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AIDS
FREEDOM AND THE MORAL COMMUNITY OF CITIZENS IN SOUTHERN AFRICA

Bridget O'Laughlin

May 2006

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Comments are welcome and should be addressed to the author:

c/o ORPAS - Institute of Social Studies - P.O. Box 29776
2502LT The Hague - The Netherlands

workingpapers@iss.nl

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CONTENT

1 LIBERAL POLITICS AND THE AIDS CRISIS

In her recent book, *The Moral Economy of AIDS in South Africa*, Nattrass appeals to basic liberal values suggesting that '…if society lacks the political will to help those in need, then the notion of a moral community of citizens is empty'(Nattrass 2004: 179).[1] The book itself is an extended economic rationale for making antretroviral therapy generally available for those in South Africa who need it, but it is also part of a new literature that insightfully treats AIDS in Africa as a political issue (Eboko 2005, Fassin 2004a, Patterson 2005). Nattrass's notion of the 'moral community of citizens' is embedded in the prescriptive discourse of liberalism, which currently dominates both political and economic agendas in southern Africa. This paper asks whether the discourse of liberalism and its current normative project in southern Africa – the construction of liberal democracies – can provide a political answer to AIDS.

The liberal project has various interdependent elements. The first is the construction of the provident citizen, informed about the range of choices individuals enjoy as well as their respective risks.[2] The second is an active pluralistic civil society, assuring the collective goods of its various 'communities' either directly or through advocacy and political pressure on states in a multi-party system. The third is the minimalist regulatory state, an efficient neutral vehicle serving the interests of its citizens. Beneath all is the market, its boundaries increasingly vague since its logic is to govern not only the flow of material goods and services but the logic of individual choice, the relation between state and civil society and the functioning of the state itself. Democracy in this liberal project is construed as the individual subject's freedom to choose.

Whose project is this? It appears to have a near monopoly of political voice in the post-Soviet world where alternative socialist discourse has lost both legitimacy and resonance.[3] The liberal project has been adopted by multi-national corporations that claim partnership status with governments and civil society in global philanthropic ventures while accepting no constraint on their rights of property and movement. The Bush administration deploys the language of liberalism to project its

[1] Nattrass is herself invoking Rorty.
[2] O'Malley (2000 p.479) emphasises the fundamental continuity between neo-liberalism and the underlying assumptions of liberalism that construe '…common-sense reasoning and uncertainty as fundamental conditions of the autonomy of the rationally calculating, free subjects of liberalism'.
[3] I deliberately do not use the term 'post-socialist'.

latest ideological vision of how democracy works in the United States as a universal 'manifest destiny'. Much of mainstream social science has adopted liberalism as an analytical language as well as a political project.[4] What is perhaps more surprising is that the voices of secular opposition also rely on the liberal project. The anti-globalisation movement, trade unions, women's organisations – many invoke the language of universal individual human rights to inspire resistance and ground emancipatory claims. This quality of liberalism, to carry its own ethical critique within, to be a utopia never realised (Foucault 1997), constitutes its enduring political appeal.

AIDS, and particularly the debate over access to antiretroviral therapy (ART), is a revelatory crisis for liberal democracy in southern Africa. On the one hand the normative liberal vision of the provident citizen informs the 'best practice' package for HIV/AIDS prevention, promoted with particular assiduity by United States government agencies, the World Bank and, the United Nations. 'Best practice' has changed over time in response to its evident failure to address the continuing spread of HIV/AIDS. In providing its own critique – failures in participatory pluralism, the lack of 'political will', the ethical imperatives of universal human rights – liberal discourse and its corresponding institutions have defined the political space for confronting AIDS. The liberal critique thus creates its political legitimacy through its critique of neo-liberalism. This paper argues that this self-critique is not enough. Though the language of individual rights may polemically inspire emancipatory demands, it provides no guide to a political process for sorting out the conflicts over basic health rights that confronting AIDS requires.

This paper first summarises the HIV/AIDS agenda and locates it within liberal discourse. It also draws attention to some of its significant silences, particularly around provision of formal health care. Then it discusses how this approach has been applied in two different but related contexts in southern Africa – South Africa and Mozambique. It argues that the debate around access to antiretroviral therapy illustrates the limits of the discourse of liberal citizenship as an analytical approach and political response to AIDS in southern Africa.

[4] Including Sen's capabilities framework as well as rational choice theory and neo-classical economics.

2 HIV/AIDS 'BEST PRACTICE': FROM PREVENTION TO CARE AND TREATMENT

Until recently dealing with AIDS in southern Africa meant above all attempting to stop heterosexual transmission of the HIV virus. In the absence of a vaccine and accessible treatment, mortality appeared certain. Increasingly, however, both research and the availability of new forms of treatment have made mortality contingent. In a sense AIDS is a prototypical liberal disease. There is much about it that is uncertain and that uncertainty compels us all to become the ideal provident liberal subject – each exercising agency by acting prudently in a world of risk and uncertainty.

There is uncertainty and contingency in every phase of the development of AIDS. The consequences of exposure to HIV are unclear and long-term. Not every incidence of exposure to the HIV virus leads to AIDS. The lengthy gap between exposure to the virus and the development of the disease makes it difficult to know and assess options about treatment, about work, about family. The development of new forms of antiretroviral therapy has created the possibility of living with AIDS, but we do not know if resistant strains will develop. The rapidity and virulence of the epidemic in Africa make clear that vulnerability to the risk of AIDS is not equally shared yet probabilistic calculation shows there is no absolute correlation between poverty and the disease. Provident behaviour thus requires that all entertain the possibility that they are at risk and creates a basis for co-operation between the rich and the poor.

Although liberal values imply that the human rights of those who are HIV+ or suffering from AIDS should be respected, what we have come to call the stigma of AIDS is also implicit in liberal discourse. Until the epidemic is so generalised that everyone is at risk, those living with AIDS can be construed as improvident subjects or as the other – those living outside or at the boundaries of the community – the migrant, the traveller, the prostitute, the gay man.

The dominant epidemiological model for AIDS prevention has focussed on exposure to the HIV virus, conceived as a moment of individual choice. The individual becomes an abstract statistical subject – the collective product of individuals exercising their 'right to choose'. Such a model does not assume that poverty and inequality play no role in deciding who gets AIDS and who dies from it, but their impact is thought to be indirect and long-term. The model suggests that the most pressing and effective task is to focus on prevention of exposure to HIV and to

deal with the proximate determinants of individual choice. In the absence of a vaccine against HIV, and given evidence of the predominance of the sexual transmission of the virus, this has come to mean that individuals must radically reduce the probability of exposure to HIV by practicing 'safe sex'.

In the critical literature on AIDS, this epidemiological approach is often called the 'bio-medical behavioural' approach. In their path-breaking work on the discourse of AIDS, Seidel and Vidal (Seidel and Vidal 1997) describe it as a medical discourse and link its pervasiveness to the structural dominance of medical provision and to the power invested in bio-medical culture in international agencies and health ministries. The term 'bio-medical behavioural' is, however, somewhat misleading. The problem with this epidemiological model stems from its underlying *sociological* assumptions. It is broadly based in liberal social theory – an image of how the rational individual subject can, should and does act, and thus appears eminently reasonable to many beyond the medical establishment. From this model follow the main elements of 'best practice' – those measures promoted by international institutions and backed by donor money – as a universal approach to AIDS.

2.1 Marketing Change in Individual Sexual Behaviour

The 'best-practice' package for AIDS assigns the minimization of risk through the pursuit of 'safe sex' a central place in HIV/AIDS prevention. Current angry squabbles over the funding for condom provision and the promotion of abstinence and stability of sexual partnership are important, but the basic assumptions of the ABC approach remain intact regardless of which letter receives the tonic.[5] This strategy of prevention is based on the assumption that if people practice risky sexual behaviour, they do so either because they do not have adequate information or because they choose not to understand the risk. The central tasks of a prevention strategy are thus providing individuals with the information they need to understand and avoid the risks of unsafe sex, persuading them to change their sexual practices and providing them with the means to organise their sexual lives with provident forethought so as to avoid the risk of either getting or transmitting HIV.

A distinctive feature of this approach to HIV/AIDS prevention is the importance given to techniques of social marketing: appealing to the self-interest of

[5] Abstain, Be faithful, use a Condom.

the ‘client’, using commercial advertising techniques to communicate ‘behavioural changes messages’ and promoting distribution of health services and products through regular market channels. Underlying the emphasis on using the polished suasive techniques of commercial advertising is the assumption that the principal problem in HIV/AIDS prevention is not information but attitude – people must be persuaded to act in their own interest.

The use of social marketing in public health interventions has its roots in public interest or advocacy advertising, a field that assumed particular importance in United States society (and in the curricula of U.S. business schools) in the post World War II period (Rutherford 2000). Advocacy advertising applies theories of consumer behaviour developed for advertising to the selling of goods, particularly ideas, considered to be of social value.[6] The objective is to create demand for something to which people are deemed not to give sufficient importance – such as the noxious effects of smoking, or, in condom social marketing, to the risks of unprotected sex.[7]

There is a common profile in social marketing approaches, exemplified by the initial ‘best practice’ approach to HIV/AIDS prevention, which focussed on condom social marketing. First attention goes to the product: finding a catchy brand name for condoms (e.g. the Defender), packaging them attractively and distributing them through standard market channels. Market research is done to identify messages appropriate for different segments of the market. Polished media campaigns are designed to reach target groups. ‘Peer educators’ are trained to use dialogical methods – theatre, role-plays, phone-in radio shows. Local and international celebrities and opinion leaders are brought in to endorse the campaign.

Exposure to the marketing campaign is expected to convince people to change their behaviour because they come to perceive it to be in their individual interest to do so. As people are bombarded with verbal and visual messages that appeal to their particular experience and come from sources that they trust, their consciousness is transformed, or put more cynically, the message becomes reality. The line between public interest advertising and propaganda is thus potentially thin.

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[6] The classic text by Zaltman, Kotler and Kaufman argued that programmes intended to influence the acceptability of social ideas could draw on the techniques of commercial advertising: product planning, pricing, communication, distribution and marketing research. In the jargon of social marketing, these are referred to as ‘the four Ps’: product, price, place and promote. Kotler has recently published a new definitive text ((Kotler, Roberto, and Lee 2002, Singhal and Rogers 2003).

[7] The conceptual grouping of sexually transmitted diseases with unwanted pregnancies as ‘unsafe sex’ has prompted the apparently illogical linking of HIV/AIDS prevention to genocide.

