

"AIDS is in my blood": An Analysis of Community Activism, Social Change, and the AIDS Crisis in South Africa

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With the highest rate of HIV/AIDS in the world (1 in 5 are HIV positive), the AIDS crisis permeates every realm of South African society (Coovadia 2009:818). The political, economic, and social burdens on families heightened by this epidemic demands serious reconsideration of governmental policy and recommendations into alleviating the detrimental effects of this pandemic. The current HIV/AIDS epidemic presents social and political crises for South African society. HIV/AIDS affects the longevity of families (with a majority of cases between heterosexual couples) and creates a detrimental void in the current South African labor market by affecting the most productive sector of the labor force, individuals ages 20-49. My research explores how apartheid and post-apartheid policies contribute to the spread of HIV in South Africa, key theorists who critique the epidemic, different non-governmental organizations working towards continued access to ARV treatment and community empowerment as well as recommendations for the future.

I. Introduction

I see this [HIV/AIDS] epidemic as an extraordinary threat to the population of the country. It is a health catastrophe the likes of which have never been seen before in recorded history. I don't think people in the First World fully appreciate the enormity of the statistics. They talk of millions of people dying, but they don't understand what a million means in this context. They don't understand what a thousand means. A thousand people dying is a disaster. I remember September 11th and watching on TV when the World Trade Center was attacked. The horror and the thousands-three thousand dead look at how we react "to 3,000, 5,000, or 10,000 persons we didn't know dying in an instant. That many people are dying almost every day in Africa, and we just let it pass us by. We almost become complacent; we accept that this is inevitable. It just happens. People just don't comprehend what is actually going on. You have actually got to get out there and go into those impoverished areas, those rural areas, and see the people dying and the dependent kids that are left behind (Oppenheimer 2007:6)

The HIV/AIDS epidemic in South Africa did not arise out of a vacuum. When analyzing how a pandemic as massive and detrimental to the health and well-being of a country as HIV/AIDS has been to South Africa, one recognizes that it is imperative to examine the epidemic through a comprehensive lens. Since pathology is embedded in social experience, HIV-positive individuals are understood to partake in a complex system of economic, social and political forces that inform their understanding, acceptance, and resistance of this epidemic (Castro 2005:56). While HIV/AIDS is a biosocial problem, it has social solutions. Drawing on both qualitative and quantitative methods, one may assess the epidemiological, social, and economic impact of both the epidemic and responses to it (2005:57). Understanding how these

complicated issues inform one another may help policy makers, social activists, academics and citizens work towards a common understanding and acceptance of this illness while guaranteeing affordable medical treatment is made available to those in dire need. South Africa's history and legacy of apartheid strongly influences the current policies, laws, and general understanding of the nature of HIV/AIDS. In an effort to most effectively discern the various forces which fuel this epidemic, it is important to consider historical context; in particular, the residual effects of colonialism and apartheid policies under the current democratic system. The ramifications of colonialism on South Africa are twofold and embody a racial character: "First, South Africa is colonialism of a special type (CST) meaning that South Africa is a capitalist country where the means of production are in the hands of the whites. Secondly, both oppressor and oppressed were not separated by the friction of distance" (Narsiah 2002:4). When analyzing the South African HIV/AIDS epidemic, it is critical to acknowledge how colonialism shaped "local social practices, gender politics, community cohesion, economic livelihoods and access to medical care" (Braude 2009:2059). Although power structures and systemic inequalities may be woven into an ambiguous web of complexities, colonial medicine still pervades the practice of social medicine at an individual and social level, specifically as it applies to HIV/AIDS. While white and black South Africans lived in the same country and interacted within the same environment, apartheid laws and policies did a very effective job at separating them.

II. Historical Context and the Legacy of Apartheid

Although apartheid ended over fifteen years ago with the release of Nelson Mandela from Robben Island, the lingering effects of years of racial, political, economic and social segregation remain. The end of apartheid marks a dramatic shift in policy and governmental structure within South Africa. Transitioning from a colonial democratized system with racist policies to an all-inclusive democratic nation, the Republic of South Africa looked on to Nelson Mandela with the hope that he would lead the "Rainbow Nation" into a bright and democratic future. The African National Congress (ANC) prepared to become the leading political party of a new democratic South Africa but as a previous liberation party, they were unequipped to tackle the impending fiscal and social problems inherited from apartheid. This was due to the fact that as a liberation party, the ANC did not fully understand the ways in which politics operated on a national and international scale. Party loyalties and a general mistrust for established institutions would continue to pervade popular South African leader's opinions and thus, dictate their course of action in terms of policy recommendations and legislation. South African journalist R.W. Johnson phrased it well when he articulated the problems facing post-apartheid South Africa:

The trends and conflicts of the final decades of apartheid seem set: mass unemployment; social engineering aimed at changing South Africa's demographic patterns; sanctions and subversion by foreign powers; and a generation of urban blacks in revolt. The investor class is disaffected, the intelligentsia alienated, and the working class insurgent. The state's bureaucratic-police-military oscillates between reform and repression as its power base shrinks (R.W. Johnson).

Among these numerous issues, the problem of racial oppression and violence towards people of color was most arresting¹. The former governmental regime systematically dissolved their rights and divided every form of social life into racial categories. People were separated socially, economically, and geographically in terms of racial categories. The theorists behind

apartheid-"apartness"-proposed a society in which state-defined racial groups would be coerced or permitted to follow the "inherent" but separate development as "peoples." Apartheid policies were aimed "at the eventual and completely separation of Africans, Indians, and Whites in all spheres of life, including residence, education and employment" (Mitton 2000:20). People were classified into ethnic and racial categories and compelled to live in segregated, homogeneous enclaves, with limited social intercourse (Oppenheimer 2007:8). Active racism had a plethora of effects in terms of black South African's access to resources: quality health care, education, housing, and basic services. This arsenal of oppression was "enforced by violence, torture, extrajudicial executions and massacres, detentions, dispossessions, the destruction of whole communities, and systematic humiliation" (Chapman 1998). It is in this historical setting that one may effectively analyze the beginnings of the HIV/AIDS crisis. Recognizing the complexity of the pandemic helps to critically scrutinize and evaluate South Africa's historical past: "Apartheid was more than a state policy and more than a political economy. It was a culture, a system of beliefs and actions that profoundly affected every person in the nation" (Chapman 1998).

Apartheid existed in a variety of forms; South Africa's medical apartheid is the most relevant to this paper. This medical apartheid stripped black South African's rights to where resource allocation favored white South Africans and systematically denied proper health care service to blacks. Bureaucratic fragmentation fostered the development of pervasive racial discrimination in health care by facilitating unequal healthcare budgeting practices. This medical apartheid permeated every aspect of society, from government offices; hospital directors to individual doctors. People participated in apartheid's racist policies both actively and passively. Hospitals were divided according to skin color, with white South Africans able to access the latest modern medicine and services. Black South Africans were only able to visit these hospitals if they were in critical condition (for example, in need of immediate surgery) and even then, they were attended to only after doctors finished with their white patients. Doctors were forced manage their work with these racial inequalities: "the fact that clinical settings frequented by people of different races brought vastly different per capita resources to bear on the same medical problems and followed very different practice protocols as a result" (Chapman 1998). Due to a number of social, economic and political elements working against black South Africans during Apartheid, one crucial factor from subduing the spread of HIV/AIDS was access to quality education. Racial inequalities within the health care system helped fuel the HIV/AIDS epidemic by not only limiting the resources in which health care providers could offer their patients but also in the quality of sex education and AIDS prevention programs these doctors and nurses could provide people (Chapman 1998). For example, educational inequalities prevented many people of color from learning basic reading and writing skills. Adult literacy rates remained at 61% in the years leading up to the fall of apartheid and the subsequent years that followed (Mitton 2000:20). The low education levels and high illiteracy rates during apartheid era presented a challenge for health care workers, researchers, and educators in "facilitating an understanding of the severity of such an abstract disease as HIV/AIDS among the African population" (2000:21). Even as democratic policies transformed the South African government, the residual and enduring effects of apartheid remained.

