

**The Comprehensive HIV and AIDS Care, Management and Treatment Plan
in South Africa ~
An Analysis of its Development and Implementation**

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“South Africa is infamous for its obfuscation and prevarication on AIDS policy”.
Nattrass (2004:41).

1. Introduction

It has been said that the beginnings of a comprehensive response to HIV/AIDS in South Africa were outlined in the Health Policy of the African National Congress (ANC), prior to 1994 (DOH, 2004b¹). “However, the implementation of AIDS policy in the first few years after 1994 has been characterized by a lack of progress and a breakdown of trust and co-operation, both within government and between government and NGOs” argues Schneider & Stein, 2001:724). In 2000, the South African government launched its five-year Strategic Plan for HIV, AIDS and Sexually Transmitted Illnesses (STI), which addressed four areas including “treatment and care”, which did *not* include anti-retroviral therapy (ART). It was only in November 2003 that the South African National Department of Health (DOH) announced its intention to roll-out anti-retrovirals (ARVs) in its Comprehensive HIV and AIDS Care, Management and Treatment Plan (DOH, 2003). The decision by the Government of South Africa to provide free ARVs came after much pressure from civil society groups, specifically the Treatment Action Campaign (TAC), and after the presentation of the findings of the “Joint Health and Treasury Task Team Charged With Examining Treatment Options to Supplement Comprehensive Care for HIV and AIDS²” (JHTTT) in 2003.

Roll-out of the ARV programme has been slow, gaining momentum only towards the end of 2006, and very recently (March 2007), the DOH launched its new HIV/AIDS Plan, which has been hailed as comprehensive and progressive (Cullinan & Thom, 2007).

The HIV/AIDS policy development and implementation process in South Africa has been complex, highly political, and prolonged. Various analyses exist of the early HIV/AIDS policy development processes in South Africa (Nattrass, 2004. Schneider & Stein, 2001. Jones, 2005),

¹ In fact an ‘AIDS Plan’ was developed in 1993, which had its beginnings in an ANC meeting in Mozambique in 1990 (according to Nattrass, 2004:42, and Schneider & Stein, 2001).

² In July 2002 the South African government established a Joint Health and Treasury Task Team (JHTTT) to investigate issues relating to the provision and financing of an enhanced response to HIV/AIDS.

while the more recent analyses (Ndlovu & Daswa, 2006a+b, Steward & Loveday, 2005) focus on the challenges faced in the implementation of the Plan.

1.1. Purpose of this analysis

This paper uses the findings of the existing analyses and evaluations³ to inform a triangular policy analysis and stakeholder analysis of the implementation of the ART component of the 2003 Comprehensive HIV and AIDS Care, Management and Treatment Plan⁴ (CPHA hereafter). This paper seeks to *retrospectively* identify all the key players in the CPHA's development, their interest, influence, and degree of opposition or support for the policy. The paper also considers more *prospectively* (Varvasovszky & Brugha, 2000:338), the actors involved in its implementation, in order to identify the reasons for the delays and possible solutions. The analysis is placed within a rights-based framework, based on the belief that "the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being", as stated in the WHO Constitution (quoted in Green, 1999:8).

1.2. Theoretical framework of this analysis

In this paper, policy is broadly understood as those "decisions taken by those with responsibility for a given policy area" and more specifically, health policy incorporates all those "courses of action (and inaction) that affect the set of institutions, organisations, services and funding arrangements of the health system" (Buse, Mays, Walt, 2005:6).

1.2.1. Health policy development

There have been advancements in the theoretical frameworks seeking to understand the policy development process⁵. This case study of the South African CPHA's process shows that it cannot be viewed as a purely rational, linear process, as proposed by March & Simon (1958). Nor can the process be described as a muddled, incremental approach (Lindblom, 1959), since the ART component of the CPHA represents a new, large and radical programme for South Africa, demanding a massive commitment of will, finances and other infrastructural support. Perhaps the mixed-scanning approach to decision-making, as proposed by Etzioni (1967) offers a more realistic framework for the analysis of the CPHA, since it was the ANC's scanning of the political environment which highlighted the increasing public pressure to deliver ARVs, and underscored the fact that a *fundamental* decision was required. The bounded rational approach acknowledges the reality that while certain components of the South African government were trying to make rational choices, there were elements, or personalities, within government that appeared to be swayed by uncertainties and seemingly 'irrational' opinions regarding ARVs.

1.2.2. Stakeholder Analysis

The basis for undertaking this stakeholder analysis is the understanding that the policy process is a complex one that is affected not only by the actual *content* (or topic and nature) of the policy, but also by the *context* and by the particular *process* of its development. Added to this are the influences of several actors, or stakeholders, and all these four aspects interact and affect each other. Walt and Gibson (1994) proposed the "health policy triangle" which incorporates all these

³ It was not feasible to conduct actual interviews with the key stakeholders in South Africa, given the short timeframe of this project.

⁴ It was also not feasible to undertake an analysis of the entire complex process since 1994 (including the land-mark Constitutional Court ruling on Prevention of Mother to Child Transmission, the settlement with the pharmaceutical companies, and other important events).

