



CHAPTER 4

PUBLIC POLICY FOR HIV/AIDS

CASE STUDY OF SOUTH AFRICAN PERSPECTIVES

4.1 INTRODUCTION

Public policy on HIV/AIDS in South Africa can be examined and viewed from several perspectives. Perspectives give indication of viewpoints, commitment and understanding of the policy issue. Assuredly, an examination of the viewpoints and hence perspectives on HIV/AIDS indicates where the executive and the administration have come from, its present response to the epidemic and the work that remains to be done in the area of formulating and implementing policy. This chapter discusses perspectives and viewpoints using rational choice theory as a framework for discussion. More specifically, there is reference to the muddled state of affairs whenever it appears that there is indecisiveness, illisiveness and unclear behaviours and responses. Policymaking is discussed from macro and micro perspectives, noting the mindset of the executive and the influence of activists. Moreover, policy on HIV/AIDS is examined by looking at policy actions prior to and after 1994. Additionally, policy on HIV/AIDS with emphasis on activism and the median voter is discussed to further understand the characteristics of the electorate and how it has been assisted by a latent activist group such as the Treatment Action Campaign (TAC). Thereafter, there is discussion of political incumbents' willingness to communicate policy alternatives, recognising that they are indirectly accountable to the electorate. While policy may be influenced by the electoral process, there must be recognition that the electoral system has in turn been affected by



the epidemic. Finally, the unitary state could be effective in a coordinated response to the HIV/AIDS epidemic; but when the unitary state chooses not to respond, a conflict between the national and the provincial spheres of governments may be unavoidable. Sadly, at times the unitary state (i.e., the national government) must be motivated by court action to formulate a policy response to HIV/AIDS, as has been the case in South Africa.

Butler (2006) argued that turning out to vote is not a rational act. Rather, it is an exhibition of commitment to a political system and agreement to abide by the electoral outcome. What is implied is that there is a realisation by voters that they have little influence on the electoral outcome; nevertheless, constituents (in stable but slightly increasing numbers in South Africa) exercise their franchise to vote despite feeling powerless to influence public policy decision-making. Butler goes on to highlight that this increasing air of despair is to be expected for the local government municipal elections of 2006. Notably, the years and months leading up to municipal elections were not kind to the electorate. Political elites were characterised as parasites; liberation heroes and corporate elites monopolised the attainment of public office and unethical behaviour by party members went unchecked due to the electorate's wilful submission to their [so-called] betters (Butler, 2006).

Easily, voting may be thought of as "muddled," the antithesis of being rational. In South Africa, voters thrive in a state of poverty, confusion and despair to make what in their minds is a rational [voting] decision. It should not be forgotten that Lindblom (1959) viewed muddling as a science and therefore rational (perhaps better to say normal) to muddle along towards reaching a decision to exercise one's franchise to vote - discounting political incumbents having been slow to deliver on campaign promises,



definitive programs and sound public policy decisions relating to HIV/AIDS treatment in South Africa.

The science of muddling can be viewed to have been perfected in South Africa – especially as it relates to public policy decision making for rolling out an HIV/AIDS treatment programme. Consider the (DOH, 2000:5) 2000-2005 HIV/AIDS/STD Strategic Plan for South Africa. Section 1.1 of the plan noted that the document was not a plan for the health sector. Yet, time has shown that a definitive strategic plan (of attack) is exactly what is needed. Moreover, the same section noted that no single ministry would be responsible for addressing the HIV epidemic. Yet, what is needed is strong leadership and political will emanating from the Department of Health, accepting ultimate responsibility for policy making on HIV/AIDS treatment. Finally, the 2000-2005 plan seems to advocate many plans originating from myriad numbers of government departments, organisations and stakeholders, as opposed to one centralised plan and frame of mind on how to respond to the HIV/AIDS epidemic in South Africa. In retrospect and through to the year 2006, the response to the HIV/AIDS epidemic has been muddled – as characterised by political and bureaucratic attitudes ranging from denial to guarded response, and prescribed remedies of beetroot, olive oil, and most recently cautious distribution of antiretrovirals (ARVs).

For these reasons, this chapter will through a case study approach examine public policy decision making for HIV/AIDS treatment in South Africa. Indeed, the chapter is more of an “account” that endeavours to put this dissertation into context, thereby bringing clarity to the following chapter encompassing data analysis, perhaps confirming that the



electorate does not have the ability to motivate (by voting) its representatives to spend on HIV/AIDS programmes.

What have been the problems in making decisions on the matter of, as per Dye (2002), what government will or will not do – i.e., policy on HIV/AIDS from a macro and micro perspective? What was the state of the nation (with regard to HIV/AIDS and policy making) before 1994 thru to the post apartheid period and beyond? Has the unitary state, in some way, facilitated a muddled response to the epidemic? What systems have been affected by the inadequate response to HIV/AIDS – e.g., the electoral system and the party list system? With reference to collectivism, has the median voter been marginalised, thus supporting the thesis that voters are unable to affect government spending and public policy decision-making?

