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Developing AIDS

A study of AIDS in the context of other social problems in New Crossroad, Cape Town

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Abstract

Development is often looked upon in economical terms and often research tries to investigate how one country can produce or sell more in order to increase its GDP. This thesis does not exclude these considerations but focuses on health as an important aspect of development. I investigate why South Africans (SA) would place their lives at risk with full knowledge of AIDS by not using freely available protection when having sex. Once an individual is lost to AIDS SA does not just loose an income earner to the family but years of experience, skills and that individual's personal networks. On the surface it appears that the SA government is working against development initiatives by compromising the stop AIDS campaigns.

The increase in infections is seen as a sexual behavior problem by the safe sex campaigns and I am suggesting that there is a historical explanation to the problem. With this hypothesis I went to SA to do fieldwork amongst a Township community which is affected by AIDS. As an analytical strategy the thesis aims to explore how people in SA presently understand and rationalize AIDS and what informs government strategies for developing AIDS policies. I explore through history how present individual conduct can be understood. I look at the structural failure of their AIDS prevention management through the good governance theory. I use the institutional theory to understand how history has informed government and personal perceptions of AIDS. Through the Motivation theory I examine how individual needs are structured in relation to AIDS and the violent nature of social conditions in New Crossroads, Cape Town.

Through the use of my theories I conclude that there are social structures where certain cultural and economical conditions are prominent which encourage risking infection by AIDS. I conclude that in SA there is a need for capacity building, good governance and inclusion of social conditions in their AIDS policy.

Key words: South Africa, AIDS, Development, Good governance

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Preface

I am sure that my grandfather and mother would be proud of me now. I am grateful to you both. It's been a long journey with many troubles along the way. Tata and Mama I am proud of the man you have raised me to become. I could not wish for better parents. Mama thank you for believing in me throughout my education.

This achievement belongs to the men and women who found and loved me when I could not love myself. You taught me to love and respect myself a day at a time. I would like to express eternal gratitude to you and I hope I can live long enough to give back what has been so freely given to me. To my ex wife Busisiwe Brooke Gasa there are no words that can express how I feel about you. You inspired me and kick started me into this journey. Without you there would have been no start therefore no end. Thank you.

Margit Anne Petersen thank you for teaching me that I can be a better man. It was not an easy lesson to take in but I embrace it and will never let it go. Nils Petersen thank you, you are a good man. To the Petersen family, if you had not been there for me I could not have gone this far. Thank you for the financial support. Fran thank you for being my other mother. Leif, Hanna and Per thank you for your support in the beginning of my education. The money for the books and your love helped a great deal. I still have the back pack you bought for me.

My children, if a poor African can go this far anyone can. To the community of New Crossroads, never let your conditions define who you can or cannot be. Tine Hansen I hope that as I begin this journey to the next phase of my development you will walk alongside me all the way in an equal partnership filled with love and fairness. There were times when I was in doubt but I don't remember being this content about my life. Miracles happen all the time and I am proud to say I have lived long enough to experience one.

Professor Franz-Michael Rundquist thank you for your patience. I have not been an easy student to supervise and I am grateful to you. I have learnt a lot about conducting a research. From interaction with you I learnt more than I did in the class.

Notations

AIDS	- Acquired Immune Deficiency Syndrome
ANC	- African National Congress
ARV	- Antiretroviral
DA	- Democratic Alliance
GNU	- Government of National Unity
MDG	- Millennium Development Goals
MCC	- Medicine Control Council
MRC	- Medical Research Council
NACOSA	- The national AIDS committee of South Africa
NEC	- National Executive Committee
NEPAD	- New Partnership for African Development
NPA	- National Prosecuting Authority
NP	- National Party
SA	- South Africa
SSA	- Statistics South Africa
TAC	- Treatment Action Campaign
TB	- Tuberculosis
WB	- World Bank
WHO	- World Health Organization
WTO	- World Trade Organization

1. Introduction

A lot of research has proven that in Africa AIDS prevention efforts are facing new challenges because people have continued to take the risk of unsafe sex despite their amplified knowledge and awareness of AIDS. A considerable amount of research has been undertaken in relation to stigmatization which pressures people to not declaring their status. Still research has not achieved explaining why the individual would put himself/herself at risk of exposing oneself to the possibility of infection.

Another factor is access to and effectiveness of ARV treatment which has been advanced to considerable levels of success (OPTIMA trial:2011). Access to these drugs has shown to have its side effects because in countries like the USA studies suggest that availability of ARV treatment may have lessened the fear surrounding AIDS leading to an increase of infections in vulnerable groups (CDC:2011). AIDS strikes people in their productive age impacting negatively on human resources of countries. AIDS can indeed be seen as a problem of the body or a physical medical problem thus a problem to be solved mainly by medical sciences. Airhihenbuwa proposed that AIDS should not only be considered as a development problem but also a social problem and be addressed within the context of other social developmental problems (Airhihenbuwa et al., 2000:106). As I will show later in my work this problem has many levels and if science is to find solutions it needs to tackled it from various levels including the public and private spheres. I look at AIDS as a problem of history, culture and economy (see Barnet & Whiteside:2006, 72 – 77). Developing countries are therefore facing new challenges in relation to the pandemic and the current strategies seem to be redundant and consequently not effective. Undoubtedly the strategies are effective to some level but have not explained to the core the increase in infections.

These developments call for new understandings in how development of peripheral states in regard to AIDS should be approached and should be seen as a bid for new intervention strategies. Most development projects are often from the top to the bottom and that is mainly some or the other type of development initiative suggested by developed governments through the MDGs, by the IMF, WB, WTO, WHO ect. All these are aimed at assisting developing governments and in that way the new strategies are equal to the old. The strategies for development often overlook the unique conditions in which underdeveloped countries find themselves. The dreadful shape in which Africa

was left by departing colonial powers and ideological factions in the cold war compromised important social sectors in most African countries. These preconditions have informed how most new democratic states were started (Lewis:2005). These circumstances have put some African countries permanently depended on the aid from developed countries or "welfare colonialism" (Jose et al.: 2007).

There are many challenges that can be detrimental to development which cannot always be traced directly to colonial powers or the developed world. I argue that the current standards and strategies for dealing with AIDS from the officials and fight AIDS campaigns are overlooking the uniqueness of the problem to African countries. The current solution strategies may be dismissing the theory and method which give developing countries a separate status creating problems of incompatibility between development strategies and local conditions (Martinussen, 1995:3-4). Here I bring forward what Rist sees as a false image of the world having experienced and lived through the same experiences (Rist 1997:74 see also Cowen and Shenton 1996: 57 – 58).

In his work Kohli considers internal influences to development such as personalized and tribal political struggles for power that can influence local policy (Kohli, 2004:330). It is these internal conditions that I wish to draw on in explaining the development of the AIDS policy in South Africa (SA). I go further and show how the rationalization of AIDS by individual South Africans can be explained and understood in this context. Firstly I investigate why individuals in SA do not seem to care about the risk of being infected by AIDS. Secondly I focus on challenges which inform government AIDS policies. Lastly I look at what these mean to an individual. With these reflections I went to SA, Cape Town in July 2009 for three months to do fieldwork amongst a Township community which is affected by AIDS. I looked at how it evolved historically in Africa, its institutionalization and narrow it down to how it's understood and dealt with by individuals in Cape Town, New Crossroads.

1.1 Research question:

1.1.1 Why do South Africans not behave in accordance with their level of knowledge and awareness of AIDS?

1.2 Sub-questions

1.2.1 Does the role of the government in managing AIDS encourage or discourage risk taking behaviour?

1.2.2 Does history inform AIDS policies and risky conduct?

1.2.3 Do social conditions of South Africans shape their view on AIDS?

1.3 Composition

Each of the chapters is preceded by a brief introduction of what that chapter entails. The first chapter is the introduction which introduces the AIDS problem and what has inspired my research. In the end of my introduction I introduce my main question followed by sub-questions which will assist in answering my main question. The subsection 1.4 is the background which will revolve around some of the problems behind the AIDS problem that are not visible at first glance and briefly introduces SA to the reader.

The second chapter will present my theories. The third chapter is methodology which introduces my methods and the ethnographic approach I used in conducting my research. The fourth chapter is the analysis which will try to answer my main question from various angles. This section will have three main subsections and each introduces the problem area which it will tackle departing from a specific sub question to my main question and is followed by a preliminary discussing subsection and a summarizing arguement. I will firstly present a subsection on a chronological account of how AIDS became known in SA followed by a preliminary discussion and an analytical use of the Institutional theory. This will be followed by the second sub section introducing the problem from a policy and government perspective. The sub-section will then be preliminarily discussed in a discussion subsection using the good governance theory. The third and last part looks at the social environment at the township of New Crossroads. I present the social conditions and later discuss them using Maslow's hierarchy of needs or motivation theory.

The fifth chapter will be my analysis and main discussion chapter which looks at the broader effects of the AIDS problem from all angles and answers my main question. To conclude I will have a chapter on concluding remarks and present my findings and suggestions for further research.

1.4 Background

This section outlines the background of the AIDS situation in SA. This is mainly for the reader who is not conversant with the topic in a SA context and to illustrate the impact of the pandemic to individuals, the economy and institutions in the country.

Officially known as the Republic of South Africa (RSA) the country is a forma British colony which in 1948 under the rule of D.F. Malan passed segregation laws called Apartheid. The first democratic elections were in 1994 which resulted in an overwhelming victory for the ANC and rise of Nelson Mandela to power. In 1997 the country passed a new constitution which allowed for a multiparty election and universal voting rights for all those over the age of eighteen (Freedom House: 2006). Presidential elections are held every five years and the President is the head of state and of government who has power to appoint a cabinet of ministers. There is a separation of powers between the judiciary, executive and legislature. The legislative branch consists of a bicameral parliament consisting of 400 seats in the National Assembly and the National Council of Provinces. The judiciary is headed by the Constitutional Court, then the Supreme Court of Appeal, High Courts and the Magistrates Courts. Cape Town is the legislative capital and Bloemfontein is the judicial capital (CIA:2007). The ANC has the power to amend the constitution because it has a two thirds majority. The main opposition party is the Democratic Alliance (DA) which is an alliance between the old D.F. Malan's National Party (NP) and the Democratic Party (DP) headed by Tony Leon at the time. Both parties, now known as the Democratic Alliance are the main opposition which attracts white votes and controlling one of the nine provinces in SA (IOL:2008).

Since the abolishment of Apartheid in 1994 the ANC inherited a lot of troubled institutions and an economy that was on the verge of bankruptcy. This was due to years of mismanagement, political unrest and sanctions. Moreover it had to deal with a lot of international political concern on its new government's ability to manage an economically stable country while maintaining a peaceful transition of power from its former white dominated government to democracy (Moran et. al.,

2007:647-649). With the end of Apartheid SA became the biggest national investor in Africa and was largely used as a gateway of political development in the continent. With its involvement in African development it brought with it the birth of the African Union and NEPAD (New Economic Program for African Development). With these developments exports doubled accounting for 33% of GDP and public debt halved to 23% of GDP in 2008. Interest rates charged by the banks on loans were at their lowest and inflation shrunk to 5.1%. The economy had been growing by less than 1% in the years leading to 1994 and grew up to 5% a year in the years leading to 2008 (Bureau for Market Research South Africa:2010).

SA is rated 55 out of 180 countries for corruption by the Transparency International Index of 2008. This puts at risk political stability, the government's capacity to deliver basic services like water, health and education that could mean life or death to its public (Transparency International Index:2009). The latest census statistics available to the United Nations (UN) year book suggested that it had a population of 46 888 million (Statistical Yearbook 2008:40) while the Medical Research Council of South Africa (MRC) found that there was a discrepancy in the percentage of that 46 888 million people registered as dying from AIDS. This is because the majority of the deaths due to AIDS are misclassified (MRC:2006). In these cases the cause of death behind the illness that eventually kills the individual is not recorded as being initiated by AIDS.

The AIDS issue has become a political battle ground in SA between the government, local NGOs and the international community working to prevent the spread of AIDS. The government's reluctance to bring the crisis into the open and work with prevention campaigns has led to the perpetuation of the social stigma associated with the virus (Lancet:2006). As a result there is an increase in infection leading to even more orphaned children and dysfunctional families. UNAIDS/WHO in 2008 estimated 18.1% prevalence in those 15 to 49 years of age at the end of 2007. This meant that 5.7 million South Africans were living with the virus in 2007(UNAIDS:2008). The public health costs are predicted to approach 38 billion rand. If these tendencies continue the UN expects SA's GDP to decrease by 17% in ten years (Moran et. al., 2007:650). While the number of people living with the virus had not increased in 2009 it remained the same (UNAIDS:2010). SA has experienced a lot of burden where human capital is concerned. Since 1994 with the change of government "shortage of qualified personnel has led to thousands of job vacancies, especially in the financial and banking sectors. Hence the plan for " joint Initiative for priority Skills Acquisition – to develop the needed skill base by recruiting and training more

engineers, technicians, and other skilled professionals" was devised (Moran et. al., 2007:650). With an estimated 900 dying every day the workforce is likely to be decimated by this and related diseases, thereby undermining productivity and retaining a strong human capital base (ibid.:650).

