# The contemporary construction of the causality of HIV/AIDS: A discourse analysis and its implications for understanding national policy statements on the epidemic in South Africa

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# Keywords

HIV/AIDS, discourse, policy, social constructions, South Africa, government, texts, sex, stigma, representations.

# Abstract

This study is concerned with the social construction of HIV/AIDS at the policy level in contemporary South Africa, and how such constructions shape the manner in which the epidemic is understood in popular discourse. A psychosocial discourse analytic method is employed to identify dominant and competing discourses and their relation to notions of HIV/AIDS causality. Selected texts formulated in the years 2002 and 2003 are analysed as representations of government narratives and policy statements on HIV/AIDS which mould the national response toward the epidemic. The application of discourse analysis to the texts illustrates the following: how HIV/AIDS is socially constructed within key policy texts and government narratives; the shifts in the use of particular discourses within policy texts, across the years 2002 – 2003; and what the dominant and competing discourses tell about South Africa's policy position on HIV/AIDS at given points in time. Understanding the construction of HIV/AIDS through discourse, as reflected at the level of government policy articulations, illuminates the complex sets of meanings that HIV/AIDS represent in collective interpretations at the political level. Through the research process a number of discursive themes emerged, emphasising the role of socio-political configurations in the construction of the epidemic and specific discursive subjects. These contrasting and overlapping discourses influence public policy, and raise issues of power, ideology and political interest in the representation of HIV/AIDS and reactions to it. By tracing these discourse trends over time, from a critical perspective, it is possible to reflect on their implications for broader social representations of the epidemic. The study reveals the value of discourse analysis in interpreting HIV/AIDS policy texts, and their relationship to government's recognition of, perspectives on and responses to the epidemic in South Africa.

# Declaration

I declare that "The contemporary construction of the causality of HIV/AIDS: A discourse analysis and its implications for understanding national policy statements on the epidemic in South Africa" is my own work; that it has not been submitted before for any degree or examination in any other university; and that all the sources I have used or quoted have been indicated and acknowledged as complete references.

Melanie Judge

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## List of acronyms and abbreviations

| | |
|---|---|
| AIDS | Acquired Immune Deficiency Syndrome |
| ANC | African National Congress |
| ART | Anti-retroviral treatment/therapy |
| ARV | Anti-retroviral drugs |
| CDA | Critical discourse analysis |
| HIV | Human Immunodeficiency Virus |
| MTCT | Mother to child transmission |
| NEC | National Executive Committee of the African National Congress |
| Comprehensive Plan | Comprehensive HIV and AIDS Care, Management and Treatment Plan |
| PEP | Post-exposure prophylaxis |
| PLHA/PWA | Person living with HIV or AIDS |
| PMTCT | Prevention of mother to child transmission |
| SANAC | South African National AIDS Council |
| Strategic Plan | HIV/AIDS/STD Strategic Plan for South Africa 2000-2005 |
| STI | Sexually transmitted infection |
| TAC | Treatment Action Campaign |
| TB | Tuberculosis |
| VCT | Voluntary counselling and testing |

# Chapter 1

## 1.1 Introduction

*"If the scientists say that the virus is part of the variety of things from which people acquire deficiency, I have no problem with that. But to say that this is the* ***sole cause*** *and therefore the only response to it is anti-retroviral drugs, then we'll never be able to resolve the* ***AIDS problem****……If you can accept that there can be a variety of reasons, including poverty and the* ***many diseases that afflict Africans****, then you can have more comprehensive treatment responses''*. (Author's emphasis)

(President Thabo Mbeki in GCIS, 10 September 2000)

Against the backdrop of South Africa's burgeoning democracy, the HIV/AIDS epidemic strikes at the heart of a nation in post-apartheid recovery. South Africa, at the epicentre of the pandemic, has a national prevalence rate of 11.4%[1] (HSRC, 2002). According to the 2003 National HIV and Syphilis Antenatal Sero-Prevalence Survey in South Africa, there is 27.9% HIV prevalence amongst antenatal care attendees (Department of Health, 2003:6). And, as we move into the third phase of the epidemic of increased mortality rates as a result of AIDS deaths, a phase which is to prove the most devastating yet (Whiteside and Sunter, 2000), bold questions concerning the social constructions of and associated responses to HIV/AIDS need to be asked. Some years after President Thabo Mbeki made the above quoted statement, and with over 5 million South Africans estimated to be living with HIV/AIDS (UNAIDS, 2002), there is still debate on how the epidemic is to be understood and engaged at the national level. As the statement itself illustrates, how HIV/AIDS is represented (including notions of causality) and by extension understood, is closely linked to the perceived appropriateness of national responses to the epidemic.

Touching at the very core of the human experience, HIV/AIDS throws under the spotlight sensitive issues such as sex, sexuality, sickness and death. This facilitates the varying and often competing social representation, social perceptions and reactions to HIV/AIDS, informed by the manner in which the disease is constructed in contemporary South Africa. Whether attributing the epidemic to racial or gender identity, ancestral curses, God's punishment for immorality, promiscuity, homosexuality or poverty, there are a multitude of

ways in which the human collective has found cause and meaning in reactions to HIV/AIDS. In order to strengthen our HIV/AIDS interventions we are compelled to grapple with such dominant representations of HIV/AIDS, and associated notions of disease causality, which both shape and are shaped by our national policy environment.

Turning to a discussion of the HIV/AIDS policy context in South Africa, as the backdrop to this study, attention will now be drawn to the broader socio-political environment in which representations of the epidemic take form.

## 1.2 The policy response to HIV/AIDS in South Africa

As far back as 1990 the African National Congress (ANC) released the Maputo statement on HIV/AIDS, which stressed the importance of prevention strategies in curbing the epidemic (POLICY Project, 2003a). The beginning of a comprehensive public policy response to HIV/AIDS took root in 1992 with the establishment of NACOSA (the National HIV/AIDS Convention of South Africa), bringing to the table the first plan to guide the country's response to the epidemic. However, the August 1997 review of the NACOSA AIDS Plan raised findings which included a lack of political will and difficulty in identifying national level leadership on HIV/AIDS (CHSR, 2002). This review identified areas for strengthening the public response and laid the groundwork for the HIV/AIDS/STD Strategic Plan for South Africa 2000-2005 (the Strategic Plan)[2]. Driven by the "Partnership Against AIDS" programme, the Strategic Plan and, more recently, the Comprehensive Plan for the Management, Care and Treatment of HIV and AIDS (Comprehensive Plan), serve as the broad policy framework that dictates South Africa's national response.

Since 1994, the main tenet of this policy response has been a focus on prevention programmes and social mobilisation (GCIS, May 2000; ANC Briefing Document, 2001; GCIS, April 2002). In an analysis of key policy statements on HIV/AIDS in South Africa from 1994 onwards, Khoza (2003) traces the history of the ANC's approach to HIV/AIDS and finds contained therein a multisectoral approach with clear roots in consultative processes and adherence to principles of non-discrimination. However, Khoza (2003) argues that implementation has been inadequate due to reasons including: the questioning

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[1] Other statistical sources estimate the national prevalence rate for South Africa to be 20.1% (UNAIDS, 2002)
[2] See the HIV/AIDS/STD Strategic Plan for South Africa 2000-2005. Department of Health, February 2000.

of AZT toxicity; the 1999 decision not to provide antiretrovirals for the prevention of mother to child transmission (PMTCT) and post exposure prophylaxis (PEP); and President Thabo Mbeki's questioning of HIV as the cause of AIDS. The study concludes that one of the factors impacting on the gap between policy and implementation is the mixed messages on HIV/AIDS emanating from senior government ministers and the president (Khoza, 2003). Indeed, the South African government's response has been marred by controversy: the Sarafina II scandal; the Virodene debacle; the flirtation with HIV notification; and the denial of the link between HIV and AIDS (CHSR, 2002; Mbali, 2002). The questioning of statistics for prevalence rates, projections and mortality figures have added to the confusion of government messaging and response to HIV/AIDS, and the resultant rift between civil society bodies and the state in relation to the epidemic (CHSR, 2002). The position of government around the question of antiretrovirals, in terms of costs, efficacy and toxicity, has also been a cause for concern and civil action (CHSR, 2002).

As such, the national government's response to the epidemic has gained a reputation among civil society groupings, scientists and others as notoriously confusing. Accused of dabbling with dissident theories surrounding the cause of HIV, and stalling in the implementation of the national prevention of mother to child transmission (PMTCT) programme and a national treatment plan, the country has been under the national and international spotlight regarding the state's approach to a national crisis.

In April 2002, cabinet reiterated its support for the Strategic Plan, as well as introducing new measures to enhance the national response. These included: the establishment of the South African National AIDS Council as the highest advisory body on HIV/AIDS; the use of Nevirapine for PMTCT; announcing the need for a protocol for PEP in the case of sexual assault; and the admission that antiretroviral drugs (ARVs) do have a role to play in care and support strategies for people living with HIV/AIDS (PLHAs). At about the same time, President Thabo Mbeki formally distanced himself from AIDS dissidents (Robins 2002; Fassin and Schneider, 2003). In July 2002, government established a Joint Health and Treasury Task Team to investigate the financial feasibility of ARV usage in the public sector. On 8 August 2002 cabinet received the Joint Health and Treasury Task Team report which outlined ARV treatment options for the public sector programme. Based on this report the Department of Health was instructed by the cabinet to develop a detailed operational plan for an anti-retroviral treatment programme. Cabinet then approved this

plan (the Comprehensive Plan) in November 2003, as part of government's overall strategy to combat HIV/AIDS (GCIS, November, 2003).

Despite the policy shifts since April 2002, the lack of decisiveness with which government has managed the implementation of the Comprehensive Plan has come under fire. Whilst the plan set a target of 53 000 people for ARV treatment by the end of March 2004 (Tshabalala-Msimang, 2004), these targets were shifted to a year later by the president (TAC, 2004). Government has also been accused of "secrecy and a lack of transparency" regarding information on the implementation of the plan (TAC, 2004). According to the Department of Health (2004:13) the number of people on ARVs at that time was 11 253. However, according to the Aids Law Project/TAC monitoring report released in July of the same year, closer to 6000 people were estimated to be receiving ARV treatment (TAC, 2004).

It is within the context of this somewhat controversial and contested government response to the epidemic that the rationale for the present study is firmly located.

## 1.3 Rationale for the study

Unpacking the social representation of HIV/AIDS sheds light on the ways in which lay people construct "common sense assumptions", such that confrontation with the epidemic in the public realm is integrated (Joffe, 1999:21). Policy statements emanating from the highest political levels are conduits for both reflecting and shaping public views and agendas. As such, government narratives are discursively engaged in an ever-changing social construction of the epidemic. Given the history of the HIV/AIDS policy milieu, understanding the varying and competing representations of HIV/AIDS at this level becomes important.

As such, the present study aims to analyse the representations of HIV/AIDS within national policy statements and government narratives, so as to unpack the emerging dominant discourses. Through the research process, a range of discourses holding multiple and overlapping possibilities of meaning that both inhibit and promote specific constructions of disease and discursive subjects are exposed. In particular, the implied notions of causality embedded in such representations are presented. The study also reflects on the implications

and impact of such discursive trends on the representation of HIV/AIDS in socio-political context in a post-apartheid South Africa.

## 1.4 Overview of chapters

Chapter Two provides an historical review of international and local research on the social construction of HIV/AIDS in contemporary society. Specific attention is drawn to representations of the epidemic in South Africa, highlighting the dominant discourses with an emphasis on HIV/AIDS causality and the link between HIV and AIDS. This chapter creates the framework within which the present study is located.

Chapter Three presents the methodological approach of the study and explores the theoretical background to discourse analysis as a research technique. The chapter delineates the research process followed, including the aims and objectives; research design; method and procedures; and ethical considerations. The specific location of the researcher, and the relevance of this for the research, is also explored in the chapter.

Chapter Four presents the findings of the research. The key findings reveal four dominant discursive themes, and these are illustrated by drawing on examples from the policy texts and government narratives analysed. The form, purpose and significance of the emerging discourses are examined, as are the overlaps and contradictions in and between the identified discourse patterns.

Chapter Five is a concluding discussion, building on the research results, in which the practical consequences of the findings for representation of HIV/AIDS and notions of causality are outlined. In the chapter the broader socio-political implications of the research are proposed, and the limitations of the study are presented. Suggestions for future research are also posed.

# Chapter 2
# The social construction of HIV/AIDS

## 2.1 Dominant representations of HIV/AIDS

*“Imagine a disease that is spread through sex, that has no symptoms, and may take a decade to show itself; a disease which initially seemed to ‘prefer’ marginalised and oppressed people…think of a virus which attacks the very cells that should order its destruction, which multiply, mutate and destroy, until many years later the host will die a cruel and wasting death…Well, would you believe it?”*

(Mary Crewe, 1992:2)

Social representations underpin thought and action in relation to illness, and facilitate the making of meaning in the social world (Joffe, 1999). Over time HIV/AIDS as a social phenomenon has served to represent and reproduce a wide range of social, political and ideological constructions. The way in which the facts about HIV and AIDS have been constructed and reconstructed also plays a central role in mediating and consolidating the “thought style” in understandings of the disease (Horton and Aggleton, 1989:96). The space between expert and popular knowledge of HIV/AIDS, and how the epidemic is both perceived and acted upon, is mediated through social representations.

In thinking of HIV/AIDS as a construct, within a given social and cultural context, Triechler (1992) raises the following questions: *What is the relationship between the representation of a virus and its reality and is this reality constant? What determines how this reality is constructed and how does language articulate and popularise particular constructions? Do these different social representations have an impact?* This interrogation helps frame the varying constructions of the epidemic reflected in dominant discourses over time, some of which will now be presented.

In exploring HIV/AIDS within the context of normative discourses on health and illness, the epidemic enters the discursive patterns of a myriad of human behaviours and conditions such as sex, death and identity. Consequently, HIV/AIDS as a construct embodies a set of

“powerful social meanings” that are manifest through social arenas and generated by social practises (Plummer, 1988:21).

Along similar lines to Sontag's metaphorical interpretations of AIDS (1989) (and TB and cancer before that (1977)), Kopelman (2002) argues that HIV/AIDS since its onset has been perceived as something that happens to ‘others’, resulting in a “naming and blaming” pattern of disease attribution. HIV/AIDS-related stigma has latched onto pre-existing systems of stigma such as intravenous drug use, homosexuality and prostitution (POLICY Project, 2003b). In turn, the construction of an ‘other’, be they black, gay, female or poor, has provided an explanation for disease. This also “maintains a sense of purity and comfort for the self and the in-group” and perpetuates existing power configurations and the dominance of specific ideas and groups within society (Joffe, 1999:28). Such negative constructions of HIV/AIDS, often backed by religious doctrine, fail to adequately explain why certain people get sick and lead to blame and the thwarting of compassion in the care of those living with and affected by HIV/AIDS (Kopelman, 2002). The social construction of HIV/AIDS is reflected through these dominant discourses and, as such, the epidemic serves to reflect, legitimise, rationalise and reproduce existing stigmatising, discriminatory and othering processes.

Language is critical to social representation and since the beginning of the pandemic a series of powerful linguistic metaphors were mobilised around HIV/AIDS which reinforced and legitimised stigmatisation. These included HIV/AIDS as death, horror, shame, punishment, crime, war and otherness (Triechler, 1992; POLICY Project, 2003b). Patton’s (1990) analysis of the language of HIV/AIDS and its accompanying metaphors highlights the role of power and social discrimination within dominant discourses. Focusing on how power is manifest through discourse, Seidel (1993) illustrates the links between language and politics, a relationship through which the powerful and powerless are socially constructed. As a result, contemporary constructions of the epidemic render certain sections of society less powerful than others, through discourses that stigmatise specific groups or behaviours. Popular responses to HIV/AIDS have represented “moral panic” which holds at its root a fear of disease itself, underpinned by the need to attribute blame (Weeks, 1988; Berridge, 1992; Crewe, 1992). The negative language of “killer disease” and “gay plague” served to perpetuate the initial fear associated with HIV/AIDS and the need to attribute its existence to marginalised and ‘deviant’ social groupings (Sontag, 1989; POLICY Project,

2003b). The epidemic has also been represented through discourses of silence wherein HIV/AIDS is not perceived as real or tangible, thus reinforcing the stigmatisation of both the disease and those living with HIV/AIDS (Strebel, 1993). This discourse facilitates denialism and apathy in response to HIV/AIDS and drives the epidemic underground, which exacerbates vulnerability to infection and negates prevention efforts.

The discursive construction of the HIV/AIDS epidemic intersects with pre-existing discourses related to gender, race and class (Wilton, 1997). As such, HIV-related stigmatisation is compounded by these intersecting identities. Wilton (1997) emphasises the gendered construction of HIV/AIDS whereby women's subordination to men is reflected in and reinforced through representations. By extension, the othering of those perceived to be the transmitters of disease are feminised (Wilton, 1997). Furthermore, representations of sexuality and race channel notions of blame and stigma. Emerging themes from data collection in Ethiopia, Tanzania and Zambia show that much of the stigmatising language and behaviour in relation to HIV/AIDS are attributed to the sexual nature of the disease and associated stigmas (ICRW, 2002). In addition, the "white racist imaginary" of the North created a global norm whereby the epidemic in sub-Saharan Africa was represented as a result of "pre-existing abnormalities, failures or pathologies amongst the (black) indigenous populations" (Wilton, 1997:5). HIV/AIDS has thereby acquired racial dimensions whereby social perceptions of a rampant epidemic among promiscuous African people have been further reinforced through the attribution of viral origins to parts of Africa (Sontag, 1989; Patton, 1990).

HIV/AIDS has been "progressively individualised" as a disease of lifestyle or choice (Alcorn, 1988:7). Alcorn (1988) presents the "individualisation of responsibility" in mainstream HIV/AIDS understandings as a social process whereby disease and illness are perceived as the responsibility of the individual, thus devoid of context and socio-cultural circumstance. This tension between the concerns for the public good in contrast to individual responsibility has reflected the schism between public health approaches on the one hand and rights-based approaches on the other (Strebel, 1993). Seidel (1993:176) takes this a step further, linking the notion of risk groups to individualised responsibility for the disease, due to the fact that "medical discourse is concerned with symptoms, with depersonalised seropositives". Risk groups are typically represented as prostitutes, 'promiscuous' people, and gay men, all of whom are socially constructed as core disease

transmitters. Discourses of high risk groups – gay men in particular – further capture this link between HIV infection and specific lifestyles or social identities. The focus on risk groups as opposed to risk behaviours facilitates the stigmatisation of those perceived to be part of specific social groupings and confuses messages for individual behavioural change (POLICY Project, 2003b).

The manner in which individuals make sense of disease is partly determined by cultural context. Existing beliefs and presuppositions shared by a cultural community regarding illness play a significant role in shaping an understanding of newly emerging illnesses (Horton and Aggleton, 1989; Ashforth, 2001). These cultural constructions make meaning of new situations but can also contribute to the spread of the epidemic. Exploring media discourses on HIV/AIDS, Bardhan (2002:221) points to the cultural and power differentials that inform the "intersecting discourses" on HIV/AIDS in the global context. Bardhan's (2002) study concludes that global policies on HIV/AIDS have, over time, reflected international agendas and discourses. Bardhan (2002) regards understandings of HIV/AIDS as a "polycultural" phenomenon which manifests various interpretations with various stakeholders. Through the discursive imposition of culturally familiar ways of understanding the world, social representations of HIV/AIDS can also serve to maintain the status quo (Joffe, 1999). As such, dominant discourses on HIV/AIDS represent a collective social process, rather than a reflection of individual subjective opinion, and operate by producing and reproducing existing structures of power, hierarchy and exclusion.

Despite the fact that HIV/AIDS across the world has become a disease of stigmatisation, a viral contamination affecting a multitude of 'others', representations of the epidemic have also reflected the voices of oppressed groups, such as women, gay people and people living with HIV/AIDS. The articulations and discourses emanating from these sectors have undoubtedly shifted the orientation of contemporary representations of the epidemic (Patton, 1990; Joffe, 2003).

Within these broader discourses, attention will now be turned more specifically to representations of HIV/AIDS in South Africa.

