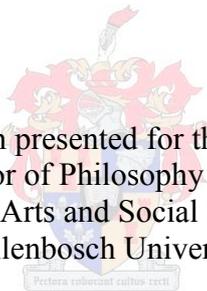


Securitisation of HIV and AIDS in Southern African policy processes: An investigation of Botswana, South Africa and Swaziland, 2000-2008

Craig Vincent Moffat

Dissertation presented for the degree of
Doctor of Philosophy in the
Faculty of Arts and Social Sciences at
Stellenbosch University

Pectora roburant cultus recti

Supervisor: Professor Scarlett Cornelissen

F gego dgt'2014

Declaration

By submitting this dissertation electronically, I declare that the entirety of the work contained therein is my own, original work, that I am the sole author thereof (save to the extent explicitly otherwise stated), that reproduction and publication thereof by Stellenbosch University will not infringe any third party rights and that I have not previously in its entirety or in part submitted it for obtaining any qualification.

Date: 9 October 2016

Copyright © 2016 Stellenbosch University
All rights reserved

Abstract

This study aims to understand the processes and factors that explain the framing of HIV and AIDS policy in Botswana, South Africa and Swaziland. Africa remains the global epicentre of the HIV and AIDS epidemic with Southern Africa remaining the most affected region in the world. The investigation centres on the HIV and AIDS policymaking discourses and dynamics leading to the securitisation of the epidemic in the three countries. The central focus of the study covers the timeframe of the leadership of President Mogae in Botswana, President Mbeki in South Africa and King Mswati III in Swaziland. This period is important as it characterises the HIV and AIDS epidemic being elevated onto the political agenda of the respective countries.

This dissertation relies on two strands of theoretical literature namely, public policy theory and securitisation theory to help explain the framing of policy decision-making that leads to the process of securitisation of the HIV and AIDS epidemic in the three countries.

This study is a multiple case study within the qualitative research paradigm. This research is based on three case studies: Botswana, South Africa and Swaziland. As far as data collection is concerned, this study drew on primary sources of data, which consisted of documents obtained during the fieldwork from various stakeholders such as such as official government documents, as well as official documents from international and domestic HIV and AIDS organisations. Twenty semi-structured interviews were also conducted between 2007 and 2008 with various stakeholders including government officials, representatives of domestic and international HIV and AIDS organisations operating in the respective countries, researchers from think tanks and academics. In addition, eleven exploratory interviews were also conducted as part of the fieldwork process. Furthermore this study also relied on various secondary sources of data such as scholarly articles and books, official documents and legislation and newspaper articles.

The preliminary results collected and analysed in this study suggest that Botswana, South Africa and Swaziland have all demonstrated a degree of formal commitment to adopting international guidelines to combat the epidemic. The thesis shows that while all three countries may share the burden of the epidemic, each presents a different political, social and cultural identity with

different institutional architects (both foreign and domestic) that determined the nature of the response policy to the epidemic.

The study shows that each of the three case studies presents an example of differing degrees of securitisation attempts: i) Botswana - successful securitisation; ii) South Africa - unsuccessful securitisation; and iii) Swaziland - partial securitisation because different actors and audiences are positioned at varying points along a spectrum of securitisation. This degree of securitisation can be linked to the acceptance of international ideas and the prevailing global discourse regarding the HIV and AIDS epidemic and the openness to forming collaborative agreements between state and non-state actors in each of the three countries.

Opsomming

Hierdie studie poog om 'n begrip te ontwikkel van die prosesse en faktore wat verklaar hoe beleid rondom MIV en VIGS in Botswana, Suid-Afrika en Swaziland geraam word. Die Afrika-vasteland is nog steeds die wêreld se MIV en VIGS-episentrum en die Suider-Afrika-streek loop die mees gebuk onder die epidemie. Die ontleding sentreer op die MIV en VIGS beleidsdiskoerse en die dinamieke wat aanleiding gee tot die beveiliging van die epidemie in die drie lande. Die kollig val op die tyd toe President Mogae van Botswana, President Mbeki van Suid-Afrika en Koning Mswati III van Swaziland aan bewind was. Hierdie periode is van belang omdat dit die tyd was toe MIV en VIGS op die drie lande se politieke agendas geplaas is.

Die proefskrif gebruik literatuur uit twee teoretiese velde, naamlik openbare beleidsteorie en sekuriteitsteorie, om te verklaar hoe daar op bepaalde beleide besluit word, hoe dit geraam word, en die proses waarvolgens MIV en VIGS gevolglik in die drie lande beveilig word.

Die studie is 'n meervuldige gevallestudie binne die kwalitatiewe navorsingsparadigma. Die navorsing is op drie gevallestudies gebaseer, te wete Botswana, Suid-Afrika en Swaziland. Ten opsigte van data-insameling, het die studie van primêre databronne gebruik gemaak bestaande uit bewysstukke wat van verskeie belangegroepe verkry is. Hierdie stukke beslaan amptelike regeringsdokumente en amptelike dokumentasie van internasionale sowel as nasionale MIV en VIGS-organisasies. Daar is ook met verskeie belangegroepe onderhoude gevoer. Die belangegroepe het bestaan uit regeringsamptenare, die verteenwoordigers van nasionale en internasionale MIV en VIGS-organisasies betrokke in die drie lande, akademici, en kundiges by navorsingsinstansies. Twintig semi-gestruktureerde onderhoude is in 2007 en 2008 gevoer. Boonop is daar as deel van die empiriese navorsing 11 verkenningsonderhoude gevoer. Die studie het ook van verskeie sekondêre databronne soos vakwetenskaplike artikels en boeke, amptelike dokumentasie, wetaktes en koerantartikels gebruik gemaak.

Die voorlopige bevindinge dui dat Botswana, Suid-Afrika en Swaziland elkeen hulself tot 'n mate formeel tot internasionale riglyne verbind het om die epidemie te beveg. Die proefskrif

bewys dat ofskoon al drie lande swaar aan die las van die epidemie dra, daar by elkeen verskillende politieke, maatskaplike en kulturele identiteite, asook institusionele argitekte (plaaslik sowel as buitelands) bestaan wat die aard van die beleidsrespons bepaal het.

Die studie dui verskillende grade van beveiliging by elkeen van die gevallestudies: i) Botswana – suksesvolle beveiliging; ii) Suid-Afrika – onsuksesvolle beveiliging; en iii) Swaziland – gedeeltelike beveiliging. Hierdie grade van beveiliging kan verklaar word aan die hand van die mate waartoe daar by elkeen van die lande aanvaarding was van internasionale denke en diskoers oor die MIV en VIGS-epidemie en of samewerking tussen staats- en nie-staatsakteurs bewerkstellig is.

Acknowledgments

I would like to thank God for bringing me this far. Without his blessings this would not have been possible.

I am extremely grateful to my supervisor, Professor Scarlett Cornelissen, for her guidance and all the useful discussions and meetings we had along this journey. Her deep insights and patience helped me at various stages of my research. I also remain indebted for her understanding and support during the times when I was really down and depressed by the enormity of this journey. I thank you for all your help, guidance and patience.

To all the individuals I interviewed that gave freely of their time in Botswana, South Africa and Swaziland I thank you all.

Words cannot express the feelings I have for my parents Vincent and Dawn Moffat for their constant unconditional support, their commitment to furthering my education and for their belief in the ability of the human spirit to triumph in the face of adversity. I would not be here if it not for the two of you.

I would like to acknowledge my greatest supporter my wife Marte. She has been a constant source of strength and inspiration. There were times during the past few years when this task seemed impossible and without you by my side I may not have finished. I can honestly say that it was only through her constant encouragement (and sometimes a kick up my backside) that ultimately made it possible for me to see this project through to the end. I am deeply grateful to you.

I wish to express my sincere appreciation to all those who have contributed to this thesis and supported me in one way or the other during this amazing journey.

Finally, I would like to thank our beautiful darling daughters, Olave and Marie for understanding that “Pops” needed quiet time to work after work. Hopefully this will inspire you to follow your dreams.

List of Tables

Table 8.1: Analytical Factors and Case Studies Findings.....	219
--	-----

Acronyms and abbreviations

ABC – “Abstain, Be Faithful, Condomise”

ACHAP - African Comprehensive HIV/AIDS Partnerships ACHAP

AIDS – Acquired Immune Deficiency Syndrome

AMICAALL – Alliance of Mayors Initiative for Community Action on AIDS at the Local Level

ANC – African National Congress

ART – Antiretroviral Therapy

ARV – Antiretroviral

ATICCs – HIV and AIDS Training, Information and Counselling Centres

AZT – Zidovudine

BCF – Bill Clinton Foundation

BGP – Botswana Congress Party

BDP – Botswana Democratic Party

BNF – Botswana National Front

BOCAIP – Botswana Christian AIDS Intervention Programme

BONASO – Botswana Network for AIDS Service Organisations

BONELA – Botswana Network on Ethics, Law and HIV/AIDS

BONEPWA – Botswana Network of People Living With HIV/AIDS

BOTUSA – Partnership between the Botswana Ministry of Health and the U.S. Centres for Disease Control and Prevention

CANGO – Coordinating Assembly of Non-Governmental Organizations

CARE – Christian Action Research and Education

CBO – Community-Based Organisation

CCM – Country Coordinating Mechanism

CDC – U.S. Centers for Disease Control and Prevention

CIDA – The Canadian International Development Agency

CMTC – Crisis Management and Technical Committee

COSATU – Congress of South African Trade Unions

CSIS – Centre for Strategic and International Studies

DMSAC - District Multi-Sectoral AIDS Committees

DCF – Donor Communication Forum

DFID – British Department for International Development

DoH – Department of Health

DoS – Department of State

GDP – Gross Domestic Product

GFTAM – Global Fund to Fight AIDS, TB and Malaria

GPA – WHO’s Global Programme on AIDS

HBC – Home-Based Care

HDI – Human Development Index

HEARD – Health Economics and HIV/AIDS Research Division

HIV – Human Immunodeficiency Virus

HSRC – Human Science Research Council

ICASA – International Conference on HIV/AIDS and Sexually Transmitted Infections in Africa

ICASO – International Council of AIDS Services Organizations

IDASA – Institute for Democracy in South Africa

IEC – Information, Education and Communication

IHAA – International HIV and AIDS Alliance

IMAI – Integrated Management of Adult and Adolescent Illness

IMC – Inter-Ministerial Committee

IMF – International Monetary Fund

INGO – International Non-Governmental Organisation

IISS – International Institute for Strategic Studies

MACs – Ministry of AIDS Coordinators

MandE – Monitoring and Evaluation Framework

MCC – Medical Controls Council

MOHSW – Ministry of Health and Social Welfare, Swaziland

MSF – Medicins Sans Frontiers

MTP – Medium Term Plan

MTCT – Mother-to Child Transmission

NAC – National AIDS Council

NACA – National AIDS Coordinating Agency

NACOSA – National AIDS Convention of South Africa

NACP – National AIDS Control Programme

NAP – National AIDS Plan

NAPCP – National AIDS Prevention and Control Programme

NAPWA – National Association of People Living With AIDS

NERCHA – National Emergency Response Council on HIV/AIDS

NGO – Non-Governmental Organisation

NIH – US National Institutes of Health

NP – National Party

NPPHCN – National Progressive Primary Health Care Network

NSP – National Strategic Plan

NTP – National TB Programme

PACHA – Presidential Advisory Council on HIV/AIDS

PEPFAR – U.S. President’s Emergency Plan for AIDS Relief

PLWHA – People Living With HIV/AIDS

PMA – Pharmaceutical Manufacturers Association of South Africa

PMTCT – Prevent Mother-to-Child Transmission

PSI – Population Service International

RCSA – Regional Centre for Southern Africa

RHAP – Regional HIV-AIDS Programme (USAID)

RICA – Royal Initiative to Combat AIDS

SADC – Southern African Development Community

SADF – South African Defence Force

SANAC - The South African National AIDS Council

SASO – Swaziland AIDS Support Organisation

SIPAA – Support to International Partnership Against AIDS in Africa

SNAP – Swaziland National AIDS Programme

SWAGAA – Swaziland Action Group Against Abuse

SWAPOL – Swazis for Positive Living

STD – Sexually Transmitted Disease

STI – Sexually Transmitted Infection

STP – Short Term Plan

SWANNEPHA – Swaziland National Network of People Living with HIV and AIDS

TAC – Treatment Action Campaign

TB – Tuberculosis

UN – United Nations

UNAIDS – Joint United Nations Programme on HIV/AIDS

UNCT – United Nations Country Team

UNDP – United Nations Development Programme

UNFPA – United Nations Population Fund

UNGASS – UN General Assembly Special Session on HIV/AIDS

UNICEF – United Nations Children’s Fund

UNSC – United Nations Security Council

VCT – Voluntary Counselling and Testing

WFP – World Food Programme

WHO – World Health Organisation

WLSA – Women in Law in Southern Africa

WTO – World Trade Organization

Abstract.....	ii
Opsomming	iv
Acknowledgments	vi
Acronyms and abbreviations	viii
Chapter 1: Introduction	1
1.1 Background and rationale.....	1
1.2 Problem statement and research questions.....	5
1.2.1 Problem statement.....	5
1.2.2 Research sub-questions.....	5
1.3 Preliminary literature review.....	6
1.4 Aims of the study	9
1.5 Theoretical framework	10
1.6 Significance of study.....	15
1.7 Methodology.....	17
1.8 Limitations and delimitations	17
1.9 Thesis outline	18
Chapter 2: Theoretical Framework and Literature Review.....	21
2.1 Introduction	21
2.2 Socio-economic characteristics of the developing world: cultural, economic and political	23
2.3 Public policy process.....	25
2.4 Public policymaking and agenda setting	26
2.5 Public policy theoretical frameworks and literature review	28
2.5.1 Pluralist model.....	28
2.5.2 Elite model.....	29
2.5.3 Statism - the institutional model.....	32
2.6 A new security paradigm	34
2.6.1 Traditional approach to security	34
2.6.2 Non-traditional approach to security: expanding the debate	36
2.7 Securitisation approaches	39
2.8 The process of securitisation	46
2.8.1 Framing as a speech-act	47
2.9 Conclusion.....	50
Chapter 3: Research Design and Methodology.....	52
3.1 Introduction	52
3.2 Research paradigm	53
3.3 Research design.....	54
3.4 Case study method	54
3.5. Research process	58
3.5.1 Sources	58

3.5.2	Interviews.....	59
3.5.3	The interview processes.....	63
3.5.4	Data analysis.....	64
3.6	Challenges and limitations.....	66
3.7	Research ethics	68
3.8	Conclusion.....	69
Chapter 4:	HIV and AIDS – Journey from Biomedical to Global Security Threat	70
4.1	Introduction	70
4.2	From a biomedical issue to a security issue.....	70
4.4	Brief overview of the influential HIV and AIDS global securitising actors.....	77
4.4.1	UNAIDS.....	77
4.4.2	The US government.....	79
4.4.3	Role of civil society organisations in securitisation attempts.....	82
4.5	Conclusion.....	83
Chapter 5:	Policy Issues, Processes and Framing around HIV and AIDS in Botswana	84
5.1.	Introduction	84
5.2	Dimensions of the HIV and AIDS epidemic in Botswana	86
5.3	Observable policy responses	89
5.3.1	Early efforts to address the epidemic	89
5.3.2	Change of approach in the policy decision making process.....	90
5.4	Factors that influenced the policy decision making process	94
5.5	Role of relevant stakeholders in the policy-framing.....	96
5.5.1	Political space for domestic non-state actors in Botswana - Historically weak civil society with close government links	96
5.6	Politics and differing priorities - political space for transnational actors in Botswana	102
5.7	Policy processes and power dynamics – engagement between the actors	105
5.8	Securitisation approach and the relevant actors involved.....	111
5.9	Prevailing political culture in Botswana	113
5.10	The USA’s involvement as a key securitisation partner in Botswana	118
5.11	Conclusion	122
Chapter 6:	Policy Issues, Processes and Framing around HIV and AIDS in South Africa	124
6.1	Introduction	124
6.2	Dimensions of HIV and AIDS in South Africa	126
6.3	Observable policy responses	128
6.3.1	Early efforts to address the epidemic	128
6.4	Changes in the policy decision making environment.....	132
6.5	Factors that influenced the policy making process.....	135
6.6	Role of relevant stakeholders	145
6.6.1	Politics and differing priorities - political space for domestic non-state actors in South Africa	145

6.7	Policy power dynamics – engagement between the state and domestic actors.....	148
6.8	Politics and differing priorities - political space for international non-state actors in South Africa	149
6.9	Policy power dynamics – engagement between the state and international Actors	151
6.10	Securitisation approach and the relevant actors involved.....	153
6.11	Conclusion	162
Chapter 7:	Policy Issues, Processes and Framing around HIV and AIDS in Swaziland	165
7.1	Introduction	165
7.2	Dimensions of the HIV and AIDS epidemic in Swaziland.....	166
7.3	Observable policy responses	168
7.3.1	Early efforts to address the epidemic	168
7.4	Changes in the policymaking environment	170
7.5	Factors that influenced the policy making process in Swaziland.....	173
7.5.1	King Mswati III, the traditionalist - prevailing cultural values and practices.....	173
7.5.2	Prevailing political and social gender bias society.....	177
7.5.3	Neopatrimonialism.....	180
7.5.4	Funding concerns	183
7.6	Politics and differing priorities - political space for domestic non-state actors in Swaziland	185
7.6.1	Role of relevant stakeholders.....	185
7.6.2	Weak civil society	188
7.7	Policy power dynamics – engagement between the state and domestic actors.....	189
7.8	Domestic cooperation	192
7.9	Politics and differing priorities – political space for international non-state actors in Swaziland	195
7.10	Policy power dynamics – engagement between the state and international actors in Swaziland	197
7.11	Securitisation approach and the relevant actors involved.....	200
7.11.1	Domestic securitising actors - NERCHA and SWANEPWA	200
7.11.2	The USA as a key-securitisation actor in Swaziland	202
7.12	Criticisms of PEPFAR activities.....	206
7.13	Conclusion	207
Chapter 8	Conclusion	209
8.1	Introduction	209
8.2	Major findings from each of the case studies - summary	211
8.2.1	Botswana – successful securitisation	211
8.2.2	South Africa – unsuccessful securitisation	214
8.2.3	Swaziland – partially successful securitisation	216
8.3	Results and the implications for the theory	220
8.4	Issues for Further Research	226
8.5	Conclusion	227

Bibliography	228
Appendix 1	264
Appendix 2	265

Chapter 1: Introduction

1.1 Background and rationale

This thesis will show how the securitising move of HIV and AIDS by global securitising actors in the early 2000s influenced domestic policies regarding HIV and AIDS in Botswana, South Africa and Swaziland. Although these countries are all at what Hwedie (2001) calls the epicentre of the epidemic, the policymaking process in the respective countries were shaped by different factors and consequently the epidemic was securitised to different degrees.

At the turn of the century a significant shift in thinking towards policymaking to address the human immunodeficiency virus (HIV) and the acquired immunodeficiency syndrome (AIDS) epidemic occurred. Firstly, in 1996 the Joint United Nations Programme on HIV and AIDS (UNAIDS) was launched to deal with the increasing global epidemic. This was the first time that the international community established a global structure of governance to deal with an epidemic of a single disease. Secondly, on 10 January 2000, a milestone UN Security Council meeting was held to specifically discuss the security impact of HIV and AIDS in Africa.

Soon after the Security Council passed Resolution 1308, which stated “the HIV/AIDS pandemic, if unchecked, may pose a risk to stability and security”. This was the first time in the history of the UN that an issue outside the realm of conventional military issues was considered as a potential threat to international security. This led to many governments adopting a number of high-profile declarations of commitment and multilateral agreements. This shift in thinking set the foundation for new ideas and policymaking dynamics intended to address the emerging threat of HIV and AIDS. These two events were the precursors for the HIV and AIDS epidemic to be placed on the international security agenda.

According to McInnes (2006:315), the UN and its related agencies have been among the most important actors in raising HIV and AIDS awareness. Consequently, the intervention of the Security Council in 2000 was very influential in securitising HIV and AIDS. This was carried out by framing the disease as something extraordinary demanding international attention and action. Through this the Security Council set the agenda for the subsequent debate on HIV and AIDS as a security issue.

In response to this, governments and international institutions have attempted to address the epidemic not only as a public health and development issue, but also an international security concern (Elbe 2005:403; International Crisis Group Report 2001). As a result, this move was largely identified by most scholars (Girshick, 2004; Elbe, 2005; Pereira, 2006; Rushton, 2007) as the global securitisation of HIV and AIDS epidemic. Seemingly the global community agreed that securitising HIV and AIDS would be beneficial in terms of generating political action.

The acquired immunodeficiency syndrome (AIDS), which is caused by the human immunodeficiency virus (HIV) had killed 25 million people in the world by 2008, with 37.4 million more affected by HIV (*UNAIDS Epidemic Update*, 2009:1). When examining HIV and AIDS trends it is important to note the distinction between prevalence and incidence. Prevalence indicates the number of individuals who are HIV positive at a given point in time. Incidence indicates the number of new infections over a given period of time. Since the introduction of antiretroviral treatment (ART) the levels of prevalence may have increased due to the fact that people living with HIV and AIDS are living longer. Therefore, the declining incidence is a better tool to measure a country's success in combating the HIV and AIDS epidemic. However, incidence remains more difficult to estimate than prevalence. Botswana's prevalence rate is 25 per cent of adults, making it the second highest in the world (*UNAIDS Epidemic Update*, 2009:19). In 2009 South Africa's prevalence rate was 16.9 per cent with 5.7 million people infected, making it the country with the largest number of people living with HIV and AIDS in the world (*UNAIDS Epidemic*, 2009:27). Swaziland has the highest rate of HIV prevalence in the world with just over a quarter of adults living with the virus (*UNAIDS – How Africa Turned AIDS around*, 2013).

Africa remains the worst affected continent with incidence levels peaking in the mid-1990s (De Waal, 2006:2). In 2002 Sub-Saharan Africa had 28 million or 70% of the 40 million HIV and AIDS sufferers in the world (Pharaoh and Schonteich 2003:2-3). From 2008 onwards many national HIV and AIDS epidemics were stabilising but still at extremely high levels. In 2009 the nine states in the world with adult prevalence rates exceeding 10 per cent were all found in Southern Africa – Swaziland, Botswana, Lesotho South Africa, Zimbabwe, Namibia, Zambia, Malawi and Mozambique (*UNAIDS Epidemic*, 2009).

Since the HIV and AIDS epidemic has been one of the most researched diseases in recent history, there is an abundance of literature on the disease. Much of the literature focuses on the socio-economic and humanitarian concerns stemming from the epidemic. For instance several scholars have raised questions regarding the economic impact of the disease affecting the family and community levels, how the epidemic is endangering millions of orphans, whether it has the potential to become a threat to food security, how it contributes to crime and the implications of the epidemic for governance and economic development (Elbe 2001; Piot 2001; Fourie and Schonteich 2001, Chen 2003).

A number of academic studies and policy reports have addressed the epidemic within the more traditional framework of security. More often this literature seeks to explore the indirect impact that HIV and AIDS could have on the territorial security and integrity of the states. The issues covered include for example, whether high prevalence rates can constitute a threat to the national security of regimes friendly to the West, therefore possibly requiring external intervention (Vieira 2006:49). Within the bio-political framework, the securitisation of HIV and AIDS is significant, because it constitutes a revealing example of the gradual geographical extension and globalisation of the West's bio-political strategies to the non-Western world (Elbe 2004).

Barnett and Whiteside (2006) provide a review of the literature on epidemiology and impact. The authors have also written separately on the epidemic in each of the case study countries but not in a comparative or regional manner. There is less literature available on Swaziland in comparison to Botswana and South Africa regarding the epidemic. An important study on Swaziland was carried out by Whiteside et al. (2006) in an attempt to identify the drivers of the epidemic in Swaziland. This study differs from that of Whiteside et al. (2006) as their research is limited to primarily only this one factor. This study on the other hand examines multiple factors present in the country, which influenced its policymaking processes. It is hoped that the findings of this study will fill the gaps and help expand the literature available regarding the factors influencing the policymaking processes in Swaziland to deal with the HIV and AIDS epidemic.

There have been two major contributions to the field of HIV and AIDS and public policy and security in Southern Africa. Fourie's (2005) research covered public policymaking on HIV and AIDS in South Africa. Vieira's (2006) research examined Southern African countries responses to International HIV and AIDS norms. This study differs from both the above studies as Fourie's

study is limited to South Africa and does not include the discursive processes that featured in and shaped the policymaking leading to the differing degrees of securitisation of the epidemic. Vieira's (2006) study provides a regional dimension only to a limited degree. My research adds two important perspectives to the existing literature: firstly, the inclusion of the agency aspect gives this study a unique dimension; and secondly, it expands the regional perspective with the range of case studies. Where this study differs from previous studies is that it not only focuses on factors influencing policymaking processes, but it also incorporates the element of security studies beyond the traditional territorial security perspective therefore, its contribution to this field is multi-fold.

While conducting the literature review, I found that there was no study that explored the link between factors influencing HIV and AIDS policymaking and security in relation to the case study countries. It is useful to examine this link as it sheds light on the complex nature of the public policy discourse, the power dynamics between the different actors and the way that public policy is framed.