⁵ The models discussed here are as described in Buse & Walt (2005:40-45).

aspects, and recognises their influence in the policy process, the stakeholders having a central role. Stakeholders might be defined as any individual, group or organisation which has interest in, influence over and/or is affected by the proposed policy. This paper seeks to utilise this approach (as described by Varvasovszky & Brugha, 2005) in understanding the development and implementation of the South African CPHA. Before doing so, let us examine briefly the HIV/AIDS situation in South Africa and the content of the CPHA.

2. HIV/AIDS in South Africa

The most recent 2005 South African National HIV and Syphilis Antenatal Sero-Prevalence Survey found a further rising trend in HIV prevalence in South Africa. Prevalence among pregnant women attending antenatal clinics had increased from 27.9 percent in 2003 to 29.5 percent in 2004, and to 30.2 percent in 2005. The Survey estimated that 5.5 million people were living with HIV and AIDS, and that the prevalence among adults between 15 and 69 years was 18.78 percent. It was estimated that in 2003, there were 500,000 South Africans who had AIDS defining illnesses and who were in the need of ART (Dorrington *et al*, 2004), which dramatically increased to 770,000 people (ASSA, 2006) or 800,000 (Nattrass, 2006) in 2006.

3. The Comprehensive Plan for HIV/AIDS in South Africa (2003)

3.1. Background to the CPHA

Despite the rapidly increasing HIV prevalence rates in South Africa, it was only in August 2003 that Cabinet admitted that “anti-retroviral drugs do help improve the quality of life of those at a certain stage of the development of AIDS” (quoted in Nattrass, 2004:55). However, Cabinet expressed concerns about the feasibility, affordability and implementation of a national treatment plan and requested a detailed operational plan from the DOH. Importantly, Cabinet received the Report of the Joint Health and Treasury Task Team (JHTTT) in 2003, which provided treatment policy options and costs, and which indicated that a phased-in ARV provision was affordable to the government.

After much public pressure (described in more detail below), and due to the ANC desire to diffuse the issue before forthcoming elections in 2004 (Nattrass, 2005:56), the DOH finally released the CPHA (DOH, 2003a).

3.2. Objectives of the CPHA

The key objectives of the CPHA included increasing the preventative activities, sustained education and community mobilisation programmes, providing programmes aimed at boosting the immune system and slowing down the effects of HIV infection, improving efforts in treating opportunistic infections, intensifying support for families affected by HIV and AIDS, and importantly, providing ART to those in need of it, to be certified by doctors (DOH, 2003a). The plan also promised to provide investments to strengthen the national health care system overall, and to add new health professionals to the national health system, thereby increasing the health system’s capacity to treat all patients, HIV-positive patients.

Regarding the ARV component, there were two set **timeline**-targeted goals: 1) to establish a minimum of one (accredited) service point in every health district by the end of the first year of implementation (2004/5), and 2) to provide all in need of ARV treatment equitable access to the programme within their local municipal area within a period of five years (DOH, 2003a). The

Plan also identified a number of pre-implementation tasks that required accomplishing. These included: Accreditation and strengthening of service points; Training of health workers; Procuring drugs; Strengthening drug distribution systems; Strengthening laboratory testing capabilities; Establishing a monitoring and evaluation system with proper patient information systems; and Developing staffing norms and standards (DOH, 2003a: 40). The Plan stressed that a parallel health system would not be created, but that the provision of ARVs would be integrated into the existing national health system, and was designed to be initially executed through district hospitals and existing primary health care (PHC) facilities.

3.3. Implementation Problems of the ARV Component of the CPHA

The roll-out of ARVs began in April 2004, and by the end of 2004 only 42,000 had been placed on treatment, falling short of the Department's own targets (JCMF, 2005). An initial assessment conducted by the Health Systems Trust (HST) at 77 facilities found that all the sites possessed the basic elements of human resource, laboratory, pharmacy, and ancillary services capacity (Stewart & Loveday, 2005). However, the requirements to reach a level of service competency varied significantly among these locations, and thus technical assistance and financial resources to the weaker sites were needed. By the end of November 2004 there were 61 accredited sites. The HST report also highlighted problems with delays in access to the ARV drugs and waiting lists ranging from 2 weeks to 36 months (Stewart & Loveday, 2005:17). They also found greater availability for urban-based patients than for rural, and that children were being neglected in the process.

It was only in 2006 that the numbers of people accessing ARVs were seen to be steadily increasing, reported to be 213 828 people in September 2006 (DOH 2006a). However another 540 000 people were estimated to be sick with AIDS and in need of ART (ASSA, 2006), so clearly the services were not meeting the need.

There are a number of problems that have been identified in the implementation of the CPHA. These have included the shortage of human resources and infrastructure, the reported shortage of financial resources, the delays in the accreditation process of sites, the prolonged national tender process in purchasing and distributing the drugs, the lack of political will in pushing the process forward and specific delays in providing ART to children in need.