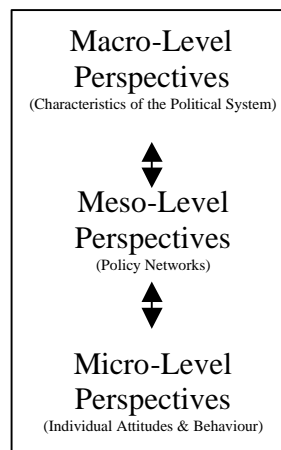
4.2 MACRO AND MICRO PERSPECTIVES ON POLICY MAKING

A perspective reflects a viewpoint, an outlook, or that which appears to be. Boeree (n.d.) posits that there are as many views, or perspectives of reality as there are conscious creatures. Moreover, diversity of perspectives [viewpoints] occurs due to genetic make-up, individual health, cultural background and experiences unique to individuals. The task here is to examine viewpoints that have nurtured policy making in response to HIV/AIDS. The examination tends towards macro-level theory and micro-level theory, while employing meso-level concepts to identify the policy networks that have provided for the development or lack of development of a response to HIV/AIDS. Evans (2001) identified the macro level as political system characteristics and the micro level as individual attitudes and behaviours – figure 4.1. A meso-level exists between the macro and micro level, and the meso-level represents policy networks that link the macro and

micro levels. Notably, levels are construed here to mean perspectives. The macro-level includes international system characteristics as well. For example, perspectives on policy making for HIV/AIDS at the Southern African Development Community (SADC) supra-national level [sphere] of government. Concern, however, in this dissertation is focused on the national and sub-national spheres of government.

Multi Level Perspectives and Relationships

Figure 4.1



(Source: Evans, 2001)

4.2.1 *Macro Perspective*

The examination of the macro perspective on policy making for HIV/AIDS encompasses focusing on the national sphere of government, represented by the viewpoint of the executive and characteristics of the political system that serves as the environment within which policy decisions are made. Firstly, at the national sphere of government the ultimate policy maker's (Thabo Mbeki) viewpoint has been and is key to the study of public policy decision making for HIV/Aids treatment. Indeed, the executive's viewpoint can be the impetus for action or the impetus for inaction. Osmanovic (n.d.) compiled a chronology of press documentation of Mbeki on HIV/AIDS. The president's numerous



remarks and his position on HIV/AIDS in the early days of his administration have been well documented. His position that “AIDS cannot be simply explained away by a virus but has to be explained in the broader context of Africa’s social and economic environment” caused pundits to label him confused if not muddled (Swindells, 2001). While there is an inclination to emphatically state that Mbeki said that HIV does not cause AIDS, it must be ascertained as to: What did the president actually say? While he may have never said HIV does not cause AIDS, a defining moment was the Time Magazine (Redmann & Hawthorne, 2000) interview where when asked “but would you acknowledge that HIV is a causal factor in Aids,” President Mbeki responded:

“I am saying sure, no problem at all, there may very well be a virus . . . What is fundamental is the AIDS. So much so that even in everyday language AIDS is said to be a disease. It's no such thing. AIDS is a syndrome. It's a whole variety of diseases which affect a person because something negative has happened to the immune system . . . I am saying we'll never be able to solve the AIDS problem.” [*sic*]

Did the President intentionally obfuscate a response to the question? If anything the discourse all but answers the question as to his position on HIV/AIDS. Indeed, there is deflection away from HIV as a causal factor and greater discussion of other ailments associated with AIDS (e.g., TB) and a less than clinical emphasis that AIDS is a variety of diseases. Rather, the interview comes across as the highly intelligent policy maker attempting to play the role of a physician – a role that the politician and policy maker is poorly equipped [untrained] to play. Why offer a diagnosis, when it would be safer to state the obvious? People are dying and there is a need for action – be it a cautious response due to the toxicity of antiretrovirals or, emphatically, a show of political will by rolling out a treatment programme forthrightly.



Indeed, a macro view is seen in the response of the executive – a viewpoint that drives the response to the epidemic at the national sphere of government. The following characteristics are evident: caution, avoidance, misinterpretation and misinformation of the pharmacology, diagnosis, regimen and treatment for HIV/AIDS. Recognising the muddled response as an indication of the state of the policy environment, that environment might then be characterised as being in [kindly] a mild state of confusion. Kindly said, despite all the confusion and muddleness, a rational decision on HIV/AIDS treatment is highly desirable. Nevertheless, commenting on the president’s interview, a muddled response is most descriptive of the president’s response; a muddled response is an appropriate description of the response to HIV/AIDS at the macro level.

4.2.2 Micro Perspective

At the micro (grass roots) level there is concern for the attitudes and behaviours of interest groups, as these attitudes and behaviours can have immediate impact on public policy decision-making. Difficulty, however, arises in accurately determining the attitudes of interest group members. A survey might be conducted but the dispersion of group members make it difficult to administer any type of measuring instrument. Gaining access to interest group members is the key challenge. Nevertheless, relative indication of their attitudes can be deduced by their outward actions – protestations, toy-toy, or their disrupting ministerial briefings for example. These actions can be viewed as methods of getting on (staying on) the agenda, one step in the policy making process. Nevertheless, these are behaviours that give clear indication, in the case of HIV/AIDS, that certain interest groups are not pleased with the executive’s response to the HIV/AIDS epidemic in South Africa. It is those behaviours that therefore reflect



collective action. More specifically then, what has the collective been doing to affect policy on HIV/AIDS treatment? The movement of the collective is most apparent in the form of the Treatment Action Campaign (TAC). Their client base can easily be considered to be the 11% of the population of nearly 44 million people believed to be infected with the HIV virus. Added to the micro perspective is the attitude and actions occurring in the sub-national sphere of government (more specifically KwaZulu Natal) where the conflict between the unitary state and provincial policy making were in conflict – i.e., unitarianism *v.* federalism.

As the Minister of Health stated (Business Day, 1999) that resources should be concentrated on preventative measures rather than spending to provide AZT and as the president fell short of proclaiming HIV/AIDS a national emergency (Afrol, 2001), it appeared that constituents and those infected with HIV/AIDS were powerless to influence public policy decision making to provide AIDS drugs. In other words, the electorate was caught in the middle [powerless] requiring the assistance of a latent group that would assist them (the electorate) as a collective to be effective in maximising their self-interests. This was no easy task as it became necessary for the TAC to challenge the South African government in the High Court over the policy to not make Nevirapine available to pregnant women with HIV. In December 2001, the TAC argued in the High Court that the government's irrational policy on combating HIV/AIDS was causing the rights of women and children to be violated. More specifically, the constitutional right of life, dignity and equality were being violated as a result of government's irrational approach to HIV/AIDS treatment. Indeed, the TAC had initiated the court action to compel government to provide AIDS drugs. Notably, the government's defence was not



helped by the revelation that the multinational pharmaceutical company Boehringer Ingelheim, the manufacturer of Nevirapine, had offered to provide the drug free of charge for five years – thus countering any argument by the Minister of Health that the government could not afford to provide drugs to HIV/AIDS infected individuals.