This study examines the processes leading to the framing of public policy and the process of securitisation. It focuses on the framing of policy and the processes and factors that explain how HIV and AIDS policy is shaped in Botswana, South Africa and Swaziland. All three countries are geographically located in "the global epicentre of the epidemic" (Hwedie 2001:55). While all three countries may share the burden of the epidemic, each presents a differing political, social and cultural identity with different institutional architects (both foreign and domestic) that determine the nature of the policy response to the epidemic. This study does not evaluate the effectiveness and impact of the policy itself.

This study also focuses on the securitisation of HIV and AIDS in each of the case studies. This is the result of the discursive processes that featured in and shaped the policymaking in each of the countries examined. The study examines the policymaking dynamics as related to the HIV and AIDS epidemic ultimately leading to varying degrees of securitisation. Little scholarly empirical research has been conducted dealing specifically with these aspects, including the approach of viewing the epidemic through a regional lens. This approach to the study intends to enhance our understanding of the factors and processes that lead to the framing of policy and the dynamics associated with this in each of the three countries. McInnes and Rushton (2010:3) claim "that

rather than an issue being either securitised or not, an issue (such as HIV) may be partly securitised, with different actors and audiences positioned at varying points along the spectrum of securitisation.” As a result, this thesis will demonstrate the degree to which each of the case study countries have been able to securitise the HIV and AIDS epidemic. It will also identify the actors, factors and dynamics that have a bearing in facilitating this process.

The HIV and AIDS epidemic is an interesting case study since the issue has gradually moved from the category of a politicised matter to a securitisation concern. This can best be described using Elbe’s (2006) metaphor of the pendulum that swings from politicisation to securitisation depending on the perceived levels of urgency and threat. The securitisation of the HIV and AIDS epidemic may be useful in addressing some of the social ills and strengthening the national response policy to the epidemic. While securitisation may produce effective policy, this study explores the process and outcomes of securitisation in policy dynamics. The theory of securitisation is relatively new to the field of security studies. An issue is said to be securitised when it is “presented as posing an existential threat to a designated referent object” thus “justifying the use of extraordinary measures” (Buzan et al., 1998:21).

1.2 Problem statement and research questions

1.2.1 Problem statement

The central problem statement of this study is: How was public policy on the HIV and AIDS epidemic securitised in Botswana, South Africa and Swaziland? This investigation follows three main lines of inquiry. It will a) study the policymaking dynamics as related to the HIV and AIDS epidemic in the three countries; b) investigate the roles of the principal policymaking actors, and domestic and international policy-influencing actors in the national response policy in each of the three countries, and lastly, c) study the discursive processes that featured in shaped policy-framing in the three countries (the securitisation dynamics).

1.2.2 Research sub-questions

The following research sub-questions will also be used in the study in order to unpack the problem statement further:

- a) What public policies were designed to combat the HIV and AIDS epidemic in the three cases?
- b) What are the similarities and differences in the adoption of international HIV and AIDS ideas in the approaches of Botswana, South Africa and Swaziland?
- c) What are the roles of principal policymaking actors as well as domestic and international policy-influencing actors? And what are the power dynamics between these actors?
- d) What were the discursive processes that featured and shaped policymaking (the securitisation dynamics)?
- e) To what degree was the HIV and AIDS epidemic securitised in the respective countries?

1.3 Preliminary literature review

The literature that was reviewed can be divided into two main categories, namely literature on HIV and AIDS, and literature on the concepts of security and securitisation approaches.

Because of the abundance of literature related to the HIV and AIDS epidemic, Fourie (2005:9) divides the existing literature on the HIV and AIDS epidemic into six categories which are listed as follows:

- a) Explications of international/comparative experiences;
- b) Publications that provide accounts of the disease's economic and demographic impact;
- c) Those focused on highly specialised medical information related to the disease;
- d) Writings based on the social sciences that fall broadly into the categories of Sociology, Psychology and Law;
- e) Those related to workplace (private) or human resource-based HIV and AIDS policies; and
- f) Publications on policy interventions related to the disease.

This study is mostly concerned with the last group of writings on this topic which deals with public policy concerns. However, the aim of the study is to analyse the policy process in order to explain observed policy outcomes, but not to evaluate policy itself. Therefore this study adds a further dimension, by expanding on the literature currently available.

Although the epidemic has had striking effects on human lives and could rightly be seen as a humanitarian issue, scholars have recently emphasised the growing negative effects of the epidemic on the core pillars of states, thus receiving increased attention by policymakers as a potential threat to national security (Elbe, 2010:418). This led to the emergence of a body of scholarship advocating the significance of HIV and AIDS as a security threat. One influential strand, which has adopted the securitisation perspective is the so-called Copenhagen School. Theorists associated with the Copenhagen School include Barry Buzan, Ole Waever and Jaap de Wilde.

Waever claims that “security should be seen as a negative, as a failure to deal with issues of normal politics (Buzan et al, 1998:29). The advocates of the securitisation model, as expressed by the Copenhagen School scholars, built on the speech-act theory (Austin, 1962; Searle, 1969) to understand how securitising actors engage in argumentative practises to influence (socialise) audiences about the threatening character of the particular issue. Consequently, securitisation, as an analytical concept, is very useful tool in demonstrating processes whereby issues are moved from the realm of normal politics (politicisation) to that of emergency (securitisation). The securitisation framework is used in the study as the theoretical device to help trace incidence of securitisation of the HIV and AIDS epidemic at the global level and subsequently in the domestic structures of Botswana, South Africa and Swaziland.

According to Buzan et al (1998), the use of instruments of securitisation by political leaders is intended to avoid catastrophe and massive death in the moment of alleged exceptional (security) crisis. As will be established later in the thesis, at the global level, HIV and AIDS was securitised by powerful securitising actors, namely UN and its associated agencies, the US government and transnational HIV and AIDS NGOs. The thesis claims that the global securitisation of the epidemic became internationally accepted by various international declarations and agreements which called for states to develop long-term policies and permanent bureaucracies. Also, the creation of UNAIDS to specifically deal with the HIV and AIDS epidemic has crystallised the

epidemic as an ongoing security threat. Because of the nature and impact of the epidemic it has transformed this security crisis into a long-term emergency. However, McInnes and Rushton (2010:3) assert that the securitisation of HIV and AIDS is more nuanced than was believed in the early 2000s and “that the reasons why HIV was not more successfully securitised were two-fold: the lack of political consensus and doubts over the empirical evidence”.

At the domestic level, the interactions between these global speakers of securitisation and their state audiences were important features in understanding the methods by which international HIV and AIDS norms were socially domesticated. The case studies will each reveal different internal dynamics of securitisation.

“Structural realists treat states as if they were black boxes: they are assumed to be alike, save for the fact that some states are more or less powerful than others” (Mearsheimer 2006:72). However, as the case studies will prove this is not the case as states represent collective entities composed of different institutions, cultures and individuals. For instance, when a government endorses the international norm claiming for the securitisation of HIV and AIDS, it is still important to understand how domestic social and power-dynamics influence its securitisation practices. It is at this point when the analyst can decisively determine whether or not a securitisation move is successful. This thesis further explores the domestic determinants that either constrained or facilitated HIV and AIDS securitisation processes within Botswana, South Africa and Swaziland. It focuses on their particular political cultures, state-society relations and the types of political leadership.

While there is a body of literature available on the HIV and AIDS epidemic in the individual Southern African countries, the process leading to the framing of public policy and the policy dynamics which lead to the securitisation of the HIV and AIDS epidemic in Botswana, South Africa and Swaziland have received scant attention. These studies also lack the comparative dimension and perspective that this study provides. This study therefore aims to fill this gap by examining a wide range of variables and factors that influence policymaking. In addition, the study adds to the literature by including the dimension of securitisation as part of policymaking dynamics which is also absent from the available literature.

1.4 Aims of the study

HIV and AIDS were first detected in each of the case studies in the 1980s. Initial data after the detection indicate that the high rate of HIV infection and incidence levels did not show much improvement despite the formulation and introduction of several intervention policies in each of the countries under review.

When conceptualising my research project I initially intended to explore the regional framing of policy and processes by investigating the Southern African Development Community (SADC) response to the epidemic. As the three countries are all situated within the SADC region and are equally affected by the epidemic, it was fair to assume that a regional coordinated response would have been more beneficial to the policymaking process. However, after a research visit to the SADC offices and interviews with officials involved in HIV and AIDS regional activities, it became clear that the organisation was at that time not in a position to coordinate the HIV and AIDS policies of its member states. Therefore SADC is not central to the policy decision-making structure in the individual countries in the field of HIV and AIDS and this study as a whole.

The study aims to examine how the policymaking related to the HIV and AIDS epidemic was shaped, and investigates the policy dynamics which led to the securitisation of the epidemic in Botswana, South Africa and Swaziland. While the aim of this study is not to evaluate the effectiveness of the policies themselves, it does examine the policymaking dynamics as related to the HIV and AIDS epidemic ultimately leading to its securitisation.

This approach is important as it will help to explain the similarities and differences in the approaches used by the actors in each of the countries. This will help to unravel who the policy-influencing actors are and how they have shaped the HIV and AIDS policymaking discourse in each of the countries under review. Furthermore, it will also demonstrate the extent to which the HIV and AIDS policy has been elevated to the status of a security threat in the respective countries. As a result, it will be possible to determine the degree to which each country was able to securitise the HIV and AIDS epidemic.

The main interest of this study is not the actual interpretation of HIV and AIDS as a security issue or why HIV and AIDS have been securitised. Instead, it aims to establish what explains the securitisation of HIV and AIDS and how this approach was spread and adopted. Also it must be

mentioned that this study does not engage with the ongoing debate about the actual links between HIV and AIDS and security, or assess the ethical implications of the securitisation of HIV and AIDS. As will be discussed later, several scholars and practitioners focusing on HIV and AIDS do so within the domain of universal humanitarianism or that of self-referential national interest. This led to some actors promoting securitisation of HIV and AIDS specifically because the human security/developmental approach to the epidemic produced only an insufficient response in the international system. While for others, the framing of HIV and AIDS in the language of national security can push the response in the wrong policy direction. Elbe (2006:121) for instance, stresses that this is because of the susceptibility for undemocratic decision-making in situations of national security crisis, with power concentrated in just a few state institutions, such as the military and intelligence services, and away from civil society groups.

1.5 Theoretical framework

Two main strands of theoretical literature are reviewed: literature on public policy decision-making processes and literature on security concepts and the securitisation approach. This study presents theories on how policy decision-making is framed. Subsequently, the literature on securitisation illustrates how issues such as HIV and AIDS are securitised through the process of policy framing. The study provides a framework for understanding the securitisation of the HIV and AIDS epidemic in Botswana, South Africa and Swaziland.

Dye (1995:15) cautions against choosing any single theoretical approach by asserting that “we doubt that there is any ‘model of choice’ in policy analysis – that is, a single model or method that is preferable to all others and that consistently renders the best solutions to public problems.” Therefore, working from this premise, several theoretical approaches are examined in relation to the study. The study examined the following theoretical perspectives on policymaking, the pluralist model, the elite model and statism.

Pluralists believe that there should be a clear separation of powers which stems from the fact that they deem liberal democracies to have become fractured and as a result power should therefore not be centred in the organs of the state. They further believe that government agencies do not stand alone, but are rather part of a myriad of actors who through their actions are in a position to

influence the political leaders of the day. Dye (1995:23) states that pluralists support the idea that the conduct of politics in society begins with the interaction among groups, with the latter consisting of “individuals with common interests”. Critics have raised the issue that pluralists focus more on group interaction and not enough on the actual issues (McLennan 1997:53).

Since each of the case study countries is in the developing world, the elite theory best describes and helps to explain developing countries’ policymaking environment. This is based on the fact that in developing countries the concentration of power remains in the hands of a minority of the population. This situation may be applicable to each of the case studies. Elite theorists have expanded their definition to include - along with the government and interest groups - the elevated power held by identifiable groups such as the economic, military, and political and aristocratic elites. The main source of power for the policy elites in most developing states remains with those holding political offices.

Elite theorists assert that in the public policy domain these elites are in a position to control and manipulate the agenda-setting process. Essentially they are able to advance their own political agendas while at the same time placing themselves in a position to ensure who benefits and when they benefit from the process. Therefore, public policies represent, “the preferences and values of a governing elite” (Dye 1995:25).

Finally statism is a term used to describe the belief in public policy that a government should control either economic or social policy or both to some degree (Levy, 2006:469). Public policy as an outcome of political institutions has been a concern of political studies from its beginning (Dye, 1995; Anderson, 1997). Intuitionism describes the more formal and structural aspects of policymaking and implementing institutions. Anderson (1997) defines an institution as a set of regularised patterns of human behaviour that persists over time and performs some significant social function or activity, whose outputs are public policy decisions. North (1991:97) expands this notion by drawing a distinction between institutions and organisations which is important for purposes of this study.

Sharing elements with elite theory, statism takes the view that elites may be better positioned in state agencies to influence public policy in order to advance their own political agendas. This

situation allows the agency of the state to become the determinant of policy content so as to reinforce the state's elite position.

Regarding the second strand of literature related to the security paradigm, traditional and non-traditional approaches to security are investigated focusing specifically on the issue of securitisation. The end of the Cold War left the field of international relations in a state of flux. This led to the concept of security becoming more contentious. Several scholars have theorised about the evolving concept of security with Haftendorn (1991:15) arguing that, "there is no common understanding of what security is, how it can be conceptualised, and what its most relevant research questions are".

This led to a call for a wider, more constructivist approach to security analysis. Scholars argued that the traditional concept of security was too narrow to be applicable to 'new non-military threats' posed by economic and environmental issues. They claimed that the increased importance of issues such as the environment and economics and the resulting inability of a militarily-focused framework for security studies to adequately deal with these matters has heightened the need for a more inclusive conception of security (Buzan, 1991:4). From the early 1980s the neorealist conceptualisation of inter-state security relations was challenged by an increasing number of writers who advocated for an alternative understanding of security (Buzan, 1983/1991; Ulman, 1983; Jahn, Lemaitre and Weaver, 1987; Tinkner, 1992; Buzan et al., 1998).

The end of the Cold War saw the introduction of this new security agenda by scholars seeking to shift the referent object of security from the state to the individual. The United Nations was influential in these developments of the emerging human security perspective. This new perspective focused on a broad understanding of security that includes not just the security of states against external or internal armed threats, but also gives priority to the security of people living within states against non-military threats such as disease, environmental degradation, economic and social instability.

HIV and AIDS fall into this latter categorisation of security, leading to the adoption of this broad perspective by a wide range of governments, multilateral agencies and academics (Vieira, 2006:48). They raised questions regarding the economic impact of the disease affecting the family and community levels, how the epidemic is endangering millions of orphans, whether it

has the potential to become a threat to food security, how it contributes to crime and the implications of the epidemic to governance and economic development (Elbe, 2001; Piot, 2001; Fourie and Schonteich, 2001; Chen 2003).

The emergence of the so-called Copenhagen School brought a new impetus to the securitisation approach. Williams (2008:68) believes that the Copenhagen School presents the most concerted attempt to develop a theory or framework for the study of security in the constructivist tradition. Collaborative work culminated in the seminal 1998 publication, *Security: A New Framework for Analysis*, co-authored by Buzan, Wæver and Jaap de Wilde. They posit that security is not a static concept, as understood by traditional security studies, but rather an inter-subjective rhetorical practice.

The Copenhagen School sought both to widen and broaden traditional security concepts. They placed two important steps in front of any such effort namely there must be an “existential threat requiring emergency action” to be identified, and a significant part of the audience must accept that description (Buzan et al., 1998:27). The type of threat may not be as self-evident as a natural disaster or an invading army, but is more likely, that a political actor will have to build a persuasive case for securitising the threat. While securitisation draws attention to a range of issues it remains “largely based on power and capability and therewith the means to socially and politically construct a threat” (Taureck, 2006:55). Although securitisation allows for greater openness, it acknowledges that the advantage remains with those who begin with more power and more access to certain elements such as the media.

The study will follow McInnes and Rushton (2010), who assert that it is not fruitful to speak of an issue being securitised as a simple binary equation. The empirical findings in this study will show that the outcomes of the policymaking processes for HIV and AIDS will reveal differing degrees of securitisation in the different countries.

Securitisation may prove particularly advantageous at drawing attention and prompting responses from national, regional and international actors. In the context of the present theoretical framework, Elbe (2006:132) argues that the linking of HIV and AIDS with security would activate “a shift out of the non-politicised status in many countries,” thereby allowing “a proper politicisation of the issue” as a result increased funding can be allocated to address the

concern. For example, when governments securitise HIV and AIDS, health sectors may benefit through better allocation of resources to address the concern.

At an economic level, a major obstacle preventing many African countries from obtaining sufficient HIV medicines constitutes the Trade-Related Aspects of Intellectual Property (TRIPS). These agreements entitle Western pharmaceutical companies to hold the patents on drugs, thus giving them exclusivity on the manufacturing and the pricing. Generally these drugs were unaffordable for many African states. Therefore, by linking HIV and AIDS to the security nexus it enables the TRIPS agreements to be overruled on the grounds of “security exceptions” set up by the World Trade Organisation (WTO). This agreement compels pharmaceutical companies to lower their prices (Elbe, 2006:134). Therefore, it is advantageous to many developing world countries unable to afford the expensive patented AIDS drugs to securitise the HIV and AIDS epidemic in order to fully benefit from the above agreement.

While the above stressed the potential benefits of securitising the epidemic, Mc Innes and Rushton (2010) identify three specific areas of tension associated with the securitisation of HIV and AIDS:

- Regarding ethics and the extent to which the rights of the individual should be maintained over the rights and interest of society.
- Securitising HIV may help to secure greater attention and resources, however in doing so it should not change the priorities for resource allocation away from those in need and towards political benefits.
- Securitisation of HIV and AIDS might run the risk of creating a new form of stigma directed at those living with the disease who are not only health risks but also security risks.

Therefore, it is important that governments put measures in place to safeguard their populations from the dangers associated with the securitisation of the HIV and AIDS epidemic.

Securitisation and the public policymaking process are closely linked through the use of appropriate language to frame the issue or threat. Central to this study is speech-act theory which is an essential component of the securitisation approach as defined by Buzan. This approach rests on the assumption that “by saying words something is done”; meaning that language does not

only convey information, but also has a constitutive role (Buzan et al, 1998:26; Elbe, 2006:124). In other words, security threats do not exist independently, but rather are socially constructed through language (Buzan et al, 1998:31). Therefore, policy-makers use speech-act as a social activity involving shared understandings, with the objective to frame specific issue as threat to security (Elbe, 2006:124).

This study takes into account the valid limitation raised by Mc Innes and Rushton (2010:5) when questioning that when issues are created as security issues through speech-act it raises a problem, “who are the actors who, through their speech-acts, can create security issues?” Buzan et al (1998:31) also raised the issue that there is a bias towards certain actors who are “generally accepted voices of security”. Therefore in order to address this issue the study will adopt the following as the analytical tool to examine the securitisation attempts in each of the case study countries. For a speech-act to be successful three facilitating conditions are required in the process of securitisation:

- It must follow the recognised grammar of security;
- It must come from an actor in position of authority to pronounce on security;
- The object should generally be said to be threatening.

Buzan et al (1998:25) claim that the “definition and criteria for securitisation is constituted by the intersubjective establishment of an existential threat with a saliency sufficient to have substantial political effects”. As a result, McInness and Rushton (2010:6) emphasise their point that when defining health issues as security issues, “they do not need to meet external criteria but rather be agreed upon intersubjectively as constituting an existential threat which cannot be dealt with in a normal way, and which has a political impact”.

1.6 Significance of study

When conceptualising the focus of my study, it was evident that there is an abundance of literature dedicated to the HIV and AIDS epidemic. To try and provide a balanced view of the epidemic a wide range of factors were examined. As a result, the study presents factors in each of the case studies that are both very similar and entirely unique. Each of the factors presented has played a role in influencing the policymaking processes and dynamics in each of the three

countries. This was achieved through the process of disaggregation by analysing all the relevant different actors and factors at play in Botswana, South Africa and Swaziland. Also, as my research adds some agency to the body of literature on the policy-framing process surrounding HIV and AIDS, as I am part of the policymaking process as a government official dealing with security threats to the Southern African region. This study therefore makes a contribution to the existing knowledge, because of the author's 'real world' study of securitisation. Since the study of securitisation tends to be highly theoretical, this study adds a unique empirical dimension to the existing literature. This is done by demonstrating the degree to which the HIV and AIDS epidemic was securitised at the national level of all three case study countries.

McInnes (2010:14) raises an important insight regarding the limitations of available empirical research related to the securitisation processes in different countries which this thesis attempts to address. The US government has been identified as a key securitising actor. According to McInnes (2010:14) in the US "key security institutions [...] recognise AIDS as being within their remit, and are taking steps to address it". However, McInnes (2010:14) argues that "there has been little work which has demonstrated a comparable impact on the policies adopted by other countries, nor do the security policy institutions in other countries appear to have seized on the issue to the same extent". This thesis aims to expand and contribute to address this limitation in the literature by demonstrating the securitisation processes, policies adopted and influence of security policy institutions in each of the countries under review.

One intention of this study is to steer away from viewing Southern Africa as a monolithic region. It is necessary that each case study is examined on its own merits in order to demonstrate the uniqueness of this study. This approach makes the research significant as it provides the reader with a wide range of comparative factors and dynamics, which present certain similarities and dissimilarities, an important aspect, which is not covered by the existing literature. The significance of this study compared to related studies is that it focuses on factors, implicit in policymaking processes and the policy dynamics that resulted in the level of securitisation of the HIV and AIDS epidemic in Botswana, South Africa and Swaziland. HIV and AIDS entered the political agenda as mainly a health concern. Looking at the link between policy-framing and security it is interesting to examine how this non-traditional security threat has been elevated to find a place on the security agenda.

1.7 Methodology

This study is a multiple case study within the qualitative research paradigm. The investigation centres on the HIV and AIDS policymaking dynamics leading to the securitisation of the HIV and AIDS epidemic in Botswana, South Africa and Swaziland. I chose to examine the securitisation of HIV and AIDS because it was the first non-traditional (health) security threat to enter the global security agenda.

When selecting the case studies I looked at the Southern African region as this was the epicentre of the epidemic. The countries here have similarities in the ways they were affected by the HIV and AIDS epidemic. The three countries were chosen for three main reasons. Firstly, they all have an extremely high HIV and AIDS prevalence rate, exceeding 20 per cent. This has caused them to be subjected to considerable pressure to formulate and implement policies to securitise their HIV and AIDS policies. Secondly, despite being neighbouring countries, each of the three countries represents distinct domestic and political structures, which has resulted in three different models of state reaction responses to the epidemic. And thirdly, they were chosen for their geographical accessibility for the researcher. The fieldwork for the study was conducted in 2007 and 2008.

The main primary data sources for the study were semi-structured interviews with representatives from the policymaking actors and policy-influencing actors in the three countries. All the interviews were recorded except for one interviewee who declined to be recorded on tape. Other primary data sources were statistical data, government publications, administrative records as well as secondary sources such as media reports and academic publications on related topics.

1.8 Limitations and delimitations

The central focus of the study covers the timeframe from 2000 when HIV and AIDS first entered the security agenda to 2008 when the last of the fieldwork was undertaken. This was during the periods of the leadership of President Mogae in Botswana, President Mbeki in South Africa and King Mswati III in Swaziland. This period is important as it was the time when the HIV and AIDS epidemic was placed on the political agendas of the respective countries and the epidemic spread at an alarming rate in all of the case study countries.

The findings presented in this study are unique, given that this dissertation draws on the results from empirical research conducted in Botswana, South Africa and Swaziland. Nevertheless, two important factors were taken into consideration for the completion of the study; firstly, the fieldwork research conducted in the three countries did not cover the whole of the respective country. Secondly, because of time and financial constraints the researcher was unable to undertake additional rounds of fieldtrips to the three countries. During this period I was based in Norway and therefore could only carry out fieldwork study visits at certain times to ensure maximum interviewee participation.

While it was the intention of the study to conduct as wide a range of interviews with as many relevant actors as possible, unforeseen circumstances such as timetable schedule clashes or unavailability of interviewees while I was in the region meant that this limited the study to some degree.

While there are more recent statistical HIV and AIDS data available, these statistics do not show any major results that refute the findings of the study. This study has relied on statistics primarily from the UN and associated agencies, although there has been some controversy surrounding the accuracy of some statistics. There was a lack of other sources of comprehensive and comparable statistical data covering the countries under review.

1.9 Thesis outline

The thesis is divided into eight chapters, which includes the present introductory chapter.

Chapter 2 provides an analytical framework for guiding the subsequent empirical chapters. The chapter discusses the conceptual and theoretical frameworks of the public policymaking process. It then also looks at the origins and evolution of the academic and policy debates linking HIV and AIDS and security by focusing on the securitisation approach.

Chapter 3 further discusses the scope and limitations of the study, as well as the research methods that have been applied.