The expertise in developing social marketing programmes for HIV/AIDS prevention has usually been contracted from one of a set of large international social marketing organisations originating in the United States and classed under United States law as non-profit private voluntary organisations (PVOs).[8] Most of the large PVOs now implementing social marketing approaches to HIV/AIDS prevention in Africa draw on experience in applying social marketing techniques in family planning programmes, for which USAID has been for decades a leading donor (Warwick 1982).

Many social marketing programmes now market much more than condoms – HIV testing, tolerance, home-care, even life style. The 'voluntary' in VCT (voluntary counselling and testing) once meant the right to informed consent by those tested at sentinel sites; it now means giving people a service they can choose to buy. In contexts where the epidemic is well-established, avoiding risk is easier if one knows one's HIV status and that of one's partner. Walk-in voluntary counselling and testing centres have been set up; the new forms of testing that make instant results possible are made available at subsidised prices. Advertising campaigns create demand for VCT by emphasising 'the right to know'.

There is a certain ethical ambiguity in pitching HIV/AIDS prevention in terms of the individual's 'right to know'. Avoiding risk through condom use and testing is obviously in the individual interest of those who are not HIV positive, but it is difficult to see what individual advantage accrues to the person who is already HIV positive if treatment is not generally available.[9] Most social marketing programmes recognise this problem and thus include a campaign component aimed at reducing the stigma of AIDS – explaining why those who have AIDS are both needy and worthy of support.

Marketing life-styles means providing messages on how to challenge gender relations, how to live healthily with HIV, on why an HIV positive person is not to be blamed. A particularly polished example is loveLife Corporate, South Africa's national HIV prevention programme for youth, which markets the advantages of a

[8] Major actors include the Futures Group, Population Services International (PSI), Family Services International (FSI), Family Health International (FHI) the Population Council, John Snow, the International Planned Parenthood Federation (IPPF) and Marie Stokes.

[9] Weak demand for VCT in some countries, low uptake of test results, and violence against HIV positive women who reported their results to partners led to some hesitancy about extending VCT.

positive healthy life style.[10] LoveLife has a broad range of activities, including a network of peer educators – the groundBREAKERS – some travelling through the country on the loveTrain or loveTours, others working in Y-centres ('youth centres providing HIV education and health services in a recreational environment'). It has catchy youth oriented publications – S'camtoPRINT, thethaNathi (let's talk together), loveFacts – sponsors sports contests, operates regular radio and television talk shows and designs eye-catching billboards.

As long as the boundary between prevention and treatment was clearly maintained, the centrality of social marketing in AIDS 'best practice' sat happily with neo-liberal approaches to health care reforms. They share both the language of consumer choice that redefines a patient as a client and a preference for market solutions. The conjuncture of growing morbidity and mortality and the development of antiretroviral therapy (ART) have effaced the boundary between prevention and treatment and exposed the instability of the earlier 'best practice' package. With the availability of ART, there is now a much stronger rationale for VCT – not just a right to know but as an entry to treatment. Yet even if antiretrovirals are to be provided at accessible prices, they must be carefully administered and monitored. Opportunistic infections must be treated. Liberal norms of social justice demand that norms of care and treatment apply to those who are not HIV positive as well as those who are. How can this be done?

2.2 Mainstreaming AIDS: Community Involvement and Private-Public Partnerships

Current public health systems in southern Africa clearly cannot cope with rising AIDS morbidity as well as new demands for antiretroviral therapy. Moreover, the results of prevention programmes based on condom social marketing have had disappointing results. Current orthodoxy has found a common response to both of these problems: 'mainstreaming' AIDS. There is no critique of the 'best practice' package *per se*. The problem is rather the limited scale of its implementation, having to do both with insufficient funding and lack of participation by civil society.

[10] I have drawn this listing of its activities from the loveLife web-site. My spelling of these 'branded names' is correct. Marketing psychology must have some directives on using unexpected type sequences to draw the attention of the customer. See Epstein (2003) for a good critical description of the loveLife programme.

Classic condom social marketing programmes are now viewed as top-down efforts that did not effectively relate to the values of the community, particularly those of religious groups, and failed to enlist political leaders in their campaigns.[11] Their approach to HIV/AIDS prevention is thought to have been too technical and too narrowly focused on the health sector.[12.]There is a new 'best practice': HIV/AIDS prevention must be brought out of health ministries; a broad range of civil society groups should be involved in care and even treatment as well as prevention; and resources should be decentralised to give these groups greater access to funding.

In the evolving 'best practice' package, a country that is making a serious effort to confront AIDS should have a particular set of institutions. There should be a National Aids Council, located outside health ministries, and preferably with a high degree of autonomy. It is a co-ordinating body charged with bringing government together with private enterprise, voluntary organisations and donors in the campaign against AIDS. There should also be a local NGO linking voluntary organisation providing support to those living with AIDS, and which should be an affiliate of the International Council of AIDS Service Organisations (ICASO), which is supposed to be the umbrella body for all civil society organizations working on support to those who are HIV positive across the world.

The new mainstreaming orientation guides donor funding priorities. Over half the US$ one billion in the World Bank's Multi Country HIV-AIDS Programme (MAP) for Africa is expressly reserved for grassroots organizations and other civil society groups.[13] USAID has long had a strong preference for working with non-governmental organisations rather than national governments, but funding for local NGOs has until recently generally been channelled through U.S. PVOs. It has now decided that more aid should be given directly to local NGOs.[14]

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[11] Uganda's apparent success in reducing HIV prevalence is said to be based in such community involvement and 'political will', usually understood as Museveni's open approach to AIDS.

[12] World Bank, Intensifying Action Against HIV/AIDS in Africa, http://www. worldbank.org/afr/aids/map.htm, read 31.7.03.

[13] Keith Hansen Manager of the AIDS Campaign Team for Africa, The World Bank, letter of response to H. Epstein, *New York Review of Books* 50 (8): p.57.

[14] Local NGOs generally lack social marketing experience, however, and thus use aid funds to contract PVOSs as service providers. The largest PVOs had already been able to mitigate the problems of over-dependence on a single donor and the current ideological vagaries of the Bush administration on sexual education by turning to the new corporate philanthropies, the Gates and Clinton Foundations, and by internationalising, obtaining contract funding from European development agencies.

As the boundary between prevention and treatment has become blurred, 'communities' are now called upon to do what government health services cannot manage. In many African countries health spending is heavily dependent on donor funding. In these countries, public health systems have been obliged to embrace the principles of health sector reform. They should work towards a system where informed clients purchase appropriate forms of care in the market, voluntary community groups pool their resources to complement what the market offers, and the state provides only a complementary or residual role. If government is involved directly in care, it should submit competitive tenders to itself to assure that it is not stifling initiatives by private providers.

Private-public partnerships are encouraged. Enterprises may be willing to sponsor social marketing or VCT or antiretroviral drug therapy in order to maintain the productivity of their labour force. Members of religious groups may assist public health services in providing back up 'home-care' for terminally ill AIDS patients.[15] Teachers and shop-owners can be trained to participate in the monitoring of ART treatment. More broadly, in the name of corporate responsibility, enterprises and privately funded philanthropic foundations, many of them U.S. based, have become major AIDS donors. loveLife is a good example of a private-public partnership. Both direct funding and in-kind support come from private foundations and companies well as government.[16] 'loveLife Corporate' has 'loveLife franchises', affiliated community groups contracted to carry out its programme at a local level.

Mainstreaming AIDS does not require any fundamental change in the principles of social marketing. Advocacy advertising has always emphasised the involvement of civil society in the marketing of public goods, in part to ward off the spectres of propaganda and manipulation.[17] Mainstreaming remains firmly rooted in

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[15] See J. Geberding, (2004) Steps on the critical path: Arresting HIV/AIDS in developing countries. PLoS Med 1(1): e10, director of the CDC (US center for disease control), currently playing a major role in HIV/AIDS programmes in Africa for the rationale for home-care in the current best-practice package.

[16] Direct funding is from the Henry J. Kaiser Family Foundation, the Bill and Melinda Gates Foundation, the South African Government, The Nelson Mandela Foundation, The Global Fund for HIV/AIDS, TB and Malaria, the Anglo American Corporation. Major in-kind support is provided by the South African Broadcasting Corporation, Independent Newspaper Group and Times Media Ltd. Additional Corporate support is provided by Avis, Comutanet, Mondi Paper, SAA, Spoornet, Ster-Kinekor, UU-Net and Vodacom. The chair of loveLife's advisory board is the well-known ANC figure,Tokyo Sexwale, now chairman of Mvelaphanda Holdings and formerly premier of Gauteng. http://www.lovelife.org.za/corporate/.

[17] Remember the critiques of McLuhan (1965) and V. Packard (1957).

the discourse of the market – members of religious groups assisting desperately poor terminally ill AIDS patients are trained to refer to them respectfully as their 'clients'. Though the poor may remain poor, voluntary associations can help them to survive through building their 'social capital'.

There are some peculiarly U.S. constructions in the current 'best practice' project. One is a populist emphasis on 'participation', which characterises civil society as local communitarianism (Anheier 2004). Also particular is the elision implicit in the terms NGO or PVO which are used to characterise both non-profit enterprises that employ workers to deliver services and membership-based mutual assistance groups.[18] Nonetheless, apart from some discord around whether enough attention has been given to abstinence and fidelity in the ABC recipe, the 'best practice' package dominates the agenda of the global HIV/AIDS establishment.

2.3 Significant silences: the academic critique and the liberal response

Some social scientists, particularly anthropologists and those of the left, have been robust critics of the sexual behaviour modification focus underlying social marketing approaches to HIV/AIDS prevention (Barnett and Whiteside 2002, Farmer 1997, Farmer 1999, Fassin 2004b, Klein, Easton, and Parker 2002, Parker 2001, Schoepf 2001, Seidel and Vidal 1997, Stillwaggon 2002, Turshen 1998, Vidal 2000). They argue that it makes no sense to put the freely choosing universal subject, ripped out of any particular historical context, at the centre of policy concern. The context of choice is from the outset one of inequality. Gender inequality is a particularly flagrant example since the choices that many women make about their sexual behaviour are clearly not free.