The high court case of the Minister of Health v. Treatment Action Campaign, CCT9-02, (2002) is actually considered to be a landmark case pertaining to socio-economic rights. Although the government had in place a programme distributing Nevirapine on a limited basis (10% rate of distribution), the court considered: 1) the government's policy of non-availability of Nevirapine and 2) whether indeed the government had to set out in a timely manner a national HIV/AIDS treatment programme to prevent mother to child transmission of the virus.

In short, the government was ordered to immediately remove restrictions on the use of Nevirapine and to implement measures through the public sector to expedite the use of Nevirapine (Community Law Centre, 2006). Oddly enough, the Minister's response was that the high court had stepped into the realm of policy making by ruling in favour of the TAC. The response, however, did not preclude the Minister from expanding government's HIV/AIDS treatment programme, at least, on the matter of providing Nevirapine to pregnant women. Much remained to be done, with regard to others infected with the HIV virus.

A micro perspective is also reflected in the conflict between national government and provincial government on public policy decision making for HIV/AIDS treatment. At least two provincial premiers had grown impatient with national government's (the



president's) muddled approach to policy for HIV/AIDS. Premier (IFP-KwaZulu Natal) Lionel Mtshali deviated from national policy to distribute on a limited (10%) basis Nevirapine to pregnant women infected with HIV. In February 2002, the Premier authorised Nevirapine to be distributed to all HIV positive prospective mothers, in order that mother to child transmission be prevented (Afrol, 2002). Notably, forty percent of the women giving birth in KwaZulu Natal were found to be HIV positive. The Premier's departure from the national government's cautious approach to HIV/AIDS policy marks one of the few occasions that provincial [state] government deviated from the unitary state. Characteristically, federalism and devolution of authority is not a prominent feature of South African government and politics. To avoid conflicts, chapter 3 of the Constitution (RSA, 1996) legislates for co-operative [intergovernmental] relations between the spheres of government, requiring the spheres of government to co-operate and foster mutual trust and good faith by:

1. Assisting and supporting one another.
2. Informing and consulting one another on matters of common interest.
3. Coordinating actions and legislation with one another.
4. Adhering to agreed procedures.
5. Avoiding legal proceedings against one another.

With emphasis on policy making, a precedent had been set with provincial government exercising independence from central government. In this instance there was added motivation to do so, with the KwaZulu Natal provincial government being an Inkatha Freedom Party (IFP) opposition provincial administration. A conflict between the two spheres of government (national v. provincial) again was evident in (this time) ANC Gauteng provincial Premier Mbhazima Shilowa breaking ranks to declare that provincial



hospitals and community centres would provide Nevirapine to prevent mother to child HIV transmission (Afrol, 2002).

Often, the analysis of policy pertaining to HIV/AIDS treatment focuses on actions (or inactions) of the president. The analysis fails to exam the true dynamics of policy making pertaining to HIV/AIDS. That is, a conflict between two spheres of government can impact the implementation of a policy and subsequent policy outcomes. Heuristically, policymaking and implementation extends beyond the political aura of any one individual. Analysis should recognize all associated dynamics. Consequently, while national government (the unitary state) desires to centralize authority and policy making, the role of the province (sub-national government) cannot be minimised, nor legislated into submission. Conclusively, if national government will not act on the policy problem, it should expect the next level (sphere) of government to act and formulate a policy response. Indeed, policy problems flow from a macro level perspective down through to the micro level; and it would seem that successful implementation occurs at that level (the micro), with it being so closely associated and located at the grassroots level.

4.3 POLICY BEFORE AND AFTER 1994

The AVERT Organisation (Berry, 2006) provided a chronology on HIV/AIDS in South Africa, noting that the first cases of HIV/AIDS were diagnosed in 1982. First identified in white gay men, soon after 1982 the virus was found to be prevalent in all areas of society. The AIDS crisis in South Africa, however, should be further demarcated by the year 1994. That year marked the succession of the ANC political party, the un-mantling of apartheid and the beginning of the demise of the National Party. What was the state of



AIDS policy under the old regime [National Party] and what has the state of HIV/AIDS policy under the new [ANC] regime?

4.3.1 Policy Before 1994

The year 1982 marks the beginning of the time-line for HIV/AIDS in South Africa, with the official reporting of the first two AIDS related deaths. As an indication of the policy response, at that time the Department of health assured that AIDS was a threat to homosexuals only. In 1985 the apartheid government responded by setting set up the first AIDS advisory group, with the immunologist Dr. Reuben Sher featuring prominently. Sher (Online News Hour, 1998) commented that: “AIDS was not a priority. Jobs, housing and political freedom were the priorities. The only benefit of apartheid (relative to the prevalence of HIV/AIDS) was that the government did not allow people to the north to come into the country and most of the local indigenous population did not travel to the north.”

As the literature is scoured in search of evidence of the work of Sher’s advisory group, it quickly becomes evident that no significant progress was made until 1990 when antenatal testing was conducted to ascertain an AIDS prevalence rate in pregnant women – at that time .8% (Berry, 2004). Indeed, a review of the history of HIV/AIDS in South Africa reveals that little was done on the matter of HIV/AIDS – as reflected in the historical overview by AVERT, the international AIDS charity (Berry, 2004). The decade 1980 and 1990 therefore could be characterised as a decade of apathy on HIV/AIDS. By 1993, the prevalence of the virus in pregnant women was found to be 4.3%.