III. Post-Apartheid Transitional Democracy: Policy and Personality Differences

"We have a crisis of AIDS in our country. On the one hand that crisis is one of illness and suffering and dying-dying on a larger scale and in conspicuously different patterns from before;

on a scale globally that dwarfs any disease or epidemic the world has known for more than six centuries. On the other hand that crisis is one of leadership and management ... The most fundamental crisis in the AIDS epidemic is our nation's struggle to identify and confront and act on the truth about AIDS ... The denial of AIDS represents the ultimate relic of apartheid's racially imposed consciousness, and the deniers achieve the ultimate victory of the apartheid mindset. " (Robins 6)

When the apartheid regime ended, the world looked to South Africa as the symbol of hope for Africa, with representative democracy and equality paving the way for future African nations. As the wealthiest country in Africa, post-apartheid South Africa was projected to be a period of anticipated growth and economic prosperity. However, South Africa inherited its own share of difficulties. The new government was forced to deal with "high levels of government debt and an explosive budget deficit, both legacies in large part of the profligate final years of the old apartheid government" (Seekings 2005:349).

In an effort to reform the current system, the new post-apartheid government underwent a series of public policy reforms. "Deracialization" was the dominant theme in public policy. The government attempted to reform policy in two steps: "First, the government completed the process of removing racial discrimination from public policy ... Second, it pursued policies designed to open up new economic opportunities for black-especially African-South Africans via policies of affirmative action and 'black economic empowerment'" (2005 :343). By executing these measures, the new government sought to "level the playing field" and break down racial inequalities within South Africa.

The ANC's commitment to a "social democratic vision in which the needs of both organized labor and the poor would be addressed, but within a capitalist economic framework" was reflected in their transitional public policies (2005:347). Their vision "saw the state providing a safety net for the poor while promoting major structural adjustment toward a high-wage, high-productivity economy" (2005:347). This social commitment reflected a distributional regime, whereby policies endorsed a "capital intensive growth path, despite high unemployment but increasingly mitigated the ensuing inequality with redistributive social spending, including especially public welfare and public education" (2005:341). Additionally in 1994, the South African government enacted the Reconstruction and Development Plan (RDP), which was formulated to stimulate growth and development. The RDP focused on "basic welfare rights," which apparently embraced "the right to basic needs such as shelter, food, health care, work opportunities, income security" (2005:357). The RDP sought to create gender and racial equality in South Africa in terms of an increased sustainable economy and the build-up of capacities and resources in rural areas (Mitton 2000:23). In 1996, the RDP was replaced by the Growth, Employment and Redistribution Program (GEAR). GEAR stressed deregulation policies and the privatization of basic services. As scholar Sagie Narsiah explains: "The GEAR policy was a combination of the standard IMF and World Bank stabilization and structural adjustment policies ... GEAR strategy proposed stimulating growth through and export-oriented economy" (Narsiah 2002:6). This strategy effectively "sidelined the RDP and committed the government to more orthodox fiscal policy" (Seekings 2005:349). These structural adjustments reinforced neoliberal ideologies and supported capitalist ventures in the new democratized South Africa.² The South African government emphasized neoliberal policies through increased privatization, where a "systematic transfer of appropriate functions, activities or property from the public to the private

sector, where services, production, and consumption can be regulated more efficiently by the market and price mechanisms" (Narsiah 2002:7). In essence, neoliberal policies reflected capitalism in an increasing globalized and market-driven world.

In South Africa, tensions were heightened by the slippage between neoliberal discourses on privatization and individualism, and liberation discourses on self-empowerment (Mindry 2008:79). This tension is particularly complex given the different philosophies behind each discourse. Liberation discourses focus on self-empowerment where individuals possess agency in order to take control of their lives. With an epidemic as pervasive as HIV/AIDS, individuals are recurrently limited in terms of access to drug treatment. This is due to socioeconomic status and the structural violence working against them. So while empowerment is certainly a characteristic that many HIV -positive South Africans care to embrace, "discourses on empowerment shift the focus away from social problems, toward a neoliberal emphasis on individual actualization through self-management" (2008:79). By emphasizing individual action and agency, one oftentimes fails to address government/corporate social responsibility in tackling issues as extensive as the HIV/AIDS epidemic. Governmental responsibility is reflected in political leaders who help shape popular opinion and possess vetoing power for legislation regarding highly active antiretroviral therapy (HAART). While an epidemic of this magnitude ravaged the South Africa countryside, past political leaders have been in denial regarding the origins of the pandemic and how to most effectively manage the crisis.

As ANC political leaders (Thabo Mbeki and Jacob Zuma) were elected to office, South African policies and programs altered due to the differing temperament and personality of each leader. While some political leaders supported the neoliberal policies which fuelled industrialization and economic growth in South Africa, others believed that Africans were capable of self-sufficiency and should become self-reliant to develop their economies. Foreign aid inundated the continent of Africa; South African leaders did not desire their country to become a charity case, particularly in regards to receiving medical aid: "While the postcolonial South African context is more nuanced than a simple binary structure, the ambiguity within beneficence as a form of colonial command still forms the basic structure upon which other medico-ethical, legal-, and societal structures are overlaid" (Braude 2009:2055). For instance, in an attempt to rid South Africa of neocolonial dependency on western nations for HIV/AIDS drug treatment, former President Mbeki argued that the HIV/AIDS crisis could be eradicated by reversing inequality and finding "African solutions for African problems" (Kevin Patrick Lecture). For Mbeki, "AIDS marks the African immune system of the living legacies of imperialism" (Comaroff2007:214). As an anti-apartheid activist and head of the ANC liberation party prior to its reinstatement as the leading political party in South Africa, Mbeki gradually developed distrust for western nations' perspective when it came to addressing the HIV/AIDS crisis. A huge advocator of finding a HIV/AIDS solution independent of western nations, "Mbeki's questioning' of established scientific knowledge and best-practice medical interventions succeeded in driving a wedge between the scientific community and the government" (Natrass 2004:51). As the AIDS epidemic festered and more people were withheld access to ARV/AZT treatment due to their political leader's subsequent denial of the crisis, many South Africans became outraged at Mbeki's ignorance and the lack of affordable drugs:

The dispute between President Mbeki and the 'AIDS world' should be seen as a struggle over symbolic power: Ultimately policy contestation around AIDS in South Africa can be

understood as a series of attempts by the state to legitimately define who has the right to speak about AIDS, to determine the response to AIDS, and even to define the problem itself (Natrass 2004:54).

As previously stated, HIV/AIDS is a biosocial problem with social solutions, which entails a thorough and comprehensive understanding of many facets of illnesses surrounding AIDS. This paper examines past and present governmental policies and ideologies which have shaped HIV/AIDS patients' access to treatment, current community organizations working to reduce stigma of marginalized HIV-positive people and fight for better treatment as well as analyzing current scholar perceptions of what the HIV/AIDS epidemic represents in the larger social context of international development and globalization. While historical context reaffirms the current political climate in addressing the HIV/AIDS crisis, an examination of the South Africa's neoliberal policies, particularly as they apply to marginalized people by the overpowering forces of development, is needed to humanize their perspective and work towards both education and empowerment on the part of the HIV-positive individual.

IV. Neoliberalism: Fuelling the AIDS Fire

"For AIDS makes scandalously plain the human costs of economic and political marginalization, the limited impact of humanitarian intervention, the toll of an ever more monopolistic control over the means of life itself." (Comaroff 2007: 202)

As previously articulated, the government dealt with AIDS by focusing on the biological aspects of the epidemic and failed to effectively address the multitude of social, cultural, economic and political elements which affected the crisis as well:

Neoliberalism is largely consistent with the biomedical construction of AIDS, which reduces the AIDS pandemic to its individual, clinical, and behavioral dimensions. In effect, what is erased or obscured are the material conditions which allow the virus to thrive, the broader factors that condition access to treatment, and the day-to-day realities of affected households where the tangible impacts are felt (Mindry 2008:77)

Tangible impacts are felt by people who have been denied rights and services guaranteed to them in the South African Constitution.