More generally, critics point out that the bio-medical approach does not explain why people were in a situation of vulnerability to begin with. They argue that focussing on sexual exposure to the HIV virus has failed because it abstracts from underlying social processes. AIDS, like other epidemics before it, is imbedded in structures of poverty and inequality, which can and should be addressed now (Farmer 1999). To take a southern Africa example, social causes of vulnerability to sexually

[18] The term CBO is now often used for membership organizations to capture this distinction. Hall (Hall 1999) notes that contrary to American ideology PVOs are a post WWII phenomenon in the United States, largely a response to government contracting out services that were once considered its responsibility.

transmitted diseases include gender inequalities and migration systems predicated on spousal separation, residential hostels and commercial sex services. Why should not the dismantling of the hostel system be a focus of policy?

The left critique of standard HIV/AIDS prevention has found little official resonance in Africa. Although African leaders are regularly criticised for failing to show the 'political will' demonstrated by public prevention campaigns in Senegal and Uganda, Thabo Mbeki is the only leader who has openly questioned the assumptions behind 'the best practice' approach. This absence of official dissent is notable given the frequent sub-text of 'politically incorrect' positions expressed in letters to the newspaper, phone-ins, remarks by ministry officials, or casual conversations with friends. There dissenting comments range from suggestions that AIDS is a conspiracy imposed by the rich countries on Africa to doubts about the skewing of public health budgets towards AIDS prevention and treatment. It is remarkable that a strategy putatively based on a liberal model of democratic participation has led to so little open policy debate on these issues, despite the continuing spread of HIV/AIDS.

It may be, as Seidel and Vidal (op cit) suggest, that the resilience of the 'best practice' approach derives simply from its present hegemony in international agencies. The World Bank, one of the main promoters of social marketing, as well as market-oriented health sector reform, has become lead donor for health in many African countries. A consultancy report from the Futures Group noted the proportion of the HIV/AIDS budget going to prevention as opposed to treatment was directly related to the proportion coming from donors (Bollinger and Stover 2000 pp. 16-17).

There are, however, other possible reasons for the resilience of the 'best practice' approach. One is the difficulty in turning the poverty and inequality critique into an alternative agenda. This in part derives from the appropriation of the poverty critique by the denial strategy of the dissidents (a point to bear in mind when considering Thabo Mbeki's position). But structural explanations of AIDS can also appear to have profoundly pessimistic implications. Poverty in Africa is long-term and profound. Further, epidemiological patterns suggest a complex relation to poverty – AIDS kills both rich and poor and has decimated relatively rich countries such as Botswana and South Africa. Must we resolve the problem of poverty in order to address AIDS or must we rather address AIDS to prevent the deepening of poverty? Green (2003), for example, strongly endorses Uganda's approach because it reduced

HIV prevalence despite pervasive poverty.[19] Similarly cannot the forms of AIDS prevention explicitly address gender inequality and thus empower women?

Perhaps even more important for the resilience of 'best practice' is the political legitimacy it derives from the compatibility of rational actor models with liberal theories of citizenship. Liberal theory recognises after all that structural inequalities are reflected in the market and predicts that they will lead to imperfect market outcomes. This proposition is what neo-liberals and social democrats share. It has thus not been difficult for the social marketers to recognise that gender inequalities skew the context of choice. Shaping more egalitarian attitudes towards gender has been absorbed into the programmes for 'peer educators', and women's community organisation are brought into HIV/AIDS campaigns. If poverty makes people vulnerable to HIV/AIDS, then the participation of the poor in advocacy groups will make it possible for them to demand the rights of citizens, or they may join voluntary organisations to provide alternative forms of care. If those living with AIDS in developing countries have treatment options much more restricted than those in OECD countries, advocacy groups can appeal to the emancipatory discourse of universal human rights to demand global norms of treatment, including access to ART.

Thus advocacy advertising has been able to agree with its critics that earlier forms of 'best practice' 'over-medicalised' AIDS. The answer is to be found in 'mainstreaming AIDS', mobilising civil society, forging new partnerships between government and corporations, achieving a collective change of mentality towards AIDS rather than simply an individual assessment of risk. The political response to AIDS demanded by the critique of best practice has thus been subsumed into the 'best practice' package.

2.4 HIV/AIDS and the mandate for a public health system

This vision of a pluralistic informed citizenry confronting AIDS hides an important lacuna in HIV/AIDS best practice. AIDS may be a social problem, but it also remains a medical problem, a question of prevention, treatment and care if not healing. There are substantial grounds for thinking that at the level of a particular population both the

[19] I assume that Green's doubts about condom social marketing are real, not the result of his being embraced by the US fundamentalist anti-condom lobby.

probability of HIV infection and the experience of morbidity and mortality are strongly shaped by the functioning of public health systems. With the advent of ART, the blurring of the boundaries between prevention, care and treatment also effaces the political and ethical boundaries between those who have HIV/AIDS and the rest of the population who may not have AIDS but are chronically or seriously ill.

It has long been considered probable that co-infection by ulcerating sexually transmitted diseases increases vulnerability to HIV infection (Ferry 1995), and recent work suggests that other STDs also do so (Cohen 2004, Hanson et al. 2005). It is also considered possible that co-infection by other parasitic infections or chronic diseases such as malaria, hepatitis, schistosomiasis and tuberculosis that affect the immune system may contribute to the efficiency of heterosexual transmission of HIV (Ferry 1995). More generally, some suggest that, as in the case of other infectious diseases, poor nutrition and general health may affect resistance.

Whether or not co-infection contributes to HIV transmission, there is no dispute about the fact that co-infection and the state of the immune system shape variability in trajectories between infection, immune system collapse and AIDS mortality. The time from infection to death, kinds of illness and conditions of suffering vary greatly among those who die of AIDS. Access to antiretroviral therapy has prolonged life and allowed some of those who are HIV positive to work productively. It also can play a role in prevention: it limits mother-child transmission in childbirth, lessens the probability of heterosexual transmission, and it provides an incentive for testing.

Pools of endemic infection within the general population expose those who are HIV positive to diseases such as tuberculosis. Tuberculosis interacts symbiotically with HIV, leading to high rates of incurable tuberculosis among those who are HIV positive who in turn replenish pools of tuberculosis infection. Packard's (Packard 1989) classic work on tuberculosis in southern Africa traced the ways in which poor working and hostel conditions for black workers on the mines led to silicosis and tuberculosis returning with migrants to rural communities. Well before the rapid increase in HIV prevalence, southern Africa had high rates of passive presentation as well as notified TB cases. Whatever the link between co-infection and vulnerability to HIV, it is clear that in a context of endemic malaria, tuberculosis and sexually transmitted infections, one should be prepared for high HIV-related morbidity and mortality.

The interdependence of HIV/AIDS and other health problems makes it difficult to isolate HIV/AIDS prevention, treatment and care from other areas of health provisioning. For political as well as ethical and practical reasons, it is not easy to separate the diagnosis and treatment of the various opportunistic infections that consume those who have developed AIDS from diagnosis and treatment for those suffering from tuberculosis, recurrent chronic diarrhea, malaria, or sexually transmitted infections who are only potentially HIV positive. If the quality and availability of health care matter both for rates of infection and for the progression of the disease, then treatment and care for those who are HIV positive has to be co-coordinated and balanced with treatment and care for those who are not HIV positive but who have similar health problems.

Public health experts are quick to remind us that in the long-term improvements in livelihood and nutrition may be more important for public health than are medical interventions. But AIDS is an immediate medical problem. There are reasons for thinking that the quality of the general public health system affects AIDS morbidity and mortality as well as the general health of the population. Non-clinical STD diagnosis and treatment do not work well for women, nor for the kinds of chancroid infections particularly associated with HIV. Reliable laboratory testing treatment regimes are required. To address chronic or endemic dysentery, malaria, hepatitis, trypanosomiasis, tuberculosis, leprosy or bilharzia the functioning of broad preventive public health programmes – including immunization and water-control – are required. Responding to co-infection means having reliable information, laboratory testing and drug-stocks. It requires a permanent cadre of trained health personnel, facilities with water and electricity, a reliable cold-chain and the availability of transport.

Poor public health systems give rise to nosocomial infections, those transmitted by health practitioners in either the formal or informal health sectors. Gisselquist and others have argued that more attention should be focused on HIV transmission through contaminated blood, particularly through needle exchange (Brewer et al. 2003, Gisselquist et al. 2003) Clinical transmission through transfusion of infected blood is not thought to be a major source of infection in African countries since WHO/UNAIDS programmes have supported the development of blood testing programmes and access to clinical transfusion is limited. Needle exchange and faulty sterilisation of cutting instruments are, however, another matter. Disposable plastic

syringes (that cannot be sterilised), widely introduced in health services in developing in countries in the 1980s to reduce infection through blood transfer, are resold in markets across Africa.[20] Incidence of injection use is high in many developing countries. Ferry (Ferry 1995) reviewed risk factors related to HIV infection in a WHO sponsored study of the relation between sexual behaviour and AIDS in developing countries. He found that in almost all the areas studied, a very large proportion of general population aged 15-49 had received multiple injections in the last 12 months. The roundly negative response to the questions raised by Gisselquist *et al.* by UNAIDS and the WHO was thus somewhat surprising.[21]

In contexts of great poverty and inequality, new treatment options cannot be organised on a mainly commercial basis. It would be neither ethical nor practical to leave the market to organise the diagnosis of those who are HIV positive or to decide who will receive ART and under which conditions. The social marketing approach to VCT treats testing as a commodity that individuals must be convinced to buy, but from a public health point of view it is a tool for monitoring the progression of HIV prevalence and assessing preventive measures and planning treatment responses. Testing facilities must thus be located so as to provide reliable estimates of prevalence whereas responding to demand will concentrate facilities in areas of high prevalence where people can afford to pay. HIV transmission from mother to child in the birth canal or through breast milk can be treated by short-term antiretroviral treatment of HIV positive mothers if they have access to clinical care. Making ART widely available requires not just that manufacturers reduce prices; it means investing in the training of personnel and the expansion of laboratory facilities.

Such a public health system does not necessarily have to be a single government operated National Health Service. One could envision government regulation and subsidy of commercial and non-profit health providers. But in most of southern Africa, levels of poverty and inequality are so high that this would have to be a redistributional public health system; i.e. it could not rely on mobilising the savings of the poor.

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[20] Recognition of this problem underlies the use of self-destructing disposable syringes in the new global immunisation initiative (Brugha, Starling, and Walt 2002).

[21] Gisselquist's work was compromised by a tendency to overstate his results and thus to align himself too closely with the dissidents in the 'sex doesn't explain it' camp. His argument is based in part on negative statistical evidence on the association between rates of HIV infection and mortality. It is not clear, nonetheless, why the 'right' to a clean needle or sterile blade should not figure in HIV prevention campaigns.