These shall be explored in more detail below, using a policy analysis approach to explain their underlying causes. They are arranged by those aspects that relate to the content, those context issues, the process factors, and finally those relating to the stakeholders.

4. Aspects of the Content of the Policy which Affected/ are Affecting its Implementation

There are specific aspects about the content of the CPHA that contributed to the delay in the national DOH committing to and implementing the roll-out of ARVs.

4.1. Concerns about the Toxicity of ARVs

Senior government officials, namely the President and Minister of Health, questioned the effectiveness of the ARV drugs, and stressed their potential toxicity. This point is mentioned only briefly here under content, because it relates to the clinical efficacy of the drugs. However, it is discussed in more detail under the political context and under stakeholders, since it was due

to more to political prevarication, rather than to sound clinical evidence (Nattrass, 2006). These attitudes have had a negative impact on policy formulation in South Africa, discussed further below, but worse, contributed to the fear, powerlessness and uncertainty already faced by PLWHAs.

4.2. Paediatric ART

The JCSMF reported that several factors have slowed down the delivery of ART to children, including: a) the long time it took for the national DOH to finalise the paediatric treatment guidelines, b) “Paediatric formulations are often non-existent or inappropriate for a low literate society, difficult to estimate quantities, comparatively complicated and more expensive” (Doherty *et al*, 2005), c) the reluctance of doctors and nurses to treat children, because of their inadequate training in paediatric treatment, and d) the misconception that only a paediatrician can treat HIV-positive children.

4.3. Financing - Drug Prices, Funding Mechanisms and Absorptive Capacity

The initial argument of the DOH was that a free national ART programme was unaffordable to the State. However, the CPHA was devised at a time when the price of ARVs had decreased significantly, due to international negotiations and pressure on pharmaceutical companies. Thus the findings of the JHTTT were that a phased roll-out of ARV provision was indeed affordable and sustainable. Also importantly, other analyses by academics in the field also proved that a national ARV programme was affordable, and cost-effective (Nattrass, 2004. Cleary *et al*. 2003. Vassall & Compennolle, 2006. Walker, 2003) and that national revenue was adequate (Hickey, 2004). Based on the JHTTT findings, the National Treasury (NT) in its 2004/05 budget, committed increased funds for the initial phase of the roll-out (NT, 2004a), and increased these again by 18% in its 2005/06 budget (Ndlovu, 2005a:2). This implies a financial commitment to the delivery of the programme by the NT, shown again in the recent 2007/08 budget with increased funds for strengthening the health sector and for HIV/AIDS (NT, 2007). While the CPHA is primarily funded from the national level through Conditional Grants, additional commitments from the provinces from their Equitable Shares are encouraged. Certain provinces have been able to do this – Gauteng, Western Cape and KwaZulu-Natal in particular (Ndlovu & Daswa, 2006b).

While increasing budgets are being allocated to HIV/AIDS, the question is whether the provinces have the absorptive capacity to spend these. Although this aspect relates to capacity at provincial and districts levels (which is discussed in detail below), we shall comment here that the expenditure rates of provinces have improved dramatically over the years. In 2001/02 there were reports of 80% unspent HIV/AIDS funds (Guthrie & Hickey, 2004), but this has steadily improved to around 100% in some provinces, however with differences in spending capacity between provinces (Ndlovu, 2005a). So from a financial perspective, availability of funds, decreasing drug prices, and increasing absorptive capacity are all contributing positively to the implementation of the CPHA.

4.4. Monitoring and Evaluation System

The CPHA stressed the importance of a robust monitoring and evaluation system to monitor the efficacy of the intervention, adverse drug events, and drug resistance. The DOH (2004b) subsequently developed a framework with a list of primary indicators, and stated that more information on core indicators would be available incrementally as the data collection systems matured over time (DOH, 2004b: iv).

This is an important framework to have in place, and will enable the quick identification of problems and their efficient handling. However, Ndlovu & Daswa (2006b) report that there are still poor provincial monitoring systems for ARV patient numbers, and that there appears to be blocks in communication and information sharing, mainly between the national and provincial health departments as well as between government and civil society organisations.

5. Contextual factors affecting the implementation of the ARV Component of the CPHA

5.1. Situational factors

“While positive progress is evident, the sheer magnitude of the HIV epidemic results in demand for treatment continuing to outstrip supply” (Stewart & Loveday, 2005:7).

The high HIV prevalence and large numbers of people needing ART in South Africa are some of the factors contributing to the greatest challenges for the ARV programme – that of meeting the need. There are various factors which have contributed to the rapid transmission of the virus in the country, but that discussion is outside the scope of this short paper.

Poverty

The general levels of poverty and under-development in the country also contribute to people’s susceptibility to the illness (Zanakis & Alvarez, 2007). The President of South Africa argued that in fact it was poverty which was causing AIDS (Jones, 2005:426), a statement which effectively removed all responsibility from the government to do something about such a deeply entrenched problem. This paper does not agree with this argument but acknowledge that poverty has contributed to increased risk of infection among vulnerable groups, and to the reduced ability of poor people to maximise their health potential (Hunter, 2007).