Chapter 4 traces the political journey of HIV and AIDS, as it moved from the biomedical sphere to that of an international security threat. It also briefly examines HIV and AIDS and Global Health Governance by highlighting the process that lead the international community to accept

the disease as a security threat. The chapter further traces the origins of HIV and AIDS and security. Finally, the chapter concludes with an examination of the three influential global securitisation actors namely, UNAIDS, the US government and the role of civil society actors, which have been instrumental in furthering the global securitisation approach.

The empirical section is presented in chapters 5 (Botswana), 6 (South Africa) and 7 (Swaziland). These chapters focus on the countries' social and political cultures, the particular characteristics of their state-society relations as well as sources of political leadership. They also provide the analysis based on theoretical considerations.

In the case of Botswana, chapter 5 illustrates that there was a significant degree of unanimity between international and national actors which helped to define the HIV and AIDS policy process in the country. It is argued that Botswana's approach of being open to Western ideas and values was reflected in its national response policy. Furthermore, the stable political system and the government's continued commitment to the social and economic uplifting of its citizens contributed to a national response to the HIV and AIDS epidemic in accordance with that of the international agenda of the securitising actors.

Chapter 6 on the South African case argues that under the leadership of Thabo Mbeki, the South African government adopted a political agenda, which opposed perceived Western influence. This approach caused tensions between the government and both domestic and international HIV and AIDS actors. The chapter also demonstrates that, unlike in Botswana and Swaziland, in South Africa a vibrant and proactive civil society sector actively confronted the government's stand and policies on HIV and AIDS. In addition, the influence of domestic activism is explored as key links were formed with international organisations and major donor states to exert pressure on the government to change its HIV and AIDS policies.

The Swaziland case study (chapter 7) examines how, under the absolute rule of King Mswati III, the international and domestic actors were able to create a political space to influence and strengthen the country's HIV and AIDS national response policy. The case study demonstrates that HIV and AIDS programmes and policies should be formulated in a more country-specific way, since cultural practices are different in each of the case studies. In the case of Swaziland, it was argued that once both the international and domestic HIV and AIDS actors reached this

realisation, they were able to work in partnership with the state. This placed them in a position to influence the policymaking processes to a certain degree, which was not possible before that.

Chapter 8 starts off by revisiting the aims of this study as well as the main research questions. The chapter sums up the most important theoretical and empirical findings of the thesis with reference to the three case studies, Botswana, South Africa and Swaziland. It also highlights areas of continued academic interest in this field.

Chapter 2: Theoretical Framework and Literature Review

2.1 Introduction

The aim of this chapter is to lay the conceptual and theoretical bases for analysing the processes related to the formulation, adoption or non-implementation of HIV and AIDS policy in Botswana, South Africa and Swaziland. Two strands of theoretical literature are reviewed, namely literature on public policy decision-making processes and literature on the securitisation process. This chapter presents theories on how policy decision-making is framed. It will then consider the literature on securitisation this illustrates how issues such as HIV and AIDS are securitised through the process of policy framing. The study provides a framework for understanding the securitisation of the HIV and AIDS epidemic in Botswana, South Africa and Swaziland.

Although the epidemic has had striking effects on human lives and could rightly be seen as a humanitarian issue, scholars have recently emphasised the growing negative effects of the epidemic on the core pillars of states. The epidemic has consequently received increased attention from policy-makers as a potential threat to national security (Elbe, 2010:418). This has led to the emergence of a body of scholarship advocating the significance of HIV and AIDS as a security threat. One influential strand that has adopted the securitisation perspective is the Copenhagen School theorists associated with the Copenhagen School include Barry Buzan, Ole Waever and Jaap de Wilde.

The chapter seeks to establish the link between the framing of public policy analysis and securitisation approaches, which leads to the varying degrees of securitisation of the HIV and AIDS epidemic. It explores the extent to which the epidemic is considered a threat, which is in turn dependent on how the disease is framed. The framing of the disease is important as it has an impact on public policy decision-making and the securitisation processes. Speech-act theory is useful in the framing process as it demonstrates how HIV and AIDS can be constructed by securitising actors as a threat through the use of specific language. This is important as it allows the epidemic to shift from being regarded solely as a health issue to being understood as a security issue, which then necessitates the formulation of relevant policies to address the epidemic.

The securitisation framework offers, with some degree of precision, the analytical parameters to understand the historical processes that led to the current global securitisation of HIV and AIDS. Through the application of the four constitutive elements of the securitisation speech-act, it is argued that HIV and AIDS has been successfully constructed as a security threat by international securitising actors. While in each of the case study countries, the degree of securitisation attempts differed because of several factors, which will be analysed in more detail in chapters 5-7.

The chapter has three parts. The first part presents the socio-economic characteristics of the developing world, examining certain shared features that can be found in each of the three countries in this study, which are also all found in the developing world. Keeping these features in mind when analysing the case studies may help identify the certain similarities or differences between Botswana, South Africa and Swaziland in terms of how each country deals with the epidemic. Furthermore, these characteristics may help to explain some of the factors that influence policy decision-making on HIV and AIDS in the three countries as they share many features and are located in the “the global epicentre of the epidemic” (Hwedie, 2001:55).

The second part examines the decision-making process through which policy is framed. The section also reviews theories on public policymaking processes drawing from amongst others the elite theory and institutional model of policymaking. The third part reviews the literature on the securitisation processes. The section explores the new security paradigm focusing on traditional and non-traditional approaches to security, in particular the securitisation approaches presented by the Copenhagen School. There is also an examination of the limitations and critiques of the securitisation process.

According to Buzan et al (1998:23):

‘Security’ is the move that takes politics beyond the established rules of the game and frames the issue either as a special kind of politics or as above politics. [...] In theory, any public issue can be located on the spectrum ranging from nonpoliticised (meaning the state does not deal with it and it is not in any other way made an issue of public debate and decision) through politicised (meaning the issue is part of public policy, requiring government decision and resource allocations) to securitised (meaning the issue is

presented as an existential threat, requiring emergency measures and justifying actions outside the normal bounds of political procedure).

The HIV and AIDS epidemic has moved along this spectrum from non-politicised to politicised and finally securitised. As will be demonstrated, through the use of public policy processes and framing of the HIV and AIDS epidemic, its movement along the spectrum determines the degree of the securitisation of HIV and AIDS experienced in each of the case study countries. The politicised stage brought the HIV and AIDS issue on to the political stage. Without this stage, its movement along the political spectrum might have been limited. This shows that there is a link between the framing of public policy analysis and securitisation approaches as each can be found on the same spectrum but at different points. Depending on the movement of a particular issue along the spectrum, public policy processes may lead a particular issue to the securitisation stage.

2.2 Socio-economic characteristics of the developing world: cultural, economic and political

Cloete (2000:83) describes the following characteristics of most developing states:

Lesser developed states normally have much larger numbers of illiterate, poorly educated people and on the average a much younger and less mature population. The role of the extended family is crucial in community life, while in many cases women still occupy subordinate roles in society and ethnic tolerance is sometimes superficial. They frequently have only primitive means of transport available to them and are therefore not really mobile. Their populations have relatively short life expectancies compared with the inhabitants of more developed countries, with incidences of infant mortality and poor health services that struggle to cope with ballooning populations. Large numbers of people still live in primitive conditions in rural areas, where they eke out an existence, barely surviving from day-to-day. They have only rudimentary services and facilities, with large regions of the country frequently being inaccessible owing to a serious lack of transport and other communication routes. The governments concerned cannot provide for even the most basic needs of their citizens.

The large rural-based populations in developing states tend to live more widely distributed and consequently geographically further away from the public institutions that make important policy

decisions impacting on their lives. As a result, many rural-based populations do not have easy access to adequate information that will help them understand what their government is doing. It also leaves them with little influence on the policy decision-making processes itself. Furthermore, they also have limited, if any, access to important decision-makers. This creates a situation that isolates these sectors of the population (Grindle and Thomas, 1991). Grindle and Thomas (1991:51) elaborate further by stating that:

The age distribution of the population is significantly different in developing countries than in industrialised countries, and this tends to reinforce the aloofness of decision makers from their societies [...] significantly larger proportions of population in low-income and middle-income countries are fourteen years of age or less. This means that the politically aware and active percentage of the population is also lower in developing countries than in industrialised ones. A large rural population, limited communications, low levels of literacy, and limited adult population tend to mean that a much larger percentage of the population is out of touch with what is happening, especially when government is strongly centralised. This inevitably enhances the role of policy makers while tending to isolate them from critical information about what is occurring in their societies.

The most frequently used economic indicators for measuring socio-economic development are the gross national product (GNP) per capita and the gross domestic product (GDP) per capita. Although there may be limitations regarding per capita GNP in terms of income distribution, it helps to illustrate the disparities in distribution of wealth between richer and poorer countries. The HIV and AIDS epidemic negatively impacts on both GDP and GNP of affected countries. Many developing countries' economies experience this negative impact. The World Bank (2003:233-235) divides countries of the world into low-income (US\$745 or less per capita), lower-middle-income (US\$746-2975 per capita), upper-middle-income (US\$2976-9205) and high-income economies (US\$9206 or higher). It includes low-income, lower-middle-income and upper-middle-income countries into the category of developing economies. All three case study countries fall into this category.

Because of their economic shortcomings, many countries in the developing world find themselves trapped in a cycle of international debt. This debt is usually high, which in turn, does

not only reduces the decision-making autonomy of the developing countries' governments, but also makes them more vulnerable to policy prescriptions from international aid agencies (Cloete, 2000). This assumption will be further examined in the case of Botswana, South Africa and Swaziland's HIV and AIDS response policies later in the study.

2.3 Public policy process

When examining the public policy decision-making process, it is useful to start looking at the way different scholars have defined it. According to Theo Jans (2007:3) public policy is primarily concerned with the following questions:

- i) How are problems and issues defined and constructed?
- ii) How are the problems placed on a political or policy agenda?
- iii) How do policy options emerge?
- iv) How and why do governments act or do not act?
- v) What are the effects of government policy?

According to Dye (1995), public policy represents what governments choose to do or not to do. However, this definition is rather too generalised and fails to provide the means to adequately conceptualise public policy. It is flawed as it includes every aspect of a government's activities and as a result provides very few means of separating the trivial activities from the significant aspects of a government's activities (Howlett and Ramesh, 1995). Dye's definition does stress that the agent of public policymaking remains the government. There are currently several definitions of public policy. Fourie (2005) warns about falling into the trap of choosing a single overly defined conceptualisation of public policy instead he has provided a list of the many definitions of public policy.¹ Anderson (2000:4) defines policy as "a relatively stable, purposive course of action followed by an actor or set of actors in dealing with a problem or issue of concern", adding that public policies "are those developed by governmental bodies and officials".

It is necessary to contextualise policies within the greater scheme of things with continual outcomes as opposed to individual outputs. Therefore, a policy is the result of a political process

¹ For the complete list see Fourie (2005:15).

² The contemporary international relations paradigm is based on the European state-system, a system that can be traced back to the signing of the Treaty of Westphalia in 1648.

that may involve the following steps: negotiation, bargaining, persuasion and eventually a widely accepted compromise. This process is vital because the policy arrived at should be broad enough so that it does not have to be replaced or reformulated every year “it is clear [...] that policy has a cyclical nature and arises from a process over time” (Van der Waldt, 2001:91).

In democratic states public policies arise from public demands. These demands are directed at the government, which in turn, is expected to resolve the concern or deal with an issue of concern in society. For the purposes of this study, this point can be best illustrated using the example of the public demanding ARV treatment for all HIV-positive people. This public demand for ARVs was experienced in each of the case study countries and will be further discussed in Chapters 5, 6 and 7.

The mere formulation of a policy in itself is not enough as the implementation of the policy is an important factor. In other words, once the government has formulated a particular policy, an important step will be to implement an appropriate plan of action to carry out the policy. Therefore, policy is two-pronged the government’s stated intentions and actions coupled with their ability or inability to carry out the intended implementation plan. This is a vital aspect since the framing of policy and the processes and factors associated with it help to a certain degree to explain the effectiveness or not of a certain policy decision after implementation. According to Anderson (2000:7), even the failure to formulate a policy, will become policy since “inaction becomes a public policy when officials decline to act on a problem.”

2.4 Public policymaking and agenda setting

The policy process is “messy, replete with considerable randomness, but careful research can have an important impact - from agenda setting through to the implementation state” (Heinemann et al., 2002:48). Fourie (2005:23) believes that it is important to view policy processes as a series of stages, “since the different values and perspectives brought to bear on each phase of the policy process can determine the definition of the issue at that point”. This is because the process or series of stages should be contextualised within a policy environment, since they do not occur in a social vacuum.

In its broadest sense the policy environment includes several factors such as natural resources, demographic variables such as population size, race and age distribution, location, political

culture, the regime type of the state in question, social structure, class system, other nations, geopolitical position and the economic system (Anderson, 2000:44). Anderson (2000:45) highlights the fact that a state's political culture and the prevailing socio-economic conditions will have a significant impact on what are deemed to be important societal issues. As discussed in detail in chapters 5, 6 and 7, in each of the case study countries the state's political culture and the prevailing socio-economic conditions had an impact on what were deemed important societal issues.

Anderson (2000:93) asserts that the policy agenda consists of those demands that policy-makers choose or feel compelled, to act on at a given time, or at least give the appearance of acting on them. Because of the vast number of public problems that may prevail at any given time in society it is not possible for all of them to make it onto the public policy agenda. In order for a public problem to make it onto the public agenda, it needs to be elevated and made into an issue that the government will respond to. Cobb and Elder (1983:85) make a helpful distinction between the systemic public agenda, which refers to issues on which there is general political consensus as to what merits public attention, and the institutional, which refers to issues on which the government and its institutions feel compelled to act upon.

Agenda building is made possible by the conscientisation of large sections of the population rallying together over a specific issue; such a process could place a fairly isolated issue onto the public agenda (Parsons, 1997:128-129). Fourie (2005:27) argues that this can be achieved in a threefold process: firstly, the problem must be defined ambiguously in an attempt to encompass as many individuals and interest groups at the same time; secondly, by impressing on the audience/public the dire long term effects of inaction on an issue; and thirdly, by ensuring the definition remains non-technical and fairly easy for the general public to be able to identify with and understand.

Several influential actors such as the media, interest groups, the government organs and the Head of State (expressing/passing on his or her own beliefs) all play important roles in establishing both systemic and institutional agenda items. These actors are influential, as they have the ability to elevate the status of a particular issue into the public sphere by either their actions in addressing the issue or even by their inaction. However, certain individuals or groups in society may seek to ensure that certain issues do not attain agenda-setting status. Anderson (2000:101)

highlights this by mentioning that the denial of an issue or certain causal links may in fact be used to give effect to this intention.

2.5 Public policy theoretical frameworks and literature review

Dye (1995:15) cautions against choosing a single theoretical approach by asserting that “we doubt that there is any ‘model of choice’ in policy analysis – that is, a single model or method that is preferable to all others and that consistently renders the best solutions to public problems”. Therefore, working from this premise, several theoretical approaches will be examined to identify their most significant aspect of public policymaking and the problems facing it in relation to the study.

2.5.1 Pluralist model

An important theoretical perspective on public policy making is that of the pluralists of whom Robert Dahl is an influential proponent. Pluralists believe that there should be a clear separation of powers in the state, which stems from the fact that they deem liberal democracies to have become fractured and as a result power should therefore not be centred in the organs of the state. Pluralists are of the opinion that the government agencies do not stand alone, but rather are part of a myriad of actors are in a position through their action to influence the political leaders of the day. Dye (1995:23) states that pluralists support the idea that the conduct of politics in society begins with the interaction among groups, with the latter consisting of “individuals with common interests”.

In linking it to public policymaking, theorists view society and its power relations as a complicated arrangement. “There is no single group, individual or agency that controls all the power resources in society (pecuniary, knowledge-based, status, and so on) – power has, in the modern state, become diffuse and unequally spread out across the plain of politics” (Fourie, 2005:38).

As stated earlier, pluralists believe that the government does not have the monopoly on power, as it is merely one of many actors/interest groups that are influential in making policy demands. While these actors/interest groups may be influential, they are not self-contained units. Fourie (2005:38-39) considers them to be composed of individual, cross-cutting memberships. He

explains that when policies are made or demands made to identify policy problems, these groups will find themselves either contracting or expanding their memberships as they mobilise around issues of common concern (Fourie, 2005:38-39). Essentially, these groupings will be able to exert pressure and raise issues that will be placed in the public domain as problems which the government will be expected to respond to by formulating and implementing public policies to address the problem. Dye (1995:24) describes this process by saying that “public policy at any given time is the equilibrium reached in the group struggle”.

Critics of the pluralist approach have highlighted the fact that it tends to focus more on the group interaction and not enough on the actual issues and why such issues are different across sectors and countries, since the pluralists remain silent on how interests interact in order to produce policies (McLennan, 1997:53). Furthermore, the critics claim that pluralists' analyses of the policy making process are prone to using tautological arguments: “if the approach explains everything in terms of group processes, the account leaves little to be explained because it makes no distinction between cause and effect” (John, 2000:76). Fourie (2005:39) contends that this “approach seems to be facile on the level of content explanation, and so bent on demonstrating the interplay between the groups that it underplays the importance of the state and its institutions”.

2.5.2 Elite model

A useful approach that is a variant of classical pluralism is the elite theory. The elite theory best describes and helps to explain developing countries' policymaking environment. This is based on the fact that the concentration of power remains in the hands of a minority of the population. Ham and Hill (1993: 31) argue that,

In all societies - from societies that are very meagrely developed and have barely attained the drawings of civilisation, down to the most advanced and powerful societies - two classes of people appear a class that rules and a class that is being ruled. The first class, always the less numerous, performs all political functions, monopolises power and enjoys the advantages that power brings, whereas the second, the more numerous class, is directed and controlled by the first, in a manner that is now more or less legal, now more or less arbitrary and violent.

In a modern state the definition of the elite has expanded to increasingly include persons other than those who hold formal political power. These theorists believe that political demands within a society emanate from plural sources in the form of interest or pressure groups that the state might assume greater power than other groups. Elite theorists expand their definition to include along with the government and interest groups, the elevated power held by identifiable groups such as the economic, military, political and aristocratic elites.

The identifiable groups listed above can simply be defined as follows: the economic elite are those groups in society that controls the means of production; the military elite refers to those groups in charge of the security apparatus; the aristocratic elite refers to those groups and who have attained political clout because of their prominent family political connections; finally, there is the political elite, who gain their status from being connected to the business, military and economic sectors as well as to those who hold public office (Mills, 1956). The main source of power for the political elites in most developing states remains with those holding political offices. The creation and proliferation of bureaucratic positions in governmental institutions has resulted in bureaucratic positions and technical expertise strengthening the power positions of political elites in developing countries.

Elite theorists assert that in the public policy domain these elites are in a position to control and manipulate the agenda-setting process. Essentially they are able to advance their own political agendas, while at the same time placing themselves in a position to ensure who benefits and when they benefit from the process. It is important to point out that elite theory holds that the populace is essentially apathetic and as a result it is in fact the elite who influence the majority of the population in agreeing to agenda setting and policy formulation (Fourie, 2005:43). With the influence that the political elite have, they are positioned to determine how public policy is drawn up, what it will contain and also who will benefit from the policy once implemented. Therefore, following this logic, public policies represent “the preferences and values of a governing elite” (Dye, 1995:25). In view of this, the policy decision-making process can be regarded as top-down since it implies that the elites actually determine policy problems and sell these issues to the populace.

Elite theory asserts that public policy decisions are formulated not on the basis of the demands and interests of the people as such, but rather on the basis of the interests of governing elite,

whose choices are approved and brought into effect by bureaucratic agencies. Dye (1995:25-27) notes that elite theorists perceive the masses as being passive, apathetic and ill-informed, and as such mass sentiments are more often manipulated by the elites, more than elite values actually being influenced by the needs of the masses. Policy decisions are not only made by the elites, but communication also flows top-down. As a result, democratic institutions, elections and political parties act as a means of creating symbolic value that binds the population to the prevailing political system. In most developing countries political institutions such as the executive, bureaucratic agencies and ruling parties employ strong statutes to force the masses to observe the rules of the game of the prevailing system (Wolde, 2005). However, this is not true for many parts of the global South. The South African case study will show that there is participation in politics through informal channels such as protest and illegal strikes.

Secondly, public policies reflect the demands and interests of governing elites, rather than the masses. Changes and innovations in public policies come about because of redefinitions of their own values by the elites (Dye, 1995; Anderson, 1997). According to Anderson (1997), because of the general conservatism of elites acting to preserve the system, changes in public policies are seldom fundamental. More significantly is the fact that changes in the nature of the political system may occur only when events threaten the status quo. Once this occurs, the elites will be obliged to formulate and introduce reforms that tend to protect and maintain their fundamental values in the system.

Lastly, elites also preserve consensus about the continuation of the social system as well as the basic rules of the game. The survival and stability of the system depend on the elite consensus in ensuring the preservation the fundamental values of the system. Therefore policies that echo the shared consensus and values of ruling elites may be given preference and the appropriate attention. The circumstances in many developing countries largely demonstrate that “people are generally ill informed about policy issues and, hence, apathetic both the political and bureaucratic elite fashion mass opinion rather than the masses shaping the leadership’s views” (Saasa, 1985:311).

2.5.3 Statism - the institutional model

Statism (also known as the institutional perspective) is also a useful approach to examine in this context. Statism is a term used to describe the belief in public policy that a government should control either economic or social policy or both to some degree (Levy 2006:469). Public policy as an outcome of political institutions has been a concern of political studies from the beginning (Dye, 1995; Anderson, 1997). Public policy is authoritatively determined, legitimated and implemented by governmental institutions (Hanekom, 1987). Institutionalism describes the more formal and structural aspects of policy making and implementing institutions. Anderson (1997) defines an institution as a set of regularised patterns of human behaviour that persists over time and performs some significant social function or activity, whose outputs are public policy decisions. North (1991:97) expands this notion by drawing a distinction between institutions and organisations which is important for purposes of this study,

Institutions are the constraints that human beings impose on human interaction. They consist of formal rules (constitutions, statute law, common law, regulations) and informal constraints (conventions, norms and self-enforced codes of conduct) and their enforcement characteristics [...] Organisations consist of groups of individuals bound together by some common objectives. Firms, trade unions cooperatives are examples of economic organisations; political parties, the Senate, regulatory agencies illustrate political organisations; religious bodies, clubs are examples of social organisations.

Sharing elements with elite theory, statism notes that elites may be positioned in state agencies, where they influence public policy to advance their own political agendas. Because of the political rule in Swaziland, chapter 7, will discuss a variant of statism namely, neopatrimonialism. For purposes of this study, Thomson's (2004:127) definition of neopatrimonialism will be used. Patronage consists on the centralisation of power on "an individual to whom all within the system owe their position". This essentially means that it is, "an exchange relationship between unequals" (Boas, 2001:700). In doing so, the agency of the state becomes the determinant of policy content, so as to reinforce the state elite position. However, this is not to say "that the elites within government agencies have narrow convergent views on the policies they require; rather, the point is that the state becomes the main stage

through which policy is made – this is where politics happen” (Fourie 2005:43-44). As a result, the state is in a position to dominate political life in society by feeding policy demands and providing prescriptions to society’s problems in a top-down manner through the public policymaking process.

Dye (1995) contends that the government lends public policy three distinctive characteristics. Firstly, the government provides legitimacy to public policies, which in turn have legal obligations. Secondly, unlike policies or regulations formulated by organisations, public policies have universal application that extends to all people in the society. Lastly, only the government institutions can enforce their legal mandate against citizens who violate their policies, since only the state has the legitimacy to sanction violators of its policies (Dye, 1995:19).

Therefore, the government becomes the all-important actor of policy processes, since the theory informs us that interest or pressure groups will have to bring their issues to the attention of the state with the hope that it will be placed on the public policy agenda. Fourie (2005:44) raises an important point by noting that “by implication this demonstrates the erroneous argument of pluralists, who claim state institutions to be neutral adjudicators in the determination and implementation of public policies”. In attempt to counter this shortcoming, John (2000:53-55) notes how certain pressure groups will seek ways to circumvent the state by insisting on certain policies or policy changes. Statism’s demand that the government is all-powerful should therefore be qualified. Fourie (2005:44) believes that “the pluralists are correct in that the social context of policy making has the potential to shape and mediate formal policy arrangements”.

Dye (1995) argues that, as is the case in most developing states, policymaking institutions give an unfair advantage to certain interests in the society and withhold it from other interests. This creates a situation whereby those elites who allocate values and resources are also the same elites who benefit from greater access to the government and bureaucratic power in developing countries. The existing structure of the government institutions can have important policy consequences. It has thus been argued that “both structure and policy are largely determined by social or economic forces and that tinkering with institutional arrangements will have little independent impact on public policy if underlying forces remain constant” (Dye, 1995:21).