## 2.2 Representations of HIV/AIDS in the national response

Key works in the South African context have highlighted a number of salient discourses on HIV/AIDS, and related debates, as outlined below.

a. Lifestyles and individual behaviour

The power of representation is that it provides comfort and security and defends the individual from the perceived threat of the unfamiliar (Joffe, 1999). This is apparent in the discourses which stigmatise and 'other' disease, by reducing HIV transmission to notions of lifestyles, often underpinned by moral judgement and prejudice-laden assumptions (Alcorn, 1988; POLICY, 2003b). Public prevention campaigns in South Africa, such as loveLife, have emphasised individual behaviour and lifestyle change as the central mechanism for infection control. Responses that focus on the level of behavioural risk reduction tend to rely on the individual as the unit of intervention and emphasise knowledge, attitudes, beliefs and practises on sexual behaviours (HSRC, 2002:7). The limitation of this approach is that it individualises and decontextualises the epidemic, as well as assumes that individuals have rational control over their sexual behaviour and related decision-making (Melkote, 2000 in HSRC, 2002). In turn, interventions aimed at the individual may not adequately address the social, economic and political factors that affect behaviour and decision-making. These constructions may also serve to stigmatise HIV/AIDS and reinforce notions of blame through the othering of disease, thus attributing it to already stigmatised out-groups, as outlined in the previous section.

b. Development discourses

From within the medico-scientific discourse, the retro-virus HIV undermines the immune system to such an extent that the immune system becomes susceptible to opportunistic infections leading to the clinically determined syndrome of AIDS. However, only under specific social conditions does a virus transform into an epidemic (Whiteside and Sunter, 2000; Marks, 2002; Van Niekerk, 2002:146). Factors such as the migrant labour system, high mobility, growing urbanisation, and gender imbalances create the social breeding ground for HIV/AIDS (Whiteside and Sunter, 2000; HSRC, 2004). The side-effects of poverty – poor levels of education and healthcare; the increased potential for transactional sex; and the low bargaining power of women in sexual interactions – collectively aggravate

the epidemic's spread in the South African context (Van Niekerk, 2002). The HIV/AIDS-poverty cycle is self-perpetuating in that whilst poverty creates higher susceptibility to HIV infection, AIDS-related ill-health deepens poverty further (UNDP, 1998; Whiteside and Sunter, 2000). Benetar's (2002) overview of the social fractures which heighten South African's vulnerability to HIV/AIDS transmission, such as historical social dislocation, poverty, gender disparities, and the developmental roots of the disease, reinforces this developmental perspective. Marks (2002:1-26) provides the wider social and historical context for these structural factors, arguing that the unequal world order is the facilitator of public health crises such as the HIV/AIDS pandemic.

These development discourses position the HIV/AIDS epidemic within the broader realm of human development, thereby emphasising the influence of widespread poverty in the sub-Saharan region on disease transmission and impact (UNDP, 1998:7). From this vantage point the inequities of a complex and disparate global system, manifest through poverty and the marginalisation of certain sections of the population, are emphasised as fuelling the epidemic's spread. This is further reflected in discourses that frame HIV/AIDS as a human rights issue, and position people living with HIV/AIDS within the broader struggle for access to health care, non-discrimination and a rights-based approach to HIV prevention, treatment and care (Seidel, 1993). The 'developmental' and 'lifestyles' discourses are at times in antagonistic relationship to each other, the former being focused on changing the context in which the epidemic operates, the latter emphasising behaviour as the point of entry for strategies.

c. African culture and sexual identity

*"HIV/AIDS however is an invisible enemy. Unlike colonialism and apartheid, there are no moral certainties in tackling HIV/AIDS. On the contrary, one of the characteristics of the pandemic is that is forces us to question moral certitudes, including deep seated assumptions about the core values of African societies. It requires exceptional leadership skills to confront these complex and intimate issues."*

(Justice for Africa, undated)

The public discourse on the epidemic has, given the country's history of colonialism and apartheid, been shaped by representations of race and cultural identity. The meanings attributed to HIV/AIDS – across the many cultural spectrums it covers – emerge from both

the "lived and mediated experiences" of discourse (Bardhan, 2002:221). In parts of Africa and South Africa, HIV/AIDS is perceived as being linked to witchcraft. Consequently, the afflictions associated with AIDS are attributed to the actions of invisible forces acting through individuals, who then inflict harm such as disease on those who are perceived to be bewitched (Ashforth, 2001). According to Ashford (2001:5), "[d]iscourses of 'witchcraft' can thus be represented as modes of posing and answering questions about evil – about the beings, powers, forces and modes of action responsible for causing suffering in the world; about the nature and meaning of their effects". Caldwell (1999) links the dominant belief system that HIV/AIDS is caused by malevolent forces, or divine punishment, to leadership responses in Africa. Thus, Caldwell (1999) identifies the inability of leadership to acknowledge the African sexual system as the problem and asserts that "the central plank in the victory over AIDS is the recognition by African governments of social and sexual reality" (Caldwell, 1999:18).

In her exposé of African culture, sexuality and gender identity, Becker (2003) posits that "colonial imaginaries of excessive sexuality and patriarchy as primordial features of African culture continue to live in contemporary social configurations in southern Africa" (2003:1). Becker traces the colonial notions of African sexuality and purports that contemporary constructions of African sexuality are reinvented by the global consumerist culture through processes of modernity – antithetical to notions of traditional culture – resulting in collective conceptions of "African difference" (2003:24). President Thabo Mbeki's utterances have also been interpreted as a strong response to colonial discourses, of 'excessive' African sexuality and the racialised origin of disease, wherein Africans are positioned as "natural-born, promiscuous germ carriers" with an "unconquerable devotion to the sin of lust" (Mbeki, 2001 in Becker, 2003:3). In this vein, Mbeki argues that "whatever lessons we draw from the West about HIV/AIDS, it would be absurd and illogical to make a simple superimposition of Western experience on African reality" (GCIS, May 2000:4). There is little doubt that racialised Western representations of African sexuality and culture both influence and direct the international AIDS agenda (Patton, 1990; Whiteside, Barnett and Van Niekerk, 2002). Dissident texts, such as "Castro Hlongwane, Caravans, Cats, Geese, Foot and Mouth Statistics: HIV/AIDS and the Struggle for the Humanisation of the African" (Author's name not provided, 2002), which was widely distributed within the ANC and on its website, reflect strong racialised

representations of the epidemic as a colonial construct which undermines the identity of the African people and threatens nationalist struggle.

Further compounding negative representations of African sexuality, suggestions that causality could be linked to 'unregulated sexual desire' form the basis of the moral agenda explanation for HIV/AIDS prevalence amongst particular population groups (Alcorn, 1982; Horton and Aggleton, 1989). Investigating how HIV/AIDS is talked about in sub-Saharan Africa, given the prevalence of competing and overlapping discourses, Seidel (1993:175) highlights the medical and medico-moral discourses as having significantly shaped HIV/AIDS policy in the region. Unpacking the medico-moral discourse, Seidel (1993) depicts this as primarily driven by broader Christian discourses underpinned by notions of God's punishment for 'immoral' sexual behaviour.

The identification of HIV/AIDS as a sexually transmitted infection (STI) has greatly affected popular perceptions of the disease as well as the manner in which people living with HIV/AIDS are represented. Thus the HIV/AIDS epidemic is to be located within broader discourse on STIs (Van Niekerk, 2002:157). In their discourse analysis of varying social constructions of STIs in South African communities, Shefer, Strebel, Wilson, Shabalala, Simbayi, Ratele, Potgieter, and Andipatin (2002) reveal the dominant discourse of stigmatisation, with particular prominence given to associations with stereotypes of 'promiscuity' and 'deviance', and links to gender identity constructions. Shefer *et al* (2002) highlight the negative constructions of STIs, with reference to genderised and racialised notions of STI causality. Along a similar trajectory, issues of sex, morality and blame are closely associated with HIV-related stigma and discrimination in sub-Saharan Africa and South Africa (ICRW, 2002; POLICY 2003b). Furthermore, these othering and pathologising discourses of African sexuality, underpinned by racist narratives, have created a discursive space for the views of AIDS dissidents (Robins, 2002).

d. The politics of HIV/AIDS

Debates have raged over both the form and content of the South African government's articulated response to and understandings of the epidemic. Government has been criticised on many fronts, essentially for its perceived lack of political commitment with regard to the implementation of a comprehensive response to the epidemic, as well as for poor coordination and collaboration in programme implementation (Benetar, 2002; CHSR, 2002;

Marks, 2002; Mbali, 2002; Van Niekerk, 2002; Becker, 2003; Whiteside *et al*, 2003). The resultant controversy surrounding the South African policy response has infiltrated discourses on the epidemic both in the media and within government articulations.

In the beginning of 2001, the ANC stated that "HIV/AIDS is a complex disease, about which a lot is not known" (ANC Today, 15 February 2001). The primary obstacle to an effective response to the epidemic was, at that time, cited as inadequate empirical data (ANC Briefing Document, 30 November 2001). Inevitably, the challenge of affecting behavioural change in the context of a newly democratised developing nation raises complexities for political and economic governance. However, Whiteside *et al* (2003:2) address the issue of insufficient data about the pandemic, stating that this should not result in the "continued denial and obfuscation, as occur in the statements and policies of some African countries, South Africa in particular". In contrast, Fassin and Schneider (2003) argue that a social epidemiology of disease was lacking due to the dominance of biomedical approaches to the epidemic, which indirectly facilitated government's questioning of HIV/AIDS. In their interpretation of the suspicion and denial of government toward the epidemic, Fassin and Schneider (2003) propose that issues of "racialisation" and "conspiracy" have specific historical roots in the South African context. The fact that epidemics have in the past been used to enforce racial segregation, and that the apartheid regime's subversive activities included chemical and biological weapons designed to eliminate black activists, provides an explanation for government's "mistrust towards Western science, medicine and public health" (Fassin and Schneider, 2003:497). As such, "an understandable defiance is thus an important element of what is usually termed denial" (Fassin and Schneider, 2003:497). Joffe cautions that conspiracy theories associated with AIDS are "a rhetorical defence against blaming aspirations" (1999:35). Robins (2002), in his analysis of political perspectives of science in relation to HIV/AIDS, argues that the cultural politics of race has influenced government's defensive response to HIV/AIDS-related statistics. He asserts that dynamics of race inform the interpretation of the science of HIV/AIDS, and that African nationalist perspectives draw attention to the legacy of colonialism and apartheid in shaping scientific racism, against which President Thabo Mbeki has rallied (Robins, 2002).

Despite these explanations, government's power to determine the dominant representations of HIV/AIDS has been actively contested in the public sphere. Social movements such as

the Treatment Action Campaign (TAC) allow for the poor to exercise some degree of power within the limited space (Geffen in Friedman and Mottier, 2004:24). As such, within the broader discourse of human rights, the moral consensus that the TAC strategically seeks is one in which government is positioned as 'immoral' in its response to HIV/AIDS and PLHAs (Friedman and Mottier, 2004). Alternative discourses articulated by people living with HIV/AIDS offer up destigmatising representations of the epidemic (Robins, 2002). These social actors are a source of discursive power in political context, and vie for space within popular constructions of HIV/AIDS.

Against the backdrop of these varying HIV/AIDS representations in South Africa, the specific implications for discourses on the causality of HIV and AIDS will now be presented.

## 2.3 Discourses on the cause of HIV and AIDS

*"The evidence for HIV is overwhelming. There is a primary etiologic agent, the* sine qua non. *Take it away and you don't have an epidemic."*

(Robert Gallo, 1989, co-discoverer of the HI virus in Triechler, 1992:77)

In this section discourses already discussed will be related specifically to representations of causality and the relationship between the HI virus and AIDS. As the above quotation suggests, AIDS is described in medical discourse as being caused by the human immunodeficiency virus (HIV) that can be reliably diagnosed. By 1985, the cause of this biomedical condition was explicitly linked to HIV (Crewe, 1992). Triechler (1992), in her anthropological account of the cultural construction of HIV/AIDS, highlights the power and influence of scientific discourse on the conceptual 'realness' of HIV. This draws into focus the "linguistic markers that assign statements about reality to specific provinces of meaning" (Triechler, 1992:85). By example, the statement *HIV causes AIDS* versus *HIV is a result of sexual deviance* versus *HIV is caused by poverty* illustrates how multiple realities interact in social constructions and in what we know to be 'real' of the epidemic. It is therefore argued that "different realities are signalled by these differently constructed accounts of viruses" (Triechler, 1992:85). How we understand and interpret the cause of

disease will inform our construction of what HIV/AIDS is, and what it therefore comes to represent for both ourselves and others.

The debates surrounding the origin of HIV and AIDS have impacted on the attribution of cause. What these vying theories of origin hold in common is the identification of the problem of HIV/AIDS as being rooted elsewhere, and the assigning of blame to ‘others’ e.g. gay men; colonial imperialists; promiscuous people; Africans etc. (Strebel, 1993; Kgamadi, 2004). Against the backdrop of HIV/AIDS denialism, myths abound about the cause of HIV and, by extension, AIDS. Due to fear and ignorance many of these myths have been reflective of the need to attribute blame (Crewe, 1992). These discourses of defence, underscored by conceptions of blame, serves to demarcate a particular group as being affected differently to everyone else (Kgamadi, 2004). This in turn results in the othering of HIV/AIDS and those infected and affected, as well as the stigmatisation of specific groups. The questions and meanings of HIV/AIDS causality have been steeped in confusion, often underpinned by these notions of stigma, moral judgement and blame.

Representing both a biological disease and a social institution, Plummer (1988:23) draws attention to the ‘medicalisation’ of AIDS, locating the cause of disease in the body, which draws on technical and diagnostic terms to identify, interpret and understand it. In contradiction, discourses that further the stigmatisation of HIV/AIDS locate causality along social rather than medical dimensions, allowing for moral, political and theological explanations for the existence of HIV/AIDS. These constructions shape HIV/AIDS responses that are othering, discriminatory or exclusory (Plummer, 1988:22-25). As such, both biomedical and moral discourses coexist and offer up varying understandings of disease causality, shaped through language.

Central to social representations of the epidemic in the South African context has been the public and political discourse around the cause of AIDS and the link between HIV infection and AIDS-related death. President Thabo Mbeki's questioning of the cause of HIV as not exclusively the result of a virus has impacted on public perceptions of the disease (Mbali, 2002). The 33 person Presidential Advisory Panel set up to address this very issue of causality in South Africa included numerous prominent AIDS dissidents (Swindell, 2001). In 2001, in an HIV/AIDS briefing document, the ANC refers to key questions that remain with regard to understanding HIV/AIDS, and which included: *Does the HI virus in fact*

*exist? If so, is it the main cause for the immune suppression seen in patients who have tested HIV positive? Are HIV tests reliable and do they measure HIV? What are the reasons for the differences in modes of transmission between the developed and developing countries?* (ANC Today, 30 November 2001). These discourse patterns, representing notions of causality of both HIV and AIDS respectively, point to the role of politics and power in mediating the course of disease construction and reality. Confusion surrounding causality is further compounded by the long latency period between HIV-infection and AIDS-related death that works against people making the causal link between earlier sexual behaviour and the consequence of AIDS (Justice for Africa, undated).

Representations of HIV/AIDS causality are mostly embedded within the discourses outlined in the previous sections of this literature review, and reflect elements of disease othering, stereotyping, and blame attribution. HIV/AIDS as the 'African problem' highlights the blaming and stigmatisation of black Africans, seen as the carriers and core transmitters of the virus. Linked to earlier described discourses of African sexuality, bio-anthropological studies point to the cultural variables that influence explanations of different disease patterns in a given context e.g. the heterosexual nature of HIV/AIDS in Africa (Gatter, 1995). Some explanations for HIV/AIDS are attributed to the negative results of modernity in Africa, which signify the movement away from ancestral norms and values, bringing forth illness (Seidel, 1993:14; Ashforth, 2001). These racialised discourses of HIV/AIDS as the 'African problem' represent the politicisation of the pandemic (Seidel, 1993; Ashforth, 2001). President Thabo Mbeki's claims in a series of letters to Democratic Alliance leader Tony Leon that racist notions of the 'excessive' nature of African sexuality drive the epidemic (Thom and Kullinan, 2004) reflect this racialised discourse in which colonialism is implicitly blamed for disease. Similarly, deviant sexual practices that are linked to both racist constructions of African sexuality through exoticisation and othering, as well as gay sexuality and promiscuity, are represented as moralistically problematic. From this perspective HIV infection is a result of deviant sexual practices that are punished by illness. This creates discursive space for moral scapegoating, with the 'guilty' and 'innocent victims' of HIV infection infiltrating common understandings of causality of disease (Plummer, 1988:33; Kgamadi, 2004).

Amidst the medico-scientific debates concerning causality, the social link between poverty and HIV/AIDS has also been drawn. As previously discussed, with reference to

development discourses, factors such as poverty and gender inequality are seen to be structural causes of the epidemic. In analysing the social context for HIV/AIDS in South Africa, Van Niekerk (2002) argues that confusion has been sown by Thabo Mbeki with regard to the distinction between the cause and the social context in which the epidemic thrives. Therefore, it is cautioned not to overstress the poverty aspect of HIV/AIDS causality as an avoidance of other pressing issues that can be tackled as a response to the epidemic (UNDP, 1998; Van Niekerk, 2002; Justice for Africa, undated). Whilst development discourses are critical to underscore socio-economic and racial transformation concerns, they are also used problematically to argue against the provision of ARVs and against decisive action towards the epidemic. There has been pressure, from both within and outside of government, to categorically ascribe the HI virus as the primary cause of HIV/AIDS. In mid-2000 one such document, produced by the ANC National Health Committee, urged the President and the Minister of Health to acknowledge that HIV causes AIDS (POLICY Project, 2003a:114).

*"It is also likely that recent debates in the country discussing the fact that HIV causes AIDS has produced unintended effects, including greater confusion about prevention needs in some subgroups of the population"*

(HSRC, 2002: 88)

The confusing and contradictory discourses on HIV/AIDS causality in South Africa impact negatively on public perceptions of disease. In its analysis of HIV/AIDS knowledge levels, the HSRC study reveals that a high proportion of the sample gave a "don't know" to the question of whether HIV causes AIDS (2002:83). This amounted to 1 in 5 respondents (20.3%). In addition there was a strong correlation between these low levels of HIV/AIDS knowledge and stigma towards PLHAs (HSRC, 2002:86). Conversely, increased knowledge about the epidemic impacts directly and positively on prevention behaviours and attitudes toward PLHAs (HSRC, 2002:88).

This chapter has outlined dominant and popular discourses on HIV/AIDS, with specific reference to the South Africa context, drawing attention to the representation of disease causality embedded within these contemporary constructions. In shaping our understanding and interpretation of the world in a meaningful way, the multiple discourses presented draw into focus the discursive contestations of science, culture, politics and activism in the social

making of HIV and AIDS. The following chapter outlines the methodological approach used in identifying the dominant discourses articulated in selected government policy texts and narratives.

# Chapter 3
# Methodology

## 3.1 Discourse analysis framework

This chapter provides an overview of the methodological theory and approach that frame the current research. The discourse analysis techniques informing the analysis will be outlined, including: the research aims and objectives; research design and methods; issues of reflexivity; and ethical considerations.

Discourse is underpinned by theories of social constructionism, and is broadly defined as "processes by which human abilities, experiences, common sense and scientific knowledge are both produced in, and reproduce, human communities" (Shotter and Gergen, 1994 in Potter, 1996:2). Discourse means many things to many people, but central to its definition is the making of meaning above the level of the utterance, and what lies behind the utterance, e.g. relationships between subjects and subjects and objects, as well as the wider institutional and contextual underpinnings (Potter and Wetherell, 1988). Discourses, through structured text and other forms, produce and reproduce the material world, and as such are beyond mere description of the world, as they also categorise and shape it (Parker, 1992).

Sawyer (2002:434-436) charts the varying forms and disciplines that have embraced discourse analysis, including: post-colonial theory as exemplified by Edward Said's prolific work on the social construction of the Orient; anthropological perspectives on discourse as a culture or ideology; sociolinguistic focuses on "speech style"; psychological interpretations of discourse as "physical practice"; and a feminist approach of discourse as "a type of subject". This delineates the multidisciplinary nature of both interpretations and practises of discourse theories.

Depicted as a study of "language in use", discourse is linked to both communication and interaction and as such discourse analysis "provides us with rather powerful, while subtle and precise insights to pinpoint the everyday manifestations and displays of social problems in communication and interaction" (Van Dijk, 1985:7). HIV/AIDS is a dynamic entity, interfacing with many paradigms of thought and meaning. As one of the most pressing

social problems of our era, HIV/AIDS demands an understanding of the dynamics underpinning the communications and interactions surrounding this complex and multi-layered manifestation of social disease. Discourses are positioned within the spectrum of other discourses and in relation to cultural, ideological and social forces (Wodak, 1996; Fairclough and Wodak, 1997). Social representation of HIV/AIDS, its nature and cause, are infused with dynamics of power, culture and ideology. Thus, given the social aspect of HIV/AIDS and the multifaceted nature of how it is interpreted and acted upon, critical discourse analysis (CDA) presents a suitable methodology in the present study, given its focus on configurations of power in relation to language (Wodak, 1996). The current research draws strongly on a CDA approach, which aims to show non-obvious ways in which language is involved in social life, including power/domination and in ideology, while pointing to possibilities for change (Fairclough and Wodak, 1997). CDA works in a 'transdisciplinary' manner by which it develops both in theory and methodology, in dialogue with other areas of social theory and research. In the analysis process of CDA it is important to observe the heterogeneity and contingencies within discourse patterns, and the crossovers and similarities between them (Fairclough, Pardoe, Szerszynski, undated).