Unequal Infrastructural Capacity

The health sector in South Africa has been undergoing decentralisation to the district level. The newly Democratic government inherited in 1994 a weak and flawed district health system (Schneider & Stein, 2001:726), and has been trying to strengthen this since. However, some provinces have had faster and more extensive development than others. Thus there exists across the provinces unequal development, infrastructure and capacity to implement the ARV programme. This is evidenced in the differential uptake of the services, as well as in the differing expenditure rates of allocated funds. Thus, the Joint Civil Society Monitoring Forum (JCSMF, 2005) found that the wealthier provinces such as Gauteng and the Western Cape are scaling up faster than the poorer provinces such as the Eastern Cape and Limpopo Provinces.

South African Constitution

“Due to its highly innovative and progressive constitution and Bill of Rights, South Africa is often hailed as an ‘exceptional’ example of making socio-economic rights justifiable”, states Jones (2005:439). The South African Constitution enabled the TAC to take the government to court regarding the provision of PMTC. Thus TAC tested the indivisibility of health rights (and other socio-economic rights) with the broader civil and political rights (Jones, 2005:422), and the Constitutional Court ruled in their favour. This is an important factor positively contributing to the roll out of the ARVs.

Historical and Current Role and Power of Civil Society

The role of civil society in bringing down the apartheid era is well documented, and led to an empowered and vocal civil society in South Africa. Some commentaries acknowledge that much

of this momentum was lost after Democracy in 1994, for a number of reasons (Schneider & Stein, 2001:728). However, the issue of the human rights of people living with HIV/AIDS became a key issue around which NGOs organized. TAC was able to mobilise people (especially grass-roots), by networking with labour, community and faith-based organisations, doctors etc., building an effective movement and voice, and strategically using different methods in their campaign, including Constitutional Court cases against the government. It was TAC's carefully constructed political public pressure on government which was "pivotal in contributing to a dramatic recalibration of policy on antiretroviral treatment", explains Jones (2005:423).

5.2. Structural factors

Lack of Capacity in the Health Sector ~ human resources and infrastructure

The JCSMF (2005) reported that severe human resource shortages in clinics and hospitals across the country were impeding the delivery of the ARVs. Indeed, this was a challenge identified early by the DOH, and they therefore reported that "*there are challenges with regard to acquiring adequate numbers [of health professionals] mainly due to inadequate numbers of certain health professional categories in the country, limited number of people trained or experienced in HIV and AIDS care and treatment as well as the difficulties in recruiting and retain health professionals to rural and underserved areas*" (DOH, 2004a).

Thus a comprehensive country human resource (HR) plan was developed and finalised in 2006 (DOH, 2006b). The HR plan proposes a number of strategies to facilitate the recruitment and retention of more health professionals to the public health service. Ndlovu & Daswa (2006a) note that the activities suggested under the new HR plan do not sound like new initiatives, and suggest that government needs to intensify its investment in human capital. Of concern is that there is no acknowledgement of the impact of HIV/AIDS on the demand for human resources in the HR plan, with HIV/AIDS being mentioned only twice (DOH, 2006b:15+27).

Location of the AIDS Programme Directorate in the DOH

Instead of being placed in the President's office, it was decided to locate the HIV/AIDS Directorate within the national DOH, and similarly with the Provincial AIDS Programmes within the Provincial DOHs. This seriously impeded the ability of the AIDS Programme Managers to co-ordinate a comprehensive response that had components outside of the health sector. Guthrie & Hickey (2003) note that in other African countries, the national AIDS commissions were located within the Presidential offices, which gave them greater political power, and enhanced the coordinated response across the sectors. In addition, Schneider & Stein (2001:726) argue that the provincial AIDS managers had fairly low levels of seniority, and had to implement their programmes through weak district structures, over which they had no direct line of authority. These factors continue to hamper the implementation of the ARV programme at district level, as well as contributing to the 're-medicalisation' of HIV/AIDS by placing the response squarely in the DOH (Guthrie & Hickey, 2003).

5.3. Political contextual factors

As Natrass (2004:44) claimed, the South African government is *infamous* for its response to HIV/AIDS. She described their "disastrous high profile 'quick-fix' solutions", their questioning of the cost-effectiveness of ARV treatment, and even denying the HIV-AIDS link. "South Africa's political leadership propelled AIDS policy making into a scientific dark age" says Natrass (2004:50).

Policy formulation in South Africa has also become increasingly centralized and depoliticised under the Mbeki rule (Jones, 2005:424). This has been further compounded by the system of proportional representation, meaning that those ANC members openly criticising Mbeki's views would not be placed near the top of the ANC election list. At the same time, civil society after 2004 focused on transition and development, and so resulted in a "culture of 'non-criticism' which blunted civil society's cutting edge of advocacy and political opposition", explained Jones (2005:424). This lack of opposition from within and without government gave key personalities in government greater power in delaying the roll-out of ARVs.