Between 1982 and 1992, the apartheid government responded to the threat of an HIV/AIDS epidemic by focusing on mineworkers and the importation of the virus from neighboring countries. Notably, 130 mineworkers were diagnosed with the HIV virus, after which contracts of foreign mineworkers infected with the HIV virus were not renewed. A proposal by Dr. Marius Barnard to isolate HIV/AIDS carriers was considered as well. In 1989, Dr. Sher warned that HIV/AIDS could become a biological holocaust but the apartheid government did not immediately heed his warning (Online News Hour, 1998). In 1992 the National Aids Convention of South Africa (NACOSA) was formed to develop a national AIDS strategy. Considering Nelson Mandela's release from prison in 1990, policy making by the soon to be ousted apartheid government on the matter of HIV/AIDS may have seemed futile. With its willingness to concede and relinquish power, the apartheid government's HIV/AIDS problem would indeed become the ANC government's problem (AVERT, 2007).

Interestingly, in 2004 former South African president F.W. de Klerk caused an uproar when he commented that the apartheid government had a policy document (plan of action) on HIV/AIDS and that the policy had been shelved by the ANC (Reuters, 2004). A viewpoint was that ANC government had lost valuable times [years] in its fight against HIV/AIDS by not considering the policy on HIV/AIDS put forth by the last white South African government (DOH, October 2004). Nevertheless, the precursor to the ANC government's HIV/AIDS policy and strategic plan was the strategy put forth by NACOSA between 1992 and 1994, thus clearly delineating a concerted effort to address the HIV/AIDS epidemic in South Africa.



4.3.2 Policy After 1994: Post Apartheid Policy on HIV/AIDS

By 1994 there was worldwide awareness that modern humanity was faced with an epidemic that had the potential to match the black death of the middle ages. In light of this, South Africa had the unenviable task of orchestrating a regime change – a massive change in government, ushering in a new ruling party. Supposedly, while in exile the ANC conducted a number of meetings on HIV/AIDS (*epoliticsSA*, 2000). In 1995, NACOSA recommended that a national AIDS policy should emanate directly from the office of the president. Remarkably, there was some resistance from the executive – the first signs of scepticism emanating from president’s office. Scepticism would become most apparent during the presidency of Nelson Mandela’s successor Thabo Mbeki. In 1996 when NACOSA conducted a briefing on AIDS, a mere 14 Ministers of Parliament attended (Anonymous, 2004). Clearly, there was disdain for any administrative body held over from the apartheid government. In time, however, the successor to NACOSA would be the president’s advisory panel that had its first meeting May 2006 (ANC, 2000).

From 1994 on and from the first antenatal testing in 1990, the prevalence rate of HIV positive was steadily increasing – 0.8% in 1990 to nearly 28% by 2003 (Berry, 2004). Notably, antenatal testing of pregnant woman was used to estimate the rate of infection in the overall population. Thus with the coming to power of the ANC, factors impacting policy making on ANC were: 1) steady rise in the HIV infection rate, 2) the establishment of the first [ANC] presidential advisory panel, 3) a slow muddled response to the HIV/AIDS epidemic by the new ruling party, 4) activism by the Treatment Action Campaign (TAC) that led to the high court case compelling government to expediently roll out an HIV/AIDS treatment programme and 5) the



implementation of a 5 year (2000-2005) HIV/AIDS STD strategic plan that replaced NACOSA's HIV/AIDS strategy.

Based on antenatal testing, in 1994 the HIV/AIDS prevalence was 2.4%. More than 2% the pregnant women tested positive for HIV/AIDS. At that time, the Minister of Health was highly critical of the NACOSA HIV/AIDS strategy but no other policy was forthcoming from the new ANC government. In 1996 President Mbeki confirmed that indeed more than 2% of the total population was estimated to be infected with the virus. The infection rate in pregnant women was found to be 8%. In 1997 a ministerial committee on HIV/AIDS was established in Parliament. In the following year, 1998, the TAC was formed. Its chairman Zackie Achmat became a leading activist to influence policy making by abstaining from taking AZT unless 1) it was made widely available by government and 2) pharmaceutical companies offered AIDS drugs at a fair price to all infected individuals. By 1998 the prevalence rate was estimated to be nearly 23% based on antenatal testing (AVERT, 2007).

South Africa was found to have the fifth highest HIV prevalence rate in the world (AIDS Foundation, 2005). Until the HIV/AIDS/STD Strategic Plan (2000), there was no formal policy to address HIV/AIDS in South Africa. Up until 2000, the most prominent HIV/AIDS programme was the Partnership Against Aids launched in 1998. In 1999 free condoms were distributed and the educational campaign [Lovelife] was launched. As an indication of the muddled approach to policy formulation, in 2000 President Mbeki established an AIDS task force headed by the AIDS dissident Peter Duesberg who professed that HIV/AIDS drugs were the cause of the disease. Prevention emphasised lifestyle choices, focusing on homosexuality and drug addiction. President Mbeki



seemed more of a sceptic than an advocate for combating HIV/AIDS in South Africa. Asser (2000) wrote: “South African President Thabo Mbeki has become a champion for a small but vocal minority of medical and lay opinion which says HIV does not cause AIDS.” This was an opinion expressed by Asser upon the appointment of Peter Duesberg, a leading HIV/AIDS skeptic appointed to be an advisor to Mbeki. His comment in Parliament that “a virus cannot cause a syndrome” served to further muddle the policy response to HIV/AIDS in South (SAMRC, 2000). Scepticism arose from, at that time, the much-touted toxicity of drugs such as AZT and Nevirapine. Meanwhile, the Minister of Health had advocated a diet of beetroot, olive oil, potato and garlic, rather than proceeding to administer, or support the administering of potentially harmful antiretroviral drugs (ARVs). Responding to a high (25%) antenatal prevalence rate, the TAC and Dr. Harron Saloojee filed a motion in the South African [Pretoria] High Court to compel the South African government to make Nevirapine available to all women giving birth in government hospitals.