One of the biggest employers in SA, SAB Miller suggested that the costs associated with AIDS included absenteeism, healthcare costs and reduced productivity to the business (Global Business Coalition:2011). The country produces 30% of the world's gold and is also diverse in what it produces. Its produce includes chemicals, petroleum, food products, coal products and transport equipment. It has a per capita GNP figure of USD 3,400 which is mostly concentrated within 13% of the population while 53% are very poor and only 50% of them have primary education (Bollinger and Stover: 2009). With the world economy in trouble SA went into recession shrinking by 1.8% but the Soccer World Cup 2010 seemed to have boosted its economy significantly. It still however has a 25% unemployment rate having had 870 000 jobs lost in 2009 alone it ranks as the highest unemployment rate in the world (Statistics SA:2009).

2. Theories

In the following subsections I present my three main theories that I will be using in my analysis. The first theory is *Good governance* which will deal with the issue as an administrative problem and tell us who or what is governed and who can govern the issue or people. It will measure institutional capacity including what governing an issue means. Lastly it will tell us analytically how the AIDS issue is governed in SA. Through the *good governance* theory we are provided with tools for analysis that bridge a gap between health, development and the government.

The second is the *Institutional theory* and will explain how behavior or formal institutions can be explained and understood over a timeline or historically. This theory will assist in understanding how the social perception of AIDS evolved in SA. The third will be *Maslow's hierarchy of needs* which will show where AIDS fits in the priority of pressing problems from a personal angle. Through the theory I will investigate how needs inform risk taking behavior. Moreover that needs can be interrelated, support other needs and can conflict with other needs at times.

2.1 Good Governance

Good Governance is predominantly used as a tool for measuring the exercise of power by country governments and its effect on the lives of citizens seen in their standard and quality of living (Larmour,1998:1). Organizations and international actors like NGOs, IMF, WB and the UN have criteria for what is termed 'good governance' and have based a lot of their development welfare to assist countries which adhere to this criterion. There have been a lot of debates about what 'good governance' is and whether it is logical to come up with a unifying way of looking into how countries are governed. What I would rather like to look at here are the contributing components of 'good governance' which are broadly acceptable to all that I can use as an analytical tool. I choose to use the definition used by the UN. My motivation for choosing the UN's definition of good governance is based on the broad acceptance and use of its criterion by most governments.

The UN sees the government as one of the actors in governance and there may be various other actors depending on the structure of the political system in a given country or type of democracy (UNESCAP:2010). In principle the term 'governance' is used to define a form of collective action. The Aberdeen Agenda of 2005 which was legitimatized by the Commonwealth outlines twelve principles of good governance that should be emphasized and used as a measurement for adherence in member countries (Amis 2009:2). These principles define who should be involved in decision making and in what capacity. I will look at these principles in a national space which is seen as the exclusive right of the national government as opposed to global governance. These principle are concerned with how civil society plays a role in taking decisions on matters of public concern. Below I present the twelve principles as outlined by the Commonwealth Local Government Forum in Aberdeen, Scotland (CLGF: 2005) :

1. Constitutional and legal recognition for local democracy: local democracy should enjoy constitutional and legal recognition.
2. The ability to elect local representatives: citizens should be able to elect their local representatives in conditions of political freedom.
3. Partnerships between spheres of government: there should be cooperation and partnership among local,

regional/provincial and national spheres of government.

4. Defined legislative framework: local democracy should ensure local government has appropriate powers in accordance with the principle of subsidiarity.
5. Opportunity to participate in local decision-making: all citizens should be able to participate actively in the local democratic process.
6. Open local government – accountability: local government should be accountable to the community it serves.
7. Open local government – transparency: the local decision making process should be open and transparent.
8. Openness to scrutiny: The work of the executive should be subject to scrutiny.
9. Inclusiveness: the process of local decision-making must reflect the social, economic, environmental and cultural needs of the entire community.
10. Adequate and equitable resource allocation: in order to respond to the needs of the local community.
11. Equitable service delivery: the distribution of services should reflect the diverse needs of the local community.
12. Building strong local democracy and good governance: commitment to continuous capacity development of democratic local government

Accountability, transparency and inclusion which are stated as points six, seven and nine remain the fundamental principles which all twelve points can be summed to. While transparency can be seen as disclosure or the opposite of secrecy (Florini:2002), I define accountability as an "authoritative relationship in which one person is officially entitled to demand that another answers for his or her actions, rewards or punishments may be meted out to the latter depending on whether those actions conform to the former's wishes" (Harmon 1995:25). The United Nations Development Program's (UNDP:1997) policy on Governance and Sustainable Human Development puts emphasis on legitimacy, voice, rule of law and equal opportunities which I see as a variation of the principles advocated by the CLGF. In that sense these principle may overlap but do not conflict from the various developmental organizations. The principles are essentially designed to assists in looking

analytically at governance frameworks that define policies and procedures of who gets power, accountability and how decisions are taken.

2.1.1 Analytical Implications of good governance

In using this theory it is important that I am critical of what it can and cannot declare. I do not believe that the theory can indiscriminately answer all the challenges of governance. The challenges facing these concepts have been spoken about by Poluha and Rosendahl (2002) in regard to the cultural differences that conflict with Western standards and definitions of good governance. This poses a problem when "NEPAD claims that good governance is a precondition and foundation for sustainable development and poverty eradication" (NEPAD Secretariat, 2003:58). Cultural and traditional mechanisms are not recognized by these principles and in that way they become a blanket way of solving the bad governance problem.

Some of the challenges facing these concepts lie deeply in the concepts themselves because they require accountability to civil society from the government but what defines civil society in a developing world? Who confirms transparency of a given government in the developing world?

On face value it appears that the co-authors who represent the developing world and people who police adherence at local levels are the same people. Through use of the theory one can conclude that delivering a selective range of political goods to citizens is good governance but it could just be another corrupt activity by the agents of the system seeking to legitimize themselves. Accountability and transparency mechanisms already exist in most social and traditional structures of developing countries. Good governance principles may be a threat to already existing systems of accountability and therefore counterproductive.

As the good governance program selects agents of change who will advocate its principles locally, it removes those agents from the intensity of their local authority. For the locals who have absence of knowledge in these topics the principles seem like new measures and practices that contest traditional settings. In a nutshell these principles just become another inappropriate one size fits all solution only understood by the elite whom it seeks to hold accountable. I do not seek to devalue the current principles of good governance but on the contrary am suggesting that there may be already existing practices of accountability, inclusion and transparency. If these could be examined

and incorporated into the principles the process of capacity building could be more effective and strengthen good governance processes.

2.2 Institutional theory

By definition the word '*institution'* has several meanings and is used for different meanings by different disciplines. In the social sciences pioneers and developers of the institutional theory like economist North (1990) and sociologists like Zucker (1987), DiMaggio and Powell (1983) and Scott (2006) have contributed to its spread and application. Scott suggests that there is no single and universally agreed definition of an 'institution' in the institutional school of thought (Scott 1995:33, 2001:48). Institutional analysis is therefore complex and requires that the issue in question be thoroughly addressed including the definition of an institution the researcher is using when an analysis is being carried out.

What is an institution then? An institution can be seen as defining formal structures of government, hospitals, schools and alike which Von Mettenheim (1996) has put emphasis on. His definition of an institution is rather common sense and focuses more on governments as institutions that shape and inform individual behavior. The second meaning is as a way of thinking that directly influences behavior or an actual mechanism of social order that governs the behavior of society individually or as a group. Thus "One can, indeed, without distorting the meaning of this expression, designate as 'institutions' all the beliefs and all the modes of conduct instituted by the collectively." (Durkheim [1895] 1938:lvi, as cited by Hetcher et. el, 1990: 1). Thirdly an institution can also be seen as a formal rule or a policy which advocates how an organization should function this is known as Historical institutionalism (Steinmo, et al :1992). This is an approach that seeks to explain policy persistence and not its change. Even within one discipline there are various approaches to defining an institution and why it has hegemony. However the core intellectual argument of all the various approaches to institutions is that history matters, structures do matter whether theoretical or empirical and there is emphasis on 'path dependency'. These concepts shall be explained thoroughly in the following arguments. I look at an institution as a legitimate guide of social conduct as defined below:

> "A rule that has been institutionalized identifies an institution. Institutionalisation is the process through which rules or norms are implemented in the sense that they meet with

> acceptance and that violations towards them are met with sanctions, in one form or another, that are considered legitimate by the group concerned….According to what one may call a thin interpretation, an institution is a norm that has been institutionalized, meaning that it actually governs behaviour by means of sanctions. Such a thin conception of institutions entails that the concept has a very broad range of applications, covering all norms that somehow govern human activity." (Jan-Eric Lane and Svante Ersson, 2000:3 - 4).

This does not only mean the social meanings attached to institutions but also encompasses the economical and political views which in turn attach importance to them. DiMaggio and Powell (1983) suggest that organisations adopt formal structures that mirror institutions in order to gain social legitimacy with stakeholders in their environments. This means that by default any structures which attempt to influence behaviour have got to reflect some pre-existing formal rules and norms that inform how the structures should be set up. If there is change in the structures without a change in the norms or the norms do not comply with the changes in the structure or institutional set up then there will be a compatibility problem.

Therefore "the substantive content of institutions-especially those residing in commonly shared norms is internalized within individuals. When internalised, norms hold a privileged position in the individual's cognitive structure: by being at the very fountainhead of action, they help to socialize behaviour." (Hechter, 1990: 3). Seen like this "it is not difficult to imagine how [...] this behaviour contributes to cooperative social outcomes" (ibid). Brinton mentions the implicit and explicit rules that guide the interests and preferences of a community. In his view formal rules are monitored by the state while informal norms are monitored by family, relatives, friends and community (Brinton, 2001:8). Persistent antisocial behaviour and instances of social disorganisation must also be seen as a stable outcome of both formal and informal institutions (Hechter, 1990: 3). Both formal and informal institutions are met with sanctions when not adhered to and offer gains when the individual cooperates (Brinton and Nee:1998).

How do individuals choose then what norm to follow and respect between the formal and informal? Under certain conditions the choices are equal based on the result of each choice when taken including circumstances under which the choice was taken and in relation to the benefits the individual is seeking (Mas-Collel et. al.,1995:91-92). That brings us to one of the core arguments of this theory and that is 'path dependency' in the historical evolution of both formal and informal institutions. If one is to use the institutional approach to analysing a problem it is important to

understand why there is such a grounded and unshakable belief in how formal and informal institutions operate and maintain themselves or why they are path dependent.

Pierson explains path dependency as the "eventual outcome [that] can be exerted by temporally remote events, including happenings dominated by chance elements rather than systematic forces." (Pierson:2000). That means that potentially relevant and irrelevant choices or circumstances in the past influence future events or an outlook upon a given issue or problem today. The concept of 'path dependency' begun with the idea that past choices and outcomes can alter the course of the future (Ibid.). The concept has since been sporadically used to explain and claim evidence of current events or situations being the result of a decision taken in the past which has 'locked' it to a certain path. Page has summed up four related causes for path dependency: Increasing returns, self-reinforcement, positive feedbacks, and lock-in.

Increasing returns is inspired by a choice that is made repeatedly which offers greater benefits every time it's made. It can be seen as benefits that rise smoothly as more people make that choice. *Self-reinforcement* has to do with a choice which when made puts in place complementary institutions that encourage that choice to be continued. *Positive feedbacks* creates positive externalities when that same choice is taken by others. Little bonuses are thus given to the people who have made that selection or who will make it in the future. *Lock-in* is a choice that is influenced by the fact that others have made that choice making it a better and logical choice to make than any other available choice (Pierson, 2000:88).

2.2.1 Analytical implications of the Institutional theory

Though this may be a plausible explanation, historical accidents can neither be ignored nor neatly quarantined into a singular way in which the world works (Ibid.332). In that regard path dependency cannot be taken as the only logical explanation to why things happen the way they do through time. It does however offer a limited way of interpreting and enables us to understand how and why things happen the way they do and offers a framework or guide of where to look for evidence.

