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Understanding policy implementation:

An exploration of research areas
in the health sector

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INTRODUCTION

This paper presents the findings of the first phase of a study of policy and its implementation in the health sector. It forms part of a broader research project aimed at examining the gap between policy and implementation in South Africa, and identifying ways in which this can be closed. Case studies are being conducted in four selected sectors – education, justice, water, and health – and on three key policy instruments: the RDP, the Growth, Employment and Redistribution (GEAR) strategy, and the National Crime Prevention Strategy (NCPS). Finally, the findings of these studies will be synthesised and some general conclusions formulated.

The case studies are proceeding in two phases. During the first, researchers have undertaken literature reviews, aimed at identifying the main issues in each sector or policy area and formulating research hypotheses. These issues and hypotheses are examined in depth during the second phase, which is marked by substantive, empirical research.

New health objectives

The 1997 white paper on health¹ committed the government to addressing a wide range of issues in the health sector. This study will concentrate on two: HIV/AIDS, and the role of hospitals in the public health care system. These two areas of focus have been selected as they are critical to health service delivery, and because they provide a good cross-section of the kinds of problems being experienced in implementing health policy.

Health policy in South Africa is being thoroughly transformed. In line with an international trend promoted by the World Health Organisation (WHO), health policy is moving away from curative tertiary medicine towards a largely preventive primary health care system, and achieving equity within that system.

Curative tertiary medicine addresses the needs of the sick and injured, is largely dependent on doctors, and tends to be technology-intensive. Preventive primary health care emphasises the prevention of illness and injury via education, immunisation, and the promotion of sound dietary, hygienic, and behavioural practices.

The implications of this shift in orientation are far-reaching. The success of the new policy will depend on the government's ability to balance the interests of the various role players in the country's medical arena, including doctors; medical academics; health personnel; patients; government health officials at the national, provincial, and local level; the health spokespersons of opposition parties, and drug and medical insurance companies. Participatory decision-making processes are thus increasingly considered to be essential to effective and equity-oriented policy-making in this sector.²

According to the white paper on health, the government's main objectives in this sector are to:

¹ Department of Health, White paper for the transformation of the health system in South Africa, *Government Gazette*, vol 382 no 17910, Pretoria, 16 April 1997.

² L Gilson, Equity and district health systems development: an overview, in *Promoting equity through the district health system*, Johannesburg: Centre for Health Policy, 1997.

- develop a comprehensive and integrated national health system that provides accessible health services to all South Africans;
- provide appropriate human resources for policy, planning, management, and service delivery;
- reduce mortality and morbidity, including infant mortality and morbidity;
- improve health and nutritional status;
- reduce the personal and social impact of HIV/AIDS;
- improve the availability, and ensure the affordability, of essential drugs; and
- improve response to emergencies.

These objectives seem logical in the light of South Africa's demographic, socio-economic and health profile (see appendix 1). The department is trying to realise them by establishing a single national health system (NHS), administered in a number of health districts. Clinics are meant to assume a central role, while hospitals are supposed to attend only to serious cases referred to them by clinics. The reorientation of health policy is meant to impact on every element of the health system.

At the same time, while the health system is being fundamentally reoriented, the ministry has faced the challenge of fighting the spiralling HIV/AIDS epidemic. To this end a national AIDS plan has been developed. The level of HIV infection among adults in South Africa was estimated to be 8,9 per cent in 1997, 12,4 per cent in 1999, and is expected to reach 21,7 per cent by 2010. These figures are estimates based on currently available data and trends in other countries that are further advanced along the epidemiological curve, and the actual percentages may therefore be higher or lower. The global distribution of HIV infection is given in table 1.

Table 1: The global distribution of HIV, 1997

North America	860 000	2,8%
Western Europe	480 000	1,6%
Eastern Europe and Central Asia	190 000	0,6%
South and South East Asia	5 800 000	19,0%
East Asia and the Pacific	420 000	1,4%
Australia and New Zealand	12 000	0,03%
Sub-Saharan Africa	21 000 000	68,6%
North Africa and the Middle East	210 000	0,7%
Caribbean	310 000	0,1%
Latin America	1 300 000	4,2%
Total	30 600 000	99,03

Source: UNDP, *HIV/AIDS & human development South Africa*, Pretoria: Amabhuku Publications, 1999.

The AIDS epidemic therefore presents the entire sub-Saharan region with a major health challenge which is threatening large-scale loss of life, massive demands on health facilities and personnel, and the need to care for millions of orphans. South Africa's health policy has been formulated in this context.

The development of policy in respect of hospitals and HIV/AIDS will be evaluated against this background. In doing so, policy-making is considered to be a continuously evolving process, involving both government and non-government actors, which crystallises from time to time in policy documents and statements against which the success or failure of implementation can be measured. Where gaps are found between a policy and its implementation, an attempt will be made to answer the following questions:

- What is the nature of the gap?
- How has it come about?
- Is it a result of inappropriate policy, capacity problems, or something else?
- Is anything being done to bridge it?
- What options are available for bridging it?

In assessing the nature of gaps between policy and implementation, the study will refer to ten preconditions identified by Hogwood and Gunn³ that need to be met if policy objectives are to be achieved. These are:

1. Circumstances beyond the control of the implementing agency do not impose crippling constraints on implementation.
2. Adequate time and sufficient resources are available.
3. The required combination of resources are available.
4. Policy is based on a valid theory of cause and effect.
5. The relationship between cause and effect is direct.
6. Relationships of dependency on external actors, such as insurance companies or professional organisations, are minimal.
7. There is an understanding of, and agreement on, objectives between policy makers and policy implementers.
8. Tasks are fully specified in the correct sequence.
9. Communication and co-ordination are functional.
10. Those in authority can demand and obtain compliance.

The evolution of new health policy

The ANC's *A national health plan for South Africa*, published in 1994 and prepared with the technical support of the World Health Organisation (WHO) and the United Nations Children's Fund (UNICEF), not only outlined a new vision of health services but also:

- specified new directions in 23 areas of health policy;
- proposed the reorganisation of the national health system at all levels: community, district, provincial, national, and in both the private and public sectors;
- proposed a new national health insurance, and other means of financing health;
- addressed the questions of human resource development in the health sector, and
- outlined a set of health priorities.