Still, a clear policy response was not forthcoming from the executive or the Minister of Health, with President Mbeki (2002) expressing doubt over the AIDS statistics that were released. By 2003, however, the government relented to popular pressure and committed to rolling out a comprehensive HIV/AIDS treatment plan (GCIS, 2003). In response, the Minister of Health (2003) formed a National Task Team chaired by the Medical Research Council’s Dr. A.D. Mbewu; the team was charged with coordinating the drafting of an operational plan to make ARVs widely available (Consumer Project on Technology, n.d.).



As an example of the lag time associated with policy implementation, it was not until August 2004 that the cabinet actually approved the distribution of anti-AIDS medicines in government hospitals. While the government had in principle committed to distributing ARVs through its hospitals, distribution was bogged down due to the requirement to register ARVs with Medicines Control Council to administer the allowable dosage to be dispensed. By November 2004, the cabinet finalised and approved the task team's operational plan. It, however, would be another year before at least one dispensing point would be operational in every health district; moreover, it would take five years to establish a dispensing point in every (284) municipality (Irin, 2006).

Despite government's long last commitment to roll out a treatment programme, policy is still nonetheless muddled, with the Minister of Health (to the present) advocating traditional remedies as treatment for HIV/AIDS. Moreover, between 2004 and 2006, policy implementation has had to overcome barriers associated with forming win-win partnerships with pharmaceutical companies, assisting and educating infected individuals on taking AIDS medicines, and reacting to the continued activism of the TAC that has been a relentless advocate for a definitive policy response action from government. A shift in corporate objectives has had to take place as well, as it relates to pharmaceutical companies. Profit maximization and ARVs has proven incompatible. In response, for example, Boehringer Ingelheim, the manufacturer of nevirapine had offered to provide the drug free of charge for five years. Additionally, in a regimen in the treatment of HIV/AIDS, an infected individual may have to take as many as four types of medicines 3 times a day. An argument has been made that dispensing HIV/AIDS medicines requires



counselling on the regimen of drugs to maintain the quality of life. Notably, many HIV/AIDS infected individuals will take drugs for added ailments such as Tuberculosis and side effects can occur (HIVdent, 2003). Finally, government still remains susceptible to legal actions from other interest groups that strive to influence government's policy on making HIV/AIDS drugs available to everyone no matter their socio-economic status. For example, 15 Westville prisoners filed a court petition to force the South African Correctional Services to provide them with ARVs (Anonymous, 2006).

4.4 ACTIVISM, AIDS AND THE MEDIAN VOTER

Besley and Burgess (2002) suggested that informed and politically active constituents motivate government to be responsive. Their work is most relevant for two reasons. Firstly, their work examined the responsiveness of government to poor and vulnerable groups. While HIV/AIDS does not discriminate, those most susceptible to being infected are the poor uninformed constituents. Secondly, their work is most relevant as a framework for discussing the median voter's activism because there is discussion of voters [constituents] being imperfectly informed about the actions of the incumbent politician. In short, those voters who are vulnerable and informed vote for the candidate that puts forth the most effort. Conversely, those voters who are vulnerable and least informed do not vote. Implicitly, those incumbents that are most active apply great effort in keeping voters informed. Finally, Rosen (1999:118) reminds that the median voter is situated in the middle of all voters. Half of the voters will prefer a policy alternative and the other half will reject a policy alternative. The median voter theorem then states that the outcome of majority reflects the preferences of the median voter – that voter, or those voters whose preference [preferences] lie in the middle.



Hereafter, the case study looks at policy in terms of: 1) the extent to which constituents in South Africa have been informed of HIV/AIDS policy alternatives; 2) who is the median voter and what is the nature of their [midline] preferences; and 3) the extent to which political incumbents have informed constituents of, say, their (the incumbent's) position on HIV/AIDS. The informed constituents will then be inclined to vote and the uninformed voter will be inclined to not vote.

4.4.1 Communicating Policy Alternatives

It is important to differentiate between government, say, using mass media to communicate HIV/AIDS awareness and policy makers communicating the government's policy alternatives in response to a national epidemic. While indeed the former educates on how to protect against being infected, the latter informs of the many alternatives contemplated by government to meet the needs of all citizens. The discussion here is not of government's media campaign as a tool to prevent HIV/AIDS. Rather, the discussion is of government informing of the actions the executive would take to implement programmes in favour of citizens regardless of party affiliation. Naturally, government is expected to intervene when there is a market failure. The private sector finds it unprofitable to provide a particular public good – e.g. national defence, or even AIDS medicines. The government is looked to for leadership on a dilemma that has far reaching implications. When the government of the day communicates clearly its policy alternatives, it maintains the support and confidence of its citizens. It is argued that from 1994 to 2000 the government of the day did little to communicate policy alternatives. In fact, from its inception the government, if anything, struggled to formulate policy on HIV/AIDS. The epidemic was, perhaps, not so high a priority of the Mandela



administration due to the need to get the new ANC government up and running. The government of national unity had adopted NACOSA's (a late apartheid regime advisory body) national AIDS plan (Hickey, Ndlovu & Guthrie, 2003:10) but a policy position was not evident, nor communicated until the Mbeki administration came into its own. Although the HIV/AIDS/STD Strategic Plan for South Africa (2000) had communicated a policy promoting prevention, treatment care and support, from 1998 onwards (from the beginning of the Mbeki administration) policy communicated alternatives ranging from what government should do in response to conspiracy theories against Africa. As well, there were policies reflecting denial that the HIV virus causes AIDS and policies indicating technical and financial concerns for rolling out a national HIV/AIDS treatment programme. Indeed, policy alternatives communicated reflected vacillation on the part of the executive. Mbeki was accused of being trapped in an intellectual boundary defined by coercive and racist arguments typical of late apartheid public health policy (Mbali, 2002). All in all, the senior most policy maker (the president) had succeeded in muddling the message [communications] indicating government's responsiveness to the HIV/AIDS epidemic.