The theory does not focus on how people actually shape institutions but rather focuses on understanding how they are legitimized. It looks at the norm rather than its manifestation. In that

sense it does not explain the birth or rise of institutions but their maintenance. It cannot guarantee the benefits an actor seeks when he/she behaves a certain way. Therefore suggesting that a person opts for a given choice because of specific institutional benefits is speculative. In that way it does not offer a cut clear way of analyzing which institutional benefits the actor seeks. If thus one is conducting a research which seeks to understand why people behave a certain way, the theory can only confirm through history that they do but cannot explain which institutional benefits they seek. The potential implications of using the institution itself as a point of departure are not accounted for. Not all motivation for behaving a certain way comes from outside influences some are from personal preferences of the individual which cannot be explained in a group context as the theory does.

2.3 Maslow's hierarchy of needs

Over fifty years ago Abraham Maslow coined a theory on motivation. His theory was radical to the existing psychological theories of human nature at the time. Freudian psychoanalytical approaches put their emphasis on destructive tendencies while Darwin's approach was survival of the fittest. Maslow recognized that the study of unhealthy specimens or the dark side of human nature can only yield unhealthy results (Maslow:1970 As cited in Goble, 2004:17). He emphasized that humans have a tendency to grow positively and that the 'dark side' of human nature was brought up by a desire to overcome whatever obstacles would be standing in the way of the goal to be achieved. Abnormal human behavior like stealing, lying, cheating and murder is thus seen as a result of unmet legitimate human needs. In his view there are four basic needs that when not met cause a person to act selfishly as presented in figure 1 below:

Figure 1 Maslow's hierarchy of needs

Physiological needs include breathing, food, water, sex, sleep and excretion. He referred to these needs as "deficiency needs" and as long as they were met one would be moving towards growth but if they are not met they create a tension within us which stimulates deviant behavior (Maslow:1970). Safety needs include security of the body, of employment, of resources, of morality, of the family, of health and property. Social needs are needs for friendship, family and sexual intimacy. Esteem needs are of self esteem, confidence, achievement, respect of others and respect by others. Self actualization involves creativity, spontaneity, problem solving, lack of prejudice and acceptance of facts.

The genius of the pyramid lies in its simplicity and its recognition and concept of 'prepotency needs'. In this theory everyone has a prepotency need which is a need that has the greatest influence over our actions. A prepotency need is usually the lowest unmet need in the hierarchy of needs and this need will differ from one individual to the next. Necessarily physiological needs take priority as primary urges for the prolongation of life. In order to move upwards in the needs scheme lower needs have to be met the upwards move is possible only by satisfying one need at a time. The desire for safety then love and a quest for esteem are needs we are drawn to and the lowest needs we are driven to satisfy.

In a manner of speaking one can say needs are never going to be satisfied by moving up the pyramid because once the lower need is met at once another need which is higher appears (Ibid.:38). In that regard as one's desire is taken care of another one emerges to take its place and in the hierarchy of needs this is seen as working towards self actualization (Maslow, 1943:381). Self actualization is the ultimate goal and this need is the desire to be more or the best of what one can

be and is a need that can take any form depending on the individual. Needs are directly influenced by individual goals and there can exist needs within a desire to fulfill a need. The conditions that influence or motivate what actions individuals take in order to achieve a goal are seen as "enviromental presses" (Murray:1953) or "mediating factors" (Hargie, 2006:43) and it is at this stage that an individual "makes appropriate courses of action for goal achievement" (Hargie, 2006:43). Mediating factors can be seen as social conditions that define what our lowest unmet need is. For example, a person in the middle of a civil war will have a bigger need for safety than a person living in a safe society. The need for safety is this person's prepotency need while the conditions that define this need are mediating factors.

2.3.1 Analytical implications of Maslow's hierarchy of needs

Yankelovich saw Maslow's hierarchy of needs as an intellectual justification for selfish actions undertaken by human beings (Yankelovich ,1981:pp. 234-243). Under scientific scrutiny the hierarchy has shown that the needs are not always necessarily in the same order.

The theory suggests that a person who is hungry should at all costs (even risking personal safety and being held in esteem by others which are higher needs) seek to satisfy that need. The hierarchy does not hold true in a case of "political prisoners who starve themselves to death in order to achieve a certain goal." One can come up with numerous examples which are an exception to the order of needs (Hargie, 2006:42). This is to say that a need placed higher in the hierarchy can conflict with other needs that are lower than it which is caused by "mediating factors" . As in the example of political prisoners on hunger strike needs can conflict, complement each other and be interrelated. In this case the prisoners compromised their physiological needs in order to achieve an esteem need.

One of the challenges of the theory is its definition of a need if contrasted with a desire. A need is something we have to have in order to survive while we may desire something which is luxurious. I can argue that one does not need love to achieve self actualization. In that case love is more of a desire rather than something we can die of if deprived. In reality no one can challenge the need of humans for aspiring to something. The order in which those desires for aspiration are placed has been a contested topic though.

3. Methodology

In this section I outline the methods I used in putting this research together and discuss briefly the work proposed and undertaken by other researchers as well as the current practices in writing a social science project . I summarize my activities during my fieldwork and explain why my research is scientific for the sake of validity and consistency.

Andrew Sayer sees misconceptions as compromising the validity of a social science research project and that they "generate problems in our understanding of the world and ourselves" (Sayer, 1992:22 – 23). Even when a researcher has avoided these misconceptions science cannot be seen as the absolute truth. It is rather a version of many truths. Flick points out that "science no longer produces 'absolute truths', which can uncritically be adopted. It furnishes limited offers of interpretation" (Flick, 2006:13).

Thus as a researcher one has to be critical of the approach he/she chooses when conducting a research project. Through social science we tell stories of other people's lives and make meaning of their realities during the writing and interpretation process. "Meaning making" during the writing or interpretation process becomes a luxury of those who are exposed in that respective field and does not always reflect the reality of the people we research (Stringer et. al., 1997:86). Hence it is invaluable to include an elaborate methodology section that illustrates for the reader how my data was collected and interpreted.

3.1 Philosophy of social science

Methodologists like Descombe have touched on the danger of disrupting the "naturalness of a given setting" which is the object of the study during fieldwork (Descombe, 2003:193). This statement by Descombe suggests that the field and data a researcher collects changes and is affected by many situations from collecting the data itself, what happens during fieldwork and interpretation. Philosophical perspectives assists scientists in structuring a system for an observed reality which considers these changes in collected data. In order to understand the work of any given social scientist it is important to have a sense of how he/she views the world from a philosophical point of

view. In its most general form "the philosophy of social science concerns the principles regulating the search for and acquisition of knowledge" (Delanty and Strydom, 2003:3).

My research topic cannot follow stringent and structured methodological approaches. Armed with research questions like mine a researcher cannot just go to any situation and start questioning people about an intimate and stigmatized topic like AIDS. This is a highly sensitive topic with racial, social and class stigmatization implications in SA (Sierber & Stanley, 1991:49). With potential implications and consequences to racial groups and directly to participants I have then tried to "separate a phenomena or social reality from it's simple appearance to reaching a deeper level in order to understand the mechanisms that activate that specific behavior" (Delanty and Strydom, 2003:3).

It would be pointless and academically discredited if I would suggest that my entering the field during fieldwork did not change the dynamics of the activities and discussions the people usually have. In a sense one can never achieve a description of a given field in its natural form. Even as a covert researcher by being present in the company of a crowd the dynamics change. Becker categorizes these as epistemological "oughts" rather than "is's" (Beck, 1996:318). What Beck is trying to illustrate is what the field should ideally be like. Additionally the researcher should by all means at his/her disposal try to record the field as objectively as possible with minimal disruption. During my fieldwork I experienced a lot of resistance because the people assisting me with my research were concerned about their anonymity and approached me with suspicion. In that sense the 'naturalness' of my field was changed and any knowledge generated from this situation that leaves out these complex conditions would be incomplete. If my work presented only my formal activities during fieldwork then I would be only presenting how it ought to be rather than how it is or was.The goal here is to develop a deep understanding of the social phenomenon I have chosen to research as objectively as possible and not an attempt at objectivity.

I therefore choose a critical realist approach. In this philosophical tradition the socio-economic relations are seen as existing independent of the researcher. What can be observed is only a part of reality and there are deeper mechanisms which remain vague to initial observations (Jespersen: 2008). While in this tradition the future is seen as being uncertain and cannot be predicted the evolution of socio-economic phenomenon over time is seen as important for analysis which means that social phenomenon can be analysed in relation to institutional arrangements over a historic timeline (Sayer, 1992:115-117). Therefore, there are specific ontological domains that are important

for an analytical approach, toward generating a description of a phenomena: (1) the empirical, (2) the actual, and (3) the deeper level of understanding or real level.

My aim is to understand social behaviour and what governs it in SA and not a mathematical precision for drawing out the scenario based on an ideally perceived world. This is essentially a core argument of Critical Realism where the analyses start from the ontological level rather than the epistemological (Danermark, 2001: 20-21).

3.2 Methods

In this section I outline my activities during fieldwork and explain why and how I chose my methods as the best possible for my research. This is essentially a qualitative research and I will briefly discuss the methods I choose, present my material which makes up my research and demarcate my field.

I include discussions like my activities and defining my field because opinions vary about this topic as there are no longer clear cut rules about what constitutes an adequate fieldwork or definition of the field (Troman et. el. 2005:5). This thesis is based on fieldwork but also challenges the traditional conception of the field as described by classical anthropologists such as Malinowski.

3.2.1 Fieldwork

The field in my case is a concept that I develop which collectively does not necessarily exist. Instead of having a group of people who share a commonly agreed behavior or everyday life I have had to choose from what are accessible situations that could help answer my question. Thus when I mention fieldwork in this thesis it is made up of a geographical location but also individuals, politics, ideas, personal experiences and the internet. My concept of a field can be viewed in the postmodern anthropological thought which does not exist as a field a researcher can enter or leave but as constructed and delimited by the social researcher himself (Dick and Richard, 2006:347).

My fieldwork was conducted in SA 2009 from July for three months. The community I chose is one of SA's socially marginalized areas called New Crossroads situated about 20 Kilometers from the central business district of Cape Town. These socially and economically marginalized communities are referred to as the Cape Flats or commonly the *Townships*. There are several ethnic groups in SA and this township is home to the Xhosa ethnic group and I chose the township because of accessibility and language. It is also regarded as one of SA poverty stricken areas with a general income of one dollar a day (UNICEF:2011) which is below the international poverty line. These areas are often the most affected by AIDS and have limited access to medical help or nutritious food (National Strategic Plan: 2007).

My empirical material is from participant observations, interviews, information gathered from the internet, official government documents and lastly I used books from researchers who have done AIDS research in Africa. Before heading to SA I had made preparations of whom I would be speaking to and even went further to make specific appointments with AIDS activists whom I knew from a project I worked on in 2004 to 2005. I was convinced of this plan's effectiveness because I came from the country, spoke the language and therefore should be accepted very easily. This was not the case, my plan fell apart and no one was available to assist me or spend time on my project so I had to start all over and throw out the original plans. I therefore experienced during my fieldwork what Stringer calls 'loss of self identity, its redefinition and re-emergence during ethnographic fieldwork (Stringer et. al., 1997:95). The above issues are dynamics of gaining access to the field. Flick discusses gaining access to the field and stresses the problems involved and how researchers should enter the field:

> "The problem of getting access to the field understudy is more crucial in qualitative research than in quantitative research […] you cannot adopt a neutral role in the field […] Rather you will have to take or be allocated certain roles and positions […] Which information you will have access to and which you will remain debarred from depends essentially on the successful adoption of an appropriate role or position." (Flick, 2006:113-114)

As Flick states the problem of access is not only limited to access to institutions or interview subjects but also in what information you can get out of those institutions and individuals once you have gained a 'go ahead' from the situations. I started participating in support groups for people infected with HIV which I had done a few years ago during a similar project. Participating in the meetings was an attempt to understand how people deal with and rationalize the virus after they had

been infected. I thought I would interview those who had been infected and try to understand what they believed before learning they were infected with the virus and what they believe after. My being a part of these meetings seemed to discomfort and turn away a few people so I decided to try another approach. Each meeting has a representative who is part of a bigger organization called TAC (Treatment Action Campaign) who coordinates and links the groups to others. It was through this meeting's coordinator that I received an opportunity to participate in a clinic for testing TB (Tuberculosis) as a volunteer ushering people. This clinic informed the basis of my research and later led to my gaining access to a high school. At the school I was hoping to get access to young people who would be a little more open to talking to me about sex and intimacy and try to get their view on AIDS.

I did participant observation at the school and clinic, distributed a survey at the school to students between the ages of 15 to 19, and interviewed two teachers, two nurses from the clinic and a patient. During this process I was seen as an outsider who spoke the local language and when introduced to people they often referred to me as the guy from 'England'. I acquired this reputation which in many regards gave me some form of authority and at the same time reduced me to the status of a foreigner who spoke the local language. I chose to use these different qualitative methods mentioned above which I will discuss below not because I see one of them as being superior to the other rather as complementary in exploring my research question. My motivation for employing them is their ability to answer the question I ask from different angles.