Post-apartheid South Africa's Constitution stands as one of the most liberal constitutions in today's world. The Constitution of South Africa is unique in that it "enshrines a Bill of Rights, access to adequate housing and sufficient water. In other words these rights are recognized as universal and cannot be applied subjectively privatized. However, these socioeconomic rights have been systematically undermined and violated at the grassroots [local] level" (Narsiah 2002:7). So while the South African Constitution guarantees certain rights, as a result of neoliberal policies infused into the new democratic system, increased privatization has left thousands of South Africans without basic necessities such as access to clean water, affordable healthcare or adequate housing.

The neoliberal economic framework was constructed so that certain groups of people benefit, namely those who possess more political and human capital, thus resulting in the ability to more easily move up the socioeconomic ladder. There has been improvement in efforts to

reduce the inequalities between classes but the crux of effort has come from not from the public sector but rather from the private sector. Aligning with capitalist philosophy, neoliberalism also stresses an individual's ability to work the system to his/her advantage. The wealthy South Africans hold more cultural and social capital and thus, possess more political power. In terms of the HIV/AIDS epidemic, those who possess political power align with pharmaceutical companies to acquire more biocapital and further the inequalities perpetuated by capitalist systems.³ Understanding how the system operates places an individual at an advantage to advance further than someone with limited knowledge. A better way to understand income inequality and subsequent access to medical services may be understood by the following metaphor:

South African society might be viewed in terms of a game of snakes and ladders. The "ladders" are the jobs that people find and the "snakes" are retrenchment, morbidity, and mortality of household members. There are a lot of snakes and ladders, but they are not distributed randomly. At the bottom end of society there are few ladders because people lack social and human capital and are more vulnerable to AIDS-related illness. The further up the board one proceeds, the more ladders there are: opportunities favor the already advantaged. En route there are many snakes, but the incidence of snakes declines just as the incidence of ladders rises" (Seekings 2005: 336).

Funding and policies directed towards alleviating the HIV/AIDS epidemic were largely concentrated in the private sector as the government withheld from constructing a universal AIDS plan: "The history of AIDS policy in South Africa is a sorry tale of missed opportunities, inadequate analysis, bureaucratic failure and political mismanagement" (Nattrass 2004:41). Policies geared towards addressing the spread of HIV/AIDS were historically limited and reflected the zeitgeist of apartheid: "The apartheid South African government's early response to AIDS was 'lukewarm' because of prejudices against homosexuals ... Unsurprisingly, the apartheid government's belated attempts to promote condom use were denounced as racist and politically motivated" (2004:41). Academics argue that the various efforts to control the pandemic and AIDS plan seriously overestimated the implementation capacity of the transitional government (2004:41). While the new democratic government sought to reduce inequality through a variety of different programs and mechanisms, three major inequalities remain which have helped fuel the AIDS crisis: First, labor-market and other policies that encourage growth along a path that favors a small group of economic "insiders" while excluding the poor; second, spending on public education that fails to improve significantly the educational opportunities open to poor children; and finally, the lack of any welfare provision for people who are poor because they are unemployed" (Seekings 2005:47).

V. Economic Challenges

The health effects of inequality have shown us how deeply people are affected by these structural features of our society. But even more important than the few extra years which great equity would add to the average length of life is the improvement in the social quality of life which it would also give us. Not only is the cost of inequality a cost we incur for no economic benefit, but all the indications are that it imposes a substantial economic burden which reduces the competitiveness of the whole society. (Richard Wilkinson, 1996)

While many governmental officials, academics and the general public may analyze the AIDS pandemic and argue that a reallocation of resources is necessary to effectively address the AIDS crisis, questions concerning who provides resources (public or private sector), and where money is derived (government spending or increased taxation) are critical and frequently the source of debate and controversy. In addressing the development dilemma, an economic analysis shows the positive correlation between poverty and AIDS prevalence. The link between the two may be summarized as follows:

- 1) Poverty contributes to the spread of AIDS.
- 2) AIDS treatment and prevention programs are more effective when people are well nourished. Therefore *poverty alleviation is a precondition for combating AIDS.*

But:

- 3) AIDS undermines productivity and economic growth.
- 4) Economic growth is necessary for sustainable poverty alleviation. Therefore, *addressing AIDS is a precondition for addressing poverty.* (Nattrass 2004:34)

Finding the balance between economic growth and poverty alleviation, while simultaneously combating the AIDS epidemic is a difficult challenge impressed upon the South African government. In 2009, the majority of people living with HIV/AIDS (67%), new HIV infections (70%), and AIDS-related deaths (70%) are in this region [sub-Saharan Africa], which only accounts for about 12% of the world's population (HIV/AIDS POLICY FACT SHEET). These statistics coupled with South Africa's tumultuous political and social past renders the country in a precarious situation.

In analyzing how HIV/AIDS as a pandemic affects the economy, an examination of the AIDS death toll on the current South African active labor force is essential to this project. Active labor forces are the economically viable workers (ranging from ages 20-64) who fuel the economy by bringing in revenue: "AID'S is 'welfare-enhancing' because the size of the economic pie is shrinking slower than the population, thus resulting in a greater piece of the pie for the survivors" (Nattrass 2004: 174). According to the Actuarial Society of South Africa (ASSA) 2002 demographic model, "an estimated 10.8 percent of South Africa's 45.9 million people were HIV-positive in 2004.⁴ This proportion is 18.7 percent for adults aged twenty to sixty-four" (Seekings 2005:333). Of this 18.7 percent of infected HIV-positive adults, about 15.3 percent are women and 3.4 percent are men (UNAIDS 2008:7). These statistics remain a socioeconomic crisis of major proportions: "It [HIV/AIDS] reduced the economic security of households by reducing the productivity of (and eventually killing) income earners while simultaneously diverting scarce household resources toward medical expenditure" (Seekings 2005:333). Families with HIV -positive individuals suffer from a lack of income flowing into their households. This income loss coupled with outstanding medical expenditures can leave families destitute before, during, and after their HIV -positive family member succumbs to AIDS. While it has been stated that the economically active and viable adults possess the highest rate of HIV contraction, considering where these individuals are geographically located within South Africa, their education levels, as well as family size is important to understanding the situation. In studying the impact of migration on HIV -1 transmission in South Africa, researchers discovered that migrant males tended to have higher rates of HIV due to a number of factors: lower socioeconomic status, lack of educational opportunity, and substantial time period away from

spouse and family while working.⁵ Research demonstrates that within the mining industry (a predominantly male migrant profession in South Africa), 23.6 percent of males entering the field are HIV-positive (UNAIDS 2008:23). All of these factors contribute to a higher prevalence rate in an already high target population. Researchers reported that significant risk factors included "having more than one current regular partner, being younger than 35 years, and having STD symptoms during the previous 4 months" (Lurie 2002:149). Migration continues to directly correlate with higher rates of HIV. Research reveals that frequently migrant workers move multiple times in order to secure jobs to support their families: "In South Africa, people who have recently changed their residence were three times more likely to be infected with HIV than those who had not" (2002:150). When examining post-apartheid policies, it is interesting and fairly ironic to note that the lifting of stringent apartheid laws has increased mobilization and indirectly contributed to the spread of HIV. However, while migration spreads disease, it may also be used to spread prevention messages and intervention programs that could possibly alleviate the profound impacts of the epidemic (2002:156).

Another important group dramatically affected by the AIDS crisis includes children orphaned by AIDS. According to an UNAIDS report, "an estimated 830,000 children were AIDS-orphaned in 2005, a figure that is predicted to rise to 2.3 million by 2020" (Cluver 2007:755). Due to sickness and copious amounts of medical expenses, AIDS takes a substantial toll on the psychological and financial well-being of a household. When an economically active person dies, the family is left to cope with the repercussions, including how to manage the children left behind. Besides coping with the difficult concept of a parent's death, the child may be left to take care of him/herself. If there are extended family members in the area, the child may reside with relatives. Regardless, children orphaned by AIDS may be a particularly vulnerable group in terms of potential emotional and behavioral problems, following the death of a parent: "Qualitative evidence suggests that AIDS-orphaned children are exposed to multiple stressors which may contribute to mental health problems, including debilitating parental AIDS-illnesses, multiple losses and stigma" (2007:755). Furthermore, orphans may experience psychological trauma in the form of depression, post-traumatic stress disorder, peer relationship problems and suicidal ideation (2007:756). Intervention programs may be necessary to help AIDS orphans deal with the realities of losing a parent, particularly if children are already experiencing difficult circumstances. Children are just one other element of the already devastating impact AIDS has on the population of South Africa.