5.4. International or exogenous factors

The international attention to the South African situation, and specific pressure from donors and potential investors also played a role in bringing about government's commitment to the ARV programme, and their continuing monitoring keeps the pressure on government to implement the programme. However, the influence of donors is somewhat limited because the government does not depend up external financial resources to fund its ARV programme. Nevertheless, at the HIV/AIDS International Conference in Toronto, TAC and academics effectively used the media and international political pressure to shame the Minister of Health for her slow delivery of ARV and for her continuing claims about the effectiveness of African potatoes and garlic in treating AIDS.

6. Process factors contributing to the Implementation of the CPHA

The CPHA was coordinated within a national framework to ensure uniform quality, equitable implementation and efficiencies of economies of scale. However, it is the provinces and health districts which are responsible for its roll-out and implementation, and the national DOH is supposed to provide assistance as required (Ndlovu, 2006). From this perspective it may be described as a top-down approach. However in developing the various policy options and in the drafting of the CPHA, the JHTTT met extensively with provincial level managers and the potential service providers, as well as NGOs, academic, labour etc, and sought to include their opinions in the development of the Plan (DOH, 2003b). In addition, it is said that the Provincial government structures had been putting pressure on the national structures to agree to the roll-out long before national DOH actually did, with the Western Cape Province deciding to go ahead and implement its own ARV programme prior to the CPHA. So from another perspective, it may be seen as a bottom-up approach.

Interestingly, KwaZulu-Natal (KZN) undertook a further devolution process which allowed for the effective devolution of services from provincial level to health districts, and this has been indicated as a factor assisting their implementation process. "The devolution process helps to avoid top-down processes and to develop, cost and budget [for programmes and plans] consultatively" states the Acting Manager of the KZN Provincial AIDS Action Unit (in Ndlovu & Daswa, 2006b:12). A bottom-up approach, that is devolved as far as possible, would now contribute to improved delivery of the programme.

7. Identification of the key stakeholders involved in/ affected by the process

"Stakeholder analysis is an approach, a tool or set of tools for generating knowledge about actors – individuals and organisations – so as to understand their behaviour, intentions,

interrelations and interests; and for assessing the influence and resources they bring to bear on decision-making or implementation processes” defines Varvasovszky & Brugha (2000:338). Ideally, stakeholders should be interviewed, but due to the short timeframe for this project, only a review of the literature and the experience of the author were relied upon. The details of each actor’s primary interests, their potential source and level of influence, and the forcefield analysis are presented in Appendix A and B. Below is merely an identification of all the players, followed by a brief summary of their involvement and influence in the process.

Government actors: the President and Deputy-President of South Africa, Cabinet, Minister and Director-General of Health, Minister of Finance, Parliamentary Health Committee, Provincial MECs of Health, the JHTTT, the South African National AIDS Council (SANAC) (headed by the Deputy President and which was also supposed to include NGO representation), Departments (national and provincial: Health, Education, Social Welfare, Justice), provincial HIV/AIDS Programme Managers, district level health personnel, clinic doctors, nurses, home-based carers etc.

Non-state actors/ pressure groups/ civil society organisations: Treatment Access Campaign (TAC), AIDS Legal Project, Associations of People Living with HIV/AIDS (PLWHAs), Joint Civil Society Monitoring Forum (JCSMF), Absolute Return for Kids (ARK), School of Public Health (UCT), Centre for Social Science Research (UCT), AIDS Budget Unit (Idasa), other academics and advisors to the government.

Donors and International bodies: UNAIDS, WHO, USAID, PEPFAR, GFATM, UNDP, World Bank, UNICEF, SIDA, NORAD, international Associations of PLWHAs, African Union, European Union, international pharmaceutical companies, international NGOs (eg Medicine Sans frontiers) etc. There are many others not listed individually here.

8. The involvement, concerns, influence and power of stakeholders in the CPHA process

The previous discussion has already mentioned the involvement of most of the main key actors in the CPHA process. Appendix A provides greater detail about their concerns and level of influence.

In summary, within government, it is easy to see that the President of South Africa, the Minister of Health, and the Minister of Finance played the largest roles in the process, the latter more positively in making funds available, while the President and Minister of Health deliberately tried to prevent government’s commitment to ARVs, and they continue to slow implementation with contradictory and confusing messages about the efficacy and toxicity of the ARV drugs. However, their power should lessen over the coming years, as the force of civil societies demands will have to be addressed. The role of the government-formed JHTTT was important in shifting government’s (primarily the Minister of Finance’s) perspective to accept that a treatment programme was indeed cost-efficient, affordable, and made good economic investment sense.

From the civil society side, TAC has been the strongest player, using various strategies, and now extending their impact through the JCSMF which brings together a wider range of skills and resources to monitor the roll-out. This watchdog role must continue unabated.

The valuable analyses by various academics and research agencies have further contributed to the growing body of evidence of the cost-effectiveness and affordability of ARVs to the country, making it more difficult for government to ignore the logic any longer. This supports Etzioni (1967) argument for a rational mixed-scanning approach leading to fundamental decisions (in Buse & Walt, 2005:45).

But now the major power resides with the implementing agencies, at provincial and district levels, and is dependent upon their capacity to deliver and to efficiently absorb the funds being directed at the programme.