3.2.2 Interview

I interviewed two nurses, two teachers and a patient and the interviews were semi-structured(see appendix 1). I did some informal and spontaneous interviewing with patients waiting to be seen by a doctor. The spontaneous interviews were not recorded but I took notes and wrote key words that would be elaborated later. The nature of the interviews was relaxed and there were no problems with understanding the concepts I was using for my research because the people I interviewed were very conversant with the topic and to some extent specialists. I recorded the interviews and the participants seemed pleased with contributing to what they perceived as a way of finding a solution to the problems around increased infections.

The international identity I acquired and the broadness of the AIDS concept often drove the interview subjects to AIDS international affairs which were not the focus of the interview. This is what Denscombe (2003:167) regards the 'interviewer effect'. The sessions were much longer than I anticipated but gave a broad knowledge of the problem beyond my research. The benefits of the semi-structured interview I chose are explained by Denscombe:

> "the interviewer still has a clear list of issues to be addressed and questions to be answered he is prepared to be flexible in terms of the order in which the topics are considered and there is more emphasis on the interviewee elaborating points of interest." (Ibid.)

The qualitative research approach has a deeper level of measurement if contrasted with the statistical power of measurement or quantitative research methods. In this approach I am able to achieve depth of the interview subjects' perceptions of a scenario. The qualitative interviewing approach compromises the broad application of my findings. It is not easy to generalize findings based on interviewing two teachers, two nurses and a patient.

3.2.3 Participant observation

I chose to do participant observation because it offers the social researcher a distinct way of collecting data (Denscombe, 2003:192). Moreover during the interview people say they do or do not do a lot of things and participant observation does not rely on what people say they do, or what they say they think. Instead it draws on the direct evidence of the eye to witness events first hand (Ibid.). As part of my research strategies I participated at the school, clinic and followed a group of teenagers ranging from 16 to 19. During my participating at the clinic, school and some social setting I experienced that there was a lot of contradiction between information given in the interview and practice.

At the clinic I was regarded more as a volunteer and so I fulfilled that role which also privileged me in being part of the staff and getting more than just the information they gave to me. I went to the clinic in the morning with a colleague who lived close by me and left around lunch time. I did a lot of informal interviewing of the patients in the waiting room where I received invaluable information about their perceptions of the clinic and of the staff. Taking notes for reminding me of my observations was not easy because of the type of work they do. People are often skeptical of going

to the clinic and declaring their status and the note book would turn away a lot of the people and discomfort the staff. I took notes at intervals and mostly wrote down at home. At the time I was conducting this observation I was not certain how it would become relevant to my work. On hind sight I can see that I was observing the nurses and how they receive the patients including how they themselves rationalize AIDS.

In reviewing my notes I realized that the nurses had systematically become agents of the system while the patients became the clients and this is the line of thought my notes followed without me consciously planning it. In a manner of speaking my observation was not structured and key terms were developed as I reviewed my notes. The observations at the school were much easier because I could take notes and ask questions during classes. I was also asked questions and was viewed as both a teacher and a student during the discussions.

3.2.4 Document analysis

Texts serve three purposes in the process of qualitative research "not only are they the essential data on which findings are based, but also the basis of interpretations and the central medium for presenting and communicating findings" (Flick, 2006:83).

Here I am facing a challenge of translating what has been translated from reality into text back to reality and into my own interpretation presented as text. Flick (2006) addresses some of these challenges during the process of writing which can lead to epistemological biases. With these reflections I have used news paper articles that discuss the topic of AIDs in SA, official documents from TAC, books from researchers in this field, government documents and largely articles including information from the internet. In working with these texts I am aware that these messages were produced with considerations of the reader or audience depending on the intended purpose of the text.

The documents from TAC are largely contra government while the government produces documents that seek to legitimize its authority. News paper articles have helped in shaping my research and served as a form of historical accounts of the opinions of government officials. On the other hand media messages written or spoken ones alike are multiple and produced through an interplay between target audiences and producers of the message. I do not consider them as uncritically valid in my research (Schrøder:2007) they served as inspiration for direction.

3.2.5 Survey

The purpose of the survey was to try and portray perceived life circumstances of my sample. The sample were the people I interviewed and the youths at the school. The questions of the survey were based on the life circumstances of the respondents (see appendix 2). I designed the questions of the survey for use in analyzing my respondents' concept of life and death and to portray their ambitions for the future.

I presented the survey before the interviews and the first day I participated at the school without giving too much information about how long I would be there. Because it was a controlled environment and I was present all the surveys were answered. I cannot argue that the results of the survey are representative of the entire population of New Crossroads but it does offer a limited insight within the scope of my research.

3.2.6 Data reliability

I have considered the question of data reliability and relevance to this specific case. Securing first hand data for all areas of my thesis is beyond the scope of my work thus secondary data becomes a valuable resource. It needs to be accounted for though that the secondary data was not put together with the intentions of supporting a project of this nature. I make the previous statement because reliability seems to be at stake when using secondary sources as definitions and policies regarding the phenomena in question vary over time.

Bryman points out that another factor that may impair data reliability is the fiddling or manipulation of data by officials (Bryman, 2004:210). Such changes will inevitably influence my case study and to try and avoid this I triangulate sources like reports from the UN, WTO, WHO, NGOs and official government documents to make sure that I have the most reliable data. Secondary data does not fully show the reality of the actual situation, but offers a relatively strong overview.

3.2.6 Ethical considerations

> "All aspects of the research process, from deciding upon the topic through to identifying a sample, conducting the research and disseminating the findings, have ethical implications." (Flick, 2006:49).

Conducting a research of this nature requires ethical considerations because I have to deal with private and intimate information. There is also the lurking temptation to use information from one informant to get more information from the other. This would not be credible behavior and there are a lot of ethical codes suggested in social research text books (see: Flick, 2006 44 – 53 and Bryman, 2004:505-520). These texts deal with consideration to participants in an interview, informed consent, deception and invasion of privacy amongst others. Some of the consideration I had to take into account were not just what questions to ask but how to ask those questions. This was to avoid provocative statements to my interviewees.

In regard to my interviewees there were no significant problems in understanding what I was doing and for what purposes. I presented myself as a student from Lund University and chose to be honest in every respect about my work and intensions. Therefore there was no potential risk of "harm to participants, lack of informed consent, invasion of privacy or deception" (Bryman, 2004:509). Lawrence has extensively described how ethics and politics of social research should be understood and applied during research. He talked about unethical but legal actions and behaviour, misconduct, physical harm, psychological abuse and legal jeopardy among others (Hopkins, 1997:16). With these considerations, I tried as much as possible to stay within the confines and limits of acceptable ethics and politics of social research.

4. Analysis

This section will present the three different sub-sections. Each sub-section will start by presenting the problem area then discuss it using the three theories presented in section 2.

4.1 Chronology of Aids

4.1.1 Origins

> "Epidemics do not just happen. They are not random events. They have histories. Histories always depend on how they are told, by whom and for what reason." (Barnett and Whiteside:2006, 71)

Social perception of illnesses and what AIDs is are important to understand because society deals with illness in relation to their understanding. The medical explanation of AIDs implies that in order for infection to occur the virus has to enter the body and attach itself to host cells. Once it has entered a host it attacks the body's overall immune response to foreign infections. These defense cells are called 'CD4 positive T cells' and are the prime target of HIV which copies their DNA to the point where it cannot be identified by the cells as a foreign infection thus cannot be recognized and destroyed by the body's mechanisms. The general estimate in the developed world is that a person can live a period of 12 to 24 months without treatment between infection by HIV to full blown AIDS and eventually death (ibid. 32 – 35).

There have been a lot of theories about where AIDS comes from but everybody agrees about what it is. AIDS derives from a monkey immunodeficiency virus that crossed species barriers into humans. The crossing of disease from animals to humans is not unique to AIDS and vice versa. A cross species infection of a virus from animals to human beings is called a zoonotic infection (ibid.:37). A more recent example of a cross species virus are the reports of the Influenza A (H5N1) virus also called "H5N1 virus" or commonly known as the bird flu in late 2003 and early 2004 (WHO:2011). While it is an issue of debate how the virus crossed from monkeys to humans it is known that at some point it did. The two main theories of how this could have happened are the consumption of bush meat from a monkey where the blood of an infected monkey could have contaminated a cut from a hunter. The second theory is contaminated vaccine using DNA cultured from chimpanzee kidneys in central Africa in the late 1950's (Barnett and Whiteside, 2006:39 – 40).

The first cases of AIDS were recorded in the USA between the years 1979 and 1980 when doctors suddenly started reporting clusters of extremely rare diseases. The cases were mostly detected amongst homosexual men hence the disease was named Gay-Related Immune Deficiency

Syndrome (GRID). In subsequent years cases were reported in other groups and in countries outside of the US. In Zambia, Tanzania, Congo, Rwanda and Lusaka there were similar reports of cases similar to those detected in the US. In 1981 there was a global recognition of the syndrome and questions about what it is and where it comes from were posed (ibid.30 – 32). Since its detection in the 80's AIDS has become a global problem which has experienced over 17 million deaths and sub-saharan Africa encompasses an estimated two-thirds of global AIDS cases (Kalipeni et el, 2004:1).

4.1.2 Perception of AIDS

In order to make sense of the epidemic people in power categorized people into groups such as 'risk groups' and homosexual men. Haitians and Africans were placed amongst these groups. Culture was seen as the main culprit and promiscuous sexual behavior including African marriage patterns that were different to those of Europe (ibid. 18 – 19). Systematically two groups evolved. Those who categorized and defined what AIDS was and where it came from officially and those affected highly who tried to make sense of the disease and live with it.

The two groups are fundamentally those who have power and those who don't thus the rich and the poor. Those in power unconsciously created dehumanizing and degrading definitions to blame and therefore avoid responsibility of the risk groups (ibid. 19). Before the affected community in Africa recognized AIDS as a legitimate disease with a potential to kill they understood it is as a scare by the government and churches seeking to control their sexual behavior. When it became clear that there were deaths associated with the pandemic perceptions changed to seeing it as a form of biological warfare, a laboratory accident or a result of a vaccine testing gone wrong and all these theories had supporters with evidence (ibid.20). The first South Africans to be diagnosed of AIDS were two white gay men who had both been recently in the USA (Ras et el.:1983). Thus the view that this was a disease of homosexuals was acquired and maintained itself because more and more gay men were diagnosed with AIDS in the following years. By 1990 there had been 353 cases reported and they were of gay or bisexual white men (Zwi and Bachmayer, 2011:316). In 1987 the first black South African man was diagnosed with AIDS and he had been working in the mines where there was contact with other men from particularly Malawi where prevalence at the time was much higher (Van de Vliet:2004).

The AIDS problem became worse with time and as more people got infected in heterosexual relationships shame and stigma became a problem. In 1998 Gugu Dlamini was killed by a mob in her local township when she admitted her status in public. She did this in order to fight the stigmatization problem and to show that it is not shameful to be infected. Her husband felt that she had brought shame on their community (Stein 2003:95). In 1992 a study on stigma showed that 38% of adults wanted people with AIDS to be separated from their local communities and locked up somewhere by the government, 6% thought they should be killed while 34% thought they should be taken care of by their families (Delius and Glaser 2005:29). Recently a lot of research has shown that tolerance for people infected with AIDS has improved but Stein writes that there is a difference between what official research shows and what actually happens in reality (Stein:2003).

In 2003 president Thabo Mbeki refused to acknowledge that AIDS was caused by an HIV infection and attributed it to being caused by poverty. He suggested that he personally knew no one in SA who died of AIDS. This reassured the public who at this time had trouble defining what AIDS was and where it came from that witchcraft was the problem and that AIDS did not exist (Murphy: 2003). A lot of people have since developed their own strategies in understanding what AIDS is and how to deal with it. One of the strategies is a grounded belief in what is called ´virgin cure' for AIDS (Taylor:2002). The virgin cure suggests that one who is infected is actually bewitched and should sleep with a virgin. The purity of the virgin will then clean the impurity of the spell. This results in infants being raped and this is supported by a belief which is recommended by witch doctors (AGIS:2011). In lack of a better explanation and with the government's ignorance witch doctors or what is called *isangoma* are left to be trusted authorative opinion makers by the public.

