

HIV/AIDS, LOCAL POLITICS, AND THE LIMITS OF TRANSNATIONAL
GOVERNANCE IN SOUTH AFRICA

By

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Abstract

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This dissertation analyzes the social and political contestation that surrounded the implementation of a new national HIV/AIDS policy in South Africa. I contend that that the African National Congress developed new institutional forms and cultivated alliances with non-governmental organizations to limit the influence of organizations and international donor funding through the implementation of the new AIDS policy. At the national level, my research on the National AIDS Council found that intransigence on the part of government officials undermined the implementation of the national policy. In the Western Cape province, I discovered that a consultative process for the new policy was deeply influenced by the transfer of the Global Fund grant from the provincial health department to a single non-governmental organization. In the townships located outside of Cape Town, I found that local branches of ruling party developed alliances with local non-governmental organizations to disseminate alternative AIDS treatment. However this association between the African National Congress and non-governmental organizations

focused particularly on initiatives and organizations that were supported by international funding. As such, I argue that the politics of the South African AIDS epidemic were partly oriented around the influence of transnational political and economic forces.

The conclusions I reach in my dissertation offer a critical perspective on the ways that contemporary theories of globalization and transnational governance characterize the capacity of states to maintain political autonomy. Here I argue against those who see a growth in non-governmental organizations or global interconnectedness as marking a retraction of the state. This trend has been particularly emphasized in developing countries, where the privatization of social services has been viewed as an essential ingredient in macroeconomic stabilization. While the capacities of the South African state have been diminished due to privatization, the ruling party has expanded its influence through alliances with non-governmental organizations and by strategic control over institutions that can be used to limit transnational political influence. Thus, rather than a weakening of state power, in South Africa the influence of neoliberal globalization has precipitated a transformation of the modes through which political power is achieved and/or maintained by the African National Congress.

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between local, provincial, national and transnational forces that serve as its primary theoretical contribution.

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List of Key Organizations and Abbreviations

AIDC:	Alternative Information Development Center
AIDS:	Acquired Immune Deficiency Syndrome
ALN:	AIDS Legal Network
ALP:	AIDS Law Project
ANC:	African National Congress
ARV:	Anti-retroviral drug
ART:	Anti-retroviral therapy
BCM:	Black Consciousness Movement
CBO:	Community-based organization
Cosatu:	Congress of South African Trade Unions
CSP:	Comprehensive Services Plan, also referred to as Healthcare 2010
DA:	Democratic Alliance
FEDUSA:	Federation of Unions of South Africa
GEAR:	The Growth, Employment and Redistribution Macroeconomic Strategy
Global Fund:	The Global Fund to fight AIDS, Tuberculosis and Malaria
HIV:	Human Immunodeficiency Virus
IDASA:	Institute for a Democratic South Africa
IMF:	International Monetary Fund
JCSMF:	Joint Civil Society Monitoring Forum
LRS:	Labour Research Services
MCC:	Medicines Control Council
MDM:	Mass Democratic Movement
MEC:	Member of Executive Committee
MRC:	Medical Research Council
MSAT:	Multi-Sectoral Action Team
MSF:	Médecins sans Frontières (Doctors Without Borders)
MWT:	Marxist Worker's Tendency
Napwa:	National Association of People Living with AIDS
NDA:	National Development Association
Nedlac:	National Economic Development and Labour Council
Nehawu:	National Education, Health and Allied Workers Union
NGO:	Non-governmental organization
NPO:	Non-profit organization
NSP:	National Strategic plan for HIV/AIDS and STIs, 2007-2011
NUMSA:	National Union of Mineworkers in South Africa
PAC:	Provincial AIDS Council
PIDAC:	Provincial Inter-Departmental AIDS Committee
PMTCT:	Prevention of Mother-to-Child Transmission of HIV
PSP:	Provincial Strategic Plan (Western Cape)
PWA:	Person living with AIDS
SACP:	South African Communist Party
Samwu:	South African Municipal Worker's Union

RDP:	Reconstruction and Development Program
RSA:	Republic of South Africa (post-apartheid)
Sanac:	South African National AIDS Council
Sanco:	South African National Civics Organization
SANDoH:	South African National Department of Health
SARB:	South African Reserve Bank
Saso:	South African Student Organization
STI:	Sexually transmitted infection
SWEAT:	Sex Workers Education and Advocacy Taskforce
TAC:	Treatment Action Campaign
TB:	Tuberculosis
TRIPS:	Trade-Related Aspects of Intellectual Property Rights and Services
UDF:	United Democratic Front
UNAIDS:	The Joint United Nations Programme on HIV/AIDS
WCCAPHC:	Western Cape Coalition Against Public Health Cuts
WC-Nacosa:	Western Cape Networking AIDS Coalition of South Africa
WWMP:	Worker's World Media Productions
ZAR:	South African Republic

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Introduction

Locating the Transnational and Untangling Historical Continuities in Post-Apartheid South Africa

“Things have changed, the Minister is coming back.”

After I had heard Themí’s statement, I turned to look to the female activist sitting at the desk next to me. The look on her face that served to confirm that the worst fears of the HIV/AIDS movement in South Africa had been realized: the era of AIDS dissidence was not yet over. South Africa’s Minister of Health, Manto Tshabalala-Msimang, had left her position on sick leave in November 2006 after her presentation of lemon, garlic and beetroot alongside antiretroviral drugs as a viable AIDS treatment at the 16th International AIDS Conference held in Toronto, Canada in August 2006. Rumors regarding the Minister’s return had begun to circulate in May 2007, with academics analyzing the AIDS epidemic stating that she had recovered from a liver transplant and might return to office. Themí, an AIDS activist in the Treatment Action Campaign organizing people living with in the peri-urban township of Khayelitsha, shook his head with frustration, “We are really going to be struggling.” This anti-apartheid activist who had been previously affiliated with the Pan-Africanist Congress was a key figure in the AIDS movement on the Cape Flats, and his foreboding words proved to be a prescient analysis of the political dynamics that unfolded over the course of my fieldwork in South Africa.

During Minister Tshabalala-Msimang’s extended leave, the political terrain of HIV/AIDS had shifted away from a divisive process focused on the slow implementation

of orthodox AIDS treatment in the public health sector and the resistance of a political faction within the African National Congress to an orthodox public health response to the epidemic based on a lack of belief in a scientific link between HIV and AIDS. This “AIDS dissident” faction with the ruling party was led by President Thabo Mbeki and included party members in key positions in South Africa’s national health institutions including the National Minister of Health, Director General of Health, President of the Medical Research Council, and several Provincial Health Ministers. However a brief moment of hope had emerged in the political struggle surrounding the HIV/AIDS epidemic during the Minister of Health’s absence as a new national AIDS policy had been drafted by AIDS activists, members of academia, biomedical researchers, non-governmental organizations and the South African Department of Health under the direction of Deputy Minister of Health Nozizwe Madlala-Routledge.

This policy, the National Strategic Plan for HIV/AIDS and Sexually Transmitted Infections (NSP), set out the ambitious targets of a 50% percent reduction in new HIV infections and the extension of AIDS treatment to 80% of people living with AIDS by 2011. The policy had been drafted in the aftermath of the 2006 International AIDS Conference in Toronto, during which the South African government had displayed lemon, garlic and beetroot alongside antiretroviral drugs as comparable AIDS treatments. This had led to a furious confrontation between AIDS activists and the South African delegation to the conference, with the Minister of Health Manto Tshabalala-Msimang being shouted down during a presentation and the director of UNAIDS Stephen Lewis denigrating the South African government for their continued lack of action on the epidemic.

In the months following the August conference Minister of Health Tshabalala-Msimang went on an extended leave of absence due to illness. Her absence created adequate political space for the aforementioned parties to work together and draft the new national AIDS policy, the NSP, at a rapid pace. The excitement produced by this abrupt turn in the politics of AIDS in South Africa was tangible, with news coverage of the policy launch on World AIDS Day 2006 rejoicing in the dawn of a new era. I had planned to monitor the implementation of the NSP in the Western Cape province and to conduct interviews with members of the National AIDS Council, the joint government-civil society institution charged with national oversight of the implementation of the new AIDS policy. I had selected the Western Cape for analyzing implementation because the province had moved ahead with implementing an orthodox AIDS treatment program in its public health sector earlier than South Africa's other eight provinces. This was due to the fact that the Western Cape had applied for funding from the Global Fund to fight AIDS, Tuberculosis and Malaria (hereafter referred to as the Global Fund) to support its program while under the control of the African National Congress's political opposition, the Democratic Alliance.

The context that I had anticipated conducting research in, an open political environment within which a new AIDS policy was being rapidly implemented, was not what I found when I arrived in South Africa. As I learned weeks before my research was to begin, Minister of Health Tshabalala-Msimang was returning to her post from her sick leave. This fundamentally changed the trajectory of the research initiative I was to undertake in ways I could not foresee. Most fundamentally, this turn of events underscored the ways in which the national Department of Health was able to exert

significant influence over the implementation of a policy that had been passed into law. The fact that the renewed intransigence on AIDS treatment was also a rejection of international consensus forced me to take another look at the institutional dynamics through which the orthodoxy of AIDS science had been challenged in South Africa.

The AIDS dissident position elaborated by former President Thabo Mbeki built upon elements of African Nationalism, a critique of multinational pharmaceutical corporations, and circumspection towards international institutions. The predominant interpretation of Mbeki's public statements in and outside of South Africa was to examine them as a curiosity, a set of ideas that from another eccentric ruler in sub-Saharan Africa (Specter 2007). However critical analyses of Mbeki's discourse on AIDS have revealed the foundations of this position. Natrass (2007) and Fassin (2007) have pointed out that the scientific basis for Mbeki's claims were based upon the research of AIDS dissident U.S. scientists such as Peter Duesberg and David Rasnick. Steinberg's (2008) examination of AIDS beliefs in a part of the rural Eastern Cape province underscored the role of apartheid medicine in producing skepticism amongst black South Africans towards Western Medicine. By taking Mbeki's statements seriously, these scholars revealed critical elements of the historical foundation and social resonance of AIDS dissidence in South Africa.

My own foray into the well-traveled path of AIDS politics in South Africa builds upon these analyses in taking the AIDS dissident position seriously, thus analyzing the politics of HIV/AIDS with a focus on the role of transnational influence. While Natrass (2007) produced a thorough analysis of AIDS politics in South Africa, it tended to focus on the political struggle between the African National Congress and the Treatment Action

Campaign. The element of the AIDS dissident position that seemed to have escaped thorough analysis in this and the other accounts of AIDS politics in South Africa was the role of international political forces in the history and politics of the epidemic. A key tenet of the AIDS dissident position has been the characterization of those who back orthodox HIV/AIDS treatment as complicit in an imperialist agenda aimed at destabilizing the national democratic revolution in South Africa. The rejection of the new AIDS policy that was produced in response to international furor at the 2006 International AIDS conference in Toronto is just one of many examples that can be highlighted to underscore this point. Given this focus in the AIDS dissident faction in the ANC, a central aspect of this analysis of AIDS politics in South Africa is the re-assertion of state autonomy in the face of increasing international influence during the period of neoliberal globalization.

This is a significant phenomenon for an analysis of AIDS and neoliberal globalization as it runs against the grain of what has been described as a central feature of this period, decreasing state autonomy. South Africa is an interesting case study through which to examine this issue due to the fact that, unlike many of its neighbors in southern Africa, it has not ceded national political autonomy to the international financial institutions, the International Monetary Fund and the World Bank. Therefore the question of indirect or “soft” forms of influence from transnational political forces must be analyzed through an in-depth study where the various instances of transnational political influence can be examined in detail. For this project, the field of study for analyzing this dynamic will be the public health response to the HIV/AIDS epidemic in South Africa.

Globalization and the AIDS Epidemic in South Africa

While contemporary analyses of globalization and development have often proclaimed the demise of the state under neoliberal global governance, this project examines the ways in which South Africa has re-asserted national political autonomy towards transnational political forces in its public health response to the HIV/AIDS epidemic. Theories of globalization have tended to characterize it as an inevitable process of increasing global interconnection via trade, finance and telecommunications organized around central urban 'nodes' such as New York, London, and Tokyo (Sassen 1990, Castells 1996). This has led scholars to characterize contemporary cultural change as contingent upon shifts in circulatory financial processes that seem to operate with relative autonomy from 'real production' (Comaroff & Comaroff 2001:10). However other scholars of globalization have insisted upon continued attention to changes in the productive base of the global economy (Robotham 2005), a focus which brings into sharp relief the processes of flexible accumulation enabled by the unfettered movement of finance capital (Harvey 1990), the feminization of the global workforce (Eisenstein 2010), and the unequal impact of the HIV/AIDS epidemic on women in the Global South (UNAIDS 2006). A point of agreement among the varying perspectives on globalization is the rising level of social inequality that has accompanied the implementation of the 'neoliberal' economic policies that characterize global economic integration (Dumenil and Levy 2005). While the debates over the effects of globalization continue to offer new insights into the way in which geopolitical power is constructed, they have tended to underestimate the extent to which national governments and local political authorities continue to maintain decisive control over their territory, resources and citizenry.

While this unidirectional perspective on globalization predominates in the social sciences literature, other scholars have begun to question the extent to which this normative positioning reflects actual political processes in developing countries. Sandbrook et al. (2007) have argued that ‘developing’ countries have increasingly found ways to balance the competing demands of international capital and internal pressure to respect social, political and economic rights. Harvey (2005) contends that globalization and neoliberalism must be understood as a ‘class project’ whereby national elites implement socio-economic policies that increase their share of a given society’s wealth. Bond (2005) has utilized a similar approach in characterizing the leadership of the ANC as catering to the interests of global capital rather than South Africa’s poor by privatizing social services and implementing fiscally conservative macroeconomic policy. While Bond’s perspective offers insight into reasons why the policy norms associated with globalization have been put into place, it does not theorize how political influence operates through international institutions and across nation-states beyond a correlation of speech acts with the global balance of economic power.

Ferguson (2006) argues that the globalization process has been accompanied by a coalescence of international institutions such as the International Monetary Fund and the World Bank into a loose coalition that focuses on the implementation of neoliberal social policies via a process of transnational governmentality. While this process has been debilitating for the governments of the Global South, Ferguson argues that neoliberal globalization has enabled non-governmental organizations to access international donor funding, thus leveling the traditional hierarchy between state and civil society and fundamentally changing the basis of politics in “developing” countries. While this project

builds on the insight that non-governmental organizations are increasingly significant for an analysis of political processes, it does so with an understanding that this perspective may underestimate the extent to which the governments of “developing” states continue to maintain power over their citizenry and can respond to, or defy the dictates of transnational political influence.

The anthropology of development and the state have also offered significant contributions to the theorization of transnational political forces. Ferguson (1990) provides a foundational inquiry on the contradictory outcomes of foreign aid that also brings into question the developmental role of modernist and neoliberal models of socio-economic development. Ferguson and Gupta further argue that anthropological studies of the state have been predominantly predicated on vertical modes of analysis by theorizing national political processes in a hierarchical relationship to local dynamics (Ferguson and Gupta 2002). On the privatization of services that were formerly the purview of the state, Gill’s (2000) ethnography of non-governmental organizations describes the privatization of state functions coupled with increased international funding, a dynamic that led many non-governmental organizations to embrace market-based values in their development projects amidst increased militarization of Bolivian society. Hibou (2004) counters traditional analyses of privatization by arguing that the privatization of state functions does not entail a withering away of the state, but a diversification of governing institutions that, due to increasing privatization, are not accountable to the population. Analyzing development and transnational political processes in post-structural adjustment Egypt, Elyachar (2005) paints a challenging picture that unveils how the extension of microfinance in post-structural adjustment Egypt serves as a method of accumulation for

international capital by incorporating the social networks and survival strategies developed by working class Egyptians into the formal economy. These accounts synthesize the overlapping spheres of political influence emanating from transnational and national institutions while emphasizing the expansion of social inequality during the period of neoliberal globalization. However a common theme in these narratives is the “withering away” of the governmental capacities of the states of the Global South, which is a dynamic that may not occur in all contexts.

Thus, while contemporary analyses of globalization and development have often proclaimed the demise of the state under neoliberal global governance, this project examines the ways in which South Africa has re-asserted national political autonomy towards transnational political forces in its public health response to the HIV/AIDS epidemic. In doing so, this research contends that the ruling party in South Africa, the African National Congress, has utilized the institutions of the state to counteract the influence of international donors and create limitations on the autonomy of non-governmental organizations that are critical of the ruling party. A further insight that derives from this analysis is that the institutional actions of a particular state do not fit neatly into a single, unidirectional process. Institutions at different political scales can be directed to serve vastly different political ends, partly due to the possibility of accessing the same pool of international donor funds available to non-governmental organizations. Thus an examination of transnational political influence might also be extended to include an analysis of changing state behavior at multiple institutional scales in the context of neoliberal globalization.

These insights from the body of theory on neoliberal globalization overlap in many ways with the AIDS epidemic, a disease that has infected millions around the world. The AIDS epidemic is a phenomenon that is simultaneously everywhere and nowhere, often transgressing the bounds of expectation and assumption when it manifests in the public domain. An epidemic that has often been characterized as a symptom of, or a disease that embodies, the process of globalization that occurred in the latter half of the twentieth century, it is also one which forces a reconsideration of the foundational categories through which social scientists understand the world. It is at once intensely public, through debates, public health programs and the wide swath that follows in the wake of its arrival. Yet it is also intensely private, via the moments of intimacy through which it is spread, through the individualized foundation of statistical indices through which we understand the human toll of the epidemic, and through the ownership of intellectual property rights that govern access to life-extending medication.

The transgressive nature of the epidemic for the analytical categories of academic and social analysis has led to innovative socio-cultural critique via the work of several anthropologists. Farmer (1992, 2004) has underlined the negative effects of structural adjustment programs, globalization, and low-intensity state violence on HIV prevalence in rural Haiti, terming this process 'structural violence'. Expanding on this approach to the analysis of public health and HIV at the global scale, the era of globalization can be characterized as one that has exerted structural violence on poor and working class populations across the world through increasing social inequality. Emerging in the midst of this process, the HIV/AIDS epidemic is an event that has often been described as a 'disease of the global system' (Singer et al. 2003). This project builds on these

perspectives in emphasizing the limitation of approaches that emphasize the national political scale in the analysis of an epidemic that is without question global in scope. And, as will be elaborated upon in greater detail below, I adhere to an approach which emphasizes the tangible structural aspects of the HIV/AIDS epidemic, be it in relation to the South African state, internationally funded non-governmental organizations, or community institutions. This project will attempt to draw out the ways in which global forms of structural violence inform the public health response to the HIV/AIDS epidemic in South Africa.

However, much of the literature examining the AIDS epidemic in South Africa has taken on an analytical framework that utilizes the “local” scale to understand the political dynamics that surround the syndrome. Ashforth (2002), analyzing the AIDS epidemic through rumors of witchcraft, views a lack of official action against the epidemic and accusations of witchcraft as a situation that may undermine the fragile authority of the state in the post-apartheid period. As has been highlighted in recent research, HIV/AIDS is often spoken of in coded terms in order for the subject to distance herself from possible attributions of witchcraft, stigma, or culpability in an “unnatural” death (Wood and Lambert 2008, McNeil 2009). While these analyses uncover the additional layers of meaning associated with the epidemic in South Africa, they tend to frame the epidemic solely within the context of local socio-cultural processes. Given the central role of foreign donors in supporting non-governmental and community-based organizations that operate in ‘local’ contexts, these perspectives may not sufficiently take into account the additional dimension of transnational political influence.

Other analyses of the epidemic have taken a more historical approach to understanding the socio-cultural complexities that define the politics of AIDS in South Africa. The analysis offered by Marks (2002) points to southern Africa's historical of racial inequality, labor migration, and the social struggle to overthrow apartheid as key factors in predicting the rapid spread of the epidemic in the region. Fassin (2007) has conceptualized AIDS as the 'embodiment' of apartheid's legacy of social inequality while pointing to the legacy of race in the politics of AIDS dissidence. Nattrass (2007) has outlined the contentious political struggles over AIDS treatment and scientific knowledge between social movements and the state, theorizing the political leadership as the key factor in the ongoing political struggle. Building on the work of Hunter (1936), Steinberg (2008) has underscored the significance of kinship and alternative modes of cultural understanding in producing differential levels of HIV testing amongst Xhosa-speaking South Africans in the Eastern Cape. Building off of an analysis of comparative societal change, Thornton (2008) uses the concept of a sexual network to understand why the HIV/AIDS epidemic has manifested differently in Uganda and South Africa. While each of these accounts offers an important perspective on the South African AIDS epidemic, the frame of reference for each is the national political scale.

While analyses assuming local and national frames of reference neglect the role of transnational political power in producing local social outcomes, analyses of international political forces have tended to underestimate the importance of the local levels of political institutions in the political management of the HIV/AIDS epidemic in South Africa. Analyzing the South African government response to the AIDS epidemic in an international context, Youde (2004, 2007) contends that the AIDS dissidence of the

African National Congress constitutes a “counter-epistemic” community that “translates South Africa’s history with public health interventions and its identity commitments into actual governmental policy (Youde 2007: 3).” While this perspective highlights the central role of international forces in the discourse of AIDS dissidence, it tends to undervalue the role of political and economic forces outside of international health organizations and the political actions of social movements and other non-elite actors due to a focus on discourse.

Also analyzing the South African AIDS epidemic in a global perspective, Comaroff (2007) focuses on the ways in which social movements have responded to international political and economic forces in a manner that reproduces their terms of exploitation by adopting the “knowledge, patents and systems of exchange and command” typified by multinational pharmaceutical corporations. While AIDS activists have adopted many of the biomedical norms championed by institutions such as the World Health Organization, they have tended to do so in a pragmatic and tactical fashion where positions are changed based on whichever is most advantageous to the cause of furthering the availability of AIDS treatment at a particular point in time (Robins 2009). As with Youde’s analysis, greater attention on the ways in which the biomedical norms associated with international institutions circulate and affect the public health response to the epidemic in local communities would strengthen the analysis offered by Comaroff.

In contradistinction to these approaches I contend that South Africans infected and affected by the HIV/AIDS epidemic can offer insight into the limits of transnational political influence and point to new possibilities for re-thinking the way in which this process is shifting the strategies of the state relative to non-governmental organizations

and the South African citizenry. The analysis that follows builds its theoretical claims based upon the insights offered by research participants rather than applying a set of international norms to what is invariably a historically particular socio-cultural process. In doing so, this work builds on the approach of Susser (2009), who utilizes Gramsci's concept of "practical sense" to discuss the ways in which working class and poor South African women develop pragmatic local solutions to the social turmoil created by the AIDS epidemic. A similar approach has been used by Robins (2004) to analyze the ways in which AIDS activism transforms the identities of HIV positive South Africans. Maintaining this focus on the insights of everyday people, I turn my attention here to the ways that transnational political forces are interacting with communities infected and affected by the epidemic and the institutions developed to manage the social impact of HIV/AIDS in South Africa. I contend that a focus on political processes operating at several scales in South Africa enable one to observe how, when, and why particular social outcomes have come to pass, and thus to be able to determine how transnational forces affected a given political process in the context of neoliberal globalization.

Locating the transnational in an ethnography of AIDS politics

Contemporary anthropological analyses of the HIV/AIDS epidemic in South Africa have tended to focus on the role of "AIDS dissidence" in national politics, often neglecting the complex negotiation of stigma, sexuality and politics by non-governmental organizations working at the community level. These analyses have also often characterized the political struggle surrounding HIV/AIDS as a national, rather than intrinsically transnational social, cultural, political and economic process. This project

departs from this approach in emphasizing the articulation of multiple political scales as a key explanatory factor in the social construction of the different AIDS “epidemics” that exist within South Africa. While this investigation is anchored in the experiences of South Africans living in the peri-urban townships of the Cape Flats, I argue that political activity in this area rotates around transnational, in addition to the national, provincial and municipal forms of political and economic influence.

My research examines this issue through a multi-scalar analysis of the first year of implementation of South Africa’s National Strategic Plan for HIV/AIDS and STIs (2007-2011). Based upon interviews with members of government, civil society and township residents, my dissertation investigates the way that transnational, national, provincial and “local” political processes operate in relation to the institutions, policies and treatment that makes up the public health response to the HIV/AIDS epidemic in South Africa. Central to the processes of articulation outlined above are non-governmental organizations that operate nationally, provincially and “locally” in the township of Khayelitsha. These organizations, some of which are funded internationally, some funded by the South African state, interact with the ideas and politics of AIDS dissidence through national, provincial, municipal and sub-municipal institutions. The negotiation of policy, consequent division of resources through these institutions, and the political dynamics that ensue from these political actions form the basis of this study. As such this is a study of politics as a social process operating at multiple political scales, with the point of reference for understanding the concrete effects of these processes being the communities infected and affected by the HIV/AIDS epidemic on the Cape Flats.

The core questions posed by transnational political influence pose to anthropological analysis by way of the dynamics of neoliberal globalization have been addressed at some length by earlier schools of thought. The Manchester School of anthropology, led by Max Gluckman, grappled with the limitations of the structural functionalist approach during a period of rapid social change in Central and Southern Africa. The concept of bounded cultures that the functionalist approach depended upon, while always a social fallacy given the European colonization of the African continent, was discarded as anthropologists such as Gluckman, Epstein, Mitchell, and Turner analyzed the social and cultural complexities produced by migration and urbanization in and around the Zambian Copperbelt. While some have underlined that the Manchester School theorists often maintained ethnically bounded categories of culture, ignored the role of colonization and imperialism, and overlooked the circular migration patterns of urban Africans (Werbner 1984, Magubane 1969, Ferguson 1992) my focus here is on the concept of the social field which emerged out of this body of scholarship.

The concept of the social field was developed in order to taken into account the social conflict and complex cultural dynamics that arose out of rapid urbanization and modernization in Central and Southern Africa. This concept emerged from the work of Max Gluckman, who sought to find more nuanced conceptual frameworks than those such as political structure, which characterized society as a series of interdependent social processes operating at equilibrium with one another within a broader social system. This approach, typical of the structural functionalist mode of anthropological analysis, was incapable of fully taking into account the dynamic socio-cultural processes that were unfolding in Central and Southern Africa in the context of rapid urbanization and

modernization. This juxtaposition of the traditional and the modern necessitated a theoretical framework that acknowledged the simultaneous and overlapping existence of the spheres of modern and traditional political authority and law that framed individual action. Building off of Gluckman's focus on conflict and resolution, the Manchester School was based on a processual analysis of political power, a sharp diversion from the timeless cultures of functionalist and structural functionalist approaches.

These dynamics of conflict and social change were theorized to be operating not within one historically bounded society, but within a social field that contained international capital, modern urban residence, White settlers, colonial authorities, and traditional African polities and belief systems. The concept of the social field¹ was theorized to have had:

[M]any dimensions, with parts that may be loosely integrated, or virtually independent from one another, and that have to be studied over time if the factors underlying the changes in their social relationships are to be identified and analyzed (Schwartz, Turner and Tuden 1966: 3).

Broad enough to contain various scales of political activity and specific enough to give meaning to individual political action, the concept of the social field was a major contribution of the Manchester School to anthropological analysis. Within this broader concept, two new modes of anthropological inquiry were developed: network theory, best characterized with the work of Mitchell (1969) before becoming a major subfield in anthropology, and the concept of the political field, which was theorized by Schwartz, Turner and Tuden (1966). Given the directly political nature of the study pursued here,

¹ Bourdieu (1996) later proposed a theory of the social field that analyzed cultural fields that are changing slowly over time. However due to the fact that the focus of this concept is on the lifepaths of practitioners of a particular line of work, it is not useful for my purposes here.

the political field is an appropriate concept to apply to the politics of AIDS in South Africa.

The development of the political field focused the concept of the social field onto political processes, but critically, did not apply the same restrictive criteria to state action and power as concepts such as state structure. The fluidity of this concept, which viewed processes as migrating through groups and across geographic areas, is critical for an understanding of political processes beyond the scope of intra-national dynamics. As such, the political field approach does not center on communities or organizations, but on the process itself, and the changing group dynamics that unfold over time (Schwartz, Turner and Tuden 1966: 8). An extended reference offers additional insight into this school of thought:

A political field does not operate like clockwork, with all the pieces meshed together with finely tooled precision. It is, rather, a field of tension, full of intelligent and determined antagonists, sole and corporate, who are motivated by ambition, altruism, self-interest and desire for the public good, and who in successive situations are bound to one another through self-interest or idealism – and separated or opposed through the same motives. At every point in this process we have to consider each unit in terms of its independent objectives, and we also have to consider the entire situation in which their interdependent actions occur (Schwartz, Turner and Tuden 1966: 8).

I build on this concept for the fine distinctions it enables in identifying the actions of organizations and individuals within a broader terrain of political activity that extends beyond the scope of formal political institutions. However I do not adopt the focus on motive or intention, as I believe that this is too difficult for the ethnographer to discern, even with extended fieldwork and long-term relationships with research participants.

The open and inclusive characteristic of the field concept makes it a useful means through which to frame the ways in which transnational processes unfold, and has been

used by scholars of transnationalism to this end over the course of the past decade. This area of anthropological research has utilized the concept of a transnational social field to encompass the activities of migrant laborers and their extended social networks (Basch, Glick Schiller, and Szanton Blanc 1994, Levitt and Glick-Schiller 2004). However these approaches are based on separate national and transnational fields, a separation that I view as not adequately representing the increasing influence of transnational political and economic forces. Recent studies have utilized the concept of the social field and extended its scope to include networks of internet users (Postill 2008) and the legitimation of state power (Baker-Cristales 2008). Building on these recent analyses and the early work of the Manchester School theorists, I apply the concept of the political field to frame the processes produced by the organizations, individuals and institutions that interact to produce the divisive political dynamics of HIV/AIDS in South Africa.

I build on this concept of the political field in my research but with a focus on including the influence of transnational power on the politics of AIDS in South Africa. Key to this approach is my focus on institutions as the nodes around which the political fields form as political parties, non-governmental organizations and social movements produce the political dynamics of AIDS. In the course of my research in South Africa, social movements and non-governmental organizations focused upon the local, provincial and national institutions of the state in the campaign to increase access to antiretroviral treatment and expand the scope of the public health sector. Organizations and their representatives interacted to produce a political process that then influenced the social impact of AIDS policies on infected and affected communities.

It is this issue-based gathering of agents and their constituencies around institutional nodes that, I contend, constitute the political field of HIV/AIDS in South Africa. Institutions operate as nodes in this field due to the fact that the primary source of contention between the organizations involved in the social conflict of AIDS. Therefore, the centers where political activity gravitated towards were the institutions of the South African state. However the form of this political field, driven by social, political and economic forces, was unstable as it was based upon alliances between organizations that were accountable to constituencies with different material needs and social values. By focusing on a political field, the interaction of actors enables a researcher to easily identify and assess the key organizations involved in a given political process. This approach also allows a researcher to easily access the key figures from each significant organization, allowing for a clear view of the network of actors and organizations that produce a given political field.

The issue of scale is critical in thinking through the political field of AIDS in South Africa due to the country's decentralized system of governance. For the purposes of this study, scale is used to refer to the different levels of political institutions that play a role in the political field of HIV/AIDS (international/transnational, national, provincial, local). South Africa's provincial and municipal institutions deliver health and social services in the country's political system. The provincial political scale is also the administrative level responsible for budgeting and allocation for all social services. As such, it is necessary for the political field to incorporate political processes that are influencing dynamics at the national, provincial, municipal and "local" levels. At each political scale, this study examines the ways that the South African state attempted to

assert its political authority within the field of organizational actors described above. At the national level, the primary institution within which AIDS policy was negotiated was the South African National AIDS Council. At the provincial level, this contestation took place within the Western Cape Provincial AIDS Council, in the provincial district consultations for the National Strategic Plan for HIV/AIDS and STIs (2007-2011) and amongst non-governmental organizations with differing relationships with the South African state. At the municipal and sub-municipal level, this conflict played out in Cape Town's sub-district coordinating mechanisms, in community political institutions, and through organized protests led by social movements such as the Treatment Action Campaign and the People's Health Campaign.

The scale of the community is key for the conceptualization of the political field as it is the site at which the poor and working class of South Africa come directly into contact with the social impact of the politicization of HIV/AIDS. The health sub-districts on the Cape Flats that I carried out research in, Nyanga, Gugulethu and Khayelitsha, had HIV prevalence rates between 25 – 30% of pregnant women (WCDOH 2006). These are the geographic zones that have been hit the hardest statistically by the AIDS epidemic in the Western Cape province. The high HIV prevalence rates in these areas are due to the high rate of migrant labor, the existence of informal settlements, and high rates of transactional sex as a survival strategy for women, an issue that is discussed at greater length in Chapter 6. Particularly important for this process is the continued relevance of the social organization of the anti-apartheid movement in these areas that manifest in new forms in the post-apartheid era. The street committees and urban councils developed

during the anti-apartheid struggle in the 1980s continue to play a central role in township politics.

The urban council structure that played such a central role in the anti-apartheid movement has been formally subsumed into the South African state as Development Forums and township-wide bodies such as Health Forums. These institutions play an important role in community AIDS politics on the Cape Flats. Internationally recognized social movements such as the Treatment Action Campaign play an important, but less central political role in the community due to their relative infancy in comparison to the social institutions of the anti-apartheid movement. With respect to the HIV/AIDS epidemic, my research will underline that the informal social institutions of the anti-apartheid movement have proven to be a barrier to policy coordination activities and have even served as mechanisms for the distribution of scientifically unproven alternative HIV/AIDS therapies on the Cape Flats. The dispersal of political power between non-governmental organizations, social movements and the ruling party and the differing ways that state and community institutions operated to influence AIDS politics, a theme which emerged from my research in Khayelitsha, necessitates the utilization of a broad yet flexible concept for encompassing the political dynamics of AIDS. It was due to these ethnographic insights that I garnered from research participants in the communities of the Cape Flats that I moved to the concept of the political field as a way to theorize the political dynamics that I encountered.

While the political field approach offers a programmatic approach to outlining how a political field is formed around key actors and institutions, I contend that the concept of hegemony best describes the exercise and maintenance of power with the

political field of HIV/AIDS in South Africa. For this aspect of my research, I turned to the theory of hegemony first conceptualized by Antonio Gramsci (1971). While Gramsci's concept of hegemony has utilized as a means of understanding the cultural dynamics of class struggle (Williams 1977, Hall 1980), as a method for understanding more nuanced forms of political struggle outside of the labor-capital dynamics ascribed to by orthodox Marxists (Comaroff and Comaroff 2001), and as a mode of understanding the 'weapons of the weak' (Scott), I here follow on the interpretation offered by Crehan (1997, 2002). Crehan approaches Gramsci's theory as a series of questions posed about power, or as a guide to unpacking the political, economic and cultural dynamics of power within a particular historical context. Particularly useful for this project is Crehan's embrace of Gramsci's "messiness" in discussing the boundaries between state and civil society as growing out of a focus on the "relationship between things, not the things themselves (Crehan 1997: 26)." Building off of this insight, an inquiry into the modes through which consent is produced and how state coercion enforces discipline, key factors in the maintenance of societal power can not be limited to the state itself. For the study of AIDS politics in South Africa, this is a critical point.

The realm of "civil society" in South Africa is not a homogenous, undifferentiated mass of non-governmental organizations. As has been discussed at length elsewhere, the term "civil society" encompasses a wide variety of organizations and actors ranging from multinational corporations and professional associations to community-based organizations (Comaroff and Comaroff 1999, Ferguson 2006). As such, it is important to embrace the idea that civil society does not necessarily operate autonomously from the state and to incorporate this relationship as a central question in an analysis of power

(Crehan 1997: 28). The political field of AIDS was clearly demarcated into camps that either sided with the critique of the African National Congress that emanated from the Treatment Action Campaign and its partners, or backed the government response to the AIDS epidemic and dismissed the demands of AIDS activists as radical and unrealistic. The encampment of two political factions led me to examine the loose coalitions of actors and organizations that produce and challenge the social power relation, or the hegemonic and counter-hegemonic alliances.

The definition of hegemonic and counter-hegemonic alliances is based upon the contention that control over the institutions of the state is an important element in national political dynamics. As such, I have chosen to categorize the AIDS dissident position as the discourse associated with the hegemonic alliance given the fact that this political faction exercised control over the South African state. As will be discussed at length in Chapters 4 and 5, control over the organs of the state silenced potential sources of opposition within the public health sector and within “civil society”. While the core ideas of AIDS dissidence run against the global norms for AIDS treatment, within the context of South Africa this political position was sustainable due to the control of the state by the AIDS dissident faction of the African National Congress. Furthermore, control of state institutions and an intermediary position between international donor capital and non-governmental organizations enabled the ruling party to expand the influence of AIDS dissidence into communities via para-state political alliances.

The counter-hegemonic alliance, led by the Treatment Action Campaign, adhered to and leveraged international norms in its campaigns for access to AIDS treatment in South Africa. As the organizations in this coalition aimed to undermine the moral

authority of the ruling party for its intransigence on implementing a comprehensive AIDS treatment program, they often had to look for funding outside of the state. This led to accusations by the ANC-led hegemonic alliance that the leading organizations of the counter-hegemonic alliance were proxies for foreign interests such as multinational pharmaceutical corporations. While these charges were baseless, it is critical to note that the axis along which the hegemonic and counter-hegemonic alliances orbited was one associated with transnational political forces. This is the central problematic that the study follows: to trace the extent to which transnational political forces produce the opposing organizational blocs within the political field of AIDS in South Africa, to assess the underlying factors that contributed to this political division, and to analyze the effect of the politicization of HIV/AIDS on the public health response to the epidemic in Cape Flats. Central to this project is a thorough analysis of the ways that the actions and narratives of individuals operating within the political field of AIDS can offer critical insight into the limitations of existing theoretical approaches to understanding transnational political power.

While recent contributions to the literature on globalization and transnational processes have offered new possibilities in the theorization of transnational political influence, a re-examination of the way in which non-governmental organizations and states are influenced by the rising influence of transnational political forces may allow for a wider array of political practices to be incorporated into existing analytical frameworks. The balance of political forces that influence political decision-making in South Africa has shifted towards the transnational scale with the negotiated transition out of apartheid and the country's re-entry into the neoliberal global political economy. This has

fundamentally affected the role of non-governmental organizations in governance, as increasing opportunities for international funding have produced autonomous social movements that have challenged the ANC's intransigence on implementing orthodox AIDS treatment in the public sector.

In response to this influx of international donor funding, the South African state has developed institutional mechanisms and alliances with non-governmental organizations to mediate the influence of this form of transnational political influence. As I will discuss in this dissertation, the example of South Africa indicates that the ANC, acting through the institutions of the South African state, maintains the capacity to shield the realm of national politics from the forces of transnational governance, at least to some degree. This adaptation of the institutions and practices of South African state to the forces of transnational governance is also changing the way in which non-governmental organizations operate internationally and organize locally. As such, the inclusion of the ways in which national parties are utilizing the institutions of the state is vital to include in an analysis of how non-governmental organizations are operating in the context of neoliberal globalization.

The element that ties the political processes surrounding the South African AIDS epidemic operating at the different socio-political scales is transnational political power. However these forces do not influence the politics of AIDS in South Africa in a proscriptive manner. Rather, transnational influence operates through, and manifests as, a historically and socio-culturally particular political processes. In South Africa, this interaction between the transnational, the national, the provincial, and the "local", builds upon the legacies of late apartheid, the anti-apartheid movement, and the ways that these

historical continuities have re-formed around new political struggles in the post-apartheid era. This process is one that builds upon the legacies of the anti-apartheid struggle in the form of non-governmental organizations, anti-apartheid activists that have taken oppositional stances regarding the HIV/AIDS epidemic in the post-apartheid period and the social, spatial and material inequalities produced by the apartheid regime.

Methodology

Building on the theory of a political field, the research for this project focused upon the key institutions for AIDS politics at the national, provincial and “local” levels. In order to carry out this project, I had to identify the key organizations and individuals involved in the political field of AIDS in South Africa. Once identified, I set out to observe the activities of these organizations, become involved with their activities, conduct interviews with the key individuals involved in the political process, and to the extent possible, attend meetings at each of the key institutional nodes. As such, I spent a considerable amount of time identifying and observing the key organizations and institutions involved with the politics of AIDS.

During the first eight weeks of the project I spent the majority of my time in the township of Khayelitsha, where I was involved in the production of a human resources analysis in one of Khayelitsha’s health clinics (Powers and Monte 2007). Spending time within the formal institutions of South Africa’s public health system underscored the extent to which the politics of AIDS operated outside of this institution and led me to search for a more grounded vantage point from which to understand the social impact of the politicization of AIDS. During this time I also conducted an in-depth study of the

organizational structure of the Treatment Action Campaign (TAC) using the methodology of participant observation. While I continued to be involved with the TAC throughout my time in South Africa, it was during this initial period that I worked most closely with the organization.

After these first eight weeks of research, I shifted my focus to Johannesburg to identify key non-governmental organizations and conduct preliminary research on the South African National AIDS Council. My time in South Africa's metropolis allowed me to cultivate several key relationships that proved to be very important for my research on the ways that the AIDS dissident faction within the ANC was undermining the implementation of the NSP, the new national HIV/AIDS policy. I later returned to Johannesburg for a three-week period in May 2008 to conduct follow-up interviews with several of the contacts made during this initial research trip. This trip coincided with the xenophobic riots that targeted the lives and property of foreign nationals. This was a challenging turn of events that forced me to temporarily suspend my research in the townships of the Cape Flats on my return to the Western Cape due to recurring violence.

After my initial research trip to Johannesburg, I returned to the Western Cape. I had begun working with the Western Cape Coalition Against Public Health Cuts from the start of my research, and I continued to work with this coalition of health professionals, labor unions, and non-governmental organizations that were challenging the effect of fiscal austerity on the public health system in the Western Cape. I also became aware of the existence of a Provincial Strategic Plan at this point, which was a provincial strategy for implementing the NSP developed by the Western Cape Department of Health. I acquired a copy of the draft policy and volunteered to assist with the note-taking process

for the policy consultations that were scheduled to begin in February 2008. I attended all six of the consultation sessions for the Provincial Strategic Plan, utilizing a methodology of intensive observation for these meetings. Further, I conducted interviews with meeting participants to gauge their perspectives on the consultative sessions.

After nearly 10 months of fieldwork on the Cape Flats, I interviewed a research participant that I refer to as Sipiwe in this study. Sipiwe shed light onto the ways in which local social institutions such as street committees worked with hybrid community-state institutions such as Development and Health Forums to produce the local political field of AIDS in Khayelitsha. In addition to these bodies, I conducted several interviews with members of the sub-district AIDS coordinating mechanisms called Multi-Sectoral Action Teams (MSATs) that served as the first line of the state response to the epidemic. Envisioned as an intermediary between community organizations, non-governmental organizations and the public health response of the state, these institutions were a site of critical political struggle on the Cape Flats. My investigation into these dynamics was the final phase of my research in South Africa.

In sum, I conducted 12 months of participant observation research in the greater Cape Town and Johannesburg metropolitan areas from June 15, 2007 until June 14, 2008. I collected research data through participant observation (of community meetings, sub-district HIV/AIDS coordinating meetings, the Western Cape provincial aids council) and longitudinal observation (of key non-governmental organizations involved in HIV/AIDS advocacy in the Western Cape). I also conducted 53 interviews with community members, community activists, doctors and nurses working in both the public and private health sectors, city health officials, members of non-governmental organizations,

provincial health officials and members of the South African National AIDS Council.

With respect to the national political field of HIV/AIDS, interviews were conducted with non-governmental members of the South African National AIDS Council. At the provincial node, a sitting of the Western Cape Provincial AIDS Council was observed and interviews were conducted with governmental and non-governmental members of this council. Also at the provincial scale, the policy consultation sessions for the National Strategic Plan for HIV/AIDS and STIs (2007-2011) was observed and interviews were conducted with attendees of these meetings. At the municipal and sub-municipal scale, interviews were conducted with governmental and non-governmental members of the city coordinating mechanisms for the public health response to the HIV/AIDS epidemic. At the “local” or least abstracted political scale, that of Khayelitsha, interviews were conducted with public health doctors, public health nurses, community leaders, activists and residents.

These interviews focused on the role of their organizations or institutions in responding to the epidemic, their perceptions on the role of the state in responding to HIV/AIDS, and the political and social obstacles individuals faced in the course of their work. My motivation in compiling this data was to gather various institutionally oriented views of the state through the idiom of HIV/AIDS and public health. My analysis of the political field of AIDS in South Africa is based upon my field notes gathered through observation (intensive, participant) and interviews (semi-structured, open-ended) with research participants from all of the categories described above. In the analysis that follows, my observations and interview data are clustered into a narrative that rotates around the national, provincial and ‘local’ political scales. Although this it is rather

predictable that an anthropologist would emphasize the site of the “local” as the focal point of an ethnography, this is not what I intend to depict or describe in the pages that follow. Rather, I will use the experiences and voices of the people of Khayelitsha as a grounding point for an analysis that weaves together national, provincial and transnational political processes. Just as the impact of South Africa’s unequal history on its public health infrastructure can only be truly understood when one spends time in a day hospital or a HIV clinic in Khayelitsha, the impact of transnational politico-economic processes can only be fully appreciated when contextualized through their impact on human experience as measured in social, spatial and material terms.

Chapter Outline

The organization of this dissertation mirrors my theoretical and methodological focus on the activities of organizations and individuals at different political scales. As such, the overall trajectory of the narrative begins with a discussion of national political processes before moving on to next discuss provincial political processes, and concluding with an analysis of “local” political processes in the townships of the Cape Flats. While each chapter will focus on a particular aspect of the political field of AIDS in South Africa, this study is grounded in an analysis of the historical continuities that exist between the late apartheid and post apartheid eras.

In Chapter 1, Contemporary South Africa and the Influence of Late Apartheid, I will offer a historical overview of the ways that South Africa’s history of colonization and apartheid continue to influence social life in the post-apartheid era. Building on politico-economic analyses of South Africa’s history, I will discuss the overlapping

organizational histories of the African National Congress and the Treatment Action Campaign from 1976 onwards. I argue that the two key organizations in the politics of AIDS in South Africa have intersecting historical trajectories that can be seen in the prominent role of former and current ANC members in the Treatment Action Campaign. This chapter will argue that the contemporary political dynamics of HIV/AIDS trace their roots in the late apartheid period, particularly with respect to the internal dynamics of the ruling party. The primary contribution of this chapter is a reading of the HIV/AIDS epidemic within a politico-economic history of South Africa.

In chapter 2 of my dissertation, *The Political History of the HIV/AIDS Epidemic in South Africa*, I will offer an overview of the politics of HIV/AIDS during the Mbeki administration. In analyzing the 1998 – 2008 period, I identify a shift towards alliances between the ruling party and non-governmental organizations as a mechanism for disseminating the messages of AIDS dissidence and undermining the efficacy of the counter-hegemonic alliance in policy development. Further, I argue that this shift to a decentralized alliance to disseminate the messages of AIDS dissidence coincided with the efforts by the counter-hegemonic alliance to transform the national institution charged with overseeing the public health response to the epidemic, the South African National AIDS Council. This chapter contributes to the anthropological literature on the HIV/AIDS epidemic through the isolation and analysis of this “double movement” in the politics of HIV/AIDS in the post-apartheid period.

In Chapter 3, entitled *Negotiating Silences, Confronting Barriers: Examining the Institutional Dynamics of HIV/AIDS Politics at the National Scale*, I will examine how the South African National AIDS Council was re-structured and how the capture of key

committees by ANC dissidents affected the implementation of the National Strategic Plan for HIV/AIDS and STIs (2007-2011). Building upon interviews with National AIDS Council delegates, I will offer an overview of the how the ANC systematically undermined the efforts by non-governmental organizations, health professionals and researchers to transform the public health response to the AIDS epidemic and the South African state itself. I add to the ethnographic analysis of the South African HIV/AIDS epidemic in this chapter by analyzing the institutional dynamics of the South African National AIDS Council, the effects of government intransigence on implementing the National Strategic Plan for HIV/AIDS and STIs (2007-2011), and offers the first ethnographic description of the perspectives of civil society delegates to the joint civil society-government institution.

Chapter 4, A Means to an End: the consultative process for the Western Cape Provincial Strategic Plan for HIV/AIDS and Sexually Transmitted Infections, 2007 - 2011, will focus upon the provincial policy consultation process for the National Strategic Plan. Building on an analysis of key institutions such as the Western Cape Provincial Aids Council and the Western Cape Department of Health, I will outline the institutional framework through which HIV/AIDS policy was negotiated through policy consultation in South Africa. Central to this analysis is the ways that the Department of Health leveraged its financial and organizational support of the Western Cape Networking AIDS Coalition of South Africa (WC-Nacosa) into having the organization serve as the primary consultant for this process. In this chapter I analyze how local-level, provincial and national political processes produce the form and character of provincial-level institutional politics and point to the extension of the influence of the ANC into the

realm of ‘civil society’ through partner non-governmental organizations. Until this research project, there had been no ethnographic analysis of the ways that political processes at the provincial level affected local-level or national political dynamics. This is an important contribution due to the fact that South Africa has a decentralized political system whereby implementation strategies and budgets are redefined at the provincial scale of state institutions. Furthermore, I analyze the effects of international donor support from the Global Fund on the dynamics of HIV/AIDS within the Western Cape province.

I will continue with an analysis of the provincial political scale in Chapter 5, entitled The Western Cape Coalition Against Public Health Cuts: popular movements, public health crisis and authoritarian political dynamics. In this chapter I analyze the social impact of neoliberal macroeconomic policies on the public health system in the Western Cape. This chapter focuses on the political struggle between the Western Cape Coalition Against Public Health Cuts and the Western Cape Department of Health. I will build on interviews conducted with members of the National Treasury, provincial-level politicians, and members of the Coalition Against Public Health Cuts to analyze how the quasi-federal South African system reproduces the social, political, economic and spatial inequalities inherited from the apartheid era and how these inequalities are exacerbated through the imposition of neoliberal fiscal austerity. The primary contribution of this chapter to the ethnographic analysis of the South African HIV/AIDS epidemic is a detailed description of the ways that a broad alliance of AIDS activists, public health doctors and the labor movement challenged the imposition of a neoliberal public health model that threatened to close 90 beds in the Western Cape public health sector. In

addition, this chapter offers a detailed ethnographic and human resources analysis of the challenges faced in providing health care in the public sector after the implementation of this fiscally austere public health policy entitled the Comprehensive Services Plan, or Healthcare 2010. This chapter offers the first thorough analyses of the role of the labor movement in local-level political struggles over HIV/AIDS and addresses the lack of attention on the public health crisis in the anthropological literature on the South African HIV/AIDS epidemic.

In Chapter 6, *Local Political Institutions and the Politics of HIV/AIDS in Khayelitsha*, I analyze the local political dynamics that are obstructing implementation of the HIV/AIDS policy initiatives on the Cape Flats. The key institutions for HIV/AIDS policy in the greater Cape Town metropolitan area are local AIDS coordinating mechanisms called Multi-Sectoral Action Teams, and township-scale political institutions such as Development Forums and Health Forums. In this chapter I analyze how local community politics pivot around the influence of transnational political and economic forces. Particularly significant here are the ways that local political leaders systematically undermined scientific knowledge of the AIDS epidemic by supporting the distribution and consumption of scientifically unproven alternative AIDS therapies such as micronutrient-based vitamins. My contribution to the anthropological literature on HIV/AIDS in this chapter is an on-the-ground analysis of how the politics of AIDS dissidence affected local social dynamics in the township of Khayelitsha. Despite accounts that analyzed the role of AIDS activists, the actions and beliefs of these individuals has not been contextualized within the setting of an urban township. Additionally, I analyze the way that internationally-funded sub-district HIV/AIDS

coordinating institutions were systematically undermined by local branches of the African National Congress and the South African National Civic Organization.

In the Conclusion, I will contextualize my findings on the policies and politics of HIV/AIDS in South Africa by revisiting contemporary theories of the globalization and transnational governance. I will review my research findings concerning the role of transnational political power in the political field of AIDS, the ways that the ruling party worked to limit the influence of transnational political forces in South Africa, extended its sphere of influence into communities and local level political processes, and systematically undermined the implementation of a comprehensive AIDS policy in the form of the NSP. The Conclusion will summarize my research findings and my contribution to the anthropological literature on the HIV/AIDS epidemic and theories of the state, globalization and transnational governance.

Chapter 1

Contemporary South Africa and the Influence of Late Apartheid

The only freedom that we have in South Africa, is the thing of the pass. We are no longer carrying the pass or don't [have to show the] pass when you are walking on the street. And you can stand, you can stay, you can walk, you can talk with a white guy. Firstly, that government of apartheid, that wasn't happening. That's the only freedom that we have. On the other hand, we don't have freedom. We tend to say, we do have freedom, but our freedom is being vandalized or is being misused by the other guys that are up there in the government institutions [constitutions]. So I for one, I don't have freedom and I don't know what to celebrate. As much as I celebrate that I am free in terms of walking, I can walk everywhere I want, and I can talk with whom I want; that is the only freedom that I have.

During the course of my research I spoke with HIV/AIDS activists and community members in townships throughout South Africa. I had asked many of them how their lives had changed since the negotiated transition out of apartheid and I received different versions of the same answer from many people: life had not changed in a significant way. But it was Gwede, a Xhosa man in his twenties from the township of Khayelitsha, who offered the direct analysis of the differences between the apartheid and post-apartheid period in South Africa above. This tendency in the historical narratives offered to me by many research participants stands in stark opposition to the periodization of South African history into different epochs. As Gwede's statement points to an understanding of the contemporary world seen through the lens of the past, the factors influencing South Africa's post-apartheid social processes trace their roots to a history of over 300 years of colonization and internal political segregation. While the role of apartheid in creating social inequality has rightfully figured centrally in academic

analyses of South Africa (Posel 1991), the system of “separateness” that was put into place by the National Party after coming to power in 1948 was far more an expression of continuity with the period of Dutch and British colonization than a sharp break with the country’s past. In much the same fashion, I argue that rather than examine contemporary South Africa through the lens of a sharply demarcated version of history, examining this period as a single historical continuity may offer greater insight into the ways that the AIDS epidemic has been managed in South Africa.