Furthermore given the current research's explicit focus on the discourses within policy texts, this choice of analytical tool facilitates understandings about the role of discourses in "ideological formulation, in their communicative reproduction, in the social and political decision procedures, and in the institutional management and representation" (Van Dijk, 1985:7). Similar to the analysis of racist discourses (Potter and Wetherell, 1988), the current study draws on the way in which descriptions are utilised in a particular context to position HIV/AIDS and the discursive subjects HIV/AIDS has come to represent.

As an analysis of language that goes beyond the sentence to include semantics, morphology, phonetics, syntax and grammar, discourse draws attention to the context in which text is produced (Wodak and Meyer, 2001). The issue of context is significant to understanding the nature and function of discourse – which must be viewed in context in order for meaning to be inferred for a particular text (Lalouscheck *et al*, 1990 in Titsher, Meyer, Wodak and Venter, 2000). Van Dijk's (1977) definition of discourse sees text in context, and as defined in action (in Titsher *et al*, 2000:26). By extension, Wodak and Fairclough (1997:26) view social practice as being essential to discourse, implying "a dialectical relationship between a particular discursive event and situations(s), institution(s)

and social structure(s) which frame it: the discursive event is shaped by them, but also shapes them". This focus on discourse as a determinant of reality, whilst at the same time creating that reality, is particularly useful given the current focus on HIV/AIDS. The epidemic needs to be understood through the ways in which is it discursively mediated and as a product of its own social construction.

As a form of social critique, CDA is concerned with social problems and socio-cultural processes and structures (Wodak, 1996:17-20). In relation to method, CDA considers the larger discourse context and the meaning that lies beyond grammatical construction (Fairclough, 2000). This includes taking into consideration, in the process of analysis, the political elements of language use and production. In addition this method of analysis accounts for power both *in* and *over* discourse, placing text firmly within a given social and political frame (Potter and Wetherell, 1988; Parker, 1992; Wodak, 1996). Recognising the role of discourse in processes of social change, there are competing and contesting strategies in times of crisis purported by different social agents in an attempt to resolve the crisis (Jessop, 2000 in Fairclough, 2000). Notwithstanding the complexity of this relationship, social change is led by discursive changes resulting in changes in the associations between discourse and the emergence of new articulations through discourse (Fairclough, 2000). Discourses of the HIV/AIDS epidemic hold clues about the role of ideology and power, mediated through social construction, and the impact of these forces on approaches to the epidemic over time.

It is important to note that discourse analysis is also accused of being a biased interpretation loaded with ideological interpretation, and therefore limited in terms of the extent to which it can be presented as value-free research (Widdowson in Titsher et al, 2000:163; Sarangi and Callin, 2003). Another criticism levelled at discourse analysis is that the researcher is both an object of inquiry, as well as the source of analysis (Sarangi and Callin, 2003). In response to concerns of validity and reliability, Potter (1996) argues that due to the theoretical assumptions which by definition embody discourse analysis, more traditional forms of such concerns are difficult to apply. Processes of self-reflexivity and triangulation can contextualise discourse interpretations during the research process and are seen as further ways in which such methodologies achieve validity (Potter and Wetherell, 1987). In terms of the research process, an exploration of social categories and theoretical perspectives is clearly necessary to inform what the analyst looks for, what she is

potentially capable of noticing within the data, and the analytic methods she selects. The insights from this research process will in turn respond to and even challenge these categories and theoretical perspectives, and thereby demand further empirical analysis (Fairclough, Pardoe and Szerszynski, undated).

## 3.2 Research aims and objectives

The study is an analysis of contemporary constructions of HIV/AIDS and causality in South Africa, using the methodology of discourse analysis. Focusing on the dominant discourses embedded in selected policy texts and government narratives in the period 2002-2003, the study will raise implications for HIV/AIDS representations of the epidemic.

Key questions that will guide the analysis include:

1. How is the social construction of HIV/AIDS reflected in key policy texts and government narratives (with an emphasis on the cause of HIV/AIDS) in the years 2002-2003?
2. What are the dominant discursive trends to emerge? Are there shifts in the use of particular discourses in policy texts over time?
3. What do these dominant and competing discourses tell us about South Africa's policy position on HIV/AIDS at given moments in time? What are the broader implications of such inferences?

## 3.3 Research design

### 3.3.1 Method and procedures

In line with the key research questions the study concentrates on texts which represent specific utterances of a particular group of people (i.e. HIV/AIDS policymakers). In such cases, the text itself is not the only selection criterion but rather the source from which the text emanates as well as its links with the central research questions. Units of analysis are at the level of themes, focusing on the relevant categories within the text as they relate to identified discourses on HIV/AIDS. Discursive themes are theoretically justified, and informed by the existing literature and previous analyses in the area of study.

The initial pool of 35 texts was sourced from:

- National government policy documents on HIV/AIDS.
- Cabinet statements on HIV/AIDS.
- ANC statements and papers on HIV/AIDS.
- Speeches and press releases by government policymakers.

These 35 texts were selected according to the following criteria:

- Being developed by key policymakers/policymaking structures in the South African government.
- Giving policy direction to the nature and/or content of the South African national response to the epidemic (directly or by implication).
- Having policy implications for national programmes with regard to HIV/AIDS prevention, treatment and/or care.
- Being formulated during 2002 or 2003.

*a. Selection of texts for analysis*

From the initial pool of 35 texts, identified according to the criteria outlined above, 19 texts were selected for analysis based on their richness and depth in illuminating discourses relevant to the present study. These 19 texts were grouped as primary texts and secondary texts, as elaborated below. It is important to note that the selected texts are not a true representation of the full range of government narratives on the epidemic over the years in question. The specificity of the text selection is not aimed to limit the many ways in which government articulations represent HIV/AIDS but to illuminate the more dominant discourses to emerge within key policy texts at critical points in government's policy position on HIV/AIDS over the years in question. All the selected texts are produced by individuals, structures or organisations that play a key role in the development and communication of national policy, namely: the Cabinet; the Government Communication and Information Services; the National Executive Committee of the African National Congress; and the Department of Health. The texts are official policy documents and are all publicly available (see Appendix 1 for a detailed citation of all primary and secondary texts).

*b. Primary texts*

Of the 19 texts selected for analysis, 11 texts were identified as primary texts. These are all formal representations of government's policy position on HIV/AIDS at significant points in time. The texts are chosen for their richness in discursive representations linked to the research topic itself, and highlight dominant discourses in government representations of HIV/AIDS.

*c. Secondary texts*

In addition to the 11 primary texts, 8 secondary documents were selected for analysis. These texts serve to deepen the primary text analysis by raising further confirmation and/or contradiction to the discourses that emerged from within the primary texts. They are a means to expand the analysis process by allowing for further interrogation of the primary texts, thereby substantiating and reinforcing the primary level of analysis. Whilst the secondary texts may not all be formal pronouncements of government policy they all emanate from policymakers. In some instances, spoken texts are included in this sample. As such, the secondary texts allow the findings to be linked to other contextual frames as well as the articulations of key policy actors at given points in time.

*d. Data analysis process*

Approaches to discourse analysis are varied, ranging from Potter and Wetherell's (1987) ten steps, to the identification of implicit themes (Billig, 1988), to more intuitive methods using the researcher's own experience (Hollway, 1989). In recognition of the complexity of discourse analysis and the considerable variety of analytical methods available (Wodak and Meyer, 2001), the present research design draws from a number of analytic procedures.

A staged approach to data analysis was adopted which involved an initial reading of all 19 texts, with a focus on the primary texts, to establish thematic categorisation. This was followed by a number of re-readings of texts with a more comprehensive examination of the discursive trends that emerged. The discourses present in the primary texts were then further corroborated through the analysis of the secondary texts. This served to raise both contradictions in and between discourses as well as to provide further explanation of the emerging discursive trends. At the various stages of analysis, thematic groups were tweaked and refined so as to more accurately capture those discourse patterns most linked to the central research questions. The application of a range of methods to the analysis process

produced a fuller understanding of the complexity in construction of the current subject matter. A degree of intuition was also employed in the identification of discursive themes (Hollway, 1989).

Parker's (1992:6-17) seven stages of discourse analysis were particularly useful in identifying discourses and unpacking meaning within the texts. The following questions were applied to each text:

1. What discourses emerge from the texts in relation to the research questions? (The identification of discourse through text and exploration of connotations, allusions and implications raised by the texts.)
2. What representations of HIV/AIDS are evoked through the discourses? (How the discourse creates a set of meanings of a specific object, and thereby the construction of a set of representations.)
3. How are people spoken about in the various discourses? (The subjects contained in a discourse: the articulation of relationships through discursive patterns.)
4. How can one group discursive statements into topics/themes? (Exposing coherent sets of meaning.)
5. How do the identified discourses relate to other discourses? (The relationship among discourses.)
6. How can one reflect on the terms used to describe discourses? (The way that discourses speak and the audiences they address.)
7. How do discourses shift over time and in context? (Locating discourses in historical context.)

Discourses support institutions through the reinforcement of some and the subversion of others, and as such reproduce power relations through promoting specific sets of meaning. They therefore have an effect on ideology through enabling dominant groups to "tell their story" through the narrative (Parker, 1992:20). As such, the relationships between discourses and power, ideology and institutions are criteria that were also applied to the analysis (Parker, 1992:17).

Drawing on Billig's (1988) identification of implicit themes in the analysis, dominant discourses were identified from the existing texts based on the broader literature. These

emerging discursive themes were then analysed in more depth, applying the following questions (Potter and Wetherell, 1987; Fairclough, 2000):

1. What is the discourse doing?
2. How does it reproduce, undermine and highlight specific constructions of meaning?
3. What ideological and political positions are frequently rationalised and legitimated through the discourse?
4. How does the discourse position, prioritise and privilege certain constructions of meanings (or one discourse over another)?
5. How are contradicting and multiple texts represented within the discourse?
6. How are discourses repositioned over time (frequency; dominant/marginal and shifts over time)?

It is important to note that discourse analysis does not constitute a specific method but rather a broad theoretical framework with a set of suggested techniques for application (Potter and Wetherell, 1987). As such the present study utilises a number of these techniques, in combination, in its attempt to elicit relevant discourses within the texts. The application of the range of discourse analytic techniques and the subsequent findings of the analysis are detailed in Chapter 4.

In the process of analysis, consideration was also given to the identification of the social actors involved in the discursive construction of HIV/AIDS, as well as to the reasons behind such constructions and the implications thereof on policy and public discourse. The critical orientation of the research was central in reflecting on the implications of the emergent discourses for the social construction of HIV/AIDS and the development of policy within a given socio-political context. These implications, and the resultant conclusions and policy recommendations, are outlined in detail in Chapter 5.

### 3.3.2 Reflexivity

CDA recognises that the construction of the research object and topic involves specific theoretical frameworks and perspectives, and that such theorising informs method, data selection and analysis (Fairclough, 2000). The researcher is thus central to this process of applying theory and perspective to the research focus. CDA as a methodological approach recognises that the researcher cannot be positioned outside of discourse. Instead it allows for consideration of "how discourses shape our experiences of *the real* in its proposal that

the way we speak and write reflects the structures of power in our society" (Lather, 1991 in Shefer, 1999:137). The relationship between the researcher and the research topic, as well as the ideological and socio-political persuasions of the researcher, are acknowledged as impacting on the research process and conclusions drawn (Van Dijk, 1985:3).

The analysis that follows does not pretend to be objective. It is rooted within the researcher's particular understanding of HIV/AIDS within a specific historical, policy and political context and the perceived implication of these. In the analysis the researcher is not assumed to be neutral or impartial, both in terms of the selection of texts to be analysed and the process of analysis and interpretation. The social identities of the researcher position her in a particular discursive relationship to HIV/AIDS, as a white, middle-class South African woman who has worked extensively in the field of HIV/AIDS. It is noted that the researcher's firsthand experience in working with HIV/AIDS, within the context of policy dialogue at both governmental and community level, provides the impetus for the current line of enquiry as well as a rich understanding of the nature and impact of contemporary discourses in relation to the epidemic.

## 3.4 Ethical considerations

As the current research methodology does not require the use of human subjects, there are no ethical considerations to be demonstrated. However, that the study concerns itself with politically sensitive issues is to be acknowledged. As such, the analysis endeavours to serve as a critical examination of the messages and discourses within policy texts, and not as a critique of government's HIV/AIDS policy *per se*. It is believed that government representations have significant implications for the broader social construction of and approach to the epidemic, and as such warrants academic investigation. With the intention of making conscious the meanings constructed through the discourses revealed in the analysis, the research enables readers to critically engage with underlying HIV/AIDS representations that shape and are shaped by government policy.

# Chapter 4

# Discourse analysis of key policy texts and government narratives

At the outset of the study the focus for analysis was on discourses concerning the causality of HIV/AIDS. Through the analysis process it became clear that a much wider range of discourses are present in the texts, many of which inform both direct and indirect representations of disease causality, as well as discursive responses to the epidemic. Given the volume of discourse in the texts, in documenting the analysis the researcher has chosen to concentrate on specific discursive patterns which draw out the subject role of government in responding to the epidemic, and which illuminate the socio-political dynamics within HIV/AIDS constructions.

Drawing on Potter and Wetherell's (1987) model of discourse analysis the texts were searched for themes related to the research question. The process was cyclical in that as the researcher's understanding of a particular theme developed, she returned to the text to re-search for instances that could be identified as relevant. The analysis focused on emerging patterns in the data, including both variance and consistency of discourse configurations (Potter and Wetherell, 1987). During this process themes merged, together in some instances, and separate in others. There was much overlapping of both complimentary and competing discourses across and within the texts. However, in order to better understand the nature and implications of the emerging discourses most relevant to the study's central questions, four themes have been used to structure the discussion of the findings. The function and consequence of each theme was explored in detail, drawing on both the broader literature and the theoretical paradigm of discourse analysis.

These themes were derived from the research interest underpinning the study and the nature of the subject under investigation, and are named as follows:

1. The struggle against HIV/AIDS: War, enemies and partnership
2. ''It's all part of the plan'': Consistency in government's response
3. HIV/AIDS the unknown: Complexity and questions
4. The treatment of treatment: Positioning ARVs

The analysis explores how texts in the sample relate back and forth to each other, and interprets the representations within texts with reference to the context in which they are produced. Contextual information provides a fuller account of the detailed organisation of discourse patterns (Potter and Wetherell, 1988; Parker 1992). Furthermore, recording the date of the texts was important in identifying discursive shifts over time and examining intertextuality. Selected extracts from texts, accompanied by detailed interpretations which link with analytic claims, are extensively drawn upon to illustrate the analysis[3]. Where appropriate, inferences are made between the discourse patterns embedded in the texts and the broader literature.

## 4.1 The struggle against HIV/AIDS: War, enemies and partnership

This theme is one which constructs HIV/AIDS within the discourse of struggle, mirroring the historical anti-apartheid struggle where there are clear enemies and allies and a strong call to unity. The theme is a powerful one, steeped in the language of South African history within which conceptions of "unity", "partnership" and "struggle" conjure up a strong sense of collective identification and alliance. Political rhetoric is embodied in the use of specific linguistic forms imbued with strong associations (e.g. "struggle", "comrades", "amandla"). The epidemic itself is represented as a site of struggle and contestation, which is to be defeated primarily through support of government policy.

According to Lakoff and Johnson (2000:118), "everyday thought is largely metaphorical". Through the metaphors of 'war' and 'struggle', disease is constructed as the enemy against which a nation launches attack and assembles weaponry. Those associated with the virus become, implicitly and inextricably, part of the target of attack. Notions of "unity" and "solidarity" then forge a "united front" against this common enemy. The theme highlights unity amongst all sectors of society, in both understanding and response to the epidemic, as a requirement to adequately tackling HIV/AIDS. As such, the need for compliance and support of government's response is constructed through this discursive theme.

[3] The following abbreviations will be used to reference the specific texts under analysis:
T = primary text and S = secondary text. As such, T1 indicates primary text 1 and S2 indicates secondary text 2. The numerical order of the texts, arranged chronologically for both primary and secondary texts respectively, bears no significance in terms of the analysis.
[ ] = author's addition

When the metaphors in a given discourse support the interests of the group which uses that discourse and act against the interests of other groups, such metaphors may be serving a particular ideological function. The theme serves to affirm government policy in the light of divergent or oppositional voices, reflected in the form of an implied ‘other’ in the texts. As such, the questioning of government’s position on HIV/AIDS is challenged in the discursive construction of the dissenting or opposing ‘other’. Through this, the articulated position on HIV/AIDS is affirmed.

Sontag (1989) warns that metaphor elevates HIV/AIDS well above its abstraction as a medical disease, creating meaning that goes far beyond the medical condition it represents. The constructions of disease, facilitated and enabled through discourse, hold immense power (Sontag, 1989). The specific metaphorical constructions of HIV/AIDS, as represented in the discursive theme under discussion, serve to reinforce human proneness to depict disease as similar to something, i.e. war. This removes the abstractness of the epidemic and allows humans to better understand it (Sontag, 1989). There is a dual usage of the military metaphor: on the one hand reflecting broader international constructions of illness as site of struggle but also, in the South African context, performing a political role that links it with a particular history of struggle. Through the mechanism of “anchoring”, the new event (in the present case HIV/AIDS) is shaped such that it becomes associated with existing ideas, i.e. already existing representations of struggle (Joffe, 1999). This process allows for the coming to terms with the unfamiliar, through linking it to the historically familiar systems of categorisation and the attribution of disease to an existing out-group, i.e. the ‘other’ (Joffe, 1999).

The texts produced in 2002 have a stronger presence of the theme, a time when much political pressure was brought to bear on government’s HIV/AIDS policy stance. In texts produced post-November 2003, after the Comprehensive Plan was approved, there is once again a strong presence of the theme which perhaps points to the public debate around the introduction of ARVs into the public sector and the pressure being applied on government to implement this programme at that time.

### 4.1.1 It's a war against HIV/AIDS and others

Across all texts, HIV/AIDS is represented using the metaphor of war, through constructions such as "the fight against HIV/AIDS", "defeating HIV/AIDS", "the nation's armoury", "silent enemy", "frontline", and "weapon against HIV/AIDS".

Three of the texts consciously expand this metaphor to the South African anti-apartheid struggle, thereby linguistically and metaphorically connecting the epidemic to political resistance:

*"I would like you comrades to bring your collective wisdom to this challenge. How do we get all South Africans to identify with HIV as our struggle in the same way we embraced the fight for liberation?" (S3)*

*"Many of you know the history of our struggle. Given that knowledge, is it possible that our new government can suddenly ignore the needs of the people or fail to pay attention to what people say they want from government?" (S3)*

*"This World AIDS Day, under the banner of Khomanani, we are celebrating the power of our people to care, the power of our people to make a difference, the power of our people to safeguard the future. Let us build this power, let us care together. Amandla!" (S8)*

Utterances associated directly with the struggle occur in the secondary texts only. This may be due to the fact that these texts were articulated by politicians and are therefore couched in higher levels of political rhetoric. Political power is exercised through this discursive theme, whereby language becomes a political object and resource drawn upon by policymakers to facilitate the construction of specific forms of HIV/AIDS meaning.