With the foundation for public policy decision-making process set out, the next section of the chapter will examine the processes necessary for the securitisation of the HIV and AIDS epidemic and how it relates to policy responses and policymaking dynamics

2.6 A new security paradigm

The end of the Cold War left the field of international relations in a state of flux. As a result of this, the concept of security became more contentious and cluttered with numerous debates on its real meaning. Many scholars have theorised about the concept of security, with Helga Haftendorn (1991:15) arguing that “there is no common understanding of what security is, how it can be conceptualised, and what its most relevant research questions are”. Traditionally, the concept of ‘security’ has been interpreted in militaristic terms as the military defence of the state, involving “structured violence manifest in state warfare” (Maclean 1992:8). Within the Westphalian² paradigm, definitions of security were invariably linked to the nation-state. According to Zacarias (1999), the nation-state was therefore the primary referent of security and “state goals and state interests [...] occupied the top of the security agenda”. However, the traditional concept of security has become less relevant, resulting in the formation of two contending schools of thought concerned with the conceptualisation of security.

2.6.1 Traditional approach to security

The first school of thought is rooted in the realist tradition of international relations. The realist understanding of the national security problem is well exemplified by the widely acknowledged idea of the security dilemma (Herz 1951). Buzan (1991:14) builds on this premise by arguing that the security needs of one state will necessarily lead to the insecurity of another as each interprets the behaviour of others as potentially dangerous. These scholars interpret security mostly as national or state security that remain true to a more traditional outlook and they advocate the centrality of war and the use of force as the central tools to understanding international security. Realists view the international system as anarchic, signifying the lack of a central authority restraining state behaviour. Therefore, in this unstable environment, states will inevitably develop military capabilities to protect themselves.

² The contemporary international relations paradigm is based on the European state-system, a system that can be traced back to the signing of the Treaty of Westphalia in 1648.

Stephen Walt (1991:212), a proponent of this school, argues that “the main focus of security studies is easy to identify [...] it is the phenomenon of war. Security studies assume that conflict between states is always a possibility and that the use of military force has far-reaching effects on states and societies. Accordingly, security studies may be defined as the study of the threat, use, and control of military force”.

While Walt (1991:213) does acknowledge and recognise that there may be potentially other threats to states and individuals beyond the threat of war, he remains steadfast in his opinion that it would be counterproductive to broaden the scope of security studies to include these threats. He further asserts that:

Some writers have suggested broadening the phenomena of ‘security’ to include topics such as poverty, AIDS, environmental hazards, drug abuse, and the like. Such proposals remind us that non-military issues deserve sustained attention from scholars and policymakers, and that military power does not guarantee well-being [...] Defining the field in this way would destroy its intellectual coherence and make it more difficult to devise solutions to any of these important problems.

This traditional view of security is shared by contemporary neo-realists, scholars such as Kenneth Waltz (1979) and John Mearsheimer (1990), who envisage the balance of power politics as the permanent structural feature of the international system (Baylis 2005:302). Waltz’s views have been very influential in the area of security studies. His neorealist theory argues that the structural characteristics of the international state system should mould state behaviour. He believes that states remain the most important analytical units in international relations. He asserts that the main goal of states is self-preservation, “since no one can be relied on to do it for them” (Waltz 1979:109). Waltz (1979:97) argues that “the units of an anarchic system are functionally undifferentiated. The units of such an order are then distinguished primarily by their greater or lesser capabilities for performing similar tasks”. In essence, the structure of a particular system is defined by the distribution of the capabilities among like units instead of through differences in their character and functions (Waltz, 1979:98). Therefore, in Waltz’s view

of security it can be achieved only through balancing the power capabilities of the most important units in the system (Vieira, 2006:46).

The main concern with employing such narrow definitions of security stems from the fact that insecurity threats have become much more complex. More importantly, the need to shift the referent object of security from the state to the individual has already occurred. Furthermore, scholars who attempt to move beyond these confines often fall into the same trap as the proponents of the traditional approach and fail to fully establish a new framework for the broadening of the field.

2.6.2 Non-traditional approach to security: expanding the debate

Proponents of the non-traditional approach argue for a wider, more constructivist approach to security analysis. They argue that the traditional concept of security was too narrow to be applicable to 'new non-military threats' posed by economic and environmental issues. They argue that the increased importance of issues such as the environment and economics, and the resulting inability of a militarily focused framework for security studies to adequately deal with these matters have heightened the need for a more inclusive conception of security (Buzan 1991:4). Since the early 1980s the neorealist conceptualisation of inter-state security relations was challenged by an increasing number of writers, who have advocated for an alternative understanding of security (Buzan, 1983/1991; Ulman, 1983; Jahn, Lemaitre and Weaver 1987; Tinkner, 1992; Buzan et al., 1998). They argued that the traditional concept of security was too narrow to be applicable to 'new non-military threats' posed by non-state actors, economic and environmental issues. For instance, Richard Ulman (1983) argued that national security can be undermined by events which fall outside the realms of military conflict. He defined a national security threat in terms of an action or series of events (such as internal rebellions, blockades and boycotts, decimating epidemics, catastrophic floods etc.), which have the potential to drastically threaten the quality of life for the citizens of a state and/or to narrow the policy options available to the government of a state or a non-governmental entity (Ulman, 1983:133). Barry Buzan (1983/1991) added to this by making clear distinctions between the economic, political, environmental, social and military security threats that could affect both state and non-state

actors alike. Buzan (1991:20) notes that while these five areas are closely linked, each sector exists in a complex network of linkages and not in isolation from the others.

The end of the Cold War saw the introduction of this new security agenda by scholars seeking to shift the referent object of security from the state to the individual. The United Nations was influential in these developments. In 1992 UN Secretary General Boutros Boutros-Ghali produced the first of a series of important documents to address the changing international security order. His *An Agenda for Peace* outlined the rationale and methods for moving away from a Cold War understanding of state security towards a closer focus on the security of the individual. The subsequent emergence of the human security perspective is intrinsically linked with the principles and themes initially developed in *An Agenda for Peace*. This new perspective focused on a broad understanding of security that includes not just the security of states against external or internal armed threats, but also gives priority to the security of people living within states against non-military threats such as disease, environmental degradation, economic and social instability etc.

The United Nations Development Programme (UNDP) took the lead in officially championing the human security perspective. In 1994 the UNDP launched the concept of human security through its Human Development Report which listed several categories placing human security at risk such as food insecurity, economic insecurity, personal insecurity, community insecurity and political insecurity. Following the lead of the UNDP, other international organisations such as the International Monetary Fund (IMF) and the World Bank adopted the concept of human security in their policy frameworks. A number of countries soon followed suit and embraced the concept when defining their national security policies³.

HIV and AIDS fall into this latter categorisation of security, leading to the adoption of this broad perspective by a wide range of governments, multilateral agencies and academics (Vieira 2006:48). They raised questions about the economic impact of the disease affecting the family and community levels, about the ways the epidemic is endangering millions of orphans, about whether it has the potential to become a threat to food security about how it contributes to crime

³ The human security agenda has been primarily associated with 'middle power' countries such as Canada, Australia and Norway. In 1999, a group of states with human security policies launched The Human Security Network. It is currently formed by Austria, Canada, Chile, Costa Rica, Greece, Ireland, Japan, Jordan, Mali, the Netherlands, Norway, Slovenia, South Africa, Switzerland and Thailand. For more on this, see www.humansecuritynetwork.org

and about the implications of the epidemic for governance and economic development (Elbe, 2001; Piot, 2001; Fourie and Schonteich 2001; Chen, 2003). A number of academic studies and policy reports have set out to address the epidemic within the more traditional framework of security. More often this literature seeks to explore the indirect impact that HIV and AIDS could have on the territorial security and integrity of the states. The issues covered include for example, whether high prevalence rates can constitute a threat to the national security of regimes friendly to the West, therefore possibly requiring external intervention (Vieira 2006:49). Within the biopolitical framework, the securitisation of HIV and AIDS is significant, because it constitutes a revealing example of the gradual geographical extension and globalisation of the West's biopolitical strategies to the non-Western world (Elbe, 2004). Furthermore, they assess whether the economic and social burdens associated with HIV and AIDS could cause domestic or regional instability in areas already characterised by entrenched conflict, and whether new strands of the HI virus may be able to penetrate Western societies (Heinecken, 2000; National Intelligence Council (NIC) 2000; Singer, 2002; Elbe, 2003; De Waal, 2003; Prins, 2004; Ostergard, 2005). Other scholarly studies and policy reports explore the impact of HIV and AIDS on the readiness of national armed forces with high prevalence rates (Mills, 2000; Heinecken, 2001; Elbe, 2002) and how international peacekeeping operations can serve as an important vector for further spreading HIV in the emergency areas the forces are deployed (Bratt, 2002; Elbe, 2003; IASC, 2003).

While the above security concerns are important, there are other security issues which should also be considered, such as household economies being placed under financial strain exacerbated by the loss a parent who was the main source of income for the family. Families also face financial difficulties as a result of the added strain brought on by the epidemic in the form of increased medical care, special dietary conditions and funerals. In addition, families affected by the disease also have to deal with their human rights being infringed as a result of being stigmatised by their communities.

Barnett and Prins (2006) cautioned about accepting all empirical evidence and have raised questions concerning the reliability of the evidence presented in some of the studies linking HIV and AIDS to security. They found that the HIV and AIDS and security connection has been over-interpreted and also misinterpreted in the rush to respond to a perceived threat. They point to the

fact that serious problems have arisen in terms of poor data collection and the pervasiveness in some analysis of ‘factoids’, meaning “soft opinions that have hardened into fact” (Barnett and Prins 2006:18). These authors’ analysis helps to shed light on the social construction of reality concerning the links between HIV and AIDS and security. “This means that the case of HIV/AIDS, the interaction between the various discursive articulations (or speech-acts) about the security impact of the epidemic is what really makes HIV/AIDS a security issue rather than any identifiable objective fact” (Vieira, 2006:51). A key finding of Barnett and Prins’s (2006) research is that researchers are advised to refrain from accepting the findings of only a few examples of good evidence and generalise them as fact.

2.7 Securitisation approaches

The theory of securitisation is relatively new to the field of security studies. An issue is said to be securitised when it is “presented as posing an existential threat to a designated referent object” thus “justifying the use of extraordinary measures” (Buzan et al., 1998:21). At the end of the Cold War the theory of securitisation emerged and offered a tentative compromise: not a full-scale retreat from realism but a growing recognition in parts of the interstate community that states are ultimately made up of individuals and households (Alker, 2005).

An article by Richard Ullman published in *International Security* in 1983, was influential in bringing about a change in security analysis by broadening the notion of security. Ullman (1983:33) proceeded to classify a threat to national security as “an action or sequence of events that (1) threatens drastically and over a relatively brief span of time to degrade the quality of life for the inhabitants of a state, or (2) threatens significantly to narrow the range of policy choices available to the government of a state or to private, non-governmental entities (persons, groups, corporations) within the state”.

A few years later the work of the so-called Copenhagen School came to prominence. Williams (2008:68) believes that the Copenhagen School constitutes the most concerted attempt to develop a theory or framework for the study of security in the constructivist tradition. The Copenhagen School was a label attached to the collective research agenda of a number of scholars at the

Copenhagen Peace Research Institute (COPRI)⁴ in Denmark, centred on the work of Barry Buzan and Ole Wæver. From the early 1990s various combinations of authors developed a series of observations and arguments about the operation of security in Europe. This collaborative work culminated in the seminal 1998 publication, *Security: A New Framework for Analysis*, co-authored by Buzan, Wæver and Jaap de Wilde. They posit that security is not a static concept, as understood by traditional security studies, but rather an inter-subjective rhetorical practice.

The Copenhagen School sought both to widen and to broaden traditional security concepts. They stated two important prerequisites namely; that there must be an “existential threat requiring emergency action” to be identified and a significant part of the audience must accept that description (Buzan et al., 1998:27). The type of threat may not be as self-evident as a natural disaster or an invading army, but is more likely that a political actor will have to build a persuasive case for securitising the threat. While securitisation draws attention to a range of issues, it remains “largely based on power and capability and therewith the means to socially and politically construct a threat” (Taureck, 2006:55). Although this approach allows for greater openness, securitisation acknowledges that the advantage remains with those who begin with more power and more access to certain elements such as the media.

Identity rather than sovereignty is the focus of existential threats to society “because it defines whether ‘we’ are still us” (Buzan and Wæver, 1997). This means that the concept of securitisation incorporates both the critical theorists’ interest in expanding the scope of issues which reflect security (Booth, 2005) and the traditional realists’ primary emphasis on issues affecting the state (Smith, 2005). But this has led to the approach facing criticism from both camps, from the latter for straying too far from the fold (Buzan et al., 1998) and from the former for not straying far enough. Some critical scholars praise the Copenhagen scholars’ work for its originality and its systematic study of what it means to place non-military issues on the security agenda (Elbe, 2006).

In order to understand which kinds of issues fall into this category, it is useful to look at the definitions provided by Buzan et al. (1998). Securitisation can take place in politics (“anything that questions recognition, legitimacy or governing authority”), society (including “the abilities

⁴ In January 2003 COPRI was merged into the Danish Institute for International Studies.

to maintain and reproduce a language, set of behavioural customs, or a conception of ethnic purity”), or the environment (“baseline concerns about the relationship between the human species and the rest of the biosphere”) Buzan et al. (1998:22-23). It must be noted that none of these threats are measurable on an objective scale. Instead, they are invoked, more or less successfully, by political actors whose goal it is to build a shared understanding of what such threats look like (Buzan et al., 1998).

Securitisation is the form of framing that highlights the existential threat of an issue and undermines the arguments for dealing with it as simply a matter of routine. Securitisation is a distinct form of framing, because while declarations are made by and on behalf of a vested authority, the right to wield that authority is not guaranteed and the declarations are also not necessarily final. For some actors it is necessary to securitise HIV and AIDS because the human security/developmental approach to the epidemic produced only an insufficient response to the international system. While for others, the framing of the HIV and AIDS in the language of national security can push the intended response in the wrong policy direction. Elbe states that this is because of the susceptibility to undemocratic decision-making in situations of national security crises when power is concentrated in just a few state institutions, such as the military and intelligence services, and away from civil society groups. (Elbe 2006:121). The language of securitisation is the political instrument utilised to categorise actors and situations, while also outlining appropriate sets of solutions. The process of securitisation can be described as follows: “Security is the move that takes politics beyond the established rules of the game and frames the issue either as a special kind of politics or as above politics” (Buzan et al. 1998:23). Understanding the way in which this is carried out is derived from speech-act theory.

Securitisation and the public policy making process are closely linked through the use of appropriate language to frame the issue or threat. This part of the study aims to shed light on the process of securitisation itself, with a focus on language in order to ascertain how HIV and AIDS has been articulated as a threat to security, which in turn requires the appropriate policy formulation by the relevant decision-makers to address the epidemic.

The Copenhagen School demonstrated how an issue can be securitised “meaning the issue is presented as an existential threat, requiring emergency measures and justifying actions outside the normal bounds of political procedure” (Buzan et al., 1998:24). Before the securitisation has

occurred, an issue may also be ‘nonpoliticised’, which implies that the state has not acted on it, or move into a ‘politicised’ phase in which “the issue is part of public policy requiring government decision” (Buzan et al., 1998:23).

Central to this study is speech-act theory, which is an essential component of the securitisation approach as defined by Buzan. This approach rests on the premise that “by saying words something is done” meaning that language does not only convey information, it also has a constitutive role (Buzan et al, 1998:26; Elbe, 2006:124). In other words, security threats do not exist independently, but rather are socially constructed as such through language (Buzan et al, 1998:31). Therefore, policy-makers use speech-act as a social activity involving shared understandings, with the objective to frame specific issue as a threat to security (Elbe, 2006:124).

However, despite its relevance to the present discussion, numerous scholars have contributed to the growing body of literature critiquing the Copenhagen securitisation framework. McDonald (2008) provides an important review of the framework and he identifies and explores three specific aspects of the process of securitisation that he deems problematic. Firstly, he explains that the form of act is defined too narrowly, and asserts that the Copenhagen school fails to adequately investigate other methods of representation beyond the discursive speech-acts. Secondly, the context of securitisation is too narrow, since it emphasises the securitising move as the single most important point in the process. He argues that this limitation does not take account the construction of security over a period of time nor does it explain why certain issues are securitised while others are ignored. McDonald (2008:564) also adds that this only perpetuates the negative and reactive connotations associated with security. He also raises relevant issues in relation to areas that have been identified as under-theorised, including the speech-acts themselves, the lack of attention to context of securitisation, and finally threat recognition. (McDonald, 2008:568) states that “the securitisation framework [...] is narrow in ways that are both analytically and normatively problematic, providing a partial account of the construction of security and potentially reifying traditional security discourses and practices in the process”. He argues that the Copenhagen process of securitisation is problematically linked to traditional realist understandings of security. Specifically, the framework maintains too much of an unchanging identification of security, bound by specific and strict rules that resonate with militaristic action (McDonald, 2008:579). The last and the most challenging critique from

McDonald (2008), is that the nature of securitisation is only understood by way of its recognition of threats to security, resulting in security being understood only in terms of dangers and threats.

Roxanna Sjöstedt (2008) critiques the Copenhagen School framework by pointing to one of the essential requirements set out for successful securitisation to occur: the necessity for a securitising actor to call for extraordinary measures to be taken in order to achieve successful securitisation. Sjöstedt (2008) believes that the prescribed requirement for successful securitisation limits the analytical and empirical potential for securitisation, since a decision-maker would only resort to bypassing normal political procedures in the most extreme of circumstances. Sjöstedt (2008:10) offers an alternative conceptualisation where the securitising move is “operationalised as the public framing of an issue as a national threat, accompanied by a strategy to act”. Sjöstedt (2008) also focuses on the interactions between norms, identities and securitisation. Sjöstedt (2008:12) clarifies that an observable or traceable “discursive change is sufficient to conclude that some form of norm internalisation has taken place”. She continues by arguing that a noticeable difference in the way an issue is discussed, framed and worded can demonstrate norm acceptance. This would imply that HIV and AIDS are regularly framed as a security issue or threat associated with words such as threat, fight and combat being used to describe the approach to addressing it. This is a vital requirement that is important for tracing the influence of the United Nations on and for recognition of the extent to which states have followed suit (Sjöstedt, 2008:24).

The Copenhagen School has been critiqued by McSweeney (1996:83) for appearing to give an exaggerated importance to the ‘speaker’ and ‘audience’ that are at odds with a more constructivist perspective of identity. Michael Williams (2003) raises the point that the Copenhagen School’s method of securitisation can be found in other theories of sovereign authority, and that securitising moves are an attempt by the sovereign to decide the exception and thus remove the sector from democratic debate. To him it appears that the Copenhagen School represents securitisation as a threshold, particularly within a democratic society. “Either a threat is represented and then accepted as a security issue, or it remains contested within the realm of normal, deliberative politics” (quoted in Salter, 2008:324).

Rita Floyd (2007) contends that within the Copenhagen School framework individuals can be both securitising actors and/or referent objects of security. Buzan et al. (1998:36) quite clearly

state that “in principle, securitising actors can attempt to construct anything as a referent object”. This has led to several critics arguing that the Copenhagen School’s approach to securitisation operates with a state-centric reading of security that is little different from mainstream approaches to security such as the realist approach (Booth 2005:37). Floyd (2007:41) believes there is some discrepancy in Wæver’s numerous writings on the role of the state in security analysis and by extension, therefore, in the securitisation approach. In 1995, Wæver vehemently argued that “the concept of security belongs to the state” (Wæver 1995:49), while just three years later in their seminal book *Security: A New Framework for Analysis*, they argue for the incorporation of other referent objects of security, including the individual (Floyd, 2007:41).

According to the securitisation approach, potentially anything can become a referent object of security; yet much of the Copenhagen School’s analysis still deals with the role played by the state in security analysis. Floyd (2003:71) points out that despite all that was stated in the earlier published *Security: A New Framework for Analysis*, the 2003 book *Regions and Powers*, the state once again takes centre stage in the Copenhagen School’s analysis. This has led to critics interpreting this as realist state centrism. Since securitisations are still primarily performed by state actors, as opposed to most other securitising actors, because tend states to have the capabilities to make securitisations occur. Therefore, as stated by the authors of the Copenhagen School, the securitisation approach is “not dogmatically state-centric in its premises, but [...] often somewhat state-centric in its findings” (Buzan and Wæver, 2003:71).

Vieira (2006) raises two very important limitations. Firstly, the pendulum analogy illuminates a fundamental concern to most of the advocates of the securitisation approach, including Buzan et al (1998). This relates to the tipping point in which an issue is moved from an area of normality to one of exceptionality. In other words, the question is “how, in practice, can the analyst draw a line between processes of politicisation and processes of securitisation” (Buzan et al, 1998:21). For example, in the military sector, emergency measures are very clearly defined such as a declaration of war, but in the case of health, is the international community really responding to the epidemic in emergency mode? Certainly, with the creation of special HIV and AIDS bureaucracies and policies at system, regional and state levels is indicative of the fact that the pendulum has moved towards the institutionalisation of the security threats.

However, Vieira (2006) contends that it does not imply that a large global audience was convinced about the urgency of the threat posed by the epidemic. For instance, when comparing it to other security threats such as international terrorism, the insidious nature of HIV and AIDS has concealed the actual magnitude and emergency of the security threat. This feature of the securitisation of the HIV and AIDS epidemic challenges previous understandings about the determinants of successful securitisation claims. Therefore, it is useful to understand that the successful securitisation of HIV and AIDS can only be measured by examining the internalisation of its constitutive principles in the domestic structure of states.

According to Buzan et al (1998:41), the defining characteristic of a successful securitisation lies on the acceptance by an audience that something is indeed threatening and demands exceptional action. Vieira (2006:41) argues that “the actual understanding of the limits between politicisation and securitisation is dependent on a strong analytical focus on the acceptance of the audience”. At the global level, it has been demonstrated that the securitising of HIV and AIDS can be empirically proven by the widespread acceptance of the securitisation claim in multilateral organisations, such as the UN. With the state’s adhering to prominent international declarations of commitment shows that the large audience of UN member states were convinced of the particular security nature of HIV and AIDS. However, this compliance of national governments at the international level did not filter down into the immediate internalisation of the securitisation approach at the domestic level. This means that in the domestic structures of states, the securitisation of HIV and AIDS offered varying outcomes in terms of its assimilation.

Secondly, Vieira (2006) claims that Buzan and his supporters disregard the empirical verification of actual processes whereby issues, “after being successfully securitised in the realm of discursive practices (speech-act), become widely embedded in transnational institutions and states’ bureaucracies”. Buzan et al (1998) also lack conceptual tools to understand the impact of externally induced securitisation processes in pre-existing regional and domestic systems. Several scholars (Balzacq, 2005; Strietzel, 2005; Vieira, 2006) point out that the need for proper social contextualisation in the analysis of processes of securitisation. Buzan et al (1998), fails to satisfactorily expand on the interplay between the autonomous linguistic practises of securitisation and the structured social and power contexts in which those practices take place.

Rather, they centre the analysis almost solely “on the subjective practices of discourse, omitting, therefore, the strategic environmental factors that deeply influence them” (Vieira 2006:42).

Finally, successful securitisation is at root a political process, but the actual politics of the acceptance are left very under-determined by this model. Buzan et al (1998:25) make a case that “the issue is securitised only if and when the audience accepts it as such [...] [it must] gain enough resonance for a platform to be made from which it is possible to legitimise emergency measures”. It is precisely the dynamics of this acceptance, this resonance, this politics of consent that require further unpacking. The Copenhagen School certainly open their model to consideration of the “external, contextual, and social roles and authorised speakers” of the speech act “and, not least, under what conditions (i.e. is the securitisation successful)” (Buzan et al., 1998:32). However, it must be noted that an omission in the securitisation model is that there is no mechanism to gauge accurately whether the actual securitisation process has been successful or not. Therefore, to address this limitation, I choose to trace the degree to which each of the case study countries adopted the securitisation framework into their domestic structures by examining the roles played by both state and non-state securitising actors in each of the countries under review. In order to achieve this aim the study supports Mc Inness and Rushton’s (2010:17) claim which suggests that “the securitisation is not a binary condition – there is a spectrum from failed to partial to successful securitisation process”. Therefore, this study will use the above premise to examine the degree to which the securitisation processes took place in Botswana, South Africa and Swaziland.

2.8 The process of securitisation

The attempt at securitisation is called a securitising move, which must be ‘accepted’ or rejected by the target audience. The Copenhagen School authors argue that the conditions for success are (1) the internal grammatical form of the act (2) the social conditions regarding the position of authority for the securitising actor - that is, the relationship between the speaker and the audience and thereby the likelihood of the audience accepting the claims made in a securitising attempt, and (3) features of the alleged threats that either facilitate or impede securitisation (Buzan et al., 1998:33). In line with this basic premise, successfully framing something of security entails a

securitising actor having to convince a significant audience that a specific issue constitutes an existential threat (Buzan et al., 1998:32). This is done through the action of a speech-act.

2.8.1 Framing as a speech-act

It is necessary that two characteristics are present when an issue/concern is to be securitised firstly, the issue must be seen as an existential threat – one that endangers the very physical or cultural continuity of the state, and secondly, this threat must be the kind for which extraordinary, if not extra-legal measures may be invoked.