4.4.2 The Median Voter and Midline Preferences

With the median voter having preferences that lie in the middle of a set of all voter preferences, several questions are raised. Firstly, who is the median voter and what are the characteristics of the median voter? Secondly, what is the nature of their midline preference – policy response desired? Is it truly a preference that government should, for example, expediently roll out an HIV/AIDS treatment programme? Or in keeping with elite [model] theory, are voters apathetic and ill informed of public policy on HIV/AIDS



(Dye, 2003:23)? In other words, are voters, and for this discussion the median voter, passive and unconcerned over public policy decisions pertaining to HIV/AIDS treatment.

Willan (2004:2) found it curious and odd that the ANC enjoyed continued support despite broad criticism of its policies. The about turn in 2003 on AIDS policy (being forced to roll out an HIV/AIDS programme for pregnant women) no doubt has contributed to continued support from the electorate. Assuredly, the median voter(s), of who the majority are ANC supporters, has in some way been affected either directly or indirectly by HIV/AIDS. As reporting of declared AIDS related deaths become more definite and proficient, the median voter will be most like see AIDS as a political issue. The threat to the ANC will then come from the median voter (an electorate) increasingly dissatisfied with government's inadequate response to a national epidemic of HIV/AIDS in South Africa?

When the HIV/AIDS epidemic was in its early stages and on the rise (1990-1997), citizens prioritised unemployment and poverty as the most important issues requiring government attention, intervention and policy formulation. With an infection rate greater than 20% of the population and on the rise, a shift in the median voter's midline preference is occurring. As the rate of infection increases, the midline preference will shift reflecting preferences for policies and programmes to combat HIV/AIDS and maintain quality of life for those infected with the AIDS virus. Moreover, the median voter will tend to be more informed and less apathetic as the rate of infection increases. Political and policy elites should then become more responsive to the electorate, thus strengthening the relationship between HIV/AIDS, democracy, citizenship and governance.



4.5 POLITICAL INCUMBENTS AND INFORMED CONSTITUENTS

The problem that arises in discussing HIV/AIDS in terms of political incumbents and their keeping constituents informed is that the epidemic then becomes politicised. A desire to not politicise HIV/AIDS is perhaps one reason for political candidates not informing the electorate of a policy [alternative] position. In South Africa, the optimal policy alternative would be to roll out an all-inclusive HIV/AIDS treatment programme. Over the local government elections of 2006, hardly a word was heard of incumbents' political and policy position on HIV/AIDS. In Trevor Manuel's 2006 Budget speech, the most one can glean of the executive's policy on HIV/AIDS is that: "192 health facilities in South Africa have HI/AIDS treatment facilities and the government is strengthening AIDS programmes (Manuel, 2005:29)." There appears to be a disconnection between political elites and their communicating policy alternatives for HIV/AIDS.

Strand, Matlosa, Strode and Chirambo (2004) examined the potential for democratic governance to be marginalised by a "non-response" to the HIV/AIDS crisis in South Africa. That South Africa lacks a HIV resilient society, it can be argued, enables incumbents to address HIV/AIDS with minimal enthusiasm, resulting in their not revealing their policy positions on the epidemic. Thus, the electorate does not hold decision makers accountable due to the absence of resiliency. If it were not for the activism of the TAC, the executive's response may have been far different than it has been.

Theoretically, there is no subsequent reason for incumbents to inform constituents of policy alternatives on HIV/AIDS because their constituents do not make demands of the political representative. The threat of not being re-elected is less plausible –



especially in an electoral system that is based on party lists. Indeed, this alludes to the hypotheses of this dissertation that the electorate is unable to affect policy decisions and influence government to spend on HIV/AIDS treatment programmes. It should then be expected that HIV/AIDS has impacted the electoral system and the management of elections in South Africa.

4.6 HIV/AIDS AND SYSTEM EFFECTS

Practically, no subsystem of the infrastructures of government and society has gone unaffected by the HIV/AIDS epidemic. Kelly (2000:7, 43), for example, noted that in many countries the epidemic has undermined the educational system – e.g., reduced teaching capacity, decline in community support, inadequate planning and financial support. Moreover, the epidemic has affected personnel, disrupted the system itself by causing uncertainty, bewilderment and paralysis in the educational system. Taylor (2004) documented the affect of HIV/AIDS on health care systems, noting requirements of follow-up services for adherence to treatment, management of opportunistic infections, research and laboratory support, and mechanisms to insure access to quality treatment. The need to balance the protection of patents and intellectual property rights with the rights of infected individuals has impacted procurement systems for HIV/AIDS related medicines and supplies (Taylor, 2004:11).

Indeed, almost every subsystem conceivable has been affected by the HIV/AIDS epidemic. Here, however, the subsystem of greatest concern is the impact of HIV/AIDS on the electoral system. Sight should not be lost of the focus and thesis of this dissertation – notably, the effect of the voting franchise on policy decisions and spending for HIV/AIDS. Can the voters influence government spending? Notably, the hypothesis



is that voters cannot influence government spending for HIV/AIDS and therefore not able to influence public policy decisions.