In its last chapter, the document listed 53 health priorities, together with targets and time frames. Some examples were:

³ B Hogwood and L Gunn, *Policy analysis for the real world*, Oxford: Oxford University Press, 1984.

- ‘all schools to be running comprehensive [health] education programmes on a regular basis by January 1996’;
- ‘develop and implement an effective HIV/AIDS strategy by end 1995’; and
- ‘improve universal access to reproductive health services’.

A number of problems are immediately apparent. Firstly, to prioritise such a vast range of objectives is overambitious and defeats the whole purpose of prioritisation, which is to focus attention on a few key objectives which then stand a chance of being realised. Secondly, in many cases the targets and timing were extremely unrealistic and revealed a serious lack of insight into the requirements of implementation – even independently of the problems besetting a transforming public service. Thirdly, some of the priorities were too vague to operationalise.

Most of the themes in the ANC document were taken up in the white paper on the transformation of the health system, published in April 1997.⁴ In its final chapter, entitled ‘Year 2000 health goals, objectives, and indicators for South Africa’, the white paper again listed multiple objectives within 20 broad goal areas, covering the whole spectrum of health services in the country.

This policy document, too, was overambitious, vague, and lacking in meaningful prioritisation. At a parliamentary media briefing at the end of June 1999, the new minister of health, Dr Mantho Tshabalala-Msimang, narrowed down health priorities to the following nine, albeit very broad, areas:

- improving access to primary health care;
- improving the functioning of the hospital sector;
- improving the quality of care throughout the system;
- transforming training institutions;
- escalating the fight against AIDS and TB;
- instituting a telemedicine network to support primary health care;
- expanding partnerships between the public and private sectors;
- speeding up the development of the district health system; and
- establishing social health insurance as part of a comprehensive social security system.

Two of these nine priorities have been selected as focus areas of this study: improving the functioning of the hospital sector, and escalating the fight against AIDS. The nature of the gap between policy and implementation in these two areas will be investigated.

THE ROLE OF HOSPITALS

The repositioning of hospitals in the health care system flows from the government’s adoption of a primary health care (PHC) approach, which emphasises preventive health care and educating people in leading a healthy lifestyle. One of the main goals of PHC is to make health services more accessible to people where they live. For this reason the

⁴ White paper 1997. Chapters deal with reorganising the health service, health finances, human resources, health research and information, nutrition, maternal, child and women’s health, HIV/AIDS and STDS, communicable diseases, environmental, mental, oral and occupational health, academic health service complexes, laboratory services, the role of hospitals, donor agencies and NGOs, health promotion and communication, international health, and health goals for the year 2000.

department of health has introduced a major clinic upgrading and building programme. In building new clinics, priority has been given to rural and peri-urban areas where the need for accessible health facilities is the greatest. It has also been envisaged that the equitable distribution of clinics will ensure effective access to health care for all.⁵ Some 2 218 public health clinics were operational in 1994. The 1997 white paper stated that 1 000 additional clinics were required. During 1997, it noted, 204 new clinics had been built, 38 clinics upgraded, residential units added to 364 new and existing clinics, and 53 mobile clinics purchased.⁶ According to the 1999 *South African Yearbook*, by September 1998 some 474 clinics had been built and 212 upgraded.

Under the PHC approach, communities have been encouraged to help administer and maintain clinics. It has been hoped that community participation, organised via community representatives, would engender a sense of ownership of clinics, thus contributing to their sustainability and also their protection against vandalism. It has also been envisaged that community leaders would play an important role in educational campaigns undertaken by clinics. In short, under PHC, the idea has been that clinics would move to centre stage in health care provision.

This has had major implications for hospitals. Instead of forming the core of the health system, as they had done in the past, the idea has been that hospitals should complement clinics by accepting serious cases referred to them by the latter. However, hospitals have remained a vital component of the health care system. As the white paper put it:

Hospitals have always been and will remain central to the health system. Adequate health care services cannot be provided without them. The PHC system cannot function efficiently without the support of the hospitals to which they refer patients. Therefore, substantial improvements to the PHC system are intimately connected with the functional efficiency of hospitals.⁷

However, the white paper went on to identify a number of problems surrounding hospitals, including a lack of proper maintenance, inequity and inefficiency, widely varying quality of care, breakdowns in referrals to and from hospitals, poor distribution of resources, poor industrial relations, poor personnel management, and a continual loss of highly trained staff to the private sector. The report of the commission of inquiry into hospital care practices in Gauteng in September 1999 underlined many of these problems, which clearly need urgent attention.

With their workloads expected to diminish as more clinics became operational, hospitals have been expected to scale down. Therefore, attempts have been made to rationalise hospital services, facilities, staffing and capital investment; also, to promote efficiency and cost-effectiveness, attempts have been made to decentralise hospital management. In addition, hospital boards have been established in an attempt to increase local participa-

⁵ ANC, A national health plan for South Africa, May 1994, pp 48-9.

⁶ Department of health, Annual report, 1997.

⁷ White paper on health.

tion and accountability, and a user fee system has been planned to encourage efficient fee collection and improved services.

However, the implementation of these policies has run into serious problems, and consequently into opposition and objections from doctors and hospital managers who argue that their ability to deliver essential health services is being severely compromised by drastic cost-cutting without adequate consultation.