International attention and pressure has been, and will continue to pressurise for equitable access.

9. Strategies required to counter the opposition, and to facilitate implementation

Firstly let us acknowledge that the South African free ARV programme is potentially one of the largest in the world. With the high HIV prevalence rate and huge numbers of people in need of ARVs, the task to which the South African government has committed is indeed a daunting one, especially given the weak health infrastructure at district (implementation) level. Also we must acknowledge that many of the initial delays, such as those due to accreditation of sites and the tender process, have now been overcome, and the numbers of people accessing treatment are now steadily and swiftly increasing. Indeed, even the political opposition by the President and the Health Minister have been weakened. This is evidenced in the recent drafting and promotion of the new comprehensive plan, being launched by the deputy President and deputy Health Minister, and which has been hailed as innovative and far-sighted (Cullinan & Thom, 2007). Nevertheless, there remain some chronic structural issues which may continue to undermine and delay implementation. In addition, acknowledgement of the political nature of the HIV/AIDS debate in South Africa is required.

Based on the policy analysis triangle approach and the stakeholder analysis conducted, various solutions are suggested below for addressing the issues identified above, so as to ensure the successful implementation of the CPHA. While one of the limitations of a stakeholder analysis is that it only provides a snapshot in time, this paper has sought to consider the historical dimensions of the roles of various actors, and acknowledges that implementation of the policy will change the power dynamics again. The suggestions below are made bearing this in mind:

Political Commitment and Management

The President, the Minister of Health and the Minister of Finance must constantly state that HIV/AIDS is a national development challenge that is requiring and getting their highest level of attention and commitment. HIV/AIDS should be mentioned in every public discussion, and particularly in the State of the Nation address and the Budget Day speech. Greater discussion and disagreement should be allowed within the ANC ranks. The implementers of the policy need to be inspired by the obvious commitment of their seniors in the governmental ranks, and people who are battling the ravages of AIDS need not be further confused and frightened by mixed messages from their leaders. Hopefully the new deputy President and Deputy Health Minister will bring 'enabling leadership', which can harness the considerable energies outside of government, and "which is very different to the notion of leadership as control that has tended to

characterize the national government response to AIDS”, but rather the ability to mobilize the many potential players (Schneider & Stein, 2001:729).

Wider Primary Health Care Approach

This approach calls for broader interventions, including individual and community empowerment and anti-poverty measures (Green, 1999:7) and would be necessary to build capacity throughout the country, and reduce the vulnerability of persons who are vulnerable to HIV infection through poverty. In addition, integration of the the ARV services into existing health services is critical, rather than in parallel, silo services (Pienaar et al, 2006).

Capacity building

Not only are operational and administrative capacity building within the provincial and district health departments required, but also needed are: strategic planning capacity, visionary management, transformational leadership, human resource management, interpersonal relations, interdepartmental or intergovernmental relations (Ndlovu, 2006). This requires specific investment of financial, infrastructural and technical resources, with particular attention to those provinces that are lagging behind due to inherited undeveloped systems and continuing poverty. Human resource development and management is critical, to retain, retrain and remunerate professionals at all levels and sectors. The implementation of the 2006 HR Plan must be monitored and its impact evaluated.

Role of Civil Society

Mobilizing the input of civil society organizations more effectively in South Africa should be a key strategy in the implementation of the CPHA. It has been proven that the human rights lobby groups having played an important on-going role in monitoring the protection of the rights of PLWHA, government’s protection of these, and in highlighting shortfalls in the delivery of services quickly, as the JCSMF has been doing. As well as this watch-dog role, NGOs could also play an important role in the actual delivery of services in various ways. Already TAC’s treatment literacy campaigns have been very effective in enabling people to understand and adhere to their treatment regimes. ARK’s role in supporting treatment to children has been critical in improving their access to ARVs. These could be expanded – if DOH and the other relevant sectors could discuss openly the gaps in their delivery and to acknowledge where CSOs had crucial skills and manpower to offer.

Role of Donors and International Agencies

Regarding the contribution of the donors, there are no clear lines of responsibility and interaction between the DOH and major donors such as the GFTAM, PEPFAR, DFID, and the EU. If these relationships could be clarified, these stakeholders could make greater contribution to capacity-building efforts and bridging the implementation gaps (Ndlovu, 2006). In addition, support to particular departments is often delayed by the protracted process of developing the Memoranda of Understanding – this process should be streamlined.

Role of Academics

The health economists and other professionals who act independently, through academic institutions or research agencies, should continue to contribute their knowledge and insight to improved efficiency of spending, enhanced financial systems, streamlined reporting and information mechanisms and generally improved governance, both economic and political.

Their skills and expertise should be consciously enlisted in the ‘national’ response to HIV/AIDS.