What chance, then, that the idioms of associational democracy and partnership promoted by the best practice package can respond to the redistributional public health system that would be needed to confront AIDS in southern Africa? In Marshall's (1998) classic formulation, social rights evolved much later in Europe than did civil and political rights. The emergence of social citizenship was linked to the political articulation of class and grounded in the rights of organised workers (and thus notably more uneven in the extension of these rights to home-workers and those working in what we now call the informal sector). Can we expect political processes in southern Africa to reproduce the basis of social liberalism in a very different historical context?

Here is where the communitarian populism of the current 'best practice' approach to HIV/AIDS is problematic. The poor, particularly poor women, are likely to be excluded from advocacy groups, because they face discrimination, because they are often illiterate and because they have less time to organise, particularly when there are also charged with taking care of the ill and dying. Trade unions lobby on behalf of their members, but in many Southern African countries they represent only formal sector workers, covering only a small part of the population. Is the contingency of AIDS sufficient to create a moral community of risk in which those who have access to ART and commercial health care are willing to be taxed to provide it to those who do not?

The next section of this paper suggests that the answer to this question is no. Looking at two different but related experiences of HIV/AIDS, those of South Africa and Mozambique, it argues that in the present context of global capitalism, the discourse of liberal citizenship cannot mount the political challenge to rights of property that a redistributional public health system would demand.

3 HIV/AIDS AND THE POLITICS OF PUBLIC HEALTH IN SOUTH AFRICA AND MOZAMBIQUE

Mozambique and South Africa share similar languages and a common history of settler colonialism. They are also united by at least four generations of oscillating migration from southern Mozambique to the mines, farms, and now street-corner businesses of South Africa. In both, the parties in government have retreated from their former discourse of socialism to the discourse of liberalism. The rapid evolution

of their HIV/AIDS epidemics through the 1990s is also similar. Yet in many ways they are very different – in wealth, in economic and class structure and in their institutions of governance.

Though both governments signed themselves up for the liberal economic policy espoused by NEPAD, their positions within global markets are quite different. South Africa has a powerful capitalist class of international scope. All state enterprises have now been privatised in Mozambique, but domestic accumulation is still largely based in political privilege. Processes of proletarianisation are much more firmly rooted in most regions of South Africa than in Mozambique. This is reflected in patterns of settlement, but also in the impact of the current decline in demand for formal sector workers. South Africa has a large unemployed population while in Mozambique the impact of declining demand for labour on mines and plantations is hidden by the claims that the rural population has to land.

Absolute poverty is much higher in Mozambique than in South Africa (whether one uses income or social indicators), but inequality is much lower. South Africa's Gini coefficient was 59.3 in 1994 while that of Mozambique was 39.6.[22] South Africa has much larger and also more established middle-classes although racial divides remain important. Much has been made of the role of the 'mulatto elite' in Mozambican politics, but currently regional tensions are more important than racial differences. Whereas in Mozambique social expenditure is heavily dependent on donor funding, South Africa mobilises substantial tax revenues domestically for health and education. Its pension scheme reaches most rural households.

Both countries have formally adopted liberal constitutions.[23] Each extends a series of basic rights to its citizens, though South Africa's list of rights is much longer and more detailed.[24] It includes specific reference to gender equality and includes the rights to health and education as two fundamental human rights. Even more importantly, legal struggles waged with reference to rights have had a much more important political role in South Africa, including under *apartheid*, with corresponding legal expertise available for all sides.

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[22] See table A1 in the appendix for a comparison of Gini coefficients in the 1990s.

[23] Mozambique's 1990 constitution, in an explicit rejection of its earlier socialist charter, wrote the market-economy into the text.

[24] There was, however, an intense political debate over the right to citizenship of those who were treated as Portuguese citizens under colonial rule. See O'Laughlin 2000.

The racial divide in political institutions was abrogated in 1975 in Mozambique, but only in 1994 in South Africa. Nonetheless South Africa has a much better established and pluralistic civil society. The trade union movement, though mainly urban and industrial, plays an important and increasingly independent political role. The unions in Mozambique in the socialist period, like all recognised mass organisations, were organised by Frelimo. They are active in national lobbies in Maputo, but their provincial bases are weak. Religious organisations were discouraged in Mozambique during the socialist period. Today, as in South Africa, independent evangelical groups are active in both rural and urban areas. Traditional congregations – Catholic, Protestant and Muslim – are urban based. The UDF, an explicitly cross-class front played a key role in opposing *apartheid*. Frelimo set up liberated zones, but was not able to operate organisationally outside these areas during the war. South Africa has a large, diverse and independent media sector. New media ventures appear nearly every month in Mozambique, particularly local radio stations, but with limited coverage most people have no choice about what they listen to (Bonin 1999).

The role and heritage of the civics formed in the transition period as community based organisations in South Africa is a subject of debate, as is the impact of youth revolts. The civics were in practice a form of alternative government that withered with the transition (James 2004). Youth revolts were central in 'making South Africa ungovernable', but have been accused of further weakening the fragile social fabric (Van der Vliet 2001). On the other hand, movement connections and experience are seen as the basis for successful coalition building today (Petchesky 2003, Robins and Von Lieres 2004). Similar issues are raised by the experience of neighbourhood and community 'dynamising groups' in Mozambique. Current convention is to treat them simply as instruments of Frelimo rule, but many new community organisations take both their language and organisation from this earlier experience.

The funding basis of voluntary associations differs sharply in the two countries. South African NGOs obtain grants from development agencies but also mobilise contributions domestically from government, enterprises, and local donors. In Mozambique, local NGOs are overwhelmingly dependent on development agencies or international federations. Despite all these differences, throughout southern Africa

sharp inequalities compromise the capacity of liberal politics to determine equitably who will receive ART and how it will be organised.

3.1 Confronting AIDS: Citizenship, social rights and ART in South Africa

South Africa is clearly not a representative case as far as the politics of AIDS in southern Africa are concerned. It is an important case, however, for if the liberal approach to AIDS interventions fails in South Africa, then we would certainly not expect it to do better elsewhere in the region where the institutions of liberalism are less firmly established.

Although estimates on the prevalence of HIV and the evolution of the epidemic vary, there is general accord on certain patterns. HIV prevalence increased dramatically through the 1990s. There is regional variation in the extent of HIV infection with particularly high prevalence in the cluster of provinces with a long history of labour immigration: KwaZulu-Natal, Gauteng, Mpumalanga and Free State.[25] Prevalence rates are now higher for women than for men, higher in the age group from 25-34 than in other cohorts and much higher for people who are black than for other racial/ethnic groups. There is also consensus that the impact of AIDS is reflected in disproportionately increased mortality rates among people aged 25-49 years, and in the particularly sharp increase in tuberculosis deaths (Harries, Hargreaves, and Zumla 2003).[26]

South Africa has had various classic social marketing AIDS prevention programmes since the late 1980s, usually implemented by groups with family planning links. Van der Vliet (2001) points out that effective prevention programmes would have been difficult to carry out in the political climate of that time. Community groups were unwilling to cooperate with government, there was deep and (justifiable in some cases) suspicion of the racialist genocidal motivations for sex education programmes in schools and family planning programmes. The number of registered cases of AIDS was also very low.

In the optimism of the period of transition, NACOSA (National AIDS Coordinating committee of South Africa) was formed in 1992 with a broad prevention

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[25] From The South African Department of Health Study 2004, as posted by AVERT, http://www.avert.org/safricastats.htm, downloaded 15 September 2005.

[26] For current HIV/AIDS statistics and a good methodological discussion of the reasons for variation in estimates, see AVERT (op. cit.).

programme and participation from political parties, trade unions, business, civic associations, churches, academic, government departments, AIDS service organizations and others (Robins and Von Lieres 2004, Van der Vliet 2001). After a number of misconceived initiatives, government largely withdrew from an active role in HIV prevention, leaving the terrain to NGOs.[27]

The conjuncture of two processes forced the ANC government back into a central place in AIDS politics. The rapidly growing number of AIDS patients strained medical resources, particularly hospital care, while at the same time new possibilities of sustaining life with ART were revolutionising treatment in the OECD countries. Pressure mounted on government to mobilise treatment resources and particularly to extend access to antiretrovirals. It was at this point (2000) that Mbeki openly proclaimed – in a letter addressed to the leaders of the world and in his speech at the Durban conference – that while South Africa was assiduously carrying out standard HIV/AIDS prevention programmes, he was less than convinced that HIV was the cause of AIDS. He hinted some support for the dissidents' position that ART is a worthless and possibly noxious treatment pushed by profit-hungry pharmaceutical companies.

There is a substantial literature on the political response to AIDS in South Africa (*inter alia* Fassin and Schneider 2003, Furlong and Ball 2005, Willan 2004). Much of it focuses on questions of 'political will' and Thabo Mbeki's controversial position on the links between HIV and AIDS. Government ambivalence is thought to underlie weak involvement in behavioural change programmes and resistance to making antiretroviral drugs widely available as a treatment option. Two recently published important books (and related articles) make it possible to question some aspects of this account (Campbell 2003, Fassin 2004a).

One of the many merits of Fassin's work (Fassin 2002, Fassin 2004b), and of Posel's (Posel 2004, Posel 2005) more detailed reading, is the analysis of Mbeki's texts as political interventions. They were not simple expressions of idiosyncratic hubris, but resonated within the ANC and more generally among many black South Africans. Both the patterning of the epidemic and the response to it have their roots in the long-term structural inequalities inequalities of *apartheid*: racial differences in

[27] Funds wasted in mounting the Serafina play and bogus claims of finding a South African treatment for AIDS –Virodene.

political rights, income, social provisioning, employment and corresponding patterns of mobility; gender inequalities expressed both in gender violence and conceptions of sexuality (Fassin and Schneider 2003, Schneider 2004).

Suspicion that in its focus on African sexuality the South African health establishment was out to destroy the black population was grounded not only in the dualistic inequality of the health system but also in real attempts to do so during *apartheid*. The need to reproduce the African nation against this assault was a theme and objective of young ANC sympathisers in the townships in the 1980s, sometimes with bitter consequences for young women (Niehaus 2000).[28] Fassin and Schneider suggest that Mbeki's political failure had also to do with the silences in the 'best practice' approach to AIDS:

> Had a coherent social epidemiology of HIV been more prominent in the scientific arena, rather than the dominant biomedical and behavioural approach, Mbeki might have found interesting alternatives to the explanations of the epidemic given on the dissidents' websites(Fassin and Schneider 2003 p. 495).