Although the intention has been for hospitals to assume a complementary role to the clinics, they have remained crucial to the latter's success. As the white paper put it:

The PHC system cannot function efficiently without the support of the hospitals to which they refer patients. Therefore, substantial improvements to the PHC system are intimately connected with the functional efficiency of hospitals.⁸

But, although the broad shift to primary health care has been welcomed, detailed policies have not had the intended effect; instead, financial cutbacks have plunged hospitals into a crisis. The white paper envisaged that most of the resources needed to expand the PHC system would be drawn from previous allocations to hospitals,⁹ which accounted for more than 75 per cent of public sector health expenditure. However, while their budgets have been cut, their burden of care has not shifted to clinics to the extent envisaged; as a result, hospitals have increasingly been unable to provide quality services to patients. As the department of finance's medium-term expenditure review for 1998 stated:

The policy shift towards primary health care services and the refocusing of services to the previously disadvantaged and underserved areas in the context of limited increases in government budgets are leading to increased financial pressure on public hospitals. Coupled with this is the increased pressure on both the national and the provincial health authorities to ensure equitable access to all levels of services for all the citizens of the country. The result of this is that provinces are reporting a decline in the state of hospital infrastructure and an inability to deliver services as required by national policy. In this context it is key that all possible sources of revenue be utilised. Despite this, the trend is apparently one of substantial decreases in revenue generated previously through private patients and those who are members of medical schemes.¹⁰

At the centre of this crisis is the fact that, contrary to expectations, hospitals are still providing the bulk of health care. Clinics, are supposed to relieve the hospitals of substantial numbers of patients, are not yet functioning or are experiencing various operational problems. In some cases, clinics have been built without considering infrastructure, supplies and staff. In its annual report for 1997 the department of health noted that of the 204 clinics built during 1997, 115, or more than half, had not begun to operate by the end of that year. Reasons given included a shortage of staff, budget constraints, and a moratorium on filling new posts. International experience also shows that the mere construction

⁸ Ibid.

⁹ White paper on health, p 164.

¹⁰ Department of finance, Health services, in 1998 *medium-term expenditure review*, September 1998, p 21.

of clinics, particularly in rural areas, does not necessarily translate into access to health care. For instance, a study undertaken in 1983 at a maternal health care facility at the rural town of Obukpa in Nigeria¹¹ revealed that variables such as distance, mode of transport, costs, levels of education, and personal beliefs may all play a role in determining whether people use clinics or not.

Hospitals in South Africa themselves need to be renovated and upgraded. In 1997 the department of health estimated that about R8 billion would be needed to rehabilitate public hospitals over the next ten years,¹² partly because expenditure on them had been minimised. So, while the total health budget has increased, hospitals' share of it has declined. For instance, health expenditure by all provinces has risen from about R16 billion in 1995–6 to about R22,3 billion in 1998–9, amounting to a real annual growth rate of about 3,7 per cent. However, hospitals' share of provincial health budgets has either remained steady or declined. For instance, Eastern Cape hospitals' share of the provincial budget has declined from 43 per cent in 1996–7 to 38 per cent in 1997–8 and 36 per cent in 1998–9. The share of Free State hospitals has been relatively constant at 31 per cent in 1996–7, 32 per cent in 1997–8 and 31 per cent in 1998–9. Additional funding has been absorbed by salaries, the clinic building programme, and the elimination of charges at clinics.¹³

In short, instead of complementing clinics, hospitals remain at the centre of health care, but with increasingly declining resources. A study commissioned by the Gauteng government, for example, has showed that public hospitals are failing to deal with their long queues of patients.¹⁴ The envisaged decline in demand for hospital services has obviously not materialised. This is partly because, as this study will show, the clinics have not been operating efficiently.

Therefore, although the general policy shift towards primary health care provision has been welcomed, problems in formulating and implementing the specifics of that policy have led to it not having the intended effect. Hospitals, which still provide the bulk of health care, are being downgraded, while many of the new clinics, which are supposed to relieve the pressure on public hospitals, are either not yet functioning or are themselves experiencing operational problems. This has led to hospitals facing a crisis of being unable to meet the demands of the public.

Given this, the hypothesis to be tested in the course of this study is as follows:

The gap between policy and implementation in respect of managing hospitals is due to problems in both policy formulation and in policy implementation:

- *policy was formulated hurriedly because the ANC wanted to demonstrate that it could rapidly improve the standard of social services;*
- *policy was formulated without seriously consulting with key actors who would have to implement it, such as hospital superintendents and heads of department;*

¹¹ B. Nwakoby, The influence of new maternal care facilities in rural Nigeria, *Health Policy and Planning*, 7(3), 1983, pp 269–78.

¹² Department of health, Annual report, 1997, p9.

¹³ Department of finance, Health services.

¹⁴ Report of the commission of enquiry into hospital care practices, September 1999.

- *policy implementation lacked prioritisation and proper time scales; and*
- *policy implementation lacked co-ordination among different departments, national and provincial governments, and provincial governments and implementers.*

THE HIV/AIDS PROGRAMME

The challenge

In 1999 the WHO ranked AIDS as the leading cause of death in Africa, being responsible for one in five deaths in 1998. It is estimated that more than 30 million people are HIV-positive worldwide, and that most of these (68,6 per cent) live in sub-Saharan Africa. Thus far the epidemic has orphaned an estimated 10 million children in Africa. According to conservative estimates, South Africa will have close to 1 million AIDS orphans by 2005.¹⁵

As regards South Africa, HIV first appeared in 1982 and has spread dramatically to the point where about 3,5–4 million people are now living with AIDS and about 120 000 people die from it annually.¹⁶ The first appearance of the epidemic (clade B virus) was linked to the disease in western Europe and North America. A second wave arrived in South Africa in the late 1980s from east and central Africa (clade C virus).

The global distribution of various subtypes of HIV-1 – the virus causing AIDS – is shown in table 2, and the regional distribution of the clade C virus in table 3.

Table 2: Global distribution of subtypes of HIV-1, 1997

Clade A	25%
Clade B	16%
Clade C	48%
Clade D	4%
Clade E	4%
Others	3%

Source: Los Alamos National Laboratory Human Retroviruses and AIDS Database 1997, cited in Q A Karim, Trends in HIV/AIDS infection: beyond current statistics, *South African Journal of International Affairs*, 7 (2), Winter 2000.

Table 3: Regional distribution of clade C virus, 1997

Region	Infections
Africa	10 801 000
South/South East Asia	3 596 000
East Asia/Pacific	240 000
Latin America	35 000

¹⁵ UNDP, *HIV/AIDS & human development South Africa*, 1998, p 66.

¹⁶ Sunday is AIDS memorial day, *Sowetan*, 14.5.1999.

TOTAL	14 680 000
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Source: J Esparaza, UNAIDS vaccine programme, personal communication, cited in Karim, Trends in HIV/AIDS infection.