After 1994 migration, mobility and mixing have created conditions that encourage sexual mixing amongst different groups including those from other regions of Africa. Migrant men from other parts of SA and Africa came into areas which encourage and create promiscuous sexual patterns. An example are the gold mines where they are without their wives and resort to buying sex. Eventually these men return to their sending communities where they spread STIs including AIDS. Often these communities are in the periphery and lack the resources for dealing with AIDS and bear the cost of illness and death (Barnett and Whiteside, 2006:164 – 165). New Crossroads reflected the views portrayed to them in the media and through rumor as in the quote below from one of my observations:

> "AIDS does not exist it's just **A**merican **I**deas of **D**estroying **S**ex that is what it stands for. You are going to die anyway who cares what you die of. For example you could crash with your plane or get run over by a bus then you have been careful and using condoms. Using a condom is no different from eating wrapped candy […] I want the real thing skin to skin or nothing" (OBS, 1:2009)

The youths I spoke to reflected the lack of seriousness of the AIDS issue which was seen in the public servants. None of them believed that AIDS was a problem as suggested by the posters and TV ads they saw. At best they thought that if infected there is medicine and one could live a pretty decent life even if they were infected and at worst it was simply their time to die. Another view was that AIDS was brought to SA by foreigners from other parts of Africa. Through the observations and survey I distributed 90% of the respondents believed AIDS to be a problem brought to them by homosexuals or foreigners 5% did not know and the rest thought it was a biological attack.

4.1.3 Discussion

In this section I analyze the process through which formal and informal rules have been institutionalized and how they have become path dependent. By that I mean decisions ranging from the formal bureaucratic government departments to cultural norms and informal groups like the traditional local explanation of AIDS. These environments have the ability to both create and change institutions and there are many other factors like taste, values and knowledge that can shape institutions.The history of AIDS in SA has informed a lot of public opinion about what it is and where it comes from. The institutional theory suggests that whether regarded as good or bad, there is a rational process to each decision that is made by an individual. The continued perception of the AIDS problem as a foreign problem or a disease of homosexuals is explained by path dependency. This perception is tied to a historical perception and has now become path locked.

I look at these decisions to perceive or act a certain way by individuals and the government as legitimate guides of social conduct as suggested by the institutional theory. A cultural explanation for understanding and dealing with AIDS is considered an informal institution that governs behaviour in this theory. In this case it is rather difficult to define which formal institution or rule guides modes of conduct. This is because as it has been presented in the preceding section there

were a lot of organisations sending what they all labelled as legitimate and formal explanations of AIDS. For the sake of analysis I will look upon these conflicting messages as the recipient would. To the people who received these different messages all were seen as formal. The actor then would have to weigh the pros and cons in relation to institutional benefits when deciding which formal or informal approach to choose.

From the beginning the country did not give the necessary focus on the virus because of the more pressing political, economic, and environmental uncertainties presented in sub-section 1.4. The global nature of the AIDS problem and the transformation of SA from dictatorship to democracy became the ground conditions for its future perception and policy development. President Mbeki's reluctance was informed by pre-existing institutions which have explained AIDS in a specific way.

In dealing with the virus the government has developed organizations which adopt institutions that mirror social norms in order to gain legitimacy with the people they govern. This is one of the key arguments of the theory which suggests that if they come up with rules that the public they serve does not comprehend there will be an incompatibility problem. I am not suggesting that this was a conscious decision but the institutional theory holds true in this case.

In addition to the complexities, AIDS was initially seen as a disease of the gay community. This view has been inherited by the youths I observed and largely the community. During my discussions with the youths they showed that they were aware that AIDS was not only affecting the gay community but they also believed that it was essentially a disease of gay people. In their view the disease was transferred to heterosexual people by those who were bisexual. Secondly they did not think AIDS was an accident rather a conscious biological warfare by Europeans on the black community. In the discussions they told stories of how ANC activists were told they were being given a vaccination when they returned to a democratic SA after exile which was actually infected blood (OBS:2009). As the theory suggests this way of thinking has become institutionalized over time and contributes to social outcomes (Hechter:1990). These are essentially informal rules monitored by family, friends and community (Brinton:2001). They must be seen with the gravity they have in influencing behavior.

The consultation of traditional healers must be seen as a result of informal institutions and not irrelevant for analysis. The continued preference to consult traditional healers in light of all the information for formal explanations of AIDS can be used as a way of measuring which rules have supremacy between the formal and informal. When they attributed an infection to witchcraft it is not a lack of an ability to understand how one is infected or the medical explanation of AIDS. To

them it is a witch that caused the person to sleep with someone who is infected and the process can somehow be reversed. The traditional history of belief and how illness is defined and dealt with is a relevant history for analyzing an illness of this nature. As the theory suggests history matters in understanding the evolution of institutions.

Borhek and Curtis suggest that belief systems are neither fleeting perceptions nor private fantasies. In their explanations of what belief is they reflect on what it includes. They analyze the linkage between the different beliefs that form a system, the amount of commitment those beliefs ask for and are accorded, the degree to which they control reality and the degree to which the belief is tolerant or antagonistic to competitors and how it is organized. They go further to suggest that belief systems have an element of independence. That is not to say they are living creatures but that they exist independently of groups or individuals hence they often have longer lives (Borhek & Curtis:1975).

These reflection by Borhek and Curtis confirm that once a belief which is an informal norm is institutionalized it becomes path locked hence it has an element of independence and a longer life than the people who invented it. Antisocial behavior like the belief of a virgin cure and social disorganization must also be seen as a stable outcome of institutions (Hechter:1990). If institutions are met with sanctions of some kind if not adhered to then the individual looks at his circumstances and makes the choice based on institutional benefits. The men who make this choice are seeking benefits from it and are basing their choice on previously made choices. If the one choice means certain, slow and painful death from AIDS it is logical that they choose the virgin cure. The latter strategy has more benefits if contrasted with the former. If the men rape a virgin as suggested by the traditional healer they may face some years in prison if caught but will be cured. The former strategy of dealing with their problem is not promising since it is not supported by the government officials and ends in certain death. The decision to seek virgin cure can in this case tell us which institutions between the formal and informal have hegemony.

Because the choice to consult traditional healers has been made before by others it becomes locked-in. In that way it becomes a better and logical choice to make than any other available choice as suggested by the theory. The result is that the threat of AIDS has been minimized in society because traditional healers claim to have the power to cure AIDS. The formal institutional set up in SA contradicts cultural understandings of AIDS. There are formal institutions which attempt to dismiss the cultural understanding. The institutional theory suggests that any structures which attempt to influence behavior have got to reflect some pre-existing norms. Here the current formal

explanations of AIDS have been compromised by path locked previous formal and informal explanations. The historical explanations were that AIDS is a disease of homosexuals and foreigners or a biological warfare. How AIDS is dealt with by South Africans tells us which institutions have the power to influence social outcomes.

4.1.3.1 Summary

In these discussion above through the use of my theory we are shown not only which strategy the actors choose but a historical connection to the choice. The tendencies for a traditional choice tells us which institutions inform what AIDS is and explain the lack of fear for AIDS.

There are a lot of questions that can arise from my statements like how can an individual's unique choice be attributed to a collective choice? The answer to that question would lie in the general choice and pattern in society of the specific choice. These choices are made repeatedly because of what Page (2006) sees as causes for path dependency: increasing returns, self-reinforcement, positive feedbacks and lock-ins. In this regard self reinforcement can be seen as the cause for the traditional strategy to be chosen. Self reinforcement has placed complementary institutions which encourage the choice to be made again.

History has shown that the political performance of institutions inform how AIDS is understood and dealt with in SA. From my use of the institutional theory I conclude that people do care about AIDS in SA. The two main problems are interpretation and dealing with AIDS. The interpretation process deals with what AIDS is. By far the people I interviewed were not in doubt about AIDS but were in doubt about what it is and where it comes from. The second part is that the risks of infection and dealing with infection have been minimized by traditional methods.

4.2 AIDS politics in SA

Describing the origins of AIDS in SA is a history that is filled with a fair level of controversy. In its history for dealing with AIDS there has been a lot of political conflict between the ANC, NGOs and scientists. This marked a unique situation to SA where science was politicized. To top that SA has

had an exploitative and bloody history with a system that was based on racial discrimination prior to 1994 (Barnett and Whiteside, 2006:159).

When the ANC took over power with Nelson Mandela as leader it feared that the challenge of dealing with AIDS would be too great and compromise their nation reconstruction plans. The National AIDS Committee of South Africa (NACOSA) was then formed and it was made up of joined forces between the outgoing white dominated government's health ministry and the ANC. Soon the country had a national AIDS plan which included people living with the virus in developing a policy (Scheeider and Stein, 2007: 724 – 725). With the ANC burdened by the task of transition from dictatorship to democracy and pressure to come up with workable policies for dealing with AIDS Mandela then licensed an AIDS therapy drug called Viroden (ibid.728). Viroden was developed in SA by a medical technician Michelle Olga Patricia Visser at Pretoria Hospital but the drug was rejected and proven to be poisonous and ineffective by the Medicine Control Council (MCC) and Medical Research Council (MRC) (ibid.102).

The SA government was soon put under pressure by NGOs and international organizations to come up with an alternative treatment. They responded by passing a legislation amendment act in 1997 for saving money which allowed them to import cheaper generic versions of the AIDS medicine. The legislation also allowed local companies to manufacture cheaper versions of the drugs. This move by the SA government violated the Intellectual Property Rights agreement which is a brainchild of the WTO designed to protect intellectual property rights (WTO:1995). As part of the strategies that seek to protect scientific inventions the WTO established in 1994 an Agreement on Trade Related Aspects of Intellectual Property Rights (TRIPS). Through this agreement member states are forced to comply with certain rules regarding the protection of Intellectual Property Rights (IPR). The TRIPS agreement has the greatest impact on the pharmaceutical sector and access to medicines. TRIPS enforces all forms of intellectual property rights and member states cannot choose to adhere to some of the rules and not others. The agreement provides protection for twenty years after a patented product or process of producing a product has been registered (WTO:2008).

That means that if a country wishes to be part of international trade it is confined to oblige to those rules. The WHO respects these agreements in pursuit of certain standards of health. It is these agreements which caused difficulty for the SA government to achieve its objectives of providing ARVs to its public. SA's violation of the trade agreement resulted in an international law suit by 39

international pharmaceutical companies led by the USA for infringement of the TRIPS agreement. When SA's national health started deteriorating the international pharmaceutical companies filling the lawsuit experienced pressure from international organizations who sympathized with SA's move. In 2001 the case was dropped against SA allowing them to proclaim their act into law (Lanoszka:2003 97 – 181).

The rejection of Viroden and the lawsuit caused a split in the ANC politicians. The then deputy president Thabo Mbeki saw the rejection as a Western Medical view that failed to recognize African innovation. Mbeki accused the MCC and MRC of working with big pharmaceutical companies who wanted to use Africans as test subjects for their drugs (ibid.101 – 102). Nelson Mandela's health minister Dlamini Zuma responded by accusing the then chair of MCC of being disloyal to the ANC and pushing the agenda of big pharmaceutical companies.

4.2.1 Managing AIDS

When Thabo Mbeki took over from Nelson Mandela in 1999 he and his health minister Manto Tshabalala-Msimang started investigating the link between AIDS and poverty. Subsequently their management plan recommended traditional cure and the use of a diet that included garlic, beetroot and olives (Nattrass, 2004:48 – 49). Manto with Mbeki's support claimed that ARVs were not effective and called for more research to show that it was safe to use in preventing mother to child infection of AIDS. These arguments consequently placed the researchers of Viroden as victims of huge pharmaceutical companies and political discrimination (Van der vliet, 2004:48 – 96). The use of international funds for a controversial education program about AIDS by the ANC and its stance on medical interventions caused a rift between the government, NACOSA and NGOs.

President Thabo Mbeki's next move was to associate with AIDS denial theories which suggested that AIDS was not caused by HIV but rather by social conditions, malnutrition and poverty. With this view he commissioned a Presidential Advisory Panel (PAP) which he would consult on the use of AZT and causes of AIDS. The panel included scientists who supported the mainstream view of AIDS and scientists who were regarded as denialists. This combination gave the panel prominence which it would otherwise not have in medical science. Its main aim was to discredit the mainstream view of AIDS causes which cost Mbeki a lot of political capital. The director of the AIDS and research society unit suggested: "The panel served as a means for Mbeki and the Health Minister to

portray AIDS science and policy formation as deeply contested and contestable. This in turn provided them with the space to resist the introduction of AZT and other ARVs on the grounds that more research was needed into their toxicity and effectiveness." (Nattrass:2007). The chronicle between the government and the scientific community continued with public statements and letters back and forth. With international, political and public pressure escalating President Mbeki withdrew from public debate on the topic.

There are many views on why Mbeki withdrew from public debate on the AIDS issue but even in his silence he made claims that there was only two percent deaths caused by AIDS in SA and that government resources and health policies should be revisited (Van der Vliet, 2004: 66). The MRC responded by releasing its own cause of death study report which contradicted the statistics released by the government's official statistical body called Statistics South Africa (SSA). The government started putting individual pressure on the members of the MRC to disassociate themselves with the report released by the MRC. The director of the MRC refused to cooperate with the government and was later replaced and since the end of his term there were no further disagreements with the government. In the following years cooperation between the government and the MRC increased (ibid.:2005).