At the same time, Mbeki's political indictment stopped short with *apartheid* and its legacy. He has offered no critical reflection on the ANC's own faithful adherence to liberal economic policy post-1994 or to its commitment to reform mediated through the maintenance of property rights and a liberal judicial system (and thus, for example to a cautious approach to land reform).

A consequence of Mbeki's emphasis on the expense and possibly noxious side-effects of ART has been to focus the critique of government AIDS policy on access to treatment. A major role in mobilising this pressure was played by TAC (the treatment action campaign) that used connections and tactics of the anti-*apartheid* movement (including civil disobedience) to build an alliance that cut across racial and class divides (Furlong and Ball 2005, Meerkotter 2005, Petchesky 2003, Robins and Von Lieres 2004, Willan 2004). TAC employed the language of rights to press legal challenges in the South Africa courts against government policy on antiretrovirals and to force pharmaceutical companies to accept the importation of cheaper generics. Antiretrovirals are now administered to pregnant women, to workers by some

[28] Niehaus (2000) provides a poignant possible cross reference to Mozambique. Young militants in Lebowa obliging young women to have unprotected sex so as to produce new soldiers for the nation called this 'Operation Production', the name Frelimo used for the campaign that obliged the unemployed to return to rural areas.

enterprises, and in experimental programmes in some government health facilities and community programmes.

One risk in TAC's victory is that the social marketing approach to HIV/AIDS prevention (which was after all not explicitly challenged by Mbeki) remain unscathed, free to attribute its lack of results to the lack of political will shown by ANC leaders. This has not happened. Some involved in HIV/AIDS programmes and research have reflected critically on their own practice. Campbell's (Campbell 2003) dissection of a prevention programme in 'Summertown' a mining community in Gauteng, is a case in point. Instead of taking 'political will' as a measurable property, Campbell breaks it down to show what it meant for all 'stakeholders' involved.[29] The programme began in the late 1990s when the critique of narrow condom social marketing approaches was already established. It was funded by an international development agency and was the result of an alliance between a local council and a group of academics. Nonetheless, Campbell (2003) observes, the conceptualization of the project had a narrow definition of those who needed to change – mineworkers, sex workers and young people. These groups had no role in overall project management or decision making while those community leaders and middle-class groups who did were not obliged to confront their own gendered assumptions and attitudes towards AIDS.

Hayem's (2004) work in gold and coal mines of Mpumalanga provides another account of the difference between HIV/AIDS prevention 'for them' and HIV/AIDS prevention 'for us'. Initial efforts were mainly organised by management and followed the 'best practice' package for behavioural modification – videos during induction, posters, leaflets, theatre groups, peer educators, STD treatment for commercial sex workers living around the mines and VCT. Initial response was not good. The youthful peer educators were not accepted by the older miners, who also did not trust the mine health services to assure confidentiality nor management to refrain from dismissing HIV positive workers.

The situation improved when the NUM switched from a defensive posture on maintaining confidentiality and salaries to more active involvement in AIDS prevention. Miners spoke of the importance of being treated as people not things. Hayem notes a shift in language with miners expecting government and management

[29] This is another term taken from the specifically U.S. version of associational liberalism. Campbell's book is an example of liberalism's powers of self-critique.

to play a role but also accepting their own individual responsibility. This is illustrated by the initially puzzling quotation from a miner:

> I should be responsible for my health; It's a collective responsibility, it's for everyone, each should take care of himself (Hayem 2004 p. 203).

Hayem's interpretation of this statement presents the miners as provident liberal subjects: aware of the risks, demanding accountability from others but ultimately responsible for themselves:

> In the opinion of all, if protecting oneself is one's own responsibility, it is because this protection follows from a decision that in the last instance has to be that of the individual concerned 'because there it's you who choose and you alone (Hayem 2004 p. 222).

Does not the South African case illustrate, then, the capacity of liberalism to generate its own self-critique? Can we expect the participation of community organizations to lead to a collective change of consciousness on HIV/AIDS?

There are some loose ends, implicit in a less optimistic interpretation of the miner's 'each should take care of himself'. In a world of deep inequality, like South Africa, surely that capacity is very unequally shared. One division is in the world of work itself – between those with secure employment and the vast numbers in South Africa who are unemployed or casual workers. In the Summertown survey, miners were fatalistic about AIDS. They linked their insecurity about their future health to their insecurity about greater job losses, contracting out, and casualisation (Campbell 2003 p. 156).

Masculine insecurity about work is at least part of the reason for the upsurge of sexual violence in South Africa. When peer educators are truly peers, their own attitudes on gender and sexuality mirror those of those whose consciousness they are expected to transform, often like themselves unemployed youth. The participatory method is supposed to be dialogic rather than didactic, but conversation quite often leads to the reproduction of images of inequality (James 2002, Seidel and Vidal 1997, Vidal 2000). The Summertown survey found that gender attitudes had if anything gotten worse in the five years of the project, though Hayem (op cit: 229) suggests that the NUM's participation changed images of masculinity in the Witbank mines.

Another problem that remains unresolved within liberal discourse is that which lurked behind Mbeki's speech. The introduction of ART definitively breaks down the boundary between prevention and treatment which in turn effaces the line

between HIV/AIDS and other forms of illness. Some companies have agreed to provide ART to their workers on grounds of productivity, but what happens when they become redundant? Who provides ART to their sexual partners? Who cares for those who die? How should the sharp rise in tuberculosis be handled? What kind of public health system can provide the response to these questions?

South Africa's public health system fits the normative image prescribed for most African countries under principles of health sector reform – those who can afford to pay for health care should be free to choose what they want while the state confines itself to regulation and residual provisioning for those who cannot afford to pay. *Apartheid*'s two-tier system based on race has given way to a two-tier system based on class (Benatar 2004), though in practice there is still considerable overlap between race and class.

The problem is the growing gulf between the two tiers. In the 1970s, 30% of all health expenditure was for the 20% of the population with private insurance; today 60% of health expenditure goes to the 18% with private insurance. In the 1970s, 40% of all physicians worked in the private sector; today it is 60% (Benatar 2004). Not surprisingly access to insurance reflects income, but as table 1 shows, it is also skewed against rural areas.

Table 1
Insurance coverage by quintile:
South Africa rural and urban 1996

Income quintile	% of those ill covered by an illness insurance	
	Rural	***urban***
1 (lowest)	1	5
2	1	9
3	2	22
4	4	49
5	16	72

Source: Schneider (2004 p. 95)

The result is enormous pressure on government health facilities, particularly hospitals and particularly in rural areas. Case-loads of government health facilities in rural Hlabisa illustrate this dilemma (Benatar 2004). HIV prevalence increased from 4% 1992 to 35% 2002. Clinic visits increased by 88% between 1991 and 2001. Hospital admissions increased by 81% between 1991 and 1998. Health workers are stressed and exhausted and up to 16% of them are also HIV+. It is not surprising that

campaigns to recruit South African nurses for European hospitals have been successful.

South Africa has followed the vision of 'best practice' for confronting this public health crisis, relying on private-public partnerships, philanthropy, development aid and appeals to self-help through 'community' participation. There are interesting efforts involving local traders and teachers in ART programmes that show that ART is not impossible for people who are poor and illiterate to handle. But these programmes also involve back-up by the government health service for laboratory monitoring and treatment of opportunistic infections.

Thus far home-care programmes for those with AIDS are the most important example of community participation intended to take the pressure off public facilities. De Wet's (2004) moving study of such home-care programmes in the Orange Free State raises some doubts about the meaning of such 'public-private partnerships'. Most of the volunteers participating in the home-care programmes are unemployed. The small government stipend (250-500 rands) they receive is their main income, though for some religion and a sense of civic responsibility also motivate their participation. The volunteers have limited training; their work is to show compassion rather than healing. They have no drugs or bandages, and sometimes no disposable gloves.

There is ample literature on the gender bias in home-care programmes, which often assume that women are able and more suitable than men to take on the burden of care. De Wet shows that this bias extends to the tasks of the volunteers – men are more likely to carry out the mental tasks of organization and counselling while women do the manual labour of bathing, feeding, cleaning and bandaging. But de Wet also unmasks the class bias in home care that sends those who cannot pay for formal care home to die. Misery afflicts not only those who are dying but also their families. In small dark houses without running water, families live with the daily stench of death. Volunteers are often asked for money to pay for food. De Wet asks whether the limited resources dedicated to such programmes might not be better spent on extending formal care.

There is one final loose end in the liberal appeal to communities to participate in 'mainstreaming AIDS' in South Africa. This is the problem of the imagined communities of immigrants ('the Mozambicans', 'the Zimbabweans', 'the Congolese'), most of them undocumented, who are seen by many South Africans as a

drain on their public health system (and a threat to their jobs and security). The rights of national citizenship do not apply to them, yet their patterns of living make them vulnerable to HIV/AIDS. At an epidemiological level it is clear that this vulnerability is shared with South Africans, but the discourse of citizenship construes this at best as a rather vague invocation of their human rights.

Nattrass characterises the government's hesitancy to make ART widely available as a restriction of the space for liberal debate among citizens:

> By locating the AIDS policy discussion in a seemingly technical discourse of affordability and sustainability, the space for public deliberation over the appropriate size of national treatment programmes has been sharply curtailed (Nattrass 2004 p. 17).

She thinks it possible that South Africans might be prepared to pay taxes to finance the expansion of the public health system that providing ART will require.

Nattrass may be right. Politics works within the possibilities and contradictions of context. South Africa provides good examples of how the liberal critique has been used from within liberal institutions to challenge the power of the drug companies, the inaction of capital, the reticence of government and the silences of media and public opinion. But, I would argue, the liberal critique requires a political viewpoint that comes from outside itself. TAC's success was based on mobilisation around a clear class issue that could unite racial groups against multi-national drug companies. Yet this egalitarian demand will rapidly become exclusionary if access to antiretroviral treatment is determined by the intertwining relations of race and class in South African society.

Without a challenge to the class base of the two-tier health system and the informal/formal structure of employment that underlies it, it seems unlikely that South Africa can avoid massive AIDS mortality. If such support is not forthcoming, the long-term dualism of the *apartheid* health system will be maintained in treatment of AIDS – ART for middle income groups and those working in the formal sector, particularly in urban areas; home-care and slow death for those in rural areas. To make a redistributive health system a political possibility will demand a change in the political discourse on AIDS – from the rights and responsibilities of the individual provident citizen to social goods.