As in all wars, there are enemies. Through the theme, government is positioned at the forefront of the "fight" against HIV/AIDS – an enemy represented through an implied 'other'. This 'other' takes various forms, including the media, scientists, and those who advocate for ARV treatment. In the earlier texts in the sample, there is the linguistic construction of *us and them* within the texts, representing an 'other' that is in opposition to, and antagonistic toward, the HIV/AIDS approach of the ANC. This oppositional 'other' is thereby negatively constructed and problematised:

*"Not once in its history has the ANC been corrupted into acting as an agent for any force, no matter how powerful…nor shall we mislead our people in search of adulatory news headlines." (T1)*

*"…their pronouncements and actions are then portrayed by agents of doom as being antagonistic to the objectives we pursue….The ANC rejects such insinuations. We shall continue to seek co-operation with all who are genuinely interested in joining the fight against the epidemic. At the same time, we shall combat populism and opportunism that derive from cheap politicking." (T1)*

*"…the unfortunate reality that some in our society seem very determined to impose the view on all of us that the only health matters that should concern especially black people are AIDS, HIV and complex anti-retroviral drugs." (S2)*

*"We will ensure that the interests of this group [people living with HIV] will not be undermined by those who want us to believe that there is only one end-all solution to this major challenge." (S6)*

*"At the same time, we shall not be stampeded into precipitate action by pseudo-science, an uncaring drive for profits or an opportunistic clamour for cheap popularity."(T1)*

The discourse also reflects a suggestion of misrepresentation of government's stance on HIV/AIDS, fuelled by the 'other':

*"The NEC calls upon its leadership in its entirety to explain the policy of the ANC on AIDS to its constitutional structures, including its branches and regional general councils, in a coherent and simplified manner." (T1)*

*"So you can see that we have a very comprehensive treatment programme. Unfortunately, when you read the newspapers and listen to the radio and television, this message is not given freely to the South African public." (S4)*

*"An unfortunate impression has been created that government in particular is not committed to tackling this epidemic." (S3)*

*"...there is a studied attempt to hide the truth about diseases of poverty…through agendas and falsehoods." (S2)*

The construction of the 'other' is further reflected through a racialised discourse. This draws on racial identity as a dividing factor which distances the 'other', i.e. those who are engaging in a "propaganda offensive" and those who "force" the adoption of particular policies, from government. It is implied that the "black experience" and capacity for self-determination is undermined by this antagonistic and oppositional 'other'. These problematised 'other' voices are portrayed in racialised terms, in not having the good of "poor and black" people at heart, and who are by implication white and wealthy. This fosters a politicisation of HIV/AIDS discourses and through negative constructions may, as suggested by Van Niekerk (2002:151), "raise the level of inflammatory rhetoric and moral outrage about the injustices of the universe and the global economy…". Theories purporting that the pandemic originated in Africa have been charged with implied racism (Sontag, 1989), and may well underpin discursive patterns which emphasise racialised notions of the epidemic as outlined in the literature (Patton, 1990; Becker, 2003; Fassin and Schneider, 2003).

*"Despite the propaganda offensive, the reality is that the predominant feature of illnesses that cause disease and death amongst the black people in our country is poverty." (S2)*

*"We will not be intimidated, terrorised, bludgeoned, manipulated, stampeded, or in any other way forced to adopt the policies and programmes inimical to the health of our people. That we are poor and black does not mean that we cannot think for ourselves and determine what is good for us." (S2)*

### 4.1.2 We need unity and solidarity

Positioned within the broader discursive theme of the "Partnership Against Aids Declaration"[4] (GCIS, 1998), the discourse of "partnership" represents an antithetical position to the implied 'other'. The construct of partnership represents notions of "unity", "solidarity" and "working together", and is present across all texts.

*"Defeating it (HIV/AIDS) depends on strengthening the Partnership Against AIDS launched in October 1998, in which all sectors society (sic) work with government to implement a comprehensive programme."(T3)*

*"Our best weapon is solidarity." (S3)*

*"A critical element of this strategy is the strengthening of partnerships among all South Africans and their organisations to fight this epidemic." (T2)*

*"Together we can overcome the disease by working in the Partnership against AIDS now represented by the South African AIDS Council (SANAC)." (T6)*

*"Success depends on close collaboration and continuing strengthening of partnership…" (T10)*

*"What is critical is that we should work together as a united force to achieve the best interest of our society." (T2)*

*"Success also relies on strong partnership across society, including the communication of objective facts about the pandemic and its management." (T7)*

This construction of partnership inhibits an oppositional 'other' that is *not* in solidarity with government. It may serve to inhibit alternative views represented through dissenting texts, and promote the representations offered by government, which largely shape the policy plane. As such the discourse serves the goal of promoting loyalty to and support for the HIV/AIDS policy approaches presented in texts.

The role of government is fore-grounded in the "strengthening of partnership" through which state structures are assumed to be the mechanisms through which partnership is to be bolstered, in particular through the South African National AIDS Council (SANAC). Government structures and support of them are reinforced through the notion of partnership.

*"HIV/AIDS is a challenge for all of us, in every sector. Together we can overcome the disease by working in the Partnership against AIDS now represented by the South African National AIDS Council (SANAC)." (T5)*

Furthermore, the partnership construction is directly linked, in two of the texts, to discourses of struggle. In one such text, the theme of the 5th anniversary of the "Partnership Against AIDS" is titled "Five years of partnership moving towards ten years of democracy" (S6). This constructs a representational connect between support of government policy and allegiance to national democratic struggle. The stress on national unity and solidarity expands on the struggle discourse, utilising language strongly reminiscent of the anti-apartheid mobilising discourses. As such, an emphasis is placed on the importance of "constructive engagement" and "a cooperative relationship among all sectors of society" in relation to the implementation of national HIV/AIDS strategy:

*"…together we can overcome the disease by working in the Partnership against AIDS..." (T5)*

*"What is critical is that we should work together as a united force to achieve the best interest of our society." (T2)*

*"…under the banner of Khomanani, we are celebrating the power of our people to care, the power of our people to make a difference, the power of our people to safeguard the future. Let us build this power, let us care together. Amandla!" (S8)*

*"…we should all be aware that this is a complex programme with many elements requiring cooperation of various role-players, inside and outside government - the actual pace of change will depend on how well we all cooperate in implementing the plan." (T10)*

*"A **cooperative relationship** among all sectors of society, particularly in the implementation of this element of the comprehensive strategy, the spirit of letsema and vuk'uzenzele, as message of hope and responsibility, as well as **constructive engagement** in the realm of practical work will ensure that South Africa advances even more decisively in this endeavor." (T9)* (Author's emphasis)

Implicit in these linguistic constructions are antithetical constructions of *non-cooperation* and *unconstructive engagement* which in turn *dis-advance* the response. As such, cooperation with government is represented as a prerequisite for an effective response and any dissenting or challenging voices are constructed as against the struggle and therefore problematised (ironically) as conservative voices through the setting up of government as the voice of liberation and resistance. This signifies the link with national democratic forces, through metaphors of the struggle, as othering challenges to government's HIV/AIDS standpoint. By example, in five texts a negative construction of those who contest government policy appears:

*"Creating false expectations or an atmosphere in which society lowers its guard on matters of awareness or change in lifestyle, or engaging in mutually debilitating contestations about what can be achieved by when, could undermine not only the treatment programme but set back the hard-won advances made curbing the spread of HIV and reducing the impact of AIDS." (T10)*

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[4] See "Partnership Against AIDS Declaration". GCIS, 9 October 1998.

*"It is up to various sectors to enter into a constructive engagement in the realm of practical work to ensure that South Africa enhances its advances in curbing the spread of HIV and reducing the impact of AIDS." (S7)*

The theme "the struggle against HIV/AIDS" points to a conflation between HIV/AIDS and historical oppression, and the associated systems of unity, deception and loyalty. Broadly speaking, discourses of dominance tend to be characterised by a rejection of oppositional discourses for social change, by dominant groupings, as these are perceived as attacks on power (Johnson, 2004 in Kgamadi, 2004). If the "war" against HIV/AIDS is not waged against a visible, tangible virus, but rather against those who want to divide, derail or undermine this new struggle, how are we to understand the real nature of HIV/AIDS and the response it demands? This construction may well facilitate racialised representations of the epidemic as a product of colonialism - which negates African nationalist struggle - as seen in texts such as "Castro Hlongwane, Caravans, Cats, Geese, Foot and Mouth Statistics: HIV/AIDS and the Struggle for the Humanisation of the African" (Unknown author, 2002).

The function of this discourse then may well deflect from the reality presented by a biological disease, fuelled in social context but nonetheless a virus, in favour of a more intricate political, social and ideological contestation. From this vantage point the present theme constructs a causal notion of HIV/AIDS as a socio-political force, driven by key actors contesting for power, and in doing so may undermine more practical and concrete intervention options.

The theme also raises issues of identity and constructions of the self and others in the conceptualisation of HIV/AIDS. Drawing on Billig's (1988) work on rhetorical organisation of talk and texts, it is clear that the political rhetoric present highlights a specific version of HIV/AIDS designed to offset real or potential discursive alternatives. Those that question government on HIV/AIDS policy represent a counterpoint to the established government narrative on the epidemic. These representations, anchored to existing historical constructions which are core to the South African experience, make HIV/AIDS more manageable and familiar. At the same time, this maintains the dominance of certain groups and ideas (Joffe, 1999) - in the present case those in support of government policy and in identification with the national liberation struggle. Consequently

solidarity within groups is fostered, and a system of identification which distinguishes in-groups from out-groups is provided (Joffe, 1999). This enables the categorisation of people and events, which is an adaptive process for distinguishing and dealing with the world (Billig, 1985 in Potter and Wetherell, 1987).

Drawing on Parker's (1992) auxiliary criteria of discourses in relation to institutions, power and ideology, it can be said that different sets of meaning of HIV/AIDS contend for political space, and vie for dominance of power and ideological meaning, alluded to through the theme. If one focuses on the politics of meaning it is apparent that "the struggle against HIV/AIDS" positions the epidemic as a political object, such that its associated representations contend for political power through narrative.

## 4.2. ''It's all part of the plan'': Consistency in government's response

This theme represents changes in national HIV/AIDS policy as "planned for" and "consistent" with the increase in knowledge of the disease, over time. Through the theme, government's approach is represented as following a "natural progression", influenced by government actions, internal processes and understandings alone. "It's all part of the plan" is grounded in representations of the Strategic Plan (Department of Health, 2000), which creates a reference point for discursive meaning. The theme is dominant in that it emerges across all the texts. Those texts which represent clear policy shifts in their content, consistently and explicitly affirm government's commitment to the Strategic Plan. This framing of policy narratives within notions of "consistency" and "continuity" may be interpreted as a counter-response to the fact that sources outside of government may have, or be perceived to have, facilitated policy change. The representations in the discourse offer a contradiction to the competing constructions which attribute policy shifts to external change agents and pressures outside of government. This may further be demonstrated by the fact that the dominance of the discourse is heightened in texts produced at the end of 2003 – a time when national policy reflected a significant shift regarding government's approach to ARV treatment.

The theme's construction of "continuity in response" also hinges upon notions of authority and control, through which government is represented as the instigator of the best approach (as opposed to outside agents) and in control of the HIV/AIDS policy terrain. These

representations enforce issues of ownership over policymaking as well as affirm government's authority on matters related to HIV/AIDS policy.

### 4.2.1 The "natural progression" of the Strategic plan

With regard to content, the texts produced over the period March – April 2002 constitute specific policy changes with regard to the role and potential usage of ARVs for both treatment and prophylaxis. However, this sign of departures from previous policy positions on ARVs is qualified across all such texts by notion of "continuity" in government's overall approach.

In a text produced in March 2002, the position on ARVs is captured as follows:

*"On preventing transmission following sexual assault or needle-stick injury, the meeting noted that the efficacy of the use of anti-retrovirals in this regard was unproven…..they[ARVs] could not be provided in the public health system because of prohibitive costs and the complexity of management with disastrous consequences in instances of non-compliance." (T1)*

In a text produced a month later, in April 2002, the position on ARVs for both PEP and treatment had changed substantially, although still framed in a negative construction:

*"In this regard, survivors [of sexual assault] will be counseled, including on the risks of using anti-retrovirals as preventative drugs, so they could make an informed choice. If they so chose (as in the case with needle-stick injuries), they will be provided with such drugs in public health institutions." (T2)*

*"On anti-retroviral treatment in general, Cabinet noted that they could help improve the conditions of PWA's…." (T2)*

The changes in policy reflected in the above quotes are positioned within constructions of "continuity" and "consistency", further reinforced through reference to the Strategic Plan:

*"The work of the current period should be categorised by 'continuity and change' - continuity in broad strategy and policy, and change in intensity and coherence of implementation and articulation." (S1)*

*"The policy framework which government is following is set out in the 'HIV/AIDS and STI (Sexually Transmitted Infections) Strategic Plan for South Africa 2000-2005'. It is in line with international trends, and it is in fact among the best in the world." (T3)*

*"…the NEC concluded that our work in the current period should be categorised by an approach of 'continuity and change': continuity in broad strategy and policy, and change in intensity and coherence of implementation and articulation." (T1)*

*"…cabinet reiterates its commitment to the HIV/AIDS Strategic Plan for South Africa, 2000-2005.Cabinet noted the progress in the implementation of the Strategic Plan, and decided on a number of measures to strengthen and reinforce these efforts including noting that anti-retroviral treatment can help improve the conditions and health of people living with AIDS…." (T7)*

*"The Plan [operational plan] is the final piece completing the jigsaw puzzle of the national strategic plan for HIV and AIDS 2000 – 2005." (T9)*

*"The possibility of considering sustainable and effective antiretroviral therapy in the public sector is a* ***natural progression*** *of the implementation of the comprehensive 5-year strategic plan." (T10)* (Author's emphasis)

At the time of approval for the Comprehensive Plan in November 2003, the link with policy consistency is once again apparent:

*"This major decision has put in place the last element of our HIV/AIDS Strategic Plan for 2000 to 2005…" (S7)*

*"Let us build on the foundations laid in the past three years through implementation of the five-year strategic plan." (T10)*

*"Has government made a u-turn? In April 2002 after renewing its approach to HIV and AIDS, Cabinet reaffirmed its commitment to the Strategic Plan. Noting progress in the implementation of the Strategic Plan, Cabinet decided on a number of measures to strengthen and reinforce these efforts, including…" (T10)*

It is significant that the Strategic Plan itself does not either directly or indirectly make reference to the use of ARVs as a treatment option for people living with HIV/AIDS.[5] However, specific aspects of HIV/AIDS policy are rendered unproblematic through the discursive theme and government strategy is therefore constructed as being clear and coherent over time. The absence of articulations that represent an explicit acknowledgement of policy changes serves to undermine such changes. This in turn lessens their significance and minimises the salience they represent in the expansion of national HIV/AIDS strategy. The discourse therefore protects government's historical policy framework from criticism and challenge through constructing it as rational, consistent, correct and rooted in an ever-consistent plan.

There are, however, contradictions within the theme in which changes in policy are more clearly articulated, yet still firmly within a discourse of continuity:

*"While reaffirming the correctness of the strategies currently being implemented, the meeting [Cabinet, March 2002] underlined the commitment of the ANC to continuing search [sic] for better and more effective ways of fighting the spread of HIV infection and the management of AIDS." (T1)*

*"As we continue to work within that broad framework [the Strategic Plan], we are intensifying and expanding the programme." (T3)*

*"The Cabinet decision last Friday to adopt measures to enhance government's HIV/AIDS programme, which includes the provision of antiretroviral drugs in public health facilities, reaffirms its commitment to respond in a comprehensive and sustainable manner." (S5)*

[5] See the HIV/AIDS/STD Strategic Plan for South Africa 2000-2005. Department of Health, February 2000.

Interestingly, despite representing the radical shift in policy that saw the introduction of ARVs in the public sector, the following statement is made in a text entitled "**Consistency** at the core of the enhanced treatment plan" (Author's emphasis):

*"The decision, which follows an extensive and wide-ranging process of investigation, is consistent with the approach taken since the ANC took office in 1994." (S5)*

The discursive theme "It's all part of the plan" may serve to counteract a national HIV/AIDS response that has been coloured with dissent, disagreement and active resistance (both through civil mobilisation and court action) toward government policy. The constant reference to a "consistency in approach" based on the Strategic Plan may point to a discursive pattern held up in contradiction to the notion that popular pressure has impacted on government's change in public policy on HIV/AIDS. As such, the theme serves to actively underplay the role of civil society in facilitating processes of policy development after the formulation of the Strategic Plan. Rather, government's 'independent, planned and rational' approach to HIV/AIDS is neatly projected. "It's all part of the plan" is a reminder that government exerts control and authority over the development of HIV/AIDS policy, reinforcing the notion that government, and government alone, determines policy content. It also attempts to obscure the actions of others that may question government's HIV/AIDS strategic framework. Through this construction of an oppositional 'other' the "upright, righteous self" - in the present case, government or the ANC - is upheld (Joffe, 1999).

The grounding of the theme within the discursive construction of the "Partnership Against AIDS", an initiative launched under the leadership of President Thabo Mbeki, could serve as an implicit political endorsement of Mbeki's leadership on the epidemic. The theme may therefore hold up a convenient contradiction to the criticisms leveled at government for lack of HIV/AIDS political will and leadership, and the resultant rift between government and civil society groupings on matters of HIV/AIDS policy (CHSR, 2002). The theme reinforces the legitimacy and rightness of approach, untainted by transient "populist demands". As such, government and its leaders are represented as following a logical trajectory of progress with regard to HIV/AIDS policy development, impervious to external change agents and pressures. In this way, the theme illustrates the role of discourse in constructing social perception (what HIV/AIDS is), self-presentation (how government responds to it) and cognitive consistency (the desire to be consistent to self and others)

(Potter and Wetherell, 1987). Alternative discourses, in opposition to government policy on HIV/AIDS, subvert and defy the dominance of the theme's central message.

## 4.3. HIV/AIDS the unknown: Complexity and questions

As Seidel (1993:176) points out, "[i]n the construction of African AIDS, both Northern and Southern aetiologies have contested for political space and meaning". "HIV/AIDS the unknown" represents the search for truth in the midst of an unprecedented scourge. As stated in the opening sentence of the Strategic Plan, "the HIV pandemic has entered our consciousness as an incomprehensible calamity" (Department of Health, 2000:5). This discursive theme highlights government's search for "objective facts" and the questioning of the truth about aspects of and responses to a "complex" epidemic. Through the theme, ongoing scientific enquiry and research are positioned as central determinants of government's HIV/AIDS policy approach. Although our understanding of HIV/AIDS has progressed swiftly, the new knowledge has at times produced more concern and uncertainty than relief (Sande in McCombie, 1990:19). In addition, the denial of the causal link between HIV and AIDS, reflected through the questioning of the nature of HIV/AIDS, hampers HIV prevention and care efforts (Jackson, 2002). Moreover, the inconsistency in how the epidemic is named serves to construct it as complex and enigmatic. This in turn casts doubt on the nature of HIV/AIDS, creating discursive space for the questioning of AIDS causality. The theme establishes ideological divides in relation to perspectives on HIV/AIDS origin and response, as well as the perceived uncertainty of causality and the relational link between HIV and AIDS.

If poverty is the defining difference between North and South realities, and it is linked causally with HIV, what does this say about Western produced treatment options? The doubts about the facts of HIV and AIDS which are projected in the theme, fuel the questions of virus origin in the public domain. The scientific questioning underpinning "HIV/AIDS the unknown" overlap and reinforces the "Treatment of treatment" theme (still to be discussed) through the consistent posing of doubt concerning origin and essence of disease. This, by extension, facilitates the interrogation of the perceived appropriateness of specific responses (e.g. ARV treatment) to the epidemic.

In the presence of a clear discourse about the established causal link between HIV and AIDS, contextual factors such as poverty could be well represented. However, in the absence of this clarity, the link between poverty and HIV serves to further reinforce confusion of disease causality. This may protect particular ideological positions on what may or may not be the best policy approach to prevention and treatment.

### 4.3.1 The complex nature of HIV and AIDS

Across all texts the epidemic is framed as a complex phenomenon that is difficult to understand, underscoring the questioning of the nature, cause and response to HIV/AIDS:

*"The mechanisms of HIV infection remain difficult to fathom, and the downhill plunge of the infected, to severe immune deficiency, over 2-14 years is ill understood." (T9)*

*"The difficult and complex questions it [the epidemic] raises..." (T1)*

*"Many uncertainties remain and our knowledge of HIV and AIDS continues to evolve..." (T10)*

*"The peculiar South African nature of the problem demands South African solutions; solutions contained within this complex and detailed Comprehensive Plan for Treatment and Care." (T9)*

*"..the immense complexity of the human immune system operation within the environmental milieu of Africa..." (T9)*

The theme suggests that the complexity of the virus is linked to the context in which it manifests, i.e. Africa, and that this context further compounds its complexity. This mirrors McCombie's suggestion that stigmatising constructions of the epidemic are often voiced in terms of the paradigm of "we just don't know enough about the virus. It's too new" (1990:19). Indirectly the discourse pattern furthers the posing of "difficult questions" that equally demand difficult and complex responses. Complexity serves to gate-keep the authority on HIV/AIDS, the production of knowledge on the disease and the making of decisions as to how to best respond. Simply stated, if we are unsure of what HIV and AIDS are, how can we be sure of the best modes of response? This central question gives credence to the lack of decisive action on the part of government's response to HIV/AIDS, evident in the consistent questioning of HIV causality and treatment across all texts.