When Mbeki withdrew from public debate on the issue of AIDS his health minister pushed forward with the agenda and refused to give treatment to pregnant women and chronic AIDS cases. This gave rise to public criticism and an NGO which became known as the Treatment Action Campaign (TAC). In the following years the ANC lost a constitutional court case to TAC on their policy of denying administering treatment to pregnant women and people sick from AIDS. In 2006 there was an internal revolt by politicians in the ANC against the health minister's approach and a public criticism of her policies in an AIDS conference in Toronto, Canada. The ANC responded by removing her from the responsibility and replaced her with her deputy. The health minister still acted in her capacity as minister of health however her duties were delegated to her deputy. The deputy health minister spoke against the party's former policies and cooperated with mainstream science and NGOs. While cooperation was improving in the political front lines between NGOs like TAC and the government in the background the health minister still continued her public criticism of ART. She recommended alternative therapies while pointing out the poisonous side effects of official medicine now made available by her party. This in turn caused reluctance in patients suffering from AIDS to take the recommended medicine (AVERT:2006).

4.2.2 The AIDS business

The health minister's support for alternative treatments opened up business opportunities for all sorts of treatment gurus. Regulation authority for the MCC for what drugs were on the market became increasingly impossible because of the minister's personal involvement in supporting alternative treatment which included olive oil and garlic (Ashfoth, 2005:54). These approaches by the minister gave prominence to fake drugs and traditional healers like Siphiwe Hadebe and his Umbimbi which claimed to cure AIDS (Laurier:2003). International business men and women like German entrepreneur Matthias Rath's multivitamin treatment for cancer and AIDS had the support of the health minister. Part of Rath's marketing strategies for promoting his drugs were a scare against the side effects of ART which had been ruled against in a number of countries (Nattrass:2007). A retired Dutch nurse with close ties to the minister offered an AIDS remedy called "African Solution" which was branded in the ruling party's colors and supported the garlic diet as complementary to the remedy (ibid.:17 – 23). The minister also approved a traditional remedy claiming to cure AIDS to be administered in a home based care project to AIDS patients. The remedy was called "Ubhejane" which is a zulu word meaning Rhino and symbolic of a powerful animal in the culture. Doctors later complained to the minister that the traditional remedy caused patients to stop taking their prescribed treatment which caused drug resistance and the remedy itself caused liver failure when consumed (BBC:2006).

The main opposition party (Democratic Alliance) criticized what they referred to as 'back yard chemists' or the support of traditional and unscientific methods by the ANC. The DA soon landed itself a label as racists who promoted white methods and failed to recognize traditional methods. In 2005 TAC filled a court case against the minister of health for approval of scientifically untested AIDS remedies for public distribution (Ashforth:2005). The regulatory act of 1998 freed traditional and alternative remedies from scientific regulation but was cancelled in 2002 which still gave authority to the MCC as the scientific regulator for all medicines on the SA market. The minister's decision to disregard the MCC was thus seen as contravening legislation (Nattrass, 2005:2).

4.2.3 Discussion

In this section I wish to discuss the management of AIDS by the ANC, NACOSA, pharmaceutical companies and other actors like the TAC, MCC and MRC using the good governance theory. If good governance defines collective action then one can already assume that there was no good governance in managing AIDS between these different parties. But that conclusion would be short sighted and overlook a lot of important factors in these different actors' relationships. The twelve principles of good governance are a guide of how civil society should play a role in taking decisions on matters of public concern. The governance of AIDS in SA is thus not about who was right or who was wrong but the results AIDS management produced in society. Gordon sees the rationality of government as a way or a system of thinking about the nature of the practice of government (Gordon,1991:3).

It is thus the nature in which the AIDS was governed that is important for my work. How the government governs AIDS can be analyzed in various ways. For example does the government form policies that marginalize AIDS from its broader development agenda or does it form policies that see AIDS as one of the preconditions for poverty reduction? In my case it seems that the government took a strategy that does not include AIDS in broader development and made an attempt at seeing it as a precondition for reducing poverty. The formation of NACOSA was meant as a plan for dedicating a special forum for dealing with AIDS but as a consequence it sidelined it from the national agenda. NACOSA's approach compromised a lot of important factors like transparency and accountability because it was made up of former enemies who lacked willingness to trust each other and work honestly together.

If we take accountability and transparency as the foundation of good governance then from the formation of NACOSA between the ANC and outgoing NP these principles were compromised (SAHO:1992). AIDS was not only marginalized from broader agendas of developing the country but was seen as an isolated problem of a specific group. With these dynamics as being part of the founding principles of governing AIDS, partnership between the spheres of government was virtually nonexistent and therefore no accountability to the communities they were seeking to serve. Instead each of the parties made an effort to legitimize itself as the more knowledgeable and authoritive in relation to the other to the public (van Wyk, 2009:15). Public servants like the minister of health who were delegated and trusted with the authority to govern AIDS did not show

respect or accountability for the policies which are aimed as a means for keeping in check the criteria for performance in their responsibilities.

This tendency to undermining regulating policy continued to manifest itself within the ranks of the ANC when the party eventually took power from the Government of National Unity (GNU). The GNU was a negotiated multi-party government that served during the transition period. The monitoring of transparency and being transparent became sole responsibilities of the ANC once it took over as the majority ruling party with a two thirds majority and power to amend the constitution. As a result officials within the ANC like the health minister and President Mbeki took the advantage of overlooking regulations in deciding to implement alternative treatments to mainstream science. Replacing the director of the MRC because he refused to recognize alternative treatments compromised legal recognition for local democracy. The president and his minister of health appointed people in key positions within the MCC and MRC who could confirm their stance as valid. This gave rise to a lot of international criticism and the rise of TAC into the public sphere. The rise of TAC was a way of demanding transparency officially and respect of regulating policies from the governing party. Main opposition parties feared challenging the ANC because of the new and fragile democracy and they could amend the constitution and have exclusive power because of their two thirds majority.

The ruling party did not have the capacity to manage and respect regulations which resulted in a law suit by international companies. The law suit and TAC supported by international NGOs became a reminder of European dominance over Africa and President Mbeki responded by rebelling. His putting together a panel of researchers to scrutinize the orthodoxy of the causes of AIDS which excluded experienced researchers from the MRC was a clear vote of no confidence in existing capacity and a move away from transparency into secrecy.

While this move by Mbeki caused a split within the ANC it received support from some of the public and politicians who saw anyone supporting TAC as a traitor to the goals of the struggle against European domination. The biomedical argument was for transparency, social mobilization and advanced medical establishment campaign groups. They demanded publicly funded post exposure prophylaxis for rape survivors and health professionals, prevention of mother to child transmission programs and a scaled up public ARV treatment program (De Waal:2000). These were valid demands from the biomedical groups which correspond the fifth point of the principles for participation in decision making. Local policy protocol provided many loop holes which the

president and his minister could use to justify their approach.

The criticism of the minister's support for traditional cures can be seen as a lack of sound knowledge for cultural practices by the international community and NGOs. Unless there is recognition of its history and inclusion of its traditional methods of dealing with deviant behavior then there is risk of the principles excluding themselves. These deviant behaviors have existing traditional structures for punishing offenders. Traditional structures for dealing with such behavior were not considered in official protocol. This left a picture that undermines the existence of AIDS.

4.2.3.1 Summary

I do not see good governance and the traditional approaches as being mutually exclusive because entrenched in these traditional principles are some of the good governance principles. Researching and understanding what traditional regulating principle already exist could benefit governance. Understanding them and their inclusion in dealing with AIDS could be advantageous because development partners can build on those traditions. The failure to recognize traditional approaches by NGOs and opposition parties has shown to have disastrous consequences resulting in lack of support of their campaigns by the public. The manner in which the campaigns against increased infections were managed did not show to be transparent and accountable. Each actor pulled the campaign to its direction and as a result compromised good governance principles.

These conditions have left the society vulnerable to AIDS which threatens institutional set up, structural transformations of government including economical contractions. If democracy is the cornerstone of good governance which should promote human rights, the rule of law, transparency and legitimacy and the participation of civil society as outlined by the NEPAD then SA has failed in their efforts to show good governance in managing AIDS (NEPAD Secretariat, 2003:59). I do not see any of the parties as being interested in people dying from AIDS. All parties involved are trying to work towards a solution but each will not recognize the other's approach. This lack of recognition of the parties has led to a compromise of all the 12 principles of good governance.

4.3 Life in the Township

As a point of departure this chapter will present my experiences during fieldwork and the people I came into contact with in SA. The central presentation will be the people living in New Crossroads' everyday life and their relationship to government officials. This section attempts to move away from the AIDS issue and focus on daily challenges which do not exclude AIDS but defined by the priority of the individuals' daily needs. In order to understand how AIDS is prioritized I have had to look at other challenges in their lives which would define where AIDS fits.

4.3.1 The clinic

The Desmond Tutu TB centre is named after one of SA's icons for the struggle against apartheid. It has been an extension of an already existing clinic called the Nyanga community clinic. The clinic is a government clinic where the poor community who cannot afford expensive private healthcare can go to get help. In the clinic there are various sections for delivering babies, a trauma section for emergencies and the section in which I was a volunteer which is for testing people for TB combined with AIDS testing (ANOVA:2011). The reason for combining these two is because Cape Town has one of the highest TB infections in SA. SA has a TB ratio of 511 cases/100,000 people making it one of the highest prevalence of TB in the world (Wood:2007). People with AIDS are prone to these infections and they usually ignore going to test for AIDS until it manifests itself through TB. The WHO declared since 1990 that in countries like SA TB is the number one cause of death in people living with AIDS. It is during this test that patients at the clinic are encouraged to consider testing for AIDS.

Doing participant observation at the clinic gave me insight of how patients experience nurses and doctors including how nurses and doctors view the patients. This approach allowed me to observe and feel what it is like to be the patient sitting waiting to be seen. The clinic is situated next to a busy bus and taxi terminal in Nyanga. This is for making it accessible to the public which also discourages those who do not want to be seen by commuting people when going to the clinic. Because of the stigma associated with AIDS a lot of the patients tried to come very early to the clinic so that by the time people woke up to go to work they would not be seen and associated with

the clinic. While the clinic tries to situate itself as a TB testing clinic it is assumed by most people in the township that if you contract TB you are infected by the AIDS virus. The fact that it was winter and therefore daylight came later helped in keeping the people standing in line outside the main gate to stay a little longer than they would if daylight came.

The line started around six in the morning while the nurses would open up for registering patients who would see the doctor around 7.30. After 12 in the afternoon the nurses would turn down any new patients and pay attention to those who were already registered. Most of the people who came to stand in the line were visibly ill and could be seen from their loss of weight and often accompanied by someone or some carried in wheelbarrows. The patients who came to the clinic were often from other parts of Cape Town not New Crossroads and had to take a thirty minute taxi drive to come to the clinic in trying to avoid being associated by their local communities to their local TB testing clinics.

The waiting room in itself is very unwelcoming and rarely meets hygienic standards of a room meant to be a part of a clinic. The walls are grey and it has a sitting arrangement reflecting a prison cell for social outcasts. Because it was winter the windows were closed and that made it very stuffy. The waiting room has a reception with two nurses attending and registering a minimum of 25 patients at any given time of the day. Because the people who go to the clinic are already ill the nurses are often overwhelmed with work. Frequently the nurses have complained of a lack of working gear because they have to put on masks that cover their noses which is the only insurance they have against contracting TB themselves and they were often short of gloves. As a result they had to boil and recycle their gear and uniform. The nurses I spoke to often seemed unenthusiastic about their work which often reflected in how they handled the patients.

Their main complaints were the timing of the patients for coming to the hospital often waiting until they are too ill before coming to the clinic for help and a lack of appreciation in remuneration from the government for their efforts. Discretion was a problem for the nurses because while they were forced to sign an oath to keep the anonymity of the patients most of them came from the same townships the patients came from. Therefore they would sit particularly during lunch and talk about who they have seen coming to the clinic and what their AIDS test results were. They would then connect his or her status to whom he or she has been dating so that more people are suspected and stigmatized in their local communities through the nurses' hearsay. My observations during and

after work of the nurses proved that the patients may be justified in their fear of being associated with the clinic.

The patients viewed the nurses as agents of the system and the patient I interviewed referred to how the nurses treated him as “the government treats us” whenever he spoke of the nurses. The clinic is thus the only place where the public from the townships which is affected by AIDS get to meet with the nurses or agents representing the government’s care for the ill. The clinic is thus a face to face interaction atmosphere between these two parties. This is where patients newly diagnosed with an AIDS infection are informed of decisions they can make which can potentially prolong or shorten their lives. This atmosphere is filled with a lot of distrust, disrespect, nervousness and anger from both sides because the nurses do not want to be agents of the system and the patients demand respect and care from them as government agents. What is clear from this situation are the power relations some are hidden and some are obvious. Here there is a medical language that the patient has to learn, respect and understand in order to prolong his/her life and the nurses are systematically in a position to make decisions. The nurses are not immune to these complex power relations because they are guided and influenced by a bureaucratic hierarchy and political goals.