3.2 Confronting AIDS: Global citizenship and the right to choose in Mozambique

If we look beyond the borders of South Africa to the other countries of the region with which its past and future are inextricably linked, appeals to the rights of citizens in a liberal democracy are even less likely to lead to the massive public health response needed to deal with AIDS. Mozambique represents the other end of the continuum – a place where ART will be available only on the basis of appeals to global citizenship.

If figures on HIV/AIDS are insecure in South Africa, this is even more true in Mozambique where available health and demographic statistics do not allow one to trace the evolution of the epidemic nor to estimate its consequences for mortality.[30] The first case of AIDS was diagnosed in 1986. Though war would seem to breed the conditions for its spread (mobile soldiers, sexual violence and destruction of health facilities), HIV prevalence and AIDS related mortality rose sharply only after the war ended in 1992.[31] In 2002, median national HIV prevalence among pregnant women attending ante-natal clinics was 13.6%, varying from 7.5% in Cabo Delgado to 19% in Manica (Moçambique 2004).

Mozambique has followed the familiar trajectory on AIDS prevention in Africa. A National Programme of Combat against AIDS was established in 1988 within the Ministry of Health did little beyond blood control during the war. Among the flood of INGOs working in health in the post-war period, some combined family planning with HIV/AIDS prevention.

The real take-off of condom social-marketing began at the time of elections in 1994, when Population Services International, known by its acronym PSI, arrived. PSI has trained and pays a network of 'community agents' assigned to priority districts. They organise focus group discussions that emphasise 'self-efficacy' (again the provident subject), defined as 'the confidence to purchase condoms, negotiate their use with one's partner, and use them correctly'. Theatre groups have been set up to

[30] During the war there was little public health information or service available outside the main urban centres. It was thought, however, that HIV prevalence was high along the Beira corridor (Manica and Sofala provinces) given high rates of prevalence in Zimbabwe, traffic along the Beira corridor and the presence of Zimbabwe troops protecting the corridor. It was also thought that prevalence was high in southern Mozambique, with its flux of migrants back and forth to South Africa. Sentinel site HIV prevalence testing set up in 1992 confirmed the high incidence of HIV infection in these areas. Testing sites were established in all provinces in 2000, generally confirming expectations about regional differences in the incidence of infection with some unexpected anomalies. Central and southern Mozambique still have the highest rates of HIV prevalence, but rates have begun to rise in northern Mozambique as well.

[31] This does not tell us that health conditions declined but rather that AIDS acts like other epidemics.

tour all the provinces with plays such as 'Only Life Offers Flowers', the story of a couple whose lives are disrupted when the man puts himself at risk for HIV through an affair. PSI developed radio campaigns aimed at risk reduction based on market research, targeting messages to particular market segments. International celebrities – including Bill Clinton and Bill Gates – came to Mozambique. PSI became itself a celebrity – its logo on billboards, its vehicles on the roads, its jingles hummed on the streets.[32] Social research on HIV/AIDS was also dominated by the PSI agenda, with questions on responses to marketing messages added to demographic and health surveys.

As in other African countries, PSI and other condom social marketing programmes are now criticised for their narrowness and relative inefficacy. As elsewhere, knowledge of AIDS has not always translated into changing sexual behaviour or condom use. With a few outstanding exceptions, such as Graça Machel's problematic announcement that Samora Machel's brother had died of AIDS, Mozambican public figures said little to reduce the stigma of AIDS. Moreover the condom social marketing programmes alienated community groups, particularly in rural areas. Pentecostal and independent Churches have grown rapidly in membership in post-war Mozambique. Pfeiffer (2004) observes that the condom advertising campaigns clashed with the positions on sexuality of such religious groups. This was problematic not only because such groups form opinion, but also because they were expected to be an important source of volunteers for home-care programmes.

Calls for 'mainstreaming' AIDS prevention have been made principally by bilateral donors and major INGOs or PVOs, but the Mozambican government has responded rapidly. It has introduced most of the institutions that figure in the USAIDS and World Bank guidelines for countries that wish to obtain funding AIDS initiative funding (and some that are not formal – government ministers began to wear the AIDS ribbon in their lapels). The mandate of the National Programme of Combat against AIDS in the Ministry of Health was narrowed and a new National AIDS Council, with a prestigious director, was set up to coordinate private-public initiatives.[33]

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[32] A radio jingle called "Only with JeitO" became a popular dance song [PSI site, Karlyn 2001, Agha et al.].

[33] Janet Mondlane, widow of Eduardo Mondlane, the founder of FRELIMO.

Mozambican NGOs have also responded with alacrity, in fact many of them have been tailored to the possibility of new funding.[34] MONASO, the AIDS advocacy umbrella organisation, took on many new members. One of the first projects of the new CNCS in 2003 was to carry out an inventory of groups carrying out AIDS projects.[35] 56% of the organizations listed were working in IEC (Information, Education and Communication), with a focus on AIDS awareness.[36] Of the projects working in 2002, 47% had come into existence in 2002, when funding for social marketing projects became more widely available.

Some of these groups, particularly the Red Cross and some of the religious organizations, are membership organizations, bringing in part-time volunteers. Many of the others are really small enterprises, dependent on donor funding, with high fixed labour and administrative costs. Still others are theatre and cultural groups, subsidizing other activities with occasional skits or AIDS educational programmes. I spoke to the members of one such youth group in Niassa in 2000. They once ran a weekly newspaper and a social centre, but funding had dried up. Their remaining income came from occasional requests from the provincial health service to perform their AIDS play in rural localities. The rapid 'civil society' response to new AIDS funding has much to do with youth's need for jobs and the shifting of donors' enthusiasm towards providing them.

This is then a client civil society, dependent on donor funding and exercising political self-censorship. The largest and most reputable national NGO working on AIDS prevention in Mozambique is the Foundation for Community Development (FDC), headed by Graça Machel.[37] It is the prime grantee for USAID's HIV/AIDS programme. The solicitation notice for Kulhuvuka, its two-year USAID funded $11 million project in the Maputo corridor, states: 'Behavior change is at the core of the HIV/AIDS prevention project (the project recognizes the parallel importance of factors increasing susceptibility) (USAID 2002)'. The parenthetical comment is only parenthetical; the project has focussed on 'mainstreaming' sexual behavioural change.

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[34] The influx of foreign NGOs into Mozambique during the post-war period is blamed for competing with the public health system and local NGOS. New restrictions require that the HIV/AIDS INGOS be sub-contracted by a Mozambican organisation.

[35] The CNCS was later criticized for spending too much time on this bureaucratic process, though it fit with its mandate of private-public coordination.

[36] Author's calculation from CNCS data base.

[37] A leading and respected activist, intellectual and political figure in Mozambique, widow of Samora Machel and wife of Nelson Mandela.

Its main action areas were defined as: prevention (saturation through IEC and behavioural intervention); mitigation and care, including reducing stigmatisation, 'as a means of prevention'; advocacy for those living with AIDS and their families; training and network development; and research and data collection with particular reference to 'identification of local practices of alleviating the effects of opportunistic illnesses and improving living standards of those living with AIDS' (Cipriano 2001). It sub-contracts international PVOs to implement programmes.

Kulhuvuka has been by most accounts a successful project, and it is of course correct that a project focus its activities in its areas of competence. The FDC is not a health provider. Nonetheless the project takes as given two premises sacred to 'best practice' that are at least discussable: providing people with clear and effective information about HIV/AIDS requires the specialized and expensive skills of international social marketers; and AIDS care must be mainly provided by communities themselves.

As the number of Mozambican organisations broadcasting prevention messages increases, it is assumed that attitudes towards AIDS will be transformed. But there is an alternative explanation of why social marketing messages on AIDS prevention have been unhearable – i.e. they do not fit with the conditions of everyday life for many Mozambicans, particularly in rural areas. I spoke with a PSI theatre group in upper Zambezia in 2002. They were disappointed with the response they received in a rural locality where people said that AIDS was an urban problem. That was improvident, for although the farms and plantations no longer recruit much labour, their sons were on the road, working as bicycle traders (Bowen 2000) and HIV prevalence rates in Zambezia have risen. I visited that same rural locality later and did not find people fatalistic about health. Indeed one of their main complaints was the cost of transport needed to get to the nearest health post. But poverty was so deep that most had given up using the manufactured paraffin lanterns common before the war. Despite its flickering light and noxious fumes, they were using tiny amounts of long-burning diesel in small artisanally produced lamps. In such a context, it is difficult to envision regular purchase and use of condoms, even at $0.02 each.

Table 2 gives an overview of health and poverty indicators in Mozambique. There are differences between regions, above all between the capital city of Maputo and the rest of the country, but that should not hide the general prevalence of poverty in rural areas. Poverty relativises risk while awareness of risk does not necessarily

Table 2
Regional Differences in Health, health care and poverty, Mozambique 1997-1998

Province	Under-5 mortality (5q0)	Index of life expectancy	% of children 11-23 months, no vaccines	Number of persons per hospital bed	Persons per NHS doctor or nurse	Head-count index of poverty (HDR 1998)
			Northern Mozambique			
Niassa	213.1	0.295	17.9	1098	2555	70.6
Cabo Delgado	164.7	0.248	29.8	1498	3226	57.4
Nampula	319.1	0.257	18.2	1443	4210	68.9
			Central Mozambique			
Zambezia	183.1	0.208	50.6	2390	4023	68.1
Tete	282.7	0.322	6.5	1041	2317	82.3
Manica	158.8	0.325	15.7	1339	2679	62.6
Sofala	241.6	0.297	27.3	841	1862	87.9
			Southern Mozambique			
Inhambane	192.7	0.375	6.5	911	2556	82.6
Gaza	208.0	0.367	3.3	788	2293	64.7
Maputo	146.5	0.452	5.3	878	2365	65.6
Maputo City	96.9	0.567	1.2	409	887	47.8

Source: Atlas demográfico e de saúde de Moçambique (Schoemaker et al. 1999), Human Development Report 1998.

translate into the ability to avoid it. In rural areas of Mozambique, people must constantly take selective life-threatening risks in everyday life. Just as unprotected sexual intercourse may lead to AIDS, drinking unsafe water may result in cholera, sleeping in a mosquito-ridden place may lead to cerebral malaria, cultivating rice in marshland made lead to schistomiasis.