Building on this point of analysis, in this chapter I will analyze the broad contours of South Africa’s history and the ways that the forces of the past have affected the social and political processes of the present. As I will argue, the politics of HIV/AIDS can be best understood through a critical analysis of the ways that the social, political and material forces of South Africa’s past influence the present. In taking this approach, I am building on the tradition of historical anthropology developed by Eric Wolf (1982) by examining South Africa’s internal dynamics and its external connections with the forces of global trade and finance as an interconnected process that has produced the context within which I conducted my research. Wolf’s insistence on couching socio-cultural phenomena within the social forces that have grown out of a particular cultural history has been an influential one within the discipline of historical anthropology. In an edited volume dedicated to the legacy of this work, Schneider offers a brief synopsis of how Wolf conceptualized social forces and social history.

Some anthropologists balk at the concept of ‘forces’ for being too abstract, disembodied and determinative. Yet powerful forces like militarized chiefdoms, merchant and industrial companies, banking houses, and governmental regimes (whether tributary, capitalist or socialist) are conceptualized by Wolf as human products and repositories of human agency, having developed out of historical processes of political-

economic-ideological competition. Their seeming impersonality derives from the open-ended and inherently unstable fields within which they are constrained to operate, for any particular concentration of power provokes others into being, with which it must then contend (Schneider 1995: 5).

With respect to the HIV/AIDS epidemic in South Africa, there are several key social forces that grow out of the country's history that must be taken into account in the contextualization of contemporary socio-cultural phenomena. These historical continuities grow out of the particular form of European colonization, the way in which European settlers expropriated the land of the autochthonous peoples of Southern Africa, the political and labor systems that the European settler population developed to maintain an unequal division of land and resources, and the social institutions that were developed by both European settlers and Black Africans in the social struggle over political control of South Africa.

The South African example of settler colonization was based on the expropriation of land from indigenous African populations, the development of a racially segregated social geography, and the management of the Black South African population through strict labor and pass laws. These characteristics typified the period of British political control of South Africa, which the period of apartheid planning concretized with the expropriation of Black South Africans from urban areas and the creation of formal homelands that were designated as separate nations. Given the extremes to which the apartheid model incorporated the logic of racial separation into the political geography and labor systems of South Africa, a group of expatriate 'neo-Marxist' scholars debated the categorization of South Africa as an example of racial capitalism, as it defied the standard classifications of settler colony, capitalist society or post-colonial state (Trapido 1968, Marks 1970, Wolpe 1972, Legassick 1974, Marks and Trapido 1987). This

perspective posits that the apartheid system was adapted to the particularities of the articulation between the capitalist settler community and the traditional authorities of the indigenous South African population and was dependent on the subsidization of wage labor by subsistence activities in the homelands. One shortcoming of the neo-marxist historiography is that it gives a special role to the way that race was used as a means of social segregation in South Africa. As such, it fails to take into account the central role that race and ethnicity placed in the settler colonization of other regions, such as the Americas. Despite the fact that South Africa continues to function as a capitalist country following the formal closure of the country's labor reserves or *Bantustans*, this theoretical framework continues to influence analysis of South Africa to this day.

A major critique of the neo-Marxist interpretation of South Africa's history was developed by the scholars who participated in the University of Witwatersrand History Workshop. Modeled off of a workshop on social history at Oxford University, this school within South African historiography was initiated as a response to the massive uprising of students in Soweto in 1976. These scholars critiqued the neo-Marxist emphasis on capital accumulation and the articulation of different modes of production as not adequately taking into account a new phase of political struggle that emanated from the urban youth rather than the traditional political authorities in the homelands. Instead, the academic analyses developed by the scholars of the history workshop utilized anthropological methodology in emphasizing the role of popular movements and the state in producing the particularities of South Africa's historical development (Beinart and Bundy 1986, Posel 1991, Bonner et al. 1993, Bonner 1994, Delius 1996).

I build on the contributions of the history workshop both in approach and methodology in this dissertation, through the gathering of first-person histories of individuals involved with the politics of HIV/AIDS and a focus on the role of urban movements in shaping the parameters of change in post-apartheid South Africa. However, a shortcoming of the Wits History Workshop was the extent to which urban social movements were characterized as operating outside of the historical forces that shaped the perspective of the neo-Marxist scholars. Particularly influential in their work was the characterization of apartheid as “colonization of a special type” by the South African Communist Party in 1962. In this formulation, the homelands onto which Black South Africans were moved after the forcible expropriation of land and property were colonized by the White South African population through the mechanism of the apartheid state. This approach was based upon the dynamics of labor migration, poverty and capital accumulation that were put into place by the White South African population during apartheid. Critical to this approach was that the political battle for the emancipation of South Africa had the same goal as class struggle for the Black South African proletariat: the destruction of the apartheid state. This correlation between race and class continues into the post-apartheid era, as with the basic economic organization of the South African economy, and is an important factor to include in any analysis of the post-apartheid era.

Building on these contributions, I focus here on a description of the ways that the politics of HIV/AIDS has been influenced by the historical continuities of the colonial period and apartheid era in the form of the built environment, the particular labor structure and class formations produced by these epochs, and the political and institutional forms engendered by late apartheid. In this perspective, I view the social

movements that have demanded access to social services such as HIV/AIDS treatment as part of a historical continuum with the social movements that demanded the end of apartheid, such as the United Democratic Front (Seekings 2000). This is partly due to the focus of these social justice movements on the rights of the poor and working class in South Africa, and that many members of these post-apartheid social movements trace their political roots back to the anti-apartheid movement. The continued political activity of anti-apartheid activists in South Africa's townships and the central role that this process plays in the politics of AIDS underscores the extent to which it is necessary to rethink the temporal delineation of "post-apartheid" offered in the vast majority of historical analysis on South Africa.

I continue to employ the term "post-apartheid" in the analysis that follows due to definite changes that have occurred in South Africa, such as the negotiated transition of political power, the onset of democracy, the development of a new constitution and the current deployment of state contracts and resources to facilitate the development of a new Black South African middle class. However I do so while emphasizing Gwede's statement: that change has occurred in the political sphere, but that this change has not affected the lives of many Black South Africans, particularly with respect to their prospects for work, a home, or the ability to support a family financially. It is my goal in this chapter to offer a broad historical account that covers the key factors in South Africa's history that is highlighted by critical events and academic perspectives. My focus in this narrative is to highlight the historical materialist forces that influence post-apartheid political dynamics, the role of institutional memory in producing various post-

apartheid political processes within the African National Congress, and to underscore the continued influence of the South African labor movement in the post-apartheid era.

In producing this historical narrative, I hope to offer a new perspective on the actions taken by the AIDS dissident faction of the African National Congress on HIV/AIDS between 1998 and 2008. This period has often been characterized based upon the personal qualities of Thabo Mbeki, who served as President of the African National Congress and South Africa during this time. This is primarily due to the fact that Mbeki offered obfuscating public comments on the scientific link between HIV and AIDS while serving as President of South Africa. These comments and the dissident position on HIV/AIDS has been characterized as part of Mbeki's autocratic leadership style and his distaste for consultative political process marked a break with the historical norms of the African National Congress (Gumede 2005). As I will argue below, this personification of the organizational dynamics of the African National Congress depends upon a misreading of the effects of the late apartheid era on the party's internal democratic mechanisms while in exile. Others have analyzed Mbeki in a psychological fashion, pointing to an interrupted relationship with his father, and alienation from the South African people due to a life spent in exile to explain the behavior of the South African President (Gevisser 2008). Here too, however, factors that are defined as Mbeki's own internal dynamics blend seamlessly into an account of South Africa's social, economic and HIV/AIDS policies. Rather than argue that Mbeki's leadership defined the African National Congress during this time, I argue that it is more productive to ask the question of why his behavior and beliefs resonated within the internal structures of the African National Congress.

In the chapter that follows, I will broadly describe how the political economy of South Africa shaped post-apartheid societal dynamics and the ways that the African National Congress fits within this history. In particular, I will argue that the late apartheid period was pivotal in creating a culture of hierarchical decision-making within the African National Congress, and that Mbeki's style of leadership was effective within the party due to institutional memory of this period. In asserting the significance of memory in the political decision-making processes of the African National Congress, I follow the work of Halbwachs (1994) in pointing out the continuation of something from the past into the present. Unlike some recent work in anthropology on memory, I am not interested in how different individuals offer competing viewpoints on a given historical event (Appadurai 1981, Rappaport 1990, Stoler and Strassler 2000). Rather, I am interested in how history has manifested itself within a particular institution, the African National Congress, and the ways in which this historical influence affects its political decision-making processes. Further, this chapter will argue that analyses put forward by Nattrass (2003) and others that delegitimize the argument that economic factors played a significant role in Mbeki's AIDS policy have inadequately taken into account the role of debt inherited from apartheid. I take the position that is not possible to fully understand the underlying logic behind AIDS dissident stance taken up by the African National Congress under Mbeki barring a tell-all biography by a member of this faction of the party.

As such, in this chapter I will contribute to existing accounts of this period in South Africa's history by emphasizing the political and economic factors that have been largely left to the periphery in discussions thus far. Although I take the periodization of

South Africa's history as the primary point of critique for my own historical narrative, in order to properly critique this structure I will maintain a tripartite division for the purposes of analysis. I begin this chapter with a discussion of the period of colonization and colonial governance that focuses on the establishment of particular labor management systems and modes of accumulation as central to the formation of the South African state and the formation of the African National Congress. The second section will focus on the apartheid era, the development of the capacities of the apartheid state, the effects of this formation on the African National Congress exile community, and the rise of an internal anti-apartheid movement around urban civic structures and the trade union movement. In the third section, I will trace the continuities from the two earlier periods into the socio-political dynamics of the post-apartheid period.

Colonial Governance, Labor and the Pass

The key dynamics that have governed South Africa's history since contact with European colonists in 1648 have been labor regulation, the segregation of the population into racial categories, and of an unequal distribution of social wealth amongst its inhabitants. The Cape was first settled by Europeans by the Dutch East India Company in 1652. Government, and the state, arose in the early colonial period as an extension of the Dutch East India Company (VOC²). In order to serve as a port for fuelling trade with the East Indies, the VOC actively encouraged the settlement of land for farming and for herding sheep. The territorial expansion and authority of the VOC was contested by the indigenous people of the region who were displaced by the colonizing process. In the

² Vereenigde Nederlandsche Ge-Octroyeerde Oost Indische Comagnie

case of the Cape colony, this was primarily the pastoral Khoikhoi and the San hunter-gatherers in the semi-arid flatlands north of the Cape Peninsula. This process was not passively accepted, as the Khoi intermittently took up arms and rebelled against the forcible expropriation of their lands, most notably with the Khoi rebellion of 1799-1803. This process pushed the Khoi into agricultural labor in the service of the colonial apparatus. However Dutch control over the Cape was ceded to the British after an attack in 1795. After returning the Cape to the Dutch in 1803 via the Treaty of Amiens, the British once again repossessed the Cape in 1806.

The British were able to adopt and maintain authority in the Cape by crafting an alliance with the older Dutch elite from the beginning of their rule. The British administration and the local Dutch bourgeoisie developed “a close and functional relationship” based on similar class interests³ (Keegan 1997: 50-51). A useful example of this was the extension of the pass system for non-white racial groups into British rule:

More specifically the system of slavery generated the first implementation of passes for ‘non-white’ racial groups. From the 1760s slaves and Khoisan were obligated to carry passes signed by their employers to prove that they were not runaways (Lester 1996: 24).

The bureaucratic extension of passes into the British colonial period was significant as this system served to establish a racially segmented labor structure in the Cape Colony. Part of the reason why the practice of labor passes for Africans was continued was that the new British administration needed the support of Dutch frontier farmers to maintain social order in the rural areas upon which the colony was dependent for food and wool

³ A common example cited here is the Slagtersnek rebellion of 1815, “when a group of frontiersmen took up arms against the British rulers, the most prominent and propertied of the local colonists supported the reassertion of British authority” (Keegan 1997: 54).

production. Given the decentralized system of the early Cape Colony, the outlying areas had an ostensibly arbitrary legal system in this early period, making enforcement of colonial policy difficult if not impossible. The British, therefore, upheld and extended the “labour-securing practices” of the Dutch settlers, which in practical terms meant enslavement (Lester 1996: 28).

Two points are important to mark before moving on from the transition from Dutch to British colonial rule. The pass system, often characterized as the most degrading feature of the apartheid system, did not originate during apartheid. It was established prior to British rule but was extended into the period of British rule to ensure continuity in the Cape labor system. Secondly, the onset of British rule reinforced the class structure of the Cape colony and the arbitrary enslavement of the Khoikhoi and San peoples. While many historical accounts have characterized British rule as having led to a period of liberalism in the Cape colony due to the colonial government having ended slavery, it is more accurate to see this period as one that marked a continued appropriation of the land and labor of the indigenous peoples of South Africa.

The end of slavery in 1834 and war in the eastern Cape in 1834-5 further consolidated British hegemony in the Cape colony. The conflict with the Xhosa on the eastern front of the Cape Colony enriched British traders, while the end of slavery in the Cape also led to the mass exodus of Afrikaner farming families. The emigration of Dutch settlers to the areas north of the Orange River, commonly known as the “Great Trek”, precipitated an increase in British landownership in the Cape colony. In turn, this increased the production of cash crops, reconfiguring the Cape farming economy away from the pastoralist model of the early Dutch settlers. As the economy and society of the

Cape increasingly turned towards London, the movement of European peoples Northward sent reverberations throughout Southern Africa as Dutch settlers came into contact with established African polities and negotiated access to land and resources.

The Dutch settled into the northern areas of present-day South Africa and reestablished their social models outside of the influence of British colonial power with the formation of the South African Republic (ZAR). (See figure 1 below) However, this period of relative calm between the British and Dutch settlers did not last long as the discovery of diamonds fields in the Kimberley region in 1868 led to the British annexation of the ZAR in 1877. After a brief war in 1880-81, known as the first Boer War, the ZAR regained its autonomy until 1899, when the British again annexed the ZAR after the discovery of a massive gold reef in the Witwatersrand, located in present-day Johannesburg in 1886. This period is of central importance to the history of South Africa, as the labor systems and political compromises made between British imperialists and Dutch settlers set into motion the politico-economic dynamics that mark South Africa to this day.

Figure 1: British Southern Africa and the South African Republic (ZAR)



At the Kimberley diamond fields, the pass system of the Cape colony was extended into the mining industry, formalizing the system of racial segregation into the northern reaches of Southern Africa. Many features of the Kimberley mining system were to be replicated in the gold mines, from the formal segregation of African laborers into all male hostels, to the exclusion of women and families from the mining area and the extraction of massive profits for the newly formed De Beers Company. The development of a diamond mining industry in South Africa also created competition for labor between the British and Dutch settlers. The higher wages and cash payment system created a labor shortage for farmers in the ZAR, and perhaps more significantly, depriving European settlers of skilled agricultural laborers (Delius 1983). The South African mining industry worked with the state to construct a migrant labor system with labor sourced from its internal black African population and other Southern African countries such as Mozambique, Lesotho, and Swaziland (First 1977, 1983). The extension of the racially segregated labor structure of the Cape Colony into the ZAR was a critical development in South Africa's history that concretized the correlation between race and class in South Africa. The victory of British-dominated mining interests within the White South African capitalist class had set into motion the incorporation of Black Southern Africans into the global capitalist economy as manual laborers.

In order to maintain segregation, the pre-apartheid South African government maintained a policy of 'influx control' whereby black African men had to carry passes to work in urban areas. The 'structural segregation' of the colonial period was continued with the Native Reserve Location Act No. 40 of 1902 until the rise of the apartheid through which these concepts became institutionalized (Cook 1985: 62). Mine workers

were housed in compounds, and this variant of labor organization was also applied to those working on urban areas as they stayed in all-male hostels (Moodie 1994). A circular pattern of labor migration was established during the colonial period as a result of work on the mines and in urban areas. The nearly 80,000 Black urban residents that survived on mining wages lived in backyard shacks, overcrowded compounds and informal settlements at the turn of the 20th century in Johannesburg (Harrison 1992: 15).

The tension between the survival of the white rural farmer and the question of how to manage the flow of Black African male miners to urban areas became the key question for South African policymakers following the formation of the Republic of South Africa in 1910. The first political act of major significance by the power-sharing government was to pass the Natives Land Act (1913), which annexed 80% of South Africa's land for white citizens and created the native reserve system with the remaining 20%. At the time, whites in South Africa constituted 20% of the population. This act, also known as the Black Land Act, created sufficient land to support white farming while simultaneously alleviating the competition for labor between farmers and the mines by pushing Black farmers off of the land. The state-led expropriation of vast tracts of arable land from Black farmers also eliminated competition in the agricultural sectors, as African farmers generally outperformed their white counterparts with higher per-acre agricultural production (Bundy 1979). Without adequate land for farming, wage labor became the primary mechanism for survival for Black South African families.

The political response to the expropriation of land was the formation of the South African Native National Congress in 1912, which was later renamed the African National Congress in 1923. Early leaders of the party such as John Dube and Sol Plaatje led

campaigns against legislation that formalized racial segregation, such as the Land Act and the expansion of pass laws. However as McKinley (1997) emphasizes, the early ANC leadership was not focused upon a radical reorganization of South African society, but represented the interests of an emerging Black South African middle class. Despite the class differences between the leadership of the ANC and the vast majority of Black South Africans, the party rose to prominence in the 1920s as the primary organization leading the campaign against the *de jure* formalization of racial segregation in national government.

While the British empire flexed its muscles to ensure control over the mineral economy of Southern Africa, in doing so it set into motion the contradictions that were to coalesce with the rise of the National Party and the apartheid state. One of the key areas around which Afrikaner nationalist ideology began to coalesce was around the question of the urbanization of the Black African population, and the threat of social instability that was believed to accompany this process. Known as *swart gevaar*, or ‘black peril’ in Afrikaans, the predominantly Black male urbanization led to a series of rape scares in several cities in South Africa. African men would be recruited from their homelands to work on the mines for a period of six to nine months, after which time they would return to the ethnically distinct homelands (Mayer 1980, Sharp and Siegel 1985). These areas of “separate development” served as a key source of labor for the mining industry in the northern provinces while female-driven agricultural production in the homelands subsidized social reproduction, as mining wages were inadequate to support a family.

The growth of the South African economy during the interwar period only exacerbated the contradiction between the mining industry’s demand for cheap Black

labor and the rejection of African urbanization. While urban communities such as Johannesburg's Sobotown blossomed with cultural expression with the publication of magazines like Drum and an influential music scene, the social and political distance between the liberal-leaning British South Africans and nationalist-leaning Afrikaner South Africans grew. In analyzing this situation, O'Meara (1983) emphasizes this disjuncture as emerging out of conflict between British and Afrikaner capital, as the rise of the *Broederbund* and other organizations that espoused Afrikaner nationalism were funded primarily through Afrikaner-owned financial institutions. Following the growth of urban industries and commensurate increase in the demand for Black urban labor during the Second World War, the South African public was faced with a clear choice on how to address urban racial segregation. A vote for the United Party would lead to a policy that normalized the two-tiered racial structure of the labor market and led towards desegregation, or to vote for the National Party, which would reverse Black urbanization and deepen existing policies of racial segregation and separate development. Here again, South African history is marked by continuity rather than a break with the politico-economic processes of the past.

Apartheid and the Continuation of Racial Segregation

The rise of the apartheid system under the guidance of the National Party was the most significant event in the 20th century in South Africa. Due to the intensification of racial segregation, increasingly unequal allocation of societal resources and the subjugation of the Black majority to the violence of the state, the political process between Whites and Non-Whites within the country transformed from a non-violent

struggle into a guerilla war that enveloped all of Southern Africa. As the apartheid state grew from an apparatus focused on urban relocation into a regional military and intelligence apparatus, so too did the structure of the African National Congress and its military wing, *Umkhonto We Sizwe*, or ‘Spear of the Nation’. The peri-urban townships, the battleground on which much of the social struggle to end apartheid was fought, became the center of a social mobilization against the stringent new laws of the apartheid system.

Upon coming to power in 1948, the National Party went about building its apartheid project by expanding ‘influx control’ policies intended to keep black African laborers outside of cities. This was done in response to South Africa’s rapid urbanization during the 1940s, during which time the number of Africans living in Johannesburg increased from 244,000 in 1939 to 400,000 in 1946 (Harrison 1992:15). This rapid urbanization led to the proliferation of informal settlements in urban areas in Johannesburg, Cape Town and Durban (Harrison 1992:15). Among other legislation, the Group Areas Act of 1950 and the Prevention of Illegal Squatting Act of 1951 were enacted by the National Party in the early 1950s created separate residential areas for different races and legalized forced relocation to achieve this end with the aim of reversing the movement of black South Africans into urban areas (Harrison 1992: 16).

During this period the mass removal of black inner-city inhabitants in Sophiatown (Johannesburg), and District Six (Cape Town) was accompanied by the construction of the development of the major townships, such as Soweto (Johannesburg), Nyanga and Gugulethu (Cape Town), and Umlazi and KwaMushu (Durban) (Harrison 1992:16). Pass laws were also extended to the movement of women, intensifying the use of *Bantustans*

or rural homelands as a means of controlling the movement of black South Africans. The newly formed townships, where local authorities built much of the housing, became extremely overcrowded in the 1960s as new construction in African areas only took place in rural Bantustans. While this approach was intended to decrease urban residence, it instead led to an increase in subletting, construction of backyard shacks and general peri-urban densification (Mabin 1992:19). As Posel (1991) has demonstrated, the creation of the apartheid system was a gradual and piecemeal process that was never a completed project. Rather than subdue the Black African urban population, the new measures galvanized the delegates of the African National Congress to elect new leadership from the Youth League.

Nelson Mandela, Oliver Tambo and Oliver Sisulu, revitalized the African National Congress by working with the South African Communist Party to challenge the implementation of the stricter measures of racial segregation being imposed by the National Party. Along with the Pan-Africanist Congress, the African National Congress led a “defiance campaign” that involved civil disobedience against the pass laws, leading to the arrest of nearly 8,500 protesters. However, this period of defiance came to a halt with the Sharpeville Massacre on March 21, 1960. In a protest against the pass laws led by the Pan-Africanist Congress, 69 men, women and children were shot and killed by the security forces of the apartheid state. Following this act of aggression against peaceful protesters, the United Nations Security Council passed a declaration condemning the violence and calling for the end of apartheid, the African National Congress formed its military wing, *Umkhonto we Sizwe*, and the political parties and organizations leading the anti-apartheid struggle were banned from activity within South Africa, leading to the

mass exodus of the party leadership of the African National Congress, Communist Party of South Africa and the Pan-Africanist Congress. The Sharpeville Massacre marked the end of the first wave of mass protest against the apartheid state and the militarization of the social struggle for freedom in South Africa.

Following the banning of mass organizations following the Sharpeville Massacre, the Black Consciousness movement rose to prominence in South Africa. Under the leadership of Steve Biko and Bernard Pityana, the Black Consciousness movement grew in the South African Students Organization, or SASO, to organize students against apartheid across the country. Black Consciousness theorists such as Biko and Pityana focused on the liberal assumption that the elimination of racial segregation would ensure Western modernization in South Africa, which was, of course, assumed by liberals to be an ideal outcome. The Black Consciousness movement pushed for a focus on race as the founding dynamic in post-contact Southern African history, and due to this historical fact, racial inequality as the dominant force in South African society. This perspective, coupled with the coupling of “Blackness” with subjugation by the apartheid system, led the Black Consciousness movement to grow beyond the racial boundaries of the African National Congress to include “Coloured” and “Indian” South Africans.

As the Black Consciousness movement grew, the apartheid intelligence apparatus systematically infiltrated and undermined the guerilla activities of the armed branches of the African National Congress and the Pan-Africanist Congress within and outside of South Africa. The struggle against apartheid again moved to the townships, where students radicalized through the teachings of the Black Consciousness movement rejected the implementation of Afrikaans as the *lingua franca* of South Africa, which had

previously been English. On June 16, 1976, students from Orlando West Junior School in Soweto left their classrooms and marched to protest the change in the language in which curriculum was taught, only to be met with gunfire from the South African police. Hector Pietersen's death, now an iconic image in the global imaginary, marked the start of a second wave of protest against the apartheid system emanating from South Africa's peri-urban townships. As Biko's leadership and power grew within South Africa, he was targeted by apartheid security forces and killed while in prison on September 12, 1977. The late 1970s marked the beginning of intermittent states of emergency as Black South Africans living in townships rejected the legitimacy of the apartheid regime.

The apartheid state underwent a rapid militarization led by P.W. Botha as the 1970s turned to a close. Responding to the social unrest unleashed by the Soweto uprising, the growing security apparatus of the apartheid state was centralized with the creation of the National Security Management System in 1979. The growing power of the military in the apartheid state was also evidenced by the State Security Council usurping many of the functions of the cabinet during this time (O'Malley 2007: 199). The transformation of the apartheid state culminated with intermittent states of emergency during the 1980s as the Mass Democratic Movement attempted to make the country "ungovernable" through mass stay away campaigns, rent boycotts, strikes and demonstrations. The increasingly militarized strategy inside of the country was mirrored by increasingly aggressive attempts to reach ANC leaders in exile, evidenced by Ruth First's assassination in 1982. The increased aggression of the apartheid state led to fundamental changes in the approach and structure of the ANC leadership in exile.

The National Party's increased focus on infiltrating and demobilizing the ANC led to a centralization of leadership within the party structures in Southern Africa. While the Revolutionary Council had been in place since the Morogoro Conference in 1969, it was a disorganized body with little administrative capacity for oversight (O'Malley 2007: 205). During the 1970s, the intelligence services of the militarized apartheid state infiltrated the ANC exile structures at the highest levels (O'Malley 2007: 219). This infiltration forced the organization to adapt its mechanisms for internal governance. Already noted for its strong organizational hierarchy, the ANC became increasingly centralized during late apartheid. The example of Operation Vula, whereby Revolutionary Council member Mac Maharaj transferred arms and set up a military underground within South Africa to wage a "people's war", illuminates the extent to which questions of espionage led to a closure of ranks within the organization. As an operation Vula was only known to a handful of top ANC leaders such as O.R. Tambo, and later, Jacob Zuma. While many cite the ANC tradition of collective decision-making, the reality is that this process was often concentrated amongst the organization's leadership given the clandestine nature of activities given the political circumstances during apartheid.

While the exile structure of the African National Congress struggled to maintain cohesion while under attack from apartheid security forces across Southern Africa, the Black urban population living on the peripheries of South African cities continued to grow. As conditions on the homelands deteriorated due to soil degradation and political activity was limited by traditional leaders loyal to the apartheid government, what had once been a circular pattern of male migrant labor to and from cities increasingly

included women and children. These densely populated peri-urban areas grew in the 1980s when large tracts of land for legalized informal residence were opened using section 6A of the amended Prevention of Illegal Squatting Act (Mabin 1992:22). In Cape Town this was done in response to growing numbers of people moving to the city from the rural Transkei in the early 1980s. As these numbers grew, the state lost the capacity to control the movement of people and the spaces they inhabited (Desai and Pithouse 2004:240).

As the apartheid government lost the ability to control these areas, the urban civics movement and the United Democratic Front moved in to mobilize Black urban populations to undermine the apartheid regime. The United Democratic Front was formed in 1983 as an umbrella organization to house the trade union movement, faith-based organizations and urban civics structures that combined the various elements of the anti-apartheid movement. The United Democratic Front was organized in response to attempts by the apartheid government to create a tri-cameral legislative structure that would include the input of Indian and Black South Africans, but at a rate that was not representative of population distribution and without meaningful voting power. The strongest element of the United Democratic Front was the National Union of Mineworkers of South Africa, or NUMSA, who under the leadership of Cyril Ramaphosa would lead a series of strikes that crippled the South African economy. When combined with the mass stay-aways, coordinated boycotts of companies that supported the apartheid regime, and rent boycotts coordinated by urban civics structures, the Mass Democratic Movement began to threaten the unstable economic foundations of apartheid South Africa.

Amidst the growing unrest, the apartheid government faced a financial crisis and growing international condemnation for the state-led violence against anti-apartheid protests. In the midst of a series of states of emergency in 1985 and 1986, South Africa was struck by a financial crisis unparalleled in its history. South Africa had maintained a dual-rand system, whereby international trade was carried out utilizing the financial Rand – or FinRand – and domestic pricing was structured at a discounted rate. This system, enabled by subsidization through high gold prices, essentially discounted the cost of imported goods due to the need for capital-intensive machinery in the mining industry. When the price of gold began to fall during the 1980s amidst international sanctions against the apartheid regime, the financial footing on which the apartheid project sustained itself began to crumble. The internal pressure exerted by the mining unions exacerbated these pressures, leading to elements of the white South African business elite to push for measures to liberalize the country's exchange rate and macroeconomic policy.

While proposals had come forward as early as 1980 to push for measures to liberalize the economy, the political clout of the mining industry in government had been able to limit the influence of these measures in policy discussions. The leadership of the African National Congress in exile and white business leaders in South Africa had been meeting since the early 1980s to discuss the broad parameters of a transition to democracy in South Africa. For example, led by the Frederik von Zyl Slabbert, director of the Institute for a Democratic South Africa (IDASA), a South Africa business contingent had met with the leadership of the African National Congress in Abuja in 1984. At the same time, unbeknownst to Mbeki, other factions of the exile leadership had begun Operation Vula, the aforementioned initiative to start a people's war in South

Africa modeled on the Vietnam War (O'Malley 2007). The existence of various factions predicated on whether a member of the African National Congress was in exile, on Robben Island, or within the country is a theme that was to be of utmost importance during the negotiated political transition and in the post-apartheid era. However, links between the South African business elite and elements of the leadership in exile had been developed during this time, links that were to re-emerge during the transition and the Mbeki administration.

During this time, Nelson Mandela and the leadership of the African National Congress on Robben Island had continued to support the demands of the Mass Democratic Movement to nationalize the mining interests and banks of South Africa. However after Nelson Mandela was freed and international organizations began to exert their influence on the negotiation process, the position of the African National Congress began to change. As had been argued by Gelb (1991) in the introduction to an influential volume on the political economy of late apartheid, if nationalization was removed from the negotiating table as a realistic option, the only possible trajectory forward was for South Africa to adopt economic policies that were broadly in line with the neoliberal platform pushed by the Washington Consensus through international financial organizations like the International Monetary Fund and the World Bank. As has been noted by ANC parliamentarian Andrew Feinstein, these organizations held workshops and training sessions for leading ANC members (Feinstein 2007). This analysis of the negotiated political transition follows that of Bond (2005), however it tends to downplay the influence of the collapse of African post-colonial developmental economic policies in countries such as Zambia or Zimbabwe. As has been argued by Hirsch (2005), who was a

staff member within the South African Presidency under Mbeki, the effect of Keynesian policies on post-colonial sovereignty and the rise of the Asian Tiger economies on the basis of neoliberal economic policies were influential on the ANC leadership.

As the 1980s drew to a close, apartheid South Africa saw its economy crumbling and international support dwindling. In 1989 the anti-apartheid movement in the United States mobilized support in Congress to over-ride Reagan's veto for broad sanctions against South Africa, overcoming Republican backing for the anti-communist agenda of the apartheid government. Particularly significant for the analysis to follow, these sanctions included the exchange of gold for trade credits, a tactic that had been employed at great length by the apartheid regime. However this time also marked a sea change in the economic platform on which the democratic period would be based. As with the example of the pass laws, the trajectory set with economic policies in the late apartheid period would continue into the post-apartheid period, with devastating consequences for the public health response to the HIV/AIDS epidemic.

The Post-Apartheid Era: Self-Imposed Structural Adjustments and its Entailments

As the negotiated political transition came to a close, the world looked on in wonder as the punctuated violence that had marked the apartheid era subsided. The intermittent clashes between members of the Inkatha Freedom Party and the anti-apartheid movement in the Natal Province mercifully ended, and the negotiated political transition produced what many argue is the most progressive constitution in the world. However, with the onset of democracy came many serious challenges for the African National Congress. South Africa was one of the most unequal societies in the world, a

harsh legacy from the colonial and apartheid eras. Housing, infrastructure and education backlogs for South Africa's black majority had not been addressed during apartheid, and the African National Congress faced an uphill climb in addressing these measures.

On top of a series of pressing social challenges, the African National Congress inherited an economy that had stagnated during the last two decades of apartheid. Investment in South Africa's industrial infrastructure had declined steadily since the Soweto Uprising in 1976, leaving the mining industry and several low-skill industries as the primary sources of employment in the economy. As Feinstein (2005) has argued in a comprehensive economic history of South Africa, one of the key legacies of the apartheid era was a labor force with extremely low productivity due to the system of Bantu education and a segregated labor market that limited the majority of Black workers to jobs that demanded little to no prerequisite skills. In an influential analysis, the World Bank conducted an analysis of the South African economy that pointed to an overabundance of globally uncompetitive industries, a decaying infrastructure, and inadequate skilled labor to compete in the global economy (Kahn et al. 1992). The recommendations that flowed from this document were thus predictable: to relax foreign exchange controls to attract foreign capital that might invest in updating South Africa's outdated industrial capacity to take advantage of its cheap labor supply.

Despite the dire warnings on the limitations of "macroeconomic populism" from the international community, the African National Congress developed a Keynesian model for socio-economic development called the Reconstruction and Development Programme. The Reconstruction and Development Programme served as the election platform for the ANC in the 1994 elections, after which the party took office in the first

democratic administration in the country's history. The Reconstruction and Development Programme was a comprehensive policy document that covered nearly all areas of socio-economic development that was based upon the principle of "growth through redistribution", rather than the "redistribution through growth" that had been proposed by both the South African business sector and international organizations.

Many people I spoke with informally thought that the Reconstruction and Development Programme was a policy that had something for everyone. The policy was generally characterized as having general guidelines that grew out of the demands of different interest groups during the negotiated political transition. This underhanded compliment overlooks the fact that some of the key policy decisions for the post-apartheid were not thoroughly developed in the policy. Clear decisions on macroeconomic policy and industrial policy were not included in the policy document, exclusions that would be revisited shortly after the adoption of the Reconstruction and Development Programme in 1994. However, perhaps the most telling detail was that the Office of the Reconstruction and Development Programme was not given its own budget. Rather, the Director of its implementation, Jay Naidoo, was expected to garner funds from different government departments to ensure implementation of the program. Without budgetary control and appropriate administrative support, implementation of the Reconstruction and Development Programme floundered. As would be the case with many of the comprehensive HIV/AIDS plans that were developed by government, the Reconstruction and Development Programme became a policy that looked great on paper that was not put into practice socially.

Despite the challenges faced with the implementation of the Reconstruction and Development Programme, by December 1995, international observers were in agreement that South Africa's difficult transition to democracy was a success, and a country that was on the brink of internal dissolution in the late 1980s had stabilized. President Nelson Mandela was widely hailed for his role in returning a country ravaged by decades of internal strife and external isolation to some variant of normalcy. South Africa attracted over R30 billion (~\$7 billion USD) in capital inflows from the middle of 1994 to the end of 1995 (Stals 1996). Neoliberal economists often construe foreign investment as a uniformly positive force that enables economic growth, but in fact this is not always the case. In South Africa this investment proved to be a mixed blessing as much of this money was short-term capital and could be quickly shifted out of the country. Of the R21.7 billion invested in 1995, 42 percent was short-term capital, and of the remaining long-term capital investment, more than half were nonresident purchases of securities, which are defined as long-term but in practice can often be very volatile (Lowell, Neu & Tong 1998:45). Investors had sent money into South Africa to take advantage of high-interest rates and moved their money out of the country at the first sign of instability.

Although critical voices towards some African National Congress policies had emerged at this time, no one foresaw the difficult road that South Africa would travel over the first decade of post-apartheid democracy. Currency crises in 1996, 1998, and 2001 stalled economic growth in the country, and with it any hope for broad-based redistributive policies that could have pulled economically marginalized Black African populations out of structural poverty. On February 13, 1996 South Africa's post-apartheid honeymoon with global markets came to an end as rumors about Nelson

Mandela's health shook the confidence of traders in foreign exchange markets and sent the value of the South African rand plummeting. In a market dominated by foreign investors the currency lost nearly 20% of its comparative value in the course of a few weeks as the perception of unorthodox economic policies and underlying weakness in the South African economy drove speculative activity against the rand. Although the initial depreciation was triggered by an unfounded rumor, a second depreciation in late March began shortly after Trevor Manuel was named Minister of Finance in a cabinet reshuffle. Global markets seemed concerned that there was an ANC Minister of Finance, that he was 'black', and that he was not a financier (Hirsch 2005: 94). Although the perception of weakness in the South African economy was the key factor in the severity and length of the depreciation, it is also clear that perceptions of potential instability and race played a role in this process.

The governor of the South African Reserve Bank (SARB), Chris Stals, made the following statement to the Annual Meeting of the French Chamber of Commerce and Industries in Johannesburg, South Africa on April 23, 1996 in the context of continued instability in the foreign exchange market.

We have now seen the importance of being on guard for unexpected changes in international market conditions over which we have no control. We have learned to be cautious about excessive speculative capital inflows into the country, and how important it is to take account of the effects of such flows on domestic monetary policy. We have experienced the abruptness of changes in the direction of capital flows, and the consequences thereof for the exchange rate of the rand. We have learned how important it is to remain flexible in times of essential adjustment, and to respect the forces of the global market (Stals 1996).

Reacting to continued pressure on the rand, Stals' speech can be interpreted as an attempt to 'talk down' the roiling foreign exchange markets by acknowledging the power that

they had over South Africa. As South Africa had begun liberalizing exchange controls in 1995, and given the level of debt and low foreign currency reserves, the SARB had no other effective means of intervention in foreign exchange markets.

What this financial liberalization meant, in practical terms, was that South African politicians and bureaucrats could no longer effectively control the financial sector once regulations were abolished. Foreign and domestic investors in South African securities could now indicate their views on policy decisions by continuing to invest or disinvest. In a still-fragile economy emerging from a decade of economic isolation, the threat of investors fleeing the country due to concern over economic policy had very real consequences. In the attempt to cushion the severity of the currency depreciation in 1996, the SARB spent R13.5 billion (~\$1.98 billion USD) propping up the value of the rand in foreign exchange markets, money that could have been spent on poverty alleviation measures. Given the difficulties South Africa has faced with its currency since liberalization, critics have focused on this as serious miscalculations in post-apartheid policy (Bond 1999). Responding to the currency crisis, the ANC introduced a new economic policy document in June 1996 that marked a clear break from earlier ideas about how to balance economic growth and redistribution.

Following the 1996 currency crisis, the Keynesian-inspired Reconstruction and Development Programme (RDP) was abandoned in favor of the market-friendly Growth, Employment and Redistribution Macroeconomic Strategy (GEAR) that emphasized lowering the budget deficit, lowering inflation, partial privatization of state assets and further opening the economy to trade as a means of attracting foreign direct investment

and spurring economic growth. The authors of GEAR explicitly linked this growth strategy back to the February 1996 currency depreciation.

In February 1996 a depreciation, which was largely a purchasing power parity correction, occurred. However, the subsequent movements in the foreign exchange market reflected more fundamental economic uncertainties. The depreciation presents both an opportunity and a threat. An uncoordinated response, embroiled in conflict, will cause further crisis and contraction. Linked to an integrated economic strategy, on the other hand, it provides a springboard for enhanced economic activity (GEAR 1996: 2).

GEAR, drafted by a small group of economists handpicked by ANC leadership, was presented as a non-negotiable policy proposal that had been drafted outside of established channels for policy coordination between business and labor (Gumede 2005: 87). This marked a sharp shift away from the broad consultation that had marked the drafting of the Reconstruction and Development Programme, and a process that was to be repeated time and again under the administration of President Thabo Mbeki. In practice GEAR did stabilize South African macroeconomic fundamentals, most notably lowering inflation and the budget deficit. However the foreign investment and, most significantly, job growth that were predicted to accompany the implementation of the GEAR macroeconomic strategy did not materialize.

It is now widely accepted that the adoption of GEAR by the first African National Congress (ANC) government in South Africa could broadly be described as neoliberal and ran counter to earlier ANC policy models (Michie and Padayachee 1998, ANC 1994). Following the adoption of GEAR, the ANC focused primarily on neoliberal economic targets such as inflation reduction, trade liberalization, fiscal austerity, restructuring the state bureaucracy and on “playing the globalization game”. These policy shifts echo the key principles of the International Monetary Fund’s structural adjustment

programs, including the privatization of public services such as electricity and water that have had a disproportionate impact on the health and livelihoods of the poor and underemployed (Ruiters & McDonald 2005). While this aspect of privatization has been thoroughly analyzed, the role of external financial influence and its relationship to the adoption of GEAR has not been addressed at length in the literature on South Africa.

As has been outlined above, the GEAR macroeconomic strategy specifically lists the 1996 currency crisis as central to a rethinking of the developmental policies of the ANC in the post-apartheid period. However what the policy paper does not address are the “more fundamental economic uncertainties” that played a central role in the onset of the crisis. In the seminal account of the 1996 crisis, Aron and Elbadawi (1999) point to the utilization of the large inflow of foreign capital during the 1994-1996 period to pay off a large net open forward position in the South African Reserve Bank. The net open forward position is essentially a guarantee of future payment for foreign currency subtracted by the spot gold and currency reserves held by the government of South Africa. In December 1996, the net open forward position or “forward book” stood at US 22 billion dollars. This is clearly a sizable sum, and one that essentially doubled the debt that the ANC had inherited from the apartheid regime. While the exact goods that the apartheid regime acquired with the foreign currencies purchased by charging the forward book, the burden placed on the first democratic administration by this debt were considerable.

The legacy of the net open forward position, or “forward book”, was to create a structural weakness in South Africa’s economic stability during the first decade of democracy. The forward book, which was reduced to an amount less than South Africa’s

spot reserves in 2002, created a one-way bet for currency speculators in foreign exchange markets. In short, the South African Reserve Bank would intervene to maintain a favorable exchange rate in order to uphold an acceptable rate to pay back the upcoming forward book payment, which would be due in a foreign currency, most likely the US dollar. If the exchange rate had depreciated, this would increase the value in Rands of the payment for the money that was borrowed during the apartheid era. During the currency crises in 2001, the amount of money that the ANC-led South African government had to repay more than doubled when the exchange rate of the Rand depreciated to R14/1 USD. Prior to the currency crisis in 1996, the exchange rate was R5/1 USD. Given the short-term nature of the debt and the total amount of foreign currency involved, the forward book is an important inclusion in the analysis of the decision-making process that went into changing the ANC economic platform from the Reconstruction and Development Programme to GEAR and the privatization of social services that this policy produced.

Since 1996, public policy measures of fiscal austerity adopted by the ANC have come under fire due to the increasing disparity in service provision to rich and poor communities (Desai 2002). The ANC has focused primarily on economic targets such as inflation reduction, trade liberalization, and restructuring the state bureaucracy; policies that have been described as ‘neoliberal’ and run counter to earlier models (Bond 2004). Prioritizing these financial targets has resulted in the privatization of public services such as electricity provision, water distribution, as well as inadequate AIDS treatment (McDonald + Ruiters 2005, Benatar 2001). These social policies have contributed to higher levels of poverty, unemployment and social stratification while the rate of HIV infection skyrocketed from less than 1% of total South African population during the

1980s to 21.5% of South African adults in 2003 (UNDP 2005, Schneider 2002). The imposition of the fiscal austerity measures that accompanied the implementation of GEAR had a negative effect on the extension of social services to Black South African communities.

The common theme that runs throughout the South African literature on the current challenges in service delivery is the criticism of cost recovery in the context of extreme poverty. This developmental strategy, championed by international institutions such as the World Bank, entails a community paying for the cost of its own infrastructural development. For the example of water, this is achieved through higher per unit prices of the now commodified public resource. The leaner vision of the role of the public sector in social development dovetails with the fiscally conservative GEAR macroeconomic strategy. However the social implications of adopting this approach in a country with a history such as South Africa's were seen as exacerbating the social inequality inherited from the apartheid era.

Furthermore, neo-liberal logic rejects cross-subsidization and insists that each community must, itself, 'recover' the full cost of installing new connections. Hence the poor, the black poor, must pay much more for their services than the rich in the still largely white suburbs (Desai & Pithouse 2004: 244).

Pursuing cost-recovery rather than cross-subsidization in the South African context disregards the racial legacies of apartheid. Wealthier, better-serviced areas in the post-apartheid period are predominately inhabited by white South Africans who benefited from the apartheid system. Cross-subsidization would create a class-based policy of having the rich pay for the extension of services to the poor and address the racial legacy of apartheid. As Desai and Pithouse (2004) point out, cost-recovery pushes the cost of

servicing historically underprivileged communities back onto those who have borne the brunt of apartheid government's unequal allocation of social resources. While revised metropolitan demarcations adopted in the post-apartheid period have integrated the former townships and white urban areas into a common urban policy framework, due to the policy of cost-recovery in service delivery, this shift has not eased the economic pressure on poor South Africans.

The privatization of social services has spawned a series of new social movements to demand alternative strategies for social service provision. These social movements have demanded the rights guaranteed in the South African constitution through the provision of basic social services, such as access to fresh water, electricity, and antiretroviral therapy (Ngwane 2003, Saul 2005). Chief among these demands has been the eradication of cost-recovery measures in the extension of services to those previously excluded, an end to forced evictions, and a moratorium on water and electricity cut-offs for those who are unable to pay for these services. The privatization of water in particular has led to social mobilization in the peripheries of the major cities of Johannesburg, Cape Town and Durban. The Anti-Privatization Forum, Soweto Electricity Crisis Committee and other social movements grew in response to the outbreaks of cholera and dysentery that were the direct consequence of water cut-offs (Deedat and Cottle 2002). With respect to the HIV/AIDS epidemic, the Treatment Action Campaign has pressured the ANC government into greater distribution of antiretroviral therapy through international activism and civil disobedience campaigns (Friedman + Mottiar 2004). While the Treatment Action Campaign has been successful in pushing the ANC to alter its HIV/AIDS policies, the social movements demanding a human right to water and

electricity have not had the same success in pressuring the government into expanding access to electricity and water for poor South Africans in peri-urban townships.

The key issue that cost-recovery in health service delivery poses for a public health crisis such as HIV/AIDS is that it pushes the cost of developing health infrastructure back onto communities. This is a factor that cannot be underestimated in the public health response, particularly due to the fact that South Africa's townships, which have an HIV incidence nearly twice that of other urban areas, did not have a health system developed for their residents during the apartheid era. The resultant overcrowding of hospitals have had predictable results. In 2007 the Medical Research Council of South Africa released a report that calculated that one in five infant deaths in the South African public health sector were avoidable (Beresford 2007b). In October 2007 pictures of newborn babies sitting in cardboard boxes in Soweto's Chris Hani Baragwanath Hospital (Cape Times correspondents 2007, Mail & Guardian reporters 2007, Ntshona 2007). This highlighted the effect of fiscal austerity on the public health policies of the ANC, and came amidst claims of a crisis from its own public health specialists. In July 2008, the opposition Democratic Alliance launched an appeal against the Health Department's "refusal" to approve an application for the release of its report into the deaths of 142 babies in the Eastern Cape earlier this year (Sapa 2008a).

The Eastern Cape is a particularly interesting case to analyze this issue as it was formed through the incorporation of the former homelands of the Transkei and Ciskei and a portion of the Cape Province. During the apartheid era the major hospitals for the Cape Province were located in Cape Town, while the Transkei and Ciskei were considered to be "separate" countries and as such, the apartheid government did not develop health

infrastructure in these areas. Thus, the newly formed Eastern Cape Province now lacks adequate health services to deal with many of the adverse effects of the HIV/AIDS epidemic. However one of the ways that communities have attempted to manage a situation where the cost of health infrastructure is not borne by the state is to seek partners in the private sector to provide capital to develop health infrastructure. If a community is successful in finding a private sector partner, the ANC-led government provides a matching contribution to the private sector partner, forming a “public-private partnership”. This developmental strategy has been employed at length in the provision of HIV/AIDS treatment with Médecines sans Frontières (Doctors without Borders) developing service provision centers in the peri-urban township of Khayelitsha, located outside of Cape Town, and in rural Lusikisiki in the Eastern Cape. This strategy has also been employed in the Northern peri-urban township of Diepsloot (Johannesburg), where the non-profit organization Ma Africa Tikkun, with support from Lubman (Pty) Ltd., has partnered with government to develop a health center that includes care for orphaned and vulnerable children, a crafts center to support local entrepreneurial activities and a local health clinic. Despite efforts such as these, the backlog in health service provision continues to grow as the burden of disease rises along with the HIV/AIDS epidemic in South Africa.

Due to fiscal limitation on capital expenditure, South Africa’s public health system continues to be under-developed and under-staffed. A key ANC imperative in the immediate post-transition period for public health was to extend pre-natal care to all free of charge. This was a key initiative for building a public health system that addressed the uneven institutional geography inherited from apartheid whereby public health services

were concentrated in white areas and Black areas were largely underserved. For example, the population to clinic ratios in Cape Town in 1987 were 14,838 whites per clinic and 31,008 blacks per clinic (Chetty 1992). While the shift of resources to primary care for historically underserved areas did make significant progress in the 1994-96 period, the change to the fiscally stringent macroeconomic strategy entitled Growth, Employment and Redistribution (GEAR) halted this progress (Chetty 2007). Due to the deficit reduction strategy the Eastern Cape provincial health budget fell from R3 billion in 1996/97 to R2.87 billion in 1999/00 in nominal terms (Thomas 2007). This decline in spending on health led to uneven access to key resources such as fuel, drugs, and hospital food and a drastic decline in capital spending. During this time funding levels were determined by the National Treasury and declined for all provinces (Chetty 2007). The development of health infrastructure was put under severe strain during the GEAR period, during which capital investment was cut.

However even in a context of public health infrastructure having been provided through a public-private partnership, in Khayelitsha the public health system was crippled by understaffing of both doctors and nurses in the area hospitals. During my fieldwork in the peri-urban township of Khayelitsha, I conducted a human resources analysis of a day hospital that pointed to chronic under-staffing of both doctors and nurses (Powers and Monte 2007). Another driver of the ongoing crisis in public health care is the 'brain drain' of doctors and nurses from the South African public health sector to England and the United States (Macfarlane 2007). This is a debilitating process for the fight against HIV/AIDS in Southern Africa and exacerbates the effect of HIV/AIDS on an already strained public health system (Béga 2007). There is also an in-country drain from the

private health sector which offers better pay and working conditions than the public health sector. The impact of this exodus of medical professionals to jobs with better pay and working conditions is dramatically highlighted in a recent survey showing that “Half of SA’s medics want to leave” due to poor working conditions (Smetherham 2008).

This is a vicious cycle in which the specter of AIDS-related opportunistic infections looms large. While recent salary increases offer some hope in stemming the tide of staff shortages, this strategy has not impacted on the system-wide staffing shortages in a significant way. The impact on the services received by patients can be seen at 4am, when the sick begin to stand in line in the hope of receiving care or to be tested for HIV. According to an activist from the Treatment Action Campaign named “Robert” who organizes in Khayelitsha:

They wait months to be put to treatment. And I have been asked what is going on, and I have been told that we don’t have enough staff members, or enough doctors, or nurses to increase the number for the patients to be on treatment. It compromises everything. It paralyzes almost everything. You can go out and mobilize people on testing. When people go to the clinic, they don’t get tested. They take hours to be tested, just tested, for HIV. People who are sick. There is a problem.

The crisis in the public health sector is undermining the collective response to the HIV/AIDS epidemic as the vast majority of South Africans must depend on the public sector for their health care. This is one area where the National Department of Health has been proactive by offering more competitive pay packages to lure nurses back from better paying jobs in the West and recruiting doctors from North African states such as Morocco, but this strategy had not closed stemmed the tide of doctors and nurses leaving the public sector (Zvomuya 2007, SAPA & AFP 2007).

The current human resources crisis can also be partly attributed to the effects of GEAR fiscal austerity due to the restructuring the state university system. GEAR led to various nurse-training colleges closing their doors as nursing students were channeled into Further Education and Training (FET) colleges. This cut the total number of nursing students, thus stemming the stream of new nurses into the public health system (Ramphela 2008). This shift caused less hands-on training for nurses, leading some to argue that this has caused a decline in the quality of nursing in the country. Faced with long working hours and a difficult working environment, those entering the nursing field are ill equipped to deal with the challenges of public health service delivery in the areas of greatest need. According to several nurses that I spoke with, the long hours and challenging conditions that nurses endure in South Africa's public health sector damage the morale and productivity of the front-line response to the HIV/AIDS epidemic. Despite these daunting challenges, the leadership of the ANC has maintained a detached and technocratic response to the pressing health needs in South Africa. As I will argue below, this derives primarily from the institutional legacy of the apartheid era and its influence on the managerial strategies of President Thabo Mbeki.

While it is difficult to gauge the exact extent to which the institutional memory of the late apartheid period continued into the post-apartheid period, characterizations of "centralization" under the Presidency of Thabo Mbeki may underestimate the extent to which the ANC has been a centralized organization for some time. As has been outlined above, the militarization of the South African state in the late apartheid period led to limitations on the democratic process within the ANC in exile. When Thabo Mbeki was selected as the Deputy President of the ANC for the 1994 election, this put an ANC exile

leader into administrative control of the South African government. As former ANC parliamentarian Andrew Feinstein has noted, the culture of the ANC exiles was far different than that of activists who had operated within South Africa during the 1980s:

The ANC and SACP's vanguardist and paranoid style of organization in exile – in which Mbeki was steeped – and which was required in the face of efforts by the apartheid government to fatally undermine the liberation movement, inhibits the questioning, pluralistic tradition of the organization that flourished inside the country and even, as far as was possible, on Robben Island (Feinstein 2007: 150).

In Feinstein's autobiographical account, he draws from first-person experience within the ANC to describe the differences in organizational culture between the Mass Democratic Movement within South Africa, the ANC on Robben Island, and the ANC structures in exile. In doing so, Feinstein verifies much of Mac Maharaj's autobiographical account of the hierarchical and autocratic organizational culture of the movement in exile (O'Malley 2007).

The effect of the mainstreaming of the organizational traditions of the ANC in exile was to stifle dissent within the organization and close consultative mechanisms to input from the political opposition, private sector and non-governmental organizations. The processes that centralized during the Mbeki Presidency were the consultative institutions developed during the negotiated political transition, typified by the National Economic Development and Labour Council (NEDLAC) and other institutions developed during the political transition. Put into this context, the "take it or leave it" ultimatum with which the GEAR macroeconomic strategy was presented to alliance partners was not the exception, but the norm for policy consultation during the Mbeki administration. To return to Feinstein, he offers the following analysis of the function of government under the leadership of Mbeki:

At the same historical moment, Thabo Mbeki was placing his own centralizing, technocratic stamp on the movement, rowing back from the days of mass protest and community organization. This stamp included the Presidency's active involvement in and often domination of every area of policy making, and the emergence of a small clique of trusted advisors which usurped the place of collective debate within the ANC (Feinstein 2007: 133).