Examining the demography of AIDS as understood by South Africans reveals how damaging AIDS is on the current labor force: "the standard demographic assumption in South Africa appears to be that individuals who contract HIV live for an additional seven to ten years and that most the debilitating illness and symptoms are manifest in the last two years of life" (Nattrass 2004:163). Combined at best, it is expected that an HIV-positive person will live approximately twelve years after contacting HIV. These assumptions are based on discrepancies regarding how long an individual can live in the HIV incubation period and how readily ARV and AZT treatment is available to the general population. With proper medication administered in adequate dosages over appropriate intervals, HIV-positive individuals can lead just as long and fruitful of lives as anyone. Yet these treatments come at a price. And the question of who will pay remains.

HIV/AIDS yields a large revenue gap in South Africa's economy and has both direct and indirect costs. "The direct cost of AIDS includes expenditures for medical care, drugs, and funeral expenses. Indirect costs include lost ties due to illness, recruitment and training costs to replace workers and care of orphans" (Bollinger 1999:3). Furthermore, HIV-positive individuals suffer from a number of indirect market failures, which are events and processes geared toward their disadvantage: "AIDS-related stigma and discrimination, unsafe blood transfusions, unattended childbirths, unclean water, and a lack of social services for HIV-affected individuals and families" (Castro 2005:57). These direct and indirect costs have short and long term impacts on the economic well-being of a country and more specifically, the people located within. Researchers predict the long term impact of AIDS to be catastrophic because "AIDS undermines the incentive and capacity of households to invest in education as well as the transmission of skills across the generations (Nattrass 2004: 161). There is also a sense of constrained optimism with the HIV/AIDS crisis due to the fact that AIDS kills off prime age adults (2004:35).⁶ While researchers assess potential impacts and analyze the projected outcomes of each type of intervention (medical, environmental, social), the question of resource redistribution and allocation remains. Where would money spent be most effective? Finding the delicate balance between prevention and treatment programs is of paramount concern to policy makers, researchers and social activists. As scholar Nicoli Nattrass articulates: "Epidemic control activities, by their very nature, are aimed at saving 'statistical lives' Nobody can point with certainty to the particular individual whose life was unequivocally 'saved' by a prevention intervention ... In this sense, the Rule of Rescue gives a comparable advantage to aggressive treatment activities in competing for public sympathy and resources" (2004:62).

At the end of the day, a decision about resource allocation boils down to value-laden judgments. Government policies reflect moral perspectives about how people believe the world should operate: "An economist is simply trying to do the best *technical* job of allocating resources efficiently *given social preferences* ... Economic analysis becomes dangerous when decision making power is ceded to seemingly technical arguments without realizing the nature of the implicit social judgments behind them" (2004:36). Whose values are privileged in decisions of access to treatment or affordability of drugs and whose voices are marginalized in the process are important to consider.

VI. Treatment Action Campaign and the AIDS Crisis

"It doesn't matter if you are HIV-positive," insists South African activist Adam Levine, "The World has AIDS. And if you give a shit about the world, you have it too."

South Africa's most influential and powerful NGO is the Treatment Action Campaign (TAC). Founded in the late 1980's, TAC's mission was simple: to acquire ARV/AZT medicine for those who cannot afford treatment. What began as a locally-driven protest movement erupted into a national and then an international network of allies and supporters working alongside TAC to address public health issues in South Africa. In TAC's quest for AIDS drugs, "a small group of committed activists were able to build a globally connected social movement—a form of practiced citizenship—that successfully 'persuaded' pharmaceutical giants and the South African government to put measures in place for the provisions of AIDS treatment" (Robins 20). While TAC's main objective has been to lobby and pressurize the South African government to provide AIDS treatment, it has been forced to address a much wider range of issues. These include:

"tackling the global pharmaceutical industry in the media, the courts and the streets; fighting discrimination against HIV -positive people in schools, hospitals and at the workplace; challenging AIDS dissident science; and taking the government to court for refusing to provide MTCT programs in public health facilities" (Robins 20).⁷

In managing a campaign as comprehensive and extensive as TAC's mission, the organization employs a multi-strategy approach to tackling the issues. Methods range from civil disobedience and street demonstrations through actions in the courts to measured pamphlets spelling out scientific arguments (Friedman 2005:514). In TAC's 'own understanding, it maintains its visibility through "posters, pamphlets, meetings, street activism, and letter writing" (2005:514). TAC as an organization is driven by a moral philosophy. In essence, TAC members believe that all people have a right to health and thus, access .to adequate treatment for illnesses. When governmental policies and pharmaceutical companies withhold treatment based on socioeconomic rationales, greed and affordability, TAC believes that it is their moral right to fight for those who do not have a voice. Even better, it is TAC's mission to help empower these individuals to find their own voices and fight for treatment for themselves and their loved ones: "TAC is not a numbers game. It is more about the ability to create a moral consensus. The button we are aiming to push (in planning civil disobedience) was that the government was morally weak. Morality is usually left to the churches but we all have a duty to be moral. The left needs to give a sense of morality to politics" (2005:540).

Examining the general demography of TAC as an organization, 50-70 percent of TAC members are HIV -positive. The demographics of TAC are 80 percent unemployed, 70 percent women-the group most affected by HIV, domestic violence in the schools-70 percent in the 14-24 age group and 90 percent African (2005:524). A majority of volunteers are unemployed HIV-positive black South African women, who remain the majority and most stigmatized of the groups of HIV -positive individuals. Indeed, TAC provides a lifeline for poor unemployed HIV-positive women: "Perhaps the most important reason for the successes of TAC's grassroots mobilization has been its capacity to provide unemployed HIV -positive black South Africans with the biomedical and psychological lifeline" (Robins 15). This support system and access to lifesaving drugs often occurs in contexts where these individuals experience hostility and rejection from their communities, families and friends.

In terms of funding, TAC will not receive support from the follow organizations: South African government, pharmaceutical companies or USAID (2005:517). If TAC received funding from these governmental sources or pharmaceutical and international relief organizations, their values may be compromised and there is always the risk of corruption. In an effort to align their values with practice, TAC will not receive support from the very organizations that they try to hold accountable. Funding is derived from non-governmental organizations and other sources. TAC consists of a formal government structure which provides an internal representative democracy. There are built in mechanism to ensure checks and balances within the organization. This functional internal democracy forces leadership to respond to membership, which guarantees that members retain a voice (2005:521). While major decision making resides at the national level, members at all levels are kept abreast on major news updates, times/places of political protests and rallies as well as general information. Although TAC serves the underprivileged and marginalized South African communities, formal decision making (for example, political protest strategies) generally remains in the power of only a handful of people.

Certain people possess advantages over strategy and decision making based on levels of education: "TAC strategies require technical knowledge unavailable to grassroots members who lack formal education" (2005:520). Even though the decision making process may be limited to a few, the decisions are not made without careful and close consideration for all parties involved. TAC works to retain harmony with its allies and avoid detractive labeling, which may hinder the organization's reputation. TAC workers avoid labeling such-as "white liberal" or "anti-African" camp: "By positioning themselves as supporters of the ANC, SACP, and COSA TV Tripartite Alliance, TAC activists have managed to create a new space for critical engagement with the ANC government" (Robins 14).⁸ This critical engagement is meant to serve as the groundwork for future alliances and the recognition that by working together and mutually understanding one another, organizations can find middle ground based on similar values: "Indeed TAC's legal and political strategies reveal a clear understanding of the politics of contingency in contrast to the inflexible antagonistic politics of binaries 'us' and 'them'" (Robins 14). In addition to forming productive alliances, TAC actually assists the government in providing public health services to people by ensuring that these people know where to access ARV's and how to use them (Friedman 2005:536).