Firstly, it is suggested here that submission of party lists (RSA 1998:22), the manner in which political candidates achieve office, contributes to voters [the electorate] not being able to influence policy making in South Africa. In other words, the electorate does not choose or vote directly for their representative. Rather a vote is cast for a [party] list put forth by a contesting political party. This is characterised as, albeit, a “national list proportional representation system” that leads to the elected representative being first accountable to their party and accountable to their constituency secondly. Although Reynolds (1997) claimed that this type of proportional representation system was crucial in creating an atmosphere of inclusiveness and reconciliation necessary for the establishment of a post apartheid government, arguably such a system marginalises voters and raises party allegiance above maximising the interest of the incumbent’s constituency. The incumbent remains only partially accountable and need not respond definitively to calls from the electorate for an all-inclusive national HIV/AIDS treatment programme.

Consequently, accountability is compromised by a party list proportional representation system, along with added affects resulting from the HIV/AIDS epidemic. Strand *et al.* (2004:76, 82), for example, noted that voters were negatively affected and hindered from exercising their franchise to vote. Firstly, with increasing numbers of voters being infected with the virus, special arrangements must be made to accommodate incapacitated voters. The electoral administration (the independent electoral commission) will need to develop the capacity to service sick bed ridden voters, less



their (HIV infected voters) disenfranchisement becomes the norm, accepted and commonplace. Undoubtedly, their not being able to vote would be unacceptable in a stable and legitimate democracy. Secondly, the increase in deaths attributed to HIV/AIDS would negatively affect the voter's roll. The number of voters on the roll would be inaccurate and potential fraudulent use of ghost voters would skew the outcome towards unscrupulous political candidates. Thirdly, while in South Africa the number of elected candidates succumbing to HIV/AIDS has been minimal, there is concern (in the Southern African region as a whole) that the replacement of sick or deceased representatives (either by bi-elections or a listed candidate serving as a replacement) undermines, if not destabilises, the representivity of the body politic. In other words, the changing political body of politicians consist of representatives other than those substantiated by the electorate. Notably, proportional [constituency] representation, especially in South Africa, is argued here to be compromised by the use of party lists. Replacement of elected representatives before scheduled national and local elections further compromises and marginalises the electorate, rendering it ineffective in influencing public policy making.

With regard for developing policies alternatives and government institutions between 1992 and 2004, it is striking that Strand *et al.* (2004:133) noted that:

. . . extraordinary leadership qualities are required from the political establishment to put HIV/AIDS on the political agenda at an early stage in the epidemic . . .

The irony of the statement is that over those years, in reality that the political establishment, the government of the day, had done all it could to keep HIV/AIDS



off the political and policy agenda. It is unfortunate, but Strand *et al.* (2004) appears to “whitewash” the political establishment rather than condemn it for the many controversial statements that emanated from the executive’s administration. Whether more harm than good is debatable but in light of the increasing HIV/AIDS infections rate, clearly up until the TAC’s court action there was an absence of policy making and political will to combat HIV/AIDS.

In contrast, the 2004 election reflects democracy in the electioneering mode (Strand *et al.*, 2004:132) when there is concern for HIV/AIDS amongst the electorate. What is questionable was the distrust between parties that prevented, say, political elites (Mbeki, Leon, Buthelezi, DeLille, and Van Schalkwyk) from debating, communicating, and informing the electorate on the matter of HIV/AIDS prevention and awareness. Consequently, there are a multiplicity of policy proposals that fall by the wayside once the elections are concluded due disunity and emphasis of party specific platforms; no significant policy alternative is ever implemented and the electioneering mode gives way to a day-by-day operational and administrative mode. To this end, the electorate is unable to influence public policy and government spending on HIV/AIDS. Essentially, the HIV/AIDS epidemic has rendered the South African electoral system ineffective, with the epidemic being an issue that is skirted and avoided as a campaign issue. Over time, the government has moved from denial, to avoidance, to (with the implementation of HIV/AIDS treatment for pregnant women) cautious implementation.



4.7 THE UNITARY STATE AND HIV/AIDS

Characteristically, a unitary state (no matter the number of spheres of government) is governed as a single entity. The national sphere of government dictates policy for central government and all other sub-national spheres of government – i.e., provincial and local government. Unarguably, before 1994 South Africa would have been described as a unitary state. National government and therefore the executive held tight control over all aspects of public administration and policy. In reference to post-apartheid South Africa and 1994 onwards, debate looms as to whether South Africa is a unitary state or a federal state, devolving authority and policy making to sub-national spheres of government. In reality, South Africa is a relaxed form of the unitary state, with traits of limited federalism on matters that national government declines to address.

If there is indeed a mandate for a unitary state, that mandate emanates from Chapter 3 of the Constitution (RSA, 1996) that legislates for cooperative government. Notably, section 41(h) states that legal proceedings between spheres of government should be avoided. In other words, disputes between the national and sub-national spheres of government should be argued in a forum other than the court system. Indirectly, the dispute between provincial government and national government on HIV/AIDS treatment (Afrol, 2002) was settled by the high court, with the Minister of Health being challenged by the TAC and the subsequent ruling in favour of the TAC (*Minister of Health v. Treatment Action Campaign*, 2002). National government had no choice but to roll out an HIV/AIDS treatment programme following the high court ruling.



It was not that the national sphere of government had deferred policy making to provincial government. Rather, national government's inaction on HIV/AIDS exemplified the expanded definition offered by Dye (2002:1). While defining policy, simply as what government will do or chooses to do, policy may also be defined as what government chooses not to do. Indeed, inaction by government is a conscience policy decision that, in the case of the [relaxed] unitary state in South Africa, leads to conflict between varying spheres of government.