This description largely matches that offered by Gevisser (2007) and Gumede (2005), who portray Mbeki as a centralizing technocrat who does not trust others to filter information on his behalf (Gevisser 2007: 734). Under the leadership of Thabo Mbeki, the ANC turned away from its long-standing ties with the trade union movement, community organizations and community activists, with devastating consequences for the political management of the HIV/AIDS epidemic.

Conclusion

As the tri-partite alliance between the ANC, the Congress of South African Trade Unions and the South African Communist Party bitterly contested the implementation of fiscal austerity measures associated with the GEAR macroeconomic strategy, South Africa's HIV/AIDS epidemic was exploding. Following many of the same circuits of transmission that Sidney Kark (1949) had identified in his path-breaking research on the relationship between circular labor migration and an outbreak of syphilis in the 1950s, HIV prevalence amongst pregnant women in South Africa increased from 0.7% in 1990 to 22.8% in 1998 (SANDoH 2008).

That the first democratic government in South Africa's history had to deal with an epidemic on this scale in its first decade of rule is perhaps one of the great historical injustices of our time. However any goodwill that community activists and the

international community had extended to the ANC for its management of the HIV/AIDS epidemic quickly dissipated when Thabo Mbeki and other ANC leaders issued equivocating statements on the link between HIV and AIDS. Following the work of Gevisser (2007), in the chapter that follows I will argue that the political management of the HIV/AIDS epidemic grew out of the lack of institutional capacity in the public health sector due to neoliberal structural adjustment, the autocratic cultural legacy of the exile tradition, and Mbeki's anger over the failure of GEAR, resulting in a rejection of the solutions offered by the global pharmaceutical industry (Gevisser 2007: 735).

Chapter 2

The Political History of the HIV/AIDS Epidemic in South Africa

In the winter evening of Cape Town on Somerset Road in Green Point, the South African Deputy Minister of Health stood to the cheers of AIDS activists amidst the flash of cameras and the bustle of news reporters. A series of speeches were given by leading AIDS activists that included a founder of the Treatment Action Campaign, Zackie Achmat, before Deputy Minister of Health Nozizwe Madlala-Routledge was given a chance to talk. Despite the carnivalesque atmosphere that celebrated her return, the Deputy Minister of Health was not in town to make an announcement about the newest progress with the NSP, but to announce her dismissal from office. The government official who had figured most prominently in the process of drafting the NSP and pushing forward with the restructuring of the National AIDS Council was no longer in office, recalled by President Thabo Mbeki for “not working as part of the collective”. What little hope had remained for government cooperation in pushing forward with the implementation of the NSP was dashed as Minister of Health Tshabalala-Msimang strengthened her political control over the National Department of Health.

The ripple effects of the Deputy Minister’s dismissal were far-reaching, immediate, and also impacted my own fieldwork. Following this event, several interviews that had been scheduled with nurses working in the public health sector were abruptly cancelled. In addition, I had a further two interviews from which research participants voluntarily withdrew for fear of losing their jobs, with one person stating this

directly to me following our conversation. The chilling effect of this event was further palpable on my research on human resources in Khayelitsha's hospitals as two of the three institutions withdrew their participation. Madlala-Routledge's departure from office was met with a mix of anger and frustration from AIDS activists in the greater Cape Town and Johannesburg urban areas, but no one that I spoke with was surprised by Mbeki's actions against the candid Deputy Minister.

The dismissal was not particularly unexpected, as Madlala-Routledge had become increasingly outspoken against her own government's inaction in the public health sector following the return of Minister of Health Manto Tshabalala-Msimang. In addition to public statements that supported an orthodox public health response to the HIV/AIDS epidemic, the Deputy Minister had declared a "national health emergency" following a visit to Frere Hospital in the Eastern Cape. The Deputy Minister had confirmed that a report of unsanitary conditions and inadequate resources in the hospital were true, and stated that immediate action was necessary to improve conditions that had led to the deaths of nearly fifty infants over the past year. The political reaction in defending this dismissal from the ANC leadership was swift and uncompromising – President Mbeki and Minister of Health Tshabalala-Msimang immediately denied that political factors played a role and that the report on conditions in Frere Hospital as being inaccurate. While Madlala-Routledge claimed to be "only doing her job", it was clear that the open discussion of government inaction on a pressing issue in a public health facility ran directly against the imperatives of her superiors.

The Deputy Minister's dismissal reinforced the claim by AIDS activists that the AIDS dissident faction of the ANC had returned to power along with the return of the

Minister of Health in June 2007. Despite the restructuring the National AIDS Council and the existence of a new national AIDS policy with the NSP, the climate of divisive AIDS politics had returned to South Africa. Over the course of the 1998 – 2008 period, the politicization of the AIDS epidemic in South Africa delayed the implementation of a comprehensive treatment program, which shortened the lives of an estimated 330,000 people and led to the dissemination of obfuscating messages on the relationship between HIV and AIDS (Chigwedere et al. 2008). These dimensions of the AIDS epidemic in South Africa have been well documented by AIDS activists and scholars alike. While the social impact of the politicization of AIDS are paramount in understanding the long term effects of this period on the overall management of AIDS epidemic in South Africa, I will focus here on the competing alliances through which members of the ANC in government and AIDS activists in non-governmental organizations alike built with social partners in labor, business, non-governmental organizations and community organizations. As I will argue below, the social blocs formed by the politicization of the AIDS epidemic in South Africa transformed institutions and political dynamics from the national scale to the level of ward politics. It is these transformations to which this chapter turns its focus in calling for greater attention to be paid to the “internal” political dynamics of civil society in the context of divisive political struggle between social movements and government. In order to chart these dynamics, this chapter will outline the key transformations during the political transition and post-apartheid period and the impact of these processes on the politics of AIDS in the township of Khayelitsha.

In the body of work on the history of the AIDS epidemic in South Africa, Nattrass’s (Nattrass and Geffen 2007) overview of the politics of AIDS in the post-

apartheid era is perhaps the most comprehensive. From the apartheid-era focus on the sexual containment of white homosexual men to the intricacies of Thabo Mbeki's obfuscating depiction of the orthodox science on the HI virus, Nattrass offers a comprehensive guide to the divisive political dynamics of AIDS in South Africa. This account is particularly strong in the area of national policy and politics, with a strong emphasis on the negative effects of delaying the availability of treatment for the South African people. This text builds on Nattrass' (2002) key contribution to the social debate on the affordability of AIDS treatment, while opening up new points of analysis in the history of AIDS in South Africa.

For Steinberg (2008), the history of colonial medicine in South Africa is an important but undervalued factor in understanding the circumspect reaction by some elements of the Black South African population to HIV/AIDS treatment. As Steinberg emphasizes, the association between needles, illness, and the white doctors of the colonial and the apartheid eras is not an irrational fear of Western medicine. Rather, it points to a clear correlation between the arrival of Western medical professionals and disease, be it HIV/AIDS or the syphilis epidemic of the 1940s. This is an important point that offers insight for understanding the recalcitrance of many in accessing HIV/AIDS treatment in South Africa.

Susser's (2009) point of entry into the debates on the history of the AIDS epidemic in Southern Africa focuses on the unequal burden of disease and care that women have experienced. The HIV/AIDS epidemic has always been a gendered issue, particularly with the focus initially on white homosexual men during the apartheid era. However Susser points out that the public health response to prevention in South Africa

has systematically excluded the female condom, the one barrier method that can be controlled by women rather than their male partners. Drawing from ethnographic data from meetings with women in the Kwa-Zulu Natal province, Susser observed the role of male leadership in limiting the demands of local women for access to HIV/AIDS treatment, female condoms and a greater say in the affairs of their communities. This emphasis on the gendered dimensions of an epidemic that affects women at a higher rate than men was an overdue and necessary contribution to the history of AIDS in Southern Africa.

In the anthropological literature, perhaps no one has emphasized the role of history in understanding the contemporary contours of the epidemic more than Fassin (2007). In his ethnography of the South African AIDS epidemic, Fassin characterizes the divisive politics of HIV/AIDS as emanating from the legacy of racial exclusion and the formation of a new variant of racial nationalism under the leadership of the African National Congress. As such, the central role of race in the dialogue emanating from government on the AIDS epidemic echoes the racial stereotypes employed by the apartheid regime but through a rejection of the negative values associated with traditional African beliefs and practices.

While Fassin is undoubtedly correct in locating the origin of the racial dynamics of the post-apartheid era in South Africa's past, he neglects to emphasize that the source of the HIV/AIDS movement that opposed the 'AIDS dissident' faction within the African National Congress lay in the anti-apartheid movement that operated within the borders of South Africa in the late apartheid era. Fassin's focus on identity and the processes through which this has served as a mechanism for producing or maintaining political

division takes away from a broader point. The social organizations that drove the politics of AIDS on either side of the political divide both traced their political genealogies to the anti-apartheid struggle.

My contribution to this body of literature analyzing the history of HIV/AIDS policy and politics is to contextualize the political dynamics surrounding the epidemic within a reading of the social forces that characterized the late apartheid era. In particular, my analysis of the late apartheid period underscores the extent to which the leadership of the African National Congress in exile centralized due to the relentless efforts by the apartheid intelligence services to infiltrate their party structures. The organizational dynamics that this shift engendered within the ruling party are key for understanding why party members toed the line with the obfuscating messages of the AIDS dissident faction of the party, which included President Thabo Mbeki.

Another contribution that this study offers to the historiography of the HIV/AIDS epidemic in South Africa is the identification of key shifts in the strategies employed by the ‘AIDS dissident’ faction of the African National Congress to counteract the influence of AIDS activists. Scholars of the political dynamics of the epidemic have offered clear and thorough analyses of how policy dynamics at the national level changed with the ‘cabinet revolt’ that led to Mbeki discontinuing obfuscating public statements on the relationship between HIV and AIDS. However what has been neglected in these narratives was the concomitant shift by the ‘AIDS dissident’ faction to recruit the support of non-governmental organizations and the urban civics movement to disseminate alternative messages and vitamin-based AIDS treatment.

This is a key contribution as it underscores that the AIDS dissident faction of the African national Congress shifted the direction of their political activities outside of the realm of formal state institutions after the AIDS movement successfully lobbied the labor movement and members of the ruling party to openly defy President Mbeki on the issue of HIV/AIDS. While this had been identified as a key moment by analysts of the epidemic as it led to the introduction of nevirapine to prevent mother-to-child transmission, it had not been identified as also marking the onset of a campaign to localize the messages of AIDS dissidence and disseminate scientifically unproven vitamin-based AIDS treatments.

Defining the Political Alliances: Hegemony and the State in South Africa

The conceptual framework that will be used to understand the political transformations of South African society during the AIDS epidemic derives from Gramsci's conception of hegemony. While this term has often been used to analyze discursive practices in the social sciences, it will be used here to understand the social contestation of power. It is through this theorization of power that the anthropologist Kate Crehan views Gramsci's contribution:

Gramsci's usefulness here, I would suggest, derives from his insistence that ultimately the most important question is that of power: who has power and who does not? Who is the oppressor and who the oppressed? And what are the specificities of the relations of oppression? (Crehan 2002: 6)

In the case of South Africa, the utilization of Gramsci's categories to understand the dynamics of power surrounding HIV/AIDS necessitate a recasting of the concept of hegemony beyond the scope of class position and ideology to include those infected and

affected the epidemic. Taken in this light, the formation of hegemonic and counter-hegemonic social blocs orient around two key organizations: the African National Congress (ANC) and the Treatment Action Campaign (TAC).

The ANC has served as the ruling party in South Africa since 1994 when the party won the first national elections under the leadership of Nelson Mandela. However it was during the presidency of former President Thabo Mbeki (1999 – 2008) that several party figures occupying senior positions in the South African government, including the Minister of Health, repeatedly delivered messages that brought into question the relationship between HIV and AIDS. While the statements emanating from the ANC contradicted the dominant international norms associated with scientifically sound AIDS treatment, they must be categorized as the hegemonic position on AIDS during the 1998 – 2008 period given the party's control of the South African state. As has been noted in the previous chapter, the history of late apartheid is significant for understanding the internal dynamics of the ANC as a political party, particularly with respect to the influence of transnational political forces. As will be outlined below, this circumspect positioning vis-à-vis international norms and institutions has played a particularly salient role in the politics of AIDS in South Africa.

In similar fashion, the political positioning of the TAC trace their roots to the late apartheid period due to the role of senior TAC members in the anti-apartheid movement. As with the ANC, these historical continuities figure prominently in the ways that the TAC has strategically pursued the goal of making AIDS treatment available to all in South Africa. Although the views espoused by the TAC and its alliance partners mirror the norms produced by international organizations such as the World Health

Organization, they must be considered a key member of a counter-hegemonic social bloc given the ANC's role as ruling party and that their political positions mirror the interests of poor and working class South Africans living with HIV/AIDS.

This classification of hegemonic and counter-hegemonic is one that is fraught by the units of analysis employed to understand the dynamics of power in a particular socio-historical context. Several researchers have classified these alliances in a reverse fashion due to the discursive positioning of the opposing political factions in relationship to international norms (Youde 2007, Fassin 2007). From this perspective, the ANC's maintenance of a heterodox position relative to international HIV/AIDS treatment norms serves as the foundation for analysis. While this is undoubtedly the case for the discourse of AIDS dissidence, this approach may gloss over the ways that this minority discursive faction operates as the most powerful institutional force within the confines of South Africa's national borders. As I will elaborate upon below, greater attention to the institutional dynamics of AIDS politics underlines the continued importance of the national political scale in understanding power and its limits in post-apartheid South Africa.

This chapter will investigate the paths pursued by the ANC-led hegemonic social bloc and the TAC-led counter-hegemonic social bloc in pursuit of their countervailing interests. Of particular note is the ways that the ANC-led hegemonic social bloc operated to limit the influence of the TAC-led counter-hegemonic social bloc and international donors, and the ways that the transformation of national institutions and the dissemination of AIDS dissidence impacted local community responses to the AIDS epidemic. In order to follow the trajectory of AIDS politics in South Africa, the chapter is

divided into a discussion of three historical periods. The first period to be covered is the political transition from 1990 to 1998, followed by the period of neoliberal policies and AIDS dissidence from 1998 to 2004, and the final era of the Mbeki administration from 2004 to 2008, characterized by institutional intransigence on the implementation of AIDS policies and the decentralization of AIDS dissidence through alliances with non-governmental organizations. In mapping this historical trajectory, the analysis will focus primarily on the negotiation and implementation of AIDS policies. For a more thorough analysis of the discursive aspects of this transition, one can turn to the work of Fassin (2007) and Youde (2007). For the perspective of AIDS activists during this period of time the works offered by Cameron (2002), Natrass (2007) and Geffen (2010) are instructive.

AIDS and the Negotiated Political Transition in South Africa, 1990 - 1998

The period of political transition out of late apartheid was one which brought with it high hopes for a public health response to the AIDS epidemic. After a decade during which the National Party had characterized HIV incidence as isolated to white homosexual men, a series of conferences and a scientifically orthodox national AIDS policy pointed to a movement away from policies based upon the isolation of high risk groups. While some signals had been made from the Department of Health towards a focus on heterosexual transmission as early as 1987 (Fassin 2007: 157), it was not until 1994 that national AIDS policy in South Africa took a decisive turn towards a broadly envisioned public health approach. While a public health approach to AIDS was formally adopted in 1994, it was not implemented in full until nearly a decade later. This decade,

during which HIV prevalence doubled in South Africa, can be explained by the misadventures of the Department of Health and the commensurate divisions within a broad anti-apartheid coalition that these incidents created during this critical period.

The transition period in South Africa was marked by a cohesive alliance between public health professionals, labor unions, academic analysts and the ANC on national AIDS policy. The early phase of this era was typified by a public health conference held in Maputo in 1990 where senior ANC leaders such as Chris Hani and future Minister of Health Dr. Nkosazana Dlamini-Zuma made public statements that identified HIV/AIDS as a serious challenge and advocated for a public health response to the epidemic (Susser 2009: 76). This productive phase continued with the proposal of a National AIDS Task Force at the Maputo conference, which led to a National AIDS Conference in 1992. At this meeting the coalition of health professionals, community volunteers, activists and party leaders that had driven the AIDS agenda during the political transition was formalized with the establishment of the National AIDS Coordinating Committee of South Africa. The National AIDS Coordinating Committee of South Africa was charged with developing a comprehensive public health oriented policy for addressing the AIDS epidemic in South Africa (WC-Nacosa 2010). The era of concerted cooperation between what would become divided factions culminated with the adoption by cabinet of an ambitious National AIDS Plan (1994) that served as a key pillar in the ANC's program of extending basic public health services to the historically underserved non-white population.

South Africa's first National AIDS Plan (1994) of the post-apartheid era was an ambitious attempt to control the spread of the epidemic, but one marked by systemic and

financial constraints. Although the initial budget for the National AIDS Plan was only R20 million (approximately \$4 million US dollars at the time), donations from the European Union and the United States Agency for International Development (USAID) of nearly R80 million increased the national AIDS budget by a factor of five (Fassin 2007: 37). Nonetheless the implementation of the policy was contingent upon the continued participation of the professional and volunteer associations that made up the National AIDS Coordinating Committee of South Africa. This was due to the institutional upheaval of state institutions in the aftermath of the negotiated political transition, the voluntary retirement packages offered to state officials who had staffed these bodies during the apartheid era, and the lack of a public health infrastructure in black urban areas and the “homelands”. As such the fissures that emerged in the broad public health and AIDS alliance forged during the anti-apartheid struggle and the transition seriously undermined the efficacy of the first major initiative on AIDS in the post-apartheid era.

The key events that created divisions in the post-apartheid alliance were the Sarafina II and Virodene scandals. The Sarafina II scandal focused on the allocation of funds for a play adapted from the award-winning film of the same name. The intention was to educate the population about the dangers of HIV/AIDS through the medium of theater. The play, which first showed on World AIDS day in 1995, was cancelled in February 1996 when news of its R14 million budget (nearly \$3 million USD) became public (Fassin 2007: 36). At the time, this was nearly one fifth of the budget that was earmarked to manage the AIDS epidemic (Fassin 2007: 37). The way in which the limited resources reserved for AIDS programs were allocated opened up questions among

those in the alliance who had already begun to question the priority assigned to the AIDS epidemic in the ANC-led transition process.

The Virodene scandal exacerbated the tensions created by the Sarafina II affair and further alienated the key partner organizations needed to implement the National AIDS Plan. The Virodene scandal unfolded in January 1997, when a team of researchers at the University of Pretoria presented the “discovery” of a drug that they claimed counteracted the spread of the HI virus in the immune system to the South Africa Cabinet (Fassin 2007: 41-2). The veracity of these claims was immediately put into question as it emerged that the key ingredient in the drug was an industrial solvent. At a meeting in the aftermath of the Virodene “discovery” held by the AIDS Consortium, founded by future Constitutional Court justice Edwin Cameron in 1992, AIDS activists and public health professionals expressed their dismay with the way in which this event was handled by ANC leaders in the Department of Health and Cabinet (Fassin 2007: 43-44). The Virodene scandal also provided ammunition to the ANC’s political opposition, with members of parliament attacking the Ministry of Health for their mismanagement and support for ethically questionable clinical trials (Fassin 2007: 44). In a harbinger of the politics to come, it emerged that a lead critic in the political opposition had received financial support from pharmaceutical companies, a fact quickly seized upon by members of the ANC (Fassin 2007: 39). The Virodene scandal came to a close within South Africa in February 2007 when the Medicines Control Council refused to permit any future experimentation with the drug (Geffen 2010: 178).

These two scandals are particularly important for the trajectory of AIDS politics during the Presidency of Thabo Mbeki. The association of the political opposition with

international forces sharing countervailing interests to those of the ANC is a construct that would be employed by the ruling party against the emerging counter-hegemonic coalition led by the Treatment Action Campaign. But more significant for the analysis put forward here was the attempt by the ANC to take political control of the Medicines Control Council following the institution's rejection of future research on Virodene. Following this action, the chairperson of the council and the registrar of medicines were dismissed, and the top staff of the council were all replaced (Geffen 2010: 178). While subsequent appeals enabled some of these officials to retain their positions, this event sets the precedent for the ANC utilizing the institutions of the South African government to pursue a political agenda on AIDS that falls outside of the standards associated with orthodox medical procedures.

While this period marked the end of a potentially powerful social alliance on AIDS, it is important to note that it also engendered a joint project with the newly-founded Treatment Action Campaign on medicines pricing. In 1997, Minister of Health Zuma-Dlamini challenged the Trade-related Aspects of Intellectual Property Rights and Services (TRIPS) agreement, a pillar in the mandate of the World Trade Organization, by amending the Medicines and Related Substances Control Act to enable South Africa to buy less expensive generic drugs (Nattrass 2007: 50). This development was accompanied by a call from the South African cabinet for a multi-sectoral approach to confronting the epidemic, partly in response to a lack of institutional capacity in the department of health. Thus the close of the transition period in South Africa marked the end of the alliances developed during the late apartheid period while pointing to new

paths forward for a constructive engagement with AIDS activists, non-governmental organizations and community associations.

Neoliberal Austerity and the Politics of AIDS Dissidence, 1998 – 2004

The 1998 – 2004 period in South Africa is one marked by the adoption of neoliberal macroeconomic policies, fiscally austere social spending and the emergence of Mbeki's discourse of AIDS dissidence. As has been noted in the previous chapter, this confluence of factors are best understood in terms of a dynamic, mutually constituting process that builds upon the history of the late apartheid era. This phase of South Africa's post-apartheid development must also be understood as part of the country's reintegration into a radically different global political economy than its African predecessors in the wave of decolonization in the 1960s. Out of the crucible of externally driven economic shocks and the looming threat of a trade sanctions for violating key tenets of the global trade regime emerged a fiscally austere South African state that did little to amend for the historical injustices wrought by the apartheid regime.

In this context the ANC was restricted by the inheritance of apartheid debt, the economic orthodoxy of the Washington Consensus, and the ability of unfettered finance capital to undermine the fragile politico-economic consensus that had emerged out of the transition through the threat of capital flight. In response to these external forces, the ANC took on the pricing system of international pharmaceutical corporations and subsequently espoused the ideology of AIDS dissidence. These events became part of a political platform that allowed the ANC to maintain national political sovereignty through the implementation of neoliberal reform while appealing to its core constituency

through appeals to nationalist sentiment and a critique of the unequal impact of neoliberal globalization on the global south.

In particular, this section builds on the work of Gevisser (2008), who points out the proximity of South Africa's implementation of neoliberal reform and Mbeki's dissident position on AIDS. In this analysis, Gevisser points out that Mbeki's adoption of the dissident position immediately follows the implementation of the Growth, Employment and Redistribution macroeconomic strategy (1996), which has been widely characterized as a home-grown structural adjustment policy, the East Asian financial crisis of 1998, and a counterattack from global pharmaceutical companies against the attempts by South Africa to secure access to generic drugs in contravention of the TRIPS agreement (Gevisser 2007: 740-1). As has been discussed in the previous chapter, this interpretation focuses more on Mbeki's personal politics while not paying sufficient attention as to why this dissident position was accepted within the ANC as a political platform. Nonetheless Gevisser's critical framing of this period is an important contribution that offers a valuable vantage point for understanding the ways that the ANC used the institutions of the South African state to limit international influence and the implementation of an orthodox public health response to the AIDS epidemic.

The onset of the era of neoliberalism and dissidence in AIDS politics opened with an alliance between the ANC-led hegemonic social bloc and the TAC-led counter-hegemonic social bloc on pharmaceutical pricing. In 1998 the South African government was sued by thirty-nine United States pharmaceutical corporations for violating the TRIPS agreement through the amendment of the Medicines and Related Substances Control Act. The pressure this case exerted on a South African government reeling from

currency crises in 1996 and 1998 was increased when the United States put South Africa on a watch list for potential sanctions and lodged a complaint with the World Trade Organization (Fassin 2007: 68). During the course of the court case in South Africa, United States Vice President Al Gore actively pressured President Thabo Mbeki to accept a deal for reduced pricing for anti-retroviral drugs in exchange for South Africa dropping its court case (Gevisser 2007: 739). Given this confluence of external forces, Minister of Health Nkosazana Dlamini-Zuma declared HIV/AIDS treatment to be too expensive for South Africa in October 1998 (Fassin 2007: 53). As has been noted by Fassin, this position on AIDS treatment mirrored that of international institutions such as the World Bank and UNAIDS at the time (Fassin 2007: 53).

As has been noted in the previous chapter, the Treatment Action Campaign (TAC) was formed in 1998 in response to the discovery of highly active anti-retroviral therapy in 1996 with the goal of making AIDS treatment available to people living with HIV/AIDS in South Africa. The TAC had begun as a campaign with the National Association of People Living with AIDS in Durban, and the two organizations had split over whether or not to receive funding from pharmaceutical corporations. The initial focus of the TAC was making the antiretroviral drug AZT available for the prevention of mother-to-child transmission of HIV. The organization strongly supported the reform of the Medicines Act and wrote an *amicus curiae* brief on behalf of the state in court proceedings (REF). Through a series of protests, the TAC sought to shame the U.S. pharmaceutical companies into lowering their prices for life-extending medication. This court case continued until April 2001 when the suit brought by the U.S. pharmaceutical companies was finally dropped. However the coalition between the ANC and the TAC

had already begun to splinter due to the emergence of the AIDS dissident position among ANC leaders as early as 1999.

The development of the AIDS dissident position began shortly after the ascension of Thabo Mbeki to the Presidency of South Africa and his appointment of Manto Tshabalala-Msimang to the post of Minister of Health. The critique of Western medicine and neo-imperial globalization that came to mark Mbeki's presidency arose out of a series of internet searches on the science and medical treatments developed to counter the debilitating effects of HIV/AIDS on the immune system (Nattrass 2007). According to this interpretation, when Mbeki encountered a dissident position within the scientific community on the underlying science upon which antiretroviral therapy depended, most notably with several US scientists such as David Rasnick who had legitimate scientific credentials. From this point, Mbeki began to lobby close members of the South African Cabinet and close allies in government to consider these alternative perspectives on the AIDS epidemic and the appropriate treatment to adopt for national public health policy.

A key point in this transformation of Mbeki's thinking about the AIDS epidemic and its significance as a symbol of broader global dynamics was the President's "I am an African" speech. This speech was significant as established a new politics of race in the post-apartheid era that was contingent upon the ruling party embracing racial identity and breaking with the policy of non-racialism that had served as an organizing principle for the African National Congress since the publication of the Freedom Charter in 1955. A second important event that marked a movement towards the ideology of AIDS dissidence was President Mbeki's public rebuke to the journalist Charlene Smith who had written a scathing article on rape in South Africa. In his response to this well-known

South African writer, Mbeki framed the perspective offered in the editorial as based upon Western conceptions of the African body as diseased and as typifying Africans as unable to control their sexual impulses. As such, Mbeki categorically denied the sexual violence exacted upon the bodies of South African women while also establishing the logic of AIDS dissidence as firmly based in a critique of Western medicine as emanating out of the legacy of racist colonial medicine. From this perspective, the international pharmaceutical industry was offering HIV/AIDS treatment as a means of profiting off of the suffering of African bodies much in the same fashion of the colonial apparatus did until the wave of independence movements liberated the majority of the continent in the 1950s and 1960s.

While the AIDS dissident position rejected what it viewed as colonial medicine, it also adopted positions on AIDS treatment that were being offered by international institutions that were dominated by Western interests. Prior to the development of a generic market for antiretroviral drugs, UNAIDS and the World Bank had characterized antiretroviral therapy as too expensive for emerging economies. This position was adopted by the African National Congress in response to the calls by AIDS activists for life-extending AIDS treatment to be made available in the public health sector. Among the voices that rose to reject this denial of human life, the economist Nicoli Nattrass effectively critiqued this position from the perspective of long-term costs to the economy (Nattrass and Geffen 2003). However this line of rejecting the orthodox science of HIV/AIDS and the treatment options that were developed from it began to fade as the economics of the argument were questioned. Rather, the AIDS dissident faction of the ANC increasingly turned to questions of the toxicity of antiretroviral therapy, the side-

effects of these drugs, the need for appropriate nutrition among poor and working class South Africans, and to the need for ‘African solutions’ to the epidemic in the form of traditional medicine.

Shortly after her appointment to the position of Minister of Health, Tshabalala-Msimang introduced a new dimension to the discourse of AIDS dissidence: the toxicity and potential side effects of antiretroviral drugs. Visiting a clinical trial of AZT in Uganda, Tshabalala-Msimang declared that no program using AZT for the prevention of mother-to-child transmission would be initiated in South Africa before the department of health had run its own trials (Fassin 2007: 54). President Mbeki echoed these sentiments during an address to the National Council of Provinces in 1999 when he questioned the toxicity of AZT and referenced pending court cases in the United States and United Kingdom (Fassin 2007: 54). Following the anti-colonial positioning that lay at the center of the AIDS dissident position, AZT was an attempt to continue to extract profits from the African continent while poisoning the bodies of former colonial subjects.

In contradistinction to the Western medical development of antiretroviral therapy, President Thabo Mbeki’s call for ‘African solutions’ to the epidemic underscored the extent to which traditional beliefs about medicine and health retain their significance in the post-apartheid era. Research on the size of the market for traditional medicine found that approximately 80% of Black South Africans utilized the services of traditional healers (Abdool Karim et al. 1992). Furthermore, the traditional healing sector constituted approximately R2.9 billion of the South African economy (approximately \$414 million US dollars) and had 29 million customers (Mandel et al. 2007: 189). As

South Africa has an approximate population of 50 million, well over half of the population interacts with the beliefs and practices of traditional medicine.

In a thorough analysis of traditional medicine in the KwaZulu-Natal province, Flint (2008) contextualizes the significance of this group of practitioners both historically and politically. For Flint, the political power held by traditional healers in pre-colonial societies is an oft overlooked but socially significant factor in post-apartheid South Africa. In this narrative, Flint describes the transition from a political and medical role in pre-modern Zulu society to an entrepreneurial force in the post-apartheid era. While this analysis provides a much-needed historical footing for anthropological research on traditional medicine in South Africa, the categorization of healers as primarily economic actors perhaps understates the significance of this group politically. On this point, the formal legal recognition of traditional healing as a medical practice by the South African government in 2004 points to the continued power of traditional political systems in the post-apartheid era.

The phenomenon of “AIDS dissidence” has raised important questions about the role of traditional belief systems and their role in the anthropological literature on AIDS in South Africa. The debates that arose on this topic grew out of the juxtaposition of traditional and modern beliefs, practices and political tendencies that were first broached by the Manchester School in Central Africa. From the work of Gluckman (1940) on the intertwining strands of traditional political systems and the development of the modern South African state to Mitchell (1956) on the continued relevance of traditional identity in urban areas, this body of scholarship overcame the ahistorical and atomized equilibrium model of culture put forth by the structural functionalist school of

anthropology. The theoretical precedents put forth by these scholars continue to be relevant for those analyzing the ways that Mbeki's nationalist and nativist portrayals of HIV/AIDS medicine and science interact with Black South Africans in the contemporary era.

Of the analyses put forward on the interaction of traditional beliefs and the politics of HIV/AIDS, Steinberg (2007) has offered perhaps the most nuanced and detailed ethnographic account. Focused on a series of interviews and longitudinal observation of a young Xhosa given the pseudonym Sizwe, Steinberg's ethnography offers a fascinating account of the ways that the growth of the HIV/AIDS epidemic in the midst of worsening rural poverty has set up formidable obstacles to traditional forms of African masculinity. In particular, HIV/AIDS and the inability to secure adequate work can prevent a man from paying *lobola*, or the brideprice that would secure his paternal rights over the children he fathers with his female partner. This is particularly significant as it is only with the full payment of *lobola* that a man's children would be recognized by his ancestors. Throughout Steinberg's conversations with Sizwe, the specter of long-term illness and the related inability to pay *lobola* to his wife's family served as a significant source of anxiety in Sizwe's life.

While Steinberg's analysis offers much in terms of fine-grained ethnographic detail on the ways that the social stigma surrounding HIV/AIDS is structured in terms of both modern and traditional belief systems, the analysis offered relies upon a dualistic conception of belief with the modern and traditional operating in separate spheres. This depiction largely duplicates one of the shortcomings of the Manchester School approach; that is, to continue to rely on a bounded concept of culture while pointing out the subtle

changes emerging out of increased urbanization and modernization in Africa. For Steinberg, it is the modernist conception of orthodox medical science that operates in diametric opposition to traditional modes of understanding the body and medicine.

In an analysis that incorporates the role of international donor funding in the analysis of HIV/AIDS, Susser (2009) analyzes the role of traditional political systems in post-apartheid South Africa and their role in the response to the HIV/AIDS epidemic. Rather than focus on beliefs and stigma, Susser insteads focuses on the way that Mbeki's ideology of AIDS dissidence serves to support the power of traditional leaders in South Africa's rural hinterlands. This political support is particularly important for the African National Congress as the country's new constitution granted autonomous political power for traditional leaders in designated geographic areas. As such, Susser argues that Mbeki's call for traditional leadership and solutions to the HIV/AIDS epidemic was an example of alliance-building between the ruling party and a powerful constituency group in South Africa. Susser's critical reading of the socio-political dynamics surrounding traditional medicine and authority in South Africa fuses the traditional and the modern through a reading of power dynamics.

However a critical point that is neglected in this juxtaposition of 'traditional' and Western conceptions of medicine, healing and the body is the role of community clinics in South Africa. Pioneered by Dr. Sidney Kark through the Pholela Community Clinic – which began in 1940 – the clinic system incorporated community members into the health care system in both rural areas and periurban townships (Susser 1993). Therefore, the ideas of Western medicine had been introduced and disseminated across South Africa prior to the Second World War, a point that the binaristic conception offered by Steinberg

overlooks. It is here that Susser's emphasis on the ways that women in South Africa have developed a practical and grounded understanding of medicine and the body through 'good sense' is particularly useful in overcoming the limitations of much of the literature on AIDS dissidence.

While both of these analyses offer important ways of understanding the relationship between the HIV/AIDS epidemic and traditional political and belief systems, they do not unpack the long history of pre-colonial traditional medical practices in South Africa outlined above. In addition, the reading of inter- or trans-national influences offered by both Steinberg and Susser can be characterized as uni-directional; orthodox science or culturally conservative norms are transmitted from the Global North to South Africa. While these elements are central to a nuanced perspective on the HIV/AIDS epidemic in South Africa, I argue that inadequate attention has been paid to the anti-colonial and anti-imperialist sentiments that animate Mbeki's conception of AIDS dissidence. Rather than simply a "nativist" or "nationalist" perspective on health and the globalization of medicine, Mbeki's AIDS doctrine builds upon the history of colonial medicine in South Africa, traditional identities and political systems, and a circumspect view of transnational institutions and power dynamics.

The debate over the toxicity of AZT and the role of Western medicine in South Africa's response to the HIV/AIDS epidemic came to a head when the National Department of Health intervened to curtail a pilot program initiated in the Western Cape. In 1998 the Western Cape government – under the political control of an alliance between the National Party and the Democratic Party – had established a pilot program to demonstrate the cost-effectiveness of preventing mother-to-child transmission of HIV. By

February 1999, the Western Cape department of health had tested nearly six hundred women for HIV and given AZT to ninety-six women who were close to giving birth (Fassin 2007: 53). The national department of health intervened to stop the ‘experimental program’ and Minister of Health Manto Tshabalala-Msimang called upon the Medicines Control Council to review the safety of AZT in the prevention of mother-to-child transmission in November 1999. Thus before the conclusion of the court case concerning pharmaceutical pricing, the ANC was using the jurisdictional hierarchy of national institutions to stop the use of antiretroviral drugs in public hospitals. This utilization of the institutions of the South African state by the ANC continued to intensify as the opposition to AIDS dissidence increased.

A key institutional dimension in the development of AIDS dissidence was the establishment of the Presidential Advisory Committee on HIV/AIDS. This committee was initiated in March 2000 and comprised of eminent HIV/AIDS experts from around the world and medical professionals espousing dissident views on the relationship between HIV and AIDS. While orthodox AIDS scientists found the process to be demeaning, it was an opportunity for AIDS dissidents to formalize their views in official state documentation (Susser 2009). This was accomplished with the publication of the Presidential AIDS Advisory Panel Report (2001), which established that the panel comprised of international experts included members who did not see a causal link between HIV and AIDS. This provided President Mbeki and Minister of Health Manto Tshabalala-Msimang with the opportunity to further assert that antiretroviral drugs were toxic and to emphasize proper nutrition as an ‘African solution’ to an epidemic that was causally linked to poverty. In this case, the occupancy of the office of the Presidency

enabled elements of the ANC to establish an institutional mechanism that furthered a scientifically questionable viewpoint on HIV/AIDS.

The publication of this report contradicted the increasingly pointed attempts by a coalition of AIDS activists, health practitioners, and scientists from South African and around the world to counteract the AIDS dissident position. The formation of this international coalition was driven by the TAC and its work with organizations founded during the height of the AIDS movement in North American and Europe, such as HealthGap and Act Up (Grebe 2008). Through these international networks of AIDS activists, the TAC was able to organize a march of 5,000 people at the International AIDS Conference held in Durban, South Africa (Geffen 2010: 54). The import of this protest action was reinforced when the president of the South African Medical Research Council, Dr. Malegapuru William Makgoba, gave a presentation at the conference that pointed to the growing impact of the AIDS epidemic on mortality rates in South Africa (Fassin 2007: 63). These events were contrasted by Mbeki's presentation at the conference, which pointed to poverty as the cause of AIDS and did not once mention the HI virus. The conference closed with the drafting of the "Durban Declaration", which was turned into a petition and signed by more than 5,000 physicians and researchers. This letter unequivocally asserted that HIV caused AIDS and was later published in the prestigious scientific journal *Nature* (Fassin 2007: 36, The Durban Declaration 2000). The International AIDS Conference was a seminal event in the formation of the TAC-led counter-hegemonic alliance, and one that depended heavily on international support, a theme that was to continue throughout the political struggle over AIDS during Mbeki's administration.

While the counter-hegemonic alliance drew strength from its ties with international activists and institutions, the ANC increasingly relied on the institutions of the South African government to limit the influence of this growing coalition. In the aftermath of the International AIDS Conference, Statistics South Africa critiqued Makgoba's utilization of apartheid-era statistics as a point of comparative analysis and Mbeki retorted by characterizing the institution as "irresponsible" (Fassin 2007: 64). The furor of the ANC leadership over the mortality statistics continued with an attempt by the Minister of Health to block the publication of a complete report on the impact of AIDS on mortality rates in 2001. This development, along with Makgoba's unrelenting assertion of the scientific basis of AIDS, led to the dismissal of Makgoba as President of the Medical Research Council and the appointment of Anthony Mbewu, a close Mbeki ally who supported his views on HIV/AIDS (Geffen 2010: 129). As such, the Durban Declaration enabled the TAC-led counter-hegemonic alliance to further develop its international network of support while it also provided the basis for the ANC to exert control over an important national institution.

The action to remove an obstinate opponent of AIDS dissidence from the top medical research body in South Africa was closely followed by the announcement that the South Africa government would not make the antiretroviral drug nevirapine available for the prevention of mother-to-child transmission of HIV. This announcement in April 2001 came despite the fact that the pharmaceutical company Boehringer Ingelheim had been offering the same drug to developing countries free of charge since late 2000. Building on the momentum of this victory for providing antiretroviral drugs at affordable prices, the TAC focused on making nevirapine available free of charge in the South

African public health system. Following their call for worldwide protests against the Pharmaceutical Manufacturers Association in March 2001, the body dropped their case against the South African government for their attempt to access generic drugs in April 2001. It was after the court case was dropped that the ANC made the announcement that nevirapine would not be made available in South Africa.

This decision fundamentally changed the dynamics of AIDS politics in South Africa, as it irrevocably split the ANC-TAC alliance initially formed against pharmaceutical drug pricing and led to a new phase of intensified conflict over the provision of AIDS treatment. The ANC's decision to not allow the use of free nevirapine for the prevention of mother-to-child transmission of HIV led to the expansion of the TAC-led counter-hegemonic alliance to include members of the ruling party and the tri-partite alliance. It also led to a series of court cases wherein the TAC-led counter-hegemonic alliance utilized the judicial branch of government to pressure the ruling party into the provision of AIDS treatment in South Africa.

By taking the ANC-led government to court to provide nevirapine, the TAC created divisions within the ruling party and its key alliance partner, the Congress of South African Trade Unions (COSATU). The TAC, along with its partner organization the AIDS Law Project, filed a case in the Pretoria High Court that it won in December 2001. While the ANC appealed the ruling and the case was brought to the Constitutional Court, the highest legal body in South Africa, the ruling party relented and Minister of Health Tshabalala-Msimang announced that antiretroviral drugs would be made available in the public health sector in April 2002. In July 2002, the Constitutional Court ruled in favor of the counter-hegemonic alliance, and nevirapine was adopted as part of the

government's response to the AIDS epidemic. Particularly significant in this victory was the support the TAC received from COSATU, an organization that constitutes part of the ruling tri-partite alliance.

This partnership had been cultivated by Mark Heywood, a senior figure in the Aids Law Project, who had begun conversations with labor leaders during discussions at the National Economic Development and Labor Council (Geffen 2010: 62). This alliance allowed for greater acceptance of the TAC's fight for AIDS treatment among members of the ANC and began a process of isolating President Mbeki and Minister of Health Tshabalala-Msimang within the party (Geffen 2010: 58). The TAC was able to secure the support of COSATU due to the ANC's unilateral implementation of the neoliberal policies and the negative effect of these policies on COSATU's members. This victory also emboldened the political opposition in South Africa, with the provincial government of the Western Cape partnering with Médecins sans Frontières and the Treatment Action Campaign in piloting the distribution of antiretroviral drugs in low-resource settings in the township of Khayelitsha.

From the perspective of an institutional analysis, the political struggle over nevaripine is quite significant for the political dynamics that ensued in the period leading up to Mbeki's recall as President of South Africa in 2008. The TAC-led counter-hegemonic alliance's legal victory was achieved by developing partnerships within the tri-partite alliance while also utilizing the legal expertise of its coalition partners to fight the government's intransigence on implementing orthodox AIDS treatment in the public sector. This victory presaged Thabo Mbeki's withdrawal from the "debate" over HIV/AIDS in March 2002 and the South African cabinet's decision to break with the

President by publicly announcing that HIV causes AIDS in May 2002. While some analysts have pointed to this event as a sign of democratic processes with the ruling party, perhaps more significantly this decision concretized the fissures within the ANC on AIDS dissidence as a formal government position (Butler 2005).

As senior members of the ruling party began to turn against the AIDS dissident position, Mbeki and Tshabalala-Msimang decentralized the messaging of their heterodox views on AIDS and emphasized nutrition as appropriate AIDS treatment. Mbeki's abandonment of the AIDS dissident debate, at least publicly, coincided with the circulation of the "Castro Hlongwane" document. This document, which has been broadly attributed to Mbeki's hand, elaborated the AIDS dissident position at length, underlining the greed of Western pharmaceuticals and the continuities between colonial medicine and AIDS treatment. The Castro Hlongwane document was distributed to ANC branches after an ANC National Executive Committee meeting on March 15 – 17, 2002. Minister of Health Tshabalala-Msimang increasingly stressed proper nutrition as a homeopathic alternative to antiretroviral therapy. Food items such as garlic, lemon, beetroot and African potato were touted for their beneficial health properties by the Minister of Health, leading to the popular political satirist Zapiro to parody her as "Dr. Beetroot" in popular newspapers.

While Mbeki and Tshabalala-Msimang took their fight to the local branches of the ANC with a new focus on nutrition, the department of health acted slowly in making nevirapine available in the public sector. Thus, while the TAC had scored a legal victory in the nevirapine case, the institutional control of the department of health by factions supportive of the AIDS dissident position limited the significance of this event. Impelled

by the victory on nevirapine and frustrated by the slow action on implementation, the TAC planned a series of civil disobedience protest actions to draw attention to the inaction of the ruling party. The TAC-led counter-hegemonic alliance was also motivated by government intransigence on the drafting of a comprehensive AIDS treatment program. On World AIDS Day in 2002, senior AIDS Law Project member Mark Heywood had announced a deal had been reached on such a policy, however the ANC denied that an agreement had been reached and senior business leaders sided with the ruling party (Geffen 2010: 62). As such, the civil disobedience strategy taken by the TAC was not necessarily out of line with their attempts to manipulate factions with the tripartite alliance and the ruling party to achieve AIDS treatment. It could easily be characterized as an effective negotiation tool that was used to leverage the ANC into the formal adoption of an AIDS policy that included antiretroviral therapy.

The success of the TAC's civil disobedience campaign in November 2003 led to the adoption of a comprehensive AIDS plan that included antiretroviral treatment. This was accomplished by the TAC pressuring the ANC-led government through a series of protests that led to the TAC-led counter-hegemonic coalition working with a moderate faction of the ANC led by then Deputy President Jacob Zuma. During this campaign the TAC leadership received the support of former President Nelson Mandela and organized a march on parliament that numbered between ten- and fifteen-thousand people (Geffen 2010: 63). While the major trade unions participated in this protest action including COSATU and FEDUSA, their support waned as the TAC's civil disobedience campaign intensified (Geffen 2010: 64). The TAC led several marches to police stations where they demanded the arrests of the Minister of Health and other leading ANC figures for culpable

homicide (Geffen 2010: 64). Acting as an intermediary between the TAC and the government, then Deputy President Zuma met with TAC leadership and promised to commit the government to the implementation of a treatment plan if the TAC ended their campaign (Geffen 2010: 68). Zuma and the moderate elements in the ANC kept their promise with the South African cabinet instructing the Department of Health to draft a plan for rolling out treatment in August 2003.

With this decision, the TAC had pressured the ANC-led government to providing life-extending AIDS treatment in the public health sector, a significant victory for the counter-hegemonic social bloc. The manner in which this was accomplished, using mass demonstrations to exert public pressure on the government and working with elements within the ruling alliance, was a strategy that continued throughout the remaining term of Mbeki's administration. This tactic undermined the ability of Mbeki to utilize senior party structures, but it did not limit the ability of the Ministry of Health or Provincial-level political actors to act against the counter-hegemonic alliance. As factions within the ANC turned against Mbeki and the Minister of Health, the way in which the hegemonic social bloc approached the political struggle over HIV/AIDS increasingly centered on the intransigence of the administration of the Department of Health and a decentralized network of non-governmental organizations to counteract the influence of the TAC-led counter-hegemonic alliance. The dynamics that resulted from the 1998 – 2004 era are critical for an in-depth understanding of the challenges faced by the counter-hegemonic alliance during my fieldwork.

The Decentralization of AIDS Dissidence, 2004 - 2008

During the 2004 – 2008 period, the TAC and its allies faced continued resistance from the Ministry of Health despite renewed international support and a joint government-civil society institutional mechanism for overseeing the provision of AIDS treatment. Despite the success of the counter-hegemonic alliance in pressuring the government to adopt an orthodox AIDS treatment policy, this period opened with the Department of Health initiating patients on treatment at a rate far below what the policy had called for. This process repeated itself during my fieldwork with the National Strategic Plan for HIV/AIDS and STIs (2007 – 2011). Despite the two hegemonic blocs having negotiated and adopted a new AIDS policy, a shortage of financial resources together with control over the Ministry of Health by AIDS dissident Manto Tshabalala-Msimang led to delays in the implementation of this policy. This process was further exacerbated by the systematic undermining of the newly re-structured National AIDS Council by the national Department of Health. Both processes operated to limit the influence of international donors in supporting the counter-hegemonic alliance.

As the Department of Health moved slowly to implement the comprehensive AIDS treatment policy, the counter-hegemonic alliance began to further build their social bloc amongst non-governmental organizations. By March 2004 the Department of Health had initiated only 2,500 patients on antiretroviral therapy, leading to the TAC and AIDS Law Project to threaten legal action to force implementation. The TAC-led counter-hegemonic alliance also formed the Joint Civil Society Monitoring Forum to pressure the government to speed up the slow accreditation process that the Department of Health pointed to as the factor for slowing down implementation (Geffen 2010: 70). With the April 2004 national elections looming, the legal pressure applied by the counter-

hegemonic alliance was effective as the Ministry of Health relented and agreed to purchase antiretroviral drugs on March 17 (Geffen 2010: 69).

As the ruling party continued to cede ground in the sphere of formal institutions as a result of legal pressure, the AIDS dissident faction shifted its focus to non-governmental organizations and actors. In particular, several ANC figures in influential positions begin to strengthen their ties with organizations such as the National Association of People Living with AIDS (Napwa), the South African National Civics Association (SANCO), and with the German vitamin salesman Dr. Mattias Rath. In March of 2004, the president of the Medical Research Council, Anthony Mbewu, began to meet with Rath and suggested building ties with Napwa to “counterattack” against the TAC-led counter-hegemonic alliance (Geffen 2010: 129). It should be noted that this meeting coincided with the government ceding the fight on the inclusion of antiretroviral therapy in the public health sector to the counter-hegemonic alliance. It is also significant to note that it was Mbewu who had replaced Magkoba as president of the Medical Research Council in 2001 after Magkoba had sided with the counter-hegemonic alliance on AIDS treatment. It is here that one can begin to see the central role that the ANC’s institutional control of the South African state has played in the dissemination of AIDS dissidence.

Following Mbewu’s suggestion, Dr. Mattias Rath’s Rath Foundation had begun building ties with Napwa and Sanco to begin distribution of his micronutrient-based regime as an alternative AIDS treatment in 2005. Furthermore, the Rath Foundation signed a memorandum of understanding with the Traditional Healer’s Organization in 2004 that committed the two parties to a “strategic alliance” to support the government in

its fight against the global pharmaceutical industry (Geffen 2010: 136). The Rath Foundation began distributing its vitamins and circulating pamphlets in the counter-hegemonic stronghold of Khayelitsha in early 2005 through Sanco's branch office (Geffen 2010: 142). Sanco, which was the pre-eminent organization in South Africa's black townships during the anti-apartheid struggle, staffed Rath's clinics and recruited patients to undergo the untested vitamin regime (Geffen 2010: 142). While the premature deaths of patients due to a change in their AIDS treatment from antiretroviral therapy to vitamins is a social effect of AIDS dissidence which cannot be underestimated, the import of the alliance between the non-governmental organizations and the ANC is also significant.

The coalition between the Rath Foundation and Sanco in Khayelitsha led to participants in the vitamin-based alternative AIDS therapy serving as the basis for an illegal clinical trial for Rath's vitamin therapy. While this action led to the TAC taking legal action against the Rath Foundation and the Western Cape Department of Health, it did not prevent two AIDS dissident researchers from presenting the findings of the illegal clinical study to provincial ministers and the national Minister of Health at the National Health Council in September 2005 (Geffen 2010: 144). The cooperation of government officials in Rath's actions was further confirmed when the leadership of the Department of Health ordered its Law Enforcement Unit off of an of investigation of the Rath Foundation's actions in Khayelitsha, which had been started after the TAC filed a complaint with the Department of Health to investigate (Geffen 2010). The ANC's implicit support for Rath's actions was further evidenced when the Director General of Health, Thami Mseleku, ordered the release of a shipment of Rath's vitamins which had

been seized by port officials (Geffen 2010: 145). However the ANC's support was not limited solely to the untested AIDS therapies offered by Rath, as the Department of Health had also defended the folk AIDS remedy Ubhejane by calling for it to be scientifically tested as an AIDS treatment in February 2006. While the linkages between the ANC and these non-governmental organizations and actors remain blurred, these organizations operated in concert as part of a loosely defined hegemonic alliance that operated to counteract the influence of the TAC-led counter-hegemonic alliance in the predominantly black South African townships.

It is for this reason that the growing use of race in the discourse of AIDS dissidence is significant to note in this period. Growing out of the increasingly vociferous conflict between the two hegemonic factions, the Minister of Health and Napwa began to characterize the leadership of the counter-hegemonic alliance in racial terms (Fassin 2007: 111). At a 2004 meeting of the AIDS Consortium, Napwa leaders had hurled racial insults at Mark Heywood, a white leader of the counter-hegemonic alliance, and physically threatened members of the TAC (Fassin 2007: 174). This turn towards using race as a means of distancing the counter-hegemonic alliance – now identified as 'white' – from the ANC's core constituencies in the black townships can be seen as emanating from the nationalist principles that had come to constitute the core of the AIDS dissident position. However, from an institutional standpoint it is also a broadening of the organizational profile of the AIDS dissident faction from within the ANC to a broader social and geographical base. This dispersion outside of the organizational base of the ANC is highly significant for the politics of AIDS in the township of Khayelitsha, an issue that will be returned to in chapter 6.

While the hegemonic alliance disseminating the AIDS dissident position became more decentralized through its collaboration with non-governmental organizations, the TAC-led counter-hegemonic alliance increasingly turned its focus to working within the state apparatus. After having been re-elected as the President of South Africa in 2004, Mbeki had named Nozizwe Madlala-Routledge as the Deputy Minister of Health. A member of the Communist Party with a history of social activism, Madlala-Routledge began holding meetings with TAC leaders upon her appointment to the position. As initial progress was made in developing a relationship within the institution that had previously served as a key roadblock in the implementation of the comprehensive AIDS policy, the ANC leadership and the Minister of Health blocked Madlala-Routledge from holding further meetings with TAC leaders (Geffen 2010: 71). The ANC continued to use its institutional position of power to block leading members of the TAC from attending state activities, including the United Nations Special Assembly on AIDS in May 2006. This action garnered further international support to the TAC-led counter-hegemonic alliance despite the ANC's attempts to limit the influence of international forces on internal political dynamics. Blocking the TAC from attending the conference proved to be a foolhardy decision by AIDS dissidents within the ANC as it led to Deputy President Phumzile Mlambo-Ngcuka to become involved with the political struggle between the Department of Health and the TAC (Geffen 2010: 71-2). The emergence of a powerful TAC ally in the Deputy President led to the drafting and approval of a new national AIDS plan and concrete targets on the implementation of orthodox AIDS treatment in South Africa.