TAC serves the South African HIV-positive population by fostering a collective purpose, solidarity and sense of belonging within the organization. Full blown AIDS individuals have been miraculously revived with ARV drugs and experienced a deep transformation of bodily health, self-esteem and confidence to face the world with AIDS. TAC activism "creates the conditions for more collective responses to HIV/AIDS and treatment ... TAC successfully advocates the transformation of the stigma of HIV/AIDS into a 'badge of pride' that is publically displayed on T-shirts at township funerals" (Robins 2006:314). Testimonials by HIV-positive individuals have inspired and encouraged other members to disclose their status and work towards educating and empowering others. One member shares his sentiments about TAC and the extraordinary benefits derived from participating in such an organization:

I'm a person living with HIV. I received counseling before and after I tested. The counselors at the hospital where I work as an admin clerk gave me nothing. I just found out I was HIV-positive and that was that. Three times I tried to commit suicide. Now I'm more positive than HIV-positive, thanks to TAC (Robins 2008:121).

Another survivor recounts her support for the organization: "I was very sick but then I found TAC and MSF and my life changed ... TAC is my mother. MSF is my father (2008:135).⁹ Activists who work within organizations like TAC or the MSF argue that "they are not only interested in medical treatment but also concerned with creating 'empowered citizens' who understand the connections between biomedicine, the wider social world, and the political economy of health" (Robins 2006:315). The fruits of TAC's efforts show. According to the UNAIDS Global AIDS report, the number of people receiving antiretroviral drug treatment between the years 2002-2007 has increased to 2.1 million people from 1.4 million people in the previous five years (2008:17).

While TAC has encountered a number of success stories in its effort to combat government and big business policies and legislation, it is met its fair share of opposition. South Africa's history of fighting AIDS has encountered political and religious dissident literature and propaganda, which sought to undermine scientific inquiry and evidence of the biomedical understandings of how HIV/AIDS is contracted, spread, and managed. The most evident of

dissident spokesmen was the former president and African nationalist Thabo Mbeki, who supported the AIDS denialist argument for a brief period in the last decade. As previously discussed, Mbeki's belief in dissident literature stemmed from the apartheid legacy of scientific racism: "For Mbeki and his 'dissident' supporters, such findings were not the product of neutral, rational and universal scientific enquiry" but were understood to be historically constructed and politically driven processes of specific histories of colonialism, apartheid and capitalism (Robins 4). Some AIDS activists blamed dissidents and AIDS denialists within the South African government for failing to provide ARV treatment, and "thereby contributing towards 600 AIDS deaths each day" (Robins 5). In fact, Dr. Costa Gazi of the Pan Africanist Congress (PAC) went as far as "claiming that this shortcoming constituted a crime against humanity and complicity in genocide" (Robins 5). These claims of westerner influence (and imposition) on African culture originated from the residual effects of colonialism and imperialism. In reaction to such ideologies, African nationalists "generated their own gendered nationalisms that accepted the western culture of the state, while simultaneously carving out sovereignty in the domain of African culture, and African women and family (Robins 2008:109).

Not only does TAC face political dissident but it also experiences religious opposition from fellow South Africans. Weary of western medical influence, a number of dissenters argue that "religious, spiritual and traditional explanations and modes of healing are significant contenders in the struggle fight and make sense of AIDS. If Jesus could heal leprosy, then why not AIDS?" (Robins 2008:123). Political and religious opposition to TAC's efforts made addressing class and racial inequalities even more difficult.

Although individuals may receive access to treatment, questions concerning long term benefits arise. While it is certainly positive that individuals receive affordable treatment, how much does treatment contribute to upward social mobility? While the organization strives to grant access to ARV treatment for HIV -positive individuals and thus, empower individuals to fight for more treatment, a number of racial, class and educational obstacles stand in TAC's way: "Language, class, race, and education divides and socio-cultural barriers also collude to reproduce the passivity and disempowerment of working-class users of public health facilities" (Robins 19). Even if treatment becomes affordable, there still remains the question of infrastructure: Where will individuals go to receive treatment? How will the public health facilities be managed? With scarce resources, how does one effectively orchestrate such an operation? For the average HIV-positive South African, "many do not have the material means, education or cultural capital to move beyond this structural location of marginality and liminality. In addition, they face the very real threat of social and biological death from AIDS" (Robins 2008:138). This stark reality is a difficult one to grasp; TAC's mission and objectives considers these realities and works to mitigate the potential harm: TAC, despite its focus on an issue not automatically associated with poverty eradication, is working, with some success, toward the redistribution of social power and resources" (Friedman 2005 :529).

Another critique of TAC concerns women's involvement in managing the organization. As previously stated, a majority of TAC's volunteers are HIV-positive women. While TAC is sensitive to gender by empowering women and giving them leadership positions, the organization does not always acknowledge that women are an extremely valuable asset for which they should be recognized. For example, although the upper echelon of TAC is mainly women, men occupy the public face of TAC (Friedman 2005:526). HIV-positive testimonies, public

speakers, international advocates (such as Zackie Achmat) are all male; TAC organizational leaders suspect that women tend to be more reserved when it comes to publicity than men, which may account for this tendency of male dominance in the public media. One final concern pertinent to TAC relates to issues of drug dependency on the part of the HIV-positive individual: "Whereas anti-retroviral therapy can undoubtedly prolong lives, it can also become a conduit for the 'medicalization of poverty' and the creation of dependencies on medical experts and drugs" (Robins 19).

TAC has both short and long term goals, ultimately organizing through a 'grassroots globalization' or 'globalization from below' approach. While TAC's activism strategies, methodology, and objectives have been the source of some critique and controversy, it has also been the source of keen admiration and inspiration:

TAC's mode of activism captivated the imagination of AIDS activists, journalists, and millions of supporters throughout the world: here was the archetypal David and Goliath epic. In their quest for AIDS drugs, a small group of committed activists were able to build a globally connected social movement—a form of practiced citizenship—that successfully persuaded pharmaceutical giants and the South African government to put measures in place for the provision of AIDS treatment (Robins 2008: 125).

Over the years, TAC's mobilization has been tactically creative and "underlines the ever greater salience of health in the reciprocal engagement of rules and subjects across the world" (Comaroff 2007:206).

In terms of TAC's future goals and aspirations, the organization hopes to broaden its international base "by giving priority to strengthening a Pan-African network of AIDS treatment activists. Passing on experience in coalition-building is one key goal since it believes that, in many other African countries, treatment activism is restricted to people living with HIV /AIDS and that this isolates and renders it ineffective" (Friedman 2005:548). TAC recognizes that solidarity is the key to success as an organization and stresses the importance of international solidarity in an increasingly global world. TAC officials have reported that without increased technology and medical interventions, ARV treatment would not be available. Furthermore, these TAC activists recognize that without the use of email and internet, they would not have figured out important information like parallel importation or compulsory licensing (Friedman 2005:547).¹⁰

TAC's issues are broad but the focus also returns to public health rights and educational empowerment. Despite adversity faced throughout the previous decade, TAC has managed to win court cases against powerful pharmaceutical companies and the South African government. As a social movement operating in civil society:

TAC is not a single issue campaign—we also deal with issues of governance, corporate governance and domestic violence—our concern is wider than HIV treatment. We are aiming to reorder the health sector. We need to build a culture of complaint, we need to start asking for solutions, we need communities to become more active. We have a progressive social democratic vision and shouldn't hide it (Friedman 2005:549).

Operating at the global, national and local level, TAC has challenged the intellectual property regime and drug pricing protocols and regulations imposed by the pharmaceutical industry. "At the national level, it posed a fundamental challenge to the South African government's AIDS treatment policies; and at the local level, it mobilized working-class black communities, creating the conditions for the articulation of forms of healthy biological citizenships as well as new gendered identities and subjectivities that challenged 'traditional' and patriarchal ideas and practices" (Robins 21).