Because of South Africa's location at the southernmost end of the continent, the epidemic here is estimated to be some five to ten years behind that in central and east Africa. It is aggravated by the high prevalence of TB, to which people with AIDS are particularly prone. A recent national survey conducted by the department of health revealed that the number of pregnant women infected with HIV had increased by 34 per cent in one year to 22,8 per cent. The incidence of HIV among teenage girls had also risen to 21,7 per cent. Some communities are therefore likely to lose up to 30 per cent of their young people to AIDS over the next five years.¹⁷

Southern Africa has the world's fastest accelerating AIDS rate, with about 10 per cent of its work force already infected. Zimbabwe, which is further along the epidemiological curve than South Africa, has already lost 1 million people, or roughly 10 per cent of its population. There are 2,2 million AIDS orphans in the SADC region. Life expectancy in the region is expected to decrease by 20 years to between 40 and 50 by the year 2008.¹⁸

At the 11th conference on AIDS in Africa held in Lusaka in September 1999, the executive director of UNAIDS called on African countries to declare a state of emergency in respect of the AIDS pandemic. The World Bank similarly called on African countries to prioritise the AIDS crisis in order to stop the 'fastest growing threat to development' on the continent.¹⁹ The Commonwealth Medical Association also called on heads of government to declare HIV/AIDS a public emergency.²⁰ In a statement issued after their four-day meeting in Durban in November 1999, commonwealth countries too called on heads of government to declare HIV/AIDS a public emergency, claiming that the social and economic impact of AIDS and HIV constituted a global emergency.²¹

Despite the alarming statistics, and these calls on governments to prioritise the HIV/AIDS epidemic, governments in the region – including South Africa's – have not yet devised a coherent set of policies to deal with the epidemic. Approaches have tended to be ad hoc, and fraught with problems. Both administrative shortcomings and social behaviour patterns seem to be impeding the success of anti-AIDS initiatives.

Options for treatment

The treatment of South Africans infected with HIV has become increasingly contentious. Conventional AIDS medications are exorbitantly expensive – certainly in Africa. The

¹⁷ One in three will die of AIDS in 2003, *The Citizen*, 26.5.1999.

¹⁸ Southern Africa faces dire AIDS consequences, *The Star*, 5.7.1999, and UNDP, *HIV/AIDS & human development South Africa*, p 68.

¹⁹ AIDS in Africa declared a continental disaster, *The Star*, 13.9.1999, and AIDS virus threatens our gains, *Sowetan*, 14.9.1999.

²⁰ SA must intensify fight against HIV, *Sowetan*, 10.11.1999.

²¹ HIV/AIDS make up global emergency, *The Citizen*, 16.11.1999.

government argues that providing free AIDS drugs to pregnant HIV-positive women, let alone all AIDS victims in the country, is unaffordable. South Africa could obtain the AIDS drug AZT more cheaply from other countries that have already bought the drug, as the patent right on drug sales falls away after the first sale. But this would be in breach of international law – unless it is a case of national emergency or extreme urgency, and no profit motives are involved. Hence the international calls to declare AIDS a national emergency. Local AIDS organisations believe the situation here has already become a national emergency. However, the government argues that AZT is not only too expensive but also, given its toxicity levels, has not yet been proven ‘safe’ as an AIDS medication.

The government has, at different times, given three different reasons for its decision not to provide AZT to HIV-infected pregnant women. The first is that it does not in fact reduce the transmission rate of the virus from mother to child. The second is that it would be too costly for government to provide the drug free of charge, and the third is that the drug itself might be harmful. It is therefore not clear at this stage what the government’s primary motivation is for withholding AZT from HIV-positive pregnant women. Whether the government is holding out for cheaper supplies of the drug or whether its primary concern is one of safety is not clear. If the government’s concern about the safety of the drug is the primary factor, then its cost should not be an issue, since supplying it would not be considered in any case. The three reasons will be examined in turn.

Efficacy

Transmission rates from infected mothers to babies is about 30 per cent in South Africa, and 40 to 50 per cent in sub-Saharan Africa. Studies have suggested that AZT treatment cuts this rate by between 50 and 75 per cent, and the government’s argument that AZT is ineffective has been widely rejected.²²

Cost

It will cost between R50 million and R100 million a year to provide an estimated annual average of 228 000 HIV-infected pregnant women with AZT. This would only be for the drugs themselves and would not include the costs of testing, advertising and administering such a programme.²³ The 1999--2000 health budget amounted to R24 billion, or roughly 11 per cent of the total budget. R100 million therefore represents 0,4 per cent of the total health budget.

Safety

Mbeki’s statement that AZT might be harmful and that this could have legal implications has been contested by AZT manufacturer Glaxo Wellcome, which claims that no legal action has been taken against it anywhere in the world on the grounds that the drug is unsafe. It points out that the drug had been authorised by the Federal Drug Administra-

²² Cost of AZT not really that high, *Sowetan*, 3.12.1999.

²³ *Ibid.*

tion in the United States and the Medicines Control Council in South Africa as well as the Centre for Disease Control in Atlanta, for use by infected pregnant women after the first trimester to prevent mother-to-child transmission.²⁴

However, some serious questions about the safety of the drug have been raised in respected scientific journals as well as by people living with AIDS. Like the virus itself, AZT has been associated with the destruction of red and white blood cells as well as muscular atrophy. It is also known to cross the placental barrier, and this has given rise to fears about its potential effects on foetal development.²⁵ But, given the extent of the epidemic, the fact that respected medical authorities have approved the drug for pregnant women, and the largely successful use of the drug in practice, withholding the drug on safety grounds does not seem rational.

The minister of health has invited the Medicines Control Council and a group of independent scientists approved by SADC ministers to undertake a comparative study of AZT and other HIV drugs. The results of this study are not yet available. Until it is, the government has argued that it does not have enough information on which to base a responsible decision.²⁶

Thus, despite the extent of the epidemic and its alarming rate of growth in South Africa, the government has yet to formulate its policy on drug treatment.