The working relationship between the Deputy President and the TAC-led counter hegemonic alliance strengthened in the aftermath of the International AIDS Conference held in Toronto in 2006. At this conference, the South African delegation displayed garlic, lemon and beetroot as part of their treatment program. The dismissal of Minister of Health Tshablala-Msimang was demanded by Mark Heywood and Stephen Lewis, the head of UNAIDS, who lashed out in a plenary address towards the South African government for their display. Needless to say, the conference marked a high point in the counter-hegemonic alliance's standing in international circles and a new low point for the ANC. This series of events underscores the significance of international support in the success of the TAC-led counter-hegemonic coalition and the way in which this solidarity allowed the movement to score major political victories on AIDS policy within South Africa.

Following the conference, Deputy President Mlambo-Ngcuka came forward to publicly identify AIDS as a major cause of death in South Africa and welcomed talks with AIDS activists Heywood and Sipho Mthathi, then General Secretary of the TAC (Geffen 2010: 73). The opening dialogue was facilitated when Minister of Health Tshabalala-Msimang left office to go on sick leave for undisclosed reasons. According to TAC leader Nathan Geffen:

Tshabalala-Msimang's absence gave Mthathi and Heywood the space to negotiate the NSP with Department of Health officials. This had the Deputy President's blessing and Madlala-Routledge's behind-the-scenes support. Teams of HIV experts in epidemiology, treatment and prevention as well as economists worked on the technical aspects of the plan. For once, civil society was working with government on Aids (Geffen 2010: 74).

While Minister of Transport Jeff Radebe was asked to stand in for Tshabalala-Msimang as acting Minister of Health in February 2007, the Deputy Minister of Health Madlala-Routledge was able to work with TAC leaders on drafting the broad parameters of a new national AIDS program. During these discussions, the ANC agreed to negotiate a new national AIDS plan that went on to become the National Strategic Plan for HIV/AIDS and STIs (2007-2011).

This was a time of great optimism in South Africa amongst AIDS activists. The Minister of Health, who had been the primary obstacle for the implementation of an orthodox response to the epidemic, was out of the picture. The deputy Minister of Health, Nozizwe Madlala-Routledge, was now working hand in hand with AIDS activists, health professionals and researchers on a new national AIDS policy with the support of the Deputy President. As a result, the process of drafting the National Strategic Plan came together quickly with government officials working with activists and professionals productively, something that many of my research participants looked back on wistfully. In April a large meeting was held in Johannesburg to adopt the National Strategic Plan and in May the South African cabinet approved the plan. The National Strategic Plan was something for which the counter-hegemonic alliance had fought for nearly a decade: a comprehensive AIDS treatment and prevention policy with hard target against which the government could be held accountable. This was particularly important given the intransigence of the Department of Health on implementing the first comprehensive AIDS plan (2003).

Another important dimension of this period of détente in South African AIDS politics was the restructuring of the South African National AIDS Council (SANAC).

This institution had existed since 2002 but had been ineffectual due to the relatively peripheral role played by non-governmental representatives. Two separate research participants had relayed stories of how Mark Heywood, then a representative on the council, had been shouted down in one SANAC meeting for contradicting government policy on AIDS by senior ANC party members, including the Minister of Health. However with Deputy President Mlambo-Ngcuka leading negotiations, SANAC was transformed into a joint civil society-government institution that would oversee the implementation of the National Strategic Plan and advise the South African cabinet on developments in AIDS treatment to inform South African AIDS policy. The restructured SANAC created a formal institutional space for the counter-hegemonic alliance to ensure that the South African government could no longer drag its feet on implementation and fulfill the promise of the National Strategic Plan to extend the lives of people living with HIV and limit the spread of the virus.

While it displayed great promise, this period of productive interaction between the government alliance and the TAC-led counter-hegemonic alliance did not last. Just as I arrived in South Africa in June 2007, Minister of Health Manto Tshabalala-Msimang returned from sick leave. Thus the political atmosphere that I encountered was one that could be best characterized as uncertain and anxious. Although I had received word that the Minister's return might possibly happen, I had not been fully prepared for the feeling of disillusionment amongst AIDS activists who feared the worst: a return to the politics of an era they thought had passed. Unfortunately, these fears were well founded, and the return of the Minister of Health brought the implementation process for the National

Strategic Plan to a halt and opened up a new era in the political struggle surrounding AIDS in South Africa.

Conclusion

During the 1998-2008 period, the political dynamics surrounding the HIV/AIDS epidemic transformed in several ways that were decisive for the political terrain within which I conducted my fieldwork. The first major event was the elaboration of the AIDS dissident position by high-ranking members of the ruling party, including the President, the Minister of Health and the Director General of Health. This series of events led to the formation of a counter-hegemonic AIDS alliance led by former anti-apartheid activists, that challenged the lack of AIDS treatment availability in the public health sector through a series of legal challenges against the South African government and international pharmaceutical companies. As this counter-hegemonic alliance won several high-profile legal cases at the national level, forcing the hand of government to begin distributing antiretroviral therapy within the public health sector, it also leveraged fissures within the governing alliance to negotiate for the restructuring of the highest national body coordinating AIDS policy.

As the counter-hegemonic alliance infiltrated the institutions of the South African state to force through a transformation of the public health response to the HIV/AIDS epidemic, the ruling party in turn began to cultivate links with provincial and local organizations to disseminate the message of AIDS dissidence. Through provincial Ministers of Health in provinces such as KwaZulu-Natal and Mpumalanga and alliances with organizations such as the South African National Civics Associations and the Rath

Foundation, the ruling party circumvented the efforts of the counter-hegemonic alliance by spreading the ideas of alternative therapies through para-state channels. These dynamics focused the political struggle over HIV/AIDS in South Africa's townships, where the ruling party and its political allies from the anti-apartheid movement maintained political hegemony and where the organizations of anti-hegemonic alliance had only arrived relatively recently.

Despite this decentralized focus on local and provincial political process in the ANC-led hegemonic alliance, the national scale remained an arena for active negotiations between the two factions. As has been discussed above, transnational political influence played a central role in the form and character that these political dynamics took during my fieldwork. In the following chapter, I will discuss these dynamics through an analysis of the ways in which the ruling party has transformed the interaction of national institutions with transnational political and economic influences, including the National AIDS Council, and offer insight into the institutional dynamics of this institution through interviews with several of its delegates. As has been emphasized thus far, the institutional legacy of late apartheid is central to a clear understanding of how, and why, particular outcomes were reached at the national level relative to South African HIV/AIDS policy.

Chapter 3

Negotiating Silences, Confronting Barriers: Examining the Institutional Dynamics of HIV/AIDS Politics at the National Scale

One of the most challenging experiences of my fieldwork did not come from my interactions with people living with the negative side effects of the HIV/AIDS epidemic in the midst of grinding poverty in South Africa's townships. These interactions, which brought the social, material and personal consequences of apartheid's legacy and AIDS dissidence into sharp focus, normalized over time as part of everyday life in South Africa's townships during the Mbeki administration. What perturbed me so, what led me to ask searching questions about my research and its role in the politics of AIDS in South Africa, was not an event or an interaction. Rather, it was a political cartoon, a social commentary on Mbeki's legacy on HIV/AIDS that provoked a reaction that was to focus my research on the institutional dynamics of the public health response to the HIV/AIDS epidemic at the national level.

I woke early on the morning of December 1, 2007, planning to attend multiple events that I would attend in order to properly account for the breadth of political activity produced by the AIDS movement in the greater Cape metropolitan area. Coming of age in the United States after the period of intense AIDS activism in the 1980s, World AIDS Day had always been an event that had been marked by ribbons, courteous little bows that indicate a loose awareness of AIDS and its impact on our society. But in South Africa, the day brought with a sense of urgency given the scale of the epidemic, and I

was caught up in this sense of urgency, anxiously going to a café around 7am as I waited for the morning's events to begin. I picked up that morning's Weekend Argus and went to a café in Muizenberg, one of Cape Town's southern suburbs. For an early morning, the café was surprisingly full, so I sat at a counter that ran the width of the restaurant. I paged through the paper, turning to the editorial page first to see which one South Africa's political satirists had offered the most cutting analysis of the South African response to the HIV/AIDS epidemic. What I saw that morning caused my stomach to turn and forced me to confront questions that, up until that point, I had managed to avoid.

Figure 2



Source: Brandon. 2007. Wobbly Legacy. Weekend Argus 1 Dec 2007.

Out of all the possible scenarios that I had imagined for critiquing the failed AIDS policies of Thabo Mbeki, I had never thought that anyone would depict the sitting President of the Republic of South Africa being hung by his neck. Undoubtedly this

belief is conditioned by the particular history of lynching in the United States, as it was a tool for maintaining the strict racial segregation of the Jim Crow system through systematic violence against people of African descent. Due to the different national and racial history that I had experienced as a white male growing up in the United States, this visual imagery produced in me an immediate physical effect. I felt the hairs on the back of my neck stand on end and the blood churn through my veins as I placed the paper down on the counter. I turned and looked around the room, looking for what, I could not tell you. But in doing so I noticed that the woman sitting next to me at the counter was also reading the Weekend Argus.

A white South African woman in the early fifties, she was sitting with her white husband of the same age and they both quietly read different sections of the paper. I began to watch her as she flipped the pages of the Argus, counting down to the moment she would turn to the editorial page and see the image that had shaken me to my core. I was tense with anticipation when she turned to the page featuring the image of Mbeki hanging by his neck from a red AIDS ribbon, and shot through with pangs of disappointment when, without batting an eye, she turned to the next page. In retrospect, I understand now that I needed for her to throw the paper down in disgust, to reject the symbolic violence of this imagery so that I allow myself to let go of my feelings of disbelief and shock by sharing them with another person. In this instance, as in so many others in the field, the ethnographer is left alone to battle with their own set of predispositions amidst a sea of cultural and historical difference.

I left the coffee shop shortly thereafter, trying to make sense of the meaning of the political satire pictured above. The image of Thabo Mbeki, an icon of the anti-apartheid

struggle, hanging by his neck would not leave my mind. Of the range of emotions I felt that morning, those which stung me most intensely were that of guilt and apprehension. It is my reading of this image that the illustrator's intention was to point out that Mbeki's legacy was tarnished by the human impact of his AIDS dissident position. But what I thought upon seeing this image was no one is lynched without a mob, that lynching is an inherently social act, and that by situating myself alongside AIDS activists that critiqued the Mbeki's administration and its AIDS policy, that I was a part of this lynch mob.

What had begun as a day of activity and action quickly morphed into a moment of self-reflection as I was besieged by a flurry of questions: how could it be that this image was published in a major newspaper? To what extent did my research support images of this kind by joining the chorus of activists, journalists and academics that condemned the Mbeki position on AIDS? Was it possible to adapt my research approach so as to not operate within the political dynamic that had produced this imagery? In the days and weeks that followed, I scoured the media searching for evidence of outrage to match my own feelings. I found nothing. Perhaps this was due to the looming ANC National Conference later that month and the fact that the ANC base had positioned itself behind Zuma and the party would no longer defend Mbeki's position on AIDS. But the cartoon passed without notice in the press coverage that followed World AIDS Day. And when I asked South Africans about the cartoon in the course of everyday interactions and relative to the politics of HIV/AIDS, no one seemed bothered by the images that had been so shocking to me.

The banality of this imagery to South Africans both points to the central role of race in post-apartheid society and depicts the normalization of the divisive politics of

HIV/AIDS. This environment of open hostility between the AIDS movement, the ruling party, and an encampment between the organizations and constituencies aligned with each political bloc, bled into everyday life in South Africa. From cartoons in newspapers to charges of genocide towards leading members of the ruling party, my fieldwork on the politics of AIDS in South Africa during this time involved wading into an active battlefield of political combat.

An important aspect of this process was the extent to which government officials at the national level had closed ranks behind the political line of party leadership. Despite the looming succession battle, there was no open discussion of the HIV/AIDS epidemic from government officials, particularly after the dismissal of Deputy Minister of Health Nozizwe Madlala-Routledge. One of the consequences of this political environment was that the narratives produced on the epidemic primarily drew from their information from the HIV/AIDS movement rather than from members of the African National Congress. While this was not a complete surprise, the extent to which my efforts at meeting with members of the ruling party to discuss HIV/AIDS policies were stymied was nonetheless quite challenging to deal with as a researcher. However this closure of open discussion is an important aspect of the epidemic, and particularly the academic narratives that were compiled during the era of Mbeki's political power.

The dynamics of the national political scale in South Africa has served as the primary point of analysis for scholars of the HIV/AIDS epidemic. The primary reason for this is that AIDS activists and organizations have targeted their campaigns at the level of national policy. Furthermore, the AIDS dissident position emanated from members of the African National Congress in high-ranking leadership positions in national government

such as the Minister of Health and the President of the country. As such, the towering heights of government and the angry confrontations between AIDS activists and government officials served as the starting point for analyses of how and why the politics of AIDS in South Africa had gone in such an unanticipated direction.

The work of Nattrass (2004, 2007) focuses primarily on the political dynamics of HIV/AIDS at the national level. From an economic critique of the government officials who claimed that that antiretroviral therapy was too expensive to a thorough political history of the politics of HIV/AIDS during the Mbeki era, Nattrass' work offers the starting point for any scholar interested in South African AIDS epidemic. While Nattrass' work covers the vast majority of the Mbeki era, it does not include the final chapter of the AIDS policies of the Mbeki administration – namely the implementation of the National Strategic Plan by the re-structured National AIDS Council. This is a critical omission as this period was the culmination of nearly a decade of political struggle between the AIDS movement and the AIDS dissident faction of the African National Congress.

Fassin (2007) also offers an overview and analysis of the political dynamics of HIV/AIDS at the national level in South Africa. While the discussion of events, actors and organizations overlaps with the narrative put forth by Nattrass (2007), the analysis offered by Fassin differs significantly with the emphasis on how South Africa's history of racial inequality figures into the AIDS dissident position. The historical emphasis put forth by Fassin is an important contribution to the analysis of AIDS politics in the post-apartheid era, particularly with respect to the detailed reading of the ways that race figures into the public statements made on the topic of AIDS by the central figures of the AIDS dissident faction in the African National Congress. Fassin uses the public

statements of these government officials as the basis for his analysis, but does not investigate the extent to which the obfuscating statements on HIV/AIDS put forth by state officials affected the functioning of state institutions. Thus the analysis of national politics offered by Fassin is primarily focused on discourse rather than the actions of organizations or individuals.

In the area of national HIV/AIDS policy processes, Helen Schneider has brought a perspective from public health to the narratives provided by anthropologists. In an analysis of the National Aids Plan (1994), Schneider and Stein (1997) underscore the difficulties faced by the Department of Health due to the restructuring of state institutions following the negotiated political transition. This analysis also points to the disintegration of the alliance between public health professionals, non-governmental organizations, AIDS activists and government officials that followed the mismanagement of funds with the Sarafina and Virodene scandals (these will be discussed later in the chapter). Schneider (2002) also contributed a clear analysis of the key role played by the labor movement in the ‘cabinet revolt’ that led to the availability of antiretroviral drugs in the South African public health sector. However by identifying this as a political struggle ‘within the state’, Schneider gives little weight to the central role played by the AIDS movement in fomenting this process.

Susser’s (2009) analysis of national policy processes diverges from these perspectives by focusing upon the process through which traditional healers were formally recognized by the state. For Susser, this shift is critical as it serves to legitimize the ‘African solutions’ called for by the AIDS dissident position while also mobilizing a powerful political constituency for the African National Congress – traditional leaders.

This is a critical contribution for the periodization of HIV/AIDS politics and for the development of political ties between the ruling party and traditional leadership in South Africa.

In addition to this analysis, Susser emphasizes the international network of activism that the South African HIV/AIDS movement tapped into in order to pressure the South African government to provide antiretroviral therapy in the public health sector. From the ties with the U.S. based AIDS movement ACT-UP to the utilization of the International AIDS Meetings as a platform to amplify criticism of South Africa's HIV/AIDS policies, the transnational political scale was a central aspect of this period that Susser emphasizes in her work. While the anthropological work of Steinberg (2007) offers much in terms of in-depth ethnographic analysis, the vagaries of national policy processes do not figure centrally in this narrative.

The contribution that this chapter offers to the anthropological literature on the South African HIV/AIDS epidemic is an analysis of the day-to-day dynamics of national AIDS politics as they unfolded in the National AIDS Council. This period in the history of the politics of AIDS in South Africa is critical for an understanding of the extent to which AIDS dissidence affected the functioning of national institutions in government. As discussed in the Introduction to this work, it was during the period that I conducted field research that noted AIDS dissident Minister of Health Manto Tshabalala-Msimang returned to office. As was noted to me by several AIDS activists and members of non-governmental organizations, the return of Tshabalala-Msimang marked a sharp turn away from the spirit of cooperation that had marked the development of the National Strategic Plan. A key element of the political process surrounding the National Strategic Plan was

the establishment of the National AIDS Council as the institution to oversee and ensure policy implementation. As such, I conducted an in-depth ethnographic analysis of the South African National AIDS Council. I interviewed civil society delegates to this joint government-civil society institution to ascertain how government officials interacted with them during this period. In other words, this chapter offers an ethnographic analysis of how government intransigence on HIV/AIDS operated on a day-to-day level.

Furthermore, this chapter offers a detailed institutional analysis of the way that the National AIDS council was structured. What emerged as central during the course of my discussions with civil society delegates was that notable figures within the AIDS dissident faction of the African National Congress occupied positions of institutional control within the National AIDS Council. The most notable example of this phenomenon was the fundraising arm of the National AIDS Council, the Resource Mobilization Committee, which was chaired by the noted AIDS dissident and National Minister of Health, Manto Tshablala-Msimang. As such, the chapter contributes an ethnographic analysis of how the politics of AIDS dissidence led to particular institutional arrangements and political dynamics at the national level.

Academic Analyses of the South African AIDS Epidemic: Historical Antecedents and their Place in the Present

One of, if not the, most influential intellectual, political and social developments during the apartheid era in South Africa was the emergence of the Black Consciousness movement. Under the leadership of Stephen Biko and Bernard Pityana, the Black Consciousness movement built on the thought of Frantz Fanon to argue that Black South Africans must overcome the psychological violence that had been internalized over the

course of three centuries of racialized oppression. Biko is perhaps best known for his coining of the phrase “The most potent weapon in the hands of the oppressor is the minds of the oppressed (Biko 2002[1972])”, a slogan still used in marches and demonstrations around South Africa to this day. This school of analysis also critiqued the solidarity of white South African liberals within the anti-apartheid struggle by emphasizing the material benefits that whites derived from the apartheid regime. Black Consciousness theorists such as Biko and Pityana focused on the liberal assumption that the elimination of racial segregation would ensure Western modernization in South Africa, which was, of course, assumed by liberals to be an ideal outcome. The Black Consciousness movement pushed for a focus on race as the founding dynamic in post-contact Southern African history, and argued that, due to this historical fact, racial inequality was the dominant social force in South African society.

This groundbreaking critique proved to be extremely influential in the South African academy. In addition to the foundation of the Wits History Workshop and the volumes of oral histories that it produced, the Black Consciousness movement influenced the intellectual trajectory of neo-Marxist scholarship in the 1970s. Ally (2005), in analyzing this relation, posits that the influential formulation of South Africa as an example of ‘racial capitalism’ was predicated upon the reformulation of emphasis in the political economy of South Africa to a focus on race due to the social and political influence of the Black Consciousness movement on engaged academics (Ally & Ally 2008). The position of ‘racial capitalism’ served as the foundation for left academic critique throughout the 1970s, with academics such as Howard Wolpe and Martin Legassick producing influential work from this foundation. It was, therefore, the

emergence of organic intellectuals such as Biko and Pityana that influenced the major currents of thought that continue to shape contemporary analyses of apartheid South Africa.

Over the course of the past decade, a new generation of leftist intellectuals have endeavored to understand the social, political, and cultural dynamics of South Africa's democratic entry into the post-apartheid era. One particular area of focus has been on the 'new social movements' that have emerged in opposition to the policies of the African National Congress. Organized around the delivery of basic social services such as water, electricity, land and AIDS treatment, these movements have challenged the logic of cost-recovery in the delivery of basic services utilizing the mechanisms of South Africa's newborn democracy: the Constitution and the Constitutional Court. However it might be more useful to think of these social movements as 'resurgent' rather than 'new' given the continuities that exist between the social organization of protest during and after apartheid.

Alongside these resurgent movements, a coterie of academic researchers have published extensive research on the social conditions from which these social movements spring, the substance of their demands, and the quasi-legal means by which poor and working class people are denied services which are constitutionally guaranteed. With respect to water, electricity and land, scholars such as Patrick Bond (2003, 2004), Ashwin Desai (2002, 2004), and Richard Pithouse (2004, 2008) have published extensively, while Nicoli Nattrass (2004, 2007) and Steven Robins (2004, 2006) have focused upon the politics of AIDS in post-apartheid South Africa. While the narratives constructed by these scholars have varied greatly in scope and focus, a common thread that unites their

variegated contributions is a focus on human rights and social inequality. From the conception of a right to water, to the right to land, to the right to housing, to the right to health, rights discourse has ascended to nearly unimaginable heights in the critical literature on post-apartheid South Africa. However it would be inaccurate to frame this conceptual shift as a misrepresentation of socio-cultural processes due to academic abstraction. It is instead a shadowing of the shifting discourse of the social movements themselves who have adapted the tactics of their pro-poor campaigns in an effort to take advantage of the social rights guaranteed in South Africa's constitution.

I argue, therefore, that the focus on rights in contemporary socio-cultural research derives from a new generation of South African leaders, much as the Black Consciousness movement influenced a wave of critical researcher in the 1970s and 1980s. In other words, the intervention of Biko and Pityana, which subsumed the analysis of class to the analysis of race, has been unwound by social movements in the post-apartheid period which have focused primarily on the utilization of rights as means of class struggle rather than examining the racialized legacies which structure social processes in the post-apartheid period in economic, social, political and spatial terms. In terms of the influence of social movement leaders on academic research, we are today speaking of social activists Zackie Achmat (HIV/AIDS) and Trevor Ngwane (Social Service Privatization) when in the 1970s it was Biko and Pityana. While this correlation glosses over many significant political and economic circumstances under which the Black Consciousness movement and the resurgent social movements of the post-apartheid era have formed and organized political activities, my focus here is on the

relationship between the production of academic knowledge and the social processes from which their insights derive.

As I have argued above, the academic literature on HIV/AIDS in South Africa has largely mirrored the voices of AIDS activists who have demanded the human right to life-extending AIDS treatment for people living with HIV/AIDS. This focus grows out of the AIDS movement utilizing the right to health, as it was enshrined in South Africa's post-apartheid constitution, to mount a series of legal challenges against the ANC's AIDS programs. As Asad (2000) has underscored in an analysis of United States foreign policy, to simply note that human rights are a central concept in transnational political dynamics is a necessary but insufficient condition for understanding these processes. Rather one must ask "what human rights do" in terms of the outcomes realized in a given series of events, for which human rights serve as the guiding principle. In the case of South Africa, the effect of the human rights approach as it was utilized by the Treatment Action Campaign (TAC)-led counter-hegemonic alliance, was the restructuring of the South African National AIDS Council and the development of the National Strategic Plan. These processes, interdependent and intertwined, were inexorably tied to South Africa's state institutions, the national organs of the state in particular.

Following Asad's point of departure, what the human rights approach to HIV/AIDS in South Africa did in South Africa was transform national political institutions. The key institution that was restructured due to the pressure exerted by the AIDS movement around the human right to health was the South African National AIDS Council. From a conceptual perspective, the key node around which the political field of HIV/AIDS gravitated at the national level was the South African National AIDS Council.

As I will discuss below, the dynamics that operated in the National AIDS Council displays shades of similarity in the organizational politics that led to the dismissal of Nozizwe Madlala-Routledge. In particular, the institutional processes within the South African National AIDS Council were characterized by the insular dynamics of the ANC, a lack of administrative support for civil society delegates, and a negotiated institutional structure that limited the ability of the institution to ensure the implementation of the National Strategic Plan (NSP). During the course of my fieldwork I was able to speak with over a dozen civil society delegates serving the South African National AIDS Council. While their testimonies displayed a wide range of opinions on the future utility of the National AIDS Council, but one theme continued throughout the varied conversations: that the body was not functioning properly, and this was primarily due to political intransigence on the part of government officials in key positions of power aligned to the ANC.

Institutions and Intransigence: the South African National AIDS Council

The South African National AIDS Council was founded in January 2000, taking the place of the Inter-Ministerial Committee on AIDS as the national institution coordinating the public health response to the epidemic. Prior to the restructuring of the body with the negotiation of the NSP (See Chapter 2), the body was defined as a partnership between government and civil society but was chaired by Deputy President Jacob Zuma and Minister of Health Manto Tshabalala-Msimang. According to civil society delegates in the original National AIDS Council, the body met irregularly, at times not for a year or more, and attendance from key government officials was as sparse as it was erratic. According to one delegate from the labor sector:

When we did meet, there were also problems because not all of the government representatives were present. There were many instances where there were only civil society representatives and no representation from government or very poor representation from government. These issues hampered our progress. We struggled to make progress because we couldn't make decisions because, many times, the meeting would not even quorate.

While the lack of effort on the part of government officials in the original National AIDS Council could be interpreted in any number of ways, another delegate that served during this time described a “united front” shown by government officials against any input by civil society delegates.

While this body was charged with ensuring the input from civil society, there was considerable resistance from ANC officials to critical feedback offered by civil society delegates. I spoke with several delegates to the National AIDS Council that had been involved with this institution since its inception, all of whom underscored an atmosphere of thinly veiled animosity between civil society delegates and government officials in the ANC. With leading AIDS activists such as Mark Heywood challenging then Minister of Health Manto Tshabalala-Msimang and President Thabo Mbeki for their obfuscation on the link between HIV and AIDS, this animosity is not necessarily surprising. However the active involvement of all standing ANC officials in a “united front” against civil society recalls the organizational change that the ANC underwent during late apartheid. According to civil society representatives that were involved in the original council, the insular and guarded dynamics that have marked the ANC as an organization since late apartheid played a significant role in the institutional dysfunction of the original National AIDS Council. However, what may appear to be dysfunction from one perspective may be highly productive from another.

Despite the irregular attendance of government officials, the National AIDS Council had been designated as the Country Coordinating Mechanism for application to the Global Fund to fight AIDS, Tuberculosis and Malaria (Global Fund) in 2002. This status entailed that the National AIDS Council was responsible for drafting and presenting a funding proposal that would serve as the basis for international support for the public health response to the AIDS epidemic. According to a member of the council, this was a process that did not involve any meaningful input from civil society delegates:

Now the Global Fund's expectation is that this document is a constructed document, [with] government and civil society. That's not the way it works. The department, Msimang's department, they write the document. They write it, without consultation, and then send it to the SANAC members for signature. Now this is your problem. On the day I get a phone call to say that the courier is going to come tomorrow with a document, that the courier will wait there, you must sign the document immediately because it's got to go off to New York or Washington or wherever the next day. If it doesn't, that's the end of the proposal, that's the deadline.

And along comes a document that thick (indicates 3 – 4 inches), which you've never seen, never even been part of, and now you've got a dilemma: if I don't sign this damn thing, then there is no proposal to the Global Fund for South Africa. And the political response is going to be, "Well, they refused to sign it, that's their⁴ representative who wasn't willing to sign. So, people of South Africa, we've lost a couple billion because of him." So I signed, and at the next meeting I registered my anger about this and the disrespect and this must never happen again. The following year, a meeting on a Saturday up in Pretoria near Johannesburg, "There's the book, sign." Same story, because again, same power. We put up a bigger fight that day and said we're not signing. We kept at this, those of us who were there, to create a strong front, but if you don't sign this, that's it, nothing goes forward. That's it, so we signed again.

What is critical to note here is that the budgeting process was a focal point of conflict between civil society delegates and government officials and the "take it or leave it"

⁴ This word was changed to ensure the anonymity of the research participant. The original phrasing of the sentence described the sector for which the civil society delegate served as a representative.

ultimatum with which the Global Fund proposal was presented. Reminiscent of the way that the ANC introduced the GEAR macroeconomic strategy to its alliance partners, the control that the ANC exerted over the interaction between a transnational donor organization and the public health response to the AIDS epidemic was a trend that would continue through the re-structuring of the National AIDS Council.

While the South African National AIDS Council expanded the number of civil society delegates during the 2003 – 2006 period, the first signs of substantive change within the institution came on the heels of the August 2006 International AIDS Conference. As has been discussed above, the chorus of international condemnation that came along with the South African display of garlic and beetroot combined with the Minister of Health going on sick leave created sufficient space within ANC party structures for an orthodox public health response to the HIV/AIDS epidemic to be fully supported by government. Deputy President Phumzile Mlambo-Ngcuka and Deputy Minister of Health Nozizwe Madlala-Routledge conducted an analysis of AIDS policy implementation in August 2006, paving the way for the rapid drafting of the NSP by March 2007. In April, the South African National AIDS Council adopted the NSP, and Mark Heywood was nominated as the Deputy Chairperson by civil society in May.

The rapid progress made in the Minister of Health's absence is notable for two reasons. First, it undermines the argument that the National Department of Health lacks the capacity to operate properly. While vacancies do exist that point to a moderate level of under-capacity, this period of productivity underscores that the state organ was capable of coordinating a fast and comprehensive policy evaluation and drafting process. Secondly, it eviscerates the argument that civil society delegates to the National AIDS

Council were incapable of fulfilling their roles. Quite to the contrary, during this period of spectacular productivity between state officials, AIDS activists, health professional and academic analysts, the engine of productivity was the civil society contingent. However the return of the Minister of Health from sick leave in June 2007 quickly changed the air of hope that had transformed the landscape of AIDS politics in South Africa and the direction of restructuring in the South African National AIDS Council.

After the Minister's return to office, two key changes were made in the National AIDS Council that retained the ANC's power to control the institution. In July 2007, the Resource Management Committee (RMC) was established to manage South Africa's relationship with the Global Fund and to secure additional funds to support the implementation of the NSP. This committee was chaired by the recently returned Minister of Health. In the following month, the Programme Implementation Committee was established with Director General of Health Thami Mseleku named as chair. This body was created to "identify and resolve challenges as they arise and make recommendations" to the South African National AIDS Council. Therefore, the two key committees that were charged with overseeing the allocation of resources and implementation of the NSP were chaired by two of the most notable figures in the AIDS dissident faction in the ANC. Given the history of open defiance on the part of AIDS dissidents within the ANC to the orthodox science of HIV, it could have been expected that this arrangement would have led to a series of direct confrontations between the ANC and the civil society delegation led by AIDS activists. However, due to the pressure exerted by transnational institutions after the 2006 Toronto AIDS conference, what resulted in practice was a far more nuanced attempt by the ANC to undermine the

efficacy of the South African National AIDS Council.

While the broad contours of South African National AIDS Council's restructuring had been negotiated during the Minister of Health's absence, the lack of proscriptive details included in the program drawn out during this period of time created space that the ANC leveraged to limit the effectiveness of the joint government civil society institution. A prominent figure in the field of AIDS activism and in the restructuring of the National AIDS Council outlined the process in the following way:

So there were series of arrangements that were agreed upon in terms of the restructuring but they were very vague so they set out the key kind of structures: the plenary, PIC⁵ and technical task team, sectoral coordinating committees, resource management committee and those kind of things. [It] set them out but they didn't really give much detail, and they were unclear on how the various parts are related to each other and how they would function and those kind of things.

So in that sense my participation in restructuring has really been about taking what was agreed on prior to the NSP being adopted in terms of restructuring and giving that flesh meaning and really making it workable because it was kind of so vague, that it wasn't understood on how things would operate. Just to give you an example we were at the PIC meeting and there wasn't a big start and we didn't even know which quorum is and how do we go ahead and who is responsible for what and how decisions are made. So all of those kind of things. I think the barebones of the structure were agreed on before, and certainly it was agreed on who will be represented and which sectors will be represented, that kind of stuff. And that formed enough of the basis for us to take and develop the structure more fully.

The consensus on the restructuring of the National AIDS Council was that Mark Heywood's position as Deputy Chairperson opened up significant space for input and transparency in decision-making processes. However, basic issues such as the attendance of key government figures, organizational protocol, administrative support for civil

⁵ PIC stands for Programme Implementation Committee

society delegates and a lack of funding paralyzed the political process within the national AIDS Council.

The major difficulties faced by the eighteen civil society sectors of the SANAC secretariat were a lack of funding, unclear directions on how to coordinate the sectors, and inadequate support from government administration. Furthermore, government officials from the ANC continued to implement a “united front” against input from civil society after the restructuring the National AIDS Council. According to one delegate:

Firstly, I have found the government totally, utterly, completely and unrelentingly resistant to having any input into it from anyone from civil society in any way, shape or form.

This is a critical point: despite the development of new committees, a secretariat that included a wide range of representation for civil society, and the appointment of a leading AIDS activist to the position of Deputy Chairperson, ANC officials in key government posts continued to limit input from representatives from civil society on revisions to AIDS policy. However, the difficulties with the new National AIDS Council were not limited to continued intransigence from government officials.

The difficulties faced by delegates from civil society also arose out of an unclear protocol for operating their sectors and a lack of financial support for their activities. In an interview with the director of a major non-governmental organization, the National AIDS Council delegate relayed the following difficulties in managing both their organization and sector:

And then I think the other thing that we are going to put on the table is that quite a loss has been expected on these sectors from a civil society point of view. And they are not funded for that, so the reps actually have to put in an enormous amount of time to organize this sector because the expectations are that you won't just give input as an expert on gender and HIV. You are also expected to coordinate the entire sector to partnership with the NSP, which is an enormous task.

It's actually like running the whole program and the three reps they general speak, and it not part of their key business. It is not deliverable with their co-responsibilities at their own jobs and there is no funding for it. You are expected to have a meaningful democratic process, but it's not the way to put it because it's not necessarily elective. But you should have that and you are expected as a sector to really be engaged from all levels from grassroots to provincial, regional and national level. We do that with absolutely no funding...

The time and resources demanded by the role of delegate to the National AIDS Council were, by all accounts, considerable. The vast majority of work for delegates involved managing a large amount of electronic correspondence while coordinating the activities of a given sector. This task of coordination was complicated by the fact that the NSP did not detail the relationships between the National AIDS Councils, Provincial AIDS Councils, and any local structures that municipalities or districts had set up to coordinate their efforts against HIV/AIDS. As a result, delegates worked primarily with other members of large non-governmental organizations to coordinate their activities. While this meant that the workload for managing the civil society inputs to the National AIDS Council gravitated to the larger organizations, it also entailed little to no input on implementation strategies from local state and non-governmental actors with knowledge of the challenges that existed in their areas. In my own experience this dynamic was apparent in the local AIDS councils on the Cape Flats, where local-level analysts and coordinators expressed deep frustration about the lack of input they had on the implementation strategies for the NSP and the complete lack of communication on budgetary matters.

Despite the challenges of coordinating the civil society sectors, many of the sector delegates worked day and night to ensure that adequate resources were allocated for

consultative meetings, the input of their sectors was representative, and that this information was presented to the secretariat of the National AIDS Council. Despite the heroic efforts of some delegates to ensure that the integrity of this process was maintained, there was very little space for input into the council. One delegate expressed their frustration to me at length during an interview:

The SANAC [meeting] in August (2007) I found deeply shocking because each sector had five minutes to present their implementation plan and the Department of Health gave itself five minutes as well. And I mean that was just laughable, but that a player as big as the Department of Health could think that it could do justice to the consultation process in five minutes. And then the SANAC [meeting] in November lasted an hour and a half so almost nobody presented anything, there was certainly no opportunity for any input. The SANAC [meeting] in March was cancelled, and we have a SANAC [meeting] coming up next week that I understand is a half-day again. [...] It would be laughable if it wasn't so sad. I mean, I feel very, very cynical.

While this delegate was quite frank about their frustration and cynicism, putting this to the side, there is an important point here regarding the consultative process within the National AIDS Council. Based upon my interviews and informal conversations with delegates, the majority of consultation occurred within the civil society sector via email. As such the plenary meetings, which this research participant characterized as “laughable”, were not the primary means by which civil society delegates consolidated positions to be presented to the ANC leadership. Rather, these discussions took place over email and the Deputy Chairperson Mark Heywood presented these positions to ANC leaders involved in the National AIDS Council, including the Deputy President, Phumzile Mlambo-Ngcuka. In short the ineffectiveness of the National AIDS Council's plenary sessions did not hamper the work of AIDS activists, as they circumvented the efforts by elements of the ANC dissident faction through the access to high-ranking government

officials through Mark Heywood in his role as Deputy Chairperson of the body.

In addition to this form of elite access granted to Heywood, the progress made in the National AIDS Council during my fieldwork had moments where it displayed the vast promise that the institution could achieve. I attended a meeting of civil society delegates in November 26 – 27 2007 entitled the “National Civil Society Conference on Implementing the National Strategic Plan on HIV & AIDS”, that developed a series of new guidelines for the prevention of mother-to-child transmission (PMTCT). I served as the note-taker in one of the two working groups that devised revision to government PMTCT guidelines. Ranging from leading pediatric AIDS clinicians to community activists, the working group developed fifteen policy recommendations that government should take to revise their PMTCT policy. These recommendations derived from both updated guidelines from the World Health Organization and from the experiences of poor and working class people living with HIV/AIDS. These meetings displayed the huge promise of an inclusive consultative body that could pull together the perspectives of doctors, nurses, people living with HIV/AIDS, and leading AIDS activists and non-governmental organizations working against HIV/AIDS.

Despite the promise of this meeting, this potential was left unfulfilled during the course of my fieldwork. Due to the significant time demands and high cost of holding meetings that pulled people from all across South Africa, no further civil society meetings were held during my fieldwork. The lack of progress with the implementation of the NSP, hampered by a complete lack of new funds to meet ambitious targets for prevention and treatment, was apparent at the National Civil Society Conference, held over a year after the drafting of the NSP. This lack of progress after a period of

significant advance led to the cynicism displayed by a council delegate cited earlier in this chapter. Later in the conversation with this same delegate, he offered his own theory as to why the implementation process with the NSP was moving so slowly:

A sort of key example of the government... playing civil society. I think civil society... I feel very played in SANAC. I think that what they've done is to create an expectation of massive opportunities for civil society to come together in the fight against HIV and AIDS and to set very high expectations of everybody being actually able to make an impact and actually working on a shared agenda that's exciting and dynamic and revolutionary in lots of ways. But then when you actually probe beneath the surface, you find that there's nothing there and what they're doing is trying to set civil society up with high expectations of being involved with consultation and making them very, very busy in lots and lots of processes, which are processes which you can feel that there could be the potential for you doing something or having an impact.

While it is important to note that this person had an admittedly cynical perspective on the government's role in the National AIDS Council, their cynicism was supported by both the poor functioning of the institution and a complete lack of support for the NSP by the National Department of Health.

One of the more important aspects of this process was the slow accreditation of public health facilities to dispense antiretroviral therapy for people living with AIDS. By February 2008, over 456,000 patients were receiving antiretroviral therapy treatment, but only 407 of over 4,000 government health facilities were distributing antiretroviral therapy (SADoH 2008: 283). The slow pace of accreditation prevented the expansion of HIV prevention initiatives and AIDS treatment that formed the basis of the NSP policy document, displaying a sharp contrast between public ANC support for the policy and continued intransigence on the implementation of this policy in the Department of Health. Thus, while the civil society delegation pushed ahead with consultative meetings

and the revision of guidelines, the Department of Health limited the impact of any change to national health policy through the slow accreditation of health facilities to dispense antiretroviral therapy to people living with HIV/AIDS.

While cynical, the civil society delegate's statement reinforces previous statements that the responsibilities of the National AIDS Council created a large amount of additional work for non-governmental organizations that worked with limited time and money. However it also expands on this theme to assert that the structure lacks institutional cohesion and power, that there is "nothing there". While this could be characterized as an overstatement, a closer examination of the institutional structure of the body is instructive here. In the statement from the Presidency that marked the onset of formal restructuring for the National AIDS Council, the Department of Health is charged with the responsibility to "provide guidance and technical support to the [SANAC] structures" (Office of the Presidency 2006: 5). Further, the Department of Health is designated as the secretariat of the Resource Management Committee, a body chaired by the Minister of Health. Perhaps most telling is the following sentence from the document:

The Department of Health will play a central role in providing advice and support on issues relating to HIV and AIDS policy, and will be an ex officio member of all levels of SANAC (Office of the Presidency 2006: 2).

Thus when the civil society delegate conferred to me that there was "nothing there", what they indicated were two things: 1) that the formal support that were expecting had not appeared; and 2) that, due to this lack of administrative support, the National AIDS Council, as an institution, was not capable of implementing the NSP without the backing of the ANC officials in government. Thus, what this research participant underscores for

the analysis is the extent to which the organizational structure of the National AIDS Council grants opportunities for the AIDS dissident faction in the Department of Health to undermine the consultative mechanisms, policy implementation and resource management capabilities of the National AIDS Council. While this alone is a challenging conclusion to reach, it does not address the effects of the process of restructuring the National AIDS Council on leading HIV/AIDS organizations in South Africa.

The non-governmental organizations that were most affected by the labor intensive process of maintaining the South African National AIDS Council were the most active organizations in the opposition to the AIDS dissidence of the ANC. The AIDS Law Project and the Treatment Action Campaign formed the backbone of the activist leaders within the National AIDS Council, with figures such as Mark Heywood, Jonathan Berger, Zackie Achmat and several others playing significant roles in pushing forward the agenda within the restructured institution. However, the time and effort put into restructuring the National AIDS Council in order to ensure implementation of the NSP came at a steep cost to the Treatment Action Campaign in particular. In an interview with a leading member of the organization, he relayed the difficulties that the organization faced maintaining its day-to-day operations while taking on the new responsibilities associated with the restructured National AIDS Council.

What happened at the time the NSP was probably the most critical all-around development in several years for the organization, and Sipho and Mark were all the time were dedicated in making NSP work and consequently there was less focus on the internal running and the day to day running of TAC at the time. [...] And consequently, that the internal pressure of the NSP created this pressure inside TAC, and that was the very troubling time for the organization. And at the same time we got our biggest success probably in year, which was the adoption [of the NSP] in May 2007. So that was the price we paid for that victory.

A slippage in terminology within this quote was that the work of the NSP operated through the National AIDS Council, making the work of one synonymous with the other. I had the opportunity to sit in on meetings with the Treatment Action Campaign ranging from its actions in the township of Khayelitsha, to its provincial office for the Western Cape, to the meeting of its national structures. The organization and its leaders were remarkable for their ability to both address policy-related HIV/AIDS issues while also incorporating the feedback from their organizations' members living with HIV/AIDS on the Cape Flats into a cohesive and clear message on expanding treatment and testing within South Africa. The organization demanded long hours and high-level work from its activists and volunteers, pressure which was heightened with the additional work demanded due to the intransigence of the ruling party both within and outside of the National AIDS Council.

In addition to the increased workload for many of the organization's activists, this period during which the NSP was formulated created a significant amount of pressure within the organization. This period of difficulty brought the gender dynamics operating within the TAC to the fore when a new generation of female leaders challenged the direction of the organization and its old leaders. While the split within the old and new leadership of the Treatment Action Campaign had a negative effect on the organization's ability to pressure government on the implementation of the NSP, it also shed light onto the internal dynamics of South Africa's leading HIV/AIDS social movement. In the lead-up to the implementation of the NSP, a transition in the leadership of the Treatment Action Campaign that had seen long-term activists such as Zackie Achmat and Mark Heywood stepping aside for female leaders such as Sipho Mthathi began to fall apart. As

the “old guard” stepped aside for a new generation, the new leaders had asserted a different trajectory for the organization with greater attention paid to the issues of urban poverty and gender dynamics with the Treatment Action Campaign.

The focus on gender dynamics within the organization addressed one long-standing point of critique: the gender imbalance between the majority female membership and the minority male leadership. My long-term observation of the Treatment Action Campaign certainly underscored the observation that despite the fact that the majority of its members were female, that the leadership of the organization remained largely male (Friedman and Mottiar 2004). As one of the “old guard” male leaders of the organization recounted this period to me in the course of an interview:

So we got out with the day-to-day experience of people living with HIV, the driving force in the organization. So the organization went off target for the period of 9 months, left direction, it was all over the place and there was a focus on things which were secondary to bread and butter issues of TAC, those bread and butter [issues] being insuring greater access of ARVs.

The movement away from the central goals of the organization outlined above served as the impetus for a re-structuring of the organization’s new leadership. That this occurred in the midst of the finalization and implementation of the NSP was significant, but equally significant was the way in which this process reflected gendered power relations with the Treatment Action Campaign.

That the large majority of the Treatment Action Campaign’s members were female grows out of two major currents in the politics of health in urban South Africa: 1) that the HIV/AIDS programs in South Africa had primarily been targeted at pregnant women; and 2) that men have largely avoided accessing health services in South Africa’s townships. This emphasis on the prevention of HIV transmission from mother to child in

the public health sector grew out of the legal work of the Treatment Action Campaign and AIDS Law Project that forced the South African government to supply the antiretroviral drug nevirapine to prevent maternal HIV transmission. However the factors leading men to not access public health resources are less clear. Some people that I spoke with pointed out that men are more likely to access clinics away from the areas in which they live so as to not acquire the social stigma of illness. Others pointed to the issue of masculinity, stating that it was seen as feminine to need medical aid or assistance. Despite the root causes of this discrepancy in those accessing HIV/AIDS services in the South Africa public health sector, the Treatment Action Campaign's active presence in the country's HIV/AIDS clinics acted as a magnet for women living with HIV/AIDS

Despite the fact that the original leadership of the organization was in control of the Treatment Action Campaign when I arrived in June 2007, the majority of lower-level community organizers and advocacy officers were women. As I was to learn at the Treatment Action Campaign's tenth annual general meeting, several of these women were actively being groomed to assume power of the organization in a transition of leadership. The two women elected to lead the organization at the 2008 congress were Vuyiseka Dubula and Nonkosi Khumalo, both of whom were exceptional leaders and organic intellectuals in the AIDS movement.

However to return to the narrative offered by the civil society delegate offered above, the pressure exerted by this additional workload is exactly what the previous quote referred to as the government "playing" civil society. Given the opportunity to work towards a tangible goal, social movements and non-governmental organizations banded together to draft a new national HIV/AIDS policy with academics and health

professionals and attempted to drive the policy through national government via the restructured National AIDS Council. As one can see in the example of the TAC, this additional pressure brought simmering issues within the organization to the forefront of its day-to-day operations, leading to internal divisions and a change in leadership. As such, the dissident faction within the ANC was able to undermine the implementation of the NSP through strategic control of the key organs of the National AIDS Council, the ability to undermine the civil society delegates in the council due to the fact that administrative support was housed within the National Department of Health, and through structural factors like slow accreditation of distribution points for antiretroviral therapy. While this type of political behavior and institutional transformation could be characterized as unique to the politics of HIV/AIDS in South Africa, the contours of ANC political control that were strategically placed to counteract transnational political influence in the National AIDS Council were largely mirrored by the institutional form of the National Development Agency.

Counteracting Transnational Influence: the National Development Agency

The National Development Agency was established in 1998 to allocate funding to non-governmental organizations to hasten the development of South Africa and eradicate poverty. Introduced by the Ministry of Finance through the National Agency Development Bill, the mandate of the National Development Agency is to create ‘an appropriate and sustainable partnership between the Government and civil society organizations to eradicate poverty and its causes’ (Republic of South Africa 1998: B91). But what is particularly significant for this discussion is the role assigned to the NDA by this legislation. Under clause 4 of the National Agency Development Bill, titled “Duties

and Powers of the NDA”, the institutions primary function is to:

[A]ct as a key conduit for funding from the Government of the Republic, foreign governments and other national and international donors for development work to be carried out by civil society organizations (Republic of South Africa 1998: B93).

The National Development Agency operates as a *de jure* extension of the Ministry of Finance, with the Minister of Finance responsible for naming six individuals to act as government representatives on its board. This institutional arrangement derives from the flow of foreign donor funding into the National Treasury, which is governed by the Ministry of Finance. From this point of arrival as foreign exchange, international donor funding can then be channeled to either the National Development Agency or a similar state institution.

Consultation with key civil society organizations was carried out by a ministerial committee as part of the drafting process for the legislation that founded the National Development Agency. The civil society organizations that were consulted generally played a key role in the anti-apartheid movement and included the South African Council of Churches and the South African Civics Organisation (Republic of South Africa 1998: B98). While consultation occurred, the legislation grants nearly complete authority to the National Development Agency with respect to the criteria according to which development funding will be granted.

The NDA may— (a) grant money from its funds to civil society organisations in accordance with such criteria and procedures as it determines; (b) with the approval of the Minister, raise money by way of loans from any source, on such conditions as agreed on; (c) make recommendations with regard to legislation and policies directly or indirectly constraining effective development in the Republic; (d) exercise any power conferred by any other provision of this Act; and (e) generally, do everything which is necessary to achieve its objects referred to in section 3 (Republic of South Africa 1998: B93).

While the autonomy granted to the National Development Agency for determining the funding criteria is extensive, what emerges from a close reading of the legislation is the extent to which the institution operates in tandem with high-ranking government officials. With a board named by Cabinet-level officials, the National Development Agency is politically and organizationally accountable to high-ranking members of the African National Congress rather than the non-governmental organizations it is mandated to support. The example of the National Development Agency indicates that the ruling party has attempted to limit the challenge to national sovereignty that transnational political influence constitutes.

In addition to serving as an example of political centralization, the institutional structures of the National Development Agency and the National AIDS Council illustrate that states are not unidimensional or monolithic; rather the institutions of a particular state can be directed to serve ends at different political scales that do not fit neatly into a single, unidirectional process. While academic analysts have characterized the ANC as succumbing to the dictates of global capital through the examples of the South African Reserve Bank and National Treasury, the institutional dynamics produced by the politics of HIV/AIDS at the national level indicate that this position may overstate the extent to which transnational political forces exert influence on state policy. Through the control of key positions in the National AIDS Council and the National Development Agency, the ruling party retains control over the flow and allocation of international donor funding into South Africa.

Conclusion

As this chapter has demonstrated, the political field of HIV/AIDS at the national level is oriented around key national institutions within which the ANC exerts political control over the public health response to the HIV/AIDS epidemic. This has taken the form of political control over strategic institutional positions in the National AIDS Council, such as the Resource Management Committee. As has been demonstrated with the National Development Agency, the attempt to control the flow and direction of donor capital by the ruling party is not a dynamic that is limited to the political field of HIV/AIDS in South Africa. Rather, the institutions form a countervailing tendency within the government against transnational political influence, a dynamic that mirrors the political rhetoric of the ruling party in its critique of international pharmaceutical companies and HIV/AIDS science. Thus rather than simply a discourse or speech act, AIDS dissidence is perhaps best understood as an institutional dynamic that has transformed the National AIDS Council and is in line with the anti-imperial rhetoric of the African National Congress.

Despite the vast promise shown during the short period of time that Minister of Health Manto Tshabalala-Msimang spent on sick leave, the public health response to the HIV/AIDS epidemic was once again undermined by the AIDS dissidents within the ANC during the 2007 and 2008 timeframe. While the early period of AIDS dissidence had been marked by open confrontation between ANC officials questioning the scientific basis of the link between HIV and AIDS on the one hand and AIDS activists challenging the government for the extension of life-extending AIDS treatment to the South African people on the other, the period during which I conducted my fieldwork was inexorably changed by the transnational influence exerted after the 2006 Toronto AIDS Conference

and the firing of Deputy Minister of Health Nozizwe Madlala-Routledge in August 2007. These two events mark the key dynamics that formed the political field of HIV/AIDS in South Africa during my fieldwork: the influence of, and government response to, transnational political influence, and the authoritarian tendencies of the ANC's internal party dynamics, an artifact of the late apartheid era.

Chapter 4

A Means to an End: The consultative process for the Western Cape Provincial Strategic Plan for HIV/AIDS and Sexually Transmitted Infections, 2007 - 2011

“We’re implementing some parts of it already, and it will keep improving as we go along.”

TP: And which parts are you implementing?

“Well, the health sector for example. We’re implementing what is here (gestures towards a draft plan of the Provincial Strategic Plan). Actually, most of the sectors are implementing this.”

The excerpt above was taken from an interview with a high-ranking official in the Western Cape Provincial Department of Health. After a conversation that dealt with topics ranging from the monitoring and evaluation criteria for the implementation of the National Strategic Plan (NSP) in the Western Cape to the institutional structure of the Western Cape Department of Health, this comment stood out from the balance of the conversation. What made this moment stand out was that it indicated that the Western Cape Department of Health had gone ahead with the implementation of a Provincial Strategic Plan (PSP), an implementation strategy for the national policy, without having taken into account community feedback from a series of consultative meetings on the draft policy document. This comment came after an admission in the interview from one of the highest-ranking members of the Department of Health that they had not yet reviewed the ninety pages of feedback from the consultative meetings that had been held in each provincial health district to gather input from community-based organizations for

the Provincial Strategic Plan. As such, this simple phrase served as an admission from a high-ranking government official that the consultative meetings had no effect on the implementation strategy for the NSP that was put into place in the Western Cape.

This interview came on the heels of a series of consultative meetings that I had attended in each health district in the Western Cape over the course of three months. These meetings, which were co-chaired by the Western Cape Department of Health and a non-governmental organization called the Western Cape Networking Community of South Africa (WC-Nacosa), had gathered information on the community response to HIV/AIDS in each health district in the Western Cape and collected feedback from community AIDS activists and leading members of non-governmental organizations. I had volunteered to serve as the note-taker for these proceedings, and as such, I had overseen the gathering of the ninety pages of feedback that had been left aside in the policy implementation process. The consultative process, and the manner in which it was carried out, forms the basis of this chapter. These meetings were the most direct form of consultation carried out by any organizational body relative to the NSP, yet their outcome differed greatly from the spirit of cooperation that had marked the drafting of the comprehensive AIDS policy. This chapter will analyze what occurred during these meetings, the perspectives of individuals who attended these meetings, and place the outcome of these meetings into context with the broader political field of AIDS in South Africa.

At the time of the writing of this dissertation, there had been no major ethnographic analyses offered of the manner in which political processes at the provincial level influenced the social dynamics surrounding the HIV/AIDS epidemic at the local

level. This is a significant omission, as the South African quasi-federal governmental system requires that each province produce a strategic plan, and subsequently, an implementation plan for policies developed at the national level. This system, whereby national political processes produce policy norms and provincial government produces implementation plans with itemized budgets, is the same across all sectors of government. As Friedman and Kihato (2004) have noted, this shift to sub-national forms of political autonomy is due to concern with absolute federalism by the Afrikaner and Zulu political blocs during the negotiated political transition, as this would have ceded total political power to the African National Congress.