Securitisation differs from other framing models because it suggests that this transformation comes about through a speech-act. Through his speech-act theory, Austin (1962) recognised the transformative importance of language in social relations, for instance a particular rhetorical action in which the mere pronouncing of a condition has the force of bringing the condition about. Through the use of speech-acts, social and political actors define the standards for social activity. Following Austin's lead, Waever (1989) and his Copenhagen colleagues pioneered the definition of security as a form of speech-act. Waever (1995:55) explains how such statements can work in securitisation: "By uttering 'security' a state representative moves a certain development into a specific area and thereby claims a special right to use whatever means are necessary to block it". Therefore, to label something in "security terms is nothing more than a discursive articulation in which social/political actors try to inculcate a particular quality (threat, emergency, etc.) into an issue" (Vieira, 2006:38).

Building on this premise, Buzan et al. (1998:36-37) broke down the security speech-act into four constitutive parts. According to them, in framing something in terms of security, (i) a securitising actor(s) should present (ii) a specific issue as (iii) an existential threat to the survival of (iv) a referent object. The authors feel that securitisation is only considered a success when the securitising actor is able to convince a significant audience that something constitutes a threat. Vieira (2006:38) contends that the extent of (in) security is indicated not only by an objective assessment of the actual nature of the threat, but chiefly through the analysis of the conditions by which a securitisation claim becomes widely accepted and eventually institutionalised. Once an issue has been successfully securitised, there is a need for the institutionalisation of the security rhetoric. At this stage the security argument is enough since the sense of urgency is implicit in

the standards of behaviour, principles, policies and bureaucratic processes which were created to tackle the problem. Therefore, the securitisation is institutionalised only if the threat (either perceived or real) is resilient enough to demand that the bureaucratic procedures take place with the formulation and implementation of public policies to address the perceived threat.

However a valid limitation is highlighted by McInnes and Rushton (2010:5) when questioning that when issues are created as security issues through speech-act it raises a problem, “who are the actors who, through their speech-acts, can create security issues?”. Buzan et al (1998:31) also raise the issue that there exists a bias towards certain actors who are “generally accepted voices of security”. Therefore in order to address this issue the study will adopt the following as the speech-act tool developed by McInnes and Rushton (2010:5), to examine the success of the securitisation attempts in each of the case study countries. For a speech-act to be successful three facilitating conditions are required in the process of securitisation:

- It must follow the recognised grammar of security;
- It must come from an actor in position of authority to pronounce on security;
- That it helps if the object can be generally said to be threatening.

Buzan et al (1998:25) claim that the “definition and criteria for securitisation is constituted by the intersubjective establishment of an existential threat with a saliency sufficient to have substantial political effects”. As a result, McInnes and Rushton (2010:6) emphasise the point that when defining health issues as security issues, “they do not need to meet external criteria but rather be agreed upon intersubjectively as constituting an existential threat which cannot be dealt with in a normal way, and which has a political impact”.

Following on from McInnes and Rushton (2010), the HIV and AIDS epidemic is an interesting case study, since the issue has been gradually moved from the politicised to the securitised stage. This process can best be described as a pendulum that swings from politicisation to securitisation and back again, depending on the perceived levels of urgency and threat that are allocated to a specific issue. The pendulum has already swung from politicisation to securitisation in the case of HIV and AIDS. This may not be the case in future, since the disease may eventually be controlled resulting in it moving back to the sphere of politicisation.

Since security is not a static concept, all issues can therefore be articulated as a security threat. A reason for this is that the need for security need not to portray a frightening reality, but is only a social and inter-subjective construction by means of which a subject is displayed as a threat (Gündüz, 2006:56). According to Wæver (1995:55),

Security is not of interest as a sign that refers to something more real; the utterance itself is the act. By saying it, something is done (as in betting, giving a promise or naming a ship). By uttering ‘security’ a state-representative moves a particular development into a specific area, and thereby claims a special right to use whatever means are necessary to block it.

Wæver (1995:65) also asserts that the “use of the security label does not merely reflect whether a problem is a security problem it is also a political choice, that is, a decision for conceptualisation in a special way”.

The act of securitisation implies the construction of a threat that needs to be reclassified by quick action, if need be, through extraordinary measures. This securitising act allows for the issue to be raised from the realm of low politics to that of high politics. When securitising an issue, political authorities display it as “an existential threat, requiring emergency measures and justifying actions outside the normal bounds of political procedure” (Buzan et al., 1998:24). Wæver (1995:63) asserts that securitisation consequently has “enormous power as an instrument of social and political mobilisation. Putting something on the security agenda persuades us of the need to furnish urgent and unprecedented responses; it signals imminent danger and is therefore given a high priority”.

Buzan et al., (1998:23) argue that securitisation can be described as an “extreme version of politicisation”. Buzan et al., (1998:29) continue by asserting that

Although in one sense securitisation is a further intensification of politicisation..., in another sense it is opposed to politicisation. Politicisation means to make an issue appear to be open, a matter of free choice, something that is decided upon and that therefore entails responsibility, in contrast to issues that either could not be different (laws of nature) or should not be put under political control (e.g. a free economy, the private sphere, and matters for expert decision). By contrast, securitisation on the international

level (although often not on the domestic one) means to present an issue as urgent and existential, as so important that it should not be exposed to the normal haggling of politics but should be dealt with decisively by top leaders prior to other issues.

Furthermore, for a speech-act to be successful, the addressees have to be convinced by the securitising act and be willing to accept it. Buzan et al. (1998:32) argue that “a successful speech-act is a combination of language and society, of both intrinsic features of speech and the group that authorizes and recognizes that speech”. Therefore, security becomes a political construction applicable to a range of issues and securitisation becomes the “politics of existential threats” (Buzan et al., 1998:33).

Security moves beyond the normal working rules of politics. After securitising a threat, the government is positioned to facilitate and carry out the required procedures to help address the threat. In some instances, this process may need to curtail the democratic processes. As the government works towards managing a near threat, it seems only logical to redraw the lines of the legitimating borders of politics and to limit civil and human rights (Gündüz, 2006:57). The state passes new laws, limitations and prohibitions with which it limits the area of politics, widens that of security while it frightens and subdues the public. As the concept of security is widened, securitisation can narrow the very concept of democracy, and therefore should be handled with care. Buzan et al., (1998:34) have tried to address this concern “it is possible to ask with some force whether it is a good idea to make this issue a security issue - to transfer it to the agenda of panic politics - or whether it is better handled within normal politics”.

2.9 Conclusion

The current study is concerned with the framing of policy and the processes, and factors that explain how a policy is formulated and becomes (or does not become) placed on the policy agenda. It was demonstrated that the HIV and AIDS epidemic can be elevated to the level of the policymaking agenda, depending on the way in which it is framed. Once this has occurred, a threat may become securitised.

The chapter sought to find the link between the public policy analysis process and the securitisation process. It demonstrated that whether the HIV and AIDS epidemic can be considered a threat will be dependent on how the disease is framed. Speech-act theory

demonstrated that HIV and AIDS can be constructed by securitising actors as a threat through a specific use of language. Also, shifting the epidemic from being a health issue to a security issue, creates the need for the re-framing of policies to address the urgency of the threat.

The chapter also highlighted the fact that security studies scholars have identified the need for the concept of security to be expanded beyond the traditional approach, thereby allowing the inclusion of non-traditional security threats into the security debate, in this case HIV and AIDS. The human security approach has been instrumental in placing the HIV and AIDS threat onto the agenda of the security actors. The UNDP's 1994 Human Development Report's new concept of human security was influential in changing the perspective on HIV and AIDS globally.

The process of securitisation of HIV and AIDS is not straightforward as proved by the opposing views of scholars. The shift from national security to human security is of importance. However, instead of a comprehensive replacement of one security concept by another, it may be more beneficial to accept a pluralistic coexistence of several concepts (Thakur 2005:10). It must be emphasised that human security is not in opposition to national security, nor a substitute for it.

Socially constructed threats are not considered to be constitutive of identity and personally held values, but a mere reflection of them. The Copenhagen School remains the leading proponent promoting the securitisation approach by looking more deeply into the social construction of threats. At presently the securitisation theory has demonstrated that it represents the most elaborate analytical framework for the construction of security threats for purposes of this study.

Chapter 3: Research Design and Methodology

3.1 Introduction

The purpose of this chapter is to discuss the study in light of existing research paradigms. Within the field of social sciences there are two main research paradigms, namely positivist and interpretive. This study follows the interpretive qualitative paradigm, based on reality as a social construction.

This chapter will outline the research design. The research strategy adopted for this study was to conduct multiple case studies. The units of analysis were the policymaking discourses in three different countries Botswana, South Africa and Swaziland. The roles of the policymaking and the policy-influencing actors in the discourse were also studied. In terms of the qualitative paradigm, this study seeks to highlight and analyse the differences and similarities in the countries' institutional responses to securitise and implement policies focused on the HIV and AIDS epidemic.

The fieldwork, sourcing relevant documents and the interviews with the primary sources was conducted during field trip visits to the three countries in 2007 and 2008. The time frame for the study is from 2000 when the HIV and AIDS epidemic in Africa was first elevated onto the security agenda by the UN Security Council, to 2008 when the last of the fieldwork was conducted. However, certain historical developments prior to 2000 were also examined to illuminate the framing of the respective policy responses.

Case study research is strengthened by using multiple sources of evidence for analysis, and the triangulation of these strengthens the study. It was therefore important to collect evidence from several different sources, namely key informants, prominent academics in the field, policy documents and media reports. To further strengthen this research I also gathered different types of empirical data, interviews, statistical data, reports and policy documents. Adding to this, I triangulated different empirical techniques, mainly personal semi-structured interviews with key informants, document analysis and analysis of statistical data. This chapter also discusses the scope and limitations of the research design.

This chapter has six main parts. First it will discuss the research paradigms in social science. Second it will present the research design used in the study, namely the multiple case study method. Third, it will review the research process shedding light on the data gathering and processing. The fourth part of the chapter will deal with how the data were analysed. Part five discusses challenges and limitations of the study. Part six presents the research ethics that are at the core of this study. These six parts are then followed by a conclusion.

3.2 Research paradigm

The two main paradigms in the field of social science research are positivist and interpretive. Positivism is often referred to as ‘scientific method’ or ‘science research’, which is “based on the rationalistic, empiricist philosophy that originated with Aristotle, Francis Bacon, John Locke, August Comte, and Emmanuel Kant” (Mertens, 2005:8) and “reflects a deterministic philosophy in which causes probably determine effects or outcomes” (Creswell, 2003:7). Positivism can be of relevance to the social world since “the social world can be studied in the same way as the natural world, that there is a method for studying the social world that is value free, and that explanations of a causal nature can be provided” (Mertens, 2005:8). Positivists aim to test a theory or describe an experience “through observation and measurement in order to predict and control forces that surround us” (O’Leary, 2004:5). In essence, positivists’ research is most frequently associated with quantitative methods of data collection and analysis.

The interpretive paradigm can be traced back to the philosophy of Edmund Husserl and Wilhelm Dilthey’s and other German philosophers’ study of interpretive understanding called hermeneutics (Mertens, 2005:12). The interpretive approach is used for research purposes with the intention of understanding “the world of human experience” (Cohen and Manion, 1994:36). This suggests that “reality is socially constructed” (Mertens, 2005:12). The interpretive researcher is aware of the significance for the research of his or her own background and experiences. However, the researcher is more inclined to focus on the “participants’ views of the situation being studied” (Creswell, 2003:8). Interpretive research is most commonly aligned with qualitative data-collection methods and analysis or a combination of both qualitative and quantitative methods (mixed methods). Quantitative data may also be used if they support or

expand the meaning of the qualitative data and effectively deepen the outcomes (Mackenzie, 2006).

This study is conducted within the interpretive paradigm in order to acquire a better understanding of the human experiences presented by the interviewees. Consequently, the empirical core of the research is mainly qualitative data in the form of interviews and document analysis. However, quantitative data, such as relevant statistical information are also used to support the qualitative data sources.

3.3 Research design

After the initial research and a literature review, the problem statement for this study was narrowed down to: How was public policy on the HIV and AIDS epidemic framed? In order to address the research question the case study method was chosen as the most appropriate. In order to examine the complexity of the public policy-framing process, three cases were chosen, namely Botswana, South Africa and Swaziland. To aid the data collection the rather general problem statement was further broken down into three lines of inquiry: a) a study of the policymaking dynamics as related to the HIV and AIDS epidemic in the three countries and; b) an investigation of the roles of the principal policymaking actors, and domestic and international policy-influencing actors in the national response policy in each of the three countries; and lastly c) a study of the discursive processes that featured in and shaped policy-framing in the three countries (the securitisation dynamics). The two first lines of inquiry address the policymaking discourse and its actors. The last line of inquiry was added to address a gap in the existing literature linking public policy theory and security studies.

3.4 Case study method

Political science does not have a single definition or application for what is known in the discipline as a case study. However, there is a rich history of case study research in bureaucracy implementation, as well as in public policy administration and public policy studies (Yanow et al., 2008:3). Yin (2009) cautions researchers against confusing case studies with qualitative methods using the ethnographic method. Ethnographic methods are derived from cultural anthropology. In studying institutions these methods may help the researchers to extract cultural

knowledge, and identify actions and instruments that participants utilise in their everyday life (Schwartzman, 1993; Prasad, 1997). Yin (2009) also claims that researchers conducting case studies, unlike ethnographic studies, may not even need to visit the institution under review as they could gather their data by means of consulting secondary sources or interviewing respondents telephonically or by email.

Yin (2009) defines a case study as an empirical inquiry that investigates a contemporary phenomenon within its real-life context, particularly when the boundaries between phenomenon and context are not clearly defined. Yin (2009:13) argues that, “The case study allows an investigation to retain the holistic and meaningful characteristics of real-life events such as the individual life cycles, organisational and managerial processes, neighbourhood change, international relations and the maturation of industries”.

The case study approach is particularly useful when dealing with situations where the contextual conditions of the events being studied are critical and where the researcher has no control over the events as they unfold. Therefore, the case study research strategy should encompass specific techniques for the collection and analysis of data, which must be directed by clearly stated theoretical assumptions. In addition, data must be collected from different sources and it is always necessary to ensure that its integrity is protected.

Different scholars have distinguished the types of case study available. Yin (2009) distinguishes three types of case studies:

- Exploratory – the collection of data occurs before theories or specific research questions are formulated and this is followed up by the analysis of data resulting in more systematic case studies;
- Causal – looks for cause and effect relationships and searches for explanatory theories of these phenomena;
- Descriptive – will require a theory to guide the collection of data and “this theory should be openly stated in advance and be the subject of review and debate and later serve as the ‘design’ for the descriptive study. The more thoughtful the theory, the better the descriptive case study will be” (Yin, 2009:22).

Through adopting the case study methodology to this study I hope to convey an extensive picture of the complexity of how public policymaking on HIV and AIDS was shaped in Botswana, South Africa and Swaziland. The case study will allow me to, in Yin's words, "retain the holistic and meaningful characteristics of real-life events" (Yin 2009:4). There are two main reasons for adopting the case study method for this study. Firstly, the phenomenon studied is a contemporary issue. The second reason stems from the complexity of the phenomenon. There are several institutional and governmental actors involved, and the aim of the study is to uncover the relationship between these actors and their context. The case study methodology accommodates both of these characteristics of the study. The case study method was useful for purposes of my research, since the research dealt with the contextual conditions of events that are critical and which I as the researcher had no control over as the events unfolded. When looking at types of case studies it is clear that this study is best described as a descriptive case study that looks at how events unfolded over a certain period of time.

After adopting the case study as the most suitable methodology for the study, I had to further develop the research design. According to Yin (2009:25), this is a complicated endeavour as there is "no comprehensive 'catalogue of research' to rely on. Simply put, the research design is a logical plan for connecting the empirical data to the research questions and consequently the conclusions" (Yin, 2009:26).

For case studies, five components of a research design are especially important:

1. A study's question;
2. Its propositions, if any;
3. Its unit(s) of analysis;
4. The logic linking the data to the propositions; and
5. The criteria for interpreting the findings (Yin, 2009:27).

When defining this study's question, the starting point was the key topic, which was HIV and AIDS policy and security policy in Southern Africa. After initial explorations of theoretical literature and related studies, the key topic of the research question was further narrowed down: How was the policymaking related to HIV and AIDS shaped?

In order to address the research question, the unit of analysis was the policymaking discourse, and in an extension of this, the policymaking institutions and policy-influencing organisations. I also decided to do multiple case studies, as I was hoping to highlight how the HIV and AIDS policymaking discourse was shaped by the different circumstances in the different countries.

When deciding on which countries would be a part of this study, I first looked at the countries in Southern Africa, as they are the most affected by the HIV and AIDS epidemic. There were four main reasons for selecting Botswana, South Africa and Swaziland. Firstly, they all of the countries have extremely high HIV prevalence rates. At the end of 2006 South Africa was estimated to have about 5 million people living with HIV. This represented approximately 20 per cent of the adult population. Botswana recorded an even higher HIV prevalence rate with about 24 per cent of its adult citizens infected (UNAIDS, 2006). Swaziland holds the unenviable distinction of having the highest HIV prevalence in the world 26.3 per cent (USAID, *Swaziland Country Profile*, October 2010).

Secondly, stemming from the high HIV prevalence rates present in each of the three countries, they have all been subjected to considerable pressure from the international community to securitise their HIV and AIDS epidemics. Furthermore, each of the three countries is a major recipient of bilateral and multilateral aid to combat the epidemic in the form of the Global Fund to Fight AIDS, Tuberculosis and Malaria, the World Bank's Global HIV and AIDS Programme of Action and the US President's Emergency Plan for HIV and AIDS Relief (PEPFAR).

Thirdly, each of the three countries presents a very distinct domestic political and social structure, largely because of their colonial experiences, present-day political and social cultures, and differing levels of economic development. This has meant that each country presented a different national response policy approach to the international and domestic pressure placed on them regarding their national strategy to combat the HIV and AIDS epidemic.

Lastly, the countries were chosen for their accessibility for me as a researcher. Both geographically, as I knew my fieldwork would have a rather strict time limit, and also because I am familiar with government and political structures in all the three countries through my work.

Steps four and five in Yin's research design recipe deals with how to link empirical data to propositions and then conduct an analysis. At this stage of developing the research design my

main concern relating to these two steps was to make sure that a structure for gathering the data was in place in order to facilitate subsequent analysis.

3.5. Research process

3.5.1 Sources

Yin (2009) emphasises the need for triangulation using multiple sources of evidence or data. He stresses that it strengthens the case study research. “The most important advantage presented by using multiple sources of evidence is the development of converging lines of inquiry, a process of triangulation and corroboration” (Yin, 2009:115-116). I have used different types of sources in this study; secondary sources such as media reports and academic writing, and primary sources namely government publications, administrative records and personal interviews with experts and key informants.

Because of the lack of secondary materials dealing with key issues, such as the role of external actors in HIV and AIDS policy decision-making processes, much of the research was conducted directly in Botswana, South Africa and Swaziland during my field-trip study visits to each country. I was also able to consult numerous primary sources such as: government publications, for instance green and white papers, legislation and internal policy documents. These were all important, as each was able to provide a better perspective on the governments’ respective positions in policymaking decisions and also to fill in some of the gaps in the study. Furthermore, donors’ policy statements and the minutes of meetings were useful in filling in the gaps that remained after analysing government publications. In essence, both sets of documents were important to the study, as they helped in deciphering the events and policy choices taken as they unfolded.

Yin (1993:15) mentions that in case study research, unlike in ethnographic studies, it is not vital to the study that the researcher should be in the “field”. However, in this study, I found it proved highly beneficial to the study that I undertook field-trip visits to each of the countries, and that I was able to conduct most of the interviews at the different institutions in person. Another benefit from the field trips was access to documents that I otherwise would not have obtained, as some of my interviewees willingly shared administrative records and policy documents.

Primary sources relied heavily on government publications, technical documents and annual country reports from domestic and international institutions. Valuable insight was gained from the analysis of the various country briefs, namely UN reports and US Department of State Country Fact Briefs (those from the UNAIDS and the US and transnational NGOs proved very useful). Many of the key policy documents, reports and a wide collection of official documentation were available on the Internet.

Access to local media was beneficial in helping to set a context for the research questions and give a sense of the perceived relationship between the actors. Most of the primary data were collected between 2007 and 2008. The relevance of the interviews to the topic was considered in terms of consistency with the research proposal, and then included in the analysis accordingly.

3.5.2 Interviews

In addition to conducting the key informant interviews, I conducted preliminary interviews (for a full list of interviewees, see interview schedule in the Appendix). These preliminary interviews were semi-structured, informal and exploratory in nature. The three main reasons for conducting these were, firstly, to help identify key people of interest that I could contact later for the key informant interviews. As I learned from talking to people in the field and through the preliminary interviews it was not always obvious who it would be appropriate to interview, as the topic was fairly new and not, as I learned, easy to understand for the interviewees. A second reason was that they would help structure the later interviews in clearing up misunderstandings as far as the research questions were concerned. I learned from this that it was easier to use fewer questions that were open that I could then clarify in the interview situation, as the interviewees would have differing backgrounds and would therefore relate to the questions differently. The third reason relates predominantly to the interviews with academics within the field. These interviews helped reveal the field as there is not a great amount of academic writing on this specific topic. These preliminary interviews were very helpful, particularly in guiding me to the right actors to contact for later interviews. They also made it clear that the link between HIV and AIDS and security policy still is unfamiliar to many actors outside of the academic world. This was an important aspect that I kept in mind when conducting the key informant interviews.

I later conducted the key informant interviews with a wide range of actors in both the private and public sectors in the three case studies. I decided to use semi-structured interviews as the primary data-collection method because of the advantages this method offers in terms of allowing for the inclusion of both close-ended and open-ended items depending on the circumstances. These interviews form the core of the case study information. The non-interview data gave me the opportunity to assess the robustness of some of the interview data, in order to fill the prevailing gaps in the data. The perceptions, thoughts and analyses of the interviewees provide insight into the mechanics of state politics as well as the motivation and strategies adopted by all actors in an attempt to assert their influence on policy decisions. As several of the interviewees held senior positions, they were in a position to determine future policy decision-making and implementation by their respective organisations and provide informed opinions about possible future policy decisions to be made by state institutions.

When looking at the list of interviewees it is clear that the selection has its strength and weaknesses. One strength is the access I was given to interview high-level representatives from the different organisations/actors. One weakness is that, due to time constraints and availability of key informants, as a result not all organisations/actors are represented.

The exploratory interviews with academic experts in the field also added useful insight into the dynamics surrounding the securitisation of HIV and AIDS. They also added third party insight into the relationships between the actors. As these academic experts were in a manner on the outside looking in, they were able to speak more freely on how they perceived this relationship. The exploratory interviews with SADC officials revealed that there was no coordinated regional response to the epidemic as I had first assumed, it also helped guide me to possible interviewees.

When analysing the key informant interviews it is clear that not as many actors as I could have wanted are represented. However, both civil society and government representatives are interviewed in all three countries. When conducting the fieldwork I had two main criteria for selecting the interviewees. Firstly, I selected representatives from organisations and institutions that were mentioned in the preliminary interviews as being of interest in this regard. Secondly, and more pragmatically, I had to select the ones that were available to me during my fieldwork.

The government representatives from each of the case studies are either from the Ministry of Health as is the case for South Africa and Swaziland or from government HIV and AIDS initiatives such as NACA in Botswana and NERCHA in Swaziland. Although this study is about securitisation of the epidemic rather than the medical side of the epidemic there are no interviewees from the security services in either of the cases. Due to the sensitivity of the issue and general secrecy concerns surrounding the security services it was difficult to get access to representatives from this sector for interviews. However, the interviews with SADC officials were conducted in order to add some insight into the regional security aspect of the politicisation of HIV and AIDS as these are at liberty to speak a little more freely.

Another observation was that the government representatives from the South African Ministry of Health were also not very open about the issue, in my opinion this was partly due to the fact that during this period under President Mbeki, the HIV and AIDS issue was very controversial and highly sensitive.

Another shortcoming is that I was not able to interview any representatives from the South African National HIV and AIDS coordinating body, SANAC, which is the equivalent to NACA in Botswana and NERCHA in Swaziland.

There are a large number of civil society actors dealing with HIV and AIDS, and although I managed to interview quite a few of them not all are represented. In particular, no representative from the TAC was available for interviews within the time frame of my fieldwork. This is a clear weakness as the TAC is a very interesting actor within the field as discussed later in the chapter on South Africa. However, there is an abundance of primary and secondary data on the TAC which helped to address this weakness.

Both the interviewees from SADC and from the UN agencies were useful in that they were able to shed light on regional perspectives as well as each of the three case studies.

It is important to make mention that during the interview I did not want to come across as being unfriendly, biased or threatening. I tried to ensure that my questions were asked in a relatively unbiased manner, as recommended by Yin (2009:106). Due to the sensitivities of the subject matter I was also mindful of Becker (1998:58-60) cautioning about posing a “why” question to a respondent, as in his view this may create a defensive mood in the respondent. He supports

instead the approach of posing a “how” question rather than a “why” question (Becker, 1998:58-60). Therefore, it was a fine balance between the aim of satisfying the needs of my line of inquiry, while at the same time posing friendly and non-threatening questions (Yin, 2009:106-7).