International experience

Thailand

In 1990 both South Africa and Thailand had HIV infection rates of about 1 per cent. By 2000, Thailand's infection rate had increased to 2,15 per cent²⁷ while South Africa's had climbed to about 12 per cent. In the early 1990s Thailand, like South Africa, faced projections of up to 4 million people infected by 2000. South Africa has probably reached this total, whereas Thailand has managed to avert it. Thailand and South Africa are very different societies, and numerous factors probably account for this difference. But more effective government programmes are certainly among them.

Thailand has large numbers of intravenous drug users, a large and mobile population, poverty, trafficking in women and children, and a flourishing commercial sex industry – an ideal breeding ground for the disease.

However, it responded quickly to the disease and devoted substantial resources to combating it.²⁸ Firstly, a national survey of partner relations and risk behaviour was conducted to inform prevention policy. Secondly, a national media campaign was launched

²⁴ Producer challenges Mbeki on AZT's safety, *The Citizen*, 1.11.1999.

²⁵ See www.aidsinfobbs.org/debate.html for more information.

²⁶ Regering sê finaal nee vir gratis AZT, *Beeld*, 17.11.1999; Health minister digs in heels over AZT, *Sowetan*, 17.11.1999; and Price and toxicity of AZT deter minister, *The Star*, 17.11.1999.

²⁷ SA misluk in vigsstryd, sê die Post, *Beeld*, 7.7.2000.

²⁸ T Renaud and J Hess, Young people and AIDS in Thailand and South East Asia, *South African Journal of International Affairs*, 7(2), Winter 2000.

to discourage people to patronise brothels, and encourage them to use condoms if they did. Brothels that did not enforce policy on 100 per cent condom use were closed down. Thirdly, a surveillance system to track the epidemic and learn more about Thais' sexual behaviour was instituted. About 60 000 army recruits took part in a longitudinal study aimed at assessing risk factors and results of prevention campaigns. Fourthly, the government distributed about 60 million free condoms every year. The result was that by 1995 HIV infection rates had dropped significantly, with a reduction in male risk behaviour estimated to account for the prevention of about half the expected infections.

South Africa has yet to conduct a survey of sexual behaviour patterns to inform its own policy. Anecdotal indications suggest that male sexual behaviour in particular needs to be changed if the epidemic is to be curbed. In some parts of the country the incidence of AIDS is increasing rapidly among young women due, some believe, to high rates of older men having sex with younger girls, and the myth that having sex with a virgin will cure the disease.²⁹ Certainly there are girls of 14 years of age presenting at clinics and hospitals with AIDS. But policies are yet to be tailored to address specific behaviour patterns of particular groups, as identified in the course of research.

Following the early successes in Thailand, its government remained committed to the programme and continued to adapt it to new research findings. Thus, for example, the programme was expanded to include grass roots training in life skills as well as community empowerment. Civil society organisations were encouraged to participate in the campaign by facilitating discussions among young people in sport and theatre forums, and providing education, training and care for communities affected by AIDS. Buddhist monks have also provided care for AIDS patients rejected by their communities. Religious, private sector and non-governmental organisations have thus all been enthusiastically involved, together with government, in combating AIDS.

*Uganda*³⁰

The first AIDS cases in Uganda were reported in 1983 in the south-western part of the country. By June 1993 more than 41 000 cases had been reported – 90 per cent among young adults, and 10 per cent among infants and young children. In 1987 it was found that one in four women attending prenatal clinics in Kampala were infected. By 1988 levels of infection among the adult population in the central region were 21 per cent in urban areas, and 12 per cent in rural areas. But by 1999 rates of infection in urban areas had declined by about 50 per cent, especially among 15–19-year-olds, from a high in some areas of almost 30 per cent in 1992 to between 6 and 13 per cent in 1998.

The Ugandan government responded with a multisectoral approach encompassing almost every aspect of the WHO's recommended global strategy for combating AIDS, including education campaigns, condom distribution, voluntary testing and counselling, STD treatment, and a safe blood supply. The National Operational Plan for the control of

²⁹ Report on the Phillippi Community Forum held on 25.7.2000.

³⁰ See S Opolot, *Are Africa's AIDS orphans the wretched of this earth?: the response and capacity of local government in Uganda*, Paper delivered to CPS workshop on HIV/AIDS orphans, 21.7.2000.

HIV/AIDS and STDs (1994–8) called for a decentralised approach to implementation involving NGOs and communities. By 1997 more than 1 020 agencies were involved in fighting AIDS, one third of which were local government institutions. AIDS sufferers also formed associations both to support communities and educate them about the disease. As a result, almost everyone in the country is aware of AIDS.

Part of the reason for the success of Uganda's AIDS strategy appears to be the popularity of its local government system in which every village has a council consisting of all residents over 18 and an elected executive committee of ten people. Since 1997 local governments have taken over one third of the agencies involved in AIDS control, including district departments, health units, and central government departments at district level.

The commitment of top politicians as well as the active role of local governments appears to have resulted in a relatively successful campaign. Given this strong political and institutional support, the message that people need to change their sexual behaviour has been broadcast by just about all the authority figures in society – from the head of state down to political leaders, mayors, church leaders, school principals, and traditional leaders. This repetition of a consistent message seems to have had a major impact on the epidemic in Uganda.

Although South Africa has staged mass media and other educational campaigns, the vacillation of the country's political leadership on the causes and treatment of AIDS has undermined their efficacy. As a result, six years after the national AIDS plan was formulated, the HIV/AIDS infection rate in this country has increased to 12 per cent, compared to less than 5 per cent in 1994.

Key policy statements

The ANC's national health plan emphasised a multisectoral approach to HIV/AIDS in a compassionate and non-discriminatory framework. It was aimed at engendering a community-based response to HIV/AIDS. Mechanisms for implementing this policy included endorsing the AIDS charter; establishing HIV counselling and support services at community health centres; testing only with prior consent and counselling; not making AIDS notifiable; comprehensive education programmes for schoolchildren, adolescents and teachers; no restriction on the sale or distribution of condoms; and joint initiatives by the government, the National AIDS Committee of South Africa (NACOSA) and civil society organisations to develop education and prevention programmes.