Ironically, the state (Department of Social Development, 2006) views its role as that of a coordinator and integrator of stakeholders and resources in the fight against HIV/AIDS. Its role in providing social protection to those infected and affected is one that is constantly under attack and subject to the scrutiny of the watchdog special interest group the Treatment Action Campaign (TAC). Although there is commitment now to implement, for example, home based/community care, this may not have been a policy alternative without the oversight of the TAC and civil society in general.

Nevertheless, the unitary state can be highly effective in fighting HIV/AIDS when there is an aggressive definitive policy response. Gauri and Lieberman (2004) spoke of the politics of epidemics associated with South Africa's response to HIV/AIDS, as compared to Brazil. Clearly, in 1985 Brazil (the state) had made a commitment to formulate and implement an HIV/AIDS policy. In contrast to South Africa, a bureaucratic frame of mind on HIV/AIDS was established early on. In 1985 Brazil established an HIV/AIDS programme within the Ministry of Health. That is not to say that since the programme was administered without bureaucratic difficulties. There were eight name changes to the HIV/AIDS programme and AZT was not provided free to all patients until 1991.



Importantly, HIV/AIDS policy was centralised in the Ministry of Health and the ministry had significant autonomy in mobilising manpower and resources to respond to the epidemic nationally.

It is truly remarkable that Brazil realised the threat and responded forthrightly as early as 1985. In contrast, it was not until 1994 when the ANC government came into power that, at the least, significant discourse on HIV/AIDS began to take place. Conclusively, in the case of Brazil the unitary state was instrumental in implementing a national HIV/AIDS policy, while in South Africa the unitary state has wavered on formulating and finally implementing a policy on HIV/AIDS.

4.8 SUMMARY

It is questionable whether the electorate can influence public policy by way of the ballot box. The research question in this dissertation is concerned, specifically, with the electorate's ability to influence public policy, as reflected by government spending. The hypothesis here is that the voters do not have the ability to influence government spending for (public policy) HIV/AIDS. What is most interesting about the electorate in South Africa is its continued allegiance, despite not being able to effect or influence electoral outcomes. With regard for HIV/AIDS relative to political incumbents, policy makers and the electorate both appear to be "muddled" in their response to HIV/AIDS; incumbents are muddled in their communicating policy alternatives to constituents. Constituents are muddled in their persistent support of representatives that are only indirectly accountable due to an electoral system based on party lists.



The muddled state of affairs contributes to a variety of perspectives on the matter on HIV/AIDS in South Africa. From a macro perspective, the executive's (President Mbeki's) initially illusive and unclear response to the HIV/AIDS epidemic characterised the overall response of the political system – that political system being the national sphere of government. Moving from a macro perspective to a micro perspective, the attitude and behaviour of the collective in the form of the activist Treatment Action Campaign (TAC) was responsible for motivating the executive to formulate an HIV/AIDS treatment policy for, at least, pregnant women to prevent mother to child HIV virus transmission. The individual may be powerless to affect HIV/AIDS policy but a special interest group such as the TAC can be effective in mobilising the collective to affect policy making. That in recent times the TAC has been in consultation with Deputy Mlambo-Ngcuka, concerning a new HIV/AIDS strategic plan for 2007/11, indicates that the collective through the TAC is providing some input into the national HIV/AIDS policy (Cullinan, 2006).

Another way [perspective] of looking at HIV/AIDS policy is by examining policy before and after 1994. Notably, in the latter days and reign of the apartheid regime (those days coinciding with the first reported HIV/AIDS cases) there was little or no response to the epidemic. In the early 1980's the disease was considered to be a gay disease. Unfortunately, when the ANC came into power, it not only had to establish a new system of government, it also had to recognise and respond to an HIV/AIDS prevalence rate that was increasing at an alarming rate from year to year. Truly, the ANC had inherited a deadly legacy from the (apartheid) National Party. Shortly after the turn of the new



millennium, a policy response was forthcoming in the form of the HIV/AIDS/STD Strategic Plan (DOH, 2000).

The research question [dissertation] is extended to consider whether the median voter can influence public policy. The median voter is that voter whose preferences lie in the middle of a spectrum of preferences. That preference then represents the preference of the majority of voters. Do political incumbents strive to keep the median voter informed of policy alternatives? Considering that political incumbents are indirectly accountable to the electorate, they can hesitate to be responsive to constituents. Why? Political incumbents need only be responsive when seeking re-election. This is a consequence of South Africa's party list system, where voters vote for the party's listed candidates and not individual prospective representatives. Thus, in between elections incumbent's first allegiance will be to their party; come elections, incumbents will actively canvas to secure votes for the party through, for example, campaign promises – increased social welfare programmes and benefits.

Finally, the HIV/AIDS epidemic has the potential to negatively affect the electoral system. For example, those infected with the virus will require special voting facilities. As well, the voting register could be subject to manipulation, as registered voters succumb to the disease – ghost or false ballots submitted on behalf of deceased voters on the roll. Consequently, the roll will not reflect the actual number of [live] voters on the roll. These adverse affects have the potential to destabilise the electoral process, further inhibiting the electorate's ability to affect policy even when it exercises its franchise to vote. This will be especially true for smaller opposition parties whose power to influence policy is exemplified by alliances and coalitions with other small parties.



Conclusively, it could be argued that the unitary state might benefit from a destabilised electoral process. The unitary party of the day would continue to maintain control, as has been the case in South Africa. This is a paradox in that on one hand the unitary state can promote stability in its new young democracy. On the other hand, the unitary state contributes to the argument against a one party state. Questions remain, however, as to whether the unitary state 1) will or intends to make appropriate policy decisions in favour of its marginalised citizens, and 2) whether the unitary state will intends to inhibit sub-national governments from making policy on, for this matter, HIV/AIDS - especially on those occasions when national government chooses not to make policy? A conscious decision by national government to not respond with a policy should not prevent provincial governments from developing and implementing policy alternatives.