As in South Africa, the question of access to antiretroviral therapy calls attention to the exclusion of overall provisioning of public health in the best practice package. And, typical of Mozambique today, the question was first raised publicly by an INGO, *Medecins sans frontieres*, that used human rights arguments to justify initiating antiretroviral treatment without explicit government authorisation. The programme has now been expanded with the Clinton foundation acting as an intermediary in the acquisition of generics.

The government operated NHS dominates formal health care provisioning in Mozambique. There is only a very small commercial health sector outside the city of Maputo. A 2001 survey found only 31 non-profit health providers in the entire country (Kaarhus and Rebelo 2003). Most were religious organisations and were located principally in urban areas (and 60% of them in a single province, Nampula).

Many were dependent on the NHS for nursing staff, medicine and current expenses. Given the weakness of the private health sector, privatisation of the government health care system has not been demanded under the terms of the health sector reforms implemented through a World-Bank led SWAp.[38] There is, however, pressure to make the NHS work like a commercial provider, charging all but the destitute for health care.

Donors, not citizens, have had a preponderant voice in health policy because the funding of the National Health System depends on them. According to 1997 data (Chao and Kostermans 2002), 52% of health expenditure was financed by donors. Only 22% of total health expenditure came from treasury funds, just marginally more than came from households. The Ministry of Health dominated health expenditure (54%), but it was itself heavily dependent on donor funding (64%), making its policy options heavily conditioned by donor priorities. Moreover NGOs, entirely donor funded and not necessarily reflecting the same priorities as the Ministry of Health, spent about an extra 1/3 of the Ministry of Health expenditure. Drugs were funded almost solely by donors (91.8 percent) and debt relief. The NHS received an estimated 50% of total recurrent expenditure and more than 90% of capital expenditure from donors in 1997.

The quality of primary care compromises both basic general health care and treatment of AIDS, particularly in rural areas. The support needed for ART and home care is simply not available. A recent EDTS survey of primary health facilities confirmed the marked differences in quality of provisioning between rural and urban areas (Lindelow, Ward, and Zorzi 2004). Table 3 shows rural/urban differences in staffing, equipment and supplies available in primary health facilities. Lack of water, sterilization equipment and disposable needles and syringes leads to heightened risk of HIV transmission through blood exchange (18% of all those treated in health facilities received injections).

The shortages of trained staff and laboratory facilities hamper surveillance and treatment for VCT/ART particularly for communicable disease in general. The EDTS survey found widespread problems in management of information and accounting to be part of the reason for drug stockouts and unreliable health statistics (Lindelow,

[38] Sector wide approach to financial planning, requiring government/donor coordination. See Petchesky (2003 p. 157) on the place of SWAps in the World Bank approach to Health Sector reform.

Ward, and Zorzi 2004). The EDTS findings on the quality of care are backed by findings from case studies. As evaluation of implementation of the Global Vaccination Initiative in Mozambique found that the cold chain was unreliable below the level of provincial capitals (Brugha, Starling, and Walt 2002). A study on the reliability of data on the incidence of malaria found that results were often reported late, not always confirmed by laboratory analysis and sometimes invented (Chilundo, Sundby, and Aanestad 2004).

Table 3
Quality of Primary Health Facilities: Rural and Urban, Mozambique

% of facilities:	Rural	Urban	Total
With clinical staff above elementary level	60.5	77.7	62.4
offering child vaccination with all EPI vaccines available	70.7	93.6	73.3
reporting stockout of essential drugs in last 6 months	60.1	45.8	58.5
with disposable syringes	60.5	76.1	62.2
with disposable needles	58.7	68.9	59.8
with autoclave or pressure steriliser	71.6	72.3	71.7
With microscope (by norm only for Health Centre)	10.6	34.9	13.3
With access to water	69.4	80.7	70.7
With electricity	32.7	73.1	37.2
With functioning telephone	1.3	34.0	4.9
With functioning communication radio	17.3	8.0	16.2
With chloroquine in stock	96.8	97.1	96.8
With fansidar in stock	29.1	49.2	31.4

Source: (Lindelow, Ward, and Zorzi 2004).

'Best practice' advocates argue that there is no competition with the public health system because their approach uses public-private partnerships to mobilise resources that would otherwise be unavailable. In practice social marketers and the NHS dispute the same sources of funding and compete for institutional space from the national level down to local health posts. Competition for funds is reflected at health post level in the differences in availability of drugs, laboratory supplies, cold storage

and vehicles between the new VCT testing centres and the health posts to which those who are diagnosed as being HIV positive are referred.[39]

One international NGO secured funding from a large South African operated industrial enterprise in a tax-free zone in the suburbs of Maputo that at the time was particularly concerned with its public relations image. The NGO hired staff from among retired nurses, bought a project vehicle and rehabilitated an outbuilding of an existing health post, but the district health director delayed his authorisation of the centre until the NGO agreed to purchase a new water-pump and pay for the repair of the long malfunctioning water supply of the nearby health post. The contrast between the budget of the VCT centre and that of the health post was stark, though it is the health post that will have to treat the opportunistic infections of those who are HIV positive and which is expected to take over responsibility for the VCT centre when the NGO project ends.[40] It is difficult not ask the question that de Wet raised for home-care projects in the Orange Free State. Might not some of the resources dedicated to training home-care counsellors, peer educators and theatre groups be better used to train staff for jobs in the NHS and to improve primary care facilities?

For South Africa it might possibly make sense, as Nattrass suggests, to appeal to the moral community (bounded by the South African polity) to finance ART. In Mozambique, that moral community would have to be international; funding for health care depends on OECD countries, international agencies and philanthropic foundations. Claims to global citizenship and human rights are, it seems to me, a very uncertain basis for a constructing a public health system in Mozambique. If such support is not forthcoming, the predictable outcome, much as in South Africa is that the dualism of the colonial health system will be recreated in treatment for AIDS – ART for upper and middle income groups and those working in the formal sector, particularly in urban areas; home-care and slow death for those in rural areas not covered by an INGO project.

Nattrass (2004 p. 17, *op. cit.*) is certainly right to argue that the policy debate over access to ART should be conducted through public deliberation in an open political space. Questions of affordability and sustainability are not, however, purely economic or technical issues. The way we draw boundaries between the national

[39] Some of the NGO run centres are located within health posts but function with their own staff, while others have their own site, though they will in principle be handed over to the NHS after two years.
[40] Personal communication, Ruth Castel-Branco.

AIDS treatment programmes and wider systems of public health is itself political and determines how we define cost, sustainability and access. There is no absolute 'freedom to choose'.

4 CONCLUSION: THE QUESTION OF CHOICE

Liberalism has as yet little practical political reality in the struggle against AIDS in Mozambique. The 'best practice' package has been donned like a coat 'para o inglês ver'.[41] Doing so assures needed donor funding for public health, provides jobs, and appears to do some good and little harm. Liberalism as a political ideology can claim successes in the politics of AIDS in South Africa – the involvement of civil society has generated a critique of its own practice and won concessions from the national government, the pharmaceutical multi-nationals and implicitly the WTO and global financial institutions.

Yet, I would argue, in both cases liberalism's self-critique is not enough. As long as underlying assumptions about the inviolability of individual property rights and the normative efficiency of the market remain unchallenged in the rhetoric of rights and the institutions of governance, there will be little chance of constructing the kind of public health system needed to confront AIDS – or whatever 'pathology of power' (Farmer 2003) follows it if an HIV vaccine is found.

Nor does liberal rhetoric, which defines the social as the aggregation of individual rights and duties, provide an analytical language that illuminates the politics of AIDS. Negotiation and compromise in the face of competing rights are part of the liberal project. A substantial part of both litigation and the political process consists of weighing claims based on conflicting rights. The compromises reached (outcomes are ultimately market-clearing prices in a liberal model) necessarily reflect long-term structural relations of inequality. To formulate moral claims on the basis of citizenship, national or global, can be the basis for political programmes. But to go beyond simply registering the differences of power that inevitably shape outcomes, we need an analytical language that informs practical politics by linking structural

[41] 'For the Englishman to see', referring to pretending to take on advice that will only be superficially followed. The Englishman is now the donor.

inequalities to immediate demands. Finding this language requires the renaissance of class analysis in African politics.

REFERENCES

Anheier, H. (2004) 'Civil Society in the United States of America: prototype or exception? An essay on cultural self-understanding', in *Exploring Civil Society: Political and Cultural Contexts*. Edited by M. Glasius, D. Lewis, and H. Seckinelgin, London: Routledge pp. 83-92.

Barnett, T., and A. Whiteside (2002) *AIDS in the twenty-first century: disease and globalisation*. Basingstoke: Palgrave Macmillan.

Benatar, S.R. (2004) 'Health Care Reform and the Crisis of HIV and AIDS in South Africa', *New England Journal of Medicine* 351 (1): 81-92.

Bollinger, L., and J. Stover (2000) 'How Do AIDS Control Program Managers Make Resource Allocation Decisions?' The Futures Group International

Bonin, M.H. (1999) *Media Pluralism Landscape, An Overview of the Media Sector in Mozambique*. Nordic-SADC Journalism Centre, for UNESCO / UNDP.

Bowen, N.R. (2000) Traders and Livelihood Strategies in Post-Conflict Zambezia Province, Mozambique. submitted for the degree of Doctor of Philosophy, University of London.

Brewer, D.D., S. Brody, E. Drucker, D. Gisselquist, S.F. Minkin, J.J. Potterat, R.B. Rothenberg, and F. Vachon (2003) 'Mounting anomalies in the epidemiology of HIV in Africa: cry the beloved paradigm', *International Journal of STD & AIDS* 14 144-147.

Brugha, R., M. Starling, and G. Walt (2002) 'GAVI, the first steps: lessons for the Global Fund', vol. 27 February 2002: *Lancet* 2002; 359: 435–38

Campbell, C. (2003) *'Letting Them Die', Why HIV/AIDS Prevention Programmes Fail*. *African Issues*, Oxford, Bloomington and Indianapolis: James Currey and Indiana University Press.

Chao, S., and K. Kostermans (2002) *Improving Health for the Poor in Mozambique, the Fight Continues*. World Bank: Africa Region Human Development.

Chilundo, B., J. Sundby, and M. Aanestad (2004) 'Analysing the quality of routine malaria data in Mozambique', *Malaria Journal* 3 (3): 1-11.