The white paper stated that the national AIDS plan, developed in consultation with NACOSA, had been adopted and was being implemented in the form of a national AIDS control programme. The five central objectives of this programme were to:

- prevent the spread of the epidemic by promoting safer sexual behaviour, providing condoms, and controlling STDs;
- outlaw discrimination against people living with HIV or AIDS;
- use the mass media to popularise prevention concepts and develop life skills education for young people;

- provide counselling, care, and social support, including welfare, for people with HIV/AIDS, their families and the community; and
- consolidate local, provincial, national and international resources to prevent and reduce the impact of HIV/AIDS.

Specific implementation strategies included:

- developing a multisectoral approach;
- promoting co-ordination and collaboration among government and civil society organisations, specifically between the National AIDS Control Programme and the NACOSA;
- ensuring that people living with HIV or AIDS are involved in all decision-making forums of the national control programme;
- establishing a national HIV/AIDS and STD advisory group;
- obtaining technical and other support from the international community, including UN agencies such as the WHO, UNICEF, UNDP and UNAIDS;
- establishing a committee to develop a research policy and review applications for research funding;
- supporting the National Youth Development Forum and the South African National Students' Congress (SANSCO) in training their constituents in life skills;
- drawing up guidelines for the development of national, cost-effective plans for the medical management of people living with HIV or AIDS on a continuum from hospital to hospice;
- ensuring consent and confidentiality in HIV testing;
- ensuring safe blood supplies; and
- developing HIV/AIDS surveillance mechanisms to ensure that the impact of policy on behaviour is measured.

This policy and implementation strategy was agreed to after months of consultations and negotiation with the main AIDS organisations in the country. On paper the policy seems excellent, incorporating many of the successful strategies used in other countries; however, the AIDS infection rate in South Africa has not yet been reduced. Clearly, therefore, the policy has not been properly implemented.

The early development of policy

An analysis of the development of AIDS policy was published in June 1998.³¹ It is summarised here by way of providing some background.

The ANC first met people concerned about AIDS in South Africa at a conference in Maputo in early 1990. The meeting resulted in the Maputo statement on HIV and AIDS which asserted the need to prioritise AIDS prevention, especially as the epidemic was developing more slowly in South Africa, thus allowing early intervention.

³¹ H Schneider, *The AIDS policy process in South Africa*, University of the Witwatersrand: Centre for Health Policy, 1998.

The ANC's then health secretariat and the department of health began discussing AIDS in 1991; the department was willing to collaborate with other agencies as a way of overcoming public distrust of state-initiated anti-AIDS campaigns. A steering committee (SC) was formed to work towards a national strategy, and comprised representatives of business, trade unions, churches, civic organisations, political parties, the government and the ANC. A conference organised by the SC and held in October 1992 resulted in the formation of NACOSA. It was agreed that the national AIDS strategy should encompass education, counselling, prevention, health care, welfare, research, human rights, law reform, and socio-economic improvement.

The AIDS Consortium, an NGO, played a key role in defining the human rights approach to combating AIDS by developing and popularising an AIDS charter. By developing reliable and realistic scenario models, calculating the costs of HIV prevention, and drawing on lessons from preventive campaigns elsewhere, other NGOs showed that it was possible to do something about AIDS. A number of these agencies were invited to join NACOSA.

A draft national strategy was finalised in September 1993 at a NACOSA meeting attended by a WHO technical adviser. The document upheld the principles of involving people with AIDS in developing preventive and care strategies, of non-discrimination, and of confidentiality and informed consent in testing and conveying results. The strategy was translated into a two-year implementation plan and budget which were circulated to and ratified by NACOSA structures in most of the regions of the country. The new minister of health adopted the plan in July 1994, and announced that the AIDS budget would be doubled. Additional funds were garnered from the RDP and from international donors, especially the European Union.

However, a major flaw was that the plan had largely been developed by people outside government and without experience of its constraints. As such the plan represented an ideal policy, based on unrealistic assumptions about the new government's capacity to implement a comprehensive approach to the looming epidemic.

A national review

By 1997 it had become clear that the AIDS plan had not been properly implemented. There were many reasons for this; virtually none of the people who had helped to draft the plan were involved in its implementation. The plan itself was a bulky document that was difficult to assimilate. New government officials lacked experience in implementing policy. The comprehensive restructuring of the state – involving amalgamating the old separate departments and creating provincial structure – diverted attention away from implementation. Given more visible health priorities, there was a failure to prioritise AIDS. NGOs working in the field were weakened by a loss of leadership to the public and private sector. And, finally, consultation with the AIDS community on drafting policy had declined dramatically in the face of all the pressures facing the new government.³²

³² Schneider, *The AIDS policy process in South Africa*.

As a result of these factors, the government initiated a national review of the AIDS response during 1997. Consultative workshops were held in all the provinces, background documents were prepared, and assessments were made by teams of government, NGO and international representatives. The findings were discussed at a conference of almost 1 000 people in August 1997 where policy priorities were reformulated. The main priorities to emerge were mobilisation, capacity-building, and intersectoral action. The process of review also led to a greater understanding among NGOs and government officials of implementation realities on the ground. However, the review report was also a long and inaccessible document, and four of the nine provinces gave the process a rating of one or two on a four-point scale for its contribution to AIDS policy.

At the same time that the national review was being conducted, a parallel policy process seemed to be unfolding at ministerial level where an interdepartmental AIDS plan was being developed. The ministry of health subsequently made statements (such as considering making AIDS a notifiable disease) that contradicted recommendations made in the review report and thus undermined the common understanding that had been developed in the review process.

The national HIV and STD directorate began developing national guidelines for AIDS care in October 1997 by appointing task teams to develop guidelines in specific areas. Eight months later, the guidelines had not yet been completed. The repeated use of experts when much of what needed to be known was already known was probably not the best way of formulating policy. More to the point may have been a process of bringing together the insights of direct providers and recipients of care with those of policy-makers at the national level, and policy implementers at the provincial level.

Some of the lessons learnt from the policy process at that stage were:³³

- the context of implementation should be borne in mind when policies are formulated;
- policies should be seen as starting points rather than ends, in order to promote a willingness to continually modify policies that do not work;
- policies should be developed by those who implement them – a lack of continuity and ownership between policy development and implementation undermines both policy-making and implementation; and
- affected interest groups should be involved in monitoring and evaluating processes, in order to build common understandings.