VII. Biopolitics, Structural Violence, and its Impact on the HIV/AIDS Sufferer

"The third world HIV/AIDS sufferer: a being condemned to callous exclusion, to death without meaning or sacrificial value, in an age of widespread humanitarian empathy; a being left untreated in an era of pharmacological salvation." (Jean Comaroff)

Theoretical frameworks provide an intellectual foundation for comprehending the complexities of different social conditions. Understanding how diverse perspectives interpret a situation provides a more grounded framework for assessing potential outcomes or possible solutions. Applied to public health issues in the developing world, for purposes of this paper, these issues break down into specific topics: the HIV /AIDS epidemic, the epidemiology of diseases, and the structural violence which influences the decision-making process of individuals in the developing world. When one understands government policies and their intentionality, NGO/CBO missions and their objectives, one can reach a more comprehensive and inclusive perspective on how HIV -positive individuals understand themselves and work towards a more egalitarian world.

Individuals are constantly entangled in a complex web of signs, relations and affects; people cannot be removed from the social, political and economic landscape through which they interact with others (Comaroff 2007:209). These spheres of influence are not mutually exclusive. They inform one another and intersect in ways which both complicate and elucidate the nuances of larger issues such as the AIDS crisis. Understanding how the biological effects of AIDS are interwoven with politics is the focus of the following section.

Scholars coined the term 'biopolitics' as "the increasing concern with the biological well-being for the population including disease control and prevention, adequate food and water supply, sanitary shelter and education" (Agamben 1995:121). While concern for individual well-being is certainly an admirable belief, governmental laws and policies reflect judgments about whose bodies are more valuable. As previously discussed, capital (in any form, whether it be political, social, human or bio-) is necessary to advance in today's world. Those who possess more biocapital will hold an advantage over a marginalized population with lack of access to resources: "It would seem that no account of biopolitics in the modern world, no notion of bare life, can neglect this imploding history of biocapital. It is integral to the ways in which the substance of human existence itself can be objectified, regulated and struggled over" (Comaroff 2007:213). Those who acquire more biocapital are thought to be in an advantageous position relative to those who lack capital. Groups of people who possess inadequate amounts of capital may not realize that they are victims of a system built so that they remain disadvantaged. Particularly as it applies to HIV/AIDS, individuals who are HIV -positive and living in areas devoid of adequate resources to manage the crisis are understood to be victims of structural violence. In the inherent battle of the structure vs. agency binary, while individuals possess the

ability to make individual decisions such as "Will I wake up and go to work this morning?" or "Will I cook dinner for my family?", these choices are constrained by a number of external factors which inform their decision-making process. Structural violence is the result of systemic inequalities, reinforced by capitalist or neoliberal policies, which seek to build up capacities for some while undermining others.

Medical physician and anthropologist Paul Fanner analyzes the concept of structural violence and how it plays into the everyday lives of people living with HIV/AIDS in the Global South. The word "violence" can be understood in a multi-faceted number of ways, including "symbolic violence and the structural violence that is endured by those marginalized by poverty, gender inequality, racism, and even mean-spirited foreign policies" (Fanner 2004:323). Applied on a global scale:

The wider social world is characterized by conditions of unequal and inadequate health care reproduced by greed and profiteering of global pharmaceutical companies. These health inequalities are also understood by activists as the product of historical legacies of colonialism, apartheid, and (bio)capitalism as well as more recent forms of postcolonial state indifference and inaction in relation to the provision of HIV/AIDS treatment in the public sector (Robins 2006: 313).

Structural violence provides a sound conceptual framework for understanding AIDS related stigma: "Every society is shaped by large scale forces that together define structural violence. These forces include racism, sexism, political violence, and other social inequalities that are rooted in historical and economic processes that sculpt the distribution and outcome of HIV/AIDS. Structural violence predisposes the human body to pathogenic vulnerability by shaping risk of infection and also rate of disease progression" (Castro 2005 :55).

Not only does structural violence increase an individual's chance of contracting HIV but it also shapes how society chooses to accept or exclude a particular group of people, based on pathology, illness, or even an epidemic. Stigma surrounding HIV/AIDS is no longer as pervasive as it was two decades ago; however, social exclusion nowadays "has a good deal to do with the inability of governments to subject the workings of international capital to their own rules and regulations, above all, to control the pharmaceutical commodities and intellectual property that have become the elixir of life" (Comaroff 2007:210). Money and resources aside, AIDS is viewed as an "iconic social pathology", a stigmatic response to AIDS which serves to alienate and discriminate HIV-positive individuals. Before devaluing or placing judgment on HIV-positive people, one needs to re-examine the social, economic and structural forces working against people who contract AIDS.

The effects of structural violence are most felt by people at the bottom of the socioeconomic ladder, in particular, those living in poverty. When examining poverty and the different ways to alleviate poverty, Farmer argues that it is in the social construction of poverty as something inevitable that allows such atrocities to perpetuate. Critical of neoliberalism and the idea that our society enjoys a sense of equality that does not actually exist, Farmer seeks to shed light on the real perpetrators of human suffering and poverty-ourselves:

But inwardly, this same reality is a question for human beings as themselves participants in the sin of humankind ...the poor of the world are not the causal products of human

history. No, poverty results from the actions of other human beings. In discussing a socialized approach to effective medical care, Farmer advocates for liberation theology and a 'preferential option for the poor', where the sufferer is the one who receives consideration and care (Farmer 2003B:23).

Specifically in regards to South Africa, Paul Farmer addresses systems of inequality as both a product of race and class lines. For South African blacks, "the proximate cause of increased rates of morbidity and mortality is lack of access to resources: '*Poverty*' remains the primary cause of the prevalence of many diseases and widespread hunger and malnutrition among black South Africans.' And social inequality is seen in the, uneven distribution of poverty" (Farmer 2002:8). A "living laboratory" for the study of the long term effects of racism, black South Africans have repeatedly been denied access to quality resources on the failed redistributive policies of the government, thus, silencing their cries: "The world's poor are the chief victims of structural violence ... Who might this be so? One answer is that the poor are not only more likely to suffer, they are also more likely to have their suffering silenced" (2002:9). Organizations like TAC work to empower and bring these marginalized voices to the forefront of the ARV/AZT drug debate; yet not every voice is heard.

In these drug debates where pharmaceutical companies vie over intellectual property rights, large corporations control the drug market and thus, dictate which groups of people/how many groups of people are able to access these drugs. Frequently these drugs contain the cure to illnesses like malaria or TB, illnesses which have had a cure for decades; however, without the resources and proper management of these drugs, individuals in the developing world are left both financially and healthily destitute. This biopolitical control over access to drugs is discussed in a number of different philosophical texts. Philosophers like Giorgio Agamben explore the ways in which biopolitical control manifests itself in everyday and seeks to control the means of life itself: "Agamben claims that both modern and archaic political orders have been preoccupied with the capacity to control life by excluding it from meaningful social and political existence" (Robins 2006:313). Agamben draws on *homo sacer*-the archaic Roman law figure who "could be killed but not sacrificed"-to illustrate that modern life is "simultaneously sacred, and utterly dispensable"; modern society possesses the ability to not only feed the world two times over but also to provide life-saving drugs to those who truly need them (2006:313). Ideas surrounding "sacred life" are based on subjectivity of whose lives are considered more important and whose lives are dispensable. Within this philosophical framework a paradoxical coexistence occurs: that of inclusion and exclusion, human emancipation and inhuman neglect (Comaroff 2007:215). How do HIV-positive individuals manage this pain and suffering inflicted upon them by structural and external forces? Is it possible to socially transform and empower individuals to face a society which previously stigmatized them? Organizations such as TAC strive to make such efforts but at the end of the day, it is up to the HIV-positive individual to make the difference.

