the implementation of the NACP between 1997 and 2000 and the national HIV/AIDS and STIs Strategic Plan between 2000 and 2005.

7.9 INVESTIGATING THE CAUSES OF INADEQUATE ALLOCATIONS AND EXPENDITURE

The national DoSD failed to transfer the R40m allocated to provinces in 1997/1998. The money was then again made available for 2000/01, but was again not spent and was rolled over to the 2002/2003 financial year. The money came in handy for 2002/2003 because that was a year in which the Government was compelled to implement the roll out of ARV treatment in public hospitals and clinics. While the DoH and the DoSD were required to spend effectively in response to HIV/AIDS, the following information pointing to ineffective spending has been the cause for concern (South Africa 2002/2003:19):

a. Some of the provinces funded NGOs from own budgets and did not seek additional financial assistance.

b. Fewer National Funding Advisory Committee meetings were conducted during the restructuring of national HIV/AIDS unit, therefore, there was no adequate time to focus on HIV/AIDS.

c. No audited financial statements could be obtained from organisations funded in the 2001/2002 financial year. These organisations could not qualify for further funding.

d. Funds could not be transferred prior to visits to organisations by monitoring officers. The challenge was that monitoring was done by officials who did not possess financial and project management skills.

In addition to abovementioned reasons, failure to spend the money efficiently and effectively by that time is attributed to the fact that there were no clear policy framework, guidelines, and appropriate costing model for CHBC. The impact strategy was also not in place to measure the efficiency and effectiveness of intervention programmes. The fact that programme regulations and instructions were attached to conditional grants spending also created bureaucratic hurdles and delays, thereby creating under spending and unnecessary rollovers (Hickey *et al* 2004:156–157).

7.10 INTERPRETATION

On the basis of the absence of: (a) the impact strategy to measure the efficiency and the effectiveness of intervention programmes and clear policy framework; (b) guidelines and costing models for HIV/AIDS Programmes, as well as; (c) capacity to monitor funds allocated to provinces, it becomes awkward to suggest that HIV/AIDS was responded to adequately in terms of financial administration as concluded below.

7.11 CONCLUSION

Evidence unearthed in earlier chapters and the MTEF allocations set out in table 7.2 show that NACOSA and SANAC were spending inefficiently and ineffectively between 1997/1998 and 2001/2002 in implementing the principles of the NACP and the priority areas of the national HIV/AIDS and STIs Strategic Plan. Again, GAAP and SAAVI were launched in 1998 and 2000 respectively but, according to tables 7.1 and 7.2, significant expenditure was only incurred in 2000/2001 and 2002/2003 respectively. Failure by NACOSA and SANAC to spend funds aimed at promoting and implementing public/private partnership, awareness campaigns and advocating for the rights of vulnerable groups, women, youth, children and families as set out in tables 7.2 7.5, 7.6 and 7.7 respectively, is not only attributed to the lack of skills and expertise in project and financial management, but to political interference in the work of these entities as discussed in sections 4.4.1, 4.4.2 and 5.2.4. However, after the Government was being coerced by the TAC to distribute ARVs and as a result of external interference by the High Court on July 2002, expenditure for HIV/AIDS programmes and NGOs increased tremendously after 2002/2003 as set in tables 7.3 and 7.4 respectively. It is in this context that the DoH is deemed to have not acted on own volition in as far as the distribution of ARVs from all public hospitals and clinics is concerned.

The fight against poverty was intensified in 1999/2000, which is why the MTEF allocation of R205 997 for Programme 5: Vote 17 was made available for 1999/2000 and the adjusted appropriation of R106 266 was made available for 2000/01 as set out in table 7.7. In 2002/2003 the allocation increased almost fourfold in as far as the DoH was concerned and virtually

sixfold in as far as the DoSD was concerned. While appreciated that MTEF allocations were made available for the awareness campaigns and to promote the rights and care services in respect of children, youth, women, families and vulnerable groups, it is inappropriate to suggest that the DoH and the DoSD responded adequately to HIV/AID because referral systems that existed were not effective enough to deal with the cyclical nature of the relationship between HIV/AIDS and poverty.

Significant increases in MTEF allocations after 2002/2003 are set out in almost all tables and impressive increases in conditional grant allocations in 2004/2005 are set out in section 7.4.4. However, these improvements were influenced by the order of High Court in 2002 and were brought in the last year of the implementation of the national HIV/AIDS and STIs Strategic Plan for 2000–2005.

In the next chapter, the assessment of health and welfare HIV/AIDS interventions, that includes budgets as integral part, is conducted in order to answer the research question.

CHAPTER 8

EVALUATION AND RECOMMENDATIONS

There is no sudden leap into the stratosphere. Ben Stein.

8.1 INTRODUCTION

In the previous chapter, budgets and expenditure are investigated as integral parts of a broader strategy aimed at responding to HIV/AIDS. As suggested, budgetary allocations and expenditure affected programme implementation and vice versa. In this chapter, the researcher evaluates the influence of the politicisation of HIV/AIDS and moralistic debates on national structures of response and directorates. Furthermore, the impact of the invective against ARVs and MTCT between 1997 and 2004 at the highest echelons of political power is evaluated, bearing in mind the following evaluation criteria and logic of research.