Role of Public Private Partnerships (PPPs)

Again, given the shortage of capacity within the public sector for the delivery of the HIV/AIDS services, government could explore greater collaboration and contractual arrangements with private service providers, of which there are many in South Africa. In particular, government could encourage and acknowledge the important coverage provided by companies for their employees, and request that these benefits be extended to their dependants (which is not happening in all cases at the moment). There is need for innovative and mutually-beneficial PPPs, where the private sector could offer not only financial and human resources, but also training and administrative support to public facilities (JCSMF, in Ndlovu & Daswa, 2006a:11)

Monitoring and Evaluation System and Sharing of Information

The South African government still needs to strengthen its monitoring and evaluation efforts to be able to accurately report on its targets and actual outcomes (Ndlovu & Daswa, 2006b:30). This requires improved information systems at district level, and free access to this data by civil society. An attitude of open sharing of experiences between government and CSOs would contribute to our growing democracy.

Financial Resource Allocation and Expenditure

The commitment of financial resources made by the National Treasury (NT) to the implementation of the CPHA is commended. However, they are still inadequate to meet the needs of all the persons requiring ARVs. While it is acknowledged that the capacity of the provinces to effectively spend the funds varies, this is not an excuse to not fund the needed services, but rather to put additional funds, infrastructural and technical support to build those disadvantaged provinces.

It is suggested that data on the allocations and their actual expenditure be made easily and routinely available to civil society. In addition, NT should stipulate how provinces should fund HIV/AIDS from their equitable share budget, i.e stipulating that percentage which should be reserved for AIDS, TB and STI services. At the same time, it was suggested by AIDS programme managers that NT should not be too prescriptive about how the conditional grants are spent, so as to allow provinces to respond to their particular needs appropriately (in Ndlovu & Daswa, 2006b). It is also important that continuing financial emphasis be placed not only on the treatment component of the CPHA, but on also on all the other HIV/AIDS policy priorities, to avoid ‘over-medicalisation’.

Attention to Children requiring ART

The access to ART for children needs to be improved, and attention focused on the provision of holistic subsidiary care programmes for children living with HIV. The JCSMF (2005) states that the estimated numbers of children infected with and being infected by HIV remain unacceptably high, and therefore it is also critical to improve the implementation of the PMTCT programme to reduce the number of infant infections.

10. Conclusion

This policy analysis, by using the triangle approach and stakeholder analysis, has identified several factors contributing, either positively or negatively, to the development and implementation of the South African Comprehensive Plan for HIV/AIDS. The decision to roll-out free ARVs in the public health system was indeed a fundamental one, requiring massive commitment of will, resources and technical support. This would not have been possible without the contribution of every actor identified here and others. HIV/AIDS has become a unifying focus for all these players, and it is high time that government recognised, acknowledged and encouraged the full participation of all, in a national endeavour to address HIV/AIDS. The force-field analysis (Appendix B) shows a positive outlook for the roll-out of the CPHA, with the proponents being clearly in the majority.

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APPENDIX A ACTORS AND STAKEHOLDERS IN THE SOUTH AFRICAN CPHA DEVELOPMENT & IMPLEMENTATION		
ACTOR	PRIMARY INTERESTS	POTENTIAL SOURCE AND LEVEL OF POWER/INFLUENCE
Government: the President of South Africa	Good governance of the country, managing economic development, social service delivery, poverty reduction, employment creation, creating conducive investment environment, maintaining ANC rule, maintaining personal power in presidential role, protecting people from harmful drugs, challenging 'western' evidence/ influence.	<ul style="list-style-type: none"> ▪ <u>Extremely high</u> political power as the highest individual in the government. Can intimidate others to agree with him, or risk their jobs or position on the ANC election list. ▪ <u>Strong role</u> in all policy processes ▪ <u>Strong influence</u> through his high intellectual capacity, but called upon intellectual dissidents to inform his opinion on HIV/AIDS and its treatment, which lost him credibility and <u>reduced</u> his power. ▪ He strongly and openly opposed the roll-out of ARVs. ▪ <u>Power was weakened</u> by the Constitutional Court ruling enforcing delivery of PMTCT (brought against Govt by TAC). ▪ <u>Influence curtailed</u> by ANC when they realized he was jeopardizing their election prospects. <p><u>Likely influence on CPHA – high, negative</u></p>
Government: the Minister of Health	The best health care options for the population of South Africa, equal access and quality, particular focus on poor and vulnerable, personally keeping her position as Minister and future position on ANC election list, not wishing to oppose the President (for reasons unknown).	<ul style="list-style-type: none"> ▪ <u>Strong political power</u> because of leading, or preventing, directions in Health, high influence on new policy, both content and process ▪ <u>Strong political power</u> because a 'favorite' of the President. ▪ <u>Reduced influence</u> bec of her strong personal beliefs about ARVs and garlic, etc – which had no supporting clinical evidence. ▪ <u>Reduced influence</u> over civil society because seen as a 'puppet' of the President. <p><u>Likely influence on CPHA – high, negative</u></p>
Government: the Minister of Finance	Developing the economy of South Africa, gaining macroeconomic stability, investing in health as a means to improve production, concerned about the impact of HIV/AIDS on the economy and productivity, careful and efficient allocation of resources, to contain govt public expenditure and deficit, concerned that ARV not affordable or sustainable by the govt, but was made aware that ARV was a good investment option with worthwhile outputs, therefore mobilized resources to commit to the programme and has steadily increased these.	<ul style="list-style-type: none"> ▪ <u>Very strong political and economic power</u> as charged with controlling the country' economy and spending, trusted by govt to achieve macroeconomic stability, secure economy and investment. ▪ <u>Strong role in all policy processes</u> – gives the final go ahead or blocking of policies based on their affordability and cost-benefits. Once he personally was convinced of the govt ability to afford the ARV programme, and its necessity for productivity, then he committed the funds to the programme. ▪ <u>Strong oversight role</u> – of provinces management and spending on the ARV programme, will ensure delivery according to indicators. <p><u>Likely influence on CPHA – high, positive</u></p>