Current problems

But, despite these lessons, AIDS policy implementation has continued to be ineffective – apparently the lessons have not been taken seriously enough to impact on implementation.

The principles on which HIV/AIDS policy are based are the mutual involvement of government and civil society in containing the epidemic, involving people living with HIV/AIDS in strategies to combat it, and building capacity to accelerate HIV/AIDS prevention and control measures. At least, that has been the theory.

³³ Schneider, *The AIDS policy process in South Africa*.

In 1994, when the AIDS infection rate was still less than 5 per cent, South Africa had a national AIDS plan that built on lessons from other countries in which the epidemic had struck earlier. The plan had the support of the government, business, unions, and civil society and religious organisations. Yet seven years later the infection rate has more than doubled to 12 percent, sexual behaviour patterns have not changed significantly, and very little has been achieved in establishing community-based care strategies. This has been the case despite the fact that – as Mary Crewe, director of the Centre for the Study of AIDS at the University of Pretoria, argues³⁴ – there is sufficient funding, will, capacity, basic infrastructure, doctors and volunteers with experience of the epidemic, researchers with experience in trials and running services, and many local and national AIDS service organisations to enable a major response to the epidemic. Conditions for implementing policy in this area could therefore hardly have been more favourable. Tragically, this has not been not enough. So what has happened? Crewe suggests a number of reasons for the failure of implementation:

- the government has chosen to ignore considerable local expertise and rather seek advice from countries such as Thailand and Zimbabwe, as well as donor agencies;
- the provincial system of government effectively resulted in 10 different AIDS plans, as provinces have contended for autonomy and control and argued over policy and programmes;
- high-profile debacles such as the irregularities in tendering and funding Sarafina 2; the Virodene ‘miracle cure’ supported by then deputy president Thabo Mbeki and cabinet, which turned out to be a toxic industrial solvent; Mbeki’s subsequent questioning of the toxicity levels of AZT; and the government’s decision in 1999 not to supply AZT or later Nevirapine to pregnant women or rape survivors;
- policy announcements that contradicted locally negotiated and adopted policy, such as the proposal to make AIDS a notifiable disease;
- the defensive rejection by the government of local criticism of Sarafina 2 from those active in the AIDS field, and the consequent breakdown of unity of purpose;
- sectarianism and exclusionism among AIDS organisations which determined who could and could not talk about AIDS;
- distrust and intolerance, a lack of accountability, and intransigence in relations between government and civil society organisations;
- The dismissal of the AIDS advisory committee in 1998, and the creation in 2000 of the National AIDS Council on which there is no representation of those experienced in the South African AIDS arena;
- Mbeki’s public questioning of whether or not HIV is the real cause of AIDS and government’s appointment of an expert panel, largely comprising non-South Africans, to review treatment and prevention strategies - areas in which South Africa itself has internationally recognised experts;

³⁴ M Crewe, South Africa: touched by the vengeance of AIDS: responses to the South African epidemic, *South African Journal of International Affairs*, 7 (2), 2000, p 29.

- the government's failure to support its own national HIV/AIDS and STD directorate, which has consequently experienced a rapid turnover of directors and lack of capacity;
- The failure of the department of health to spend up to 40 per cent of its HIV/AIDS budget; and
- The cutting of NGO funding especially to small community-based programmes which could have formed the core of an alternative home-based approach to treating AIDS patients.

Four basic factors seem to underlie these implementation problems. Firstly, continuing policy contestation between the government and civil society organisations is thwarting co-operation. Secondly, contestation within the political system itself appears to be causing a lack of policy co-operation and co-ordination, at least within the domain of AIDS policy. Thirdly, equivocation on the part of political leaders has raised doubts about the trustworthiness of recommended mainstream prevention and treatment methods. Fourthly, changes in donor funding patterns have disrupted the functioning of NGOs and therefore the efficacy of their roles in both policy-making and policy implementation.

The hypothesis to be investigated in this area relates to these four factors. It has been formulated as follows:

The gap between AIDS policy and implementation has arisen as a result of:

- *The estrangement of government policy-makers from local policy advocates and implementers;*
- *A lack of unity of purpose and co-ordination in implementation;*
- *mixed messages on AIDS from senior government ministers, including the president; and*
- *weakened civil society organisations working in the AIDS policy advocacy and AIDS support fields.*

RESEARCH METHODS

Since health is an area of concurrent national and provincial competence, we will examine the relationship between national and provincial government on the one hand, and provincial government and health providers on the other. Provinces selected for inclusion in the study are Gauteng, KwaZulu-Natal, and Eastern Cape. The provinces were selected on the basis on HIV prevalence, and to provide a range of relatively wealthy to relatively poor provinces.

Methods will include interviews with government officials at the national and provincial levels; interviews with health implementers at hospitals, including hospital board members; observation at hospitals and clinics; interviews with academics and representatives of NGOs working in the health sector; and focus group meetings aimed at examining the problems of doctors, nurses, and patients respectively.

CONCLUSION

This paper has identified two focus areas in which the gap between policy and implementation in the health sector could be fruitfully studied: the role of hospitals, and HIV/AIDS. Based on a study of the available literature, a number of hypotheses on the reasons for the gap have been formulated for field testing; these include hurried policy formulation, problems in consulting with key actors and implementers, an absence of effective prioritisation, failures in communication and co-ordination, and a weakened civil society role in both policy advocacy and implementation support. These hypotheses will be tested by means of interviews, observation, and focus groups during a second phase of this study, due to be conducted in 2001.

APPENDIX 1: DEMOGRAPHIC, SOCIO-ECONOMIC AND HEALTH PROFILE

Demographics³⁵

South Africa is populated by about 40,5 million people; their provincial distribution is given in table 4.

Table 4: provincial distribution of South Africa's population

Province	%
KwaZulu-Natal	20,7
Gauteng	18,1
Eastern Cape	15,5
Northern Province	12,1
Western Cape	9,7
North West	8,3
Mpumalanga	6,9
Free State	6,5
Northern Cape	2,1

Source: Statistics South Africa, *The People of South Africa Population Census, 1996*.