Despite this fact, anthropological analyses have often taken either the perspective of national level or local level in their analysis of AIDS politics and policies. In the overviews of political events offered in the narratives of Fassin (2007) and Natrass (2004, 2007), it is the national politics of AIDS that serves as the focus of the analysis. Steinberg (2008) does note that the antiretroviral distribution center set up by Médecins sans Frontières (Doctors without Borders) in Lusikisiki only occurred due to the approval of the Eastern Cape Minister of Health. However the analysis of provincial political power is not taken further than a cursory description of the belated attempts by this administrator to revoke their approval for the pilot project. Susser (2009) does contextualize her description of women's political power in the AIDS movement as particular to the political dynamics in the province in which her research took place, KwaZulu-Natal. However, the role of provincial-level political processes does not figure prominently in this account. As such, the political processes that have been primarily responsible for the levels of care received in the public health sector and for the

distribution of AIDS treatment have not been thoroughly analyzed in the anthropological analyses of the HIV/AIDS epidemic in South Africa.

In order to address this lacuna in the literature on the South African HIV/AIDS epidemic, I conducted an ethnographic analysis of the consultative process employed by the Western Cape Department of Health for its 'Provincial Strategic Plan' for the National Strategic Plan. In this chapter I describe the ways that community activists, health practitioners and volunteers understood and interacted with a policy consultation led by the Western Cape Department of Health and a non-profit organization called the Western Cape Networking AIDS Coalition of South Africa. What emerged as critically important for this policy consultation and the dynamics between the Department of Health and other non-governmental organizations was the flow of international donor money from the Global Fund to fight AIDS, Tuberculosis, and Malaria. I argue that a shift in the responsibility for managing the flow of international donor funds from the Western Cape Department of Health to the Western Cape Networking AIDS Coalition of South Africa was a major influence on the consultative meetings for the Provincial Strategic Plan.

This episode in the politics of AIDS in South Africa also contributes to the theorization of the political field of HIV/AIDS as it operated at the level of provincial government. As will be discussed during this chapter, the primary nodes around which political activity oriented itself during the course of my fieldwork were the Western Cape Provincial AIDS Council and the Western Cape provincial consultation process for the NSP. It contends that the political processes operating at each of these nodes excluded the input of AIDS activists, health professionals and non-governmental organizations critical

of the public health response to the epidemic. Furthermore, the political field of HIV/AIDS, as it manifested at the level of provincial institutions in the Western Cape, served to extend the influence of the ANC-controlled provincial government, particularly in the realm of public health and HIV/AIDS, and of the organization mandated to lead the consultation sessions, WC-Nacosa. In order to appropriately contextualize these political processes and their significance, it is first necessary to situate them within the recent social and political history of the Western Cape. After having done so, I will offer an account of the consultative sessions, juxtapose my own narrative with the perspectives of individuals who attended these meetings, and offer a brief description of the political dynamics that operated within the Western Cape Provincial AIDS Council. As will emerge towards the end of the chapter, while the influence of transnational donor funding did not appear to be a key issue in the political processes listed above, it emerged as a critical factor after the consultation sessions had been concluded.

Contemporary Political Contestation and the History of the Western Cape province

The Western Cape province has a long history of political and economic processes that have influenced the broader historical development of South Africa. As discussed earlier in chapter 2, the notorious “pass laws” of the apartheid era grew out of successive manifestations of labor control that began during the governance of the Dutch East India Company and its concern with control over slaves in urban areas. The discovery of diamonds at Kimberley in 1867, then located in the British controlled Cape Colony, led to a system that is widely hailed as the root of the influx control policies of the apartheid state but built upon a racially segmented labor system that limited African immigration and aimed to secure adequate farm labor following the abolition of slavery

in 1834. During the apartheid era, the Western Cape retained the racial geography inherited from the colonial era through its status as a province with a “Coloured Labour Preference”, which made the residence of Black South Africans illegal in the province without a specialized labor pass. As such, the Western Cape province entered into the post-apartheid era with the fundamental social geography of the apartheid era intact: in urban areas, whites resided in the well-developed central areas, while Black South Africans lived in peri-urban townships that were under-serviced and under-developed relative to white areas. Despite an influx of Black South Africans from the former homelands of the Transkei and Ciskei during the negotiated transition out of apartheid, the province remained under the political control of the National Party after the first democratic elections in 1994.

Since South Africa’s first democratic elections were held in 1994, political control over the Western Cape province has been hotly contested affair. In 1994, the National Party rallied around concerns about majority black rule and won 53% of the Western Cape vote. However this period of continuity with the leading political party of the apartheid era was short-lived. The National Party re-branded itself as the New National Party in 1997 in order to mark a break with its apartheid roots. Despite this attempt by the New National Party to distance itself from its recent history, the ANC nearly took the Western Cape province in 1999 when it won 42% of the vote. In order to maintain control over the Western Cape, the New National Party formed a political coalition with the rising Democratic Party and thus formed the Democratic Alliance (DA) in 1999. However the ANC successfully managed to wrest control of the Western Cape province in 2004 through a political alliance with New National Party leadership. As the political

fortunes of the New National Party waned, party leadership negotiated an alliance with the ANC that secured victory for the ruling party in the Western Cape⁶. Following the 2004 election, ANC provincial chairperson Ebrahim Rasool assumed leadership in the Western Cape. As a result of the alliance, the New National Party voted to disband itself and was consolidated into the ANC during the controversial “floor crossing” period in August 2005. That the Western Cape was under opposition political control from 1994-2004 is significant for the analysis of HIV/AIDS as one of the key functions of provincial government in the quasi-federal South African political system is that of delivering public health services, including HIV/AIDS treatment (Pottie 2000).

While the ANC maintained control over the national political apparatus that sets the norms upon which both provincial and municipal policy must be based in the South African system of “concurrency”, the 1994-2004 period was critical in setting an alternative trajectory for the government response to HIV/AIDS in the Western Cape. During this period the city of Cape Town set up the first coordinated municipal response to the epidemic while the Western Cape Department of Health moved forward with the utilization of the drug nevirapine for the prevention of mother-to-child transmission (PMTCT) in May 2004, prior to its inclusion in national policy guidelines in South Africa. Between 2000 and 2004 the Western Cape Department of Health worked with Médecines sans Frontières (Doctors without Borders) to establish pilot sites for anti-retroviral therapy under the leadership of Dr. Faried Abdullah in the HIV/AIDS Directorate in the Provincial Department of Health. These processes were enabled by a

⁶ In 1999, the Democratic Party garnered only 11.91 percent of the Western Cape vote compared to 2004, when it won around 28 percent. However the decline of the New National Party was spectacular, with its provincial vote dropping from 38.39 percent in 1999 to 10.92 percent in 2004.

direct appeal from the Western Cape Department of Health to the Global Fund to fight HIV/AIDS, Tuberculosis and Malaria that circumvented the ANC-controlled National Department of Health. While the Western Cape made significant progress during this time, according to numerous people involved in AIDS policy, Dr. Abdullah was forced out by the change in provincial leadership in 2004. While this shift has not led to the undoing of the HIV/AIDS initiatives put into place during the 1994-2004 period, HIV/AIDS activists have openly acknowledged that the sense of urgency and pace of delivery have waned considerably since the transition from the DA to the ANC in 2004. That this alternative public health response to the HIV/AIDS epidemic occurred in the Western Cape is the direct result of the control of the provincial state apparatus by the ANC's political opposition.

It is within this history of political contestation that the Western Cape provincial consultation process for the NSP took place between October 2007 and April 2008. A critical dynamic for this study was the political environment produced by the bruising battle between Thabo Mbeki and Jacob Zuma for the ANC presidency. After having defeated Mbeki's ANC faction in December 2007, Zuma's cadre went about challenging provincial premiers who had supported Mbeki, including the Western Cape's Ebrahim Rasool. After numerous clashes between Mbeki and Zuma supporters in the Western Cape, including the stabbing of ANC Provincial Secretary Mcebisi Skwatsha at an ANC meeting in the town of Worcester, Rasool was replaced as premier by Western Cape MEC⁷ for Finance Lynne Brown⁸ (Joubert 2008). Therefore the period during which this

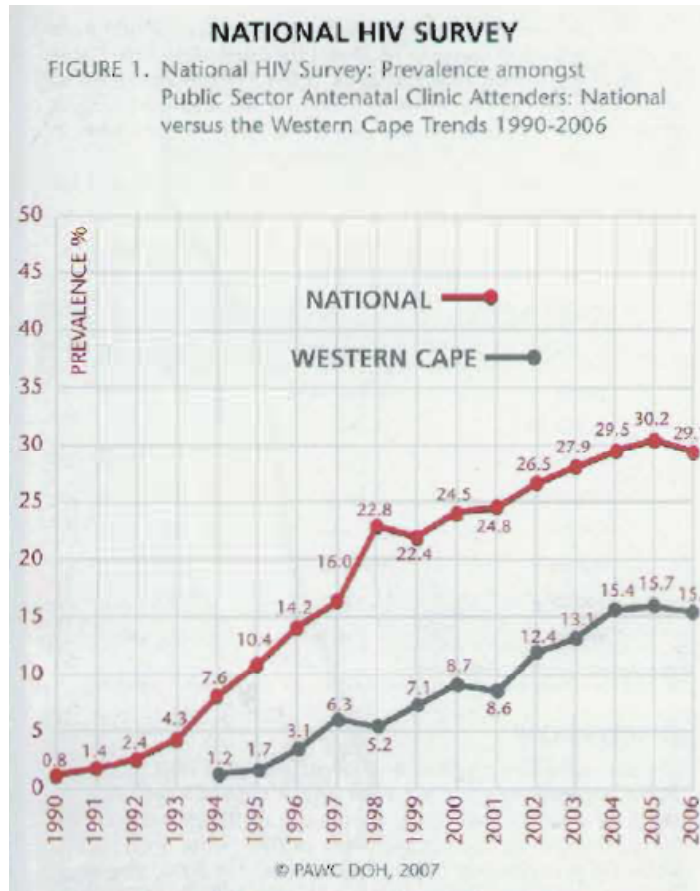
⁷ MEC stands for Member of Executive Committee. The provincial executive committee is made up of those who hold a portfolio in an area of provincial control, such as finance, education, etc. The executive committee is often described as a provincial "cabinet".

research was conducted must be contextualized as one that was marked by political struggle within the ANC that manifested itself at the national, provincial and municipal levels. The social and state institutions that were concerned with HIV/AIDS in the Western Cape did not operate outside of these political struggles during the 2007-08 period. Institutions and organizations such as the Western Cape Provincial Aids Council, the Western Cape Provincial Inter-Departmental AIDS Committee (PIDAC), the TAC and WC-Nacosa, all of which are critical to an analysis of HIV/AIDS politics in the Western Cape, had to navigate the political minefield produced by a battle over the leadership of the ANC. A more loaded political environment within which to address a public health crisis there could not be.

Despite the fact that the Western Cape has borne the brunt of political struggle over provincial government in the post-apartheid period, the province has continued to experience a lower HIV/AIDS prevalence than the national average (see figure 3 below).

Figure 3: National and Western Cape Prevalence Rates 1990-2006

⁸ The internal struggle within the ANC's Western Cape structures resulted in a resounding victory for the DA and the newly formed Congress of the People (COPE) during local elections held in 2008.



Source: Western Cape Department of Health

In a 2006 National Antenatal survey, the most exhaustive district-level survey of its kind, the Western Cape and Cape Town itself came out with a noticeably lower prevalence rates than comparable provinces and cities. As Cape Town, Durban and Johannesburg are South Africa’s largest cities, it is clear that when one places these figures side to side that the Western Cape is experiencing an epidemic of a smaller scale than the rest of South Africa.

Figure 4: 2006 Provincial and Metropole Prevalence⁹

Western Cape:	15.7%
Cape Town	17.0%
Gauteng:	30.8%
Johannesburg	32.3%

⁹ Source: 2006 National HIV Antenatal Survey

KwaZulu-Natal	39.1%
Durban	41.6%

Thus while the Western Cape is undoubtedly facing a formidable challenge in addressing its HIV/AIDS epidemic, it is of a smaller scale than its provincial counterparts. In an not unrelated matter, the Western Cape Department of Health moved more quickly than other provincial health departments in translating the NSP into a provincial plan and commenced consultation sessions while provinces such as Free State were still in the preliminary stages of transforming the NSP policy document into a Provincial Strategic Plan.

However the roots of the NSP process in the Western Cape can be traced back to 2006 when the Provincial Inter-Departmental AIDS Committee created a draft HIV/AIDS prevention plan for discussion amongst key provincial departments such as Health, Education, Social Services and Social Development. Rather than serve solely as a provincial draft document, the Western Cape HIV Prevention Strategy fed back into the NSP drafting process at the national level. After the national plan was finalized and adopted by cabinet in May 2007, the Western Cape PIDAC translated the broad goals and targets of the NSP and released the Western Cape Multi-Sectoral Strategic Plan for HIV & AIDS & Sexually Transmitted Infections: 2007 to 2011, referred to hereafter as the Provincial Strategic Plan or PSP, to representatives on the Western Cape Provincial Aids Council in October 2007. The provincial draft plan is essentially a list of pre-existing initiatives in the Western Cape that were compiled and ramped up according to the goals and targets areas of the NSP: (Prevention; Treatment Care & Support; Research Monitoring and Surveillance; Human Rights and Access to Justice).

However as a draft policy document, the PSP was not released for public discussion. I was able to acquire a photocopy of the draft in November 2007 after having spent a significant amount of time contacting several of the standing members on the Western Cape Provincial AIDS Council who had attended the October meeting when the draft was distributed and knew that a copy of the draft plan existed. According to these “civil society” delegates to the Provincial AIDS Council, the draft plan had been distributed to the attending members of the Provincial AIDS Council and the representatives from the Department of Health had asked for feedback on the draft from the sectors represented in the provincial institution¹⁰. However this process had not begun when I received a copy of the plan and after having been asked by various social organizations about the availability of the draft plan, I distributed copies of the draft plan to the two organizations that had requested a copy, the Treatment Action Campaign and the Aids Legal Network.

Manufacturing Discontent: the PSP Consultation in the Western Cape

Although many organizations had not yet had the opportunity to review the details of the draft plan, consultation with civil society and community-based organizations began in February 2008. I had been in touch with members of WC-Nacosa after having acquired a copy of the draft PSP in November and offered to assist with the consultation process in any way that I could. After meeting with the leadership of the organization, it

¹⁰ The Western Cape Provincial Aids Council is chaired by the MEC for Health, at the time of this research the MEC for Health was Pierre Uys. Furthermore, there are representatives from the key government departments (Health, Social Development, Social Services, Education), the Business Sector, the Labor Sector, the Civil Society Sector, the Religious Sector, etc. Although technically the WC PAC was mandated to create parallel sectors to SANAC’s 17 sectors in May 2007 with the adoption of the NSP, by the time of this research was concluded in June 2008 this had not occurred.

was agreed that I would assist with the PSP consultative meetings as a note-taker so that all feedback from the community would be included in a final report. While I had misgivings about participating in this process, it was only by volunteering to work for the consultative meetings that I was able to attend all six sessions.

WC-Nacosa had been asked by the Western Cape Department of Health to lead the civil society consultation process. The non-governmental organization decided to use its quarterly meetings held in each of the Western Cape's six health districts to meet with stakeholder organizations in the community and channel their feedback into a revised provincial policy. Speaking with various individuals involved in this process, I received differing accounts of how this arrangement came into place and the exact terms entailed. However over the course of these meetings it became clear that WC-Nacosa had been chosen to lead the consultation sessions due to a close relationship between the leadership in WC-Nacosa and top figures in the Western Cape HIV/AIDS Directorate and the future involvement of the Global Fund in the provincial response to the HIV/AIDS epidemic. The structural elements of these dynamics will be explored later in this chapter.

On Friday February 29, 2008, the first consultative meeting was held in the city of George for the Southern Cape health district. The meeting was held at the George Museum, in an auditorium that had long held a display of former South African President P.W. Botha's personal effects. It was hard to imagine that Botha's status as a champion of apartheid and hard-line supporter of racial segregation was lost on any of those in attendance. In the damp, musty and cavernous hall, rows of seating lined the center of the room facing a small podium and desk with a projector aimed at a small, portable screen. Members of community-based organizations slowly filed into the room around 9:15am,

with approximately 40 representatives of non-governmental and community-based organizations that worked in the South Cape health district in attendance. Outside of a member of the Western Cape Department of Health involved with the presentation, only a handful of representatives from the Department of Education and municipal government were in attendance, with the notable exception of the Department of Social Services.

The one-day, four-hour conference to discuss the provincial draft plan consisted of presentations by WC-Nacosa, the Western Cape Department of Health and the Aids Legal Network. This process began with a representative from WC-Nacosa who gave an overview of the HIV/AIDS epidemic in Africa, its particular manifestation in South Africa, and some of the specific challenges faced in the Western Cape. The presentation moved quickly through a powerpoint presentation that was full of statistical information and based upon the broad goals and data described in the NSP. In the course of the presentation, the representative of WC-Nacosa outlined that there would be consultative meetings held in each of the province's six districts and that any feedback could be submitted to WC-Nacosa via its website¹¹. The presenter emphasized that inputs from the non-governmental sector were not yet in the plan but that feedback was vital due to the fact that if initiatives were not included in the plan, they could not be funded. This issue of funding at its relationship to WC-Nacosa turned out to be particularly important for the political dynamics of the consultative meetings.

If this initial presentation left some members of the audience squinting at slides that were quickly passed through with little explanation, the following presentation from

¹¹ www.wc-nacoza.co.za

the Western Cape Department of Health exacerbated this situation. The representative from the department of health offered a dense academic presentation that analyzed the exact epidemiological aspects of the epidemic in the Western Cape, the history of HIV/AIDS policy in the Western Cape, and an in-depth discussion of the goals of the NSP. Although I had attended many lectures and presentations on HIV/AIDS and public health issues, I found this presentation to be challenging due to the rapid pace at which information was disseminated and powerpoint slides which were changed more rapidly than their information could be copied down.

After this presentation, the floor was opened to a question and answer period. One participant pointed to the need for an emphasis on, and access to, the female condom:

I am thankful to be part of the meeting. It is still a cultural issue for the schools to plant a condom dispenser. From an educator's perspective it is seen as you are opening them to sexual abuse, we have to try by all means to come up with a female condom because in all cases female rates are higher than men's. If for prevention's sake, if we can get into it, we can ensure that female condoms are ensured.

This call for female-controlled mechanisms to prevent HIV transmission echo the call by Stein to develop female-centered research on HIV/AIDS in the early 1990s and the work of Susser on the necessity of the female condom for women's empowerment in South Africa (Stein 1990, 1994; Susser 2001, 2002, 2007). Another audience participant pointed to the treatment HIV positive people receive at clinics:

People want to go on ARVs¹², but there is a lack of confidentiality, and the way that nurses are talking to patients, they just say that they are not going back. The biggest problem is that there is no confidentiality, they are there in the open, people can hear what you are saying, there is no privacy. People don't want to get into the buildings where HIV positive people are going, other people don't want to go in. What they are doing now, treatment of people with HIV/AIDS/TB they are getting it from the place

¹² Anti-retroviral drugs

where the HIV treatment was, so they are trying to break the stigma of how it was before.

A final question from the audience concerned voluntary counseling and testing (VCT), a key support mechanism offered primarily by community-based organizations in the Western Cape:

In terms of VCT, there is a big gap with meeting up with the ARVs. We pass people onto the clinic but we don't hear back because of confidentiality. Then people fall through the cracks and then they die.

Although the Western Cape was often viewed as a province with relatively low HIV prevalence within South Africa, based upon the questions posed above by members of community-based organizations it was clear that the public health response to the epidemic was still in formation at the time this research was conducted.

The final presentation from the Aids Legal Network began by addressing the issue of condom use and the necessity of expanding this if the NSP goal of a 50% reduction rate in infections is to be achieved by 2011. Picking up on the issue of access to female condoms, the representative from the Aids Legal Network asked how many of the audience members had distributed female condoms. After three women raised their hands, one remarked: "For the first time someone came last week to provide condoms." Although the presentation from the Aids Legal Network was cut short after the earlier presentations had run over time, it allowed for audience participation in addressing the issues of stigma, access to female and male condoms (in clinics and schools), and how to challenge mistreatment of patients by hospital staff.

The talk from Aids Legal Network aside, the presentations were generally in lecture form and focused upon the statistical trends of the epidemic while emphasizing the core themes of the policy: prevention with a focus on youth, increasing the age of

sexual debut, reducing the number of concurrent partners, reducing the risk and vulnerability of younger women who partner older men, and increasing the use of condoms. Although the presenters had emphasized that the provincial draft plan was a work in progress that could be shaped by the input of those attending the meeting, the way in which the information was presented did not cater to audience participation. The presentations moved quickly through dense slides containing statistical information on topics such as prevalence and mortality, which were presented in the language of public health and HIV/AIDS specialists.

Additional pressure was placed upon meeting participants by the way in which the meeting was structured. At the George meeting, the presentations began at 9am and lasted until 12pm, leaving one hour for meeting participants to work in groups organized by sub-district and present their feedback. Each group was given 20 – 30 minutes to meet and discuss the answers to the following six questions:

- What are the existing programs and projects in your region/area? (Responses to this question were organized according to the four priority areas of the NSP: Prevention; Treatment Care & Support; Research Monitoring and Surveillance; Human Rights and Access to Justice)
- What are the coordinating mechanisms/institutions in your area and do they fulfill the role of comprehensive HIV/AIDS planning?
- What role do you see yourselves playing in the NSP-PSP?
- What suggestions or concerns do you have on the PSP and NSP?
- What are the positive elements in the PSP and NSP?
- What training/implementation needs do you have in your region/area?

If one examines the six questions given to the working groups closely, there were two distinct lines of questioning in the exercise. The first was an attempt at surveillance, of gathering information on community-based activities in the health district and ways of improving and expanding existing initiatives (questions 1, 2 and 6). The second group of questions (questions 3, 4, 5) was focused specifically on the NSP and PSP. For nearly all

those who participated in the consultation session, this was the first time that they had heard anything about the NSP or PSP.

After the working groups had discussed these questions, the meeting allocated 20 – 30 minutes for report-backs from 5 groups (approximately 5 minutes per group). These report-backs consisted of requests such as access to and education on female condoms, training for educators, legal rights training and project management. These presentations were interspersed with stories of public sector nurses stigmatizing HIV positive patients, non-functioning local organizing structures and unlawful restriction on access to condoms in schools. Although little time was allocated to conference participants, coherent and organized presentations were given that painted a challenging picture of the local manifestations of the South African HIV/AIDS epidemic.

While the presentations had offered an in-depth overview of the HIV/AIDS epidemic and the goals of the NSP and the related goals of the PSP, at no point had they reviewed the details of the draft provincial policy document. Although the PSP was described by a representative from the Department of Health as “first draft,” “a collation” and “literally an audit of what people were doing”, it was not directly addressed during the meeting. As such the responses to questions 3-5 dealt with general concerns around inadequate funding, transport systems, non-functional local coordinating mechanisms for community-based organizations and access to condoms. One group however, offered a critique that presaged conflict that was to arise at other consultative meetings. In answering question 4 “What suggestions or concerns do you have on the NSP and PSP?” a working group wrote on their presentation:

Concern with policy development: when things are being said you are not happy sometimes but it is there, it is already there. There should be more involvement with PWAs¹³.

When this point was presented, the representative from the working group had made clear what this statement meant: that the policy had already been written, that they were not being asked about the details of the policy, and that people living with HIV/AIDS who knew of the realities of AIDS treatment on the ground were not adequately involved in this process. This perspective formed the basis of a critique of the consultation process put forward by community organizers as well as those guiding the sub-district coordination process for the greater Cape Town metropolitan area at the following meeting.

The next WC-Nacosa-led consultative meeting for non-governmental and community organizations based in Cape Town took place at the Novalis Institute. The Novalis Institute, located alongside the M5 highway and just outside of Cape Town's southern suburb of Muizenberg, had a main meeting room with a beautiful hexagonal structure constructed with unfinished wood that swept up into a dome that created excellent acoustics. While at other points in time this may have served to amplify a speaker's voice or a musical performance, during the consultative meeting it augmented the voices of community-based organizers expressing their dissent and protesting what they saw as a flawed process. The meeting organizers had made some minor changes to their approach for the meeting held for the Cape Metropole District on March 7, 2008. After having run over time in George, a question and answer period was scheduled to last 40 minutes and the working group meetings were extended from 20 to 50 minutes. There was also a new representative from the Western Cape Department of Health scheduled to

¹³ People living with HIV/AIDS

present an overview of the PSP. Although this new representative spoke with more emphasis on the importance of monitoring and evaluation as part of the NSP, the broad contours of the presentations were nearly identical to those that were presented at the previous meeting.

The Metropole meeting differed significantly from the meeting in George as the attendees openly expressed their frustration with the consultation process. Several participants asked that the consultation period be extended while others stated that the provincial plan should be compiled out of a needs-based district and sub-district analysis of the Western Cape. One participant demanded that civil society have authorship of the policy instead of being consulted on a plan that has already been drafted. The critical and antagonistic dynamic at this meeting was primarily driven by members of the TAC, but also came from other community activists from across the Cape metropolitan region. Those in attendance delivered a clear message to the meeting organizers: they continue to attend policy presentations but want to see concrete action in their communities. The meeting was politically divisive, with some working groups internally divided over whether to support the consultative process and one abstaining from doing so. The Metropole meeting was adjourned without a clear way forward in the decisive district for confronting the HIV/AIDS epidemic in the Western Cape.

However the atmosphere of confrontation that marked the Metropole meeting did not affect the trajectory of the subsequent consultative meetings. The meetings held for the Overberg district on March 14th, Karoo district on March 28th, the West Coast District on April 17th and the Winelands District on April 18th largely returned to the dynamics of the first meeting held in George. While there were isolated instances of critical feedback,

the vast majority of those attending these meetings did not openly critique the consultative process or demand that additional meetings be held to gather their input. This lack of critical feedback was partially due to the role of local meeting coordinators and political figures in managing the moments of critique that emerged at these meetings. At the consultative meeting for the Overberg district, the meeting chair, a local community member, responded to the critical feedback of one participant by telling them that the government knew about the problems that they faced, that they did not want to hear people complain, and that they were going to have to do the best that they could with what they had. A similar incident took place with the meeting held in the Winelands district involving a community member and a government official.

In sum, any feedback that offered a critical perspective was not welcomed in the consultative sessions. Given that the environment in these meetings was not conducive to any kind of critical discussion, I conducted interviews with a cross-section of participants from the meetings. Often these individuals were self-selecting, as several turned down my request for an interview, some of whom shot wary glances towards the meeting organizers after our conversation. Despite the initial skepticism of some research participants, the interviews that emerged from this series of meetings involved members of government, community organizations, non-governmental organizations and AIDS activists involved in the AIDS movement. Their perspectives greatly enriched my own understanding of the consultative meetings led by WC-Nacosa.

Speaking Back: Examining the Perspectives of PSP Consultative Meeting Attendees

In order to select individuals from the consultative meetings to participate in this research, I would approach several people after each event and gauge their interest in

talking more about their experiences doing community-based HIV/AIDS work as well as their perspective on the meeting. As it turned out, it was usually the more vocal and active members of the meetings that would agree to be interviewed. The interviews that I carried out were wide-ranging due to their open-ended structure but two themes emerged as dominant in the course of gathering data: 1) that the response to the HIV/AIDS epidemic in the Western Cape was being driven primarily by community-based organizations and the individuals who staffed them; and 2) that WC-Nacosa and the Treatment Action Campaign have an adversarial relationship due to the close relationship between the former and the Western Cape Department of Health. In order to contextualize these themes, I will first outline the structural factors accounting for the difference between the consultative meetings before moving on to interview excerpts from meeting participants.

A central factor in the differentiation in meeting responses was the relationship between WC-Nacosa and attendees. Although WC-Nacosa was mandated by the Western Cape Provincial AIDS Council to consult with all non-governmental organizations in the Western Cape, the meetings were primarily attended by organizations within its own network¹⁴. What made the Metropole meeting held in Cape Town somewhat unique was that it was attended by a wider range of civil society organizations than were part of WC-Nacosa's organizational network. Therefore, the organizations that attended this meeting were not dependent upon WC-Nacosa for organizational support, which focused upon assisting organizations in acquiring funding. According to one person who attended the George meeting:

¹⁴ As a networking and mentoring organization, WC Nacosa offers services to around 300 community-based organizations in the Western Cape, making it a powerful in the HIV/AIDS community.

Probably, the consultation was meant for Nacosa affiliates because all of the groups there were Nacosa affiliates. They have received some kind of assistance from Nacosa in one way or the other.

It was not insignificant that the dissatisfaction unleashed at the Metropole meeting came from organizations that were not dependent upon WC-Nacosa. As an organization, WC-Nacosa primarily trained and supported community-based organizations in applying for funding from the provincial government and international donors¹⁵. The organization thus served as a key intermediary between community-based organizations and the funding streams that emanated from the state and international donors. WC-Nacosa's structural role as intermediary between financial resources and community-based organizations pointed to an underlying power dynamic in the consultative process. After learning of this relationship through my interviews with meeting participants, it made more sense to me why organizations that worked with WC-Nacosa may have limited their critique at the meetings: they had vested interest in maintaining a cordial working relationship with the organization. While there was a clear disincentive for the majority of the organizations that attended these meetings to offer critical feedback on the way in which consultative process was conducted, this was only part of the rationale for the relatively tame political dynamics at the consultative sessions.

Another reason why organizations may have limited their feedback during meetings was that they were instructed to submit their feedback via WC-Nacosa's website. At each of the meetings, participants were asked to draft proposals specifying how their organization will work to meet the NSP targets. After the proposals had been

¹⁵ This process is channeled through district coordinating mechanisms called "Multi-Sectoral Action Teams" or MSATs. These coordinating mechanisms were developed in concert with the Global Fund, began in the Cape Metropole and have been supported with funding from the Global Fund since 2005. These structures will be discussed at greater length in Chapter 6.

drafted, they were to be uploaded to WC-Nacosa's "interactive website" so that the organization could incorporate them into their submission to the Provincial Aids Council.

An attendee of the Southern Cape meeting in George had this reaction to the recommended method for feedback:

How many people have access to the internet? I can tell you: people who go to the library. If you have a card, a library card, you have 45 minutes access in the library on that computer. So maybe they have 5 computers, and the computer is so slow that it takes 20 minutes just to upload one page. Now think about going to a website, clicking the website, and now it takes another 25 minutes to upload. So your 45 minutes is gone before you even feed the submission. So even in that room maybe you will find those two or three people who have internet access because they have a well funded, or well supported support group that maybe accesses Nacosa's funds. But it's people who could be aligned closely to Nacosa who might have access to their website and they can do that interactive thing. But the rest of the community, the rest of the people who don't have access to the internet, they're not going to participate, they're not going to care about this because it does not talk to them. It's not about them. It's about people who have access to electricity and computers and email at home.

According to this participant, the utilization of electronic submissions as the format for organizational proposals and feedback automatically omits the feedback of a certain strata of those attending the meetings. Community-based organizations without access to computers and the internet, which are contingent upon external funding, would not be able to send their feedback to WC-Nacosa. Each participant or participating organization was assumed to have the necessary grant writing and technological skills to upload proposals through the WC-Nacosa website. However the experiences of the meeting participant cited above indicate that even if individuals have the necessary skills to submit a proposal, the technological resources that poor and working class people have access to in South Africa may not be of sufficient quality to complete this task.

Although I used my computer to access the internet every day for work, I was unable to find the “interactive” mechanism through which submissions for the PSP process on the WC-Nacosa website were to be uploaded. I informed members of the organization of this at the West Coast consultative meeting held in Piketberg on April 17, 2008. Not surprisingly, they informed me that they had not yet received feedback of any kind from any of the policy consultations at that time. Not only was the selection of electronic submission uninspired given the audience, a proper mechanism for uploading feedback was not created on the WC-Nacosa website until after the consultative process had ended¹⁶.

By depending upon an avenue for the exchange of information that demands a particular level of technological expertise and access to resources, the consultation process was also selectively omitting the input of those who have been historically disadvantaged in the Western Cape. This issue extended beyond that of the assumptions of the WC-Nacosa meeting organizers. To return to the participant’s statement, they point out that “it’s people who could be aligned closely to Nacosa who might have access to their website”. While their statement is highly conditional, this person points to an important cyclical character of the process: that it is primarily those who have benefited from WC-Nacosa’s tutelage who would be in a position to offer feedback. This dynamic manifested itself in my interviews quite clearly around the use of a digital voice recorder. When the recorder was on, participants who had worked with the organization would speak politely about the process. However when I made a point to turn the recorder off, a more honest and critical assessment of the process emerged.

¹⁶ The final consultative meeting for Winelands Health District was held on the following day, April 18, 2008.

Another point of concern for many participants was that they experienced difficulty understanding the presentations given in the consultation sessions. As noted above, this was a concern that I had harbored throughout the six consultative meetings. Speaking of the presentations given at the Cape Metropole meeting, an attendee relayed to me that:

They don't make sense. They touch here and they touch there and it's there, there, there, there. The presentation doesn't flow from the one thing to the other. There were certain things that I could understand that I took from what he was saying, but then he would say something else that would throw me completely off guard in terms of now, how does that two fit with each other?

Although I could see that many of those in attendance were following the broad messages involved, the specificities of the presentations did not emerge from the interviews I conducted. When pressed about what exactly the PSP or NSP was, the majority of interviewees could not articulate a clear understanding of these abstract policy platforms. Those who were able to do so had prior knowledge of, or access to, these policies.

However, the overall theme that emerged in follow-up interviews with meeting attendees was dissatisfaction with the policy consultation process. This line of critique emerged primarily from the more vocal meeting attendees that I interviewed in conjunction with the policy consultations. According to one TAC activist based in the Western Cape who attended the Southern Cape consultative meeting in George:

They already have an idea of what they want to achieve and what they want to achieve is for them to apply for the funding. And whatever happens with the implementation of the PSP really doesn't matter to them as long as they have access to the funding, which is very vital in the sustained ability of the organization and the other organizations they are mentoring. There is nothing wrong with that, but what made me nervous the very first time was that people from Nacosa and the people from the provincial Health Department were very buddy-buddy, you know, very close. [...] It made me nervous and again I still felt that they already have

in mind what they want to achieve and what they want to get out of the consultation process. So the consultation process is not really about telling people what the NSP is or what the PSP is but what is in these communities that can make it get support from international donors or whoever so that they can roll it out. How they roll it out is not going to be a problem because they already have the money.

This interviewee offered a critique of the close relationship between WC-Nacosa and the Department of Health, but more significantly, singled out the same critique as that which emanated from the Cape Metropole meeting. This was significant because I conducted the interview prior to the Metropole meeting, and this feedback was not the result of a unified organizational policy platform, but as part of a widespread demand by community-based activists to have their ideas and suggestions included in AIDS policies.

However another line of critique came out of interviews that focused on the changing character of the Western Cape Department of Health. This institutional critique focused upon the relationship between the leadership of the provincial health department and those who had led the PSP consultations. According to a TAC activist who attended the Metropole meeting:

If I take, for instance, that representative from the department of health, it was difficult for me to follow him. And at one stage I said you can see he is a puppet of the MEC for Health because he speaks in that same line.

At first glance this characterization of the provincial health representative appeared to be simply a caricature of an authority figure that had presided over what was largely seen as an illegitimate consultation process. However, there are two major points of significance that emerge from this citation. The first major issue is that the MEC for Health¹⁷, Pierre Uys, was viewed as a political appointee rather than an individual who is qualified to hold the provincial health portfolio in the Western Cape. Although Uys was named by the

¹⁷ Pierre Uys was MEC for Health in the Western Cape during the period of my research (June 2007 – June 2008)

ANC to the provincial cabinet, Uys had previously served as a Minister in the National Assembly under the New National Party (NNP) until 2004, when the NNP was integrated into the ANC¹⁸. Given that many TAC activists, its leadership in particular, were active in the anti-apartheid struggle, this reaction may have much to do with Uys's long association with the political party responsible most closely with apartheid, the National Party.

However the disdain with which Uys was viewed was due primarily to a broad perception that the Western Cape Department of Health has moved more slowly in addressing the HIV/AIDS epidemic since the ANC had taken control of the province. A doctor working in the public health system in Khayelitsha offered this reading of the internal dynamics of the Western Cape Department of Health, which give a critical perspective on how the politics of the institution have changed:

What is clear is that when we started there was a different minister of health at provincial level and there was definitely much more political will. Well, they had started PMTCT dual therapy against national recommendations, that's how bold they were at that time. They accepted to have MSF to start here with an ARV program. So you had an openness locally, and then Faried Abdullah left; he was the director of ARV services. He was basically, I think, pushed away by national, and national pushed in political appointees to control. And the control from national on the Western Cape has increased massively since 2005.

The opinion of this doctor was based upon their experience working in the public health sector as well as discussions that they had with people working inside of the Department of Health. My informal interactions with members of the department of health confirmed the public health doctors' opinions. In a discussion with another member of the

¹⁸ Prior to his tenure in the South African National Assembly, Uys served as as Councillor (1984-89) and Mayor (1992-95) in Kuils River, was Vice-Chair (1995-96) and Chair (1996-99) of the Executive Committee of the Cape Metropolitan Council before serving as MEC for Local Government and Development Planning (2000-01). Uys represented the National Party from 1984-97, and the New National Party from 1997-2004.

department, they mentioned that they had “lost their champion” and that working in the institution was now much more difficult. This statement had been given to me by one of the central figures in drafting the PSP. This individual left the Western Cape Department of Health shortly after the consultative sessions had ended. While it is impossible to quantify the extent to which the National Department of Health was exerting influence on the provincial structures in the Western Cape, there had clearly been a political shift in the provincial institution directing the public health response to the HIV/AIDS epidemic that had negatively affected key figures in the department.

However the second point raised by this interview excerpt was that there were broad repercussions to the perception that MEC Uys was an extension of the unorthodox and scientifically unproven HIV/AIDS treatment associated with the National Department of Health and the AIDS dissident faction of the ANC. The TAC activist quoted above was drawing a direct line from the AIDS dissidence of the National Department of Health down to the Provincial Department of Health and the PSP consultative process. The significance of this was that the close relationship between the provincial department of health and WC-Nacosa during the PSP process was interpreted by members of the TAC as evidence of complicity on the part of WC-Nacosa with the project of AIDS dissidence. This association was related to me in a most direct fashion when a leading member of the TAC referred to WC-Nacosa as “collaborators” when I asked what they thought about the organization and its role in the Western Cape.

This perception reached a boiling point when an email from a leading member of the TAC in the Western Cape was mistakenly posted on the TAC website. While the email offers a run-down of the various problems with the consultation described above,

the primary source of contention between WC-Nacosa and the TAC was that there appeared to be some pre-planning by the TAC to disrupt the consultative process.

We were then split into groups to answer these 6 questions and we were evenly split amongst the groups. Every TAC member in the group was suppose to influence their group to either put all our suggestions like we discussed in our Tuesday meeting or to get the group to understand why this process is wrong in the way they are doing it. Only [TAC member] and myself could convince our groups not to fill the questions but to rather explain to them what they need to put in place and how they need to consult before we can call it a draft. [TAC member] and myself were also doing the feedback to the plenary on behalf of our groups. I was first to present. Our group did not do any of the questions, we wanted to know what are they going to do with it and why we weren't given 14-7 days notice about the questions so people can come ready with the answers.

The rationale for this strategy came later in the email, that:

We don't think that they are going to come to the district unless we make them come, cause at the end of the meeting (member of NACOSA) was still going on about the submissions that can be send through not saying anything about coming to districts. [...] I think we our achieved in showing them that the way they running this process is wrong and that the plan should be a combination/integration of district plans before we can call it a draft.

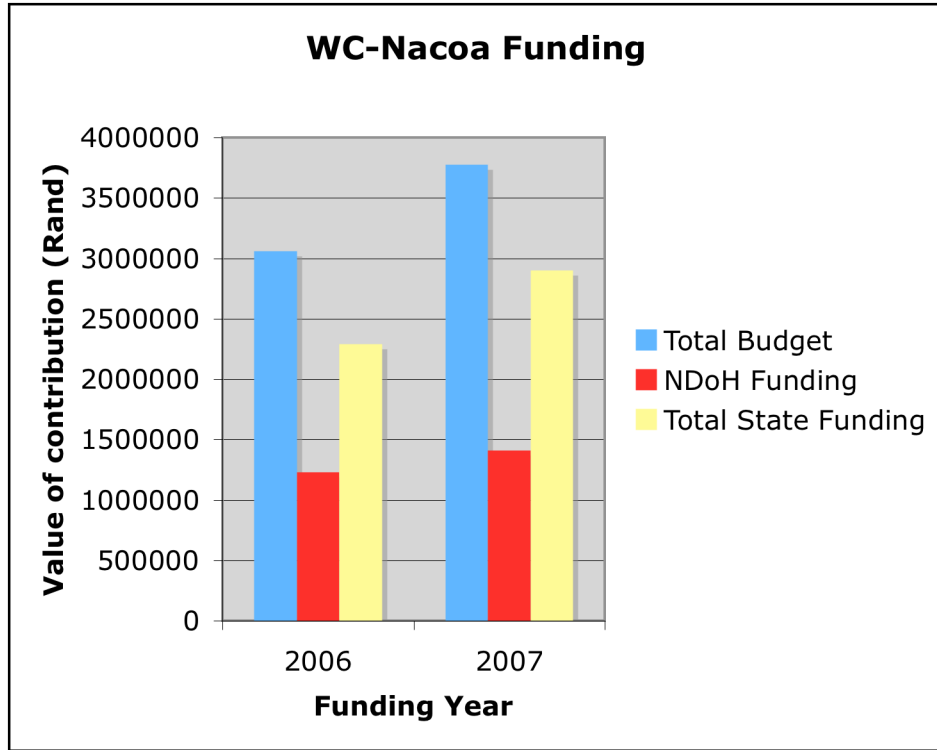
That an internal memo regarding the perceptions of TAC members was accidentally shared with the public was regarded by WC-Nacosa as unfortunate and a meeting was scheduled to “clear the air” between the two organizations.

This meeting was held at 11:00am on April 21st at the WC-Nacosa offices, and the atmosphere was tense as representatives from the TAC and WC-Nacosa sat at either side of a round table. At this meeting it became clear that after an initial meeting that outlined the broad goals of the consultations, that there had been no communication between the organizations regarding the PSP consultative meetings. In particular, the TAC representatives asked that the consultation period be extended while those from WC-Nacosa admitted that their process was not perfect, but that they had felt an urgency

to get the process of localizing the NSP started. The representatives from WC-Nacosa also emphasized that they had always conceptualized the PSP consultations as continuing beyond the initial set of district meetings that had constituted the process to that point. Perhaps most importantly, the individual who had drafted the leaked internal memo shared that they believed that the TAC had not gone far enough with its internal process with respect to the NSP/PSP and they had feared that the consultative process with single meetings held in each health district would be the only series of meetings. They admitted that this fear caused them to react differently instead of saying what the process should be like. The meeting adjourned with both organizations agreed that they needed to work together more closely, but these kind words did not lead to action. In the two months following this meeting it was my experience that the already frosty relationship between the TAC and WC-Nacosa had frozen over.

But how are we to understand this series of events in the context of other negative characterizations of WC-Nacosa by community activists from both within and outside of the TAC? And most importantly, was there any substance to the claim that WC-Nacosa was merely an extension of the Department of Health. For the sake of establishing some concrete parameters for evaluating these claims, Figure 5 below outlines the extent to which WC-Nacosa depended on state funding for its mentoring and support activities.

Figure 5: WC-Nacosa and State Financial Support



The graph makes that WC-Nacosa was heavily dependent upon funding from the South African government. In their 2006 financial year, WC-Nacosa derived 40.2% of its funding from the National Department of Health and 74.8% of its total funding from the South African government. In 2007 the percentage of funding from the national government declined to 37.4%, however the total percentage of state support increased to 76.9% of WC-Nacosa's annual budget. The fact that over 75% of WC-Nacosa's 2007 funding came from the South African government gives significant credence to the claim that they were unable to operate autonomously from the politics of the ruling party. When pressed on this issue, a senior member of WC-Nacosa denied that the source of funding had any influence on the organization. However once I had turned off my audio recording equipment, a frank admission ensued that, in fact, it was quite difficult for the organization to operate outside of the influence of the Department of Health.

While I took this statement at face value at the time it was directed to me, it does not speak to the extent that the relationship between WC-Nacosa and the Western Cape Department of Health was a beneficial one for the non-governmental organization. I had attended a sitting of the Western Cape Provincial AIDS Council in February 2008, yet the short time that I had spent observing the interaction of individuals, organizations and institutions proved to be extremely helpful in disentangling the close relationship between WC-Nacosa and the leadership of the Western Cape Department of Health. In the final section of this chapter, I will offer a brief description of the operation of the Provincial AIDS Council and the role of transnational funding from the Global Fund figured into the dynamics of the political field of HIV/AIDS at the provincial level in the Western Cape.

Friends with Benefits: the Provincial AIDS Council, WC-Nacosa and the Global Fund

As I waited nervously with the civil society representative to the Western Cape Provincial AIDS Council, light streamed down into the open foyer of the Western Cape Department of Health. Just two days earlier, the person with whom I sat had been told that they were to serve in this new role, one that they had told me they had little knowledge of. While we waited, I tried to make light of the situation within which we found ourselves: this person walking into a new institutional role about which they had little to no understanding of their responsibilities and expectations, and I, someone who was trying to attend a meeting without prior permission to do so. My fears were allayed by the arrival of a representative from WC-Nacosa and an official from the Western Cape Department of Health with whom I was familiar. We made polite small talk prior to the

arrival of the Health MEC, or Member of Executive Council, at which point the meeting would commence.

Among the people in attendance were the Director of City Health, Dr. Ivan Toms, a notable figure in the anti-apartheid movement for his leadership in the anti-conscription campaign and for opening a health clinic in the township of Crossroads during the height of the anti-apartheid struggle in the 1980s¹⁹. As mentioned earlier in the chapter, the MEC for Health in the Western Cape was Pierre Uys during the course of my fieldwork. Just prior to the start of the meeting, I went up and introduced myself along with the civil society representative and asked if it would be possible to sit in on the meeting of the Provincial AIDS Council. Uys asked what I had done to contribute to the public health effort to fight HIV/AIDS, and I indicated that I was assisting WC-Nacosa as a note-taker for the consultative meetings for the PSP. This seemed to please the MEC, and he agreed that I could attend the meeting.

As we filed into the room where the meeting was to be held, I noticed that the representative from WC-Nacosa and the official from the Western Cape Department of Health that I had earlier spoke with sat down together and continued to talk. After the usual protocol of roll call and approval of the minutes of the previous meeting, a handout was given to those in attendance that listed key indicators for the Western Cape HIV/AIDS/STI Program. Some of the highlights of the presentation were that the Western Cape HIV/AIDS/STI programs were exceeding NSP targets for the 2007/08 period for the number of Peer Educators, uptake of Voluntary Counseling and Testing (VCT), the number of patients served by Home-Based Carers, the number of Multi-

¹⁹ In a great loss to the South African AIDS movement, Dr. Toms passed away less than six weeks after this meeting due to complications from meningitis.

Sectoral Action Teams and the number of community-based organizations receiving funding.

In addition, the program had come in just under target for the number of patients receiving antiretroviral treatment (33,559 versus a target of 35,863), Sexually Transmitted Infections treatment partner rate (18.7% versus a target of 22%) and two targets related to the Prevention of Mother-To-Child Transmission [Transmission rate to babies (5.8% versus a target of 5%), and the number of antenatal clients tested for HIV (22,465 versus a target of 22,500)]. These statistics were presented in a matter-of-fact manner and were welcomed by attendees with a general air of satisfaction. While the presentation indicated that the department was taking the NSP seriously, it ignored the larger statistic on HIV/AIDS in the Western Cape: that HIV prevalence has risen from 8.7% in 2001 to 15.7% in 2005.

The next item on the agenda was to discuss the decision to mandate WC-Nacosa to lead the PSP consultation process. The matter was tabled and passed unanimously by those in attendance. It was clear that this issue had been discussed amongst leadership in both organizations prior to the February 14th Provincial Aids Council meeting. In the meeting, the WC-Nacosa representative described the qualifications of the organization to lead the process according to two main points: 1) the organization had a large network of community-based organizations that could be easily accessed for consultation; and 2) close ties between WC-Nacosa and the Western Cape Department of Health facilitated cooperation between the two key organizations involved with the consultation process. However as the critiques from those who attending these consultative sessions noted above, there were also some drawbacks to the organization leading the process: 1) since it

has a pre-existing network of community-based organizations, WC-Nacosa consulted primarily within its own network; and 2) WC-Nacosa received funding from the Western Cape Department of Health for its operations in the province, a relationship that created an environment in the meetings that precluded a critical assessment of the draft PSP.

Another agenda item that was raised later in the meeting was the decision by the Western Cape Department of Health to not seek to renew the Global Fund grant to support community-based organizations working on the HIV/AIDS epidemic in the province. In what came as a surprise to both myself and the civil society representative that I sat next to, the representative from the Department of Health had already proposed that WC-Nacosa would apply to take over the management of this internationally funded program in a meeting in late 2007. The Provincial Department of Health decided at this juncture that WC-Nacosa would manage this round of Global Fund applications for community-based organizations; this decision was formally adopted at the Provincial Aids Council meeting on February 14th, 2008.

What I did not know at the time of this meeting, was that up until the point that WC-Nacosa was proposed to take over the management of the Global Fund grant, the organization had faced the possibility that it would have had to limit its operations in the Western Cape due to decreasing funding from the provincial government. As has been noted above, WC-Nacosa received over 75% of its 2007 funding from the Western Cape Provincial government. The discontinuation of this funding stream would be devastating for the organization. The coming decrease in funding was due to the fact that the money for coordinating and mentoring community-based organizations was being provided by

the Global Fund, and the transnational institution had shifted its goals to prioritize provinces in greater need than the Western Cape such as the Eastern and Northern Cape. In concert with the changing priorities of the Global Fund, WC-Nacosa was in the process of extending its operations into the Northern and Eastern Cape during the consultative meetings for the PSP.

The shift in the primary recipient organization in the renewal application to the Global Fund was not a secret, and it was discussed openly at several of the consultative meetings for the PSP. The Director of WC-Nacosa did not attend the Central Karoo consultative meeting held in Beaufort West on March 28th, 2008 due to a scheduling conflict with a National Department of Health meeting on international funding. At the Central Karoo consultative session the director's absence was described by representatives from WC-Nacosa as due to a "high-level strategic consultation over funding and strategy". When pressed further by members of community based organizations in attendance, these representatives then stated that the meeting was in relation to the continuation of funding from the Global Fund. That WC-Nacosa should seek to expand its base of operations and its sphere of influence should not come as a surprise, as it was in the organization's interest to pursue funding opportunities as its revenue stream had run dry. However it was a notable factor in the PSP consultation process and the political field of HIV/AIDS at the provincial scale due to the link between the exclusion of community input into the policy process and the control of access to transnational donor capital.

In particular, the dynamics described above display how the provincial node in the political field of HIV/AIDS limited the policy input of AIDS activists and non-

governmental organizations that had pushed through the NSP at the national level, including the TAC. While it is not possible to draw causal ties or intentionality in this process, the outcomes reached point to two important points: 1) the central role of the state as an intermediary between transnational donor capital and non-governmental organizations; and 2) the ability of non-governmental organizations acting in concert with the interests of the state to limit the influence of other non-governmental organizations and community activists on AIDS policy. These dynamics underscore the necessity of including the state in an analysis of transnational political processes at both the national and the provincial scale.

This episode was particularly poignant due to the fact that WC-Nacosa served to limit the role of the TAC and other organizations in the AIDS movement from contributing to the local implementation strategy for the NSP. Despite the amount of attention that has been paid to the role of the ANC AIDS dissident faction in limiting the influence of AIDS activists in policy discussions, the example of the PSP consultations indicates that the array of institutions and actors involved in this process were far more varied than has been indicated in the academic literature on the politicization of the South African AIDS epidemic. Rather than merely AIDS dissidence, this example indicates that the ANC's ability to channel and control international donor capital is a central element alongside the control of state institutions in the production of the political field of AIDS in South Africa.

Conclusion

The example of the consultative process for the Western Cape Provincial Strategic Plan underscores the need to re-incorporate the role of the state in the analysis

of transnational political dynamics. This is particularly the case for a processual analysis, as it is possible to come to a more nuanced conclusion of a given series of events if one analyzes the array of outcomes involving international donor capital, state institutions, non-governmental organizations and social movements. With respect to the example of the PSP consultative meetings, the outcome was a limitation on critical feedback from community members, AIDS activists and non-governmental organizations. Further, interviews with key institutional actors in the state apparatus indicated that the outcomes of these meetings were not even considered prior to commencing with implementation of the draft PSP policy. Finally, the critical perspectives of AIDS activists and community members led to an analysis of the relationship between WC-Nacosa and the Department of Health. This insight of everyday individuals pointed to the transfer of international donor funding to the non-governmental organization from the state. Without attention paid to the role of the state in this analysis, the influence of transnational political forces and the central position of the state as intermediary between these funding flows and non-governmental organizations would be obscured.

While the PSP consultative meetings and the dynamics ensuing from the transnational influence of the Global Fund point to a one-sided dynamic operating at the provincial node of the South African political field of HIV/AIDS, these events do not fully represent the diversity of political activity at this institutional scale. As will be discussed in the following chapter, a coalition of trade unions, non-governmental organizations and AIDS activists and organizations united to challenge the implementation of a fiscally austere public health policy alongside the political struggle over the NSP. Operating in simultaneity, these two processes show that the political

dynamics operating at the provincial scale can serve also the ends of popular movements aimed at expanding the scope of public health services to poor and working class South Africans.

Chapter 5

The Western Cape Coalition Against Public Health Cuts: popular movements, public health crisis and structural violence

Look, now this year Groote Schuur's budget was increased again and it was a victory, and it was a popular victory. And I think it is a good example, and academically it is a good example of the success of popular pressure and achieving and saving our hospitals, so to speak.