Also central to the discursive theme is the "place and role of continued scientific enquiry", and the "establishment of knowledge" about HIV/AIDS. Government is positioned within this construction as follows:

*"Government is duty-bound to pose scientific questions on this (HIV/AIDS) and any other matter that affects public policy." (T1)*

*"The ANC has always maintained that the fight against HIV/AIDS must be taken up across a broad range of fronts and addressed in a comprehensive, guided by the best available scientific information and within the resources available to the country." (S5)*

*"As government focuses its efforts and resources even more intensively on the public policy challenge of HIV/AIDS, it will draw whatever it can from science to use in the fight." (T3)*

However, contradictions are present in texts through which the role of government leadership in the process of scientific enquiry and debate is further qualified:

*"Neither the ANC nor government are protagonists in the intense debates surrounding this matter…" (T2)*

*"…government is not protagonist [sic] in scientific debate but seeks to facilitate and benefit from results of research." (T3)*

### 4.3.2 The causes of and links between HIV and AIDS

The texts provide a number of causal factors for HIV/AIDS. The primary one, that "HIV causes AIDS", is framed as the "premise" or "assumption" on which government policy is based:

*"…the assumption that HIV causes AIDS 2.there is no cure for AIDS 3.socio-economic conditions, particularly poverty, play a critical role in both the transmission and progression of the disease." (T1)*

*"Government is committed to developing a comprehensive response to the HIV/AIDS epidemic, based on the premise that HIV causes AIDS, and that there is currently no known cure for AIDS." (T7)*

The word "assumption" represents a tentative link between HIV and AIDS, drawing attention to the unknown aspect of causality. Another notion of cause is frequently presented in the texts, yet less explicitly stated: that of *poverty as cause*, reinforced by the uncertainty and complexity of HIV/AIDS:

*"There are many unanswered questions with regard both to HIV infection and **progression to AIDS**, as there are on the efficacy of ARVs…" (T7)* (Author's emphasis)

*"…to improve treatment, care and support for our people living with HIV/AIDS, we require a better understanding of the nature of our problem – particularly **the progression from HIV infection to the development of AIDS-defining diseases**." (S7)* (Author's emphasis)

The conception of HIV as one of the many types of immune deficiencies that require government action forms part of this broader discourse of the relational link between poverty and HIV. In this way the discourse of poverty as cause is further promoted:

*"The Task Team Report [on treatment options] confines itself in the main to the issue of syndromic immune deficiency as a consequence of HIV infection. It therefore does not examine in any comprehensive way the causes and programmatic solutions to other manifestations of immune deficiency**, mostly attached to poverty** and related diseases such as kwashiorkor as well as other illnesses some of which may be sexually transmitted." (T7)* (Author's emphasis)

*"The ANC's approach to the epidemic is informed by the assumption that HIV causes AIDS; that, though it can be managed in a variety of ways, there is no cure for AIDS; and that socio-economic conditions,*

***particularly poverty, play a critical role in both the transmission and the progression** of the disease." (S1)* (Author's emphasis)

*"In the South African context the immune system is **assaulted by a range of factors related to poverty** and deprivation." (T9)* (Author's emphasis)

***"Conditions of poverty** – poor nutrition, a lack of clean water of effective sanitation – weaken the ability of the body to fight disease." (T4)* (Author's emphasis)

And political rhetoric expands on the relational links between poverty and cause:

*"Above all, there is hope because, through our comprehensive programme to build **a better life for all** [the ANC election slogan], we are eradicating the conditions of poverty that are critical in the propagation of HIV and progression of AIDS." (T1)* (Author's emphasis)

Although poverty and malnutrition undoubtedly create the breeding ground for HIV/AIDS susceptibility, transmission and impact, particularly in the developing countries, they are not in themselves the root cause of the epidemic (Jackson, 2002). However, development discourses that recognise the role of poverty in disease manifestation are distinct from medical discourses in that they locate HIV/AIDS in historical context and provide a useful contradiction to the oft mono-causal medical account of disease (Seidel, 1993). Strebel (1993:159) asserts that representing HIV/AIDS in broad social terms serves to highlight "power dynamics and exploitation" which shift emphasis beyond that of individual responsibility and blame, "toward possibilities for collective and structural reponses". Thus, the talk of poverty and HIV/AIDS is simultaneously necessary and confusing (Van Niekerk, 2002).

As evident in the literature (Patton, 1990; Becker, 2002; Kgamadi, 2004) the 'poverty as cause' construct also draws on racialised notions of disease to lend support to government's policy choices:

*"The truth is that poverty causes illness and death. The truth is also that ill-health causes poverty. As we work during health month to address issues of health, including AIDS, we must understand these fundamental truths, as a necessary condition for success of the sustained campaign we must wage to ensure the continuous improvement of the health of our people." (S2)*

*"The relationship between malnutrition and AIDS is well recognised. In fact, you will remember that in Africa AIDS was originally known as 'Slim Disease' because of the classic wasting syndrome typically experienced by persons with the disease." (S4)*

Drawing on Foucault (1973) it is clear that the production of truth, be it about HIV/AIDS or other social phenomena, is governed by and through discourse. As such, the texts create a reality of what is to be perceived to be true about the nature of HIV/AIDS, and accordingly how it should be acted upon. If poverty symbolises the "truth" or the "objective facts" about

HIV/AIDS then social action will be consequently determined. In the absence of an explanation as to the relationship between the two dominant causal factors of AIDS, namely viral (HIV) and contextual (poverty), there is a conflation of both in disease attribution. This creates a confusing relational link amongst the HIV, poverty and AIDS. As such, poverty and HIV respectively are positioned in the texts in mutually exclusive causal relationships to AIDS. This confusing and internally contradictory discourse pattern maintains and reinforces the 'What causes HIV and AIDS?' question, which is still dominant in popular discourse.

*"The Comprehensive Plan for Treatment and Care carves out a future for those infected with HIV; and for those suffering from immune deficiency..." (T9)*

*"We treat all the opportunistic infections that contribute to the immune-deficiency syndrome…" (S4)*

The quotations above illustrate how HIV is represented as distinct and separate from "immune deficiency" (presumably caused by poverty). In this case, the introduction of opportunistic infections and their implied link with immune deficiency further confounds understanding of what HIV/AIDS is.

There is inconsistent use of terminology to name the epidemic through the use of multiple linguistic forms referring to the same phenomenon, such as "the Syndrome", "HIV/AIDS", "HIV and AIDS" and "immune deficiency". This uncertainty in naming the epidemic strengthens constructions that question the links between HIV and AIDS and poverty. The frequent reference in the texts to "no cure for AIDS" lends further weight to the mystification of disease, and legitimates the questioning of responses to it, in particular ARVs. In terms of linguistic constructs, the notion of "cure" is only linked to AIDS (not HIV) in all the texts in which it appears. In addition, the 'Partnership Against AIDS' omits the word 'HIV' in its construct. Splitting the form HIV/AIDS to read "HIV and AIDS", which is more prevalent in later texts, compounds the causal distancing between HIV and AIDS respectively, and reflects the ideological separation through discourse between these two aspects of the epidemic. The linguistically cumbersome name of the Comprehensive Plan (Comprehensive **HIV and AIDS** Care, Management and Treatment Plan) further highlights this point (T11), as does the title of the significant Cabinet statement of 19 November called "Statement of Cabinet on a plan for comprehensive treatment and care for **HIV and AIDS** in South Africa" (T9).

The language used to talk about HIV/AIDS gains power through the way it is used in policy text and their role in shaping the conceptualisation of disease. In this way social actors utilise language, which is both constructed and constructive, to create a specific version of the [HIV/AIDS] world (Potter and Wetherell, 1987; Wodak and Meyer, 2002).

In reality, perceptions of disease hold the potential to engender prejudice, social disruption and cultural change (McCombie, 1990). In the search for truth and answers emphasising scientific interrogation within the context of disease complexity, the current discursive theme is present across all the texts. In the absence of clear representations of causality, the theme accentuates disease mystification which at times may obscure the concrete reality of HIV/AIDS and serve to muddle matters of poverty and science. The epidemic, particularly in Africa, is aggravated by the silence surrounding it primarily related to associations with sex, sin and death (Caldwell, 1999). Through the questioning and confusion it articulates, "HIV/AIDS the unknown"' aggravates this silence and perpetuates the ongoing denial and perplexity of the epidemic.

## 4.4. The treatment of treatment: Positioning ARVs

This discursive theme illuminates the contradictory constructions of HIV/AIDS treatment - represented as encompassing many facets with ARVs consistently subordinated within the texts. More specifically, ARVs are predominantly reflected in a negative and questionable light, and are positioned as inferior to other types of treatment. Despite the change in policy with regard to ARVs over the research period, the concurrence of ARV representations and specific qualifiers appear throughout the texts. These qualifiers include "research", "efficacy", "toxicity" and "non-compliance", and serve to construct ARVs in questionable terms, thus confusing more positive representation of this form of treatment. There is no doubt that issues of "efficacy", "informed choice" and "effectiveness" in relation to HIV/AIDS treatment are important, however the narratives disproportionately link these qualifiers with ARVs, pointing to specific ideological positions reflected through discourse. The "Treatment of treatment" discursive theme emerges as the most dominant, in that it appears pervasively across all texts in the analysis. It overlaps with the "HIV/AIDS the unknown" theme for it is reinforced by and serves to reinforce questions on the nature and cause of HIV and AIDS.

### 4.4.1 What is meant by treatment?

Couched in the term "comprehensive programme", the texts formulated prior to the introduction of ARV treatment in the public sector refer to treatment in broad terms that specifically exclude ARVs:

*"There is hope because of the programmes of treatment and home-based care we have initiated in the past are helping the nation manage the epidemic." (T1)*

*"With regard to treatment, Cabinet emphasised the commitment of government to treatment and the management of opportunistic infections." (T2)*

*"We treat everybody that comes to the public facilities, whether one has AIDS or not. We do not discriminate amongst our patients. We treat all the opportunistic infections that contribute to the immune-deficiency syndrome…" (S4)*

*"Alongside poverty alleviation and nutritional interventions, government will encourage investigation into alternative treatments, particularly on supplements and medication for boosting the immune system." (T4)*

*"An impression is being created that unless this government provides antiretrovirals, the government is failing in its duty to treat those who are infected with HIV and AIDS." (S4)*

*"It is also important that when we talk of issues of treatment, we acknowledge the critical role of different kinds of treatment most of which are available free of charge in the public health sector." (S3)*

The consistent emphasis on nutrition and poverty alleviation as aspects of treatment overlap with the discursive theme "HIV/AIDS unknown" in so far as *poverty as cause* strengthens support for the primacy of these forms of treatment over that of ARVs.

The final naming of the plan that heralded the incorporation of ARV treatment in the public sector (the Comprehensive HIV and AIDS Care, Management and Treatment Plan) utilises the word "comprehensive" to stress this notion of an all-encompassing response, whether it is so or not. The use of the term "comprehensive" in this context obscures the significance of the policy shift the Comprehensive Plan represents, and as such de-emphasises the role and significance of ARV treatment implementation as outlined in the plan.

Four months before the April 2002 cabinet statement a policy text stated that:

*"Therefore, in the short term we are not planning to implement pilot projects on the use of antiretroviral drugs in the public sector." (S4)*

Later in the same text we see another reference to the policy response at the time as "comprehensive", despite the absence of ARV treatment:

*"So you can see that we have a very comprehensive treatment programme." (S4)*

Therefore, when the term "treatment" is used in policy texts, it may or may not refer to or include ARVs. This has set up a deceptive discourse whereby government narrative can represent a construction of "treatment", to the exclusion of ARVs. By way of example, in the same month as the April 2002 cabinet statement, the following was reflected in a text:

*"We can make a huge difference by offering good treatment and effective medicines for infections like TB linked to HIV/AIDS irrespective of a patient's HIV status. Government will continue working with pharmaceutical companies to lower the cost of drugs to treat these infections…" (T4)*

The "offering good treatment" refers specifically and exclusively to the treatment of opportunistic infections. Therefore misunderstanding is actively created about the extent of HIV/AIDS treatment that government is providing. It is against this background that the construction of meaning around HIV/AIDS treatment and its implications for representation of ARVs should be understood. The theme legitimates the subordination and promotion of certain forms of treatment over others and also de-emphasises HIV/AIDS in comparison to TB and other life threatening diseases, thus minimising the significance of HIV/AIDS as an illness.

Moreover, treatment is at times consciously delinked from HIV/AIDS:

*"With regard to treatment, Cabinet emphasised the commitment of government to treatment and management of opportunistic infections. No South African should be sent away and not treated irrespective of their HIV status." (T2)*

*"However, no-one should be sent away and not treated, whatever their status. Therefore treatment of opportunistic infections is available at public health care facilities irrespective of HIV status." (T3)*

Instead of destigmatising HIV status this construction negates the link between treatment and HIV status, and also disassociates opportunistic infections from HIV status, thus further obscuring and complicating the construction of HIV/AIDS treatment. The texts produce an inconsistent and ever-changing representation of treatment which is misleading and which reinforces the stigmatisation of HIV/AIDS, as well as those who are HIV positive. This may also serve to both legitimise and rationalise the non-provision of ARVs, which was government policy at the time when the texts quoted above were produced.

"Treatment of treatment" holds contradictory discourses in that within texts there are inconsistencies in how ARV treatment is talked about, at times obscuring ARVs and at times emphasising them. For a period of time ARV treatment was projected in specific terms within government texts, lending credence to the representation of government as supporting the role of ARVs in addressing HIV-related ill-health:

*"Cabinet decided that the Department of Health should, as a matter of urgency, develop a detailed operational plan on an antiretroviral treatment programme." (T8)*

*"It [government] will, as a matter of urgency, start implementing a programme to provide anti-retroviral treatment (ART) in the public health sector."[6] (T10)*

*"…Cabinet instructed the Department of Health to develop a detailed operational plan on an antiretroviral treatment programme." (T11)*

Furthermore, in the "Summary Report of the Joint Health and Treasury Task Team Charged with Examining Treatment Options to Supplement Comprehensive Care for HIV/AIDS in the Public Health Sector", the introduction of the ARV treatment programme is referred to as the "rollout":

*"An analysis was made of critical public policy assumptions on the rollout." (T7)*

That the final operational plan for the introduction of ARV treatment in the public sector resulted in being named the "Comprehensive HIV and AIDS Care, Management and Treatment Plan" reflects a reversion back to broad and non-specific notions of treatment within which ARV treatment is subsumed:

*"This is a broad plan that retains prevention as the mainstay of our response and puts added emphasis of (sic) nutrition and poverty alleviation and includes a number of treatment options – from the use of traditional medicines to the provision of anti-retroviral drugs to those who have reached an advanced stage of AIDS." (S8)*

### 4.4.2 De-emphasising and qualifying the use of ARVs

Texts that include ARVs as one of the many "treatment options" do so with a set of overtly articulated qualifiers:

*"Various forms of treatment can greatly improve the quality of life of those infected with HIV. These include the early and effective treatment of opportunistic infections, the use of anti-retroviral therapy (ART)* ***at appropriate stages of illness****, improved nutrition and the administration of complementary medicines, some of which can have a positive impact on the immune system." (T6)* (Author's emphasis)

*"As such it should be emphasised that ART is one of a very large number of interventions to manage the AIDS pandemic. In can only be introduced at a particular stage of the progression in the condition, and* ***must always be combined with a comprehensive package of other interventions****, including nutrition and treatment of opportunistic infections." (T7)* (Author's emphasis)

*"The meeting reiterated government's principled approach that antiretroviral drugs do help improve the quality of life of those at a certain stage of the development of AIDS,* ***if administered properly****." (T8)* (Author's emphasis)

*"At the same time it should be noted that not everyone who is HIV positive requires anti-retroviral treatment…" (T9)*

[6] Interestingly, in this text the Plan is entitled "Operational Plan for Comprehensive Care and Treatment of people living with HIV and AIDS"

*"…on anti-retroviral treatment, in general, Cabinet noted that they could help improve the conditions of PWAs if administered at certain stages in the progression of the condition, in accordance with international standards" (T2)*

Significantly, none of the other "treatment options" such as treatment for opportunistic infections, nutrition, or complementary medicines are represented with qualifications around the conditions governing their usage.

At the time of Cabinet's approval of the Operational Plan in November 2003 under the subheading "What are the main elements of the treatment plan?" (T10) there is no specific mention of ARVs. Rather, the treatment of opportunistic infections is given prominence:

*"Care will focus on slowing progression to full-blown AIDS and maximising health through prompt diagnosis and treatment of opportunistic infections, periodic medical examinations and CD4 and viral load tests." (T10)*

There are more positive constructions of ARVs in the texts, but these are in the minority:

*"Antiretroviral therapy has been demonstrated to significantly extend life, reduce mortality, and improve health status in people in stage 3 and 4 of HIV disease." (T11)*

*"The introduction of antiretroviral therapy would have a significant impact on AIDS mortality, reducing considerably the number of deaths from AIDS during the next decade…" (T7)*

And even in these texts a qualification is still made that ARVs should succeed other forms of treatments and, as such, the construction of subordinating ARVs is once again present:

*"Current evidence shows that most people infected with HIV will reach a stage by which time the immune system will have deteriorated to such an extent that nutrition, complementary treatments and treatments with antibiotics will not be sufficient to deal with major opportunistic infections. At this stage in the progression of disease the role of antiretroviral drugs becomes important." (T7)*

Consistent links between ARVs and "research" also stress the experimental nature of ARV drug-based interventions, and reinforce the questioning of the efficacy of ARVs, specifically in the prevention of transmission:

*"On preventing transmission following sexual assault or needle-stick injury, the meeting noted that the efficacy of the use of anti-retrovirals in this regard was unproven." (T1)*

*"With regard to the matter of Nevirapine…the current programme is one of research to establish both long term efficacy of the drug, resistance to the drug and other operational requirements…" (T1)*

This discourse pattern undermines arguments for the potential of ARVs for both prevention and treatment and further entrenches government's questioning of HIV/AIDS. Moreover, the PMTCT service points are most often referred to as "research sites" and it is through this construction that representations of the PMTCT programme are predominantly mediated. By example, following the Constitutional Court's confirmatory ruling that

government should implement a universal programme of PMTCT, and in answer to its own question "Are we still on track for universal roll-out?" a text states:

*"The PMTCT research programme continues." (T5)*

Following the Supreme Court's judgement in 2002 instructing the state to provide Nevirapine pending the outcome of the Constitutional Court hearing, the framing of PMTCT within a research discourse is reiterated:

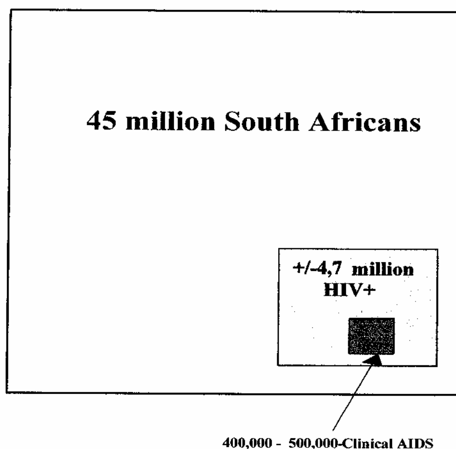
*"Research on the use of Nevirapine against mother-to-child transmission will continue; at the same time as government implements the temporary ruling of the Constitutional Court." (T2)*

*"The Prevention of Mother-to-Child Transmission of HIV (PMTCT) is being run through 18 research sites accessed through over 230 hospitals and clinics." (T3)*

The public pressure with regard to the implementation of the PMTCT programmes was immense, and the emerging discourse actively frames PMTCT in a way that legitimates government's response as antithetical to the alternative views expressed through public discourse and litigation at the time.

**Premise of Government's overall approach**

***Graphical Representation – HIV/AIDS and the Total Population***




Over the years, as the world gathers more experience in the management of the HIV and AIDS pandemic, the appreciation of the importance of social conditions and particularly poverty, both in undermining the immune system in general and in increasing susceptibility to HIV infection as well as progression to AIDS, has grown.