8.2 EVALUATION CRITERIA

As pointed out in Trochim (2006:1) evaluation involves: (a) the collection and sifting through data; (b) making judgements about the validity of information obtained and; (c) deriving inferences from such information. This methodology is linked to the PEC framework as proposed by Mouton (1998) as discussed in section 1.7.4. As shown in section 1.7.2, the *first criterion* evaluates responses in legal terms because the extent to which political and public office-bearers, as agents of State, were committed to adhere to international agreements and comply with constitutional obligations and other legislative mandates is evaluated. The *second criterion* is about the extent of commitment to provide and implement health and welfare services to the whole population. This includes evaluating the appropriateness and the accessibility of care and support programmes. The *third criterion* focuses on whether the Government has been able to promote collaboration and intersectoral relation in providing care and support to PLWHA and their destitute families, OVCs and vulnerable communities.

8.3 THE EXTENT OF ADHERENCE TO INTERNATIONAL AGREEMENTS AND LEGISLATIVE MANDATES (CRITERION 1)

Between 1997 and 2002, the Government did not only fail to comply with article 16 of the ACHPR, and article 19 and 20 of the UNCRC, that require states to protect the health of their citizens, including children by ensuring that every individual enjoys the best attainable state of physical and mental health, but also with article 12 (2) (c) and (d) of the ICESCR, which commits the State to promote, protect, and fulfil the socio-economic rights of PLWHA by preventing the illness, providing medical services and controlling the spread of HIV/AIDS. As evidenced in section 1.2 and section 2.5.2, the politicisation of HIV/AIDS, coupled with the invective against ARVs and MTCT, as well as moralistic discourses, led to the failure to comply with international agreements and constitutional obligations.

The adoption of the Constitution of the Republic South Africa, 1996*,* gave birth to a political system that recognised the interpretation of international agreements by the courts of law, forums and tribunals. This can be applied in the field of HIV/AIDS as discussed in section 2.5.4. Despite guaranteed in terms of section 27 (3) of the Constitution that no one may be refused emergency medical treatment and, in the face of section 27 (1) and section 28 (1) (b), the politicisation of HIV/AIDS and the invective against ARVs and MTCT by President Thabo Mbeki and the Minister of Health, Dr Manto Tshabala-Msimang was continued between 1997 and 2004 – see section 3.3.1. This led to the Government being pressurised by the TAC to distribute ARVs, which subsequently led to the High Court decision on July 2002 ordering the DoH to distribute ARVs from public hospitals and clinics as discussed under section 6.4. This decision was handed down against the backdrop of the national structures of response and directorates discussed in section 4.3 being faced with structural, budgetary and organisational problems discussed under section 4.4. For the purposes of maintaining chronology, systemic, structural and organisational impediments that led to inadequate response to HIV/AIDS are organised into primary and secondary factors in the next sections.

8.4 FACTORS CONTRIBUTING TO INADEQUATE IMPLEMENTATION OF POLICIES (CRITERION 2)

As was stated above, the second criterion with which to evaluate government responses pertains to the implementation of policies.

8.4.1 PRIMARY FACTORS

The factors that primarily led to the inadequate implementation of the principles of the NACP as discussed in chapter 5, the priority areas of the national HIV/AIDS and STIs Strategic Plan for 2000–2005, and the operational Comprehensive HIV Plan for the Care, Management and Treatment of HIV/AIDS and AIDS Care as discussed in chapter 6 are both systemic and structural. These factors are: (a) the failure by the State to adhere to relevant articles of the ACHPR, ICESCR, and UNCRC despite required to do so by the political system incepted in 1994, which recognised the interpretation of those by the courts of law, forums and tribunals as legal instruments; (b) the politicisation of HIV/AIDS, which led to denial that there is a causal relationship between HIV and AIDS; (c) the invective against ARVs and MTCT, which led to the untenable refusal to distribute ARVs in public hospitals and clinics; and (d) political interference in the work of NACOSA, SANAC and research bodies such as the MCC. The refusal by the Government to distribute ARVs in public hospitals and clinics nationwide without providing motivation to do so led to the: (a) inadequate implementation of palliative and paediatric care; (b) inadequate implementation and funding for CHBC and (c) delayed integration of HIV/AIDS services at ECD and VCT levels as concluded under section 5.6. These factors delayed integration of health and welfare services and the identification of OVCs and PLWHA in need of diversion to appropriate health and welfare interventions.