The interviews usually ran on average between 30 minutes to an hour. However, some ran shorter because of time constraints on behalf of the interviewee. To maintain consistency and to strengthen the data analysis, I asked all interviewees the same eight questions. (The Interview Schedule – Guiding Questions is included in the Appendix.) These questions were also asked in the exploratory interviews. It was my belief that using questions that were as general as possible and by limiting the number of questions I posed would they would structure and guide the interviews without restricting the responses.

During some of the interviews, where necessary, I probed for specific pieces of information that were not readily offered up by the interviewees. Because of several factors such as time constraints, interviewee reluctance, or interviewees not fully understanding the rationale for my study, I tailored each interview to fit the personality of the interviewee. Yin (2009:106) describes this process as “guided conversations rather than structured queries”. All the interviews were recorded with the permission of the interviewees, except for one who refused to be recorded. She stated that I should only record it in written form.

There are definite advantages to using semi-structured interviews, as indicated and expressed by Mason (2002:62):

- An interactional exchange of dialogue;
- A relatively informal style, with the appearance of a conversation or discussion, rather than a formal question-and-answer format; and,
- A thematic, topic-centred approach.

I found that using semi-structured interviews allowed the interviewees the opportunity in most cases to speak their mind without fear that I was trying to impose my assumptions on them. This approach also permitted me to remain in the position to steer the interview in the intended direction, while ensuring that certain key themes that required attention were touched on.

Interviewing as a data-collection method has several advantages. As part of my analysis I was careful not to fall into the trap of being too subjective when evaluating the interviewees' responses at face value. I was mindful that the "interview method is heavily dependent on people's capabilities to verbalise, interact, conceptualise and remember" (Mason, 2002:64).

3.5.3 The interview processes

I was based in Norway during much of the time I was collecting data for my research, and undertook study visits to all three countries at different times between 2007 and 2008. Because of time constraints and the unavailability of certain individuals while I was in the region, I was not able to interview all the interviewees in person and had to resort to some telephone and email interviews. For the telephone and email interviews I had to adopt a more focused interview approach which required that the interview still remained open-ended but owing to the fact that it was not conducted face-to-face, I had to follow the questions more closely and adopt a less conversational approach (Merton, Fiske and Kendall, 1990).

Miles and Huberman (1984) have suggested that researchers conducting qualitative research should consider four parameters:

- The setting;
- The actors;
- The events;
- The process.

These parameters aided the nature of the interviews conducted for this study. Regarding the setting, all of the face-to-face interviews were conducted in the respondents' offices, except for one interview that was conducted in a coffee shop in Mbabane. The telephone interviews were conducted over Skype and landlines. As I was fully aware that I was imposing on their time, I ensured that the date, time and venue for the interview was left to the respondents to decide upon and therefore it can be assumed that the interviews took place in a setting in which the respondents felt comfortable and to some extent in control.

With regards to the actors involved in the interviewing process, I interviewed academics, domestic and international civil society officers, and government officials. As they were experts

and professional people in their own right, I did not get the feeling that my presence intimidated any of them. However, I had to be mindful of keeping to the time schedule that they set and tried at all times to adhere to it, unless the interviewee felt the need to go beyond the time limit set.

Letting the respondents set the date, time and venue for the interview, resulted in most of the respondents agreeing and giving up their time to be interviewed. There were only three respondents who failed to provide any feedback even after they suggested that I send them the questionnaire and agreed that they would email me their responses at a later stage. Regrettably, the follow up emails did not materialise and no explanations were given.

Finally, it was important to consider the process of the interviews. The interview process was determined by personality of the interviewee. Some of the interviewees were very formal in answering and kept to the point without providing further elaboration, unless probed. Others were more interested in the larger topic of HIV and AIDS and were keen to comment more at length leading to the interview straying into other topics not included in this study which resulted in the interview having to be redirected and focused back to the topic at hand.

In addition, I had to ensure that the questions posed to the respondents covered all issues that would provide the necessary data to answer my research questions. I tried to conduct the interviews in a less structured and more conversational manner in the hope that by being comfortable in my presence the respondents would be less hesitant to share their knowledge. At the end of all of my interviews I offered the respondents an opportunity to reflect on issues they experienced as problematic, especially if they felt that these factors may have been overlooked or not adequately dealt with during the interview session. This proved very useful for my research, as it resulted in highly valuable and insightful comments provided by the respondents as they were given the space to reflect on their concerns about which they had strong feelings.

3.5.4 Data analysis

The data analysis was an iterative process. There was no rigid separation between data collections and analysis. The strategy that I applied for my data analysis was guided by the theoretical propositions I developed that were the basis for my research questions and literature review. Yin (2009:130) calls this one “of the preferred types of analysis strategies”.

The quality of the information collected is critical, as it impacts on the validity of the results or inferences drawn. The main data-collection tools utilised for the purposes of this research were semi-structured interviews, email correspondence, telephone interviews and secondary source analysis. The face-to-face interviews constituted one of the most important and valuable sources of information. The interviews were chosen for their relevance to the conceptual questions and for their representativeness in the field of study, as I tried to encompass a wide variety of actors involved in each of the three countries concerned.

The secondary data were first examined to crystallise the research questions and provide a foundation for the research, before conducting the preliminary exploratory interviews. Analysis of the secondary sources, as well as the preliminary interviews proved essential in identifying key actors and representatives of those who would be able to contribute to the study. Importantly, this helped me to identify some representatives to interview from institutions⁵ on the ground in Gaborone, Mbabane, Johannesburg, Pretoria and Cape Town. It also helped to narrow down the questions for the interviews by identifying gaps in the source material that would need further explanation or background, consequently ensuring the interviews were as focused as possible. In addition, they helped to prepare me for the possibility of probing the interviewees when necessary in order to gain a fuller insight into the subject matter under review.

After the interviews were conducted, the secondary sources were also used to further corroborate the findings in the interviews. The secondary data proved vital in helping to verify or cross-check official information, gain a better understanding of policymaking decisions, the implementation process and key institutions and institutional responses taken by the relevant actors.

All the interviews were conducted in English. Most interviews were tape-recorded and additional written notes were taken during the interview. The interviews were transcribed in Word format as close to verbatim as possible. This was done to ensure that inaccuracies did not occur as a result of poor recall by the researcher. The interviews were transcribed while in the field and where quotes are used they are a true reflection of the respondent's answer.

When analysing the interviews, I first read through the transcribed interviews thoroughly. Afterwards I started identifying the evidence that answered each of the questions in the interview

⁵ For a full list of the institutions refer to the interview table in the Appendix.

schedule. I then identified relevant information that didn't speak directly to the questions, but that added insight into the case study. After reading through the findings in the interviews, several themes began to emerge. Data and quotes from the interviews were initially grouped in a matrix of categories under appropriate sub-themes as determined by the available theoretical literature.

When it became clear that a particular respondent was not able to fill the particular gaps in the research this too was grouped and entered into the matrix. This process allowed me to use the gaps in the data as probing questions in follow up emails and other interviews. Also, depending on the personality of the respondent I attempted to appear relatively naive about the topic in the hope of allowing the interviewee to provide more insight on the topic. This was done deliberately since, "if you ask leading questions, the corroboratory purpose of the interview will not have been served" (Yin, 2009:107). During the interviewing process, in order to gain a better understanding and test the sequence of events, I intentionally cross-checked with respondents known to hold different perspectives.

The statistical data on HIV and AIDS that was used is mainly from UNAIDS. The main reason for this is that this was the best source of comparable statistical data for the three countries.

Primary data from government reports relating to HIV and AIDS and reports from the different organisations that were examined were gathered and catalogued according to country. Thereafter they were read through looking for rhetorical evidences of speech acts related to security. Furthermore the reports were scrutinised for evidence of how HIV and AIDS was framed.

3.6 Challenges and limitations

The methodological challenges to this research were related to the reconstruction of events and processes that were not documented, nor easily accessible to the public. On several occasions the study had to rely on the memory of the interviewees to retrace policy decision-making procedures, to understand the functioning of state institutions and to assess the role of international partners in influencing domestic HIV and AIDS policies.

Furthermore, some of the most relevant actors were either not available for an interview or were unwilling to provide the relevant information. It must be remembered in this respect that HIV

and AIDS remains a very sensitive and politicised issue in all three countries. In order to overcome this gap in the data, measures were taken to remedy the situation by utilising other documentary sources available on the Internet or provided by non-state actors during the interview process. Also, interviews were arranged with lower-ranking individuals, who were in possession of reliable knowledge about the topic and were directly involved with the issues at hand.

Challenges confronting the case study were bureaucracy and secrecy concerns encountered throughout the research process. National government security representatives are generally not easy to access for research purposes. This was especially the case in South Africa, where under President Mbeki, the HIV and AIDS issue was very controversial and government officials were reluctant to open up about it. Also the study was about current policy developments and not all government departments are open to disclose information about on-going developments.

When interviewing government officials about policy decisions it was important to come across as being as objective as possible. Because of criticism levelled at all three governments for their different policy responses, the subject matter was fairly sensitive. Several non-state actors interviewed also cautioned me about being perceived by the respondents (government officials) as challenging the respective governments' commitment to their national response policies. Their view was that if I came across as objective I would gain a more accurate insight into the various government perspectives.

According to an interviewee, "Avoid only pointing out the failures of government policies but rather try show an understanding as to why they may have failed" (interview, Senior Health Officer, SADC, 5/3/08) and "questioning the political status quo in the country will abruptly end your interview" (interview, AIDS Specialist, William J. Clinton Foundation Swaziland (formerly with Ministry of Health and NERCHA) 11/4/08).

There were instances when I felt that certain questions were not always accurately or honestly answered. These situations arose when discussing such issues as the relationship and problems between the donors, and the state and the civil society. In retrospect, I think that if the interviews were held in a more neutral venue outside of the official offices certain interviewees may have felt freer to discuss sensitive issues without fear of being overheard by their colleagues. This

could be because they feared their funding sources drying up if they openly criticised the donors or spoke out against the government. The interview conducted in the coffee shop in Mbabane confirms this point about conducting the interviews in a more neutral venue.

I also experienced problems setting up interviews with certain key people. After making contact through email, certain respondents did not agree to meet up in person and instead suggested other people to interview. Interestingly, they did agree that I should send them the questionnaire for the interview through email, but I did not hear back from them. In fairness, I was appreciative of the suggestions made of potential people to interview since it provided me with insights from actors, who had initially been overlooked. Also because of the sensitive political nature and the time the study was conducted, some government officials seemed unwilling to be interviewed for the study. This may be because of the high levels of criticism levelled at all the governments regarding their failures to formulate and implement relevant policies to curb the high HIV incidence. This was experienced in all three countries.

Ensuring the validity and reliability of the results is an important aspect of any study. This chapter has attempted to outline the various measures, which were implemented to produce a reliable and accurate data set for analysis. Despite all the quality control measures taken, there may still be shortcomings and limitations in the data-collection method including gaps in the data itself. Because respondents gave freely of their time to be interviewed I can only assume that the respondents were generally sincere in their responses.

3.7 Research ethics

The interviewees were all informed of the objectives of the study as well as its background by means of a brief synopsis in the letter of invitation to contribute to this study. It was explained to each interviewee that their participation in the study was voluntary and at their own convenience, and that they agreed to let me use their contribution for the study.

It was also explained to the interviewees that all information would be kept confidential and they had the choice to remain anonymous or to be mentioned by name and designation. During the interviewing process, if the interviewees were unclear about the meaning of a term or concept used during the interview process, they could ask for further clarification. This was done as a further measure to ensure the reliability of the responses given by the interviewees.

Furthermore this study was conducted within the Stellenbosch University ethics guidelines.

3.8 Conclusion

This chapter outlined the research design and methodology of the study. Adopting the case study methodology allowed for using multiple types of sources, something I believe creates a more holistic picture of the events examined. The multiple case study method also allowed for a better understanding of the complexity of the policy discourse around HIV and AIDS. The chapter demonstrated the manner in which the relevant data were obtained for purposes of this study, namely through interviews, primary and secondary documentary sources. The chapter presented the significance of having both exploratory interviews and key informant interviews, as the two processes complement each other and strengthen the research process as a whole. It also discusses the strengths and weaknesses of the interviews. The chapter also highlighted the challenges and limitations of the study such as the lack of access to some government officials because of the sensitive political nature of the study. Although the results of this study are not meant to be generalised for the whole of the Southern African region, the three case studies do provide an interesting and useful glimpse into the policy responses to the HIV and AIDS epidemic, which will be further examined in detail in the following chapters.

Chapter 4: HIV and AIDS – Journey from Biomedical to Global Security Threat

4.1 Introduction

Almost 32 years ago on 5 June 1981, the Centre for Disease Control (CDC) in the United States of America (USA) published their Weekly Morbidity and Mortality Report reporting on the first recorded cases of HIV and AIDS. Since then the HIV and AIDS epidemic has killed over 30 million people worldwide. Currently, there are about 34 million people infected, with about 22.2 million of these residing in Sub-Saharan Africa, making Africa the most infected region in the world (*UNAIDS – World AIDS Day Report*, 2011). Out of the total number of people living with HIV worldwide in 2009, 34 per cent resided in 10 countries in Southern Africa (*UNAIDS - AIDS Epidemic Update*, December 2009).

This chapter starts with tracing the HIV and AIDS journey from biomedical to international security threat that was placed on the political agenda of the international community. It then moves on to examining HIV and AIDS and Global Health Governance by highlighting the process the disease took to be accepted by the international community as a security threat requiring urgent attention.

The chapter moves on to tracing the origins of HIV and AIDS and security. Finally, the chapter concludes with an examination of the three influential global securitisation actors namely, UNAIDS, the US government and the role of civil society actors which have been instrumental in promoting the global securitisation approach.

4.2 From a biomedical issue to a security issue

Before exploring how the epidemic was securitised it is useful to trace its journey from biomedical on to the political agenda.

For much of the 80s and early 90s, multilateral agencies responses were focused entirely on the biomedical aspects of the epidemic. Because the full magnitude of the disease was still unknown at this point in time, the early efforts to address it were relatively inadequate. The disease was

first discovered mostly in the homosexual community in the USA, this might be one of the reasons behind the slow initial responses.

The World Health Organisation (WHO) was established in an attempt to manage the outbreak of diseases. It was to concentrate its resources on the provision of healthcare to poor populations (Iliffe, 2006:68). After the publication of reports highlighting the growing prevalence of HIV and AIDS in several parts of Africa, the WHO, began to address the epidemic as a serious health problem on a global scale in 1986. WHO had already established its Global Programme on AIDS (GAP) and advised governments to create surveillance structures and HIV and AIDS committees based in their Ministries of Health.

GAP was important, as it was the first multilateral initiative intended to raise the profile of the epidemic as a public health issue of global importance. To deal with the epidemic, GAP promoted a global mobilisation of institutional and financial resources. GAP's early policies focused primarily on the promotion of public awareness, blood screening, condom distribution and preventative efforts. Between 1986 and 1990, Johnathan Mann as the head of GAP, helped to devise short and medium term plans for more than 150 countries (Ilife, 2006:70).

The initial HIV and AIDS securitising move took place in the mid-90s. HIV had already spread across several African states at an accelerated pace. Because of this accelerated pace, this might have attributed to the ineffectiveness of the earlier global response as it caught out those tasked to deal with the disease. It became more apparent to the international community that HIV and AIDS was not merely a medical condition. In order to address it, there was a need for all branches of government and non-state actors to be involved in a more inclusive response effort. It became apparent that to address the global epidemic, a greater effort was necessary to provide a better coordinated level of assistance to challenge the many factors fuelling the spread of the virus and to help those countries experiencing the brunt of the impact. As a consequence, "A growing sense of urgency prompted the creation of special multilateral and national bureaucracies and more comprehensive policies to deal with the impact of the epidemic" (Vieira, 2006:55).

The end of the Cold War brought about a change in the global thinking of security. In order to address the growing number of non-traditional security threats such as HIV and AIDS, policy

decision-makers and academics were required to rethink how HIV and AIDS fits into the new security framework. For instance, the human security approach of the UNDP called for the protection of people against a wide range of new threats, including epidemic diseases, which should be a primary concern of national governments and multilateral organisations (Axworthy, 2001:19).

In 1996, the UN undertook an important initiative by drawing six organisations together in a joint and co-sponsored programme, leading to the establishment of the Joint United Nations Program on HIV/AIDS (UNAIDS). The creation of a separate multilateral HIV and AIDS agency was the first time that the UN had adopted this approach to deal with a single disease. UNAIDS was tasked with promoting a particular understanding of what HIV and AIDS is and how it should be dealt with by states and non-state actors alike. The creation of this UNAIDS signalled the change of direction concerning the multilateral response to the epidemic (Vieira, 2006:56).

From the late 1990s, an increasing number of high profile politicians, transnational activists and academics began to articulate that the global HIV and AIDS epidemic was indeed a serious threat to security (Prins, 2004). UNAIDS adopted this view and began to take the securitisation of HIV and AIDS as “a teaching mission, whereby this organisation would work to supply states and other HIV/AIDS actors with information about best HIV/AIDS policies and organisational practices at the state level” (Vieira, 2006:57).

At the turn of the millennium, at the international level, United Nations Security Council Resolution (UNSC) 1308 was passed which fully recognised the potential threat posed by the HIV and AIDS epidemic to stability and security. At the continental level, in April 2001, African countries met in Nigeria to deliberate on the challenges posed to by the epidemic. This resulted in the signing of the Abuja Declaration of 27 April 2001, which was endorsed by all members of the Organisation of African Unity (OAU). The Declaration stated that HIV and AIDS “is not a major health crisis but an exceptional threat to Africa’s development, social cohesion, [...] as well as the greatest global threat to the survival and life expectancy of African peoples” (OAU, 2001). Later that year on 27 June 2001, at the 26th Special Session of the UN General Assembly (UNGASS), the Heads of State and Government adopted the *Declaration of Commitment on HIV and AIDS*. This document was very important as far as the response policy towards epidemic was concerned. It represented an official acknowledgement by all the UN member states that the

epidemic was a “global emergency” and “one of the most formidable challenges to human life and dignity”. This called for global action and total commitment from all signatories. UNAIDS was tasked with coordinating the multilateral response, “which could assist, as appropriate, member states and relevant civil society actors in the development of HIV/AIDS strategies [...]” (UNGASS, 2001). Under UNGASS, it was agreed to establish the Global Fund to fight HIV and AIDS, Tuberculosis and Malaria. This was formally established in 2001 by the UN and the G8 group of industrialised nations to provide funds to address the three most serious epidemic diseases in the world namely, HIV and AIDS, Tuberculosis and Malaria.

In mid-2006, the Heads of State and Government gathered in New York to renew the strong commitments they made back in 2001 and also to review progress in implementing the UNGASS Declaration. The meeting ended with the adoption of a comprehensive political declaration that reaffirmed the states engagement in the implementation of the policies and principles set out in the first UNGASS (UN General Assembly, 2006).

While these events took place, there was a growing feeling amongst the developing world which led to a North-South ideological and political difference within the international community. Many of the differences related to the political disputes over treatment with generic antiretroviral drugs (ARVs). Because of the benefits derived from ARVs, countries such as Brazil and India began to produce and provide generic ARVs to their populations. As a result, pharmaceutical companies claimed their patent rights were being infringed upon. The matter was eventually decided in favour of those developing nations’ who claimed a need to produce the generic versions of the ARVs. In November 2001, in Doha, the World Trade Organisation passed an important policy decision which agreed that TRIPS⁶ should not prevent states from undertaking means to protect their societies against epidemic diseases such as HIV and AIDS.

This important exception made provision for countries experiencing a threat to public health to produce, buy and import generic AIDS drugs at the expense of patented AIDS drugs. Therefore, this makes the Doha agreement of 2001 very important, as it was an unprecedented move towards the securitisation of severe epidemic diseases. Politically this was seen as a victory for

⁶ TRIPS stand for Trade-Related Aspects of Intellectual Property Rights. It is an agreement by the WTO between 1986 and 1994 to ensure intellectual property rights are respected within international trade. It came into force on 1st January 1995, but implementation dates vary from country to country.

the countries of the South against the more economically strong North. As a first in the history of trade negotiations, it meant that states were legally permitted to issue compulsory licenses to duplicate patent drugs in the case of health emergencies. Transnational advocacy groups saw it as beneficial to pressure donor governments and multilateral agencies to ensure that the provision of generic HIV and AIDS drugs as a core priority in the domestic national plans to combat the epidemic⁷.

The introduction of generic ARV drugs revealed a difference in opinion between various international securitising actors. At the international level, the US government supported the patent protection claims of pharmaceutical companies. However, this approach was not fully adopted by UNAIDS/WHO. For example, in 2003 UNAIDS/WHO launched a global initiative expecting to treat 3 million people by 2005, which was supplied by both branded and generic AIDS drugs. Only in 2005, the US government under President Bush's *Global Initiative on HIV and AIDS* included a few generic drugs as part of its financial aid for treatment in developing countries. As will be discussed further in chapters 5-7, each of the countries under review reacted differently to the issue of patented and generic AIDS drugs. For instance, South Africa and Swaziland both supported ARV treatment plans based on generic drugs but for different reasons. Swaziland because of its financial constraints was in agreement with using the cheaper option provided by the generic AIDS drugs. At the same time, Swaziland was not against patented AIDS drugs if it was provided by international securitising actors. The South Africa government took a more ideological stance and openly accused US-backed pharmaceutical companies of exploiting the disadvantaged African countries. The government of Botswana on the other hand, dealt directly with the US pharmaceutical giant Merck and the Bill and Melinda Gates Foundation and agreed to be supplied with branded AIDS drugs in the public health system.

This study recognises the consensual agreements signed by governments at international gatherings agreeing that HIV and AIDS represents a special type of emergency, which requires governments to implement internationally devised best practises to fight the epidemic. As has been presented, the explicit and tacit links regarding securitisation of the epidemic were consolidated at successive conferences where states' representatives met and reached agreements

⁷ Chapter 6 will further explore the important role played by the HIV and AIDS advocacy group, the Treatment Action Campaign (TAC) in South Africa.

intended to develop a particular understanding of the global epidemic. At these international gatherings, the signatories of joint declarations agreed upon general principles, identified specific recommendations for state behaviour and established decision-making procedures at the multilateral and state levels. However, as will be highlighted later, despite their joint declarations and formal commitments at multilateral gatherings, the actual response of governments to the global securitisation of HIV and AIDS rested largely on their pre-existing political attitudes towards the epidemic.

4.2 HIV and AIDS epidemic and Global Health Governance⁸

The HIV and AIDS epidemic has been viewed and discussed about within academic and policy communities as an international security concern. According to Ruston (2007:1), international actors do not treat HIV and AIDS “solely as a problem of human or public health or international development: it is now widely recognised as a security threat”. Much of the available academic literature on the epidemic and security points to the United Nations as being instrumental in the ‘securitisation’ process, most notably Security Council Resolution 1308⁹. This approach has been widely supported in policy circles (Rushton, 2007:1). Dr Peter Piot, the Executive Director of UNAIDS asserted that:

When we look at the history of the fight against AIDS, there is no doubt that resolution 1308 (2000) is a milestone in the response to the epidemic. By underscoring the fact that the spread of HIV/AIDS, if unchecked, may pose a risk to stability and security, the Security Council [...] has transformed how the world views AIDS. I say “transformed” because many now view AIDS as a threat to national security and stability, in addition to being a threat to development and public health alone (quoted in Rushton (2007:1-2)).

The Security Council remains the most influential body in setting the agenda for what constitutes a threat to international peace and security. According to Rushton (2007:3), “it is the most authoritative adjudicator of securitising claims that we have. It is for this reason that Resolution

⁸ While it is not the aim of the thesis to analyse the merits of Global Health Governance, it is useful to demonstrate how the epidemic was dealt with at the international level. For more on Global Health Governance please refer to Kickbusch, 2002; Kay and Williams 2009; Cooper, et al. 2007; Garrett, 2007; Buse et al. 2009; McCoy, et al. 2009; Davies, 2010; and Harman 2012.

⁹ For further information refer to G Prins (2004), “AIDS and global security”, *International Affairs* vol. 80(5) p 931-952; C McInnes (2006), “HIV/AIDS and security”, *International Affairs* vol. 82(2) p 315-326; S Elbe (2005), “AIDS, Security, Biopolitics”, *International Affairs* vol. 19(4) p 403-419.

1308 has been widely seen as a watershed in the transition of HIV/AIDS from a development to a security issue". In terms of Global Health Governance, this was remarkable development as the Security Council was a new entrant in the field. Some of the UN organs such as the World Health Organisation, UNDP, The World Food Programme and UNICEF are key actors in Global Health Governance. However, for the Security Council this was the first time it dealt with issues regarding health specifically¹⁰. In addition, Rushton (2007) makes the claim that civil society organisations have also become noteworthy actors in global governance and as a result have influenced states and conditioned policy responses through various means¹¹.

4.3 The origins of the HIV and AIDS security approach¹²

The Copenhagen School's approach to securitisation is important in understanding how HIV and AIDS were included into the concept of security. From this analytical framework it will be demonstrated that security threats are socially constructed. This therefore allows the possibility for definitions of what constitutes a 'security threat' to be able to change over time, also that they can be changed deliberately by actors seeking to identify new security threats as and when necessary to do so.