Given this global experience, and taking into account the fact that there is no cure for AIDS, it is critical to emphasise that the approach of the South African government in dealing with the pandemic is premised on the following objectives:

5

The image on the previous page, depicting a small block (of those eligible for ARVs) positioned within two larger blocks (representing those who are HIV positive and the ‘other’ 40 million South Africans respectively) de-emphasises the numerical significance of those who require ARVs (T7). This othering and stigmatising discourse positions HIV status, and more specifically AIDS status, as a minority status within the broader population. The effect of this is to distance individuals with HIV or AIDS from the majority of the population, whilst at the same time minimising and accentuating their different-ness and comparative insignificance. Numerous texts reflect this stigmatising discourse through representing the primacy of prevention – which is prioritised over treatment – as the centrepiece of government’s response:

*“……a primary challenge in our situation is to ensure that the 40 million South Africans who are not infected with HIV stay that way…” (T8)*

*“….prevention of HIV infection is the bedrock of Government’s comprehensive approach….” (T10)*

*“In the absence of a cure for AIDS, prevention is the firm foundation on which our strategic plan is anchored.” (S4)*

The primacy of prevention appears across all texts in which HIV/AIDS treatment is referred to. And shortly after the approval of the Operational Plan, a text that appeared in a national newspaper authored by the Minister of Health again stresses the prioritisation of prevention over treatment:

*“Our major challenge is to ensure that the majority of South Africans who are HIV-negative remain that way, as there is still no cure for HIV/AIDS.” (S7)*

*“In particular it is important to ensure that the discussion on the possible introduction of the ARV component in the public health system does not remove the focus on the other elements of the response* ***which no doubt are more critical****.” (T7) (Author’s emphasis)*

These constructions serve to underplay the role of ARV treatment and position it as distinct and separate from other forms of treatment. This in turn perpetuates the othering and minimising of the importance of treatment and, by extension, those who need it. PLHAs are thereby represented in a stigmatised way that legitimises their minority status as well as the minority status of related policy responses i.e. ARV treatment provision.

The sequencing of treatment options across texts remains such that ARVs are always presented after other treatment options. The approval of the Comprehensive Plan is represented as “a far reaching decision of government”. However it refers to “the introduction of antiretroviral treatment for those who need it, as certified by doctors” as the

last item in a range of the Plan's elements, which include "stepping up the prevention campaign"; "expanding programmes aimed at boosting the immune system", ''traditional health treatments''; "treating opportunistic infections"; and others. (T9)

This negative sequencing is further apparent later in the text:

*"The proposed scope of care for patients encompasses a broad range of treatment options that include proper diagnosis, counselling, treatment of opportunistic infections……, other preventive and supportive strategies such as nutrition and nutritional supplements and traditional and complementary medicines with immune-boosting properties, as well as antiretroviral drugs for the management of AIDS." (T11)*

The Comprehensive Plan itself is premised on a number of pillars, among which ARVs are listed after a myriad of other treatment options, and in parenthesis – which further obscures their role:

*"…. Enhancing efforts in prophylaxis and treatment of opportunistic infections, improved nutrition and lifestyle choices' precede ARVs…Effective management of those HIV-infected individuals who have developed AIDS-defining illnesses, through appropriate treatment of AIDS-related conditions (including the possibility of using antiretroviral therapy in patients presenting with low CD4 counts to improve functional health status ant to prolong life), and suitable palliative and terminal care where treatment has run it course." (T11)*

The de-emphasis of the role of ARVs is also present in texts through the mechanism of omission:

*"We can make a huge difference by offering good treatment and effective medicines for infections like TB linked to HIV/AIDS irrespective of a patient's HIV status. Government will continue working with pharmaceutical companies to lower the cost of drugs to treat these infections." (T4)*

The above quotation appeared in a text that included a representation of government's current and future HIV/AIDS budgets at the time. This budget appeared in the national press in the same month as the April 2002 cabinet statement which was the first to officially recognise ARVs as a treatment option. Glaringly, there is no line item for ARV treatment for PLHAs within the presented budget, nor any direct reference to ARVs as a treatment option.

In answer to the question "Why is ART [Anti-Retroviral Treatment] now being introduced into the public sector?" a number of "positive developments" are cited that omit both implicit and explicit reference to the effectiveness of ARVs as a treatment choice (T10). As such the rationale for the policy shift to include ARVs is not presented as a policy shift at all but as a logical progression of an earlier plan - see theme "It's all part of the plan", which promotes the present theme and its associated representation of ARVs.

There is an ongoing contradiction within government narratives that obscure, undermine and confuse the representation and articulation of ARVs, and their role in the broader discourse on treatment. Government has questioned the use of ARVs in its HIV/AIDS strategy (CHSR, 2002; Mbali, 2002) and therefore this discursive theme is a reflection of the ideological and political position taken on this issue.

### 4.4.3 Questions of efficacy and toxicity

One of the key manners in which ARVs are negatively constructed in the texts is through qualifiers related to their efficacy and toxicity:

*"..the drugs can be toxic and have adverse side effects…" (T11)*

*"…the drugs have disastrous consequences in instances where they are not taken as they should be" (S1)*

*"If not taken properly and carefully monitored, they have a toxic effect. If misused they can also contribute to the development of new strains of HIV that are resistant to available medicines. Drug resistant (sic) will pose a serious public health threat and require much more resources to manage." (S8)*

*"Patients who are symptomatic and/or with a CD4 count less than 200 will be counselled and offered the option on antiretroviral therapy. They will be fully informed about the benefits of restoring immune function and improving the quality of life and about serious side effects that may result from treatment with these drugs" (S10)*

*"..some concerns have been raised with regarding the safety and resistance due to the drug Nevirapine…" (T1)*

Prior to the introduction of the ARV component of treatment, reasons for the non-provision of ARVs in the public sector included:

*"…the complexity of management with disastrous consequences in instances on non-compliance…" (T1)*

*"…because they can cause harm if incorrectly used…" (T2)*

Despite policy shifts, these discursive trends still remain within the texts, whereby the "safe and effective use" and "issues of resistance" (T6) in relation to ARVs are dominant. Just at the time of approval for the Operational Plan it was stated that:

*"These drugs **merely** arrest the progression of the disease. They can have adverse side-effects that can make patients sicker or not respond to treatment." (S7) (Author's emphasis)*

Against the backdrop of these negative constructions, notions of "informed choice" and of ARVs as one "option" are reinforcing representations:

*"In this regard survivors will be counselled, including on the risks of using anti-retrovirals as preventative drugs, so they can make an **informed choice**. If they so chose, they will be provided with such drugs in public institutions." (T2) (Author's emphasis)*

*"As such, a decision to provide ART is ultimately about weighing the risks and benefits in relation to patients already in a desperate state of illness, and even more critically, it should be on the basis of sufficient information which enables the patient to make an informed choice…" (T7)*

*"Survivors will be counselled, including on the risks, so that they can make an informed choice, and will be provided with the drugs of they so choose in accordance with guidelines and protocols." (T3)*

*"Patients who are symptomatic and/or with a CD4 count less than 200 will be counselled and **offered the option** of antiretroviral therapy." (T10)* (Author's emphasis)

These negative constructions infer an ambiguity surrounding ARV usage, which further enforces doubt and the questioning of the efficacy and toxicity of this treatment. "Informed choice" and "optionality" are not raised in relation to other forms of treatment represented across the texts. The subtext suggests a message of ARV availability 'at your own risk' - an undertone of warning.

The theme illustrates a construction of HIV/AIDS treatment that reinforces government's policy response to the provision of ARVs through consistently negative representations within the texts. Repetitive constructs that subordinate the position of ARVs and that confuse and obscure their efficacy and impact, bolster the policy positions government has taken over time with regard to this form of treatment. ARVs are either glaringly omitted or confusingly represented and their role minimised across treatment narratives. Inconsistent and contradictory representations of the efficacy and impact of ARVs cast into question their role in both treatment and prevention interventions. This creates a discursive space for government to continue along the trajectory of questioning the virus, arguably fuelling misconception and negatively impacting on the production and dissemination of knowledge about ARVs.

In closing, while the analysis has revealed numerous discourses, the focus has been to draw out those which illuminate the construction of the epidemic at the political level and shed new light on more nuanced interpretations of disease causality. Against the backdrop of metaphors of struggle, within which enemies and allies are constructed, HIV/AIDS has through discourse become a battleground for understandings, interpretations and ideas. Amidst these representations government is positioned at the helm of the "fight", following a path of consistent and logical progression in HIV/AIDS policy approach. At the same time, the very nature and origin of HIV and AIDS represent a quagmire of questions, deliberations and doubts (both explicit and implied), which maintain the complexity of HIV/AIDS as a construct and beg ongoing questions and answers as integral to the

response. The manner in which notions of treatment are represented, and more specifically ARVs, is a signifier in the construction of how HIV/AIDS should be responded to.

The negative constructions exposed in the discursive themes may well detract from a decisive acknowledgement by government of the crisis of HIV/AIDS. This in turn may facilitate the obfuscation and undue political rhetoric, which stifles the emergence of an unambiguous political and practical reaction to the epidemic.

The impact of the discourses revealed in this analysis will be further explored in Chapter 5, as well as their implications for policy and broader representations of disease causality.

# Chapter 5
# Implications and conclusions

Discourses impact on the extent and nature of public recognition and government attention given to the epidemic. More specifically, each discourse in the present study sheds light on the ideological and social construction of HIV/AIDS as well as notions of disease causality. By tracing the discourses that emerged from selected policy texts this chapter will highlight the implications of these for representations of HIV/AID causality and the broader policy environment in South Africa. The chapter will also draw attention to the limitations of the study and make recommendations for future research in this area.

## 5.1 Implications for representations of causality

*"The struggle against HIV/AIDS"* constructs strong cognitive associations between South Africa's historical oppression, systems of deception and loyalty, and the epidemic. Through metaphorical representations of the "fight" against HIV/AIDS, as not only a response to a virus but also as a battle against 'others' who undermine and contradict this new struggle, the epidemic takes on a political shape through discourse. In this theme, the 'real nature' of HIV/AIDS becomes obscured by the socio-political context – which delineates elaborate ideological contestations within which 'for' and 'against' positions are manifest. This representation of HIV/AIDS, as a socio-political force driven by key actors contesting for power, serves to subordinate practical HIV/AIDS interventions to those of a more political nature. This may well fuel the fires of conspiracy theories as to the origin of the virus and its meaning and purpose in the public domain. Within the theme, constructions of those *for* and *against* the struggle against HIV/AIDS facilitate the shifting of responsibility and cause elsewhere. This may distract from a true ownership of response at the leadership level, through indirectly attributing blame to a series of 'others'.

*"HIV/AIDS the unknown"* illustrates the quest for unfaltering truths about the nature of HIV and AIDS. Consequently, the theme casts doubt on what may be perceived to be *real* in the constitution of knowledge about the epidemic. The theme perpetuates the questioning of HIV/AIDS, as a misunderstood and complex phenomenon in terms of both its biological and social dimensions, thereby driving a disabling wedge between different conceptions of the virus e.g. scientific versus developmental versus activist representations. This

*questioning* representation distances the public from engagement with government's conceptions of the virus and its social concomitants. The power of political actors to determine its representation, through popular discourse, is thereby increased. For too long a narrow medical discourse of HIV/AIDS dominated public responses. As such, an increasingly developmental approach should be seen as a positive progression in disease management in so far as it creates a robust and holistic understanding of HIV/AIDS (Jackson, 2002). The development discourses present in the theme reflect this progression. However, the confusing AIDS causal link with poverty serves to compound uncertainty, rather than increase clarity. Lack of clarity on cause, when dominant in popular discourses, proportionately affects the degree to which chosen strategies can be enacted with decisiveness and determination. This has implications for the extent to which decision-makers are able to take decisive action toward the epidemic.

*"It's all part of the plan"* offers less direct implications for notions of causality than the other themes. A participatory democracy inevitably involves the balancing of relationships between government and civil society, based on both collaboration and confrontation. As such, the theme may serve to counteract a national HIV/AIDS response that has been characterised by opposition from a range of quarters including scientists, the medical fraternity, social movements and politicians themselves. This has manifested through public debate, civil mobilisation and court action. The unswerving framing of government's HIV/AIDS policy as "consistent" reflects a discourse trend in contradiction to popular pressure against government HIV/AIDS policy. The implications of this for causality can be understood as reinforcing the political nature of the epidemic, along similar lines to "The struggle against HIV/AIDS", thus further obfuscating non-political intervention options. The theme also undermines participatory policymaking in favour of government-led and -centred policy perspectives. Social representations protect in-group identities (Joffe, 1999). This is evident in the ideological construction of HIV/AIDS, through the centrality of the "Partnership Against AIDS" discourse within the theme, which bolsters political support and protection for government's current leadership on HIV/AIDS.

*"The treatment of treatment"*: As far back as 2001, the ANC noted the debates around treatment provision for PLHAs as represented in the media and branded them as being "characterised by gross misrepresentations" (ANC Today, 30 November 2001:3). At times ARVs are glaringly omitted or subordinated within treatment narratives in the texts, but

mostly representations include negative qualifiers linked to research, efficacy, toxicity, compliance and the like. Dovetailing with “HIV/AIDS the unknown”, this theme legitimates the questions of HIV/AIDS cause and character. The ideological position of these representations, negate the role of ARVs in both prevention and care. Perhaps the theme also raises the tension between African nationalist discourses and the “politics of class”, represented by the struggle for access to life-saving ARVs which Robins (2002:24) holds up as a contradiction to “an elite-driven politics of race and cultural identity”.

Until such time as popular discourses de-prioritise the questioning of HIV/AIDS causality, it will be difficult to instil confidence in appropriate responses, most notably the uptake of ARVs within broader HIV/AIDS strategy. A more consistent, less doubtful and overly qualified representation of ARVs would project a clearer understanding of disease and ameliorate the questioning that all too often lies behind the management of the virus.

## 5.2 Implications for policy and politics

*"Political power always expresses itself as a body of ideas. If you can create and popularise the key ideas that define the general perceptions about public issues, you will largely determine what happens politically.....Politics is only superficially about personalities: it is the implementation of* ***ideas*** *through* ***power****."* (Author’s emphasis)

Manning Marable (as quoted in ANC Today 25 February 2005)

The *idea*: HIV/AIDS. The *power*: those who determine its ideological and social construction. Linguistics and politics have always been connected, for language is used as a political tool and resource (Grillo, 1989 in Seidel, 1993:175). By its own admission, the ANC argues that there is a battle for the heart of the setting of the national agenda, which is manifest through “heated national debates” on topics such as HIV/AIDS and others (Nyati, 2004 in ANC Today, 25 February 2005). How government, civil society and their respective power blocs dialogue about HIV/AIDS in South Africa forms a critical part of the contested texture of post-apartheid South Africa. From this perspective the policy positions and public response to HIV/AIDS will constitute, reflect and create our experience of the epidemic in South Africa.

Discourse as social practice implies a dialectical relationship between a particular discursive event and the situations, institutions, and social structures which frame it (Fairclough & Wodak, 1997). Hence, exposing the relationship between action, context, power and ideology in relation to the emerging discourses has become central in the present analysis. The discourses raised in this research embody a set of ideas that, through popular expression, shape general perceptions about and reactions to the public issue of HIV/AIDS.

The interrogation of what causes AIDS; which treatment is most effective; and how appropriate government's response has been, are contested discursive spaces. Government and policymakers have the public platform to shape and communicate specific metaphors with regard to HIV/AIDS. The more the public adopts these metaphors, the less likely they are to assume antithetical positions to that of government. Conflicting discourses regarding aspects of the epidemic, from cause to cure, have come to embody the contestations waged in the public sphere between difference sectors of society. Social movements such as the TAC have come to represent these oppositional forces. Because of the antithetical nature of popular discourses on HIV/AIDS, false lines have been drawn between pro- and anti-government approaches. As such, HIV/AIDS embodies a construction of reality which points to definite socio-political, economic and development perspectives. It also reflects the nature of public debate through the thought style and opinions represented by the epidemic. The manner in which public perception is formed, policy alternatives debated, and diversity in opinion reflected within the public sphere is constructed through discourses on HIV/AIDS.

From a rights-based perspective, the question must be asked: Do the discourses that are dominant to government narratives on HIV/AIDS promote public participation in popular discourses around causality? Do they enhance the voices of PLHAs and public belief in the seriousness of the epidemic? Do they enable clear, unequivocal and decisive actions in response to HIV/AIDS? It is argued that while a number of distinct discourses contend for hegemony in the public sphere, the dominant political discourses revealed in this research have impacted significantly on the shaping of the national HIV/AIDS agenda. Each of the themes suggest a set of negative and confusing representations that serve to produce, reproduce and maintain specific ideological positions on HIV/AIDS which, in turn, inform policy responses. At best they reflect a government in defensive construction of a specific HIV/AIDS reality lacking in dialogue with other social actors. At worst, they constitute a

manipulation of public opinion and the attempt to manufacture consent for particular ideological persuasions and resultant policies. At a practical level these discourses may hinder effective understandings of HIV/AIDS and behaviour change. Also, when reflected in popular discourses, the themes may continue to obscure proactive and rights-based policy approaches to the epidemic in South Africa. Dissenting voices in the form of civil society and social movements have sought to challenge these dominant representations and offer up alternative discursive representations of HIV/AIDS. However, these have not been addressed in the present analysis. Instead, government-produced texts construct an identity of the text subject that is congruent with the ideological positions the institution assumes at particular points in time.

According to Wodak (1996:126) "[d]iscourse about others is always connected with one's own identity, that is to say, with the question 'how we do see ourselves? The construction of identity is a process of differentiation, a description of one's own group and simultaneously a separation from 'others'". It is within this context that discursive subjects such as government, the ANC, those who voice opposition to government, PLHAs and others are constituted. As such, alternative representations to those of government are subordinated through the stigmatising and othering discourses which are exposed in the present study. The discursive themes thus serve to define understandings that are congruent with government's policy stance, and through doing so, the identities of others are crafted and frequently undermined.

The present discourse analysis has provided a means to disentangle and reveal the ideological and social constructions behind policy texts. The emerging themes have also highlighted how leadership is understood, the role of public debate in a participatory democracy and the management of dissention and disagreement on matters of policy. As such, social actors draw on discursive resources with their potential ambiguities, contestations and contradictions to craft their world and responses to it. Deconstructing discourse patterns is therefore central to understanding the power and ideological dynamics that shape representations of the epidemic at the policy/political level.

What is critical is to strengthen a public discourse that is divergent in opinion, constructive in its debate, and driven by solution-seeking. As such, perhaps the groundswell of civil activism, characterised by rights-based representations of HIV/AIDS, create an opportunity

for real democratic engagement with the state and its policies. Alternative narratives that are non-stigmatising, non-pathologising and non-othering have the potential to facilitate critical engagement with how the epidemic is socially constructed. In addition, the tempering of representations which are shaped by a reductionist approach to race, gender and sexuality could enable a less loaded understanding of this epidemic. The new paradigm for public policy discourse needs to progress beyond an historical emphasis on the questioning of all aspects of HIV/AIDS. For, as long as representations of HIV/AIDS remain a battlefield of ideological and political persuasions, we will be lacking in our attempt to adequately respond to the practical imperative of effective and equitable prevention, treatment and care strategies.

## 5.3 Limitations of the research

As a methodology and approach CDA is criticised at the level of ideology; rhetoric and strategy (Fairclough, 2000; Wodak and Meyer, 2001). This critique raises the following points: the ideological position of the research with regard to social relations of power; the element of persuasion that may enter the analysis of texts; and how semiosis influences processes of social change in particular directions (Fairclough, 2000). The research has attempted to clearly articulate the ideological, rhetorical and strategic positions assumed so that the critical analysis of the texts may be understood from this vantage point. The fact that CDA by definition is concerned with language and power (Wodak and Meyer, 2001) is not what should be at fault. Rather, it is the importance of reflecting on the position within these configurations of power which the research has attempted to tackle.

The texts offered an abundance of discourses and so the task of narrowing the analysis to those discourses that most closely linked to the central research question was an onerous one. To assist in this process, the criterion of “fruitfulness” was drawn upon, referring to “the scope of an analytic scheme to make sense of new kinds of discourse and to generate novel explanations” (Potter and Wetherell, 1987:171). The broad categorisation used in identifying discursive themes can suppress and obscure the differences and variability within the themes (Potter and Wetherell, 1987). In this regard, attempts have been made to include instances of variance in the analysis itself to counteract this. However, choosing to focus on specific discourses, as opposed to others, represents a subjective and selective process that necessarily silences alternative depictions within the texts. Albeit justified and

substantiated, the results suggest one configuration of meaning. As such, the texts, abundant with multiple and contradictory discourses, are reduced to the few themes also restricted by the scope of the study itself.

There is no endeavour to generalise the result of this research, as this is not the pursuit of discourse analysis. Texts chosen for analysis are in no way representative of HIV/AIDS government policy texts as a whole. There are a vast range of additional discourses both within government narratives and the broader public sphere that provide contrasting and antithetical power positioning of HIV/AIDS. These, unexplored in the present case, highlight alternative sets of meanings, power relations and ideologies. Such discourses may well illustrate the existence of opposing discursive forces, which hold up a contradiction to those represented in the analysed government texts.