4.3.2 Sithembele Mathiso High

> "Violence has become a pervasive part of the social fabric of South African society young people are twice as likely as adults to be victims of at least one crime and schools are frequently perceived as places associated with harm and fear ..." (Casella and Potterton:2006)

Sithembele Mathiso is a high school in New Crossroads. New Crossroads is one of Cape Town’s townships situated in the Nyanga district and is considered to be a high crime area by the SA police. Cape Town has a population of 2,893,251 people with 759 767 formal houses and the rest being informal shacks with a toilet that is removed by the municipality once a week and 16.1% of the households are headed by one person (SA census:2001). The official statistics from the UN consider Cape Town as a high risk city for murder which has a murder ratio of 40 per 100 000 people (UN:2006). On average 10 cases of rape are reported everyday to the police totaling 3659 cases of rape a year (Gie & Haskins: 2007:8).

I gained access to the Sithembele Mathiso high school through a teacher I met at the clinic who is a career guidance and a sex education teacher there. I was cordially introduced to the management of the school and was allowed free access to any of the classes I wanted to observe given that I share the result of my work with the management. I went to the school with the intention of observing young adults or teenagers in their everyday activities. Normally the school would have life skills education which included education about AIDS. It became clear in the first lesson I attended that there was no lack of knowledge about what AIDS was. There was limited understanding of how to deal with it or where it comes from and they had their own methods of determining if one was infected or not. One of the students diagnosed himself HIV negative because his wounds when he was scared or hurt were healing with no problems. In their opinion loss of weight was a clear diagnosis of a person infected with AIDS while gain of disproportionate weight was a sign that a person was on ARVs because this is supposedly a side effect of the drugs (P.O.:2009). The most intellectually satisfying discussions would be undertaken at class and all students showed to be careful and considerate in their sexual activities.

Coincidentally when I visited the school in August the principal was murdered three days after I started going to classes. She was shot on school grounds in her office in front of the school children (Kobus:2009). This is not the first time in the country's history that a teacher or student is shot on school grounds. As early as 1997 the shootings were becoming popular (SAPA:2007). The violent nature of the activities at the schools escalated during the apartheid era. A lot of the schools were a common ground for stabbing children of parents who were seen as collaborating with the system by other pupils and a lot of vandalism was prevalent (SAHO:2011). As a result of gang related violence even the teachers wear weapons to school and there is a high security initiative by the government in what is now referred to as high crime areas. The shooting of the principal created a lot of tension at the school between teachers and other teachers and the same applied for pupils between each other. One of the rumors that went around the school was that this was a power struggle for her position and that the deputy may be involved in the assassination so that he could get the position as principal.

The students were visibly in trauma but in a week things were back to normal at the school grounds. The government offered security was gone and the investigating police took over the case. As the investigation unfolded it showed that the principal had been undertaking an investigation on one of the administrative staff members who had been accused of stealing student identity documents and

registering them for a death insurance including embezzlement of school funds (Booi:2010). These students then mysteriously died in gang related incidents. The admin staff member would then claim the insurance money which amounted to anything between 30 000 and 100 000 ZAR approximately 28 000 – 95 000 SEK (Witten:2010). The taking of insurance and false claims is a normal crime in high crime areas. In order to take out insurance on anyone you need their social security number and a copy of their identity book when they die.

As a result people safe guard their identity book because they fear that someone may take out a huge insurance on their name and after six months when they are legible to claim from the insurance policy they would then get someone to kill them. The accused admin staff member had access to the student social security numbers and could copy their Identity books during registration. He would then hire hit men to kill a given pupil or teacher, make the claim to the insurance and payout all parties involved. The killing often seems like a hijacking, robbery or gang related crime which are normal day to day crimes in New Crossroads. People who are master minds of these crimes are usually educated and aware of how to manipulate documents and submit false claims. Recently a syndicate involving a police woman and two men from government social services were arrested for buying unidentified bodies at a mortuary and submitting false insurance claims (IOL:2011). This seemed to be the case at the high school where a syndicate was operating to kill students for insurance claims.

The case is still ongoing but the public perception of the situation is concluded. As it is understood by the public there is now a syndicate of government officials, police and regular criminals making a business out of their lives through life insurance policies. The popular term for this is '*taking a number'* and if anyone is told that there is rumor that a number has been taken out on them it means that there is an insurance policy on them and that their life is in danger.

4.3.3 The township of New Crossroads

When the bell rang and it was time to hit the streets of New Crossroads the discussions in the classroom and the life lived in the streets did not harmonize. They used terms like *"Sipho has won the lottery"* which means that that person has AIDS. This is because the SA lottery requires that you have four numbers in order to win it and since AIDS has four letters this became the slang for

referring to AIDS. Another is "*Z4*" which is a BMW sports vehicle series used as a slang word for describing AIDS.

The township acquired a nick name too "*fabulous getto*" or as they called it "*Ghetto Fabulous*" and during the weekend it was full of color loud music and a high consumption of alcohol. There are no moral values against drinking and driving and the police are too busy chasing or investigating serious crimes for wasting their resources on drunk drivers. These parties are designed to drink and meet sexual partners and that seemed to be the primary purpose. During these activities it was not important if the people meeting were in a relationships or not but rather what was transpiring at that time. The teenagers that I followed during the weekend resembled their selves in class very little. All of them displayed promiscuous behavior with no consideration of the AIDS topic. It appeared that there was lack of understanding or rather a different definition of what consensual sex was. In these situations if a woman gives attention to a man for an extended period of time and accepts drinks from him then by default they should go home that evening together. It was during one of the discussions with some of the men that this became apparent and in these situations they would cite what happened to President Jacob Zuma when he was accused of rape and won the case. As the 18 year old participant put it:

> S "I don't think that a woman should waste my time and then want to leave it is my right as a man that she should stay with me. Otherwise I could have used the time and money to entertain someone who wants to go home with me. If she wants to play those games then she can go back to Europe with you maybe its okay there but not here!" (OBS:2009)

In these situations where there is struggle before sex between the two parties there is often no time for using protection and since this is not defined as rape it is not reported to the police. Jokingly the women responded to my question about contracting AIDS in these situations by saying "We can just take a shower after" (ibid.). Tradition does not allow young women or men to talk openly to their parents about sex and love therefore the only place for receiving any knowledge is at the schools. After the weekend they exchanged a lot of stories about what they had been doing during the weekend and for the male youths it was like a medal ceremony for those who 'scored chicks'. These discussions would give the male youths who had sex during the weekend respect by others. Safe sex was not a part of these discussions:

F: “I did not have a place to go with her so we did it in the car…”

Q: “Did you have a condom?”

F: “What!? Why do you spoil a good story! No, I cannot go around with condoms in my car what will my girlfriend think if she finds them? I don’t think she has AIDS and there was no time to think about a condom. She had such a nice light brown complexion and beautiful skin there is no way she has AIDS. I did not want her to change her mind so you have to act fast. I used a condom the second time when I knew she was putting out” (OBS:2009)

During my stay at the township I attended a funeral of one of the nurses who had died from TB. Rumor amongst the nurses was that she died of AIDS but because of the stigma to the family and for the sake of the partner who still lives they often prefer to cite other causes of death than AIDS. Paradoxically the teachers and nurses are experiencing a large number of deaths from AIDS in SA (Guardian:2005). These deaths by AIDS in these professionals has as a result caused the students to not take the topic with the seriousness it deserves.

4.3.4 Discussion

In this section I take the community I observed and analyze them as a group and that is a challenge because individuals are unique. The common denominator for this group is that they all come from what I define as a dysfunctional society. A dysfunctional society can be contrasted to a dysfunctional home where the individual has unmet needs of safety, love and comfort. I compare the rules at a home to the rules in a society reflected in laws and policies punishable by a given action if not adhered to. The priority of our needs is arranged by those conditions or what Hargie (2006) refers to as ‘mediating factors’.

In the society I observed the most challenging need is of safety and security because even though it’s a poor community basic needs for food and shelter are met. Safety and security have proven to be this society’s prepotency need which is the lowest unmet need. The impact of the violence around them has created a strong need and a lot of attention to be focused on being safe in their daily lives. As a result the long term fear of dying from AIDS is not as pressing as the short term need to survive today. The promiscuous nature of their activities must not be seen as a disregard for the possibility of infection by AIDS but rather a need for esteem and belonging.

As suggested in the theory some needs can conflict with other needs and I look at the promiscuous behavior as an example of a need for esteem conflicting with a need for safety from infection. I am not suggesting that the youth behaved as they did based on a need for esteem entirely. Needs can also be interrelated because sex is a physiological need which Maslow saw as a part of the lower physiological needs. The youths are challenged everyday at their homes or when they hang out in the streets of New Crossroads to deal with violence and even the schools are not a safe environment. These conditions inform their perception of what life and death is including time. We perceive time as smooth, flowing and something to be enjoyed and appreciated. The youths seemed to be enduring time which is a view caused by their conditions.

> "Although all societies have some system of time reckoning, some idea of sequence and duration, the mode of reckoning clearly varies with the economy, ecology, and technical equipment; with the ritual system; and with the political organization." (Goody, 1991: 31)

As Goody suggests, time is relative to perception and culture. How my participants spent their time reflects what Goody argues. Time is spent in being uncertain about their future, their safety and the safety of their families. In a sense they live their lives waiting for something to happen. It's like the concept of living in an open prison where one is sentenced to death but does not know the day and hour it will come. Since they experience constant conflict or crisis, there are often forces at work that bring out the feeling of powerlessness, isolation and insignificance (Jackson 2002:34). In light of SA's increasing economic division between the rich and the poor the existential crisis of increasingly being marginalized or "not having" is often experienced as a kind of "not-being" or worth less than the others (ibid:35).

This does not mean that these youths are not motivated to achieve the needs as suggested by the hierarchy. The hierarchy of needs is linear and based on a person being born and through their lives striving towards self actualization and then death. In that view death is the end after which there is no longer striving for needs. In these youth's perceptions death is not the end rather a transition to a continued existence either with god or ancestors. One of my questions in the survey was what is death. All the respondents did not see death as the end of life. Therefore according to them some needs may not be met in this life. In the following life they will be met where the conditions of their lives will be different. For them self-actualization can be pursued into the next phase of their existence which transcends physical life as we understand it as the patient suggests during an interview:

Q: What are your future plans?

Patient X: "It's not easy to plan the day to day activities because I do not know when I am going to be sick. But I hope everyday that my ancestors watch over me and will receive me well when my time comes…" (INT 1:2009)

Self-actualization is a product of how an individual views life. Understanding what "self actualization" is, is important for organizing the priority of the needs. There are three suggested ways in which an individual can choose to make sense of life or find meaning. The first is doing a deed, the second is experiencing something or encountering someone and the last is the attitude one takes towards unavoidable suffering (Frankl, 1984:133). These strategies allow the individual to strive for survival and fulfillment in spite of the vulnerability of life. The choice that the youths have thus taken is a specific attitude towards life. Death as shown in the citation below from an open discussion with the youths is always lurking for them:

K: "What is the point of going around being careful about AIDS when you never know what you are going to die of? Why should I even care if I have AIDS? I got it from someone so I will give it to someone."

Q: "Does that mean you would willingly infect someone?"

K: "No I would not but what I am saying is that I don't know I have not been checked. So if I have it then someone will get it and since I don't know if I have it what is the point of protecting myself. I can't protect myself from getting something I already have and if I have it I don't want to know. That is my constitutional right" (OBS:2009)

As shown by K in my discussions with him his needs have been reorganized. The need for health is higher in the pyramid in relation to the need for security of the body or resources. Security and safety needs can also be formed into a hierarchy because there are various types of safety. In a community where there is a lot of uncertainty the need for safety and security becomes constantly challenged. "Sickness in particular and crisis in general pose questions about our very sense of existence and non-existence" (Jenkins et. al,2005: 9) especially when it concerns the future. The question the youths, the nurses and patient consistently asked can be summed to: "what is the use of striving for a life goal when there is dread and despair all around?" The future for them is predictable and the picture it draws is grim. Ultimately these discussions with the youth revolved

around what the future is and my observations showed that they saw death as the future. They are uncertain of when it will come but often it is lurking and not too far.