Government: provincial & district AIDS & health programmes	To provide the best health care to the citizens of South Africa, to minimize the suffering of PLWHA, to retain and reward the health staff committed to assisting PLWHA, determined to roll-out the ARV as quickly as possible.	<ul style="list-style-type: none"> ▪ <u>Moderate (frustrated) power</u> in top-down policy decision, yet used pressure to influence in bottom-up manner (W.Cape Province deliberately going against National in committing to ARVs). ▪ <u>Strong influence</u> on the speed of roll-out. ▪ <u>Undermined power</u> by limited capacity, commitment and motivation. ▪ <u>Undermined their own power</u> by being afraid to challenge their Minister's opinions and position. <p><u>Likely influence on CPHA – moderate moving to high, positive</u></p>
Government: the Joint Health & Treasury Task Team	Established in 2002 and tasked to explore all the treatment options and their affordability. Interest to achieve the best health and investment outcomes for South Africa, concerned about affordability and sustainability, wanting rational and evidence-based policy decision-making (using costings of options – made use of the GOALS model).	<ul style="list-style-type: none"> ▪ <u>High power</u> based on their knowledge & wide consultation – findings and recommendations highly regarded by the Minister of Finance and Cabinet. ▪ <u>Strong influence</u> over decision-making process – their report enabled Cabinet to commit to ARV programme. <p><u>Likely influence on CPHA – high, positive</u></p>
Government: Provincial Treasuries	Managing and curtailing public spending in the provinces, balancing provincial needs with resources, strengthening infrastructure, maximizing investment in development.	<ul style="list-style-type: none"> ▪ <u>High economic power</u> in determining additional resources to be allocated to HIV/AIDS from their Equitable Share. <p><u>Likely influence on CPHA – high, positive or negative, varying between provinces.</u></p>
Civil Society: TAC, JCSMF, and PLWHAs	Interest in protection & promotion of rights of PLWHA, in gaining access to free treatment, equitable & efficient delivery of services.	<ul style="list-style-type: none"> ▪ <u>High political power</u> in mobilizing support of the majority of the population (HIV-positive and negative persons, especially poor rural communities). ▪ <u>High political power</u> in using Constitutional Court, international and national media shame campaign, civil disobedience etc. ▪ <u>Strong skills</u> to facilitate and assist in the roll-out and its monitoring. <p><u>Likely influence on CPHA – high, positive</u></p>
Donors	Interest in protection & promotion of rights of PLWHA, in gaining access to free treatment, equitable & efficient delivery of services, in efficient use of donated resources.	<ul style="list-style-type: none"> ▪ <u>High political power internationally</u> in promoting SA as a potential example to the rest of the world ▪ <u>Moderate economic power</u> since the SA govt is not dependent upon donor resources to fund the ARV programme. <p><u>Likely influence on CPHA – moderate, positive</u></p>
Private sector: business	Increased productivity, investment in health of employees, stable economy.	<ul style="list-style-type: none"> ▪ <u>High economic power</u> in contributing to the revenue of the govt. ▪ <u>Moderate political power</u> in pressurizing govt to fulfill their responsibility, while they themselves are contributing their share (through work-based ARV programmes and health benefits). ▪ <u>Potentially important contribution</u> to roll-out through PPPs. <p><u>Likely influence on CPHA – moderate, positive</u></p>

APPENDIX B: FORCEFIELD ANALYSIS OF STAKEHOLDER IN THE SOUTH AFRICAN CPHA PROCESS

ACTOR	PROPOSERS				OPPONENTS
	High support	<< << <<	Not mobilised	>> >> >>	High opposition
Government	JHTTT Public service providers staff, clinicians etc	Minister of Finance Cabinet Portfolio Health Committee	Provincial MECs, health depts. And AIDS programmes SANAC (ineffectual). Other dept – education, s.welfare. COSATU - labour		President Minister of Health
Civil Society	TAC, ALP, PLWHAs, academics				
Donors and international bodies	UNAIDS, WHO, USAID, PEPFAR, GFATM, UNDP, World Bank, UNICEF, SIDA, NORAD, International Associations of PLWHAs, African Union, European Union, international NGOs				
Business/ Pvt Sector		international pharmaceutical companies	Private companies, especially large ones offering work-based programmes. Private health service providers. Insurance companies.		