## 5.4 Recommendations for future research

While the present study has gone some way in raising pertinent questions relevant to understanding HIV/AIDS policy responses in South Africa, additional research focusing on the intersection between public and policy constructions of the epidemic is recommended. Future research elaborating on the discursive themes illuminated in the present study outside of the confines of policy texts would highlight possible linkages between the present findings and more popular discourses embedded in alternative textual formulations. As such, the interrelationship between policy narratives and wider discourses on HIV/AIDS causality would attract further analytic attention. In addition, as the present study limits its analysis to texts produced in the period 2002 – 2003, an area for future research is the manner in which HIV/AIDS representations in subsequent years have been shaped, within the changing policy environment that both informs and is informed by the construction and reconstruction of popular notions of the epidemic.

## 5.5 Closing remarks

*"[A critical study of AIDS discourse] contributes towards a more caring and informed society, deepening the democratic project and the struggle to achieve greater sexual equality, to uphold human rights and human dignity."*

(Seidel, 1990 in Strebel, 1993)

The study has aimed to draw attention to contemporary understandings of the epidemic, as articulated through a pool of policy texts, and in particular to the rich narratives which reflect notions of causality. Social critique, through discourse analysis, provides the opportunity to explore more enabling discourses in our constructed and constructing HIV/AIDS reality. The discourses presented provide pointers to the power relations and implications of various configurations of the HIV/AIDS actuality. Our engagement with and reactions to the epidemic are impacted upon by our unconscious (Kgamadi, 2004). By making conscious contemporary ideological and social constructions of the epidemic, as well as their functions and consequences, we will understand more fully the impact of these on our perceptions of and reactions to the epidemic. The discourses fore-grounded in this study suggest that HIV/AIDS policy narratives in post-apartheid South Africa represent more than a set of prevention, care and treatment positions. Instead, they reflect the very nature and direction of popular understanding, public debate, policy formulations and socio-political priority in a new democracy.

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# APPENDIX 1 - Listing of primary and secondary texts

## Primary texts

***<u>Year 2002</u>***

**T1**
**Title: Lending a Caring Hand of Hope – Statement of the National Executive of the ANC**
Date: 20 March 2002
Source: ANC
Policy significance: Reasserts the leading components of government strategy on HIV/AIDS; outlines the ANC national executive committee's position on all aspects of response to the epidemic; states that ARVs cannot be provides in the public sector.
Location: www.anc.org.za/ancdocs/pr/2002/pr0320a.html

**T2**
**Title: Cabinet Statement on HIV/AIDS**
Date: 17 April 2002
Source: Government Communications (GCIS)
Policy significance: Announcement of use of PEP for sexual assault and occupational exposure; recognition of role of ARVs as a treatment option.
Location: www.info.gov.za/speeches/2002/0204191246p1001.htm

**T3**
**Title: Summary of Government's position on HIV/AIDS following Cabinet's discussion on 17 April 2002**
Date: 19 April 2002
Source: ANC Today, Volume 2, No 16
Policy significance: Detailed overview of government policy including changes regarding use of ARVs for PEP.
Location: www.anc.org.za/ancdocs/anctoday/2002/at16.htm#art3

**T4**
**Title: The Presidential Task Team on AIDS: There is hope in caring**
Date: 28 April 2002
Source: GCIS
Policy significance: Key policymakers in government articulate policy positions of government in direct speech; published in a national newspaper soon after cabinet statement introducing the use of ARVs for PEP.
Location: www.info.gov.za/issues/hiv/taskteam.pdf

**T5**
**Title: Update on Cabinet's Statement of 17 April 2002**
Date: 9 October 2002
Source: GCIS
Policy significance: Reemphasis of policy position on prevention and treatment and an update on progress in line with the 17 April 2002 cabinet statement.
Location: www.info.gov.za/issues/hiv/updateoct02.htm

***Year 2003***

**T6**
**Title: Update on the National HIV and AIDS Programme**
Date: 19 March 2003
Source: GCIS
Policy significance: Reiterates position of government strategy with regard to care, treatment and support.
Location: www.gcis.gov.za/media/cabinet/hiv.htm

**T7**
**Title: Summary Report of the Joint Health and Treasury Task Team charged with Examining Treatment Options to supplement Comprehensive Care for HIV/AIDS in the Public Health Sector**
Date: 1 August 2003
Source: Department of Health
Policy significance: Lays the foundation for the introduction of ARV treatment in the public sector.
Location: www.journ-aids.org/pdf/costing%20report.pdf

**T8**
**Title: Statement of special Cabinet meeting: Enhanced Programme against HIV and AIDS**
Date: 8 August 2003
Source: GCIS
Policy significance: Outlines cabinet's position on the introduction of ARV treatment into the national response; cabinet decides that the Department of Health should develop a detailed operational plan on an antiretroviral treatment programme.
Location: www.info.gov.za/speeches/2003/03081109461001.htm

**T9**
**Title: Statement of Cabinet on a Plan for comprehensive treatment and care for HIV and AIDS in South Africa**
Date: 19 November 2003
Source: GCIS
Policy significance: Cabinet approves the Operational Plan for the Comprehensive Treatment and Care for HIV and AIDS; instruction to the Department of Health to proceed with the implementation of the Plan.
Location: www.info.gov.za/speeches/2003/03111916531001.htm

**T10**
**Title: Cabinet's Decision on the Operational Plan for Comprehensive Care and Treatment of People Living with HIV and AIDS**
Date: 19 November 2003
Source: GCIS
Policy significance: Detailed outline of government's approach to epidemic; provides an overview of how ARV access is to be operationalised, including targets and budgets.
Location: www.info.gov.za/issues/hiv/cabinetaidsqa19nov03.htm

**T11**
**Title: Operational Plan for the Comprehensive HIV and AIDS Care, Management and Treatment for South Africa (Executive summary only)**
Date: 19 November 2003
Source: Department of Health
Policy significance: Presents the key policy principles which underpin the government's approach to the epidemic.
Location: www.info.gov.za/otherdocs/2003/aidsoperationalplan.pdf

## Secondary texts

***Year 2002***

**S1**
**Title: Lending a caring hand of hope**
Date: 22-28 March 2002
Source: ANC Today, Volume 2, No 12
Location: www.anc.org.za/ancdocs/anctoday/2002/at12.htm#art1

**S2**
**Title: Health, human dignity and partners for poverty reduction**
(Statement issued as a comment on Health Month, the same month in which the Cabinet statement (T2) is released)
Date: 5 April 2002
Source: ANC Today, Volume 2, No 14
Location: www.anc.org.za/ancdocs/anctoday/2002/at14.htm#preslet

**S3**
**Title: Tshabalala-Msimang - Rooting out stigma-combating discrimination**
(Presentation at a summit for people living with HIV/AIDS)
Date: 28 October 2002
Source: Department of Health
Location: www.info.gov.za/speeches/2002/02110609461008.htm

**S4**
**Title: World AIDS Day address**
Date: 1 December 2002
Source: Tshabalaba-Msimang , Department of Health
Location: www.doh.gov.za/docs/sp/2002/sp1201.html

***Year 2003***

**S5**
**Title: Consistency at the core of enhanced treatment plan**
Date: 15 August 2003
Source: ANC Today, Volume 3, No 32.
Location: www.anc.org.za/ancdocs/anctoday/2003/at32.htm#art1

**S6**

**Title: 5th Anniversary of the Partnership against AIDS**

(Speech by Minister of Health. 5th Anniversary of the Partnership Against AIDS)
Date: 4 October 2003
Source: Tshabalala-Msimang, Meropa Communications
Location: www.info.gov.za/speeches/2003/03100713461003.htm

**S7**

**Title: Antiretroviral campaign will need everyone's support**

(Minister of Health article in Sunday Times, following the approval of the operational plan)
Date: 23 November 2003
Source: Tshabalala-Msimang ,Sunday Times
Location: www.journ-aids.org/reports/23112003c.htm

**S8**

**Title: World AIDS Day**

(Speech by Minister of Health, World AIDS Day)
Date: 1 December 2003
Source: Tshabalala-Msimang , Ministry of Health
Location: www.info.gov.za/speeches/2003/03120116461001.htm

# APPENDIX 2 – Selection of primary and secondary texts used in the analysis

The following texts are presented, in full, below:

- Primary text = T2, T3, T8
- Secondary texts = S3, S7

As far as possible the original format and layout of each text has been retained. The font has been reduced to accommodate the volume of the texts.

## Primary texts

### T2

**STATEMENT BY CABINET ON HIV/AIDS**

Cabinet today received a comprehensive briefing on the implementation of government policy on HIV/AIDS. The meeting reiterated government's commitment to the *HIV/AIDS and STI Strategic Plan for South Africa, 2000 – 2005 PDF* (outside link).

This comprehensive programme is backed up by a massive increase in resources. The total budget to be spent mainly through the Departments of Health, Social Development and Education was R350m in 2001/02; it has been increased to R1-billion in this financial year, and will go up to R1.8-billion in 04/05.

Cabinet welcomed the progress that is being made in ensuring that the South African public in general and the youth in particular are aware of the dangers of the epidemic. It called on all South Africans to take full responsibility and care for their lives. Government will intensify the awareness campaign, as part of its comprehensive strategy against HIV/AIDS. The challenge is to ensure that awareness continues to translate into a change in behaviour.

In conducting this campaign, government's starting point is based on the premise that HIV causes AIDS. It is also critical for us, as a nation, to note that there is no cure for AIDS. In this regard, promoting awareness and life skills and HIV/AIDS education forms the core of our approach.

A critical element of this strategy is the strengthening of partnerships among all South Africans and their organisations to fight this epidemic. Government commits itself to this objective, and will participate actively in the review of SANAC currently underway, in order to strengthen the organisation. "Core SANAC Ministers", now including the Minister in the Presidency and the Minister of Arts, Culture, Science and Technology, will be constituted into a Presidential Task Team on AIDS, headed by the Deputy President. Further, measures will be introduced to strengthen government structures dealing with this matter.

On other issues of prevention, the meeting decided as follows:

Research on the use of Nevirapine against mother-to-child transmission will continue; at the same time as government implements the temporary ruling of the Constitutional Court. In the meantime, the Department of Health is working on a Universal Roll-out Plan to be completed as soon as possible, in preparation for the post-December 2002 period.

Cabinet decided that, with regard to cases of sexual assault, government will endeavour to provide a comprehensive package of care for victims, including counselling, testing for HIV, pregnancy and STI's.

In this regard, survivors will be counselled, including on the risks of using anti-retrovirals as preventative drugs, so they could make an informed choice. If they so choose (as is the case with needle-stick injuries), they will be provided with such drugs in public health institutions. A standardised national protocol in this regard will be finalised as soon as possible.

With regard to treatment, Cabinet emphasised the commitment of government to treatment and management of opportunistic infections. No South African should be sent away and not treated irrespective of their HIV status. Given the critical importance of drugs dealing with infections such as meningitis, oral thrush, TB and pneumonia, Cabinet urged the public, especially People Living with AIDS, to assist government in monitoring their availability.

On anti-retroviral treatments in general, Cabinet noted that they could help improve the conditions of PWA's if administered at certain stages in the progression of the condition, in accordance with international standards. However, because these drugs are too costly for

universal access and, because they can cause harm if incorrectly used and if the health systems are inadequate, government will continue to work for the lowering of the cost of these drugs, and intensify the campaign to ensure that patients observe treatment advice given to them by doctors.

Further, alongside poverty alleviation and nutritional interventions, government will encourage investigation into alternative treatments, particularly on supplements and medication for boosting the immune system.

Cabinet reiterated government's strong commitment to assist families affected by the HIV/AIDS epidemic. We are also improving the programme of home-based care and community-based care, for which allocations of R94.5-million have been made this year, and R138-million in 2004/05.

Government calls on all South Africans to join hands in a campaign of hope: to mobilise our strength as a nation and as individuals to ensure that, we are able to manage, reduce and, in the long-run, defeat this epidemic. We have it in our power to achieve this objective. What is critical is that we should work together as a united force to achieve the best interests of our society.

**17 April 2002**

***Issued by: Government Communications (GCIS)***

# T3

**SUMMARY OF GOVERNMENT'S POSITION ON HIV/AIDS**

**17 April 2002**

**Intensifying our comprehensive programme against HIV/AIDS in partnership with all sectors**

Government is intensifying the campaign to prevent infection by the HIV and to deal with its consequences. In that regard our starting point is the premise that HIV causes AIDS.

HIV/AIDS is a challenge for all of us. Defeating it depends on strengthening the Partnership Against AIDS launched in October 1998, in which all sectors society work with government to implement a comprehensive programme. Together we can overcome the disease.

The policy framework which government is following is set out in the "HIV/AIDS and STI (Sexually Transmitted Infections) Strategic Plan for South Africa 2000-2005". It is in line with international trends, and it is in fact among the best in the world.

As we continue to work within that broad framework, we are intensifying and expanding the programme; addressing problems of implementation; and improving our approach in line with changing circumstances. (Total funding in 2002/2003 is over one billion rand, three times more than the year before.)

**Why does the programme put so much emphasis on prevention?**

Because there is no cure for AIDS, preventing infection by the HIV is critical. Each of us must exercise our individual and collective responsibility to take care of our own lives.

Promoting public awareness and the life skills and HIV/AIDS education programme are the core of the efforts to prevent transmission of HIV. The latter is now a compulsory part of the school curriculum and full implementation is expected by the end of 2003. Though we have achieved a high level of awareness - over 90% - which is beginning to have an impact especially amongst the young, we are intensifying the work so that more people translate awareness into change of lifestyles. A new phase of the campaign by the agencies contracted by government, working with partners such as Lovelife, will start in June 2002.

The effective management of Sexually Transmitted Infections (STIs), which render people more vulnerable to the HIV, plays a critical role in reducing the risk of HIV transmission. This programme, which has so far ensured that there are trained healthcare workers in 80% of our public sector clinics, is being extended. Amongst other things there has been a steady decline in the prevalence of syphilis amongst pregnant women attending public health sector clinics, and antenatal surveys show that that the rate of HIV infection is levelling off.

In the South African AIDS Vaccine Initiative scientists are working with government support and funding to develop a vaccine that will make people immune to HIV infection. It is important however to remember that success will not be quick and is not guaranteed - so prevention through awareness remains the key message.

**What progress are we making on preventing mother-to-child transmission?**

The Prevention of Mother-to-Child Transmission of HIV (PMTCT) is being run through 18 research sites accessed through over 230 hospitals and clinics. Over 38,000 mothers have gone through the programme. At the sites women are offered voluntary counselling and testing for HIV. Those who are HIV-positive are offered Nevirapine for themselves and their babies, vitamins to improve their health during pregnancy and after; preventive measures and prompt treatment of infections and formula-feed if they choose not to breast-feed. Babies are also given multivitamins and prophylaxis for opportunistic infections.

Where there is capacity to provide the package of care that is needed, and where the demands of research dictate, sites are being extended. Towards the end of the year, tests will be done on the babies and mothers being monitored, for us to then consider moving to universal access of Nevirapine. A Universal Roll-out Plan in this regard is being worked on and will be released in due course.

In the meantime, government is implementing the temporary Constitutional Court order; and we have provided guidelines to hospitals on the package of care they need, to be able to administer Nevirapine against mother-to-child transmission beyond the research sites. A special Task Team set up by the Health Minister in consultation with MECs will assist hospitals in this.
Regarding use of antiretroviral drugs following cases of sexual assault, government will endeavour to provide a comprehensive package of care for survivors, including counselling, testing for HIV, pregnancy, STIs. Survivors will be counselled, including on the risks, so that can make an informed choice, and will be provided with the drugs if they so choose in accordance with guidelines and protocols (as is done in the case of needlestick injuries)

**What does government's programme offer in the way treatment?**

The quality of life of those infected by HIV is a major concern of government. Their health can be improved greatly through the effective treatment and management of opportunistic infections.

It is important for those with recurrent opportunistic infections to know their HIV status. The programme to provide voluntary HIV counselling and testing (VCT) was started in 2000 - at the moment 359 VCT sites are operational out of 495 identified by provinces.

However, no one should be sent away and not treated, whatever their HIV status. Therefore treatment of opportunistic infections is available at public health care facilities irrespective of HIV status. Government will continue working with pharmaceutical companies to lower the cost of drugs to treat these infections.

As part of this programme Government signed an agreement with the pharmaceutical company Pfizer in December 2000 for the provision of Fluconazole (Diflucan) to the public health sector for two years. The agreement includes funding for the training of healthcare workers in the diagnosis and management of oral thrush and cryptococcal meningitis. So far 20,000 patients have benefited from the programme.

We call on the public, especially People Living with AIDS, to help us in monitoring the availability of such drugs; so that we can work together to improve treatment for the infected, and public health care in general.

Government recognises that anti-retroviral drugs can improve the quality of life of People Living with AIDS, if administered at certain stages in the progression of the condition and in accordance with international guidelines and protocols. Because these drugs are costly and can cause harm if incorrectly used or if health systems are inadequate, we will:

- continue working to lower the cost of anti-retrovirals, including through discussions with the producers of the main drugs, and investigation into possible production of generic drugs;

- work through the Global Fund to fight HIV/AIDS, TB and Malaria to access resources for the overall campaign against the spread of HIV, TB and Malaria;

- intensify the campaign to ensure that patients generally, and those infected with TB, thrush, meningitis and HIV in particular, observe the treatment advice given to them by doctors.

Though antiretrovirals are not generally available through the public health sector, guidelines for their use in the private sector have already been developed and research on their targeted use will continue.

A further initiative arises out of the fact that conditions of poverty lower the body's natural immune system making it more susceptible to infection, and more vulnerable to its effects. Alongside poverty alleviation and nutritional interventions government will encourage investigation into alternative treatments, particularly on supplements and medication for boosting the immune system.

**What about care and support?**

Government is deeply concerned about the conditions of families affected by the HIV/AIDS epidemic. We are intensifying the campaign to assist these families, including foster care grants, assistance to child-headed households, food parcels and so on.

We are also improving the programme of home-based care. In this regard the budget allocation for home-based care and community-based care increases from R25,5 million in 2001/02 to R94,5 million this fiscal year, to R138 million in 2004/5.

**What can be done about discrimination against people with HIV/AIDS?**

This is a very important matter. Negative attitudes in our society can result in people being denied the treatment, care and support they need. They discourage people from being tested to find out their status or from declaring the cause illness or death in their family. Amongst other things this leaves us without vital information our country needs to know the extent of the disease and its patterns.

Government will intensify its campaign and awareness programme against discrimination and continue investigating further legal avenues to the affected and infected.

**What does partnership mean in practice?**

Because of the scale of the disease, because it affects every aspect of our society, and because of the need for awareness, care and support, defeating it depends on a partnership of all sectors of society with government to implement a comprehensive campaign.

In the beginning the response to HIV/AIDS came just from the Health sector. The launch of the Partnership Against Aids in 1998 by then Deputy President Mbeki brought other government departments and key sectors of society together in a broad-based and multi-sectoral fight against the disease.

In January 2000 the partnership was formalised in SANAC, the South African National Aids Council under the leadership of Deputy President Jacob Zuma. SANAC has been reviewing its two-years of work and is preparing to strengthen itself to play the key co-ordinating role in our national effort against HIV/AIDS.

Government will strengthen its own contribution to the partnership, establishing a Presidential Task Team on AIDS consisting of Ministers led by the Deputy President.

As government focuses its efforts and resources ever more intensively on the public policy challenges of HV/AIDS, it will draw whatever it can from science to use in this fight. As in all areas of science research and debate will continue, but government is not a protagonist in those debates.

## T8

**STATEMENT ON SPECIAL CABINET MEETING: ENHANCED PROGRAMME AGAINST HIV AND AIDS**

Cabinet today convened in a special meeting to consider the Report of the Joint Health and Treasury Task Team on treatment options to enhance comprehensive care for HIV/AIDS in the public sector. A summary of the Report can be found on the government website: www.gov.za. The full Report will be posted on the website early next week.

The Report deals with various challenges, including in particular, a programme to administer anti-retrovirals to enhance the quality of life of those who have reached an advanced stage of the Syndrome, and it proposes various scenarios in dealing with this matter. The Report proceeds from the premise that new developments pertaining to prices of drugs, the growing body of knowledge on this issue, wide appreciation of the role of nutrition, and availability of budgetary resources do enable government to consider this enhanced response.

The meeting reiterated government's principled approach that antiretroviral drugs do help improve the quality of life of those at a certain stage of the development of AIDS, if administered properly.

Further, Cabinet noted that, as we consider details pertaining to this enhanced treatment programme, it is critical that we do not lower our guard as a nation, because there is no cure for AIDS.

It also noted the assertions in the Report that a primary challenge in our situation is to ensure that the 40 million South Africans who are not infected with HIV stay that way; and that those who are infected but have not as yet progressed to an advanced stage of AIDS lead a normal life through proper nutrition, healthy lifestyles and treatment of opportunistic infections. In other words, not everyone who is infected with HIV would need antiretroviral treatment.