Not all actors are in a position to lay claim to proclaiming an issue as a security threat. According to Wæver (1995:54), "[i]n naming a certain development security problem, the 'state' can claim a special right, one that will in the final instance, always be defined by the state and its elites. [...] By definition, something is a security threat when the elites declare it to be so". This implies that powerful actors find themselves in a more privileged position with the ability to define social issues as security threats. Rushton (2007:3) asserts that the success or failure of an attempt to securitise a particular issue may not be determined by power alone, but rather that it surely exerts a significant influence over the end result. Buzan et al (1998:32) claim that, "To study securitisation is to study the power politics of concept". From this definition it may seem that the role played by civil society actors may be limited in any securitisation attempts. Chapters 5 – 7 will empirically examine and test this limitation and demonstrate the

¹⁰ Interestingly, McInnes and Rushton (2010: 10), make the observation that following Resolution 1308, AIDS became a 'core' issue for the UNSC. However, by the end of the decade it seemed to have dropped off the agenda. "The pattern established by the Council's 2001, 2003 and 2005 meetings on HIV/AIDS has not continued and there has been no formal Council discussion of HIV/AIDS since 2005."

¹¹ The role of these civil society actors will be elaborated further on in the thesis in chapters 5 - 7.

¹² A more in depth analysis of the Copenhagen School will be carried out in chapter 4.

role played by civil society actors in ensuring the degree of securitisation in each of the case study countries.

4.4 Brief overview of the influential HIV and AIDS global securitising actors

This section will focus on three key securitising actors namely, the Joint United Nations Programme on HIV and AIDS (UNAIDS), the US government and the role of civil society. All of these actors have expressed strong views on the suitable policy approaches necessary for responding to the HIV and AIDS epidemic. For purposes of this study, I have chosen to use Buzan et al.'s (1998) definition for a securitising actor. According to Buzan et al (1998:40), "a security actor is someone, or a group, who performs the security speech act". These actors can come from political leaders, bureaucracies, governments, lobbyists and pressure groups. Buzan et al (1998:40) asserts that for the above listed securitising actors, "Their argument will normally be that it is necessary to defend the security of the state, nation, civilization, or some other larger community, principle, or system". Therefore, based on this definition securitising actors are made up of both state and non-state actors and will be explored as such in each of the case study countries.

4.4.1 UNAIDS

The formation of UNAIDS in 1996 was in response to the idea that it was not possible to defeat HIV and AIDS through the conventional public health institutions and available public policies. This was significant as it was first time in the history of the UN that an autonomous bureaucracy was created to deal with a single disease. Vieira (2006:75) argues that the existence of this highly authoritative organisation can be construed as a sign that the epidemic had gradually moved away from the dimension of politicisation. UNAIDS has become a key securitising actor by promoting and furthering the current predominant view that links HIV and AIDS and security. In July 2005 Piot, while addressing the *3rd IAS Conference on HIV Pathogenesis and Treatment*, in Rio de Janeiro, Brazil, stressed the special character of the epidemic and the need for an exceptional and comprehensive response. Piot (2005) stated:

I believe we need to move the response to AIDS into another league, on par with other critical global issues such as climate change and extreme poverty, and not stay in our

AIDS ghetto. Debating AIDS belongs as much in the UN Security Council as it belongs in scientific conferences.

UNAIDS seeks to galvanise attention devoted to HIV and AIDS concerns, which in turn legitimises its existence in the international system (Vieira, 2006). The successful securitisation of the epidemic placed UNAIDS as the principal body to lead the global response effort. This raised the institutional profile and importance of UNAIDS in the response to the HIV and AIDS epidemic. The key function of UNAIDS is to be a coordinating body rather than a direct implementing and funding agency.

At country level UNAIDS operates through the UN Theme Group. Representatives of the cosponsoring organisations meet to share information, and to plan and monitor coordinated action between themselves and with other partners. They also decide on joint financing of key AIDS activities in support of the country's government and other national partners in the Theme Group. The main purpose of the Theme Group is to offer support to the host country's efforts to manage an effective and comprehensive response to the epidemic (UNAIDS, 2006).

UNAIDS has been able to establish more than 130 UN Theme Groups throughout all the regions of the world. In order to have a wider sphere of influence, most Theme Groups have set up special work groups, which include donors, NGOs and PLWHA. In countries with high HIV prevalence rates the Theme Group make use of a Country Program Advisor (CPA). The CPA has been an influential conduit for UNAIDS' ideas to be passed on as the officer is tasked with providing information and guidance to a whole range of host partners which include government departments and civil society actors (Vieira, 2006:80).

The UNSC Resolution 1308 led to the creation of the UNAIDS Office on AIDS, Security and Humanitarian Response (SHR). It was tasked with devising strategies to assist states in meeting their multilateral commitments (UNAIDS, 2005). The call for the multilateralisation of HIV and AIDS as a security issue gathered momentum as "the intervention of the Security Council in 2000 was a critical move in securitising HIV and AIDS, constructing the disease as something extraordinary which demanded international attention and action" (McInnes, 2006:315).

Resolution 1308 was important as it empowered UNAIDS with greater institutional legitimacy necessary for it to act. In 2001 the UN General Assembly held a special session on HIV and

AIDS (UNGASS), which was an important step as it helped to place the epidemic on the multilateral agenda. During the special session former US Military Chief of Staff and then Secretary of State General Colin Powell declared, that “there is no enemy in war more insidious than AIDS” (Behrman, 2004:266). By December 2002, based on recommendations by UNAIDS, about 100 states had already set up National HIV and AIDS plans, and UNAIDS has also helped 85 countries to establish National HIV and AIDS Councils. UNAIDS has also provided support to these governments by providing assistance in many technical areas, such as the drafting of donor proposals, integrating HIV and AIDS into broader development strategies as well as assessing the progress of the national responses (UNAIDS 2004). More significant is the fact that UNAIDS/SHR, through its Global Initiative on HIV/AIDS and Security, has systematically instilled in governments with the message that HIV and AIDS should be integrated into their national and regional security strategies (Vieira, 2006:82).

4.4.2 The US government

The US government and its associate agencies also play an important role in the process of creating international understanding of the epidemic. Former President William J Clinton’s approach to the global HIV and AIDS epidemic favoured multilateral engagement. The Clinton administration was instrumental behind the first major initiative to promote the claim that HIV and AIDS was a security threat on the global stage. This is highlighted by the successful attempt of the Clinton administration to include the epidemic on the agenda of the Security Council (Prins, 2004:941). When addressing the Security Council in 2000, Vice-President Al Gore stressed the common security challenges posed by the epidemic and the “real and present danger to world security posed by the AIDS pandemic” and urged other UN members to “see security through a new, wider prism and forever after think about it according to a new, more expansive definition” (UNSC, 2000:2).

In 1999, prior to the historic UNSC meeting, Clinton officially recognised HIV and AIDS as a national and international security threat. At the same time the National Security Council (NSC) became involved in the US policy to fight the global epidemic. This was significant as it was the first time the NSC declared an infectious disease a potential threat to the US (Johnson, 2000). Clinton also doubled the budget for international HIV and AIDS relief to US\$ 254 million and

introduced a new interagency based in the White House, called the Office of National AIDS Policy. In addition, Clinton established a Presidential Advisory Council on HIV and AIDS (PACHA) which offered expertise on how the federal government should respond to the epidemic (Johnson, 2002).

The arrival of President George W. Bush saw that US policies towards the HIV and AIDS epidemic being significantly reframed and implemented further. It can be argued that Bush's approach to the global HIV and AIDS crisis is deeply embedded in the belief that the US is a special nation with global responsibilities (Vieira, 2006:85). According to the US Department of State (2003),

You know, the world looks at us and says, they're strong. And we are; we're strong militarily. But we've got a greater strength than that. We've got strength in the universality of human rights and the human condition. It's in our country's history. It's ingrained in our soul. And today we're going to describe how we're going to act - not just talk, but act, on the basis of our firm beliefs.

On 31 January 2003 the Bush administration publicly acknowledged the devastating impact of the global HIV and AIDS epidemic as a global emergency and seemed to be moving towards its securitisation. Colin Powell, the Secretary of State, stated that "bureaucracy as usual was unacceptable in dealing with this emergency, and we have moved forward urgently" (US Department of State, 2004). This was in reference to the launching of the President's Emergency Plan for AIDS Relief (PEPFAR). This new ground-breaking initiative saw the President commit US\$15 billion over 5 years, making it the largest pledge to HIV and AIDS international assistance by a single government. In comparison, assistance from all developed nations to the Global Fund¹³ amounted to only US\$6 billion in 2004 (Global Fund - *Pledges*, 2005).

Vieira (2006:86-88) argues that since the launch of PEPFAR, the Bush administration has redefined its HIV and AIDS global strategy in terms of three main axes. Firstly, it keeps the traditional foreign aid approach through initiatives formulated by USAID. This allows the link

¹³ The Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) is a multi-billion dollar international financing mechanism that aims to increase the availability of funding by directing money towards areas of greatest need. The organisation works as a partnership between governments, civil society, the private sector (including businesses and foundations) and affected communities by combining resources for fighting HIV and AIDS, tuberculosis and malaria through grant programmes.

between the US government and domestic NGOs specialising in global HIV and AIDS relief and advocacy (mainly faith-based organisations) to be more clearly defined. Faith-based organisations have been an important partner for implementing HIV and AIDS policies and programmes for USAID for many years. The use of faith-based organisations proved beneficial to the US government in order to penetrate the domestic structure of states afflicted by the epidemic. Because of their strong lobby, at least one third of PEPFAR's US\$15 billion is earmarked for projects stressing abstinence until marriage as the fundamental preventative measure against the epidemic (*The Economist*, 23 June 2005). In countries being financially supported by the US, assistance to HIV and AIDS programmes is attached to stringent moral strings.

Secondly, it explored the multilateral approach. It operates by the placement and participation of US officials in key decision-making structures of international organisations such as UNAIDS, the Global Fund and the World Bank. All these multilateral bodies are heavily dependent on US funding. This is clearly highlighted when looking at the period 1995–2005, where the US government contributed more than 20 per cent of the total contributions, making it the principal sponsor of UNAIDS (UNAIDS, 2005). Also, the Global Fund is very dependent on US funding, with the US government committing US\$2.5 billion to the fund for the period 2001–2008. This represents 30 per cent of all money pledged by states to the Fund (Global Fund, 2005b).

The third axis present is PEPFAR, which is run by the State Department and sits hierarchically on top of all other HIV and AIDS organs found in the US government structure. Garret (2005:12) makes an important observation that PEPFAR “is located inside the State Department, where its mission is defined in both foreign aid and national security terms”.

The launch of PEPFAR may be indicative of the fact that the HIV and AIDS epidemic has been securitised within the US. For an issue to be successfully securitised, securitisation theory states that a significant audience should be persuaded by a securitising actor that something is threatening which may require exceptional measures to deal with it. Vieira (2006:89) asserts that in the case of the US political system, the convincing of Congress (representative of a wider audience of the American people) could be seen as sufficient evidence of securitisation. The Bush administration approach was endorsed and mandated by the US Congress. With Congress's formal approval of Bush's securitising move, “it can be strongly argued that the Bush

administration spoke security successfully while describing the epidemic to its domestic constituencies” (Vieira, 2006:89).

4.4.3 Role of civil society organisations in securitisation attempts

A concern regarding the securitisation of the HIV and AIDS epidemic relates to the potential effect on international spending on the epidemic. By securitising a particular issue, this may create a situation, which leads to higher spending levels to address the security threat. Rushton (2007:5) argues that “it is precisely for this reason that securitisation is utilised as a political strategy”. An example of this has been the increase in spending by the US government for the fight against HIV and AIDS. This has resulted in much of the spending being utilised for the funding of NGO projects by USAID¹⁴. By channelling these large amounts of money to the civil society actors to further the US government’s policy agenda it can be interpreted as the link that makes these organisations an extension of the US government and gives them an increased status as relevant HIV and AIDS securitising actors. This assumption will be further elaborated on later in the thesis in each of the three case study countries.

Civil society organisations play an important role and tend to be at the forefront in dealing with the effects of the HIV and AIDS epidemic. There have been numerous international and domestic NGOs, faith-based organisations and other organisations that have long been active in HIV prevention and care as well as addressing the personal, family and social impact of the epidemic. In the developing world this role has been more evident where national governments have been unable or even unwilling to adequately address the epidemic, which will be demonstrated later in this study. Each of the case studies present unique features in state and non-state relations, which will be explored in chapters 5-7. Because of a shift in the way in which societal concerns are dealt with and funded (both internationally and domestically), it can be argued that this would impact on the work of civil society actors. As a result, Rushton (2007:6) states, that “by virtue of their role in relation to HIV it could also be argued that those NGOs involved have effectively (and perhaps unwittingly) become security actors.” This study demonstrates that civil society actors may not have access to high levels of power and influence as enjoyed by the state in the international system, but they can be meaningful security actors

¹⁴ According to Rushton (2007:5), in 2001 an increase of 10 percent in US funding for HIV and AIDS was seen and some 70 percent of the \$284 million was spent by USAID on HIV and AIDS was programmed through NGOs.

with the ability to adopt and promote a particular perspective or even to show resistance against it when necessary.

4.5 Conclusion

In conclusion, the chapter traced the journey of HIV and AIDS from biomedical to that of an international security threat placed on the political agenda of the international community. It also highlighted the process the disease took to be accepted by the international community as a security threat requiring urgent attention.

The chapter concluded with an examination of the link between HIV and AIDS and security. It was found that the threat posed by the epidemic does impact on both the individual's and the state's security. The chapter also demonstrated the influence of UNAIDS, the US government and the role of civil society as global securitising actors in advancing the global securitisation approach. The differential power positions and political agendas of UNAIDS and the US demonstrates that successful securitisation of HIV and AIDS is more than only a function of their linguistic competence (Balzacq, 2005).

Chapter 5: Policy Issues, Processes and Framing around HIV and AIDS in Botswana

5.1. Introduction

The overwhelming impact of the HIV and AIDS epidemic on Botswana has placed it firmly in the group of countries, which form “the global epicentre of the epidemic” (Hwedie, 2001:55). In 2001 Botswana was one of four countries whose HIV and AIDS prevalence exceeded what had previously been thought to be possible, exceeding 30 per cent and reaching 38.8 per cent (UNAIDS/WHO, 2002:17). Botswana’s stable political environment and the government’s commitment to managing the spread of the disease attracted the attention of the international community of donors, multilateral organisations and NGOs. According to Vieira (2006:105), Botswana became an important testing ground for local HIV and AIDS actors and international and bilateral agencies aiming to develop strategies to combat the epidemic.

The chapter focuses on the framing of policy and the processes and factors associated with it in Botswana. This approach helps to explain how different factors influence policy framing as part of the national response policy to address the HIV and AIDS epidemic in the country. The chapter further explores the role of relevant stakeholders such as state, non-state domestic HIV and AIDS actors, and multilateral and bilateral agencies in attempting to influence the policy decision-making processes in Botswana. This chapter also explores the national response to HIV and AIDS in Botswana in the light of three main theoretical approaches to public policy, namely Pluralism, Elitism and Statism. Looking at the theoretical perspectives can help explain the power dynamics between the actors and how the HIV and AIDS policy was framed. Finally, the chapter examines the processes and dynamics around the securitisation of the HIV and AIDS epidemic in the country. It is argued that the openness and acceptance of the securitisation discourse by Botswana’s former president, Fetus Mogae’s led to a higher degree of securitisation of the HIV and AIDS epidemic in Botswana.

The roles of certain transnational actors, notably the UN agencies and the US government, are analysed to ascertain the success of their persuasion efforts as promoters of the securitisation discourse in the policy decision making processes. It is argued that Botswana’s political leadership, primarily President Mogae, created a more open and inviting environment for

international HIV and AIDS actors to carry out their work to support the national HIV and AIDS response policy. The acceptance of international actors and their ideas led to a more collaborative approach towards the framing of policies and processes for the national response policy. As a result, in 2002 Botswana became the first African country to launch a national antiretroviral treatment project financed in equal measures by the Botswana government, the Bill and Melinda Gates Foundation and the pharmaceutical company Merck¹⁵.

It is shown that Botswana's approach to its domestic HIV and AIDS policies differs from that of most other African states, as those states tend to have a higher level of economic dependence on international funding (Baylies, 1999). Although the country is still dependent on multilateral and bilateral donors to fund its HIV and AIDS activities, unlike most of its South African neighbours (excluding South Africa) Botswana is much less in need of foreign aid (Nzau, 2011:100).

While Botswana may not have been as reliant on multilateral and bilateral donor aid as Swaziland, the aid it did receive helped to influence policy formulation and implementation. Botswana's political and social structures helped external actors gain access into its domestic policy decision-making process. Several factors, including a strong and committed political leadership, and a rather weak civil society with very low levels of political activism helped to create the internal conditions for the acceptance of international thinking about the HIV and AIDS epidemic. It is argued that the role of civil society is important, even though it was historically not very strong in Botswana. However, because of civil society participation in the HIV and AIDS environment, it was incorporated into the government HIV and AIDS structures, resulting in a mutually beneficial relationship that strengthened the HIV and AIDS national response policy.

The chapter starts with a brief overview of the dimensions of the HIV and AIDS epidemic in Botswana. It looks at different socio-economic features of Botswana and how the HIV and AIDS epidemic has impacted on the country. This is followed by an overview of policy responses to the epidemic. Here the early efforts to address the epidemic are discussed as is the process leading to a change in approach to the policy decision-making process. The third part of this

¹⁵ This will be discussed in more detail later in the chapter.

chapter examines factors that influenced the policy decision-making process. Chief among these are the government of Botswana's relationship with the West and the prevailing social culture in Botswana. The next part of the chapter explores the role of relevant stakeholders. The focus of this section is to examine the relationships and power dynamics between the domestic non-state actors, transnational actors and the Botswana government. The following section deals with the securitisation approach in Botswana. It discusses the prevailing political culture in Botswana and also the USA as a key-securitising partner.

5.2 Dimensions of the HIV and AIDS epidemic in Botswana

At the time of Botswana's independence in 1966 it was regarded as one of the ten poorest countries in the world (Murray and Parson, 1990). This extraordinary low level of economic development was apparent in the inadequate physical infrastructure and the non-existence of an industrial sector, coupled with a fairly weak administrative capacity. The country was mainly rural, with the largest urban settlements not exceeding 10 000 inhabitants and 90 per cent of the population was based in the underdeveloped rural economy (Murray and Parson, 1990). As discussed in chapter 2, large rural-based populations in developing states tend to live more widely distributed, and thus geographically further away from the public institutions that make important policy decisions impacting on their lives. Therefore in Botswana, this leaves a section of the population with little influence on the policy decision-making processes itself and with limited access to important decision-makers. According to Grindle and Thomas (1991), this creates a situation that isolates these sectors of the population. However, the government rapidly expanded the central government institutional apparatus, leading to a significant increase in the delivery of public services (Du Toit, 1995:33). Du Toit (1995:47) argues that the Botswana Democratic Party (BDP), which has been in power since independence, has succeeded in establishing a technocratic state with an autonomous bureaucracy that "contributed as a vital ingredient to the quality of statehood that evolved in post-independence Botswana". BDP's post-independence nationalism was strengthened by the fundamental task of promoting economic growth and social development (Taylor, 2005:5). Consequently, the national project was embraced and advanced by the political and bureaucratic elites and, concomitantly, it gained widespread acceptance amongst both the rural and urban populations (Taylor, 2005:5).

Soon after independence prospecting operations revealed a vast potential for diamond and copper-nickel mining and the government allocated a large share of public spending and administrative capacity to the development of the mining sector. Harvey and Lewis (1990:53) have characterised this turning point in 1972-3, when Botswana ceased to rely only on financial support from the United Kingdom, as the achievement of “a second independence.” The 1970s and 1980s saw the government considerably reduce the rates of child mortality as well as malnutrition. In the public health sector Botswana had a per capita expenditure of US\$358 making it the highest in Southern Africa (UNDP, 2003). At independence the per capita income was P70 (US\$12) and the latest UNDP results show the per capita income to be P18, 340 (US\$ 3,056). The World Bank rates Botswana as an upper-middle-income economy. With diamonds constituting almost half of the state’s income, together with import duties and development aid, the state has been equipped with financial manoeuvrability, meaning that the state has financial systems in place which are able to adjust and respond to changing market conditions. This is exceptional in the developing world (Harvey and Lewis, 1990:192-4). Botswana is today a relatively wealthy and politically stable country.

However, Botswana still faces numerous challenges. Chief among these is the urgent need to curb and manage the threat posed by the HIV and AIDS epidemic. The first officially recorded HIV case there was diagnosed in 1985. Since then the number of infections HAS increased exponentially regardless of social grouping or economic class. The spread was extremely rapid that in 1989 the cumulative number of people living with the virus was 35, but by 1996, eleven years after the first recorded case; it had risen to nearly 4, 000¹⁶. *The 2008 Report on the Global AIDS Epidemic* by UNAIDS, placed the figure at 300 000 in 2007¹⁷ and with an adult prevalence rate of 23.9 per cent. With a relatively small population of approximately 1.8 million, this amounts to almost one in six of the entire population infected with the disease. Wæver (1995:63) asserts that “Putting something on the security agenda persuades us of the need to furnish urgent and unprecedented responses; it signals imminent danger and is therefore given a high priority”.

¹⁶ In a report published by the National AIDS Coordinating Agency, Botswana, December 2000 *Botswana 2000 HIV/AIDS Sero-prevalence and STD Syndrome Sentinel Survey*

¹⁷ According to UNAIDS data sourced from the following web link-

http://www.unaids.org/en/KnowledgeCentre/HIVData/GlobalReport/2008/2008_Global_report.asp

According to an interviewee, “Botswana has a rather unconventional relationship with the epidemic as it seems to defy the common belief that economic underdevelopment is directly linked to the spread of the HIV virus” (telephone interview, Senior Officer AIDS Specialist UNDP Regional Service Centre JHB, 09/05/08). While Botswana’s health care system is among the best on the African continent, it continues to experience high levels of HIV and AIDS prevalence in the population (UNDP, 2004). Since the first recorded case the government has been quick to act in accordance with international medical guidelines for action. However, some critics noted that while the government was quick to react once the disease had been identified, the actions it took did little to prevent a rapid increase in infections in the late 1980s and early 1990s (Games, 2006:8). This may be due to the fact that the full magnitude of the disease had not yet been properly understood.

The impact of the epidemic saw life expectancy falling from 65 years in 1990-1995 to below 40 years in 2000-2005 - an estimated 28 years lower than it would have been without AIDS (UNFPA, 2001). It is estimated that approximately 95,000 children have lost at least one parent to the epidemic (UNAIDS, 2008). In order for these children to become productive citizens of Botswana, it is vital that they have access to education, but because of their circumstances this is challenging for many families already weakened by the epidemic, where children may be forced into provide care for ill relatives or supporting siblings (UNAIDS, 2008).

The loss of the adult population in their productive years has serious economic implications for the country (NACA, 2005). This loss is carried through and experienced in the economic output of Botswana which in turn is reduced by the loss of workers and skills in the agricultural and mining sectors as well as the private and public sectors. At the turn of the millennium it was estimated that if the epidemic were not curbed by 2021, Botswana’s GDP will be in the region of 24-38 per cent less than it would have been without the epidemic (UNDP, 2000:2). While there may have been some successes in Botswana’s approach to curbing the epidemic since then, there is still a real concern that if more is not done, Botswana’s hard-won social and economic achievements may be negatively impacted (Carr-Hill et al., 2002:24).

5.3 Observable policy responses

5.3.1 Early efforts to address the epidemic

In order to deal with the disease the government had to accept that the HIV and AIDS issue should be included in the agenda-setting process. As discussed in chapter 4, Anderson (2000:93) argues that at any given time there are a vast number of public problems in the society, and it is not possible for all to make it onto the public policy agenda. Policymaking occurs in response to a certain societal ill with the aim of providing a remedy or recourse. Thus, for HIV and AIDS to make it onto the public agenda it was elevated to the level of a societal ill, which the government believed made it necessary to formulate policy responses.

Because of the stable political environment and relatively efficient health system, Botswana was able to respond to the epidemic earlier than the rest of Southern Africa, including South Africa and Swaziland. At this point the government may not have been in a position to comprehend the full magnitude of the impending epidemic, but it was preparing the policy environment to address the problem. Fourie (2005:23) believes policy processes should be viewed as a series of stages which should be contextualised within a policy environment, since they do not occur in a social vacuum. The state's prevailing political culture and the socio-economic conditions are key factors in determining what is deemed as important societal issues.

The Ministry of Health confined the initial responses by the government to a number of policy interventions. In 1986 two initiatives were launched one year after the first reported case. First, the public health service launched a blood-screening programme in order to eliminate the risk of HIV transmission through blood transfusions. Second, the government set up the Minimum Programme located in the epidemiology unit of the Ministry of Health. In 1987 the government set up the National AIDS Programme (NACP) with the help of the World Health Organisation (WHO), which developed a Short Term Plan (STP) for HIV/AIDS (1987-1987). Its primary focus was on increasing national public awareness of the disease and the introduction of epidemiological surveillance and monitoring.