Anthropologist and researcher Victor Turner studied the biosocial effects of illness on indigenous tribes in Africa. Turner "interpreted the sick individual body as a sign of disease and disorder in a wider social body; here, healing involved the realignment of the social" (Robins 2006:313). Turner conducted his fieldwork in the 1960's; researchers use his theoretical framework as a tool for understanding the current AIDS epidemic and how organizations like TAC transform HIV -positive individuals into agents of social change. Turner focused his

analysis on the ritual process, which identifies three stages/rites of passage: separation, liminality, and reintegration. It has been argued that HIV -positive individuals undergo similar feelings when confronted with the reality of their illness and follow up with treatment. A full blown AIDS patient can return to a normal life after having taken his/her medication. While the stigma may linger, support groups, organizations and various programs have been enacted to help support these individuals throughout the process. Turner's analysis of ritual processes demonstrates "how illness and treatment experiences can, together with forms of HIV/AIDS activism, contribute toward the protection of new social subjects" (2006:214). Moreover, his analysis of the ritual process provides a "rich heuristic device and analytical lens through which to interpret how the extremity of "near death" experiences of full-blown AIDS, following by "miraculous" recovery through ART, can produce the conditions for AIDS survivors' commitment to "new life" and social activism. It is the activist mediation and retelling of these traumatic experiences that facilitates TAC's highly successful grassroots mobilizations" (2006:314).

VIII. Challenges, Lessons and Recommendations for the Future

"The global HIV epidemic cannot be reversed, and gains in expanding treatment access cannot be sustained, without greater progress in reducing the rate of new HIV infections." (UNAIDS Global Health Report 2008)

This paper highlights the complexities surrounding the HIV/AIDS epidemic. There are a number of key factors which contribute to this epidemic. Scholar Ian E.A. Yeboah (2007:1135) articulates the complexity of HIV/AIDS:

This web of significance reveals how the different factors of the AIDS epidemic dramatically" affect the development of the region as a whole. The AIDS crisis has claimed hundreds of thousands of economically active individuals; thus, resulting in a loss of human capital. In turn, this loss requires the government to spend their already scarce resources on managing HIV /AIDS related problems rather than developing their economies (2007:1135).

While earlier accounts of the HIV/AIDS crisis were met with denial, blame and stigmatization, valiant efforts have been made to effectively combat these various forms of discrimination. In the earlier years of the epidemic, individuals associated the sub-Saharan Africa region as origin of the AIDS pandemic: "By ascribing sub-Saharan African as the origin of HIV there is a tendency to construct the region as a problem region rather than a region with a problem." (2007:1129). After three decades of this virus erupting around the world, HIV has now translated to a global virus whose implications are "international and transcultural" (2007:1129). However, in order to ensure long term success with global health initiatives to curb the crisis, efforts "will require sustained progress in reducing human rights violations associated with it, including gender inequality, stigma and discrimination" (UNAIDS 2008:10). These efforts may coincide with South Africa mobilizing sufficient financial resources to reach "global target of universal access, putting in place innovative mechanisms to sustain financing the long term" (2008:30). By strategically planning for the future (three to five year time cycles) and focusing on long term goals, South Africa may move towards universal access to HIV prevention, treatment, care and support (2008:28). Resource allocation, effective budgeting practices, and policy reform are three conditions necessary to facilitate the reduction of inequalities.

The HIV/AIDS epidemic forces the South African government to address a number of issues ranging from public health benefits to educational inequalities. The challenge lies in how to effectively tackle both issues in a country of scarce resources. TAC demonstrates how community activism and increasing political pressure can transform and empower HIV-positive individuals into avid agents of social change. Additionally, TAC's lessons reveal how big-business/for-profit pharmaceutical corporations can bend to international pressure and begin to provide life-saving drugs to those who need them the most. By empowering people living with HIV to fight for access to treatment, involving these individuals in a national HIV response would greatly help with the development, implementation and evaluation of national HIV strategies (2008:28).

Through the noble effort of organizations like TAC, pharmaceutical companies and transnational corporations (mCs) "have finally succumbed to providing HIV/AIDS drugs at subsidized rates to peripheral countries; however, they are not as enthusiastic about the development of an HIV vaccine. After all, the people who can benefit most from a vaccine are the least able to pay" (Yeboah 2007:1147). International pressure to create a vaccine would greatly improve the social and economic well-being of millions in the developing world. As members of humanity, questions concerning moral obligation arise in terms of western countries' abilities to research, test, and potentially produce an HIV vaccine.

In addition to accessible health care rights, services and provisions, quality education is essential for the mitigation of this epidemic. The target group for this education should be young people, the group most at risk for contracting the virus: "Although young people, 15-24 years of age account for 45% of all new HIV infections in adults, many young people still lack accurate, complete information on how to avoid exposure to the virus" (UNAIDS 2008:13). Sex education should be introduced at an early age and continue into adulthood, with companies requiring their formal workers to participate in HIV education. Sex education should be followed up with monitoring and testing such groups 'to give better indications of the magnitude and scale of the problem and find target populations (Yeboah 2007:1144). HIV education should be required as part of employment: "To combat fatalism, education about HIV/AIDS can be mandated as part of employment (on job seminars) for both mobile and stationary populations employed in the formal sector (military, mining workers, agricultural workers, etc.) ... Considering the enormity of the HIV/AIDS pandemic in the region, this should not be seen as a violation of a civil right but rather an empowerment of persons to make decisions based on knowledge" (2007:1145). Furthermore, culturally sensitive and appropriate media should be geared to people of all ages, addressing the risks associated with unprotected sex. Media may provide the vehicle through which to spread knowledge and diffuse information about "what HIV/AIDS is, how it is spread, how to protect oneself from acquisition, and how to treat people living with HIV/AIDS" (2007:1144).

The challenges facing South Africa are complex and require a multi-faceted approach. No one sphere of influence (governmental policies, NGO, CBO, or religious organizations) can effectively manage the crisis alone. Through a combined and concerted effort to address the AIDS crisis, South Africa may hope to develop combative prevention and treatment programs which seek to include all South Africans, irrespective of color or creed.

¹ "Racial terminology in South Africa is a complicated matter. The terms most widely used in South Africa are as follows: "African" refers to people classified by the apartheid state as "native," "Bantu," or "black." "White" refers to people classified as European and later as white by the apartheid state. "Indian" refers to people who were brought to or came to South Africa from the Indian subcontinent and were sometimes classified as "Asiatic" by the apartheid state. "Colored," referring mainly to people in the Western Cape, designates those who did not fit the other categories. We use "black" to refer to African, colored, and Indian people collectively" (Seekings 2005: ix).

² Neoliberalism is characterized by fiscal austerity, deregulation, and privatization. There is a distinct withdrawal/shrinking of the state and a transfer of competence to the private sector. (Narsiah 2002:3).

³ Biocapital is knowledge, patents and systems of exchange and command that make the difference between life and death [in terms of an individual's access to treatment, ability to effectively combat an illness, etc ... (Comaroff 2007:213).

⁴ The ASSA2002 AIDS and Demographic model is a model of the AIDS epidemic in South Africa, released in July of 2004 (<http://aids.actuariesociety.org.zalASSA2002-3157.htm>).

⁵ There are different strains of the HIV -1 virus. Worldwide, the predominant virus is HIV-1. There are two types of HIV: HIV-1 and HIV-2. Both are transmitted through sexual contact, through blood, or through congenital means (<http://www.avert.org/hiv-types.htm>). Although there is no conclusive evidence, some researchers suspect that HIV-1C, which appears to have a high replicative rate and concentration in bodily fluids, may be more infectious than the HIV-1B virus found in the US and Europe (Nattrass 2004: 26)

⁶ Constrained optimism: constraints imposed by AIDS on human resources (Nattrass 2004: 35).

⁷ Mother-to-child-transmission (MTCT): when an HIV infected women passes on the virus to her baby.

⁸ SACP: South African Communist Party; COSATU: Congress of South African Trade Unions; Tripartite Alliance: Historic alliance between the ANC, SACP and COSATU. Source: <http://www.southafrica.info/about/democracy/polparties.htm#sacp> .

⁹ MSF: Medecins sans Frontieres or "Doctors without Borders" (Robins 2006:312).

¹⁰ Parallel importation: A non-counterfeit product imported from another country without the permission of the intellectual property owner.
Source: http://en.wikipedia.org/wiki/Parallel_import
Compulsory License: When a government forces the holder of a patent, copyright, or other exclusive right to grant use to the state or others.
Source: http://en.wikipedia.org/wiki/Compulsory_licensing

Bibliography

Agamben, Giorgio.