About 53,7 per cent of South Africans are urbanised. Given that there is little or no public transport in rural areas, accessing health care facilities is a major problem.

About 10 million women (or 25 per cent of the population) are of childbearing age (15 to 44), and about 4,4 million children (or 11 per cent of the population) are 4 years or younger. These two groups are particularly dependent on health care for pregnancies, childbirth, postnatal care, childhood illnesses, and immunisation.

Socio-economic profile³⁶

South Africa has one of the largest income gaps in the world. Not only is the unemployment rate about 34 per cent; of the 9,1 million employed, 62 per cent earn R1 500 or less a month, including 26 per cent who earn only R500 or less a month. Less than one per cent of the population earn R16 000 a month or more.

Somewhat more than half (57 per cent) of the 9 million households in the country live in formal dwellings. About 47 per cent of households have access to electricity for cooking, 44 per cent for heating, and 57 per cent for lighting. Sixty per cent of households have access to piped water either in their dwelling (44 per cent) or on site (16 per cent), and about 30 per cent of households have telephones. Some 50 per cent have flush or

³⁵ Based on data in Statistics South Africa, *The people of South Africa population census, 1996*.

³⁶ South African data based on Statistics South Africa, *The people of South Africa population census, 1996*.

chemical toilets in their homes, and some 53 per cent have access to refuse removal services by a local authority once a week or less. An international comparison is given in table 5.

Table 5: access to safe water and sanitation, 1995

Country	% access to safe water	% access to sanitation
South Africa	59	53
Algeria	n/a	n/a
Brazil	69	67
Ghana	65	32
India	85	16
Korea	83	100
Namibia	60	42
Sweden	100	100
Tanzania	49	86
US	73	n.a.
UK	100	96
Zimbabwe	77	66

Source: World Bank, *Entering the 21st century: World Development Report 1999/2000*, p242.

Health profile of the population

Average life expectancy in South Africa was 64 years in 1995 but, given the AIDS epidemic, is expected to decline to 48 years by 2010.³⁷

The overall infant mortality rate in 1991 was 54 per 1 000 live births, but between 94 and 124 for black children. The maternal mortality rate in 1989 was 8 per 100 000 births for whites, but 58 per 100 000 births for blacks. An international comparison for 1997, with comparative figures for infant mortality rates given for 1988, appears in table 6.

³⁷ UNDP, *HIV/AIDS & human development South Africa*, p 68.

Table 6: Infant and maternal mortality rates in selected countries, 1997

Country	Infant mortality rate per 1 000 live births	Maternal mortality rate per 100 000 live births
South Africa	48 (1988*: 71)	230
Algeria	32 (1988: 73)	140
Brazil	34 (1988: 62)	160
Ghana	66 (1988: 89)	740
India	71 (1988: 98)	440
Korea	9 (1988: 24)	30
Namibia	65 (1988: 105)	220
Sweden	4 (1988: 6)	7
Tanzania	85 (1988: 105)	530
US	7 (1988: 10)	12
UK	6 (1988: 9)	9
Zimbabwe	69 (1988: 71)	280

Source: *World Bank*, World Development Report, 1999/2000.

* Source of 1988 data: *UNDP*, Human development report, 1990.

In 1989 some 2,3 million people, 92 per cent of whom were children younger than 12 and 8 per cent of whom were pregnant or lactating mothers, were believed to need additional nutrition.³⁸

The incidence of HIV³⁹ in the annual national antenatal HIV survey of 1997 is shown in table 7, and the HIV-seroprevalence among voluntary blood donors in table 5.

Table 7: incidence of HIV in the annual national antenatal survey, 1997

Area	%
South Africa	16,1
KwaZulu-Natal	26,9
Gauteng	17,1
Eastern Cape	12,6
Northern Province	8,2
Western Cape	6,3
North West	18,1
Mpumalanga	22,6
Free State	19,6
Northern Cape	8,6

Source: UNDP, HIV/AIDS & human development South Africa.

³⁸ ANC, A national health plan for South Africa.

³⁹ HIV data taken from UNDP, UNDP, *HIV/AIDS & human development South Africa*.

Table 8: HIV-seroprevalence among voluntary blood donors, 1996 (per 100 000)

White		Indian		Coloured		Black	
Men	Women	Men	Women	Men	Women	Men	Women
127	82	313	196	329	719	7796	12719

Source: R L Crookes and A P Heynes, 1992. HIV seroprevalence – data derived from blood transfusion services, *South African Medical Journal*, 82, 1992, pp 484-5, cited in UNDP, 1999, pp 53.

The figures in tables 7 and 8 relate to specific groups: tested pregnant women attending health facilities, and tested persons volunteering to donate blood. They therefore cannot be taken as reflecting general trends.

Health facilities and personnel

South Africa has about 700 hospitals, of which about half are public and half private. Of the 160 000 hospital beds in the country, public hospitals provide some 100 000. Of the available hospital beds, 19 per cent are in academic hospitals, 20 per cent in tertiary hospitals, 18 per cent in secondary hospitals, and 43 per cent in first-level hospitals.⁴⁰ In metropolitan areas there are about seven beds per 1 000 population whereas in the rural areas the ratio is about 2,7 beds per 1 000 population. In 1994 there were some 2 218 health care clinics in the public sector serving an average of 16 000 people each.⁴¹ Since then 474 new clinics have been built, and 212 existing clinics upgraded.⁴²

The number of medical personnel is given in table 9.⁴³

Table 9: Medical personnel, 1998

Profession	Number
Medical practitioners	29 369
Dentists	4 387
Medical interns	1 791
Nurses	174 754

About 40 per cent of doctors work in the public sector. The overall ratio of doctors to population is some 1:1 300, but in the metropolitan areas it is about 1:700, and in the non-metropolitan areas about 1:1 900. It may, however, even be as high as 1:30 000 in some former homeland areas.⁴⁴

⁴⁰ ANC 1994, SA Health Review 1998, and South Africa Yearbook 1999.

⁴¹ ANC 1994.

⁴² South Africa Yearbook 1999.

⁴³ Ibid.

⁴⁴ ANC, 1994.