Evidence presented under section 1.2 and sections 4.3.2 and 4.3.3 show that SANAC did not only operate in the veil of secrecy, but also failed to: (a) bring political commitment in response to HIV/AIDS and formalise multi-sectoral collaboration; (b) implement democracy in HIV/AIDS work by disallowing meaningful expression of opinions by participants from different political, socio-economic and professional persuasions; and (c) mobilise the civil

society against the scourge of HIV/AIDS. Despite being launched in 1992, the finding is that SANAC remained ineffective and continued to under spend between 1997 and 2000 as set out in table 7.2. This confirms that SANAC did not have clear policies and effective strategies to respond adequately to the impact of HIV/AIDS. It is therefore suggested that delayed responses to HIV/AIDS is primarily attributed to primary factors identified and, to a lesser extent the following secondary factors.

8.4.2 SECONDARY FACTORS

The causes of inadequate implementation discussed above, were at a level far removed from the implementation level. However, they did contribute to factors at the policy implementation level.

Whereas inadequate response to HIV/AIDS may be attributed to the absence of appropriate AIDS notification legislation and an effective HIV surveillance mechanism as discussed under section 5.2.5, organisational factors also received attention in section 4.4. By her own admission, the Minister of Health, Dr Manto Tshabalala-Msimang, emphasised that the quality of healthcare service depended critically on a sufficient number of health professionals with relevant and appropriate knowledge and skills. As explored under section 4.4, the response to HIV/AIDS was rendered inadequate by, among others, a lack of a trained cadre of skilled healthcare professionals and the non-availability of retention strategies to stop the emigration of available ones overseas. As discussed under 4.4, the most effective and decisive retention strategy would have been to pay them competitive salaries. The situation was compounded by the implementation of the moratorium on the filling of vacant posts issued in terms of resolution number 7 of 2000 by the Department of Public Service and Administration. The situation was further compounded by the inadequate funding of training in prioritised preventative strategies and other interventions such as; (a) pre-test and post-test counselling; (b) the implementation of a continuum of care between individuals/families and ECD, CHBC and VCT facilities; (c) infrastructural developments, particularly in rural parts of South Africa; and (d) the implementation of PMTCT, particularly in rural parts of South Africa. As

suggested under chapter 5, 6 and 7, lack of funding for appropriate training in financial and project management led to ineffective monitoring of HIV/AIDS funds allocated nationally.

8.4.3 BUDGETS AND EXPENDITURE

As set out in table 7.2, expenditure between 1997 and 2002 could not be incurred for, among others, the support of (a) the building of public/private partnerships in order to promote individual and collective capacity building; (b) the implementation of the HIV preventative strategies and the goals of social development; and (c) the principles of care and support contained in the NACP of the WPoTHS and HIV/AIDS services advocated in the WPoSW by SANAC as concluded in chapter 7. The structure could not monitor funds allocated to provinces for the implementation of HIV/AIDS activities in accordance with the principles of the NACP in the period 1997–2000. The same was applicable to GAAP and SAAVI because the former was launched in 1998, but according to table 7.2, significant expenditure was only budgeted in 2000/2001, which is a year after the adoption of the national HIV/AIDS and STIs Plan. What this suggests is that skills in terms of financial and project management were lacking and, as admitted by the Minister of Health, Dr Manto Tshabalala-Msimang as quoted in section 4.4**,** the success of responses to HIV/AIDS depended critically on a sufficient number of trained health professionals with appropriate and relevant experience. It is therefore difficult to suggest that assistance to PLWHA and OVCs were reached adequately at various stages of their development and in different circumstances by the DoH and the DoSD between 1997 and 2005.

8.5 PROVIDING CONTINUUM OF CARE WITHIN DEVELOPMENTAL PARADIGM (CRITERION 3)

The Government has been able to appropriately promote and enhance collaboration at the coalface of HIV/AIDS service delivery between healthcare workers, officials and social workers of the DoH and DoSD for the provision of continuum of care and reduction of the personal and socio-economic impact as discussed under sections 3.3.4, 5.2.1, 5.3, 6.3, 7.3, 7.4, 7.7 and 7.8. However, due to: (a) organisational problems encountered; (b) failure to monitor

HIV/AIDS infection rate; (c); failure to keep track of spending on programmes and progress towards implementation; and (d) the socpen system which could not separate PLWHA from the rest of the beneficiaries, it has been difficult to suggest convincingly that progrmmes for care and support were implemented effectively and that they were accessed adequately by PLWHA, OVCs, destitute families and vulnerable communities living in farming and rural areas (see sections the 5.4, 5.6, 7.9, 7.11).

8.6 CONCLUSION

Based on failure by the State to adhere to international agreements and the DoH and the DoSD to implement constitutional obligations, as well as the impact of primary and secondary factors identified, it can be concluded that the DoH and the DoSD in South Africa did not respond adequately to HIV/AIDS between 1997 and 2005.

8.7 RECOMMENDATIONS

As follow-on to health and welfare interventions beyond 2005, it is recommended that another study be conducted to investigate and evaluate the continuation of the implementation of HIV/AIDS interventions between 2006 and 2010. What the scope of the study should also focus on must be contributions of the South African Social Security Agency (SASSA) in responding to HIV/AIDS. Furthermore, future research should focus on whether an appropriate and acceptable AIDS notification system was developed and implemented.

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