A high-ranking member of the South African National Treasury provided the quote listed above during the course of an interview²⁰. The individual with whom I spoke was referring to the recent decision by the Western Cape Provincial Treasury to provide additional funding for the public health system, which prevented the closure of 90 beds providing specialized health services. As this member of the National Treasury indicated, a significant determinant of this “victory” in the allocation of public resources was the influence of a broad political coalition that challenged the closure of beds. This group, the Coalition against Public Health Cuts, was an issue-based alliance between a wide range of professional organizations, non-governmental organizations, HIV/AIDS activists and the labor movement that successfully pressured the South African government to reverse the closure of specialist beds in the public health sector. By leveraging the central role of the labor movement in the South African government, the Coalition against Public Health Cuts (heretofore referred to as the Coalition) achieved its goal of preserving specialist services that could be accessed by poor and working class South Africans. However the

²⁰ As has been emphasized throughout this study, the maintenance of anonymity with respect to the identity of research participants working in the public sector was a central concern given the dismissal of Deputy Minister of Health Nozizwe Madlala-Routledge during the course of field research. As such, detailed descriptions of research participants working in the public sector were not possible as they could reveal the identity of these individuals.

Coalition disbanded shortly after the goal of ensuring that specialist beds were not closed, leaving intact the structure of health service provision based upon neoliberal macroeconomic planning. The convergence of individuals, organizations and political interests that followed this announcement offer important insight into the way that political dynamics operating at the provincial scale interact with those at the national level and offer a productive avenue for community activists to challenge policies that negatively affect poor and working class South Africans.

This chapter will analyze the role of HIV/AIDS activists, doctors and organized labor in this broad-based political movement that confronted the ruling party of South Africa, the African National Congress, in order to ensure access to – and availability of – life-saving resources in the public health sector. The individuals and organizations involved in the coalition challenged the implementation of a public health policy that was conceptualized according to the dictates of neoliberal fiscal austerity, and refused to accept the process of structural violence that this policy put into motion in the Western Cape. Despite the provincial government’s characterization of the public health policy as “non-negotiable”, the success of the Coalition indicates that a broad coalition of labor unions, non-governmental organizations and the AIDS movement was capable of altering the course of public health policy at the provincial level. As such, the provincial node offered an additional opportunity for pro-poor public health and HIV/AIDS activists to alter public policy to redress the social, spatial and material inequalities inherited from the apartheid era.

The political campaign led by the Coalition focused on the negative effects of the implementation of the fiscally conservative public health policy, the Comprehensive

Services Plan (2007-2010) or Healthcare 2010; particularly the limitations placed on public health spending. If this policy had been fully implemented, it would have ended the provision of several specialized services in the public health sector; a development that many of the doctors I interviewed perceived as a form of structural violence that duplicated the uneven access to health services that existed during the apartheid era. As I will argue below, the Healthcare 2010 policy was a form of structural violence that followed many of the key characteristics defined by Farmer (1996, 2004) in this definition of this term:

Structural violence is the natural expression of a political and economic order that seems as old as slavery. The social web of exploitation, in its many differing historical norms, has long been global, or almost so, in its reach. [...] Indeed, one can argue that structural violence now comes with symbolic props more powerful – indeed, far more convincing – than anything we might serve up to counter them; examples include the discounting of any divergent voice as “unrealistic” or “utopian,” the dismal end of the socialist experiment in some (not all) of its homelands, the increasing centralization of command over finance capital, and what some see as the criminalization of poverty in economically advanced countries (Farmer 2004: 317).

The social process that accompanied the implementation of the Healthcare 2010 public health policy shadowed many of the dynamics that Farmer brings to the fore in the excerpt above. Perhaps most prominent was the invocation of the “common sense” of neoliberal fiscal austerity against the claims for a human right to health by members of the Coalition. However the most challenging element of this process was the extent to which the neoliberal health model embodied by Healthcare 2010 exacerbated the social inequalities passed down from the colonial and apartheid periods of social development in South Africa. Rather than redress the shortage of health infrastructure in historically under-serviced areas by opening the doors of the specialist health facilities to poor and

working class South Africans, the Healthcare 2010 policy ended access to many specialist services in the public health sector while pushing the cost of long-term care for the terminally and mentally ill back onto communities.

Much like province-level policy processes, the role of the public health system in the politics of HIV/AIDS as an area of inquiry has been largely overlooked in the anthropological literature related to South Africa. The struggle for the dissemination of AIDS treatment and the functionality of the South African public health sector have a clear connection in that the former is dependent on the latter. As such, one might imagine that the analysis of HIV/AIDS politics has been put forward within an analysis of the challenges faced by poor and working-class South Africans in accessing treatment in the public health sector. However the public health system has often served as a mechanism of historical backdrop and contextualization rather than an active vector of political contestation in and of itself.

This is particularly the case with the historically focused work of Fassin (2007). In this narrative, the lack of public health infrastructure serves as a material extension of the racial inequality engendered by the colonization of Southern Africa and its formalization during the apartheid era. Susser (2009) similarly treats the public health system as an aspect of South Africa's political economy, but as a container within which health activism and organic social movements organized around women have taken shape. Much the same could be said of the work compiled by Natrass (2004, 2007), which treats the public health sector as a remnant of the apartheid era that serves as a constraint on the extension of AIDS treatment in South Africa.

Of all the anthropological data gathered thus far, it is Steinberg (2008) who has offered the most detailed analysis of how individuals have interacted with the doctors and nurses providing AIDS treatment. In this fine-grained ethnographic description of the interactions between doctors, nurses and South Africans inquiring about their HIV status or AIDS treatment, the weight of stigma and shame figure prominently. The description of the day-to-day dynamics of HIV testing and AIDS treatment offered by Steinberg in a rural community, from the difficulty of testing, the difference in time between those who had tested positive and negative, and the stigma attached to those who came out of their consultations ashen-faced were verified by many of my research participants. Steinberg's description of the tense, anxious and at times heartbreaking environment of an HIV/AIDS clinic is an important contribution to the literature on the epidemic in South Africa.

However Steinberg's data was gathered from a pilot clinic set up by Médecins sans Frontières (Doctors without Borders) in the town Lusikisiki in the Eastern Cape province. While this clinic was later transferred over to the Eastern Cape Department of Health, during the time of Steinberg's fieldwork this clinic was not part of the public health sector. The implications of this differentiation are important, as the pilot set up by Médecins sans Frontières operated without the fiscal or human resource constraints experienced by many facilities in the public health sector. In addition, the pilot in Lusikisiki was supported by volunteers working in the Treatment Literacy and Adherence programs from the Treatment Action Campaign; however due to the divisive political dynamics of HIV/AIDS in South Africa, it would be highly unlikely for this to continue after the transfer of administrative control over the to public health sector. While

Steinberg's contributions in this area are extremely important, they must be contextualized by the special circumstances under which this fieldwork took place.

My contribution to the anthropological literature on the HIV/AIDS epidemic is to offer a contextualization of the experiences of people living with HIV/AIDS offered in different ethnographic descriptions within an analysis of the public health sector in South Africa. During the course of my fieldwork, I met with and observed the work of doctors and nurses working in the public health sector before conducting interviews with individuals who held these positions in areas with high HIV/AIDS prevalence. Furthermore, I worked with members of the public health sector to direct an analysis of human resources in a public health sector day hospital in the Cape township of Khayelitsha (Powers and Monte 2007). While many anthropologists have discussed the experiences and of people living with HIV/AIDS who access the public health sector, the staffing shortages and day-to-day challenges of nurses and doctors working in the public health sector have too often gone unnoticed.

In addition to this ethnographic grounding of first-person narratives of HIV/AIDS treatment, I contextualize how HIV/AIDS activists actively created alliances with other social justice organizations and the labor movement to ensure the viability of the public health sector. More specifically, I conducted an ethnographic analysis of a broad-based public health movement that successfully prevented the closure of public hospital beds in the Western Cape. This is an important contribution to the literature on the HIV/AIDS epidemic in South Africa because it offers clear ethnographic data on how the interests and power of the labor movement have supported the political goals of the AIDS movement in South Africa. While academic analyses have underscored the importance of

the labor movement in supporting the ‘cabinet revolt’ that led to the availability of antiretroviral treatment in the public health sector, the critical role of the labor movement in the victories experienced by the AIDS movement in South Africa has not been accompanied by attention to its influence in local-level politics.

The organizations and alliances that produced these public health dynamics also allow for further theorization of the political processes that operated at the provincial node of the political field of HIV/AIDS in South Africa. In the previous chapter, the role of the Western Cape Networking AIDS Coalition of South Africa (WC-Nacosa) underscored the extent to which the state can utilize international donor capital to influence policy development and implementation at the provincial scale. The example of the Coalition indicates that the increasing influence of transnational political processes has not led to a decrease in the significance of pro-poor political movements that unite organizations from diverse backgrounds and answer to different constituencies around a particular issue. Rather, local and provincial community health activists were able to develop relationships with labor unions to leverage their power within provincial and national government to stop the closure of beds in the public health sector.

As Ferguson (2006) has emphasized, the period of neoliberal globalization has coincided with a growth in the role of non-governmental organizations in political processes due to an increase in international donor funding for organizations that fulfill the service delivery functions that were previously the responsibility of the state in developing countries. In this formulation, non-governmental organizations can figure centrally on either side of a political struggle depending on an organization’s politics, constituency, and sources of financial support. However Ferguson plays inadequate

attention to the traditional role of the trade union movement as the foundation from which working class and poor South Africans fought for greater economic and political rights. In the case of public health cuts under analysis in this chapter, non-governmental organizations and social movements depend on the influence of leading labor unions in government in their successful fight for additional funding in the public health sector. As such, I argue that the trade union movement plays a central role in the political activities that produce the transnational political field of HIV/AIDS in South Africa.

In order to contextualize these claims, an ethnographic vignette of a meeting of the Western Cape Campaign Against Budget Cuts will be presented. Following this, I will offer an analysis of the changes that the Healthcare 2010 policy put into place in the public health system. This examination is based not only on my own fieldwork in a day hospital located in the township of Khayelitsha, but also on the perspectives of individuals involved with the Western Cape Campaign Against Budget Cuts. The negative effects that the implementation of this policy had for patients and public health workers will form the basis of an analysis of structural violence in the public health sector in South Africa. Following this discussion, the ways in which the African National Congress-controlled provincial health department attempted to limit the resistance of doctors in the public health sector to the implementation of the Healthcare 2010 policy will be evaluated. As discussed in Chapter 2, the authoritarian tendencies within the political culture created by ANC leaders is the byproduct of the transformation of the party's political structures and organizational culture during the late apartheid period.

Ethnographic Vignette: Meeting the Coalition against Public Health Cuts

Monday July 30, 2007

The damp chill of the winter rain was buffeted by icy gusts of wind that swept down across the face of Table Mountain as the day began. I felt my legs shiver as I ventured out into the misty cold of the Cape winter and the cool air passed straight through my thin winter jacket. I had not planned on the weather taking such a quick turn for the worse after an unseasonably warm spell the day before. As I piled into the car with several members of the Western Cape provincial office of the Treatment Action Campaign, I looked over to Phaedra, a leading member of the office and shook my head, laughing at myself while I shook with cold. “You have to dress warmer man, you’re going to get sick”, Phaedra chuckled as she spoke, watching me fumble the keys with my now-unmanageable fingers. I started the car and we pulled away, leaving the confines of Community House, a series of buildings that held the offices of many left-leaning social movements and non-governmental organizations in Cape Town such as the provincial offices of the Treatment Action Campaign (TAC), Labour Research Services (LRS), Worker’s World Media Productions (WWMP) and the Sex Workers Education and Advocacy Taskforce (SWEAT).

In the drive over to my first time observing a meeting of the Coalition, we began to talk about the repercussions of the Minister of Health Manto Tshabalala Msimang’s return to office. The stress of this topic drew visible lines of concern across Phaedra’s face as she described how the minister had negatively affected the delivery of antiretroviral drugs in the public health sector. I nodded my head in understanding as I made a right turn across Main Road into the Groote Schuur hospital complex. Founded in 1938, Groote Schuur is a tertiary level hospital in the South African public health system, meaning that it offers specialized and super-specialized care to 560,000 patients per year

while serving as a research center and academic hospital that trains interns and residents in Cape Town (City of Cape Town 2009). As we pulled up to the security gate, we paid the security guard two rand (\$0.35) to park amidst the debris of the ongoing renovation to the hospital. As we wandered through the labyrinthine hospital searching for the meeting room, I did not yet realize the significance of holding the meeting in a facility that was technically part of the Western Cape Department of Health. The reasons for holding the meeting at the hospital, however, soon became clear: the Coalition had its roots at Groote Schuur, as it was where a handful of doctors had challenged the decision by the Western Cape Department of Health to close specialist hospital beds at this institution and other tertiary-level hospitals in the province.

After having wandered through the hospital for some time, we walked into the meeting room after those in attendance had commenced roll call. As I was the only new face in the room, I introduced myself and offered to assist the Coalition as a note-taker and means of transport in exchange for attending their meetings and including their organizational dynamics in my dissertation research. Those in attendance began the meeting by discussing various letters sent to members of the Department of Health and the leadership of the ANC in the Western Cape province. After having discussed the letters sent to these individuals, the members of the Coalition in attendance analyzed their strategy of utilizing the media to bring attention to the impact of the bed closures.

Those in attendance at the meeting addressed a wide scope of issues that focused on the best ways to tether organizational capabilities and alliances to support the aims of the coalition. I was deeply impressed by the extent to which all members of the coalition were extremely well versed in the particulars of the Healthcare 2010 policy and the ways

in which this policy related to issues ranging from community health to macroeconomic policy. With members representing doctors from the major public hospitals in the greater Cape Metropolitan area, the National Education, Health and Allied Workers' Union (NEHAWU), the Treatment Action Campaign (TAC), the South African Municipal Workers Union (Samwu), the Congress of South African Trade Unions (Cosatu), the Alternative Information Development Center (AIDC) and Positive Muslims, the coalition touched upon many of the key interest groups in the greater Cape Town region that would be affected by the closure of the public sector beds.

As the campaign began to unfold, it became clear that the issues being addressed by the coalition had implications that reached far beyond the closure of 90 beds at tertiary or specialist level hospitals. Through the campaign against bed closures, an entire philosophy of health service delivery was brought into question. This philosophy was summed up at this first meeting by one of the key figures in the coalition, a doctor from Groote Schuur, as “what is the best health care we can offer for this amount of money, rather than what is the appropriate public health response given the burden of disease and the amount of need”. Alternately, another member of the coalition focused on the broader issue that underlay the bed closures; that insufficient government funding was a looming threat to treating the growing public health crisis that had been precipitated by the dual HIV/AIDS and Tuberculosis epidemics in the Western Cape. For the Coalition, the Healthcare 2010 policy effectively sentenced poor and working class South Africans in need of specialist procedures to premature and unnecessary deaths. As the campaign against the bed closures developed during my research, the Coalition moved on from simply challenging the issue of bed closures to confronting the logic of fiscal austerity,

the lack of public consultation in the health budgeting process, and the effect of these dynamics on the public health sector in South Africa.

The political dynamic that was produced by the interaction between public health professionals, labor unions, non-governmental organizations and the Western Cape department of health was one which traced its roots to the apartheid period and the social organizations that were developed to overthrow the repressive political environment that typified this period. As discussed in Chapter 2, this was particularly the case with the centralizing effect that the offensive actions of the apartheid intelligence services had on the institutional structure of the African National Congress. This tradition continued with the leadership style of the ANC during the Mbeki administration. Thus, one institutional legacy of apartheid was an organizational culture of intimidation and silencing in the African National Congress that had permeated into the state apparatus during the administration of Thabo Mbeki. In keeping with Farmer's (2004) conception of structural violence, this style of leadership was demonstrated by government officials in their dismissal of the invocations of a human right to health and their support for "realistic" goals in the allocation of public health services. In framing the discussion of public health around the "appropriateness" of particular services for populations accessing public health services – the majority of which are poor and working class non-white South Africans – the post-apartheid period shadowed the race-based allocation of state services during the apartheid era, but through the medium of class rather than race.

However this style of leadership and centralized decision-making has been challenged by remnants of the anti-apartheid movement that have resurfaced as social movements organizing to protect the rights of poor and working class South Africans. In

the arena of public health, this political dynamic manifested itself through the prism of social contestations over inadequate service delivery in the public health sector and the central role of the labor movement in this process. Through an alliance of social organizations that drew its roots from the political struggle against apartheid, the politics of austere health budgeting due to neoliberal macroeconomic policy decisions were highlighted as a key constraint to the fight against HIV/AIDS, tuberculosis and the right to health in South Africa.

The political process surrounding Healthcare 2010 operated in simultaneity with the negotiation of the National Strategic Plan at the national level and the development of a Provincial Strategic Plan for the Western Cape, as described in Chapters 2 and 4. The first issue to be analyzed in this process is the overlapping character of the coordinated political campaign taken up by labor unions, non-governmental organizations and the AIDS movement. In unpacking this process, I will offer an overview of the events that led up to the eventual reinstatement of closed beds interspersed with ethnographic descriptions and the perspectives of those involved in the Coalition. Following this section, I will analyze the Healthcare 2010 policy, the effects of fiscal austerity on a day hospital in Khayelitsha, and the role of the new health policy in implementing the principles of privatization into health service delivery in South Africa.

The Coalition against Public Health Cuts and the South African Labor Movement

The broad coalition of public health doctors, nurses, HIV/AIDS activists, labor union officials and non-governmental organizations that came together to challenge the bed cuts in the Western Cape public health sector developed in a reactive manner to the

Healthcare 2010 policy. Starting with meetings held between public health officials and doctors, the challenge to the underlying logic of fiscal austerity began in the upper echelons of the public health system. Doctors that I spoke with from Groote Schuur hospital recalled meetings where they dissented from the status quo, calling into question the effects of limiting the reach of specialist hospital services in the public sector. While several individuals involved in the Coalition recalled these interspersed moments of defiance, the campaign began to take form in March 2007 when the Western Cape Provincial Treasury released its 2007/08 budget figures.

After the announcement by Provincial Minister of Finance Lynne Brown of a 30 million Rand (approximately \$4.3 million USD) cut in the budget for Groote Schuur and Tygerberg hospitals in March, a meeting held at Groote Schuur hospital on April 2 led to the formation of the Coalition Against Budget Cuts. At this meeting between Provincial Head of Health Craig Househam and several hospital clinicians, Househam declared a R400m (\$57.1 million USD) funding shortfall in the provincial health budget and the need to cut services at Groote Schuur as part of the restructuring of the public health sector. A few of the doctors at this meeting formed the Groote Schuur Committee against Public Health Cuts, which later became the Coalition against Public Health Cuts. From this initial meeting, the core members of the Coalition began to build ties with organizations and individuals at the local, provincial and national level in their attempt to overturn the decision to close beds in the public health sector.

Following this initial meeting with the leadership of the Department of Health, the Coalition expanded from its roots in the specialist hospitals of the Western Cape public health sector to the network of social activists, non-governmental organizations and labor

unions located in the greater Cape metropolitan area. One of the first links created from the doctors contesting the closure of beds was with the Treatment Action Campaign. As the leading HIV/AIDS social movement, the provincial leadership of the Treatment Action Campaign saw the closure of specialist beds as a serious problem for people living with HIV/AIDS as several of the opportunistic infections that result from full-blown AIDS require specialist-level services. The organization Positive Muslims also joined the coalition due to the negative effect of the bed closures on its constituency. The Alternative Information and Development Centre (known as the AIDC) also played an important role in the coalition and the community meetings held to spread the message about the effects of the bed closures. The Alternative Information and Development Centre has operated since 1996 and has played an important role in social justice initiatives such as the apartheid debt cancellation movement with Jubilee 2000 and publishes the social justice-oriented journal entitled *Amandla!*²¹.

In addition to these social-justice advocacy organizations, three labor union organizations played significant roles in the Coalition's campaign against bed cuts. The National Education, Health and Allied Workers Union (Nehawu) was a key partner in pushing forward the legal challenges to the closure of beds through provincial and national institutions. Nehawu was formed at the height of the anti-apartheid struggle in June 1987 by South Africans working in education, health, government and social welfare (Nehawu 2011). In addition to Nehawu, the South African Municipal Workers Union (Samwu), which also formed in 1987, also supported the work of the Coalition.

²¹ *Amandla* translates to "power" in the Nguni languages and developed as a political slogan during the anti-apartheid movement to demand power for Black South Africans. This term continues to be used by political activists as a means of opening community meetings. The response given by those attending is *Awethu*, which translates to "for us".

Both of these unions are members of the Congress of South African Trade Unions (Cosatu), a national umbrella organization for the union movement that formed in 1985 to leverage the power of Black South African workers to end the apartheid regime. Cosatu played a central role in the United Democratic Front, which coordinated the political activity of the anti-apartheid movement and the negotiated transition out of apartheid. Cosatu currently operates as part of a tri-partite alliance with the African National Congress and the South African Communist Party, and as such, plays a central role in government policy decisions.

As the Coalition grew to include the powerful trade union movement, the political momentum against the bed cuts continued to build with the visit of the Deputy Minister of Health Nozizwe Madlala-Routledge on the 7th of May. As one of the chief architects of the NSP, Madlala-Routledge was unequivocal about the need to maintain coverage in the public health system, declaring that “we can’t afford to lose a single bed (Caelers 2007a).” While her comments assured the doctors, medical students and Treatment Action Campaign activists who had introduced the issue to her, Madlala-Routledge took the issue further, promising to “enlist the help of acting Health Minister Jeff Radebe to address the issue of bed cuts with Uys²² and the Treasury (Caelers 2007a).” Only two days later, public sector health care workers affiliated with Nehawu were picketing outside the provincial health administrative building, demanding an end to the bed cuts and handing over a petition calling for a moratorium on their closure. With these two events, the activists leading the Coalition had put into motion two dynamics that were to mark the eventual success, albeit limited, of the budget cuts campaign: the close

²² Pierre Uys was the Provincial Minister of Health in the Western Cape during the 2007/08 period when field research was carried out for this project.

cooperation of the labor movement in their campaign and the inclusion of national-level institutions in a provincial policy process.

After these developments, the provincial leadership of the African National Congress went on the offensive. On May 11th, the Western Cape Premier Ibrahim Rasool took the issue to the medical students of the University of Cape Town, arguing that the bed closures were in fact “unintended consequences” of the budgeting process. On the same day, the national umbrella trade union body Cosatu called on its members to support the health professionals protesting the effects of bed cuts in the Western Cape. The inclusion of Cosatu in the political action surrounding the closure of beds in the Western Cape grew out of the relationship between the core health activists involved in the Coalition and the leadership of Nehawu. As was noted in Chapter 2, the HIV/AIDS movement and its activists had actively worked with the labor movement to contest inadequate government action on HIV/AIDS since President Mbeki’s obfuscating statements on the virus in the late 1990s. However these alliances had been primarily activated at the national level in order to set policy precedents to make treatment available in the South African public health sector. The example of the Coalition working with Nehawu is an instance of local and provincial political processes activating alliances between organizations that represent groups with similar interests that then lead to action that involved national-level institutions.

These local-level ties between the labor movement and HIV/AIDS and public health activists continued after talks between the Provincial Minister of Health and the Coalition held on May 21st. At this meeting the members of the Coalition and Nehawu demanded that the provincial department of health put into place a moratorium on the bed

cuts while starting an “open dialogue” with the Coalition over the restructuring of the public health sector. Provincial Minister of Health Pierre Uys and Provincial Head of Health Craig Househam rejected both demands, declaring that the bed cuts were “inevitable” (Caelers 2007b). Following this meeting, the doctors, health workers and activists that made up the Coalition vowed to “take the fight forward” to stop the bed cuts in the Western Cape public health sector.

I arrived into the midst of this political struggle in the Western Cape when I began my fieldwork in early June. Speaking to HIV/AIDS activists, their attention was primarily on the contentious debate over the closure of beds in the public health sector. As the primary focus of this project was to tether the negotiation and implementation of the NSP from national to local level, I initially considered my research with the Coalition to somewhat peripheral to my research. However I quickly came to realize that the political struggle over budget cuts involved questions of health infrastructure and the delivery of health services that were central to the implementation of the NSP and the delivery of life-extending antiretroviral drugs.

When I began to attend the meetings of the Coalition in June, the group of activists, health professionals and union representatives had shifted towards a letter writing campaign to key members of the African National Congress deployed to the Western Cape. The Coalition sent a letter of inquiry to Mr. James Ngcuku, then Chairman of the Western Cape Government Health Portfolio Committee, requesting that he address the concerns of doctors at Tygerberg Hospital over the closure of beds in their facility. This tactic expanded the public sector base of the Coalition beyond the doctors at Groote

Schuur and while shifting the focus of the health activists away from the two office holders that had rejected their demands in the Provincial Minister and Head of Health.

As part of the Coalition campaign against bed cuts, members of the Western Cape office of the Treatment Action Campaign organized a series of community meetings on the Cape Flats to address the inaction on building promised hospitals in Mitchell's Plain and Khayelitsha. As part of the 2004 election campaign, the African National Congress had promised that new hospital were to be built on the Cape Flats as part of the shift towards primary health care. However at the time of the bed cuts, there had been no action on building the hospitals in these historically underserved health districts. The members of the Coalition picked up on this disconnect between the bed cuts and the lack of action in developing health infrastructure and highlighted this to community members in Khayelitsha on June 27th and in Mitchell's Plain on August 15th. While these meeting went forward with the full support of the Coalition, they were spearheaded by the members of the Treatment Action Campaign's provincial offices for the Western Cape.

The meeting in Mitchell's Plain was particularly significant due to the fact that it was the area of the Cape Flats that several of the Treatment Action Campaign activists called home. Phaedra, a Coloured woman in her mid-thirties, was the chief organizer of the community meetings. Phaedra had been the chief representative from the Treatment Action Campaign in the Coalition meetings, and it had been clear from the outset that this meeting was particularly important for Phaedra as a member of the community of Mitchell's Plain. I had passed in and out of the Western Cape provincial office of the Treatment Action Campaign on a regular basis in the weeks leading up to the event, and

Phaedra had worked tirelessly to make the members of her community aware of the direct impact of the bed cuts and the relevance of this issue for the promised hospitals.

I met several of the lead activists from the Treatment Action Campaign the morning of the community meeting to help drive over some activists and carry over supplies in the trunk of my car. As I drove up to the venue, the Heinzpark elementary school, the juxtaposition of education and health infrastructure was put into sharp relief. While the majority of the buildings in the educational complex were built in an older red brick that indicated that they were built in the late 1960s or early 1970s, there was a new glass and steel gymnasium within which the community meeting took place. The sparkling new interior of the building offered more than enough space to set up chairs for community members to sit and listen to presentations from several community organizations and tables for food and drink after the meeting. As parents sat and listened to these presentations, ranging from angry calls for radical reform in the South Africa public health system to more measured requests for community involvement in the protests against bed cuts, children jumped up one by one and played together in the back of the hall, blissfully unaware of their parents' concerns with the inaction over a new hospital.

While Coalition had been planning and implementing these meetings, their key labor union partner Nehawu had been actively carrying forward the campaign against bed cuts within the structures of Cosatu and in the media. On the second of August, Nehawu and Cosatu released a joint statement in the Cape Argus that challenged the rationale of the bed cuts in the midst of a budget surplus in the Western Cape. Among the reasons offered for the refusal of the union rank-and-file to accept the bed cuts by Cosatu

Western Cape General Secretary Tony Ehrenreich and Nehawu Western Cape General Secretary Suraya Jawodeen were:

- The allocation of billions of Rands for the construction of stadiums for the 2010 soccer world cup;
- A continuing crisis of under-staffing at public health facilities; and
- The provision of poor or inadequate public services (Ehrenreich and Jawodeen 2007)

The show of unity between the labor union structures and the community health activists in the great Cape Town metropolitan region resonated within the broader social sphere, with public opinion beginning to turn against the Western Cape provincial Department of Health. Contributing to this shift in the public perception of the issue was an editorial offered by Professor Emeritus Ralph Kirsch in the South African Medical Journal, which offered a critique of the bed cuts from the perspective of medical professionals (Kirsch 2007). The unity between the traditional source of the working class power in South Africa, the labor union movement, with community activists and the professional class was not a random occurrence but one that was carefully cultivated by key individuals within each of these groups.

During my fieldwork, I had the opportunity to speak with a leading member of Nehawu in their offices in Cape Town. This person, who I will refer to as Glen, was a stern and direct man in his early forties wearing a bright red button down shirt and a black hat in the mold of Lenin. During the course of our conversation, Glen displayed his militancy in class struggle by repeatedly denouncing the GEAR macroeconomic strategy and the increasing levels of social inequality between working class and poor South Africans and the emerging black bourgeoisie and white upper classes. Glen offered a thorough analysis of Nehawu's role in the political process surrounding the bed cuts,

emphasizing the way that Nehawu leveraged its position within Cosatu to push for social justice in the area of health²³.

Now we ran a series of meetings both with the coalition and the MEC, and we ran our own meetings as Nehawu and Cosatu; we acted both within the coalition and outside. And government said that there would be no health risk with bed cuts, the monies are going a lower level. We kept on pointing out that the monies are not going to any lower level. We also began making the call for the building of the hospital in Khayelitsha and Mitchell's Plain. The coalition did that, we did that. So we both participated in the coalition and acted as a union outside the coalition as well.

This dualistic conception of political activity, with the Coalition as one possible avenue of action, enabled the members and leadership of Nehawu to pull the larger and more powerful structures of Cosatu into the struggle over bed cuts in the Western Cape.

It was through these organizational links that a formal legal challenge was put forward against the budget and bed cuts in the Western Cape public health sector. As part of the joint letter sent from Nehawu and Cosatu to the Cape Argus on August 2nd, the labor unions had declared a formal legal challenge to the closure of beds in the public health sector. In the course of our conversation, Glen had offered a useful overview of how this process had come to pass:

Now what we did when we heard about the impending budget cuts, we then issued public statements saying we were going to oppose it. And we took it to a Cosatu constitutional meeting which was called the Cosatu PEC, where leadership of all the other affiliates come. And we said the department of health and provincial government; we have had strained relations with them since the strike. We thought that they were punitive with the dismissal of workers and the province did that, and we told them that. But the other affiliates of Cosatu said that public health service delivery is not a Nehawu matter, it's a socio-economic matter because all

²³ Particularly significant to note in contextualizing the following quote is that Cosatu remains part of the tri-partite alliance that rules South Africa: the African National Congress, the South African Communist Party, and Cosatu.

their members don't qualify for medical aid and they use those services. So Cosatu declared a Section 77 application, which is a Nedlac²⁴ process – that's a chamber where government, business and labor are represented – and a series of negotiations began. Now, failure of parties to find each other in that chamber would result in a deadlock that would see all Cosatu affiliates being legally covered to come out on a strike to defend their socio-economic rights. So there were several Section 77 applications before Nedlac because that's what the Cosatu PEC²⁵ decided.

The import of the decision by Nehawu and Cosatu to put forward a Section 77 application cannot be understated. The application served to set a legal precedent for strike action at a national level. That this process would follow closely on the heels of a month-long municipal workers strike that carried on from June-July 2007 made this threat all the more salient in the political process surrounding the bed cuts.

In addition to providing an a measure of leverage for the Coalition in their attempts to prevent the closure of specialist service beds in the public health sector, the utilization of the National Economic Development and Labour Council is significant for an understanding of the ways that social justice movements are building alliances and utilizing national institutions. The National Economic Development and Labour Council was founded on February 18, 1995 as “the vehicle by which government, labour, business and community organisations will seek to cooperate, through problem-solving and negotiation, on economic, labour and development issues, and related challenges facing the country (NEDLAC 1995a).” The National Economic Development and Labour Council was first established through the National Economic Development and Labour Council Act, Act 35 of 1994, making it one of the first major joint civil society-government institutions established during the post-apartheid era.

²⁴ NEDLAC refers to the National Economic Development and Labour Council

²⁵ PEC refers to Cosatu's Provincial Executive Committee

With separate chambers to address public finance/monetary policy, trade and industry, the labour market and development, and members representing organized business, labor, community/development interests and the state, the National Economic Development and Labour Council is a national consultative body that is directed to:

- (a) strive to promote the goals of economic growth, increased participation in economic decision making and social equity ;
- (b) seek to reach consensus and conclude agreements on matters pertaining to social and economic policy ;
- (c) consider all proposed labour legislation before it is introduced into Parliament ;
- (d) consider all significant changes to social and economic policy before it is implemented or, in the case of legislation, before it is introduced into Parliament ;
- (e) encourage and promote the formulation of coordinated policy on social and economic matters (NEDLAC 1995b).

What made the utilization of the National Economic Development and Labour Council as the mechanism to “take the fight forward” was its peripheral role in the protracted social conflict over the GEAR macroeconomic strategy. Despite the lack of activity in this institution relating to GEAR, as was noted in Chapter 2 HIV/AIDS activists had unsuccessfully attempted to use the Council as an avenue through which to push through a new national AIDS policy in 2003. What is critical to note is that these actions were only possible through an alliance with the structures of the labor union movement in South Africa, and that the existence of structure such as the National Economic Development and Labour Council can be attributed to the central role of the trade union movement in the anti-apartheid movement.

Carrying forward the legacy of the central role of organized labor in the anti-apartheid movement, the National Economic Development and Labour Council also serves as the venue within which the aforementioned “section 77” application can be

brought against an employer. The title of this application derives from section 77 of the South African Labour Relations Act (No. 66 of 1995) which is titled ‘Protest action to promote or defend socio-economic interests of workers’. Under the regulations of the Labour Relations Act, a section 77 application would then be heard in the South African Labour Court. The key factor in the filing of this section 77 application is therefore the ability of a labor union to argue that the closure of beds negatively affects the ‘socio-economic interests of workers’. The contention of doctors and health care professionals that the bed closures negatively affected the ability of poor and working class South Africans to exercise their right to health was therefore critical to the success of the section 77 application.

Despite the threat of legal action by the unions in early August, the Western Cape Department of Health went ahead and ordered the closure of specialist beds in the public health sector via an internal memo on September 13th. The Coalition responded quickly to the bed closures by opening up new fronts in the legal challenge to the restructuring of the public health sector. In a coordinated action on September 18th, Nehawu filed an injunction with the Cape High Court to stop the closure of beds while Cosatu requested the South African Human Rights Commission to investigate whether the closure of beds would infringe on a patient’s right to health care (Herman 2007). While the Coalition weighed its legal options in contesting the bed closures, they organized a candlelight vigil to honor those who will lose their lives due to the limitation of specialist services in the public health sector. After a divisive meeting with representatives from the Western Cape Department of Health on October 16th saw members of the Coalition walk out in protest, legal action was threatened from Cosatu by the end of the month.

In a sharp turn from the closure of beds in September, the Western Cape Department of Health re-opened 28 specialist service beds during November. This positive turn in the Coalition's favor continued in May of 2008 when it was announced that 90 additional beds would be opened for specialist services in the Western Cape public health sector. These beds resulted from two separate increases: the first from National Treasury as part of an additional allotment for the National Tertiary Services Grant and the second an increase in funding for health from the Western Cape Provincial Treasury. From the perspective of my research participant Glen from Nehawu, these increases in funding were the direct result of public pressure placed on the African National Congress by the Coalition and labor unions:

The public pressure put on by ourselves as Nehawu, by Cosatu in the Nedlac process and the coalition's public protests around it found two injections of additional funds into the Department of Health. One last year but the beds were not reinstated; instead what the additional injection of funding did last year was that it prevented any further cutbacks, so people were working within the deficit. But the Provincial Department of Health was forced to increase its budget this year. But we don't think at the actual bed level, but at the level where additional funds were set aside to build the two additional hospitals.

We think that the Department of Health reinstated because the public voices that were gaining momentum began to embarrass the department, therefore even National Treasury, who are the ones responsible for funding for tertiary-level hospitals, increased it by 11% this year and that's what we were told in Nedlac. But that didn't happen because they grasped what we were saying, that their service delivery was starting to collapse because of budgetary constraints. They did it because they were starting to look bad and felt really embarrassed.

This statement by a leading member of Nehawu offers additional contextualization to the quote that opened this chapter from a member of National Treasury that characterized the increase in the Groote Schuur budget as a "popular victory". By means of pressure on the ruling party through the office of the Deputy Minister of Health and the opening of a

section 77 application in the National Economic Development and Labour Council the Coalition and labor unions were able to extract additional funding from National Treasury to prevent the closure of specialist public sector beds. In addition, the public pressure led to public health garnering 34.7% of the total budget allocation for the Western Cape Province for the 2008/09 financial year (Joseph 2008). In terms of the absolute terms of financing, the Coalition's campaign against bed cuts was an enormous success.

The Coalition against Public Health Cuts and the Rejection of Fiscal Austerity

So to the public out there the politicians were saying we need to implement primary healthcare because that is appropriate and progressive, but to us they were saying we don't have enough money for healthcare in this province and the only way to save the money is to downgrade the service. And what we were saying as health activists is that you're killing people, you are going to continue to kill people and what we must be saying to national treasury is "give us more money".

For those who came together to contest the bed cuts and eventually turned their attention to Healthcare 2010, these technocratic decisions violated the constitutional right to health of poor and working class South Africans and challenged the ethical position of those working in the public health sector. The basic tenet of those arguing for Healthcare 2010, that the extension of primary care services would lead to lower patient intake at more specialized levels of care, was a non-starter for those in the coalition. Instead the doctors, activists and labor union representatives in the coalition argued that in fact the opposite would occur: that increased access to public health would lead to increased demand for specialist services. This is a particularly strong argument given the scope of the HIV/AIDS epidemic and the growth of highly- and extremely-drug resistant

tuberculosis in South Africa. Furthermore, individuals associated with the coalition argued that a decrease in the budget for specialist hospitals would endanger the continued training of public health doctors. Rather than a simple closure of beds, Healthcare 2010 represented a challenge to the social reproduction of the health workforce. For the coalition, the goal of Healthcare 2010 was clear: it was an attempt to limit spending on public health that would have far-reaching consequences for the public health sector in the near future. The ramifications of this contention were broad, and cut to the core of how neoliberal fiscal austerity intersected with the challenges faced by the public health response to HIV/AIDS in South Africa.

Growing out of a handful of activist doctors at Groote Schuur hospital, the Coalition Against Budget Cuts began as the Groote Schuur Crisis Coalition. This committee was formed when the leadership of the Western Cape Department of Health had decided to cut 60 level 3 or specialist beds at Groote Schuur hospital in order to eliminate a deficit in the provincial health budget. This had caused an immediate drop in the quality of care that doctors could offer to patients at the hospital, a development with which many were uncomfortable. According to a key figure in the coalition at Groote Schuur:

I'm a doctor working at the hospital that was primarily affected by the proposed cuts and I became involved because of a number of separate things I suppose. First of all as a front-line service provider I was faced with the issue of bed shortages on a daily basis, which is really one of the most frustrating parts of the work that we do. It's something that we had to deal with on a week-by-week basis. People waiting several hours to get into beds, unable to operations because people weren't in beds at that time, always giving sub-optimal care because antibiotics and medication wasn't being administered, and just the dehumanizing indignity of lying in casualty for so long for so many patients and the frustration of trying to care for people in those conditions.

When contextualizing this statement, it is important to keep in mind that doctors at Groote Schuur often work seventy hours a week in conditions that, as is clearly outlined above, are not ideal. However the doctor speaking above was not focused on their individual workload, but on the effect that the removal of beds had on the dignity of their patients. While it is often easy to portray those working on behalf of other as noble or self-sacrificing, the juxtaposition of this attitude against the technocratic logic of Healthcare 2010 reveals a oppositional relationship that lay at the heart of the conflict over Healthcare 2010: Doctors were concerned with saving the lives of patients, administrators were concerned with lowering the health budget.

However the implications for those in the coalition of reducing specialist services were not merely to deny dignity and self-respect to patients seeking treatment. Also significant was that the bed cuts, and by relation the curtailment of specialist services under Healthcare 2010, denied high-level care to those dependent on the public sector for their physical wellbeing. From the perspective of the coalition, the majority of people who would be denied specialist care in the public health sector were South Africans who had never had access to Groote Schuur hospital or any specialist-level care during the apartheid era. According to the same individual cited above:

[T]his had always been a private, white privileged hospital before under apartheid and that many people couldn't access the specialized services here, and the absolute irony is that now in the post-apartheid South Africa when poor black people could access this, the hospital was being run down and broken apart, literally, in front of our eyes.

Given these conditions, several doctors within the hospital began discussing the appropriate steps to counter the closure of specialist beds and began the campaign against bed cuts. This process began with an anonymously organized mass meeting to address the

issue of bed cuts at Groote Schuur hospital that surprised the organizers by being attended by nearly all doctors in the hospital. This meeting led to the formation of the Groote Schuur Crisis Committee, which developed and a petition to halt the bed closures and demanded that the Head of Health in the Western Cape come to the hospital to explain the cuts in service.

After an initial meeting between the Groote Schuur Crisis Committee and the Head of Health for the Western Cape province, the bed closures were not reversed. According to a person present at the meeting, the bed cuts were rationalized according to the following logic:

He basically said that this is a poor to middle income African country and that we can't expect to provide the same level of care that is given to people in the United Kingdom and the US. And as such, we need to distribute our resources appropriately and babies were dying of diarrhea, so we couldn't expect to do complex medical procedures in a hospital like this, which I think is tantamount to racism and classism on a most extraordinary level.

This spirited analysis is perhaps best categorized within the particular experiences of those working in the public health sector. As an individual working in an institutional setting where lives can be saved through advanced procedures, doctors see possibilities rather than constraints. However when looked at from the perspective of health administrators, the bed cuts and Healthcare 2010 were simply a “right sizing” of the services available in the provincial public health sector to the funds available from the provincial treasury²⁶. When examined in tandem with the restructuring strategy embodied by the Healthcare 2010 policy, the bed cuts are operating according to the same logic of

²⁶ Bed cuts and the fiscal austerity embodied by Healthcare 2010 are designed to operate within the 5-year medium term expenditure framework that is drafted provincially, approved the National Treasury, and re-negotiated at the level of provincial treasury once an overall allotment has been made for each province.

reducing high-level services in the public health sector in order to expand basic services. The net effect of this is that specialist services are downsized and centralized in order to achieve economies of scale in terms of the utilization of scarce skills and resources and to inexpensively maintain capital equipment in the public health system. However the point of critique offered by the public health doctor/health activist retains its salience: that this plan, however technocratically sound, serves to cut off technically viable life-saving services to poor, predominantly non-white South Africans that are currently in operation in the public health sector.

While the process of governing a country must entail some level of tradeoff in order to manage and distribute limited financial resources, the impact of public health cuts operated as a form of structural violence on those unable to access or afford health services outside of the public sector (Farmer 1996, 2004). While the naked state violence that marked the later apartheid period has mercifully subsided following the negotiated transition to democracy, a new post-apartheid form of structural violence based on fiscal austerity mirrors the violence of the apartheid period in terms of those are primarily affected: the Black South African poor. This fact has not been lost on activists throughout the country struggling for access to the basic services that sustain life in the face of grinding poverty amongst South Africa's disenfranchised.

Ground Truth: The Effects of the Comprehensive Services Plan, or Healthcare 2010

The Comprehensive Services Plan was first drafted in May 2005 and went through various internal revision processes within the Western Cape department of Health before its release to the public in late 2006. The plan proposed to restructure the

allocation of public health services in the Western Cape to better meet the stated goals of the African National Congress: to extend primary care to those who were historically denied adequate medical services during the apartheid era. The following excerpt is taken from the forward to the policy document, written by the Provincial Minister of Health for the Western Cape, Pierre Uys:

This plan will lead to the strengthening of the district health services and in particular the development of community-based services. This in turn will result in better quality and more accessible care for many people in the communities where they live. Further steps will allow the realistic development of more specialized hospital services in the regional and central hospitals in support of the district-based services. (Western Cape Department of Health 2007: x)

While the broad goals of Healthcare 2010 are in line with what the majority of public health advocates around the world would agree is an appropriate public health platform, Healthcare 2010 nonetheless caused significant political backlash from the public health and non-governmental sectors. The primary reason behind the rejection of Healthcare 2010 was the implementation of limits on the delivery of specialist public health services. Health activists rejected this plan for the public health sector due to the burden of opportunistic infections resulting from the dual epidemic of HIV/AIDS and tuberculosis in the greater Cape Town metropolitan area. While this rationale formed the basis of the Coalition's public platform, the Healthcare 2010 policy was also rejected due to its inability to address the uneven social geography of health infrastructure inherited from the apartheid era.

The Healthcare 2010 policy was primarily concerned with shifting the allocation of funds and resources from specialist level care to primary level care. This shift was rationalized on the basis that greater intake of patients at the level of primary care would

produce lower levels of demand for specialist-level services. According to this logic, potentially life threatening medical conditions such as diabetes would be addressed before they became serious enough to necessitate specialist care. However in order to produce a lower cost model for the provision of public health care, Healthcare 2010 based its allocation of services on total population per health sub-district and the geographical dispersal of human population within a given sub-district (Western Cape Department of Health 2007: 3,4). Because HIV prevalence and the infection rate of tuberculosis are highest in the peri-urban townships of the Cape, this methodology neglected to allocate more resources to areas with higher burdens of disease. This was an important point of critique for health activists and members of the coalition.

The most contentious element of the Healthcare 2010 plan was not the inadequate accounting for the uneven burden of disease in Cape Town's peri-urban townships, but the allocation of funding for different levels of health services in the province. This issue was particularly complicated given the quasi-federal characteristics of the South African political and administrative system, notably for the funding of tertiary or specialist academic hospitals. Funding for primary (health clinic) and secondary (day hospitals) level services were derived from the provincial treasury based upon the allocation of funds based on a formula entitled the "equitable share". The "equitable share" principle distributed funds according to the population of each province, while funding for tertiary or third-level specialist hospitals came from the National Tertiary Services Grant and 50% of the Health Professions and Training Development Grant (Western Cape Department of Health 2007: 93). Therefore, funding for specialist services has come from grants dispersed by National Treasury since the transition out of apartheid.

The National Tertiary Services Grant has decreased from the year 2000 to the present day, leading to the categorization of “some complex conditions/procedures being classified as a level 2 services (Western Cape Department of Health 2007: 96)²⁷.” In other words, what had previously been defined as specialist or level 3 services were being categorized as level 2 services due to funding constraints. Since Level 2 beds are paid for by each respective branch of the Provincial Treasury system, there has been a shift in the burden of public health funding from the national to provincial level. This decline, in line with the national directive of a shift of funds to primary level care, was a key influence on the shift to lower level or primary health services in the Healthcare 2010. In order to address this shift in national funding, Healthcare 2010 proposed the following additions and subtractions to the existing stock of beds in the Cape Town Metro health district:

Level 1 beds:	+1,038 beds
Level 2 beds:	+344 beds
Level 3 beds:	-1,014 beds
Total:	+368 acute beds (Western Cape Department of Health 2007: 93)

What immediately comes to the fore in examining the number in the re-allocation of health services is that Healthcare 2010 actually involved an increase in the total number of beds in the Western Cape province. However, the numbers provided in the Healthcare 2010 policy document are deceiving due to the fact that many of the beds included in the Level 1 total were to be provided by non-governmental and community-based organizations.

²⁷ “Currently there are a number of grey areas in the definitions applied by the National Department of Health to separate tertiary and secondary services. A set of ‘exclusion options’ was applied by the National Department of Health to facilitate the development of tertiary hospitals in under developed provinces. This means that services that were classified as secondary in more developed provinces were classified as tertiary in less developed provinces. The decrease of the NTSG from the year 2000 onwards forced the Western Cape to apply very stringent definitions that resulted in some complex conditions/procedures being classified as a level 2 service (Western Cape Department of Health 2007: 96).”

The shift in the delivery of services back onto communities, particularly with respect to mental health services, is another major aspect of Healthcare 2010 that raised the ire of public health and community activists. This shift of the burden of service delivery back onto communities was based upon the expansion of existing non-governmental organizations to serve in place of services previously offered by the state. According to the authors of Healthcare 2010, this was a progressive goal in that:

Community based services complement and enhance facility based services by providing services in a community setting and also by creating mechanisms through which communities can become aware of their health needs, i.e. the burden of disease, and the related contributory factors. This approach empowers the community which can then participate actively in preventive and adherence health programmes. If community based services function effectively there should be a significant reduction in the number of patients requiring hospitalization (Western Cape Department of Health 2007: 62).

The purpose of this change was to free up hospital beds currently occupied by terminally and mentally ill patients in order to increase the intake capacity for the public health sector²⁸. Despite what appeared to be an increase in beds, the calculations of the Healthcare 2010 policy were dependent on an expansion of community-based palliative care and mental service capacity rather than an increase in the number of beds available in the public health sector. Critically, the sources of funding through which this expansion would be financed were not detailed in the policy document.

²⁸ The Provincial department of health rationalized this policy through the logic of “de-institutionalization”: “De-institutionalization whilst an important part of mental health care reform is not synonymous with de-hospitalization and consists of three components: Prevention of inappropriate mental hospital admission through the provision of community facilities; discharge to the community of long-term institutional patients who have received adequate preparation; establishment and maintenance of community support systems for non-institutionalized patients (HEALTHCARE 2010 2006: 81).”

This transition in the provision of services was accompanied by a corresponding shift in the management and staffing structure of the public health sector in the Western Cape in the Healthcare 2010 policy document. The transformation in the managerial structure of the Western Cape public health sector attempted to overcome the traditional division of the management of health services between the City of Cape Town and the Western Cape department of health. Traditionally the city dealt with all aspects of preventative medicine while the province would fund and manage all other elements of medical care. In the new plan, this division would be eliminated and there would be one health sub-directorate per two health districts (during my fieldwork there was one directorate per district) while human resources and professional support would be centralized in one Chief directorate for the province (Western Cape Department of Health 2007: 31-34). The aim of this plan was to ensure “the availability of proficient support staff without the unnecessary duplication of these services in each sub-district (Western Cape Department of Health 2007: 34)”. While financial functions would be decentralized to each sub-directorate, the plan combined and streamlined the administrative functions of the public health sector.

This centralization of administrative functions was significant because it was used to rationalize a higher ratio of patient time for each nurse working in the public health sector. For example, while the National Department of Health set a national standard for patient time ratio of 0.62, or that a clinical health worker would spend 62% of their time with patients, Healthcare 2010 increased the this ratio to 0.75, or to 75% of nursing hours.

The fact that professional nurses are relieved from dispensing responsibilities and will receive adequate administrative support facilitates a direct patient care factor of 0.75. (Western Cape Department of Health 2007: 13)

In other words, Healthcare 2010 rationalized higher workloads for nurses based on the fact that additional administrative support and additional pharmacist assistants were, theoretically, lessening their workload. This shift towards additional patient workload ignored the difficult work environment that the dual epidemic of HIV/AIDS and Tuberculosis created for nurses working in the public health sector, an issue that will be discussed at length later in this chapter. Despite the predictable effects of this dual epidemic on the public health workforce, Healthcare 2010 nonetheless proposed a radical restructuring of the public health sector that put pressure on nurses to treat patients at a higher rate per day than that recommended in national policy norms.

While the shift from a doctor-driven to nurse-driven public health care model had been called for in low-resource settings by health activists and international health organizations for some time, the Healthcare 2010 policy dictated for an overall decrease in the number of nurses in the public health sector. In addition to this decrease in the total number of nurses, there was a concurrent shift in the Healthcare 2010 policy towards nurses with higher levels of training. For example, the policy mandated a decrease in nursing assistants and professional nurses and an increase in the number of clinical nurse practitioners, the most highly skilled and highly paid of nurses in the public health sector:

- Clinical Nurse Practitioners
 - From 2.64% (71) of current nursing staff to 13.94% (466)
 - Result: 395 new clinical nurse practitioners
- Professional Nurses
 - From 25.9% (698) of current nursing staff to 10.17% (340)
 - Result: 358 fewer professional nurses

- Enrolled Nursing Assistants
 - From 12.22% (329) of current nursing staff to 6.04% (202)
 - Result: 127 fewer enrolled nursing assistants

In total, Healthcare 2010 called for an overall decrease of 90 nurses in the Cape Metro district. In theory, this shift was counterbalanced by a 5.08% increase in the ratio of clerical staff (252 new clerks) and a 2.06% increase in the number of pharmacists (80 new pharmacists)²⁹. While this structure seemed to offer a new manner of providing services while limiting the overall cost of the public health sector, research at a day hospital in Khayelitsha that had been restructured in line with the Healthcare 2010 policy told an entirely different story.

Healthcare 2010 and the Experiences of Health Workers at Site B Day Hospital

Along with a colleague from the University of Cape Town, I carried out a brief human resources analysis that reviewed and quantified the challenge of understaffing at a single hospital complex in the South African public health sector (Powers and Monte 2007). The issue of adequate staffing was particularly pressing for nurses working in the public health sector on the Cape Flats. The townships of this area have high population densities and some of the highest burdens of disease in the country. These factors made research at the Site B day hospital in the township of Khayelitsha an ideal example

²⁹ Explanatory notes: on the proposed versus current staff numbers

1) Because of the broader scope of practice, clinical nurse practitioners will play a major role in clinics and replace a considerable number of professional nurses. Professional nurses will predominately render and supervise clinical support services. This explains the relatively large increase in clinical nurse practitioner posts and the decrease in professional nurse posts.

2) The increase in administrative posts reflects the intention to provide sufficient administrative support to enable professional health workers to spend their time providing health care.

3) The current fragmentation of PHC services is reflected in the large number of current facility managers and cleaner posts required. The future configuration will address current inefficiencies in this regard. (Western Cape Department of Health 2007: 22)

through which to analyze the constraints faced by those working to improve the health of poor and working class South Africans. What emerged out this analysis directly contradicted the restructuring paradigm outlined in Healthcare 2010 and brought into question many of the assumptions in this plan.

Site B Day Hospital was a level 2, or semi-specialized, facility made up of a day hospital (which included a 24-hour trauma ward), a maternity and obstetrics unit, a Youth Clinic, a Simelela Rape Survivors Clinic, and a joint Tuberculosis/AIDS treatment clinic. An analysis of the staffing needs of Site B day hospital was developed through consultation with key members of the hospital staff in order to take into account the verifiable needs of those working in hospital. This model was based upon the bare minimum of what would be needed to run the hospital, without doctors working unpaid 12- and 24-hour weekend shifts and with the nursing staff being able to implement a rotating shift system. In a clinic that employed 72 nurses, 10 new nurses were needed to meet this standard. Furthermore, Site B employed 10 full time doctors; 3 more full-time doctors would be needed to meet this “full” staffing standard defined by public health workers (Powers and Monte 2007).