Cabinet decided that the Department of Health should, as matter of urgency, develop a detailed operational plan on an antiretroviral treatment programme. The Department will be assisted in this work by South African experts as well as specialists from the Clinton Foundation AIDS Initiative who have not only offered to contribute to this effort; but have also been of great assistance in commenting on the work done thus far.

It is expected that this detailed work would be completed by the end of September 2003.

Government shares the impatience of many South Africans on the need to strengthen the nation's armoury in the fight against AIDS. Cabinet will therefore ensure that the remaining challenges are addressed with urgency; and that the final product guarantees a programme that is effective and sustainable.

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## T9

**STATEMENT OF CABINET ON A PLAN FOR COMPREHENSIVE TREATMENT AND CARE FOR HIV AND AIDS IN SOUTH AFRICA**

[Presented by Minister of Health, Dr Manto Tshabalala-Msimang]

Cabinet today in principle approved the Operational Plan for Comprehensive Treatment and Care for HIV and AIDS, which it had, on 8 August this year, requested the Department of Health to prepare. Amongst other things, the Plan provides for Anti-retroviral Treatment in the public health sector, as part of the government's comprehensive strategy to combat HIV and AIDS.

The meeting instructed the Department of Health to proceed with implementation of the Plan.

It is envisaged in the Plan that, within a year, there will be at least one service point in every health district across the country and, within five years, one service point in every local municipality. Some areas will be able to start sooner than others, and the Department of Health will keep the public informed of the progress of the rollout.

These service points will give citizens access to a continuum of care and treatment, integrated with the prevention and awareness campaign which remains the cornerstone of the strategy to defeat HIV and AIDS.

Concretely this far-reaching decision of government will mean:
* Stepping up the prevention campaign so that the 40 million South Africans not infected stay that way
* A sustained education and community mobilisation programme to strengthen partnership in the fight against the epidemic
* Expanding programmes aimed at boosting the immune system and slowing down the effects of HIV infection, including the option of traditional health treatments for those who use these services

* Improved efforts in treating opportunistic infections for those who are infected but have not reached the stage at which they require antiretrovirals
* Intensified support for families affected by HIV and AIDS
* Introduction of antiretroviral treatment for those who need it, as certified by doctors.

BUILDING CAPACITY

To deliver this kind of care across the country, with equitable access to all, will require a major effort to upgrade our national healthcare system. This includes the recruitment of thousands of health professionals and a very large training programme to ensure that nurses, doctors, laboratory technicians, counsellors and other health workers have the knowledge and the skills to ensure safe, ethical and effective use of medicines.

Built into the implementation of this programme will be a massive public education campaign so that patients will know what is expected of them. This will include the provision of all the necessary information about benefits as well as dangers of usage of ARVs, to allow patients to make an informed choice.

Over half of the total budget that will be spent over the next five years in implementing this programme will go to upgrading health infrastructure, emphasising prevention and promoting healthy lifestyles. As such, the implementation of this plan will benefit the health system as a whole.

Cabinet agreed that the funds allocated for this programme should be "new money". The programme will and must therefore not detract from other programmes of health care and provision of social services.

FAVOURABLE CONDITIONS

South Africa has reached this point at which qualitative enhancement of our response to HIV and AIDS, within the framework of our five-year strategic plan, is possible due to a number of factors. These include
* A fall in the prices of drugs over the past two years without which this programme would have been impossible, including new opportunities to manufacture some of these drugs in South Africa, as well as successful negotiations with pharmaceutical companies
* New medicines and international and local experience in managing the utilisation of ARV's and other interventions
* Growing appreciation of the role of nutrition in enhancing people's health and efficacy of medicines
* The building of a critical mass in our country of health workers and scientists with skills and understanding of the management of HIV and AIDS
* The availability of fiscal resources to expand social expenditure in general, as a consequence of the prudent macro-economic policies pursued by government.

CENTRALITY OF PREVENTION

Government wishes to reiterate that there is no known cure for AIDS. We cannot therefore afford, as a nation, to lower our guard. Prevention therefore remains the cornerstone of our campaign.

The eradication from the body of the HIV virus remains beyond reach. The mechanisms of HIV infections remain difficult to fathom, and the downhill plunge of the infected, to severe immune deficiency over the next 2-14 years is ill understood. The co-factors that are thought to mitigate immune destruction of healthy CD4+ cells by the minority of infected CD4+ are still uncharacterised. In the South African context the immune systems is assaulted by a host of factors related to poverty and deprivation.

The Operational Plan places a high premium on strengthening prevention efforts and it underlines the critically important messages of prevention and of changing lifestyles and behaviour. These elements of our Comprehensive Strategy remain the starting point in managing the epidemic.

At the same time, it should be noted that not everyone who is HIV positive requires Anti-retroviral Treatment. As such, the plan also provides for enhanced care for those who are infected but have not as yet progressed to an advanced stage of AIDS.

At the same time, the challenges of home-based care, the campaign to combat discrimination against those who are infected and affected remain critical. So is the task of intensifying efforts to deal broadly with poverty and poor nutrition.

STRENGTHENING PARTNERSHIPS

Progress in implementing the Plan adopted by government today will depend, to a significant degree, on intensified mobilisation across society. Besides the legion of non-governmental and community-based organisations who are involved in constructive work in this regard, the media is an important partner, as it has the potential to communicate messages of awareness and hope, and to keep the nation accurately informed about the campaign against HIV and AIDS.

A cooperative relationship among all sectors of society, particularly in the implementation of this element of the comprehensive strategy, the spirit of letsema and vuk'uzenzele, a message of hope and responsibility as well as constructive engagement in the realm of practical work will ensure that South Africa advances even more decisively in this endeavour.

The Comprehensive Plan for Treatment and Care carves out a future for those infected with HIV, and for those suffering from immune deficiency; whilst assisting the vast majority of South Africans who are HIV negative to remain that way. The peculiarly South African nature of the problem demands South African solutions; solutions contained within this complex and detailed Comprehensive Plan for Treatment and Care.

Such an ambitious goal - targeting the immense complexity of the human immune system operating within the environmental milieu of Africa - predicates a multifaceted, integrated and intersectoral response in prevention, treatment and care. The Plan is the final piece completing the jigsaw puzzle of the National Strategic Plan for HIV and AIDS 2000 - 2005 whose four key areas of intervention were: prevention, treatment, care and support; research, monitoring and surveillance; as well as legal and human rights.

CONCLUSION

Cabinet wishes to express its appreciation of the work done by members of the Task Team - including in particular experts and specialists from inside and outside the country - whose contribution has helped shape this Plan. We are confident that, as with our national prevention efforts, this Plan will rank among the most comprehensive in the world.

Government is once more strengthening the hand of the nation in the fight against HIV and AIDS, in keeping with its mandate to build a better life for all. If correctly implemented this Operation Plan provides an excellent opportunity to complete the treatment sector of the National Strategic Plan for HIV and AIDS whilst also strengthening prevention. The challenge is immense but not impossible.

We are confident that, together, bound by a people's contract for a better life, we shall all continue to make progress in building South Africa into a land our dreams.

There is hope!

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# Secondary texts

## S3

**SPEECH BY THE MINISTER OF HEALTH, DR MANTO TSHABALALA-MSIMANG, AT THE SUMMIT OF PEOPLE LIVING WITH AIDS, Eskom Conference Centre, Midrand, 28 October 2002**

THEME: ROOTING OUT STIGMA-COMBATING DISCRIMINATION

Comrades, friends, sons and daughters of the African soil, I greet you all. I am very happy to be here and for the opportunity to share this special moment with you today.

This SANAC (SA National AIDS Council) summit for the sector of people living with HIV and AIDS has been long overdue. But I hope that it will give all of us the opportunity to share our experiences and put our heads together in seeking a common understanding and vision on how to tackle the spread of HIV and mitigate the impact of AIDS at different levels.

People living with AIDS have been for a long time been one of the marginalized sector due to stigma and discrimination attached to a positive HIV status. This practice has led to a lot of communities not being able to respond appropriately in the provision of care and support due to ignorance, lack of support and in many instances due to discrimination.

We have to applaud courageous men and women who came out public to declare their status with an effort to educate communities and rally for support. Their acts and deeds have enlightened a lot of us. However, there is still a significant number that still need to be educated so as to encourage mind shift and start providing necessary support.

People living with AIDS are the most powerful advocates and living examples of the hope that society will conquer against the spread of the virus. You bring sensitivity to our approaches, as their inputs are invaluable in designing interventions that will have maximum impact. You bring together nations and communities to play their rightful role in the fight against HIV and AIDS.

I am relieved that at least today I do not have to start by having to convince my audience that we indeed have a major challenge on our hands and that we all must take the responsibility to address it. We are committed to ensuring that South Africa triumphs against the spread of HIV infection, the ill health brought by AIDS and the emotional destruction, which accompanies these.

The theme of this Summit - "Rooting out Stigma: Combating Discrimination" - is probably most appropriate. I believe that it is addressing one of the most difficult components of our response to HIV in this country. It is difficult because you cannot measure its impact, you cannot put indicators for it to assess progress. It is an intangible process which is extremely destructive.

Stigma is an individual perception. It often arises when one person makes a judgment on another and on the basis of this judgment withdraws and isolates himself from the so-called "victim".

We all know that in our societies there are many groups, which suffer stigma, such as those who have TB, those who have different sexual preferences, those with different religions, etc. When it comes to HIV infection there is an inherent belief that those who are infected did something wrong. Now we all know that this is a fallacy and that all of us are living with HIV - whoever we are, wherever we come from.

The fact that we are human and that we have relationships makes us all part of a world with HIV. The challenge is to get everyone to accept that no one is immune from HIV and AIDS. We are all affected and we need to live positively with this reality. I would like you comrades to bring your collective wisdom to this challenge. How do we get all South Africans to identify with HIV as our struggle in the same way we embraced the fight for liberation? At that time all of us united against a common enemy and fought. We did everything in our power to resist being taken over. Why can't we do the same with HIV infection?

In the current discourse, the fight is characterized as the responsibility of Government and in a way a fight for those who are living with HIV exclusively. The most popular question is: "what is government doing about it?" People living with HIV have come together to fight but those who perceive themselves as being unaffected watch silently from the sidelines. This cannot be, comrades. We have to challenge this approach and get everybody to find a way to make this his or her challenge as well.

An unfortunate impression has been created that government in particular is not committed to tackling this epidemic. I do not want to go back to highlight some of the commendable progress we have made in this country largely through the commitment of resources by government, a recognition and support for sectors such as the People living with AIDS sector and the strengthening of partnerships with all other committed stakeholders.

However, I want to say something, which does sometimes make me sad. Many of you here know the history of our struggle. Given that knowledge, is it possible that our new government can suddenly ignore the needs of the people or fail to pay attention to what people say they want from government?

Our collective challenge, comrades, is to come up with strategies, which will be equitable, affordable, accessible and sustainable. No one must assume that it is always easy to respond to such challenges. Sometimes as policy-makers we are faced with hard ethical questions and choices.

In a country where more than half of the population is historically disadvantaged, how do you make decisions on who should benefit and who should not? Given the threat posed by HIV and AIDS, how do we articulate decisions, which seem to benefit some and not others? As I said comrades, let us find a common way to respond in such a way that we move together as friends and fellow South Africans. I am keen to hear what recommendations will come out of this Summit on some of these pertinent questions.

You elected this government and you should rest assured that it is doing everything in power to address this major challenge. What is needed is for all sectors to join hands in partnership with government and other sectors to ensure that our interventions are a success.

A typical example is with regard to the Universal Roll-out Plan for prevention of mother-to-child-transmission of HIV. On top of training, budget and proper health facilities, the most critical challenge is community attitudes. As government we continue to put resources to upgrade health facilities for testing, counselling and monitoring for the roll out this programme. Addressing discrimination against HIV-positive mothers can only be addressed if we get the support of different sectors in charging attitudes within our communities.

The quality of life of those infected with HIV is a major concern to government. Health of people living with AIDS can be improved greatly through the effective treatment, management and prevention of opportunistic infections.

It is important, for treatment purpose, as well as prevention, to increase access to voluntary counselling and testing. The scaling up of voluntary counselling and testing programmes poses a challenge to people living with AIDS to become counsellors. We know that you would do this with passion and understanding towards those being counselled. Your involvement will provide guidance to those who test negative and give courage to those who test positive. Your involvement will serve as a major step towards positive living.

It is also important that as we talk about issues of treatment, we acknowledge the critical role of different kinds of treatment most of which are available free of charge in the public health sector. Treatment for opportunistic infections, such as meningitis, oral thrush, TB and pneumonia, is very important in managing AIDS. We estimate that government is spending approximately R4 billion in management of these AIDS related illnesses.

Good nutrition is a critical component of boosting the immune system and fighting diseases. Therefore, Government's poverty alleviation programme and nutritional interventions should be viewed as an essential part of the fight against HIV and AIDS. I am sure many of you are aware of the many coping strategies and simple interventions which people currently implement. A good example is the use of home remedies such as garlic and olive oil. I think it is important to make these efforts part of our response them to be part of our many programmes.

We are also encouraging investigation into alternative or complementary treatments and medication for boosting the immune system. However a protocol for research into such treatments is critical and we have therefore drafted such a protocol for submission to the Medicines Control Council.

The success of a treatment programme depends largely on the availability of drugs. We therefore need to ensure that we have an uninterrupted supply of all medicines to all health facilities. You can help in this regard by preventing theft of medicines and hospital supplies. All of us, especially people living with AIDS, should help monitor the availability of drugs, and report any problems as we come across them.

Cabinet has been discussing very extensively the issue of provision of anti-retroviral drugs in the public health sector. The major challenge comrades, is that these drugs are at present too costly for universal access. Some estimates have suggested that for one million people to get this treatment, this would require about R7-billion. However, the Department of Health and Treasury is doing further work on these and other cost implications.

The other critical element is the effects of incorrect use and the harm that can be caused by inadequate health systems. This underlines the need for the drugs to be used under appropriate supervision and monitoring.

We are actively engaged in addressing these challenges, in order to create the necessary conditions that would make it feasible and effective to use anti-retrovirals in the public health sector.

We continue to work for the lowering of the cost of these drugs and to intensify the campaign to ensure that patients observe treatment advice given to them by doctors. As a sector, you may need to explore ways in which you can mobilise around raising awareness of our people of the importance of observing treatment advice. This is not only about AIDS but also about all the illnesses affecting our people.

The major cause of stigma is ignorance. We are therefore also focusing strongly on education and training. For instance, out of 27 000 registered medical practitioners only 2 000 have been trained in providing care for people with HIV/AIDS. This has required that the Department of Health run a series of training programmes in collaboration with academic institutions and other role players to address this backlog

We are working together with provinces to disseminate guidelines on HIV/AIDS and TB care and other supportive information to ensure that health care workers are adequately skilled in providing care and support to those who need it.

People living with AIDS as a sector are particularly powerful and well positioned in ensuring that our response in this country is the best. We need to learn how to tackle the private nature of HIV infection and to have a collective response. Our current understanding and application of confidentiality requires us to have an open and honest dialogue.

We need to ask as to how do we ensure that in the context of health provision we practice respect for individuals and ensure that we take collective responsibility. As individuals and communities we need to internalise these matters and really reflect on them. How do we overcome the fear, which I believe contributes to the negativism and discrimination?

Denial is sometimes a response to fear. Sometimes fear can lead to despair. I know that as a country we probably have not done enough to prepare for the severe emotional and psychological trauma, which is the outcome of this huge challenge. We therefore need to accelerate interventions in this regard.

The nature of these interventions can only be guided and informed by those of us who are living openly with HIV. They can teach us how to live without fear and with dignity within the epidemic. They can teach us how to express intimacy, desire and sexuality in the age of the virus. We must learn together.

A "one-size fits all' approach is never going to work. We need a fusion of problem-solving approaches that apply to different categories of human needs. Obviously, clinical care is necessary, but so is counselling, social and nutritional support, spiritual support and coping strategies for the family and plans for the children. The critical point we must accept is that we need each other in order to survive. We need to strengthen our partnerships and ensure that our relationship is based on mutual trust and respect. Each one of us must identify our strengths, our responsibilities and our rights. We have to find a way to communicate with each other, share insights and experiences and work together.

The loss and pain associated with this epidemic are already too much for many to bear. But this may be have a positive aspect because in every crisis there comes a time for helplessness and a need for burden sharing instead of burden bearing.

It is a time for truth telling, the end of painful silence and the beginning of closeness. Talking is the basis for healing. I know that we all are aware that there is still no cure for HIV infection and AIDS. But even in the absence of a cure, the healing process can begin. It can begin in the hearts of each and every one of us.
We can start by together acknowledging our fears, our choices, our practices and how we interact. This is the beginning of our walk to freedom, away from the despair and pain. We can stop the blaming, the stigmatisation, and the marginalisation. We can start by reaffirming that to be alive today is to be in a world with HIV. Our best weapon is SOLIDARITY!

I wish you well in your deliberations and would like to take this opportunity to reaffirm government's commitment to the fight against this silent enemy. Remember ALL OUR ACTIONS COUNT.

I declare this Summit officially open.

# S7

**23 NOVEMBER 2003, ANTIRETROVIRAL CAMPAIGN WILL NEED EVERYONE'S SUPPORT**

Now the hard work begins, writes Manto Tshabalala-Msimang

The South African government has added another weapon to its fight against HIV/ Aids by approving an operational plan for comprehensive treatment and care. This major decision has put in place the last element of our HIV/ Aids Strategic Plan for 2000 to 2005.

Other elements of the plan have been up and running for a few years. Although they are having an impact on the ground, it is critical that we intensify them. Our world-class prevention efforts have led to a high level of awareness in our society and the signs of a stabilising HIV prevalence rate are beginning to reflect in our surveys.

Our major challenge is to ensure that the vast majority of South Africans who are HIV-negative remain that way, as there is still no cure for HIV/Aids.

The reality, however, is that there are many people who are already infected and affected.

To improve treatment, care and support for our people with HIV/Aids, we require a better understanding of the nature of our problem -

particularly the progression from HIV infection to the development of Aids-defining diseases.

The plan approved by the Cabinet seeks to address this problem with a series of interventions that are all aimed at slowing the progression of the disease.

We begin by encouraging people to know their HIV status through voluntary counselling and testing.

The plan encourages a healthy lifestyle, good nutrition and psycho-social support for those who test positive. It expands programmes aimed at boosting the immune system and slowing down the effects of HIV infection, including the option of traditional and complimentary medicines. It also strengthens efforts to treat opportunistic infections and intensifies support for the families of those infected and affected.

All these interventions address the critical health needs of the major proportion of infected people because most of them have not progressed to a stage where antiretroviral treatment may be required.

Those whose immune systems have deteriorated and whose CD4 count is 200 or less are estimated to be between 400 000 and 500 000. These are the people who may require antiretroviral treatment.

The introduction of antiretrovirals in the public health sector is indeed a major decision, as it demands major investment of financial and other resources to ensure that this programme is effective and does not undermine our overall response to HIV/Aids.

It demands a major effort to upgrade our national health care system, including the recruitment and training of thousands of health professionals; improving access to, and the efficiency of, our laboratory services; and establishing reliable and cost-effective drug procurement channels and distribution systems.

Another enormous task is to ensure that people receiving antiretrovirals, as well as the rest of our society, have all the relevant information. They should know that there is still no cure for HIV/Aids.

These drugs merely arrest the progression of the disease. They can have adverse side-effects that can make patients sicker or not respond to treatment.

We are very conscious that the real work begins now, with the implementation of the plan.

There are a number of tasks that we have to undertake concurrently to ensure that the plan is implemented. These include:

A massive social mobilisation and communication campaign to inform communities of the various elements of the plan and facilitating adherence to treatment;

The assessment of facilities' capacity to provide the highest quality care and administer antiretrovirals according to international standards, and assisting them in meeting these requirements;

An intensive staff recruitment, training and retention drive for the thousands of health professionals needed to implement the plan;

Drawing up and issuing tenders for the procurement of the drugs, equipment and other services needed to support the programme; and
An investment in a national laboratory system that is accessible and can meet the necessary turnaround times for performing HIV, CD4-count, viral load, liver function and other tests needed in caring for people with Aids.

These are some of the challenges we face in our attempts to provide treatment, as soon as possible, to the people who need it. Our target is to have at least one service point in every district across the country within one year and one service point in every local municipality within five years.

It is a major undertaking that will require the partnership and commitment of every sector of our society.

It is up to the various sectors to enter into a constructive engagement in the realm of practical work to ensure that South Africa enhances its advances in curbing the spread of HIV and reducing the impact of Aids.