I will suggest that the youths and the community have grown accustomed to the idea of death. Understandably it happens around them all the time to the point where it has become a business even threatening the lives of the living through the insurance schemes. They now spend their daily lives in uncertainty. The long term fear of dying from AIDS or a security need for health has been pushed much higher up the pyramid to where esteem needs are placed. The AIDS problem has thus become a luxury problem in relation to more pressing issues of safety. I am not trying to suggest that all the behaviors of the youth are caused exclusively by these conditions in dealing with AIDS. There is also the inherent human short coming which convinces us that "it will not happen to me" and even if it does it will not be the same. This phenomenon of risk perception, perceived likelihood and perceived damage is an important part of the considerations these individuals take in arranging the priority of their needs (see Becker: 1974).

Another factor which I consider is how those who are infected were received and treated at the clinic. The patients go to the clinic seeking more than just professional performance by the nurses but emotional support as well. They have to go through a lot just to present themselves at the clinic hiding from a society which stigmatizes them. When they are met by a cold and unwelcoming environment as a defense strategy the patients mistrust or do not disclose what they need to in order to get the help they need:

> Patient X: "I have developed resistance to the medication because I stopped taking my treatment when I started feeling better. I did not know that that would be a problem. No one had told me and now the nurses are angry with me because they say I am making their work hard" (INT 1:2009)

The relationship between the nurses and the patients has been harmed at many levels and they may be a lot of reasons and explanations to why. These conditions have unfortunately created an environment of mistrust between the nurses and the patients which is not the best for dealing with AIDS. The appropriate course of action as suggested by Hargie (2006) is thus to be silent about one's status or to not take the test at all. From these reflections I conclude that the lowest unmet need of this community is safety and security. This is their prepotency need. The safety and security needs can be divided into security of the body, of health and integrity. Since both their safety need for integrity and safety of the body are compromised by the clinic and violence respectively AIDS will always be a lower priority.

4.3.4.1 Summary

To sum up my discussion on the hierarchy of needs of my participants I observe that some of the problems with analyzing their lives lies in the definition of some concepts. Intimacy and safety are loaded concepts that are often taken for granted as understandable. The youths did not see a slight use of violence even to persuade someone to have sex with you as rape. Death is another concept which is seen as the end in most Western cultures but for my participants death was not the end it is seen as a beginning into another phase of life.

These concepts are used in their sex education at the school but are taken for granted. In this culture if you are thin you are suspected of being ill. Respondent 'F' used an examination of a woman's skin as a way of determining whether she is infected or not. This is not a completely unfounded hypothesis by this youth because one of the nurses suggests:

> Q: Can you tell if someone has AIDS without having examined them?
>
> N: "I have seen these cases so much in the time I have worked here that I can pretty much tell from walking in the street. Usually it's through loss of weight and you can see when it is because of AIDS…The complexion of the skin changes to a darker unnatural color and often there are marks line someone suffered burns that have healed. Mostly though even easier are signs of having had shingles…" (INT 2:2009)

It is not that the priority for AIDS is low but rather that they are certain that they have figured out a way that works for detecting someone who is infected. They have a web of networks that include rumor which protect them against known associates of an infected person. Through these rumors they can figure out who has been at risk of infection and avoid that person. Finally their living conditions define their sum of actions. The diverse nature of the violence that threatens them everyday such as the schemes at the school has taken up much of their attention and as a result lessened the risk of AIDS.

5. Conclusion

The institutional theory has shown a history of racial discrimination and the importance of understanding how AIDS is dealt with through that history. From the theory we have seen evidence based on history that informed policy making and AIDS strategies. I have shown the general problems and context through which AIDS is managed by the government. The economical impacts of the virus are not only concerned with the direct cost to the overall economy of the country but includes spending on health care, lower productivity and loss of qualified human resources. Because SA is not sufficiently equipped to face these challenges AIDS is likely to further undermine its formal bureaucratic norms leaving traditional informal norms to govern the country. In that regard AIDS has the capacity to change how the country is governed. I suggest that AIDS is SA's biggest problem but has got to be looked at in context of other social challenges.

In this thesis I have aggregated individual choices and showed how they fit into the collective. All the strategies chosen by the people have a logical explanation and to them are valid. I have shown that individual preferences are not identical to how they behave in reality. Further, the way political institutions for dealing with AIDS were constructed through time deprived themselves of the power of influence in contrast to competing informal institutions. This left the citizens with a challenge of reorganizing their needs which has produced socially and politically undesirable outcomes. The people from New Crossroads have as a result looked upon themselves as being worth less than the richer population. Their daily lives are confronted with constant danger to the point where AIDS is not a bigger or lesser threat than every other danger around them. The fact that AIDS has long term consequences and reduced urgency has created an environment where it seems they do not care. Fundamentally they do care as shown by all the people I spoke to but they are overwhelmed with other pressing dangers that there is no energy left to spend on this topic.

The speaking of AIDS in metaphors is a way of minimizing the seriousness of virus. In light of everything else it is a strategy to make it seem less threatening. Metaphors are used in our daily lives as means of describing the seriousness or lack of seriousness of an event or situation as Lakoff and Johnson suggest:

> "The concepts that govern our thought are not just matters of the intellect. They also govern our everyday functioning, down to the most mundane details. Our concepts structure what we

> perceive, how we get around in the world, and how we relate to other people. Our conceptual system thus plays a central role in defining our everyday realities. If we are right in suggesting that our conceptual system is largely metaphorical, then the way we think what we experience, and what we do every day is very much a matter of metaphor." (Lakoff and Johnson:1980).

They refer to AIDS as a Z4 which is a beautiful sports car and winning the lottery is not a bad thing in reality. The township of New Crossroads is called fabulous ghetto even though it's labeled a high risk area for crime. Using these terms as a metaphoric meaning for AIDS and the township is necessary for these youths. If they didn't the AIDS issue would be left to be the real threat that it is in reality and the township unbearable to live in. Given this view it is not surprising why they see anyone interfering with their sex lives as trying to destroy their pleasure and personal space since everything else is invaded. Under normal circumstances health is a private problem dealt with at the level of the household and family. Being infected with AIDS has become a public social problem for the person infected with AIDS creating even more stress and dynamics that the individual has to deal with in contrast to being silent about their infection. When a private matter becomes a public problem a connection between an individual household health problem and the national economy is forged. The government suddenly becomes a role player in ones private life because of the drugs and care that have to be made available to the public as suggested below:

> "Access to health care services is an act of individual exchange on a free market, just like entering an employment contract or buying groceries. However, for communities with a strong history of collective consciousness and weak ties to market economics, individuals act in socially embedded spheres of exchange, where the health of an individual is fully integrated into the dynamics of the household production. By looking at the household as the unit of analysis, it becomes apparent that health problems pose a significant demand on time and limited financial resources of households."(Wood, 2008:12)

Woods goes further to suggest that in such societies interpretations to medicines are often done collectively thus the group experience informs healthcare perceptions and ultimately affects access to health care (Ibid.:12). This can be seen through my work represented in the collective view the people have on the government's capacity to care for the ill through its clinics. The deep-rooted traditional approaches to illness have proven a hindrance to modern medical healing methods. To add to the complexity of the problem there is also the role of international organisations which work

closely with local NGOs in trying to influence development of policies which are aimed at eradicating AIDS.

To the locals the international organisations are interfering with issues that should be left to the South African to decide and thus become a pitiful reminder of European domination. In their defence the international organisations argue that they bring development but their concept of development is not understood by the locals because it is academic, slow and does not produce any real development as expected by them. Thabo Mbeki has defended his approach of rejecting western intervention as a way of saving money from big pharmaceutical companies who have turned the issue of AIDS into a big business. It is not clear whether president Mbeki's claims are true in regard to his approach but money is an issue in public healthcare:

> "The health sector may be governed by rules that are codified and easily accessed and understood by most people. Even so, many are actually participants only in a marginal sense. The USA, which possesses enough overall wealth to provide adequate care to all residents, is currently unable to do so because of economic, political, and logistic disagreements. Basically as everyone knows, it boils down to money." (Ibid.:1)

Thus not only money but the logistical disagreements in public servants shown in the SA media has informed how the pandemic is understood. Money is just one issue but there are various mechanisms, whether illicit or processes based, oral, formal or customary law and social relations that affect people's ability to benefit from things (Ribot and Peluso:2003). In this case customary law which is an informal institution has blocked South Africans from benefiting from any formal institution that works to decrease AIDS infections whether theoretical or empirical. Having access to something is not the same as benefiting from it. At the Nyanga community clinic all are allowed access but not all benefit from it. Access has to be separated from its simple observable legality in order to reach a deeper level if the intention is to capture the mechanisms that activate hindrances both from the government and the society. Ribot and Peluso define this process as "the ability to derive benefits from things" (ibid.: 2003):

> "The concept of access […] aims to facilitate grounded analyses of who actually benefits from things and through what processes they are able to do so. Access retains and empirical focus on the issues of who does (and who does not) get to use what, in what ways, and when (that is in what circumstances).

> Some people and institutions control resource access while others must maintain their access through those who have control. ” (ibid.:154)

The concept of access can be seen as including all possible means by which a person is able to benefit from things. The strategies that the people of New Crossroads use become part of the tactics employed by an individual, society or institution to be able through certain mechanisms to use the clinic as a resource. Ribot further explains that resource tenure cannot be fully explained by law whether written, oral or customary in regard to all the modes and pathways of accessing a resource along complex and overlapping webs of power. He also suggests that access relations always change depending on a group or individual relations to social structures (ibid:2003). The complexity of the social structures particularly stigma has proven to be a power that hinders people from benefiting from the clinic.

The institutional theory points out these informal constraints like stigma which can be traced to the evolvement of how AIDS is understood in SA historically. The troubled history characterised by dictatorship, violent riots, freedom and corruption serve as hindrances to fighting AIDS. The lack of decision making, monitoring and information puzzles are some of the bureaucratic constraints to their efforts that are linked to historical evolution of institutions. The formal, informal institutions that serve as constraints coupled with the bundles of power that are maintaining and controlling SA’s economy and political arena through various mechanisms inevitably keep it in a powerless position. The dangers of pointing out and dealing with the consequences rather than the cause must be avoided in SA. Thus the problem of AIDS should not be a precondition for alleviating poverty as in SA’s national plan. In this plan AIDS is isolated and dealt with before poverty is eradicated. AIDS should be tackled in relation to other social problem and be seen as equal to the need for safety and security. My research has shown that the people who live in these conditions do not see it differently and if it is to be solved the government will have to view it in this context.

5.1 Concluding remarks

In this thesis I have looked at the SA institutional capacity for dealing with the AIDS challenge. I went further to try and understand what the current perceptions are and how they inform their view on AIDS. Lastly I looked at what the pandemic means at a personal level. My approach has given

me several advantages because it not only looks at AIDS as an isolated problem but contextualizes it with existing problems. In that regard I have identified causal links between politics, economics and personal struggles. SA has focused a lot of its resources in public health imperatives but has shown to have sidelined the AIDS issue in its approach. The political and biomedical debates are focused on medical estimates of AIDS and fail to look at the greater struggles of the society. SA has had a volatile history which has informed a lot of public policy for dealing with the challenge.

Since 1994 SA has had to deal with a lot of social and traditional reorganization of authority. The running of government departments and bureaucracies within government require not only skilled people but years of experience and personal networking. The new social order was overwhelming for the ANC. When the ANC took power in 1994 from its reluctant predecessor on discussing sexuality they too took on this conservative approach to sexuality. As an ambitious administration for change the ANC overestimated their economical and human resources available to them for dealing with the problem (Nattras, 2004:41).

SA has woken up slowly and late for applying good governance principles to the AIDS problem. By that I do not mean that it is too late for it to move away from the self-inflicted ignorance that characterizes their national response to AIDS. In order to come up with institutions that perform they will have to make a conscious effort to openly abandon their former strategies and even apologize to its public. If there will be a solution to the AIDS problem in SA it will have to recognize and integrate its political characteristics, socio-economic and cultural aspects of the virus into its development agenda. The institutional theory has shown that good governance principles will have to be tailored to SA's unique culture.

What is clear though is that the ANC government has not placed importance of human beings in their economy. In order for positive development to occur the value of people is indispensable. People are an important aspect of economical development giving importance to attributes of a person which are productive in an economical context. The inevitability of past problems around the issue of AIDS cannot be avoided but the impact on human resources can be avoided through learning from that history. This thesis has only touched a part of the problems of inequality and lack of safety which complicate the AIDS problem. It is merely a means to understand why things are the way they are today. Further research into the socio, cultural and political conditions of communities like the one I researched could yield benefits to the reduction of infections.

Health does not have an economically rational incentive that can be measured immediately but on a long term if the SA government does not invest in public healthcare and prevention campaigns the results could be devastating socially and developmentally. Most importantly is to invest in strategies that are understandable to the individual South African, strategies that consider his/her conditions in order to achieve a decline in AIDS prevalence.

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