What became clear during my research at Site B Day Hospital was that Healthcare 2010 outlined an overall decrease in the number of nurses needed in the public health sector despite the fact that there were an insufficient number of nurses at Site B. As Healthcare 2010 was already well into implementation when this research was conducted, the nursing system in place was directly in line with the policy’s calculation of 72 nurse posts needed at the facility. The Healthcare 2010 formula apparently did not account for the 6 nurses on long-term sick leave at Site B, which left their staffing level at

66 nurses to do the work of 82. Further, despite the fact that the new public health policy called for an increase in clinical nurse practitioners and a decrease in lower level nurses, out of the 10 additional nurses needed for the operation of an appropriate shift system, only one was a clinical nurse practitioners. The nine additional nurses called for in the human resources analysis were lower level nurses who could then “free the hands” of the clinical nurse practitioners to roam from station to station in order to monitor the work of lower-level nurses, offer their expertise on particular patients, and play a diagnostic role as part of task-shifting away from doctors. Instead, clinical nurse practitioners at Site B day hospital regularly saw 50-60 patients a day in addition to supporting and managing the hospital’s nursing staff.

Clinical nurse practitioners, or “sisters” as they were known in clinics, relayed their frustration to me during the course of my research. They felt that they were unable to properly do their jobs as they had to deal with simple tasks such as taking blood or moving patients instead of supporting lower-level nurses with diagnosing patient problems. When one sister described her day to me, she calmly reviewed days and weeks of working without lunch breaks and taking on unpaid overtime. One of several clinical nurse practitioners that I spoke with talked about how she was sick and tired of the way that things were, but finished with the question of “Who else is going to do it if I do not?” The calm exterior of this highly trained nurse could not hide her frustration at the calculus that had been forced upon her: to “do the job” within the limits that had been imposed upon her, or to do what was necessary given the amount of need in her community. A question that is raised by this perspective is the extent to which health

policies that operate within the limits of neoliberal fiscal austerity, like Healthcare 2010, depend upon this type of personal sacrifice.

While I did not continue my research at the Site B facility after this short project, to speak with those who labored there left me harboring profound feelings of respect and injustice. Respect for the nurses who assume the responsibility for those lives who would fall between the cracks created by financial formulas. Injustice for the burdens they bear in silence, and of the hours, days, and weeks spent away from their families. That Healthcare 2010 was put into place in a health sub-district with a pre-natal HIV prevalence over 30% offers some insight into how South Africa has become the epicenter of the global AIDS epidemic: infection levels in urban areas did not inform public health policy and financial targets trumped the development of a robust response to the spread of the disease.

Service Delivery, Public Health and Post-Apartheid Fiscal Austerity

One of the great challenges faced by poor and working class South Africans in the post-apartheid period has been negotiating access to basic services such as water, electricity, health care and housing. The challenge to access services by those who were considered to be citizens of independent nations under apartheid is not entirely surprising given the scale of need and the short time frame to redress the unequal development of social infrastructure in South Africa over 300 years. The need for land, housing and the provision of basic services are issues that are inextricable from the socio-spatial model developed during the apartheid period that built upon the racially segregated social geography of the colonial period in South Africa. However the delivery of social services

in the post-apartheid South Africa has moved slowly in the face of great need. Further, the manner in which the African National Congress has gone about meeting the level of privation for those discriminating against during apartheid has garnered deep criticism from academic analysts and spawned a series of new social movements to demand alternative strategies for social service provision. Chief among these demands has been the eradication of cost-recovery measures in the extension of services to those previously excluded, an end to forced evictions, and a moratorium on water and electricity cut-offs for those who are unable to pay for these services.

The African National Congress has made significant progress in the extension of services to historically under-served areas since the party came to power in 1994. However this progress has not been without its problems. A study released in 2002 found that out of the 7 million people who had received access to water since 1994, approximately 18% (or 1,260,000 people) were unable to pay their bills, with another 1.2 million of this 7 million were forced to choose between purchasing water or other vital needs such as food to sustain their households (McDonald & Smith 2002:38). In sum, out of the 7 million people to whom access to water had been provided, 2.46 million, or over 35%, were not able to continue to utilize this privatized public service due to its cost. Another critical review of service delivery in South Africa analyzed these statistics and concluded that up to 2 million people had been evicted from their homes and 10 million people have had their water or electricity disconnected since the ANC came to power (McDonald & Pape 2002). The privatization of water in particular has led to social mobilization in the peripheries of the major cities of Johannesburg, Cape Town and Durban. The Anti-Privatization Forum, Soweto Electricity Crisis Committee and other

social movements grew in response to the outbreaks of cholera and dysentery that were the direct consequence of water cut-offs.

The common theme that runs throughout the literature on the current challenges in service delivery is the criticism of cost recovery in the context of extreme poverty. This developmental strategy, championed by international institutions such as the World Bank, entails a community paying for the cost of its own infrastructural development. For the development of water infrastructure, this is achieved through higher per unit prices of the now “commodified” public resource. Private corporations such as Rand Water in Johannesburg have worked as sub-contractors for the South African government and carried out this process. The smaller role of the public sector in social development dovetailed with the logic of the fiscally conservative GEAR macroeconomic strategy, with the privatization of water closely following the implementation of GEAR in 1998. However its critics see the negative social implications of adopting this approach in a country with a history such as South Africa’s as progressive:

Furthermore, neo-liberal logic rejects cross-subsidization and insists that each community must, itself, ‘recover’ the full cost of installing new connections. Hence the poor, the black poor, must pay much more for their services than the rich in the still largely white suburbs (Desai & Pithouse 2004: 244).

As Desai and Pithouse infer, pursuing cost-recovery rather than cross-subsidization in the South African context disregards the racial legacies of apartheid. Wealthier, better-serviced areas in the post-apartheid period continue to be predominately inhabited by white South Africans who benefited from the apartheid system. Implementing a system of cross-subsidization, or the creation of a graduated scale of water pricing based upon income, would also address the racial legacy of apartheid while lowering the cost of

access to water for poor and working-class South Africans. As Desai and Pithouse point out, cost-recovery pushes the cost of servicing historically underprivileged communities back onto those who have borne the brunt of an unjust history. While revised metropolitan demarcations adopted in the post-apartheid period have integrated the former townships and white urban areas into a common policy framework, due to the policy of cost-recovery in service delivery, this shift has not eased the financial pressure for the poor to access basic services in peri-urban townships.

While the neoliberal logic of cost-recovery has not been discussed at length with regard to the public health sector in South Africa, an issue that emerged during my research was the practice of enforcing hospital user fees. Akin to a co-payment, these hospital user fees were implemented in order to achieve moderate levels of cost-recovery at public health institutions to defray their operating costs. According to the doctors that I spoke with, this practice coincided with the implementation of the Healthcare 2010 policy. While Healthcare 2010 essentially places limitations on care, one member of the Coalition Against Budget Cuts saw the policy itself as a form of privatization:

This was about pushing through an agenda of differential healthcare for different kinds of people, which I think is a kind of privatization. So for people who don't have access to resources and medical aid, they'll be a certain kind of basic healthcare. But highly specialized surgery, medical intervention, would be in the domain of the private sector and that the health practitioners that were involved with that care would continually feel the pressure [that] they were unable to do their work in the public sector and move over to the private. And you can actually see this happening.

This concept of a “two-tiered” health system was perhaps the most tangible way in which the fiscal austerity of the post-apartheid period reproduced the state-produced inequalities of the apartheid period with respect to the provision of health services. However, instead

of using a logic of scientific racism to rationalize policy decisions, a rationale of efficiency and “appropriateness” was utilized to lend scientific legitimacy to a process that determined, in many cases, who will live and who will die. There is thus a convergence between the broader literature on service delivery and Healthcare 2010 with the imposition of user fees for constitutionally guaranteed services. However the critical point is that this development solidified the separation of the South African population into those who are included in the provision of life-saving or life-extending services, and those who are not, on the basis of disposable income.

In addition to representing one way that the neoliberal logic of fiscal austerity puts into motion processes of structural violence, the Healthcare 2010 public health policy moved the provision of health services in South Africa into line with privatization of other state functions in the post-apartheid era. The Healthcare 2010 policy introduced the enforcement of hospital user fees at public health hospitals; an act that moved the provision of health services towards the cost-recovery model of service delivery. The neoliberal health policy thus contributed to the continuation of a two-tiered society in South Africa, but one that now disaggregates the South African citizenry according to the factor of class rather than race. As the vast majority of the South African poor and working class are non-white, this class-based policy produces a social effect that mirrors the racial segregation that has characterized South Africa since its settlement by the Europeans in the 17th century.

Public Health, Political Struggle and the Continuing Legacies of Apartheid

The final significant element of the political process that was led by the Coalition against the Healthcare 2010 policy was the political environment that public health sector doctors endured due to their public stance against its implementation. Despite my own attempts to operate as far outside of the adversarial political dynamics of HIV/AIDS and public health, interaction with members of the Western Cape Department of Health led to me understand the extent to which the dismissal of Deputy Minister of Health Nozizwe Madlala-Routledge had affected even the lowest levels of the public health sector. In sum, this dismissal had forced all public health sector employees to consider whether or not they were risking losing their jobs when speaking of their difficult work conditions or the adverse effects of the Healthcare 2010 policy on their work environment.

The members of the Western Cape Coalition Against Budget Cuts that worked in the public health sector were not immune to this political pressure, as many of the people that I interviewed relayed the threats that had been communicated to them by their superiors. Rather than belabor this point at length, I have included an extended excerpt from an interview with a doctor based at Groote Schuur Hospital. Despite the fact that the public identity of this individual was well known to hospital administrators, I will not identify this individual beyond their institutional affiliation to maintain anonymity as I had promised prior to our conversation.

Doctor: [C]ertainly there has been a lot of personal pressure to try and get me to stop raising issues and there were letters stating that I had been insubordinate and there were numerous threats to my employment. So that has been the response to our commentary.

TP: In terms of the threats, how did that make you feel?

Doctor: I think there are a couple of sides to it. One the one hand I was surprised because I didn't think actually that they were that paranoid. Perhaps I was naïve about

that. Was I scared? Perhaps yes. Not so much of losing my job, but my experience in this health struggle has showed me how easily intimidated people are and how very few people are willing to say anything from within the public health sector. That the stranglehold on free speech and opinions and ideas is actually quite frightening and that people like Househam³⁰ can do what they do because people don't speak out. So my concern was more that there would be silence. Not so much from the community outside but from my colleagues within. I have no doubt that from the community outside there would have been an uproar and we would have had struggles around it, but certainly from within, I couldn't be that sure actually whether people would be united around me, which is quite sad.

TP: Do you think that this is one of the reasons why there hasn't been more of an outcry over the state of public health service in the province? Just in terms of the province, because you can't speak for the country. But I have had interviews with people who are involved with the public health sector who basically told me "well actually I can't do this, I'm scared, I don't want my job, my family depends on my income, I've got 3 children."

Doctor: Yes, absolutely. I have no doubt that I am in quite a privileged position. In that not only that I am single and I don't have dependents and I can do what I want to but also because I've got some political experience behind me and I do know the avenues that you can go through. But from the very first time that I said something on this issue people would come up to me and say "You've still got a job?", like from the very first time. I was told not to speak to the media by everybody. I was advised by my union not to speak to the media. I asked them on what basis, on what legislation and they could never tell me. I could not speak to the media in my individual capacity. In fact the one time that I was misquoted by a newspaper I was brought into the superintendent's office, the chief medical superintendent and his immediate subordinate, and I was basically given a disciplinary hearing for what I had done.

So I think people are terrified and part of it is based on fact and part of it isn't. And it's because they have impunity, they just do what they want to do. I'm not sure how they got to this position of power. I think historically a lot of the laws and regulations come from apartheid and the hospital administration uses them in this day and age to suppress dissent.

This extended excerpt from my interview with this doctor involved with the campaign against bed cuts at Groote Schuur since its onset highlights several key dynamics for the political struggle over public health and HIV/AIDS in South Africa.

³⁰ Craig Househam was the Head of Health for the Western Cape Department of Health during my fieldwork.

The first key point is the utilization of hospital administrators by high-ranking officials in the Western Cape Department of Health to intimidate this doctor and health professionals involved in the campaign against bed cuts. This dynamic, whereby individuals holding positions of power in state institutions utilized their office to achieve political ends, finds its mirror image with the dismissal of Deputy Minister of Health Nozizwe Madlala-Routledge. This event, which was discussed at length in Chapter 2, differed from the dynamics involved at the provincial level in that it involved the Office of the Presidency and the individual in question was removed from office. However the underlying dynamics are similar: the ruling party did not tolerate dissent from employees or party representatives working in public office or the public health sector. People who disagreed with formal government positions would either be threatened with dismissal or relinquished of their responsibilities. The personal account offered by this particular doctor at Groote Schuur was repeated time and time again by other nurses and doctors working in the public health sector: public sector employees in the health sector had experienced problems at work, they had made their supervisors aware of the problems that existed, and these interventions were greeted with threats or outright dismissal.

However the social and institutional power of the South African labor movement is another remnant of the anti-apartheid movement that decisively affected the direction of the political struggle over public sector health cuts. From the development of National Economic Development and Labour Council to the inclusion of a socio-economic interest clause in the section 77 application process, the South African trade union movement has been critical in shaping the post-apartheid state, the economic policies adopted by the government, and HIV/AIDS policy at the national and provincial levels. Despite a central

role in the South African government, the labor movement continued to exert pressure on policies that negatively affected working class and poor South Africans. The existence of the labor union power bloc in South Africa therefore serves as a key conduit for social justice movements to influence government policy. The example of the HIV/AIDS epidemic and the struggle over bed closures in the public health sector highlights the progressive possibilities that emerge from the existence of a vibrant labor movement in a particular national case study.

Conclusion

The example of the Western Cape Coalition against Public Health Cuts offers another point of insight into the political field of HIV/AIDS in South Africa. This political movement was able to challenge and defeat the imposition of neoliberal fiscal austerity in the public health sector by mobilizing public support and grassroots organizations in the Western Cape. The significance of this event for the theorization of the political field of HIV/AIDS in South Africa is that it points to the ability of a pro-poor coalition of non-governmental organizations and activists to change public health policy at the provincial level. This offers a counter-example to the utilization of the provincial institutions of the state offered in the previous chapter, where the ruling party was able to leverage its position as intermediary between international donor capital and non-governmental organizations to undermine critical feedback in the consultative meetings for the Western Cape Provincial Strategic Plan. Rather than simply a site of state domination, the provincial node of the political field of HIV/AIDS displays the necessity

of including both governmental and non-governmental actors in an analysis of transnational political influence.

Despite the success of the Western Cape Coalition Against Budget Cuts, the greater Cape Town metropolitan area remained an arena of intense struggle for the politics of HIV/AIDS throughout my fieldwork. In what was perhaps the most challenging series of dynamics to explore, the politics of HIV/AIDS on the Cape Flats was oriented around local institutions funded by transnational donor capital while the government-aligned political opposition to these bodies was based on one of the most important remnants of the anti-apartheid movement in South Africa. As I will discuss in the chapter that follows, it was only after a series of conversations with those directly involved with these political dynamics that I was able to understand the true impact of the AIDS dissidence position on communities that were highly infected and affected by the HIV/AIDS epidemic.

Chapter 6

Local Institutions and the Politics of HIV/AIDS in Khayelitsha

It seems that politics here is somehow distant from getting involved with the HIV/AIDS issues. And that is the challenge that you are sitting with. They [the ANC] receive funding and we've approached them to say that we don't receive adequate funding. And it's just like...there's really a deafness. They [the ANC] are supposed to be part of our meetings. That is one of the challenges that we sit with. Some structures are supposed to be part of the MSAT strategy. They [the ANC] don't attend meetings at the sub-district level. This is happening all over.

The quote above came from a research participant who I will call Michael, a community leader from Gugulethu who was working with local HIV/AIDS institutions to improve the community response to the epidemic. Michael and I were discussing the political dynamics that surrounded the Multi-Sectoral Action Teams, or “MSATs”, which were institutions that were financed by the Global Fund to coordinate and support community-based organizations working to fight the spread of HIV/AIDS for each of Cape Town's eight health sub-districts. During our conversation, Michael expressed his frustrations over the limited input that the MSATs had on citywide HIV/AIDS policy, the limited involvement of key government representatives in their meetings, and the lack of participation of key community-based and non-governmental organizations in the Klipfontein health sub-district. Michael had been a part of the MSAT structure and its meetings, but had become disillusioned over the impact that this institution could have without the support of local ANC representatives and their constituents.

Despite the clear picture that Michael had drawn about the political process that surrounded the local HIV/AIDS coordinating mechanism, it was only after an interview that I carried out with members of the Khayelitsha MSAT that I began to understand the

organizational and institutional dynamics of the local political field of HIV/AIDS on the Cape Flats. At a meeting with representatives from the Khayelitsha MSAT, they described an adversarial political environment with respect to the coordination of community-based organizations working to stem the tide of HIV/AIDS. The divisive environment was driven by one particular non-governmental organization, the South African National Civics Organization, or SANCO. Through control of key community institutions, members of SANCO limited the ability of the Khayelitsha MSAT to interact with community-based organizations, and consequently, to assist in the coordination of their activities.

Further research and interviews with community-based AIDS activists from Khayelitsha gave greater credence and depth to the claims from the members of the Khayelitsha MSAT regarding the role of SANCO in undermining the coordinated response to the HIV/AIDS epidemic. They described supporters of the ANC tearing down posters, members of Sanco and the ANC closing off access to local political institutions from AIDS activists, recruiting community members for an illegal clinical trial of a scientifically unproven vitamin-based AIDS treatment, and the outright attempt by members of the ANC Women's League to change the messaging of an MSAT structure to AIDS dissidence. The Cape Flats were the key flashpoint for the political struggle over HIV/AIDS in the Western Cape. However the focal point around which the local political field of HIV/AIDS oriented were the MSATs, the local sub-district coordinating institutions that were supported by funding from the Global Fund.

The perspectives of AIDS activists and people living with HIV/AIDS have served as a central focus in much of the anthropological literature on the epidemic in South

Africa. Robins (2006) conducted field research in the township of Khayelitsha but focused primarily on the perspectives of AIDS activists working within the Treatment Action Campaign. Thus the analyses offered by Robins focused primarily on identity transformation amongst activists as they became part of the organization's mission to make AIDS treatment available in the South Africa public health sector. Robins put forth the first line of research from the field of anthropology on the formation of urban social movements to contest the politics of 'AIDS dissidence' in South Africa. While this line of research has been vitally important in theorizing the dynamics of AIDS politics, there is an internal focus on the AIDS activist community in this work that tends to disaggregate the work of AIDS activists from the communities within which they live.

Fassin (2007) has focused on the way that the HIV/AIDS epidemic is an embodiment of the structural violence that Black South Africans have experienced over the last three and a half centuries on the continent's southern reaches. Fassin draws on the voices of people infected with, or affected by HIV/AIDS from urban townships to emphasize the central role of history in the experience and understanding of disease amongst the urban poor. However these excerpts tend to be intermittent and disembodied from the political process unfolding within the urban communities within which these individuals live their lives.

While an economist by trade, Nattrass (2004, 2007) has written extensively on the effects of the HIV/AIDS epidemic on highly infected communities. However her focus has been primarily on national-level government policies on South Africa's urban poor. While the voices of activists and community members figure into these analysis, the framing of the mode of inquiry inevitably derives from a top-down perspective on the

experiences of those in urban townships. The analyses offered by Natrass offer the most comprehensive analysis of AIDS politics in the post-apartheid period, but the focus here is not on the everyday experiences and perspectives of the urban poor living in areas with the highest HIV/AIDS prevalence rates.

Rather than take the views of urban residents Steinberg (2008) focuses on rural perspectives on the HIV/AIDS epidemic in his ethnography. While this geographic focus is somewhat unique in the anthropological literature, the analysis offered tends to emphasize belief systems in binaristic terms between traditional modes of understanding the epidemic and the modern biomedical approach to HIV/AIDS. Steinberg offers a fascinating description of the ways that traditional beliefs frame local understandings of HIV/AIDS and inform both individual and social processes. However this description stops at the level of the community rather than contextualizing the role of traditional beliefs in the national and provincial politics of HIV/AIDS.

In the most recently published anthropological analysis of the South African HIV/AIDS epidemic, Susser (2009) builds on the views of poor and working class women living in both urban and rural areas highly affected and infected by the HIV/AIDS epidemic to critique the oppositional view of traditional and modern put forth in the anthropological literature. Susser focuses on how the perspectives of these women have been shaped by their everyday experiences and their common sense responses to the challenges they have faced due to the effects of the epidemic on their communities. This approach emphasizes the way that women in South Africa have fused traditional and modern belief systems around a 'common sense' understanding of what works in addressing the pressing challenges raised by the HIV/AIDS epidemic in everyday life.

In this chapter, I focus on my fieldwork in the townships of Khayelitsha, Nyanga and Gugulethu on the Cape Flats. The majority of my ethnographic data was gathered from long-term participant observation with activists in the Treatment Action Campaign, observation of community meetings focused on health, marches and demonstrations carried out by community leaders, and interviews with people living in each of these communities. My contribution to the body of ethnography gathered in the urban peripheries of South Africa's cities is an analysis of how AIDS activists, community members, non-governmental organizations and political parties have interacted to produce the political dynamics of HIV/AIDS at the local level.

More particularly, I offer an in-depth ethnographic analysis of how the social institutions that remained from the anti-apartheid movement, the urban civics organizations, continued to influence local-level political processes and the community dynamics that surround the HIV/AIDS epidemic. Further, my fieldwork underscored the ways that national political dynamics were localized through a loose alliance between the urban civics organizations, non-governmental organizations, and local representatives of the ruling party, the African National Congress. Therefore, the ethnographic data collected here fuses the anthropological analysis of urban AIDS activists, national political processes, and the perspectives of South Africa's urban poor.

In this chapter I will contextualize the political field of HIV/AIDS in the township of Khayelitsha through an analysis of the political dynamics that surrounded the Khayelitsha MSAT. In particular I will examine the institutional history of SANCO, its relationship to the ANC, and the ways that these organizations interacted with local AIDS activists. I will argue that an alliance between SANCO – a non –governmental

organization with its roots in the anti-apartheid movement – and the ANC disseminated the ideas and alternative therapies associated with AIDS dissidence throughout the Cape Flats. Furthermore, I will argue that these activities counteracted the scope of transnational political influence by undermining the authority of internationally funded local HIV/AIDS coordinating mechanisms. Through this process, the institutional structures that were set up to represent the community's position on health related issues, including HIV/AIDS, were politicized by the contentious political struggle over HIV/AIDS in South Africa at the local level. The consequences of this political dynamic were that coordination between the city and the community on matters related to HIV/AIDS was disrupted, and that the local public health response to the HIV/AIDS epidemic was forced to operate without tangible feedback from its health sub-districts.

In analyzing this political process, I will contextualize the current state of affairs in the political and economic history of Cape Town and its relationship to its peri-urban townships, Khayelitsha in particular. I will then incorporate the perspectives of my research participants on the politics of HIV/AIDS on the Cape Flats with a focus on the role of local political institutions in this process. Finally, I will analyze the role of SANCO in these dynamics through an examination of the organization's history and political role in the post-apartheid era. Through this narrative, I will analyze how and why the AIDS epidemic became so politicized, and yet so distant from formal political processes on the Cape Flats.

Cape Town: Historical Continuities and post-apartheid Urban Transformation

An international tourist destination featuring the majestic Table Mountain and seemingly endless stretches of sandy beaches, Cape Town embodies many of the deep

divisions that South Africa inherited from the colonial and apartheid periods. Perhaps none of these contradictions is as striking as the continued social separation of the city's inhabitants into the racial divisions and the extent to which the uneven built environment mirrors this separation of the South African populace. While causal factors to explain the socio-spatial continuity with the apartheid period are difficult to single out, it is clear that newer market-driven forms of segregation are now being constructed on top of the racial separation of South Africa's people developed during the colonial and apartheid eras (Oßenbrügge 2003: 8). The market-driven form of segregation that typified the post-apartheid period was being driven by the rough correlation between race and class that grew out of the unequal resources dedicated to the education and development of the separate 'racial' groups under apartheid.

While it is difficult to perceive when located in the central areas of Cape Town, there is an estimated housing backlog of 265,000 homes that continues to grow by 16,000 annually that is concentrated in the city's urban periphery, the Cape Flats (Smith 2007:8). This backlog is contributing to the growing population of people living in informal settlements, estimated to comprise one third of the city's population (Smith 2007:8). While few visitors to Cape Town spend the time to drive down Landsdowne Road through the series of townships that make up the Cape Flats, the differences in the quality of housing and standard of living between different racial groups cannot be ignored. From the crumbling council houses of Hannover Park inhabited by "Coloured" Capetonians to the mazes of shacks in predominantly Xhosa-speaking Khayelitsha, the Cape Flats embodies the inequality in the allocation of public resources and infrastructure inherited by non-white South Africans from apartheid.

The mushrooming of ‘informal settlements’ or shack-dwelling communities in Cape Town during the post-apartheid period is not a phenomenon that is unique to South Africa. Throughout the developing world, as cities such as Lima, Lagos, Mexico City and Kinshasa grow, so do the populations of those who living at their outskirts in peri-urban informal settlements. In “Planet of Slums”, Mike Davis (2006) defines peri-urban informal settlements, or slums, as key geopolitical spaces, as they will be the primary source of the world’s population growth in the 21st century. Davis argues that the current phase of urban development in the developing world has become de-linked from economic development and industrialization leading to the creation of a surplus population disconnected from the formal economy. This dynamic is perhaps most acute in sub-Saharan Africa, as the pace of population growth in its peri-urban slums are growing at twice the rate of its cities (Davis 2006:18). However as Pithouse has pointed out, Davis neglects to differentiate between various forms of survival strategies utilized by those inhabiting ‘slums’ in painting a hopeless and menacing picture of urban settlement in the 21st century (Pithouse 2007). While Davis correctly points out the political and economic dynamics underscoring the growth of informal settlements globally, in South Africa peri-urban settlements trace their roots to the colonial period.

The growth of informal settlements in post-apartheid South Africa has been driven by increasing poverty in rural areas, and a concentration of economic activity in the major urban areas that has been produced by policy decisions in the post-apartheid era. While Davis ties the global wave of urbanization and the blossoming of slums to IMF policies that generate an exodus of surplus labor from rural areas, South Africa has not been forced to alter its policies due to structural adjustment or loan conditions

imposed by the IMF (Davis 2006: 15). Analyzing South Africa specifically, Bond argues that the rising influence of financial capital has produced urban policy that conceptualizes urban spaces as single economic units (Bond 2005c). This policy framework essentially decouples the governance of rural and urban spaces while emphasizing cost recovery of municipal services. This has had the predictable effect of raising the cost of basic social services for the poor in both rural and urban areas (McDonald 2002). This norm in South African urban planning has been exacerbated by trade liberalization and the GEAR macroeconomic policy that have driven rural farmers to peri-urban informal settlements located around the major urban centers in South Africa (Walker 2005).

The policy decisions related to macroeconomic policy and trade, while reintegrating South Africa back into the global economy, have also exacerbated the employment differential in South Africa's racially segmented labor market. White South Africans benefited from higher levels of education and employment due to politically imposed labor restrictions during the apartheid period, and the shift to an open market system aimed to compete in global markets has favored those with skilled labor. Therefore the formal unemployment rate of 25.5% and the expanded definition of 40% must be mediated by the racial composition of these statistics (Statistics South Africa 2007, Frye 2006). An analysis of unemployment data from 1993-2002 indicated that, under the broad definition of unemployment, Indian South Africans were 2.7 times more likely to be unemployed than White South Africans; Coloured South Africans were 3.7 times more likely to be unemployed than White South Africans, and Black South Africans were 6.5 times more likely to be unemployed than White South Africans (Kingdon and Knight 2004: 201).

It is thus unsurprising that in South Africa's shackdweller communities, which are predominately inhabited by African or Black South Africans, unemployment rates are disproportionately high. A representative sampling of these communities revealed unemployment rates of 58% and 72% (Richards et al. 2007: 383). Moreover, those living in these shackdweller areas are also nearly twice as likely to be living with HIV/AIDS.

Figure 6: Comparing HIV Prevalence in formal and informal settlements

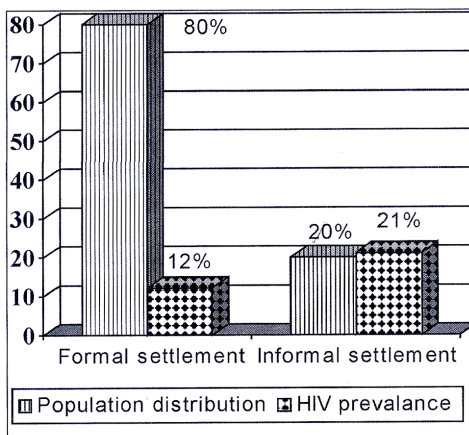


Figure 14.1: Population distribution between formal and informal settlements and HIV prevalence by settlement type in South Africa
Sources: Human Sciences Research Council (2002) & Census data.

Source: Thomas 2006

A well-established rationale for the high rate of infection in informal settlements is the negative economic impact HIV/AIDS has on a household. In order to access treatment, the cost of transport, additional food and medicine must be accounted for within limited resources (Booyesen, Bachmann & Van Rensburg et al. 2002). These costs can be devastating for households that are already stretching to meet their basic needs, and must be considered as a factor in driving households to seek lower living costs in informal settlements. However, other factors, such as environmental health, are also critical to understanding the relationship between HIV/AIDS and informal settlements. People

living with HIV eventually live with a compromised immune system, which is put under additional stress from poor water quality and high levels of exposure to other diseases put under stress. This combination of factors often results in illness and an inability to attend work on a regular basis (Thomas 2006: 283). Therefore one can see HIV as a cause of the growing number of people living in shackdweller communities, *and* the shackdweller communities as the cause for the growing number of people living with HIV.

Thus, although Cape Town has a relatively low rate of HIV prevalence compared to other major urban centers in South Africa, the differences in HIV prevalence within the city itself correspond to the divide in formal/informal settlement described above for South Africa as a whole. If one breaks down the Cape Town metropolitan area's 18.2% HIV prevalence into various areas in the city, this same pattern emerges:

Figure 7: HIV Prevalence for the City of Cape Town divided into areas

AREA LEVEL HIV SURVEY				
TABLE 1. Area Level Surveys: HIV Prevalence for the Western Cape by Area 2004-2006				
DISTRICT	AREA	HIV PREVALENCE (95% CI)		
		2004	2005	2006
Cape Metropole	Blaauwberg	1.2±1.0	7.3±3.6	5.8±3.5
	CapeTown Central	13.7±4.7	11.5±3.3	11.1±3.1
	Greater Athlone	16.4±3.6	17.7±3.5	12.9±3.1
	Helderberg	18.8±3.3	12.8±3.0	17.3±3.6
	Khayelitsha	33.0±3.5	32.6±3.2	32.7±3.2
	Mitchells Plain	12.9±3.5	5.1±2.0	11.3±2.8
	Gugulethu/Nyanga	29.1±2.8	29.1±3.9	28.8±3.8
	Oostenberg	14.8±3.3	16.2±3.5	18.8±4.4*
	South Peninsula	10.8±3.2	12.4±3.2	11.5±3.1
	Tygerberg Eastern	12.7±3.6	15.2±3.5	15.6±2.8
	Tygerberg Western	15.1±4.0	15.0±3.1	16.0±3.0
	Metropole Total	17.8±1.1^a	17.0±1.1^a	18.2±1.8^a

Source: Provincial Antenatal Survey, Western Cape Department of Health (2007)

The areas that have the highest HIV prevalence in Cape Town, Gugulethu/Nyanga (29%) and Khayelitsha (33%), are also the areas that contain the vast majority of people living in shackdweller communities. The importance of this well-established relation is that as informal settlements continue to grow in South Africa, so too do the geographic areas within which HIV infections are concentrated. However to simply underscore the geographic correlation between employment rates and HIV prevalence rates does not address the historical processes that have produced the shackdweller communities that exist at the peripheries of South Africa's major urban centers. Khayelitsha's history offers an interesting vantage point to understand the growth of these communities as it was one of the final townships to be settled during the apartheid regime.

A Brief History of Khayelitsha and the Black Township during Apartheid

The township of Khayelitsha was officially created in March 1983, when it was announced by the apartheid government that Black South Africans could legally reside in metropolitan Cape Town. At the time of Khayelitsha's formalization as a labor reserve for the city of Cape Town, 23,083 of the city's 206,482 black residents were migrant workers and there were 76,000 'illegals' that were not qualified to live in Cape Town due to influx control (Cook 1985:58). The announcement in 1983 ended the Western Cape's designation as a Coloured Labour Preference Area, the abolishment of which became official in September 1984 (Cook 1985: 57, 60). The lack of a formal policy to deal with black migrant workers had led to the construction of backyard shacks and a large number of squatters that occupied unsettled land in the township of Crossroads (Cook 1985:58). These squatter camps had been subject to increased abuse from local authorities following the passage of amendments to the Prevention of Illegal Squatting Act in 1976,

1977, and 1980³¹. In response to continuing conflict between the anti-apartheid movement and local authorities backed by the apartheid state in Crossroads, the government announced that black residents not ‘legally’ residing in Cape Town could build shacks near site-and-service plots in the area today known as Site C in Khayelitsha (Cook 1985: 60). In effect, this decision shifted the area for Black settlement further away from the urban center of Cape Town, increasing transport costs for Black workers.

The formalization of a new area for Black South Africans was taken in response to growing numbers of people moving to the city from the rural Transkei in the early 1980s. The original planning for Khayelitsha aimed to have 250,000 residents, a sharp contrast to current population estimates of 600,000 to 1 million for the same geographic area (Cook 1985, BBC 2001). This population estimate of 250,000 for Khayelitsha was based on plots that were only 35% of the size recommended for black areas in the 1950s (Cook 1985: 61). However the first building phase for Khayelitsha planned to house 800 single contract workers, continuing a pattern of providing hostel/dormitory accommodation for migrant laborers that facilitated repatriation to the Bantustans (Cook 1985: 64).

Furthermore the original proposal for Khayelitsha included the decision to cancel the planned provision of services to other squatter areas, portraying the logic of racial containment that was typical of apartheid urban planning (Cook 1985: 60). The formalization of Khayelitsha as a labor reserve brought Cape Town closer to the ideal model of the apartheid city as it “consolidate[d] black urban residents into a single, peripherally located residential area [...] large enough to contain population expansion (Cook 1985:60).” However the continuity between the segregated colonial labor regime

³¹ Cook (1985:59) citing Howe 1982

and the apartheid system was strong enough for analysts to describe Cape Town as virtually unchanged through the mid 1980s (Cook 1985, Christopher 1983). These facts bring into question whether the development of Khayelitsha was intended to create a sustainable black settlement in Cape Town – as it was portrayed by the apartheid government – or to continue the spatial logic of the apartheid city.

This is particularly true for the state of health infrastructure in the townships. Although progressive academics and medical practitioners had lobbied for an expansion of community-oriented primary care since the 1940s based on the pioneering work of Sidney Kark, health infrastructure in South Africa's townships during the early 1980s was limited to volunteer-based community health clinics supplied by and staffed by the key medical schools³². While these initiatives significantly increased the number of residents who were able to access basic health services, their scope was limited due to the voluntary basis on which key staff, such as doctors, worked, and the limited financial support for the health programs compared to the level of need. While the construction of health facilities has moved ahead in the post-apartheid period, it has done so slowly in the face of great need that continues to grow along with the rising numbers of people living in these areas. According to a community leader in Khayelitsha:

In the aftermath of apartheid there was only one day hospital in Khayelitsha that was intended to serve a population of 500,000. There were also only two high schools at that time with the balance as primary schools; there are now four high schools in Khayelitsha. Since levels of education and opportunity were so low and there was only one major police station, Khayelitsha, the biggest township in Cape Town, was dominated by shebeens and crime, which are instruments of social destruction.

³² The late Dr. Ivan Toms, a key architect of Cape Town's pioneering post-apartheid HIV/AIDS strategy, was a driving force in the provision of basic health care to residents of the Cape Flats during this period.

In Khayelitsha, there have been three major community health centers constructed in the post-apartheid era that service between 600,000 and 1 million residents: Ubuntu or Site B Day Hospital, Nolungile or Site C Day Hospital, and Michael Mapongwana or “Michael M” Day Hospital. The focus of these community health centers is on primary health care, in keeping with the ANC’s focus on addressing the inequality of health infrastructure in historically under-serviced areas.

With respect to HIV and Tuberculosis, it has been non-governmental organizations rather than the South African state that have developed the necessary infrastructure. At the three major community health centers in Khayelitsha, Médecins sans Frontières (Doctors without Borders) developed clinics for the distribution of antiretroviral therapy in conjunction with the Western Cape provincial government in 2002. These pilot clinics were developed to demonstrate that AIDS treatment, including antiretroviral therapy, could be successfully managed and administered in a low-resource setting. In this regard, these sites have been a phenomenal success as they have successfully demonstrated that this type of care is possible. Furthermore, Médecins sans Frontières and the Western Cape Department of Health had transferred the management of these facilities to the public health sector. This antiretroviral clinic pilot project has been extremely influential due to these factors.

However during my fieldwork all three clinics were experiencing difficulty maintaining their operations due to excessive demand for HIV testing and antiretroviral therapy. The result of operating at overcapacity was longer waiting times, which according to both doctors and AIDS activists, was leading to lower rates of adherence to treatment and higher morbidity rates. While there were efforts underway to decentralize

this system of AIDS treatment to men's and women's health centers by the Western Cape Department of Health, at the time of writing this initiative has yet to go forward. The example of the HIV/AIDS treatment centers in Khayelitsha does display that AIDS treatment can be accomplished in low-resource settings. However this example also points to a lack of government action to increase the capacity of the HIV/AIDS and Tuberculosis clinic at Site B in the face of a growth in demand for AIDS treatment. As such, the example of the Site B HIV/AIDS clinic brings into question whether the public-private partnership model for developing health infrastructure is sufficient to meet the level of need in South Africa's peri-urban townships. The public-private partnership model operated within the tight fiscal environment for social spending that was the result of the neoliberal macroeconomic measures put into place with GEAR.

In addition to the challenges of health service delivery in the context of macroeconomic fiscal austerity, new patterns of migration produced new trends for HIV prevalence and treatment in shackdweller communities. Recent research indicated that migration patterns have shifted for residents of Khayelitsha during the 2000-2005 period, from primarily in-migration from the Eastern Cape to internal migration within the township coupled with in-migration from other areas in Cape Town (City of Cape Town 2006b). However Hunter (2006) points to a pattern of movement between rural areas and peri-urban informal settlements that has emerged as mothers increasingly relied on familial networks in rural areas to assist with child rearing responsibilities while they sought work in urban areas. Hunter (2006) posits that shifting the conceptual focus from 'migration' to 'movement' revealed that women are moving more often than men both within urban areas and between urban and rural areas.

These patterns of movement are important because research indicates a correlation between HIV status and labor migration, with migrant men 2.4 times more likely to be infected than non-migrants (Lurie et al. 2003: 155). Furthermore, having lived in 4 or more places and working as a migrant were independent risk factors for HIV prevalence due to social disruption and relocation (Lurie et al. 2003: 155). While applying these statistical trends for migrants to Hunter's conceptual shift to 'movement' may not provide sufficient overlap for a direct relationship to be established, women involved in this new pattern of urban-rural movement are more likely to have a higher number of sexual partners due to the use of various forms of transactional sex as a survival strategy to manage unstable income streams (Hunter 2006). Unfortunately, establishing social mechanisms to channel social assistance to women at risk of HIV infection in shackdweller communities is also difficult, as high mobility rates in these settlements make it more difficult to build trust and community cohesion. The result is a dearth of community-based organizations through which care and information could be disseminated to residents in these areas (Thomas 2006:283).

In addition to the shortage of organizations and information on the dynamics of shackdweller communities or 'informal settlements', the increasing cost of basic social services due to privatization may be another reason for movement within townships and into the shack areas. To contextualize why poor and working class South Africans have struggled with pre-paid service delivery, take into consideration these figures from Khayelitsha. An independent survey done in 2003 indicated that half of residents in Khayelitsha live on less than R167 per month (\$23.19) and a third of residents on less than R39 a month (\$5.41) (Desai and Pithouse 2004: 258). Taxi fare from Khayelitsha to

central Cape Town costs R14 round trip (~\$2) and a standard fast food meal costs R25 (\$3.47). Approximately 80% of residents in Khayelitsha live in informal dwellings (Smith 2007: 18). In two areas of Khayelitsha, Sites B and C, it has been reported that there are an average of 105 people per toilet (Smith 2007: 18). It is thus not surprising that 52% of those responding to a survey on service delivery in Khayelitsha indicated their dissatisfaction with service delivery in general, with 17% indicating that they were highly dissatisfied (City of Cape Town 2006a). Given the limited amounts of disposable income outlined above, residents of informal settlements depend on the South African public sector for their health care. Given that the public health system is experiencing a deep crisis, this has pushed many people with limited resources to access the private medical sector, providing additional pressure on limited available resources.

While the social impact of cost-recovery and privatization of local service has been well documented, the effect of this model of service delivery on local political processes has not been given equal attention. Heller, who makes a valuable contribution to this literature, argues that this shift to privatizing social services in order to achieve cost-recovery has involved increased reliance on “technocratic forms of decision making” based upon “neoliberal and neomanagerial” criteria (Heller 2003: 168). Furthermore, this emphasis on technical modes of governing has led to an increased role for international consultants, the vast majority of whom have little experience working with the community and little knowledge of its political history. The role of local government in this system is reduced to that of a “night watchman”; overseeing the contracting of services with transparent financial management and cost recovery acting as the key indices of good governance (Heller 2003: 169). Moreover, Khan (1998) argues that this

focus on managerial models and financial efficiency has excluded input from the urban civics movement and communities in the policy process. Heller describes cost recovery as having a devastating effect on local democratic participation, describing a political environment in which:

[C]itizens are reduced to customers, and democratic principles of accountability (including participation) are replaced with market signals (Heller 2003: 169).

This dynamic is at odds with the vision of “integrated local development” articulated in the White Paper on Local Government of 1998 wherein consultation with communities is described as the center of the policy development process (Heller 2003: 169). This is arguably the most important policy for the post-apartheid restructuring of the South African state given that local government is the primary deliverer of state services.

A key point for understanding the effects of this political dynamic is Heller’s insight that the closure of the local policy process has pushed the urban civics movement into local representative structures (Heller 2003: 171). As I will describe below, Sanco, which is the national corporate structure of the urban civics movement, has representatives that occupy ward level and township-wide representative positions in Khayelitsha. While academics such as Patrick Heller, Elke Zuern and Jeremy Seekings have analyzed the internal dynamics of Sanco and the urban civics movement, my focus is on the effect that this shift of the organizations representatives into and alongside the local level of the state has had on the implementation of HIV/AIDS policies. However in order to contextualize this transformation of local political dynamics in the post-apartheid period alongside the politicization of HIV/AIDS, it is necessary to describe the institutions coordinating the HIV/AIDS response for the City of Cape Town.

Cape Town's Integrated Strategy for HIV/AIDS

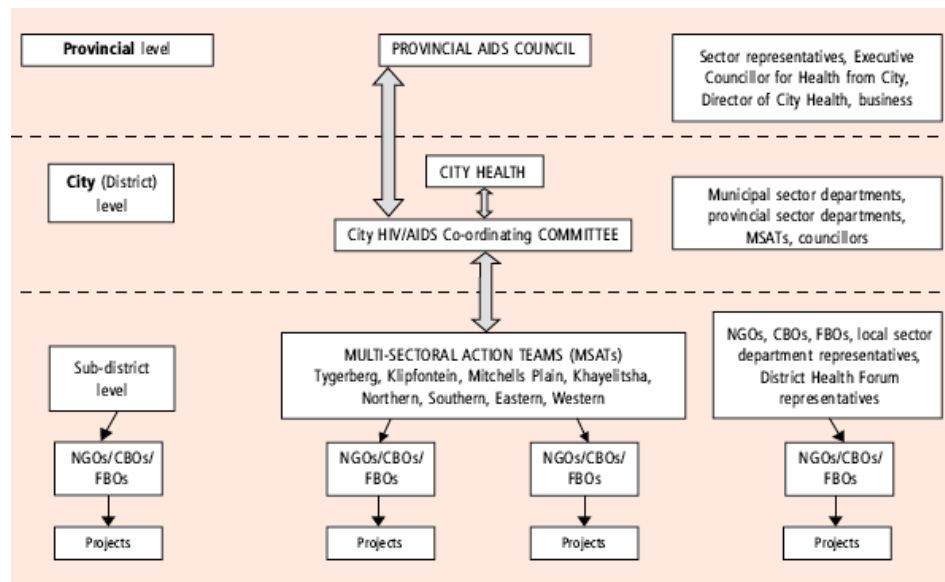
The transformation of the South African state in the post-apartheid period extended to local government in 2000 when the country held its first democratic local elections. Along with this “final phase” of restructuring came new responsibilities for local government with wide-ranging repercussions for service delivery. As discussed above, local government has struggled to meet the growing backlog in housing and other basic services, due partly to the privatization of service delivery and inadequate investments in infrastructure. However with respect to the HIV/AIDS epidemic, the local government in Cape Town was one of the first to develop a comprehensive municipal response to the epidemic, making it a useful case study to gauge how local government has managed HIV/AIDS in South Africa (Smith 2007:8).

The City of Cape Town is made up of 8 health sub-districts which each cover a population of approximately 400,000 residents (Smith 2007:27). At the metropolitan level, there is a City HIV/AIDS/TB Coordinating Committee that includes representatives “from all sector departments within the City’s administration, councillors from Health as well as other portfolio committees, staff union representatives, as well [as] external representatives from provincial government departments and civil society organizations” and through which quarterly feedback is given by municipal sector departments and Multi-Sectoral Action Teams (MSATs) on progress with their activities (Smith 2007: 24,33). (See diagram on the following page) It is at this level that monitoring and evaluation occurred so that duplication of services at the local level did not occur. However in their review of the coordinated city response, the Isandla Institute report outlined the following shortcomings in this institution (Smith 2007: 34):

- 1) A lack of consistency in representation from sector departments
- 2) Nominated representatives from sector departments do not have decision-making authority
- 3) Poor attendance by representatives from political parties
- 4) Limited representation of provincial government sector departments
- 5) No representation from the business community
- 6) Need for more two-way dialogue

Interviews and informal conversations with those involved with the City HIV/AIDS/TB Coordinating Committee confirm these conclusions. The significance of these observations was that a key local institution for implementing HIV/AIDS initiatives, the City Coordinating Committee, was not fulfilling its mandate. For my own research I wanted to examine more closely how local government structures operated below the level of citywide bodies. I chose the sub-district of Khayelitsha to analyze these local institutions and their role as intermediaries between the City HIV/AIDS/TB Coordinating Committee and the community.

Figure 8: Diagram of the City of Cape Town's Institutional Response to HIV/AIDS



Source: Smith 2007

At the level of health sub-district in the City of Cape Town there are coordinating structure for community-based organizations working on HIV/AIDS. These structures, called Multi-Sectoral Action Teams (MSATs), were founded and continue to be supported, by the Global Fund to fight AIDS, Tuberculosis and Malaria. The management of the coordination strategy in each sub-district is led by two HIV/AIDS/TB/STI Coordinators and an MSAT Coordinator. The MSATs meet monthly, have an executive committee of 5-10 individuals and 20-30 active members that voluntarily join the coordinating mechanism (Smith 2007: 40). The annual budget for each MSAT is R15,000 or at current exchange rates just over \$1,467.71 (Smith 2007: 40). Although this money is primarily used for administrative costs and awareness-raising activities, with a population of approximately 400,000 per sub-district, these crucial coordinating mechanisms currently receive less than half a cent per capita in funding.

MSATs, much like the City HIV/AIDS/TB Coordinating Committee, have had difficulty securing commitment from sector departments, lack of participation from health officials, general lack of capacity, as well as tension between MSATs and community health forums (Isandla 2007: 42-3). Although there have been promises to capacitate the MSATs to do more in their communities they remain under-funded, over-stretched and operate primarily as a mechanism for disbursing and monitoring grant money from the Global Fund and the City of Cape Town to community-based organizations. The majority of MSAT leaders that I spoke with were frustrated with this state of affairs. However, the political issues faced by MSAT leadership extend well beyond that of issues such as funding and capacity. Speaking with members of the

Khayelitsha MSAT, they described how they were unable to implement much of their initiatives due to lack of cooperation from the Khayelitsha Health Forum.

While the purpose of the Multisectoral Action Team was to coordinate the activities of government and the community, the leadership of the Khayelitsha institution described a “fracture” between the Multisectoral Action Team and the Khayelitsha Health and Welfare Forum. According to the Multisectoral Action Team leaders, this political divide was produced when a leading member of the Sanco was elected as chairperson of the Health Forum. The Multisectoral Action Team interviewees described how this person was able to “take over” the Health Forum due to the fact that the community was dependent upon the chairperson to voice their concerns, that he/she had played a role in the anti-apartheid struggle, and that he/she had close ties to well-known political figures. The chairperson of the Health Forum had taken an oppositional stance towards the Multisectoral Action Team, creating institutional deadlock and rendering the activities of community organizations in Khayelitsha opaque to the institution. The Khayelitsha Multisectoral Action Team interviewees were in agreement that the key to accessing non-governmental organizations and community-based organizations in their area was achieving the “buy-in” of the chairperson. Thus, political resistance from a leader of a national urban civics association with close ties to the ruling party undermined an internationally funded institution aimed at curbing the spread of HIV/AIDS. However the political dynamics described by people involved with the Khayelitsha Multisectoral Action Team were not a singular phenomenon on the Cape Flats. This process reproduced itself, with some variation, in the township of Gugulethu.

While a community leader affiliated with Sanco limited the ability of the Khayelitsha Multisectoral Action Team to function properly, in Gugulethu members of a local branch of the African National Congress attempted to shift the focus of the institution towards scientifically unproven alternative AIDS treatment. This information was relayed to me by Michael a member of the Klipfontein Multisectoral Action Team, a quote from whom opened this chapter. Please find below an excerpt from my interview with Michael:

M: We found that locally, where we had this foundation, he came with an alternative to ARVs [antiretroviral drugs] in our area. They wanted to infiltrate MSATs and I mean, I was in Gugulethu, there was an office setup politically aligned to drive this process. People from the league, they've operated, they're still operating this office. They were part of the MSAT. They tried to bring it into the MSAT and we said, "No, we cannot do that."

TP: But it's SANCO?

M: No.

TP: Is it NAPWA?

M: No, it's people from [the] Women's League. There's a councillor driving this process. People from the Women's League.

Steve's commentary expanded the scope of political and institutional analysis to include a local chapter of the African National Congress's Women's League and a formal political representative with the ward councillor. These comments must also be contextualized with the process through which Sanco worked with the vitamin salesman Matthias Rath to disseminate scientifically unproven AIDS treatment in Khayelitsha and Gugulethu, which was described at length in Chapter 2. While leaders of the Klipfontein Multisectoral Action Team were able to withstand political pressure to change the focus of the institution towards alternative therapy, in this case a local political branch of the

ruling party attempted to capture an internationally funded institution charged with spearheading the implementation of an orthodox response to the AIDS epidemic.

The political dynamics engulfing community and state institutions on the Cape Flats offers insight into the local political field of AIDS in the post-apartheid South African township. While Sanco operated as the public face of resistance to AIDS orthodoxy in Khayelitsha, in Gugulethu it was local African National Congress structures that attempted to use the institution as a hub for disseminating obfuscating messages on AIDS. The politics of HIV/AIDS on the Cape Flats revolved around the activities of the Treatment Action Campaign, African National Congress and the South African National Civics Organisation, with the political process that ensues from their interaction pivoting around transnational political influence in the form of the MSATs.

The Local Dynamics of AIDS Dissidence on the Cape Flats

The majority of my local-level fieldwork in South Africa was conducted in the peri-urban townships of the greater Cape Town metropolitan region, the Cape Flats. The primary reason why this area was chosen for long-term in-depth observation was its status as epicenter of the political struggle over HIV/AIDS in South Africa. From the pilot studies of antiretroviral treatment to the initiation of a full-fledged antiretroviral program in the public health sector, the Western Cape province and the city of Cape Town moved ahead far more quickly with orthodox HIV/AIDS treatment than other provinces. This was primarily due to the opposition political control in the province by an alliance between the New National Party and the Democratic Party (as discussed in Chapter 4). However, leading organizations in the HIV/AIDS movement such as the

Treatment Action Campaign and Aids Law Project also established operational bases in Cape Town and were a critical force in lobbying the provincial and city governments to break with national policy and extend orthodox HIV/AIDS treatment in the province.

While these political dynamics emerged out of behind-the-scenes lobbying between AIDS activists, engaged academics and provincial administrators, the pilot projects were based in the township of Khayelitsha. The hospital at which I conducted the human resources analysis discussed in Chapter 5, Site B Day Hospital, was the facility at which the first HIV/AIDS clinic dispensed antiretroviral treatment as part of the public health sector. While this program was run by *Medicins sans Frontieres* (Doctors Without Borders) and financed by a grant from the Global Fund, it was nonetheless the first major initiative to initiate an antiretroviral therapy-based HIV/AIDS program in a low-resource setting. The growth of the Khayelitsha office of the Treatment Action Campaign within 100 feet of this clinic underscores the extent to which Site B, as a place, was the epicenter of efforts by the AIDS movement to establish antiretroviral therapy as the standard for AIDS treatment in the South African public health sector.

While the Treatment Action Campaign carried forward of the mission the AIDS movement, organizations that were aligned with the AIDS dissident faction of the ANC also focused their efforts on spreading the messages of alternative and traditional treatments for HIV/AIDS. As discussed in Chapter 2, the efforts of organizations aligned to the ANC-led hegemonic bloc began to take shape following the widespread availability of antiretroviral treatment in the South African public health sector in 2003. The activities of the hegemonic AIDS dissident bloc began in the spring of 2004 with the invitation of the German vitamin salesman Dr. Matthias Rath to give a presentation on

traditional health at the Medical Research Council (Rath Foundation and Sanco 2007: 16). Dr. Anthony Mbewu, who was later named by Thabo Mbeki to serve as the President of the Medical Research Council, invited Dr. Rath to give this presentation. At this conference, Mbewu called for initiatives to pursue traditional medicine as part of the future of medicine in South Africa.