Cipriano, E. (2001) 'Terms of Reference - Kulhuvuka Project - The Corridor of Hope', vol. 2004: FDC - Kulhuvuka

Cohen, M.S. (2004) ‘HIV and Sexually Transmitted Diseases: Lethal Synergy’, *Topics in HIV Medecine* 12 (4): 104-107.

De Wet, K. (2004) ‘Un militantisme social. Le volontariat associatif dans les soins à domicile pour les malades du sida’, in *Afflictions. L'Afrique du Sud, de l'apartheid au sida*. Edited by D. Fassin, Paris: Karthala pp. 161-200.

Eboko, F. (2005) ‘Politique publique et sida en Afrique’, *Cahiers d'études africaines* XLV (2) (178): 351-388.

Epstein, H. (2003) ‘Aids in South Africa: The Invisble Cure’, *New York Review of Books* 50 (12): 45-49.

Farmer, P. (1997) *AIDS and Accusation: Haiti and the Geography of Blame*. Berkeley: University of California Press.

Farmer, P. (1999) *Infections and Inequalities: The Modern Plagues*. Berkeley: University of California Press.

Farmer, P. (2003) *Pathologies of Power: Health, Human Rights and the New War on the Poor*. Berkeley: University of California Press.

Fassin, D. (2002) ‘Le sida comme cause politique. Un controverse sud-africane sur la scène globale’, *Les Temps Modernes* 620-621 312-331.

Fassin, D. (ed.) (2004a) *Afflictions. L'Afrique du Sud, de l'apartheid au sida*. Paris: Karthala.

Fassin, D. (2004b) ‘Introduction. Crise épidémiologique et drame socia’, in *Afflictions. L'Afrique du Sud, de l'apartheid au sida*, edited by D. Fassin, Paris: Karthala pp. 9-19.

Fassin, D. and H. Schneider (2003) ‘The politics of AIDS in South Africa: beyond the controversies’, *BMJ* 326 495-497.

Ferry, B. (1995) ‘Risk Factors Related to HIV Transmission: Sexually Transmitted Diseases, Alcohol Consmption and Medically-related Injections’, in *Sexual Behaviour and AIDS in the Developing World*. Edited by J. Cleland, London: Taylor and Francis for the WHO pp. 193-207.

Foucault, M. (1997) ‘The Birth of Biopolitics’, in *Ethics. Subjectivity and Truth*. Edited by P. Rabinow, New York: The New Press pp. 73-81.

Furlong, P., and K. Ball (2005) ‘The More Things Change: AIDS and the State in South Africa, 1987–2003’, in *The African State and the AIDS Crisis*, edited by A. S. Patterson, Aldershot: Ashgate pp. 127-154.

Gisselquist, D., J.J. Potterat, StuartBrody, and F. Vachon (2003) ‘Let it be sexual: how health care transmission of AIDS in Africa was ignored’, *International Journal of STD & AIDS* 14 (27/08/03): 148 -166.

Green, E.C. (2003) *Rethinking AIDS Prevention: Learning from Successes in Developing Countries*. Westport, CT.: Praeger.

Hall, P.D. (1999) 'Blurred Boundaries, Hybrids, and Changelings: The Fortunes of Nonprofit Organizations in the late Twentieth Century', in *Critical Anthropology Now, Unexpected Contexts, Shifting Constituencies, Changing Agendas*, edited by G. E. Marcus, Santa Fe, New Mexico,: School of American Research pp. 147-202.

Hanson, J., S. Posner, S. Hassig, J. Rice, and T.A. Farley (2005) 'Assessment of sexually transmitted diseases as risk factors for HIV seroconversion in a New Orleans sexually transmitted disease clinic, 1990-1998', *Annals of Epidemiology* 15 (1): 13-20.

Harries, A.D., N.J. Hargreaves, and A. Zumla (2003) 'Tuberculosis and HIV Infection in Sub-Saharan Africa', in *The return of the white plague: global poverty and the 'new' tuberculosis*, edited by M. Gandy and A. Zumla, London and New York: Verso pp. 112-124.

Hayem, J. (2004) 'Histoire collective et responsabilité individuelle. Conditions de la mobilisation contre le sida dans les mines', in *Afflictions. L'Afrique du Sud, de l'apartheid au sida*. Edited by D. Fassin, Paris: Karthala pp. 201-234.

James, D. (2002) 'To take the information down to the people: life skills and HIV/Aids peer educators in the Durban Area', *African Studies* 61 (1): 169-191.

James, D. (2004) 'Civil Society in South Africa', in *Exploring Civil Society: Political and Cultural Contexts*. Edited by M. Glasius, D. Lewis, and H. Seckinelgin, London: Routledge pp. 149-153.

Kaarhus, R. and P. Rebelo (2003) *OSCs e SWAPs, O papel das organizações da sociedade civil no sector de saúde em Moçambique, Relatório para o Departamento Técnico NORAD*. Noragric/NLH.

Klein, C., D. Easton, and R. Parker (2002) 'Structural Barriers and Facilitators in HIV Prevention: A Review of International Research', in *Beyond Condoms, Alternative Approaches to HIV Prevention*. Edited by A. O'Leary, New York: Kluwer Academic/ Plenum pp. 17-46.

Kotler, P., N. Roberto, and N. Lee (2002) *Social Marketing: Improving the Quality of Life*, second edition. London: Sage.

Lindelow, M., P. Ward, and N. Zorzi (2004) 'Primary Health Care in Mozambique, Service Delivery in a Complex Hierarchy', April 2004 edition, vol. 2004: World Bank, Africa Region Human Development Working Paper Series

Marshall, T.H. (1998) 'Citizenship and Social Class', in *The Citizenship Debates: A Reader*. Edited by G. Shafir, Minneapolis: University of Minnesota Press pp. 93-111.

Meerkotter, A. (2005) 'The Impact of the HIV/AIDS Epidemic on Women's Citizenship in South Africa', in *(Un)thinking Citizenship: Feminist Debates in Contemporary South Africa*. Edited by A. Gouws, Aldershot: Ashgate pp. 157-176.

Moçambique, R. d. (2004) *Plano Estratégico Nacional De Combate ao HIV/SIDA (PEN 2005-2009), Componente Estratégica - I Parte: Análise de Situação*. CNCS.

Nattrass, N. (2004) *The Moral Economy of AIDS in South Africa*. Cambridge: Cambridge University Press.

Niehaus, I. (2000) 'Towards a Dubious Liberation: Masculinity, Sexuality and Power In South African Lowveld Schools, 1953-1999', *Journal of Southern African Studies* 26 (3): 387-407.

O'Malley, P. (2000) 'Introduction: configurations of risk', *Economy and Society* 29 (4): 457-59.

Packard, R.M. (1989) *White Plague, Black Labor. Tuberculosis and the Political Economy of Health and Disease in South Africa*. Berkeley and Los Angeles: University of California Press.

Parker, R. (2001) 'Sexuality, Culture and Power in HIV/AIDS Research', *Annual Review of Anthropology* 163-179.

Patterson, A.S. (ed.) (2005) *The African State and the AIDS Crisis*. Aldershot: Ashgate.

Petchesky, R.P. (2003) *Global Prescriptions, Gendering Health and Human Rights*. New York and London: St. Martin's Press and ZED Books.

Pfeiffer, J. (2004) 'Condom social marketing, Pentecostalism, and structural adjustment in Mozambique: a clash of AIDS prevention messages', *Medical Anthropology Quarterly* 18 (1): 77-103.

Posel, D. (2004) 'Politique de la vie et politisation de la sexualité', in *Afflictions. L'Afrique du Sud, de l'apartheid au sida*. Edited by D. Fassin, Paris: Karthala pp. 47-74.

Posel, D. (2005) 'Sex, Death and the Fate of the Nation: Reflections on the Politicization of Sexuality in Post-Apartheid South Africa', *Africa* 75 (2): 125-153.

Robins, S., and B. Von Lieres (2004) 'AIDS Activism and Globalisation from Below: Occupying New Spaces of Citizenship in Post-apartheid South Africa', *IDS Bulletin* 35 (2): 84-90.

Rutherford, P. (2000) *Endless Propaganda, the Advertising of Public Goods*. Toronto: University of Toronto Press.

Schneider, H. (2004) 'Le passé dans le présent. Épidémologie de l'inégalité face au sida et politiques de justice sociale', in *Afflictions. L'Afrique du Sud, de l'apartheid au sida*. Edited by D. Fassin, Paris: Karthala pp. 75-110.

Schoemaker, J., M. d. C. Gaspar, H.A. Cossa, and H. Le Guillouzic (1999) *Atlas demográfico e de saúde de Moçambique*. Maputo: Instituto Nacional de Estatística.

Schoepf, B.G. (2001) 'International AIDS Research in Anthropology: Taking a Critical Perspective on the crisis', *Annual Review of Anthropology* 30 335-361.

Seidel, G., and L. Vidal (1997) ‘The implications of ‘medical’, ‘gender in development’ and ‘culturalist’ discoures for HIV/AIDS policy in Africa’, in *Anthropology of Policy*, edited by C. Shore and S. Wright pp. 59-87.

Singhal, A., and E.M. Rogers (2003) *Combating AIDS : communication strategies in action*. New Delhi: Sage.

Stillwaggon, E. (2002) ‘HIV/AIDS in Africa: Fertile Terrain’, *Journal of Development Studies* 38 (6): 1-22.

Turshen, M. (1998) ‘The Political Ecology of AIDS in Africa’, in *The Political Economy of AIDS*. Edited by M. Singer, Amityville, NY: Baywood Publishing Co pp. 169-184.

USAID (2002) ‘Solicitation Notice’, vol. 2003: FBO Daily (FedBizOpps)

Van der Vliet, V. (2001) ‘AIDS: Losing ‘The New Struggle’?’ *Daedalus* 130 (1): 151-184.

Vidal, L. (2000) *Femmes en temps de sida. Expériences d'Afrique*. Paris: Presses universitaires de France.

Warwick, D.P. (1982) *Bitter Pills, Population Policies and their Implementation in Eight Developing Countries*. Cambridge: Cambridge University Press.

Willan, S. (2004) ‘Briefing: Recent Changes in the South African Government’s HIV/AIDS Policy and Its Implementation’, *African Affairs* (103): 109-117.

APPENDIX

Table A1
Income inequality in Southern Africa in the 1990s

Country	Gini coefficient
South Africa	59.3
Swaziland	60.9
Namibia	70
Botswana	54
Lesotho	56
Zimbabwe	50.1
Zambia	52.6
Angola	54
Malawi	62
Mozambique	39.6