1995. *Homo Sacer: Sovereign Power and Bare Life* Stanford: Stanford University Press.

Behera, M.C.

2006. *Globalising Rural Development: Competing Paradigms and Emerging Realities*
New Delhi: SAGE Publications.

Bollinger, Lori and John Stover.

1999. "The Economic Impact of AIDS in South Africa" in *The Policy Project*.

Boon, Hennien, Robert A.C. Ruiter, Shegs James.

2009. "The Impact of a Community-based Pilot Health Education Intervention for Older People as Caregivers of Orphaned and Sick Children as a Result of HIV and AIDS in South Africa." *J Cross Cult Gerontol* 24: 373-389.

Braude, Hillel David.

2009. "Colonialism, Biko and AIDS: Reflections on the principle of beneficence in South African medical ethics." *Social Science & Medicine* 68: 2053-2060.

Castro, Arachu and Paul Fanner.

2005. "Understanding and Addressing AIDS-Related Stigma-From Anthropological Theory to Clinical Practice in Haiti" in *American Journal of Public Health* 95(1): 53-59.

Chapman, Audrey R. and Leonard S. Rubenstein.

1998. "Underlying Causes of Human Rights Violations in the Health Care Sector. Human Rights and Health: The Legacy of Apartheid" Available: <http://shr.aaas.org/foalunder.htm> (July 10, 2010).

Cluver, Lucie, Gardner, Francis and Don Operario.

2007. "Psychological distress among AIDS-orphaned children in urban South Africa" In *Journal of Child Psychology and Psychiatry* 48(8): 755-763.

Cohen, Robin and Shirin M. Rai.

2000. *Global Social Movements* London: The Athlone Press.

Comaroff, Jean.

1985. *Body of Power and Spirit of Resistance: The Culture and History of a South African People* Chicago: University of Chicago Press.

Comaroff, Jean and John.

1993. *Modernity and its Malcontents: Ritual And Power in Postcolonial Africa* Chicago: The University of Chicago Press.

- Comaroff, John L. and Jean.
1997. *Of Revelation and Revolution: The Dialectics of Modernity on a South African Frontier* Chicago: University of Chicago Press.
- Comaroff, Jean and John.
1999. *Civil Society and The Political Imagination in Africa: Critical Perspectives* Chicago: University of Chicago Press.
- Comaroff, Jean.
2007. "Beyond Bare Life: AIDS, (Bio)politics, and the Neoliberal Order" *Public Culture* 19(1): 197-219.
- Coovadia, Hoosen, Rachel Jewkes, Peter Barron, David Sanders, and Diane McIntyre.
2009. "The health and-health system of South Africa: historical roots of current public health challenges." In *Health in South Africa*.
- Crewe, Mary.
1992. *AIDS in South Africa: The Myth and the Reality* London: Penguin Forum Series. Crossroads: A Development Reading 1997/1998 *Community Development Resource Association's Annual Report*.
- Edwards, Michael and David Hulme.
1996. *Beyond the Magic Bullet: NGO Performance and Accountability in a Post-Cold War World* West Hartford: Kumarian Press.
- Epstein, Steven.
1996. *Impure Science: AIDS, Activism, and the Politics of Knowledge* Berkeley: University of California Press.
- FaIola, Toyin and Matthew M. Heaton.
2007. *HIV/AIDS, Illness, and African Well-Being* Rochester: University of Rochester Press.
- Fanner, Paul.
2002. "On Suffering and Structural Violence: A View From Below" In *The Anthropology of politics. A Reader in ethnography, theory and critique* 424-437.
- Fanner, Paul.
2003A. "AIDS: A Biosocial Problem with Social Solutions." *Anthropology News*.
- Farmer, Paul.
2003B. *Pathologies of Power: Health, Human Rights, and the New War on the Poor* Berkeley: University of London Press.

- Fanner, Paul.
2004. "An Anthropology of Structural Violence" *Current Anthropology* 45(3):
305-325.
- Fassin, Didier.
When Bodies Remember: Experiences and Politics of AIDS in South Africa Berkeley:
University of California Press.
- Fitzgerald, Patrick, Anne McLennan, Barry Munslow.
1995. *Managing Sustainable Development in South Africa* Cape Town: Oxford
University Press.
- Friedman, Steven and Shauna Mottiar.
2005. "A Rewarding Engagement? The Treatment Action Campaign and the Politics of
HIV/AIDS" in *Politics & Society* 33(4):511-565.
- Heuveline, Patrick.
1997. "AIDS and population growth in sub-Saharan Africa: Assessing the sensitivity of
projection." *Population Research and Policy Review* 16: 531-560.
- Hoy, Paula.
1998. *Players and Issues in International Aid* West Hartford: Kumarian Press.
- Leon, David and Gill Walt.
2001. *Poverty, Inequality and Health: An International Perspective* New York: Oxford
University Press.
- Lurie, Mark N.
2002. "The Impact of Migration on HIV-1 Transmission in South Africa: A Study of
Migrant and Nonmigrant Men and their Partners." From the South African Medical
Research Council 149-156.
- Magubane, Bernard Makhosezwe.
1987. *The Ties that Bind: African-American Consciousness of Africa* Trenton: Africa
World Press, INC.
- Magubane, Bernard Makhosezwe.
1990. *The Political Economy of Race and Class in South Africa* New York: Monthly
Review Press.
- May, Julian.
2000. *Poverty and Inequality in South Africa: Meeting the Challenge* Cape Town:
David Philip Publishers.

- Mindry, Deborah.
2008. "Neoliberalism, Activism, and HIV/AIDS in Postapartheid South Africa." *Social Text* 26(1): 75-93.
- Mitton, Jennifer.
2000. "The Sociological Spread of HIV/AIDS in South Africa." In *Journal of the Association of Nurses in AIDS Care* 11(4):17-26.
- Narsiah, Sagie.
2002. "Neoliberalism and privatization in South Africa." In *GeoJournal* 57:3-13.
- Natrass, Nicoli.
2004. *The Moral Economy of AIDS in South Africa* Cambridge: Cambridge University Press.
- Oppenheimer, Gerald M. and Ronald Bayer
2007. *Shattered Dreams? An Oral History of the South African AIDS Epidemic* Cape Town: Oxford University Press.
- Praventivmed, Soz.
1991. "State of Africa's Health." 36: 198-201.
- Robins, Steven.
2006. "From 'Rights' to 'Ritual': AIDS Activism in South Africa" *American Anthropology* 108(2): 312-323.
- Robins, Steven.
2008. *From Revolution to Rights in South Africa: Social Movements, NGO's, and Popular Politics After Apartheid* Pietermaritzburg: University of Kwazulu-Natal Press.
- Robins, Steven.
"Long Live Zack, Long Live: AIDS Activism, Science and Citizenship after Apartheid."
- Rodney, Walter.
1981. *How Europe Underdeveloped Africa* Washington D.C.: Howard University Press.
- Seekings, Jeremy and Nicoli Natrass.
2005. *Class, Race and Inequality in South Africa* New Haven: Yale University Press.
- Sharp, Joanne and John Briggs
2006. "Postcolonialism and development: New Dialogues?" *The Geographical Journal* 172(1): 6-9.
- Stoler, Ann Laura.
1995. *Race and the Education of Desire: Foucault's history of sexuality and the colonial order of things* Durham: Duke University Press.

Taylor, Julie J.

2006. "Assisting or compromising intervention? The concept of 'culture' in biomedical and social research on HIV/AIDS." in *Social Science & Medicine* 64 (2007):965-975.

Turner, Victor.

1969. *The Ritual Process: Structure and Anti-Structure* New York: Aldine DeGruyter.

UNAIDS <http://www.unaids.org/en/default.asp>.

World Bank 2003. *A Guide to the World Bank* Washington D.C.

Yeboah, Ian E.A.

2006. "HIV/AIDS and the construction of Sub-Saharan Africa: Heuristic lessons from the social sciences for policy." in *Social Science & Medicine* 64(2007):1128-1150.