Less than a year later, the Rath Foundation had set up a pilot program on the Cape Flats to test the efficacy of an alternative HIV/AIDS therapy. This treatment regime was based upon vitamins that provided micronutrients to individuals suffering from the opportunistic infections that result from the failure of the immune system with full-blown AIDS. The local branches of the national umbrella organization Sanco were intimately involved with this initiative, serving as the hub from which the alternative HIV/AIDS pilot was launched. Word of the Rath-Sanco project spread quickly, and the leadership of the Khayelitsha branch of the Treatment Action Campaign sent several activists to investigate the situation in May 2005. Nathan Geffen, who during my fieldwork served as the director of Policy, Communications and Research (PCR) at the Treatment Action Campaign, published his memoirs in 2010 and offered a useful overview of the early stages of the Rath-Sanco project:

In early 2005 Rath set up clinics in Khayelitsha and other Cape Town townships where his agents began distributing multivitamins as a treatment for Aids. [...] In March, Majola asked a few TAC members to go Rath's facilities posing as patients. What they encountered was disturbing. Rath's staff discouraged them from taking ARVs and told them that Rath's multivitamins would strengthen their immune system and make them better. [...] Some of the TAC people were told to take 30 of Rath's tablets a day. Some were promised several hundred rands if they returned (Geffen 2010: 139).

According to several of the TAC activists involved in this act of surveillance that I spoke with, the Rath-Sanco operation was run out of the homes of prominent Sanco members. These activists relayed to me that Sanco had acted as a local sponsor for the activities of the Rath Foundation, served as the staff for the pilot study, distributed fliers and pamphlets advertising the activities of the Rath Foundation, and had also made attempts to recruit people living with HIV/AIDS in Khayelitsha to take part in the initiative, statements that were repeated in Geffen's account (Geffen 2010: 142).

Upon verifying the existence of this pilot study in Khayelitsha and other townships such as Gugulethu, the Treatment Action Campaign and its legal partner, the Aids Law Project, filed litigation against the Rath Foundation. In preparing for this legal action, the counter-hegemonic AIDS movement again relied on its ties with the labor movement to develop a broad base of support. This support was formalized with a joint statement from the Congress of South African Trade Unions and the South African Communist Party that pledged their support for the pending litigation against the Rath Foundation, confirmed that Sanco was working with the Rath Foundation in Khayelitsha, and affirmed that government policy dictated that the treatment for HIV/AIDS was antiretroviral drugs (Cosatu and SACP 2005). The activists of the counter-hegemonic AIDS movement solidified their legal case against the Rath Foundation with the support of the South African Medical Association and affidavits from several key medical experts on the treatment claims made based on food supplements. In addition, the global network of the Treatment Action Campaign kicked into gear, producing statements from the World Health Organization and UNAIDS condemning the unsupervised and unregulated pilot study that was carried out by the Rath-Sanco initiative.

Despite this tide of national and international criticism against the pilot study, the Rath-Sanco pilot study was promoted as a success and the project was expanded into the Eastern Cape province. On June 15, 2005, the Rath Foundation held a press conference championing the results of the pilot study in Khayelitsha as proof that vitamin-based treatment for HIV/AIDS was effective. The Treatment Action Campaign immediately condemned these claims as baseless and the result of an illegal clinical trial, while Cosatu and the South African Communist Party issued their joint statement in response to this press conference on June 30, 2005. Despite the pending litigation filed by the counter-hegemonic AIDS movement, in October the Rath-Sanco alliance confirmed that they had expanded their activities into the Eastern Cape province (Cullinan 2005). With the distribution of materials occurring in the public health sector hospitals in the province, the Treatment Action Campaign expanded its alliance into the academic sector, gaining public statements from the University of Witwatersrand and Harvard University condemning the activities of the Rath-Sanco alliance.

After this period of initial action, the conflict over the Rath-Sanco vitamin trial in Khayelitsha largely played out in the court system. The legal battle centered on the contravention of the Medicines and Related Substances Act 101 of 1965 by the actual content of the vitamins and the carrying out of a study that did not have the appropriate permissions from the Medical Research Council as per human subjects. The case was referred to the Cape High Court, where arguments were heard from both sides of the case in March 2008. Finally, on June 14, 2008 the Cape High Court ruled in favor of the Treatment Action Campaign that the laws of the South African government had been broken by the actions of the Rath-Sanco initiative. Perhaps most damagingly for the

Rath-Sanco initiative, the court ordered for the Rath Foundation to pay for the legal costs of the Treatment Action Campaign.

However, while the political battle in the courts system was under way the Sanco-Rath alliance continued to press on with their project of marketing an alternative AIDS therapy. Despite the ongoing litigation, the Rath Foundation and Sanco published a book entitled “End AIDS! Break the Chains of Pharmaceutical Colonialism” in 2007. The book was co-authored and co-published by the two organizations, with all profits earned from sales of the book given to Sanco (Rath Foundation and Sanco 2007). An introductory statement by the President of Sanco, Mlugisi Hlongwane, outlined some of the key factors behind Sanco’s involvement in the alternative AIDS therapy initiative.

I am confident that the decision we took as the South African National Civic Organisation to support the work of Dr Rath was a correct one. We recognize that as a community organisation we were not medical experts. But we equally recognized that the economic superstructures are not in favour of the poor, especially those in Africa. Therefore, although we remain ambivalent on the efficacy of anti-retrovirals (ARVs), we are in full agreement with the facts that Dr. Rath presents (Rath and Sanco 2007: 24).

There are two things that I find to be notable about this passage in this brief excerpt from the leadership of Sanco. First, there is a focus on the production of facts about the alternative AIDS therapy distributed by the Rath-Sanco initiative. This focus on the production of facts via a pilot study was modeled on the clinical trials model of Western medicine. As this quote points out, the “End Aids!” text focuses on giving scientific legitimacy to a process that was managed outside of the formal parameters of the scientific community.

The motivation for providing this scientifically backed foundation for the leadership of Sanco was clear: to rid the public health sector of antiretroviral drugs. In a

narrative that utilizes many of the core themes of AIDS dissidence described in Chapter 2, Hlongwane characterizes the global pharmaceutical industry as fomenting fascism and profiteering off of the AIDS epidemic.

For SANCO, this book represents an opportunity for South Africans to learn what we have learned about the role, nature and objectives of the pharmaceutical industry. We are convinced that this industry has its roots in fascism, has deliberately and consciously assisted the building of fascist movements, and continues to truck in keeping people ill for profits – then this industry will be appropriately regulated and its business practice obliterated (Rath and Sanco 2007: 25).

The correlation drawn by Hlongwane between the global pharmaceutical industry with the rise of fascism in Europe is anchored in the anti-apartheid struggle. In this formulation, the South African population would be liberated by the end of “pharmaceutical colonialism”. This position mirrors the cynical position towards the corporations of the former colonial powers and the critique of global capitalism in the ideology of AIDS dissidence. Furthermore, it reinforces the critical role of Sanco in the anti-apartheid movement and the authority that the organization retains in South Africa’s townships as a result of this organizational history.

While Hlongwane frames the “End AIDS!” narrative as a means for the South African population to educate itself about the dark underbelly of the global pharmaceutical industry, the book found itself circulating within the organs of the state apparatus. More specifically, a pamphlet that was based on the core findings of the Rath-Sanco initiative was distributed in the mailboxes of parliament in April 2005. The “End AIDS!” book was passed out to meeting attendees in May 2008 at a HIV information workshop in Durban, KwaZulu-Natal by the KZN Minister of Health Peggy Nkonyeni. At this meeting, the National Minister of Health Manto Tshabalala-Msimang was the

keynote speaker while the Treatment Action Campaign was barred from attending (Lombard and Cullinan 2008). While the exact ties between the ruling party, the Rath Foundation and Sanco are not clearly drawn out, the close association between the organizations and sharing of critical information on alternative AIDS treatment points to a loose yet coherent convergence of interests.

In sum, the dynamics that I observed in Khayelitsha reinforce my characterization of the 2004-08 period as the era during which AIDS dissidence decentralized. Further, the coalition of organizations and interests that constituted the ANC-led hegemonic bloc furthered the cause of an ‘African’ alternative to Western AIDS treatment via the Rath-Sanco initiative in Khayelitsha. The AIDS movement, led by the Treatment Action Campaign, continued to build a broad coalition based upon an alliance with the labor movement and utilized the institutions of the state to further entrench antiretroviral therapy as the formal public health response to the HIV/AIDS epidemic. The Treatment Action Campaign-led counter-hegemonic bloc maintained the core strategy of the AIDS movement from 1998-2004 during this period by using the legal system as the primary means of ensuring access to AIDS treatment in the public health sector. These dynamics, which were unclear to me when I began my research, were clarified by my conversations with a research participant I will call Siphiwe. Through his insight, many of the overlapping political ties that produced the political dynamics of HIV/AIDS described above emerged from the maelstrom of political activity surrounding the epidemic.

Siphiwe’s Story: critical perspectives on post-apartheid governance

As I placed my recorder on the ground, its hard plastic exterior rattled against the cool floor tiles and echoed throughout the empty room. The building, empty save for a few old mattresses, had just months earlier been an office bustling with AIDS activists. This house located in Muizenberg, one of Cape Town's southern suburbs, had become an impromptu shelter for several community activists being threatened by local gang members. As the damp air of the Cape Town night crept into this makeshift sanctuary, Sipiwe related his experiences as a community activist in Khayelitsha to me. Sipiwe had worked with several organizations in the township of Khayelitsha during the past decade, organizing around issues of water, community development, and HIV/AIDS. When we met in July of 2007 Sipiwe was working with the Treatment Action Campaign, and we had grown to know one another through various meetings and events prior to our conversation in May 2008.

We sat together in the large room, each with our backs against an adjacent wall while a single bulb reflected off the yellow plaster walls. We had discussed at length the reasons why he had been forced to move out of his shack, and I began to ask Sipiwe about the community's response to the intimidation he had experienced. When I asked him directly why community members did not offer support, Sipiwe immediately turned his focus to the South African National Civics Organization. The South African National Civics Organization (SANCO) is a national umbrella organization that was formed in 1992 and houses the urban civic organizations that played a pivotal role in mobilizing the black townships during the anti-apartheid struggle in the 1980s. While the organization went through a period of financial difficulty in the late 1990s as foreign donors turned their attention to supporting South Africa's fledgling democracy (Seekings 1996, 1997),

it had re-emerged as a key organization involved in township development initiatives in the post-apartheid era (Heller 2003). In Khayelitsha, a township located 20 kilometers outside of Cape Town that boasted a population estimated anywhere from 600,000 to 1 million residents, SANCO members continued to play a significant role in local political institutions such as area development forums and community policing initiatives.

This turn in the topic of the conversation from a focus on community to SANCO was one that I find to be instructive for an understanding of the politics of AIDS in the post-apartheid townships of South Africa. There are several correlations within the following interview excerpt that offer significant insight into the way that local politics and the HIV/AIDS epidemic mutually constitute one another in post-apartheid South Africa.

TP: So let me ask you a very direct question: what do you think is the reason that they are just acting like they don't care? Do you think is has anything to do with the fact that they would think that you are HIV positive?

S: I think the problem is that there still people who are not... You see, with SANCO it is a component of [the] ANC and SANCO is known to be supportive of [the] ANC. But it is supposed to be a non-political organization, CBOs, NGOs, churchgoers, every organization in the community should affiliate along uSANCO and should be the same to SANCO. But now its ANC and they see uTAC as an organization that is protesting against [the] government or marching against [the] government or posing a threat to the developments they want to put in place. So I think that was their reason. And two is that if they saw the t-shirt of HIV positive they think that you are going to crush the minister of health.

The first noteworthy aspect of this quote is the conflation of two distinct social units, one of a local community in Khayelitsha, and that of a non-governmental organization, SANCO. When I asked Siphwe why the community did not offer their support during the tribulations he experienced with gang members in his area, the explanatory unit is not 'the community' or 'the people', but SANCO. The association between SANCO and 'the

community' underscores the continued influence the organization and the ongoing socio-cultural legacy of the local institutions of the anti-apartheid movement in the post-apartheid era. However the significance of the South African National Civics Organization's role in Khayelitsha extends beyond its legacy as a key organization in the anti-apartheid movement.

Later in the conversation with Sipiwe, I pushed a bit further on the topic of the relationship between SANCO and the community. His answers shed additional light onto why this association is central to this inquiry into the effects of transnational political forces on the politics of AIDS in post-apartheid South Africa.

TP: So what effect does SANCO have on the community? I mean, do they have a big influence on what people think and the way that they act?

S: They have a big influence on the people in the community.

TP: How do they have an influence?

S: They are the one that is bringing development. If there is anything that is going to take place or be built in that area, it should start through their meetings.

TP: So it's through SANCO?

S: Ja, and they should agree as SANCO members before they go, there's an exco³³ meeting, and they should agree at that exco meeting before they call a general meeting for the whole area to understand what is going on to tell the community. That they should agree, if they want that they will agree, if they don't want that then they are not going to agree then they are just going to turn that down.

TP: But it's within SANCO structures that they decide that?

S: Ja. They don't decide that with everyone in the community. They will decide that. You can't just go there and be a speaker. You have to consult uSANCO, and if uSANCO is happy with what you are going to do, they are going to say it's fine, build it, or do it. And if they are not happy, they will point you to that direction, and point you to that direction, and point you to that direction, and you end up losing...

³³ The term Exco is shorthand for Executive Committee

As this passage indicates, SANCO, the social institution that arguably operated as the de facto local government in Khayelitsha during late apartheid, maintains its coherence in the post-apartheid period, albeit through new and variegated socio-political processes. The organization's survival through the political transition and into the post-apartheid period means that many of Khayelitsha's area development forums and street committees, and therefore local politics, were under the day-to-day political influence of SANCO. As such socio-economic initiatives in Siphwe's area of Khayelitsha, be they related to HIV/AIDS or housing, were funneled through the local structures of SANCO.

The effect of these political dynamics on Siphwe's attempts to educate his community about HIV/AIDS were tangible. Part of the research I had conducted with Siphwe was to drive around his area of Khayelitsha and analyze the political geography of AIDS politics and community development. At one point we sat in the parking lot of a new shopping center that had brought lower priced groceries to the area while leading to the construction of a new community center, another manifestation of the public-private partnership model. Siphwe described how AIDS activists had attempted to use the community center to educate the community about the epidemic only to turn up for the event and find their posters and pamphlets destroyed. When Siphwe had inquired into the reason why the posters and pamphlets had been removed prior to the meeting, the representatives from Sanco that he spoke with responded that it was due to the aggressive stance taken in some of the printed literature towards the Minister of Health, Manto Tshabalala-Msimang. Given the central role of SANCO in distributing alternative AIDS therapy in Khayelitsha, the solidarity with a key figure in the AIDS dissident faction of the ANC is not unexpected. However, the long-term effect of this event was to close off

access to the community center for AIDS activists. This shopping center was a significant site to have access to as it had become the hub of community activity and was the primary signifier of post-apartheid social development in Sphiwe's area.

This political dynamic also affected the ability of Sphiwe to access his area development forum, a local institution chaired by a community representative and the elected ward councillor. This body, which Sphiwe previously described as dominated by the South African National Civics Organization, was vital for planning activities as its approval was necessary for community support for a given initiative. Sphiwe described to me how, on two occasions, he had made firm plans with the local councillor and members of the South African National Civics Organization to hold meetings on how to develop a joint plan for educating the community about HIV/AIDS. However, when he arrived at the agreed upon location at the scheduled time, no one else had shown up. This type of evasion is what Sphiwe referred to when he stated "they will point you to that direction, and point you to that direction, and point you to that direction, and you end up losing". It is thus not coincidental that Sphiwe utilized the term 'SANCO' in place of community, for it is the South African National Civics Organization that is directing the developmental trajectory of his community through their presence in local political and social institutions.

This dynamic, moreover, points to a second slippage in Sphiwe's first statement between the South African National Civics Organization and the ruling party in South Africa, the African National Congress. While this connection can be partly attributed to the overlapping histories of the two organizations in the anti-apartheid struggle, it is also the result of the SANCO's organizational history and its institutional strategy in the post-

apartheid period. The organization has emerged as a key intermediary between the African National Congress and a series of resurgent social movements in South Africa's townships that have organized communities in response to the negative effects of cost-recovery in social service provision (Zuern 2002, 2006). While oppositional social movements such as the Anti-Privatization Forum have organized community protests on issues such as the privatization of water, SANCO has acted as an intermediary between disaffected communities and the ruling party due to the organization's ties with high-ranking members of the African National Congress and the influence of its members within local political institutions. These ties have their roots in the anti-apartheid movement, and they have carried forward into the post-apartheid era.

The South African National Civics Organization (SANCO) was formed in 1992 as the civic movement in South Africa sought to exert influence on the negotiated transition out of apartheid. The civics movement, which coalesced into the SANCO structure in 1992, was a key part of the anti-apartheid movement during the mid-1980s. Local civic structures, many of which were tied to the United Democratic Front, challenged the community leadership structure, or village councils, that came about as a result of the Black Local Authorities Act of 1982 (Cook 1985: 57). The black local authorities were viewed as illegitimate, were ineffective in governing the townships, and often served as an extension of the intelligence services for the apartheid state. These structures were replaced with street committees that served as the key model for social organization in townships during the anti-apartheid struggle. With the disbanding of the United Democratic Front following the legalization of the ANC and the South African Communist Party, the decentralized civic movement created a national 'corporatist'

organizational structure in order to influence policy around urban planning and local government, and were in fact quite effective to this end (Heller 2003).

After having played a key role in defeating the apartheid regime, the civic movement was faced with a period of uncertainty, as it was unclear whether the civic movement would continue to operate as an autonomous political structure given its historical support for the ANC. The civic movement had been largely supported by foreign donors during the 1980s, and had formed the street committees so critical to the success of the United Democratic Front. The organization ran into financial difficulty by the end of 1996, as donor funding for community organizations dwindled with the negotiated transition to democracy (Seekings 1997). This led to a period of uncertainty within the organization as SANCO leaders such as Winnie Madikizela-Mandela were brought into the ANC leadership, regional branches seceded from the national organization, and discussions were held at national level concerning a transition to a political party (Zuern 2006:185).

After this period of uncertainty, SANCO developed a closer working relationship with the ANC, evidenced by key ANC ministers serving as senior leadership (Zuern 2006: 189). Given its stated membership of 6.3 million people in 4,300 branches and its close relationship with the ANC, SANCO must be acknowledged a major player in post-apartheid South African civil society (Zuern 2006). This relationship grew stronger as new social movements such as the Anti-Privatization Forum and Soweto Electricity Crisis Committee challenged the ANC policy of cost-recovery for basic services in townships.

As the ANC sought to revive its branches and its connection to township residents in the wake of growing discontent and the rise of new social movements challenging the government, it was clearly reaching out to SANCO for help. In the run-up to the next elections, the ANC sought

SANCO's support for door-to-door community campaigns in return for greater acknowledgement of SANCO's role as an alliance partner (Zuern 2006: 189).

SANCO proved willing to make this alliance, lending their support to controversial ANC-backed credit control measures, such as pre-paid meters, that led to water and electricity cutoffs (Zuern 2006: 190).

However the organization's definition of a new role in the post-apartheid era took shape when it grabbed national headlines by negotiating a write-off of R1.39 billion in public service arrears for poorer members of Johannesburg (Zuern 2006:190). Zuern thus (2006) argues that the alliance between the ANC and SANCO is a tenuous one, with SANCO primarily serving as an intermediary between local government and the community (Zuern 2006: 195). Somewhat paradoxically, then, SANCO has survived a period of institutional uncertainty due to a lack of local political leadership in the aftermath of the political transition, which created demand from communities for civics that were further "left" oriented and would exert pressure on the state to meet their needs. As an organization SANCO was able to plot a course through these political struggles by leveraging the power of its local branches and relationship with the ANC government (Zuern 2006:197). Therefore rather than a "revolutionary social movement", SANCO "clearly assists the ANC in pursuing its goals "by channeling and co-opting" popular demands at the local level, leaving its political future tied into the success of the ANC (Zuern 2006:198). The analysis offered by Heller and Zuern regarding SANCO branches around Johannesburg was mirrored by the political activity I observed around the HIV/AIDS epidemic on the Cape Flats.

SANCO has performed a similar role as intermediary between radical social movement and ruling party with respect to the HIV/AIDS epidemic in Khayelitsha. The organization played a central role in disseminating an “alternative therapy” in the form of micronutrient vitamin supplements in Khayelitsha and Nyanga (Thom and Bodibe 2005). Members of SANCO served as the key liaison between the community and the vitamin distributor, The Rath Foundation, recruiting AIDS patients on antiretroviral therapy to pilot a scientifically unproven vitamin regimen and staffing the clinic where the vitamins were distributed (Geffen 2010: 142). Senior members of the African National Congress such as the Minister of Health, the Director General of Health, and the President of the Medicines Control Council supported the work of the Rath Foundation by presenting its work within formal state institutions. More specifically, a study that examined the effects of the vitamin-based regime in Khayelitsha was presented to the National Health Council, an official state forum that is comprised of provincial health ministers and the national Minister of Health (Geffen 2010: 144). What might have appeared to be confusion between the African National Congress and the South African National Civics Organization in Sipiwe’s statement instead points to a political alliance on “alternative” AIDS treatment between the ruling party and a powerful non-governmental organization in Khayelitsha.

The final aspect of Sipiwe’s analysis that is relevant to this discussion is his description of the oppositional politics between the African National Congress and the Treatment Action Campaign. As has been well documented, the Treatment Action Campaign has gained international attention due to its successful campaigns to reduce the cost of antiretroviral drugs and increase access to care for people living with HIV/AIDS.

While the Treatment Action Campaign is a relatively small organization that counted only 17,000 members at the height of its activities, it directly challenged the leadership of the African National Congress during the administration of former President Thabo Mbeki over its controversial challenge to the scientific link between HIV and AIDS. However since its inception in 1998, the Treatment Action Campaign has been branded by the African National Congress as an extension of multinational pharmaceutical corporations due to the organization's emphasis on access to treatment.

Although the Treatment Action Campaign challenged the profiteering of the major pharmaceutical corporations by attacking the pricing structure of life-extending antiretroviral therapy, the African National Congress continued to characterize the organization as catering to foreign interests. This depiction obfuscates the history of the organization's key members in the anti-apartheid movement. The Treatment Action Campaign, or TAC, was founded on December 10, 1998 to pressure the South African government and the international community to provide treatment to all South Africans living with HIV. The TAC was formed by a group of former anti-apartheid activists with varied political histories including the gay rights movement³⁴, but was dominated by former members of the Marxist Workers Tendency, a Trotskyite branch of the ANC active during the 1980s underground in South Africa and in exile (Grebe 2008: 11). Former Marxist Workers Tendency activists that were key to the formation of the TAC were Zackie Achmat, Mark Heywood, Deena Bosch, Sharon Ekambaram and Herman Reuter (Grebe 2008: 11). What is significant about this group is that the shared a

³⁴ For an in-depth analysis see Mbali, M. (2006). TAC in the history of patient-driven AIDS activism: The Case for Historicizing South Africa's New Social Movements. In Gibson, N. C., editor, *Challenging Hegemony: Social Movements and the Quest for a New Humanism in Post-Apartheid South Africa*, page 129–155. Africa World Press, New Jersey.

“common analysis of the state and state power, derived to a significant extent from Marxist thinking and a shared emphasis on the importance of mass mobilization³⁵ (Grebe 2008: 11).”

As has been discussed in Chapter 2, in its early campaigns the TAC focused on access to antiretroviral therapy and lower prices for key pharmaceuticals. Utilizing a rights-based approach, the TAC achieved major victories with campaigns that have successfully pressured pharmaceutical companies to lower prices for life-saving drugs and campaigned tirelessly for the provision of antiretroviral therapy to all those who need it in South Africa. The TAC has also taken a highly critical stance of the HIV “dissident” stance of President Thabo Mbeki and the Minister of Health, Manto Tshabalala-Msimang. The Treatment Action Campaign, along with the Aids Law Project, the Southern African HIV/AIDS Clinician’s Society and even COSATU have critiqued this position for challenging the legitimacy of modern science and the potentially damaging influence it may have on people living with HIV deciding on whether or not to access ART. Based upon interviews that I have carried out with public health sector doctors in Khayelitsha, this impact has been substantial.

What I think people very often underestimate is the depth and the level of misinformation that has crept into the population, [and] how influential Mbeki’s denialism has been at every level of society. From people in Khayelitsha drinking olive oil and eating lemons to top executives who let themselves die because they think that it’s not being loyal to the ANC to go and take ARVs.

³⁵ Although Achmat and other members of the TAC leadership have consistently pledged their loyalty to the ANC, it is critical to note that the leadership of the MWT was expelled from the ANC during the negotiated transition and that the vision of the state produced in the apartheid era is of a decidedly different bent than that espoused by MWT leaders such as Martin Legassick.

The resulting political situation was a social cleavage between supporters of the ruling party, including non-governmental organizations, and those who backed the counter-hegemonic AIDS activist coalition fighting for orthodox AIDS treatment in South Africa.

As this chapter has outlined, this political division created an insurmountable challenge to effective coordination and implementation of HIV/AIDS policies in Khayelitsha and throughout South Africa. In Khayelitsha, HIV/AIDS activism and knowledge tends to be cloistered within the activist community and those attending the ARV clinics. The political activism of TAC and other groups has not spread extensively into the community, partly due to the stigma associated with HIV, but also a product of the contentious political discourse that erupted over the ANC dissident stance towards HIV/AIDS that affected national policy. SANCO, a more conservative social organization, has rejected the direct challenges by the TAC to the ANC and systematically avoided meeting formally with representatives from the TAC in Khayelitsha. These political dynamics have affected the ability of the MSATs, the formal state institution for coordinating the community response to HIV/AIDS, to work with community-based and non-governmental organizations working to fight the epidemic.

These dynamics point to the centrality of transnational donor capital in the local politics of HIV/AIDS and to the complementary role of non-governmental organizations aligned with the ruling party in the dynamics of the political field of HIV/AIDS in South Africa. As was discussed in Chapter 2, the shift towards ANC alliances with non-governmental organizations in the political struggle over HIV/AIDS roughly correlated to the growing success of the counter-hegemonic AIDS activist coalition in changing national AIDS policy through alliances with sympathetic factions of the ruling alliance at

the national level. As this ethnographic analysis of the politics of HIV/AIDS on the Cape Flats indicates, the effect of this shift in the political dynamics has been to localize the political project of AIDS dissidence through an alliance with the key organizational remnant of the anti-apartheid movement in South Africa's townships. This is a challenging and condemning analysis for a political party that has portrayed itself as the driving force behind the liberation of South Africa's people from the racial violence of the apartheid state.

Conclusion

South Africa's history of political struggle during the 1980s was one that symbolized the power of communities uniting according to democratic principles against an unjust regime. The street committees that reclaimed control over their communities against the intelligence apparatus of the apartheid state were led by the community, often young people, and were the driving force behind the mass demonstrations of the mid 1980s. Somewhat paradoxically, local-level social institutions such as street committees, and ward-level political forums were serving as barriers to the effective coordination and implementation of the coordinated response to HIV/AIDS in the post-apartheid period due to the political division between SANCO and the TAC. While the lack of health infrastructure and burden of disease in South African townships was inherited from the late apartheid era, post-apartheid policy decisions have aggravated this situation by driving up rates of unemployment, increased rural-urban migration, and raised the cost of basic services due to the logic of cost recovery.

The post-apartheid model for local governance and service delivery has changed the role of the civics, notably SANCO, to one of an intermediary between the community

and the ANC, who have in turn occupied local representative structures in order to maintain power and influence in their communities. This political dynamic has hamstrung local coordinating institutions such as the MSATs as they do not have the political power or organizational For the most part, the AIDS movement has aimed their campaigns at a national level to de-legitimize the AIDS dissident position of the ANC and to force political change. While this strategy has produced a restructured National Aids Council and a progressive National Aids Strategy in the NSP, it has not addressed the local manifestations of AIDS dissidence in the townships of South Africa.

Conclusion

Towards Ethnographic Foundations in Theories of Transnational Power

Since 1994 the African National Congress has transformed the South African state to directly govern all the people who reside within its territory after the country's negotiated transition to democracy. While this process has been mediated by the influence of international forces and a decentralized political system that was one outcome of the transition, there have been substantial changes to the South African polity. Some these developments include – but are not limited to – the creation of new provinces, the re-drawing of municipal boundaries in major urban centers, and the fostering of consultative systems for developing government policy. Despite the considerable achievements of the ruling party during the first fifteen years after the fall of apartheid, HIV/AIDS prevalence rates have risen to levels that constitute the largest national epidemic in the world.

The seemingly exponential growth of the HIV/AIDS epidemic developed on the basis of social dynamics that stem from South Africa's colonization. Chief among these are the country's migrant labor system, high levels of social inequality and an extended period of social instability from late apartheid through the transition. The effects of these socio-economic processes on the spread of HIV/AIDS were exacerbated by the ideology of AIDS dissidence amongst key figures in the African National Congress and the self-imposed fiscal limitations brought on with the GEAR macroeconomic strategy. These political and economic decisions, which have limited the development of health

infrastructure, and the availability of life-extending AIDS treatment in the public health sector, saw the continuation of an autocratic organizational culture within the ANC that limited critical dialogue on HIV/AIDS, and the mismanagement of the public health response to the epidemic by the ANC due to these factors.

The 1998 – 2004 period in South Africa was arguably the critical period during which the spread of HIV/AIDS epidemic could have been prevented from reaching prevalence levels of over thirty percent amongst pregnant women in peri-urban areas. However, rather than a time of dedicated efforts to stem the tide of a growing pandemic, this phase was marked by the implementation of neoliberal macroeconomic policies, fiscally austere social spending and the emergence of an ANC faction that backed the core ideas of AIDS dissidence. This stage of South Africa's post-apartheid development marked the country's reintegration into a radically different geopolitical situation than its continental predecessors in the wave of decolonization in the 1960s. Out of the context of externally driven economic shocks and the threat of a trade sanctions for violating key tenets of the global trade regime, emerged a fiscally austere South African state that had little capacity to amend the historical injustices wrought by the apartheid regime on its non-white citizenry. This confluence of factors are best understood in terms of a dynamic, mutually constituting process that built upon the history of the late apartheid era while articulating with the set of political and economic norms that marked the period of neoliberal globalization.

In this political, economic and historical context the public health response to the HIV/AIDS epidemic in South Africa was restricted by the inheritance of apartheid-era debt, the economic orthodoxy of the Washington Consensus and the ability of unfettered

finance capital to undermine the fragile politico-economic consensus that had emerged out of the transition through the threat of capital flight. In response to the influence of these transnational political and economic forces, the ANC challenged the international pricing system for antiretroviral drugs developed by global pharmaceutical corporations. Following this political action, the AIDS dissident faction within the ANC espoused the ideology of AIDS dissidence that characterized the global pharmaceutical industry as part of an array of global forces that posed a threat to the national democratic revolution that the anti-apartheid movement had achieved. These events became part of a political platform that allowed the ANC to maintain national political autonomy through the implementation of neoliberal reform while appealing to its core constituency through appeals to nationalist sentiment and a critique of the unequal impact of neoliberal globalization on the Global South.

This dissertation has outlined the social, political, and institutional dynamics of the attempt by the ANC to maintain political autonomy in the areas of social development, HIV/AIDS and public health by limiting the influence of international donor funding. Through an analysis of the key institutional foci of HIV/AIDS politics at the national, provincial and local level, I have argued that the central element that tied the different scales of political process that constituted the political field of the South African AIDS epidemic was the response to transnational political influence. However these forces did not influence the politics of AIDS in South Africa in a proscriptive manner. Rather, transnational influence operated through, and manifested as, a historically and socio-culturally particular political process.

In addition to a historical analysis of HIV/AIDS based in a critical reading of South Africa's political economy, I have offered a detailed ethnographic description of the political dynamics of HIV/AIDS during the final stages of AIDS dissidence under the leadership of Thabo Mbeki. At the national level, my fieldwork consisted of observing the meeting of the national civil society delegation of the South African National AIDS Council, an institutional analysis of the joint civil society-government institution, and in-depth interviews with civil society delegates to the restructured body charged with overseeing the implementation of the National Strategic Plan for HIV/AIDS and STIs (2007-2011). The ethnographic and interview data gathered during my fieldwork pointed to a positioning of key members of the AIDS dissident faction of the African National Congress in charge of strategic posts within the National AIDS Council which allowed for institutional control by the ruling party. Further, the first ethnographic analysis of this institution pointed to tangible efforts by the civil society delegation to drive forward new developments in HIV/AIDS policy and evidence of intransigence by the government institutions that were charged with providing administrative support to the body.

The ethnographic analysis of HIV/AIDS politics in the Western Cape added a new dimension to the anthropological record of the epidemic in South Africa that had heretofore been under-represented – the significance of provincial policy processes in local-level politics and health outcomes. In addressing this lacuna, I conducted in-depth participant observation analysis of the consultative meetings for the Provincial Strategic Plan, the translation of the National Strategic Plan for the public health system in the Western Cape. What emerged as a result of ethnographic research and interviews with meeting participants was that the input from AIDS activists and community members that

had come out of the consultative sessions were ignored in the implementation of this policy. Further, the partner organization in the consultative sessions, WC-Nacosa, had been offered to take over the continuation of a grant from the Global Fund to support community-based organizations that led the local-level responses to HIV/AIDS epidemic. These socio-political processes underscored the significance of international donor funding in the politics of HIV/AIDS at the provincial level, the intermediary role of the provincial government in directing these funds to a single recipient, and the central role of this recipient organization in the consultative meetings for the Provincial Strategic Plan.

My ethnographic analysis of the provincial level also focused on the formation of a broad-based public health movement to challenge the imposition of a neoliberal public health policy. This alliance of AIDS activists, non-governmental organizations and the labor movement, the Western Cape Coalition Against Public Health Cuts, successfully pressured the Western Cape Department of Health and the South African National Treasury to reinstate the public sector beds that were closed due to limitations on public health spending – a shift that resulted from neoliberal macroeconomic policy. I conducted a participant-observation analysis of this broad-based public health movement, which underscored the importance of the labor movement in local-level struggles over public health and HIV/AIDS treatment. In addition to this political analysis, I also conducted a human resources analysis of a public health hospital in the township of Khayelitsha. This adds to the ethnographies of the South African epidemic by contextualizing the politics of HIV/AIDS within the social geography inherited from the apartheid era, the effects of neoliberal fiscal austerity on the development of public health infrastructure, and the

effects of a neoliberal public health plan on the staffing structure of a day hospital in an area with an HIV prevalence rate of nearly 30%.

This dissertation has also offered an ethnographic analysis of the way that AIDS activists and organizations aligned to the AIDS dissident faction of the ANC interacted to produce the politics of HIV/AIDS on the Cape Flats. Through observation of community meetings, political events, marches organized by the AIDS movement and interviews with community members, this dissertation contributes to the anthropological literature on HIV/AIDS by contextualizing the abstract politics of AIDS dissidence within the particular history, social dynamics and politics of the Cape Flats. In addition, this research offered a detailed analysis of the way that internationally-funded HIV/AIDS community coordinating mechanisms served as the flashpoint for political struggle between the AIDS movement and organizations aligned to the AIDS dissident faction of the ANC. My research illuminates how the national politics of HIV/AIDS were localized through alliances between the ruling party and non-governmental organizations. While AIDS dissidence has often been discussed by anthropological analyses of the South African HIV/AIDS epidemic, the details of how this belief system was localized through a political process is being offered for the first time in this dissertation. In addition to these ethnographic contributions, this dissertation has also outlined several key issues that emerge out of an analysis of the politics of HIV/AIDS in South Africa.

Narrative Undercurrents regarding HIV/AIDS in South Africa

During the course of my fieldwork, the central role of labor in the process of building a broad coalition of actors and organizations emerged as an important addition to the existing literature on the South African HIV/AIDS movement. The influence of the

labor movement in the politics of public health was evidenced by the analysis of the Western Cape Coalition Against Public Health Cuts in Chapter 5. This series of events – and particularly the relative success of this campaign – underscores the extent to which the influence of labor unions on national policy is an important factor in the analysis of HIV/AIDS in the post-apartheid period. However rather than a new element in South African society, the central importance of the labor movement in politics is yet another example of an important historical continuity.

When examined in tandem with the institutional trajectory of the ANC, the South African Communist Party (SACP) and the Congress of South African Trade Unions (Cosatu) – the key labor organizations in South Africa – play a hugely important role in the organizational survival of the ruling party in exile and the mass democratic movement within South Africa to end apartheid. From the early alliance formed with the organization as part of the shift towards direct action with the pass campaign in the 1950s, the ANC has relied heavily on the SACP as an organizational partner. The SACP was particularly important in supporting the military wing of the ANC during exile – *Umkhonto We Sizwe* – due to its close ties with the Soviet Union. The overlapping roles of many ANC leaders with the politburo of the SACP evidenced the extent to which these organizations became nearly inextricable during the protracted struggle against the apartheid regime in exile. But perhaps most significantly for the broad tent that the anti-apartheid movement housed, the partnership between the SACP and the ANC shifted the latter organization's focus to that of a non-racialist platform upon which to build alliances to end the apartheid regime.

This non-racialist platform was essential to the growth of the Mass Democratic Movement (MDM) in South Africa that was formalized with the creation of the United Democratic Front (UDF) in 1983 and – critically – the formation of the Congress of South African Trade Unions in 1985. As was noted in Chapter 3, the HIV/AIDS movement drew many of its key activists from the MDM and the Marxist Worker’s Tendency (MWT) in particular. With these activists came the knowledge of inclusive decision-making processes involved in coordinating the wide range of organizations that made up the anti-apartheid movement and the tactical knowledge of how to exert political pressure on the social blocs controlling the institutions of the South African state.

Given his history it should come as a surprise that the labor movement has played such a critical role in the HIV/AIDS movement in the post-apartheid era. While it is the case that Cosatu and the SACP – as partners with the ANC in the governing tri-partite alliance – have been credited with playing an important role in the ‘cabinet revolt’ that led to the public repudiation of Mbeki’s AIDS dissident position in 2003, the key role of the labor movement has not been seen as a thread that binds together the ability of HIV/AIDS activists to influence government policy. As the example of the Western Cape Coalition Against Public Health Cuts illuminates, the labor movement has served as the bulwark from which AIDS activists launched sustained and successful attacks against the intransigence of the ruling party on implementing an orthodox national HIV/AIDS policy.

Just as the union movement grew out of the dialectical relationship between labor and capital in South Africa, the HIV/AIDS movement has grown out of the struggle for the poor and working class to access life-extending treatment. As much of the leadership

of the first wave of the HIV/AIDS movement grew out of the anti-apartheid movement, it largely reflected the patriarchal character of South African society with male leadership and limited roles for women. However the gender composition of the HIV/AIDS movement has begun to shift in recent years, with women increasingly taking on leadership roles. This was evident with the Aids Legal Project (ALP) and the Aids & Rights Alliance for Southern Africa (ARASA), whose leading figures were women. And while the process has undergone fits and starts at the organization, the Treatment Action Campaign (TAC) elected two women to its highest leadership positions at it celebrated its 10th anniversary at its annual general meeting in 2008. While these women have headlined a change that is taking place in the HIV/AIDS movement, the shift towards female leaders is increasingly widespread in South Africa in the field of HIV/AIDS.

During the course of my fieldwork, I met with many women in or moving into leadership positions within the area of HIV/AIDS advocacy. Based on my experiences, I believe that too often the focus of academic analysis is based upon the degree to which women take leadership positions at the national or regional level rather than at the local or provincial level. For example, within the TAC, I worked closely with women at the Western Cape provincial office who were extremely capable organizers and activists. In fact, many of my insights on the importance of the provincial scale in the political field of HIV/AIDS grows out of their work and the knowledge that they shared with me during fieldwork. As academic analysts have often focused on either the local or national scales in AIDS politics, the work of these women has gone overlooked and underestimated in the representation of the political field of HIV/AIDS in South Africa.

What these dynamics indicate is that the traditional patriarchy associated with political activity in South Africa may be undergoing a shift in the arena of HIV/AIDS. As Susser (2009) has argued convincingly through fieldwork with women in KwaZulu-Natal, organic female leadership has emerged out of the everyday struggles of women infected with or affected by HIV/AIDS. I am simply adding one small point of insight to this authoritative account on the gender dynamics of HIV/AIDS in South Africa: that the rise of female organic intellectuals has grown out of the focus of the public health responses to HIV/AIDS on PMTCT, and that the dialectic relationship between the material circumstances of everyday life and AIDS treatment is manifesting itself in the growing representation of women in positions of leadership in the field of AIDS activism and advocacy.

This growth of female leaders has come in the face of women having borne the burden of the massive increase in HIV prevalence in South Africa following the negotiated transition out of apartheid. As has been noted in Chapter 2, the growth of the epidemic was driven by a lack of action on HIV/AIDS during late apartheid, which was exacerbated by inattention to the growth of the epidemic during the political transition and the intransigence on policy implementation that was accompanied by obfuscating messages on the link between HIV and AIDS during the Mbeki administration. Rather than examine the latter period through the lens of an alternative belief system or through a blow-by-blow of key political events, this dissertation has analyzed the period of AIDS dissidence in South Africa through the way that beliefs and political activities produced a social process that orbited around key state institutions.

This attention to institutions underscored the corollary institutional transformation of the National Development Association and the National AIDS Council to control the mechanisms by which transnational donor capital entered into South Africa. Further, this focus on historical continuities and social process also drew attention to the legacy of political centralization amongst the ANC exile structures and its link to the way in which AIDS dissidence circulated without outward opposition within the ANC during the Mbeki administration – with the notable exception of the ‘cabinet revolt’ in 2003. The metaphor of ‘Stalinist’ organizational tendencies that Mbeki’s leadership evoked in South Africa grew out of the training of ANC cadres in the former Soviet Union and the influence of leading SACP figures such as Joe Slovo on party leadership during this time.

While the ethic of organizational discipline served as a necessary precondition for survival in the context of the military expansion of the apartheid security apparatus into Southern Africa during late apartheid, it also served to effectively insulate the AIDS dissident faction from open attack by ANC members with orthodox views on HIV/AIDS. This position is evidenced by its counterfactual with the example of Deputy Minister of Health Nozizwe Madlala-Routledge: her open defiance towards noted AIDS dissident and Minister of Health Manto Tshabalala-Msimang, declaration of a public health crisis and critique of the AIDS dissident position led to her dismissal. Thus, the focus on the institutional memory of the ANC not only enables one to explain how the organizational dynamics of the ruling party allowed for the AIDS dissident position to influence, but also why this discipline was accepted within party structures.

However this discussion of the dynamics within the ANC is only a partial explanation of the effects of AIDS dissidence, as it does not take into account the

decentralization of this set of views outside of the ANC. The ANC dissident faction was able to couch the dissident position within the language of the anti-apartheid movement and a critique of external political influence through its characterization in neoliberal terms. However, beyond the ideological framing of the AIDS epidemic, the AIDS dissident faction cultivated relationships with non-governmental organizations to disseminate messages of AIDS dissidence or stifle the voices of critical HIV/AIDS activists. Particularly relevant for this point was the role of Sanco in mobilizing its resources to provide additional validity to Mbeki's position. As an organizational artifact of the anti-apartheid movement, Sanco representatives continued to play important political roles in South Africa's townships. As such, this organization played a key role in the decentralization of the AIDS dissident position.

As has been emphasized throughout this dissertation, it is important to note that AIDS dissidence is understood here primarily as a political phenomenon. As Black South Africans have been in contact with Western biomedicine in urban and rural areas in the forms of clinics throughout the 20th century, it is not feasible to assume a widespread adoption of AIDS dissidence as a belief system. Rather, I contend that the institutional dynamics of HIV/AIDS on the Cape Flats show that the most powerful political organizations publicly espoused the dissident position. As the ANC and Sanco both play central roles in socio-economic development initiatives, the lack of a public or social rejection of AIDS dissidence might be understood as an expression of power rather than the internalization of a belief system. In other words, the power of the ANC/Sanco AIDS dissident faction was expressed in the social silences that it produced. While this issue is clouded by questions of stigma that surround HIV/AIDS in South Africa, the

contextualization of political organizations and social institutions shows that the concept stigma may not be sufficient to represent the silences associated with HIV/AIDS during the Mbeki administration.

The silences associated with HIV/AIDS at the local level on the Cape Flats extended into the institutions of the state as well, evidenced through the aforementioned dismissal of Deputy Minister of Health Nozizwe Madlala-Routledge. In tandem with this dynamic was a parallel rejection of transnational political influence across different political scales and through social and state institutions on the issue of HIV/AIDS. The disassociation with global norms on the issue of HIV/AIDS can be seen clearly through the AIDS dissident position and the circumspect representation of transnational political and economic forces that its acolytes put forth. A similar dynamic has been identified here with the institutional transformation of the National Development Agency. However this rejection of transnational political norms only displays a partial picture of the mode of interaction adopted by the ANC leadership vis-à-vis global forces during the post-apartheid era.

Also critical to consider for a thorough analysis is the relationship between transnational forces and the policies adopted by the ANC to re-incorporate South African into the neoliberal global economy followed the negotiated transition out of apartheid. The examination of the currency crises that South Africa weathered during the infancy of its democratic era points to an entirely different series of dynamics in the arena of finance capital flows, exchange controls and macroeconomic policy. In this sphere of government policy, one can see a much clearer process of the ANC coordinating South Africa's economic policies with the norms associated with the neoliberal 'Washington Consensus'

of the 1990s. While this shift has been characterized as a capitulation by the ANC to the dictates of global capital, I see the countervailing tendencies between HIV/AIDS and economic policy as an extension of different factions within the tri-partite alliance that govern South Africa.

The different constituencies represented by South Africa's governing tri-partite alliance have produced varying state responses to the issues that have arisen during the first two decades of South Africa's democratic period. With respect to the HIV/AIDS epidemic, a faction within the ANC was able to transform the institutional composition of the state to retain political autonomy from transnational political influence in the area of public health policy. However, the tri-partite alliance partners – the SACP and Cosatu – eventually broke with the ANC due to the negative effects of the AIDS dissident position of their working class members. The 'cabinet revolt' in 2003 and subsequent public adoption of some orthodox HIV/AIDS science in state policy was primarily due to an alliance between HIV/AIDS activists and the labor movement that was able to eventually split the ANC leadership on the issue of AIDS dissidence.

Despite the work of the counter-hegemonic alliance to undermine the influence of the AIDS dissident faction with the state, this group of ANC leaders was able to maintain control over key institutions (South African Presidency, National Department of Health). Despite – or perhaps because of this institutional arrangement – the alliance between AIDS activists and the labor movement led to the drafting of the National Strategic Plan and the restructuring of the South African National AIDS Council. These political dynamics not only changed the institutional composition of the South African state, but changed the contours of the national politics of HIV/AIDS in South Africa.

Thus, rather than simply a dialectic between transnational forces and a nationalist attempt to maintain national political autonomy on HIV/AIDS policy, the South African state is instead here shown to be transforming according to the social institutions created by the working class: the SACP and Cosatu. Instead of a dynamic encapsulated by the conception of the 'global', the institutional dynamics of AIDS in South Africa instead point to the continued relevance of labor organizations in producing social outcomes that substantively affect South African society and health. Here Harvey's (2005) claim of neoliberalism as a class project shows itself through its inverse: that pro-poor and pro-working class state actions are the product of socio-political contestation of elite ideological constructs, or that organizations representing different class interests produce policies that reflect their constituencies. While this point of insight may seem straightforward, it is one that has been overlooked in the analysis of AIDS politics in South Africa.

However to focus simply on the dynamics internal to the South African state is to ignore much of what drove the political processes of HIV/AIDS at the local level on the Cape Flats. As the organizational alliance between the AIDS dissident faction and Sanco indicates, the incorporation of activities outside of the state may be critical for an understanding of state power. Rather, it may be necessary to include the interactions and associations between the loose alliance of class interests that controls the state and the non-governmental organizations that seek to expand their sphere of influence via an affiliation with the ruling party.

The Political Field Approach and Ethnographic Foundations

It is around this question of how alliances foment flows of decentralized political power where the HIV/AIDS epidemic in South Africa has much to say about theories of the state in the era of neoliberal globalization. As was discussed in the introduction to this dissertation, analyses of the state in the neoliberal era have tended to focus on how exactly the state itself has been affected by the influence of transnational political and economic forces. Far less attention has been paid to the types of socio-political dynamics that may be operating outside of – but in concert with – the interests of those who control the institutions of the state. The inclusion of the alliances and political actions that may go unseen for lack of focus is critical in the dynamics of HIV/AIDS in South Africa, and this may be true of other areas of social contestation as well.

That this series of dynamics emerged at a time when international economic and domestic political factors emerged as challenges to the ANC points to a suggestive conclusion: that when faced with these circumstances, that it was necessary for the interests that controlled the South African state to resort to para-state alliances with non-governmental organizations in order to maintain hegemony within South Africa on the issue of HIV/AIDS. Without the organizational strength of Sanco, would the ANC have been able to effectively control the social debates on HIV/AIDS on the most local levels of governance in South Africa's townships? It is hard to answer this proposition definitively, but the example of HIV/AIDS in South Africa is indicative of the fact that anthropologists focused on the relationship between globalization and the state must train their sights on a wider array of socio-political dynamics.

In order to address a broader set of individual, organizational and institutional factors in this analysis, I have utilized the social field approach as a mechanism for

framing socio-political activity emanating from different scales. I build on this concept of the political field in my research but with a focus on including the influence of transnational power on the politics of AIDS in South Africa. Key to this approach is a focus on state institutions as the nodes around which the political fields form as political parties, non-governmental organizations and social movements produce the political dynamics that surround the AIDS epidemic. Here I see the field more as an opening in a landscape, whereby the relationship between actors, institutions and forces emerge from the shadow of forest and can be seen with clarity. In this depiction it is not the activity which has changed as a result of the location, but the perspective of the analyst to see the ways in which different social formations and individuals interact with one another. In the course of my research in South Africa, social movements and non-governmental organizations focused upon the local, provincial and national institutions of the state in the campaign to increase access to antiretroviral treatment and expand the scope of the public health sector. Organizations and their representatives interacted to produce a political process that then influenced the distribution of HAART to infected and affected communities. I therefore focus here on the political field of HIV/AIDS – and by extension the social effects of HAART provision – as being centered on the institutions of South Africa’s public health sector.

These examples point to a complex process of interaction between transnational political forces, the ANC, non-governmental organizations, and AIDS activists. As I have outlined above, these interactions oriented around state institutions at the national, provincial and local levels. While these categories do not necessarily represent all vectors of transnational political influence in South Africa, these are the nodes that emerged as

decisive in the political field of HIV/AIDS. Each of these institutional nodes operates as a point of interface between the key actors and organizations involved in the politics of HIV/AIDS, and as such, are critical for the theorization of transnational political processes. I argue that this process is unfolding in a dialectical fashion, as a change in political dynamics at node led to a shift at the other key nodes at different political scales. Thus while a shift in transnational politics will necessitate accompanying changes for the national state and NGOs, a change in NGO policy may have little to no effect on the state or transnational.

In South Africa, this process is one that articulates with the legacies of the anti-apartheid struggle in the form of para-state social institutions, anti-apartheid activists that have taken oppositional stances regarding the HIV/AIDS epidemic in the post-apartheid period and the social, spatial and material inequalities produced by the apartheid regime. These forces are manifesting themselves through localized and historically particular socio-cultural phenomena that play a central role in the way that HIV/AIDS has been negotiated locally as a political issue. This dialectical conceptualization of the inter-scalar political processes that are framing conceptions of AIDS treatment for the residents of Khayelitsha may offer greater clarity in outlining how and why institutions, organizations and communities interact in particular ways. In examining the AIDS pandemic and other politically charged situations, it is through this clarity of description and analysis that anthropologists can offer their solidarity and support for ongoing political struggles where lives are at stake.

It is through this theoretical framing and accompanying multi-scalar methodology that – I argue – one can overcome the limitations of current anthropological theories on

how best to analyze the process of globalization. Whether one examines the spread of ideas from the advanced capitalist countries or examines the effects of globalization on the people of the Global South through the negative effects that the globalization process has had on the state capacities of their governments, the critical question remains: what or who is the object or subject of study and / or the vector through which one analyzes the socio-cultural dynamics in question?

This is a critical issue, as it returns to the sticky, anthropological question of what is – and who constitutes – a ‘culture’. It is a question that I have answered here by focusing on one particular facet of cultural process: politics. By observing and analyzing the congregation of different sectors of South African society and their responses to the HIV/AIDS epidemic, I have offered a sketch of how South Africa’s history manifests itself in the contemporary, carried forward by the individuals and entities that have internalized these forces, producing socio-cultural dynamics that, I argue, are particular to South Africa. It is this space of particularity where I contend that the contemporary milieu – with its broad global contours which interconnect increasing proportions of the planet’s population – can be seen to have emerged out of different political, economic and cultural formations. These moments of difference, far from serving as evidence of an essential cultural difference, are instead signals of socio-cultural trajectory, of the direction that cultural development has taken over time.

While contributions to the literature on globalization and transnational processes have offered new possibilities for socio-cultural analysis, I have shown that a re-examination of the way in which non-governmental organizations and states are influenced by the rising influence of transnational political forces allows for a wider array

of political practices to be incorporated into existing analytical frameworks. This study of South Africa shows that the balance of political forces that influence national political decision-making have shifted towards a focus on transnational processes with the negotiated transition out of apartheid. This has changed the role of non-governmental organizations in the governance process, as increasing opportunities for international funding has allowed for the existence of autonomous social movements that challenged the ANC's intransigence on implementing orthodox AIDS treatment in the public health sector.

In a global context where international donor funding enables organizations and institutions to embark upon initiatives that, at least to some degree, are autonomous from the political control of national government(s), the socio-political processes produced by the interactions between states, non-governmental organizations and social movements are increasingly difficult to categorize. In order to make sense of the local politics of AIDS in the peri-urban townships of greater Cape Town, I have proposed a complementary approach to existing theories of transnational power and globalization. This method bases itself on an analysis of the ways that political parties, non-governmental organizations and social movements mutually constitute political processes that gravitate towards the institutions that serve as nodes for AIDS treatment, education, and coordination. Rather than create increasingly complex theories to manage the overlapping manifestations of socio-cultural forces, I suggest that the insights offered by my research participants point towards a reconsideration of the tools and approaches social scientists have applied to understanding 'local' realities in the context of neoliberal globalization.

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