5.3.2 Change of approach in the policy decision making process

The first attempt of the national response policies in Botswana was from 1987-1993, which coincided with the beginning of the worldwide expansion of the epidemic. Due to the expansion of the epidemic, the government realised the need for new policy decision-making to best address the HIV and AIDS epidemic more effectively. This change in the policy decision-making process could be the consequence of the unsuitable manner in which the issues (HIV and AIDS) were earlier defined and identified in the initial policy decision-making phase (Parsons, 1997:82-83).

The STP was followed by a more comprehensive five-year plan, the First Medium-Term Plan (MTP I) for the Prevention and Control of HIV and AIDS (1989-1993). During the early 1990s, when the disease was spreading at an alarming rate there was an opportunity for the government to contain and manage the problem. The MPT I aimed to give policy and strategic guidelines for action after the inception of the NACP. Additionally, the MPT I outlined the role of the health sector and the Ministry of Health, supported and assisted by other sectors and civil society actors concerned with prevention, care and support.

In 1992 the government launched detailed surveillance for HIV and AIDS focusing on pregnant women attending antenatal clinics and male patients being treated for sexually transmitted diseases. In an attempt to demonstrate a refocusing of intent in dealing with the disease, the government renamed its Sexually Transmitted Diseases Unit, the AIDS/STD Unit. However, the government came under criticism for failing to provide adequate funding to the Unit, despite the evidence that infections were spreading rapidly (Sidiropoulos, 2006:12). This information came to the fore when data showed that HIV prevalence among pregnant women rose from 23.7% to 42 per cent in Francistown, and from 14.9 per cent to 31 percent in Gaborone from 1992-1999 (Botswana 2000 HIV Sero-prevalence and STD Syndrome Sentinel Survey).

In 1993 a revised National Policy was developed because it was felt that there was a need to broaden the policy implementation process. It called for a more all-inclusive strategy, which meant that in addition to the efforts of the Health Ministry, other government departments, relevant civil society bodies and groups from the private sector and the community were involved as well. This new revised strategy increased the involvement of development partners

and international organisations, particularly UNAIDS. This is in line with the pluralists' belief that government agencies are not alone but part of a myriad of actors who through their actions are in a position to influence the political leaders of the day. It also focused on five groups of actors to help with policymaking, namely national, district, civil society, the armed forces and applied research (Ntseane, 2002). According to the Ministry of Health's review of the MTP 1, one major constraint on implementation was the "minimal involvement of the Ministries and senior management as well as inadequate involvement of local government structures" (Ministry of Health, 1997:31). This was echoed in one of the interviews. At a time when a more aggressive policy was required, it seemed as if government officials were not entirely convinced or did not fully understand the magnitude of the crisis (interview, Senior Health Officer: SADC, 5/3/08). Therefore, there was an urgent need for the change in policy to include as wide a range of actors in the response strategy as possible.

At national level the strategy included the establishment of a focal point for co-ordination of all HIV and AIDS-related projects in each Ministry. The aim was to increase policymakers' awareness of the disease and the impact it has on development. Simultaneously management and information systems located at national and district levels were established to collect and analyse data for policy programme development. At the district level they included the centralisation of programmes to each district and then to the village context. At the level of civil society, they were used to participate in support activities, primarily through NGOs (Ntseane, 2002).

During the early 1990s, when the disease was spreading at an alarming rate there was an opportunity for the government to contain and manage the problem. However, at a time when a more aggressive policy was required, it seemed as if government officials were not entirely convinced or did not fully understand the magnitude of the crisis (interview, Senior Health Officer: SADC, 5/3/08). This is highlighted by the Ministry of Health's review of the MTP I, which highlighted "minimal involvement of Ministries and senior management as well as inadequate involvement of local government structures" (Ministry of Health, 1997:31).

In 1997 a Second Medium-Term Plan (1997-2002) (MTP II) was adopted to improve efforts to combat the epidemic. It called for an expansion of the MTP I, political leadership and consolidation. Its goals were to reduce the HIV infection and transmission rates. It substantially

changed the focus from a health-based approach to a comprehensive multi-sectoral response intended to impact on all levels of society.¹⁸

The adoption of the MPT II highlighted a change in approach and more aligned to the manner in which the HIV and AIDS epidemic was understood at the global level. The formulation and implementation of the MPT II coincided with the emergence of policy studies and academic reports seeking to address the epidemic in non-conventional terms. The launching of the MPT II also corresponded at the multilateral level with the establishment of UNAIDS. As shown in chapter 4, at this time there were a number of academics, international organisations and state organs starting to examine the links between human/national security and HIV and AIDS.

An ambitious ARV programme was attempted and also launched in 1999. The goal of the programme was that by the end of 2002 190 000 people would be on treatment. However, this proved to be too optimistic of a goal to achieve. Despite Botswana's well-developed primary health care services, it lacked adequate testing facilities and the capability to staff and maintain the infrastructure to supply ARVs on the scale intended (interview, Senior Programme Manager with the AED Centre on AIDS and Community Health, 5/3/08).

Therefore, instead a mass roll-out of ARVs was launched in January 2002 through a programme named *Masa*, the Setswana word for 'new dawn'. The programme provided free ART to eligible citizens living with HIV only. However, whereas Botswana citizens are eligible for free ART, their foreign spouses are not (interview, Project Development Worker BONEPWA, 6/03/08). By the end of 2004 there were four major centres and a total of 23 sites had been established countrywide. According to the African Comprehensive HIV and AIDS Partnership (ACHAP) data, from 2005-2006 there were 32 sites and 54,969 patients were on ART. It is estimated that 85 per cent of all people requiring ART are presently receiving such treatment (UNAIDS, 2008).

¹⁸ With the adoption of the MTP II, the Ministry of Local Government (MLG) was engaged and became a key department in the national response. It is in charge of managing, sustaining and coordinating strategic actions at the district level. In order to adapt to the HIV and AIDS bureaucratic structures in the national government, it was dealt delegated to the Ministry's divisions at local level. It controlled the administration of the District Multi-Sectoral AIDS Committees (DMSAC). Under the MTP II the DMSACs were established to coordinate all the local stakeholders' inputs. Essentially, it was to become the sole HIV and AIDS local authority recognised by the central government. The reason for the relevance of the MLG is due to the fact that the government found enormous difficulties in addressing demand at grassroots level (Ministry of Health, 1997)

The *Masa* programme was a partnership between the government, the Bill and Melinda Gates Foundation and the US pharmaceutical Merck Company Foundation. While it was the case that most countries in the region invested in the provision of generic AIDS drugs, more so in the case of South Africa, the government of Botswana instead decided to partner with the US pharmaceutical Merck to provide branded drugs to be distributed through its domestic public health system. Vieira (2006) holds the view that with this partnership Mogae's administration revealed a preference for the principles and policy ideas advocated by the US government. This was because the characteristics of Botswana's political and social structures were more open and accepting of external actors, which appealed to the US government's securitising ideals. This prevailing openness approach to external securitising actors differed in the cases of South Africa and Swaziland as will be discussed in chapters 6 and 7.

Early reports showed that after an initial rush, patients were slow to come forward. Prior to 2003 the government's policy was the opt-in approach. This means that after pre-HIV test counselling, they must specifically consent to a HIV test when visiting a health facility. Later the government introduced a policy of 'routine testing'. The 'routine testing' called for every person attending a public health facility to be tested unless they opt out, or specifically decline. By adopting a more unilateral approach towards monitoring the spread of the disease the government was criticised by HIV and AIDS activists, who were concerned about the human rights of people living with HIV and AIDS. According to Vieira (2011:19) "this system of routine HIV testing is, in fact, a recommendation of the US's CDC without the full backing of UNAIDS and other important transnational HIV and AIDS actors". This is an example of elite theorists at work since in the public policy domain these elites are in a position to control and manipulate the agenda-setting process. By adopting the recommendation of the CDC rather than UNAIDS and other important transnational HIV and AIDS actors, Botswana placed the US government in an advantageous position to advance its own political agenda.

Major challenges and shortcomings of *Masa* were the critical shortage of skilled personnel and the poor infrastructure needed to ensure appropriate, safe and effective use of ART. These hindered the successful implementation of the ART programmes. The PACT officer raised the

issue about the difficulties experienced in sourcing skilled personnel. Indeed the PACT¹⁹ office closed down its Botswana office at the end of March 2008 (interview, Pact Regional Programme Manager for the Southern Africa HIV and AIDS Prevention Programme: 10/4/08).

In order to address the challenges and shortcomings, ACHAP, in collaboration with the Harvard AIDS Institute and the Ministry of Health, developed a curriculum on HIV and AIDS clinical care known as the *KITSO* ('knowledge') programme. Since the start of the programme, it has cumulatively trained 6,300 health care workers and 1,500 lay personnel in various training modules. A key achievement of the *KITSO* training programme continues to be the creation of human capacity to roll out the ARV programmes to clinics across the country (ACHAP website, accessed 22 August 2012).

5.4 Factors that influenced the policy decision making process

i) Relations with the West

Botswana and Britain negotiated a peaceful transition of power that led to Botswana's independence in September 1966. The relationship has continued to prosper. Recently, the Minister of Foreign Affairs and International Cooperation, Mr Phandu Skelemani, stated that "such a cordial relationship, which predates Botswana's independence, is particularly beneficial in the fields of health care, trade, defence and security, education as well as the support for the civil society at large" (MOFAIC, 2011). Botswana has also been able to forge cordial relationships with other Western powers built on mutual interests. For instance, "the United States considers Botswana an excellent partner and an advocate of and model for stability in Africa. The bilateral relationship is strong, grounded in a shared commitment to democracy, good governance, and human rights" (US Bureau of African Affairs, 2012). The USA has been a major partner in Botswana's development and Botswana is one of the focus countries for the President's Emergency Plan for Aids Relief (PEPFAR).

Botswana's cordial relationship with Western powers was important as it provided transnational actors with the necessary political space within which to operate. This access placed them in a

¹⁹ PACT Globally is a capacity building organisation whose niche is working with small local organisations on infrastructure, management, accounting, bookkeeping, basically everything you would need to be a good strong well run organisation (regardless of what your mission) according to Kate McNally.

position to attempt to influence the government into accepting their ideas. As will be demonstrated later in South Africa and to some extent in Swaziland, this was not always the case since transnational actors met much resistance in attempting to have their ideas accepted by the respective governments. An interviewee emphasised that in Botswana “any ideological underpinnings of policy pragmatism is driven by what the USA want in Botswana” (interview, AIDS Expert, University of Johannesburg: 25/04/08). This he believes is the case because of the high level of funding made available by the USA and other transnational actors. Because of the political environment in Botswana at the time, transnational actors were in a position to forge working relationships at a higher level in the policy decision-making structure as opposed to merely forming coalitions with domestic civil society actors (interview, AIDS Expert, University of Johannesburg: 25/04/08). This can be viewed as evidence of an elitist theoretical perspective within the public policy theory, where the political demands emanate from plural sources of elite groups. The UN and also the US government would, in this respect, qualify as representatives of the political elite.

ii) Prevailing social culture in Botswana

As a result of cultural sensitivities there is a deep-rooted unwillingness to discuss sex openly in Botswana, partly because of the rules of respect that lie at the foundation of family and kinship structures, which in turns limits communication across generations and sexual genders. According to an interviewee, “Cultural sensitivities still persist in most parts of the country which can and does limit awareness initiatives” (interview, Senior Health Officer AIDS Expert SADC, 5/3/08). While the campaigns were well intended, they failed to take into account the predominant cultural sensitivities (interview, Project Development Worker: BONEPWA, 6/03/08). This lack of insight into cultural sensitivities may be attributed to an inadequacy in the agenda-setting process since it failed to take into account issues of sexual mores behaviour and practices.

The first national campaign to raise awareness used media platforms such as radio messages, bumper stickers and T-shirts to convey the message about the dangers posed by the disease (Ingstat, 1990). Specific catchphrases were used in these official campaigns to help spread the awareness messages regarding the dangers associated with negligent sexual behaviour and practices. These were in line with those endorsed by the WHO, such as “AIDS Kills” and

“Avoiding AIDS is as easy as ABC - Abstain, Be faithful and Condomise” (Allen and Heald, 2004:1144).

Sex education campaigns are difficult and controversial in most parts of the world, let alone in Africa. HIV and AIDS as subject matter has been shrouded in both stigma and silence from the family level and permeates the whole community at large. In order to be more effective, policies require credibility and should take into account the relevant sensitivities of the intended target group. Allen and Heald (2004) are of the opinion that in Botswana there was neither credibility nor sensitivity. This they attributed to the government’s initial response to the threat. A limiting factor regarding the ABC slogan was the fact that it was presented in English, which meant that a significant section of the population was unable to fully understand the intended message. The lack of understanding of the intended message lead to the slogan not being fully accepted or appreciated, resulting in HIV and AIDS being known as the “radio disease” (Ingstad, 1990:29). Allen and Heard (2004) also argue that the campaigns were offensive as they did not heed the necessary cultural sensitivities.

5.5 Role of relevant stakeholders in the policy-framing

5.5.1 Political space for domestic non-state actors in Botswana - Historically weak civil society with close government links

Several authors have written about the historical absence of a strong civil society movement in Botswana (Good, 1996; Tsie, 1996; Holm and Darnolf, 2000; Vieira, 2011). This view was echoed by several of the interviewees during my fieldwork in Botswana. “Civil society in Botswana is very different from most other countries. The biggest NGOs were all started by the government, so therefore the fact that government founded the NGOs it is different” (interview, Senior Programme Manager with the AED Centre on AIDS and Community Health, 5/3/08). The Executive Director of BONEPWA agreed that the government was indeed very instrumental in helping to establish many of the bigger NGOs operating in the country (interview, the Executive Director of BONEPWA, 6/03/08). “If you or anyone else was to look at an NGO in Botswana, the first thing you need to find out is: who is the leading office-holders in the NGO” (Godsater and Soderbaum, 2008:20). Godsater and Soderbaum (2008:20) assert, that this however does not mean that every NGO with government links is compromised. NGOs may still demonstrate

independence by challenging and criticising the government's actions and policies. Bauer and Taylor (2005:99) confirmed this by arguing that "the general consensus around civil society in Botswana seems to be that it has been 'historically absent' in the country, only showing signs of life from the early 90s onwards." Botswana's model of democracy is characterised by a strong state bureaucracy, driven by entrenched political elite who limit any potential of an autonomous and vibrant civil society (Taylor 2003).

After independence the government moved to control the growth of civil society organisations by incorporating them into the state's bureaucratic structure. Holm and Darnolf (2000:99) argue that; "civil society exists as an extension of the bureaucracy rather than as a set of independent actors confronting politicians and civil servants." Therefore, the relationship between state and civil society in Botswana can be characterised as top-down, thus limiting the ability of the latter to operate more independently.

Most of the HIV and AIDS-related civil society organisations experience one or more of the following problems: lack of adequate resources, lack of staff capital coupled with shortage of technical and professional expertise, (interview, Pact Regional Programme Manager for the Southern Africa HIV and AIDS Prevention Programme: 10/4/08; interview, the Executive Director of BONEPWA, 6/03/08; interview, Senior Programme Manager with the AED Centre on AIDS and Community Health, 5/3/08). Because of their limitations, the civil society actors were either co-opted by or absorbed into the state agencies they were seeking to influence with the intention to shape HIV and AIDS policies. This has resulted in them being very limited in their capacity to independently influence the process and outcomes of policymaking (interview, Senior Health Officer AIDS Expert SADC, 5/3/08).

However, this assumption was challenged by the Executive Director of BONEPWA (interview, 6/03/08), who stated in an interview that

Government felt it could not fight the epidemic alone and as a result wanted the input and experiences of civil society, which they may have helped establish. Once established and experienced, NGOs in return can advise the government. The relationship has changed from a top-down to more mutual benefiting relationship. It has come full circle.

This is evidence that forming closer links to the government also gained them a degree of access to the government's policy decision-making structures that NGOs in other countries might not have been able to access. This is an advantageous position because it offers the ability to influence policy framing in a more direct manner.

In the context of dealing with the HIV and AIDS epidemic, the coordination of civil society takes place on numerous levels. NGOs organise themselves in four key umbrella organisations which assist the varied individual organisations:

- i. The Botswana Network of AIDS Service Organisations (BONASO) acts as the umbrella body for AIDS service organisations in Botswana. Its main purpose is in supporting HIV and AIDS NGOs in terms of capacity building, information sharing, advocacy, assisting with accessing resources, lobbying the government and promoting a unified front among them;
- ii. Botswana Network on Ethics, Law and HIV and AIDS (BONELA), which includes NGOs, members of the legal fraternity, academics and individuals. It addresses issues related to human rights of PLWHA and lobbies against the use of punitive action as a legal instrument to address the epidemic;
- iii. Botswana Network of People Living with Aids (BONEPWA), an association of people living with HIV and AIDS (PLWHA) with the objective to facilitate networking and support for PLWHA as well as being the representative and spokesperson for PLWHA at NACA²⁰;
- iv. Botswana Christian AIDS Intervention Programme (BOCAIP) was created in 1996 and is a network of church community organisations to help coordinate the work of the religious sector in the government's multi-sectoral response.

The above list shows that civil society presence in Botswana is rather high yet they remain limited in power to access and directly influence the policy decision-making process structures within government. However, some such as BONASO and BONEWPA as umbrella bodies, have shown that they have convening power and the ability to network extensively throughout the country. Also, more importantly, because of the high number of civil society organisations, their

²⁰ NACA is the National AIDS Coordinating Agency that was launched in 1999 by a Cabinet directive under the office of the President.

power lies in their strength in numbers, which would greatly benefit the response policies by providing a more unified response when necessary to address the epidemic.

These umbrella organisations work to coordinate their actions with those of the government. According to an interviewee, “This relationship between the state and the non-state actors is not as politicised as was the case in South Africa and Swaziland and can be considered more collaborative (telephone interview, Senior Officer AIDS Specialist UNDP Regional Service Centre Johannesburg, 09/05/08). This follows the constructivist thinking that emerged with the revised National Policy in 1993. An official from BONEPWA echoed this, “Government might not take all our recommendations, but at least we are given the opportunity and forum to share our opinions and be part of the solution” (interview, the Executive Director of BONEPWA, 6/03/08).

However, the government strictly regulates the projects and means of funding for these local HIV and AIDS NGOs. NACA’s role in this regard is to help distribute the fund allocations from donors such as the Global Fund to the local NGOs after they have been released by the Ministry of Finance. But this process however has not been without its critics. Daniel Mutating the Executive Secretary of BONASO, which was one of the beneficiaries of the Global Fund, complained that while NGOs were playing a larger role in implementation, they also wanted to be more effective partners and be involved at both the level of management and the disbursement of the funds (*Daily News*, 16/08/06). The Executive Director of BONEPWA supported this opinion; “they coordinate and do not take part in the implementation process as such” (interview, the Executive Director of BONEPWA, 6/03/08).

Civil society’s role in the NACA framework was to participate in the discussion forum. The discussion forum was important as it presented an opportunity for the participants to assess their capacities and highlight any constraints encountered in specific areas so as to ensure that progress was being made towards combatting the epidemic. According to an interviewee, “Civil society is involved, part of the structure and is represented. Civil society is part of everything we do” (interview, Senior Programme Manager with the AED Centre on AIDS and Community Health, 5/3/08). Essentially this forum offers the opportunity to raise concerns directly to NACA, allowing civil society groups the ability to synchronise and guide their agendas and projects to be

in line with the principles and objectives set out in the National Strategy for HIV and AIDS. HIV and AIDS civil society groups are required to harmonise their activities with those of the local DMSACs. Also, quarterly reports on their progress made in the development of their projects are submitted to NACA and other stakeholders in the government as well as to international partners. While civil society actors may participate in the policy processes, they are not actual policy drivers and as such have a limited influence in the policy framing processes. This is evidence that, although there is a constructivist approach to public policy making, the civil society actors have little actual power.

Although civil society organisations may have formal participation in these HIV and AIDS structures, they tend to work more as facilitators among international partners and the government rather than as actual agenda-setters. This in turn limits their influence in decision-making processes. They also react to the decisions of their sponsors rather than influence the actual process of decision-making. Also at the level of policy implementation, these groups lack some capacity. Because of their irregular funding, NGOs dealing with HIV and AIDS have to dedicate a large amount of their time to resource mobilisation. As a result, they may be forced to adapt their programmes to appease and align them to the policy priorities of the changing donors. This situation leads to some confusion and impacts on their commitment to their programmes.

Civil society organisations in Botswana have remained to a large degree relatively passive. This may be due to the political and social stability of the country coupled with a culture of non-questioning, which is characteristic of many ordinary citizens in Botswana (Mogalakwe and Sebudubudi, 2006). Their lack of capacity and adequate resources in turn affects their capacity to help implement policy. As a result, these limitations made the domestic actors more dependent on the international donors (interview, Senior Programme Manager with the AED Centre on AIDS and Community Health, 5/3/08). This situation has created a degree of confusion amongst some civil society organisations as some are forced to adjust and align their priorities towards those of international donors at the expense of their own priorities (interview, AIDS Expert, University of Johannesburg: 25/04/08).

BOCAIP on the other hand, has a more established role within Botswana. It is the main partner of ACHAP and BOTUSA²¹ in the civil society sector. ACHAP in partnership with BOCAIP has established 11 additional counselling centres. By September 2005 these centres had offered training to 447 counsellors and provided services to over 70,000 people (ACHAP Factsheet: 2005).

BOCIAP benefitted owing to its alignment to PEPFAR's guidelines, which favoured a morally centred approach founded on abstinence and faithfulness. BOTUSA was able to help BOCAIP establish numerous counselling centres for PLWHA throughout the country without much trouble. This proved detrimental to civil society organisations' initiatives, which were perceived as not aligned with the PEPFAR guidelines. "PEPFAR does not want their money to be used for condoms because it is as if you are encouraging sex. Condoms are for prevention and not encouragement" (interview, the Executive Director of BONEPWA, 6/03/08).

Faith-based organisations supported by the USA become leading actors in the HIV and AIDS civil society sector in Botswana (interview, the Executive Director of BONEPWA, 6/03/08). Faith-based HIV and AIDS organisations have established a two-tiered strategy in order to reach out to the population as well as spreading their own securitisation message. Firstly, these faith-based organisations actively participate in the coordination mechanisms. The aim of this is to ensure that their voice is heard at the highest level of decision-making during the agenda-setting process with a view to exerting influence over government and other domestic and international partners.

Secondly, they choose to establish bilateral partnerships, which are done by undertaking intensive campaigns focusing on abstinence and faithfulness at the community level. They also initiate their own counselling services that are not always in line or integrated into the broader national plan. These independent initiatives stem from the strategies of transnational faith-based associations for combating the global epidemic. According to an interviewee,

²¹ BOTUSA is a partnership between the CDC and the Government of Botswana to help stop the spread of TB and HIV and AIDS. BOTUSA provides training, technical assistance, and research; promotes innovation and evidence-based best practices; and supports the monitoring and evaluation of prevention, care, and treatment programs for HIV and AIDS and TB.

This has led to disagreement with the government since its aim is to maintain stricter control over the activities of HIV and AIDS NGOs. This has resulted in the government not being able to efficiently monitor the true influx of resources as well as monitor the relations established between the domestic and international faith-based organisations since they tend to bypass government structures (interview, Chief Research Officer NACA, 7/3/08).

UNAIDS recommends having one coordinating authority for the HIV and AIDS national response²². Bilateral relationships of this nature counteract the aims of NACA as the one national coordinating HIV and AIDS authority in the country.

5.6 Politics and differing priorities - political space for transnational actors in Botswana

In addition to the faith-based organisations, Botswana is home to a number of HIV and AIDS transnational actors which align themselves more closely with the secular principles of UNAIDS and its partners. The leading organisations in Botswana are the William J Clinton Foundation, The International Council of AIDS Services Organisations (ICASO) and the International HIV and AIDS Alliance (IHAA). This was highlighted in December 2004, when ICASO and IHAA articulated in a discussion paper the position of civil society groups in the development of the “Three Ones”. They endorsed the “Three Ones” principles to achieve the most effective and efficient use of resources, and to ensure rapid action and results-based management:

- i) One agreed HIV and AIDS Action Framework that provides the basis for coordinating the work of all partners;
- ii) One National AIDS Coordinating Authority, with a broad-based multi-sectoral mandate;
- iii) One agreed country-level Monitoring and Evaluation System (ICASO and IHAA, 2005).

Their aim in promoting their discussion paper globally was to improve awareness and increase the involvement of local NGOs in the promotion of the “Three Ones” principles at the national level.

²² This will be discussed in more detail in the next section of the chapter.

The major difference between these secular INGOs and the US-sponsored religious groups is that the INGOs operate exclusively within the parameters and goals established by the national plan (interview, Chief Research Officer NACA, 7/3/08). They are effective in linking up with the responsible local umbrella body such as BONASO to help facilitate coordination and sharing information between and with local and international NGOs as well as with the government. The ICASO can be credited as being a good example of a transnational HIV and AIDS network that has built very complex mechanisms which link the global, regional and local HIV and AIDS organisations in Gaborone. At regional level both BONASO and BONEPWA are part of the Southern Africa Network of Aids Services Organisations (SANASO), which is part of the Southern African Development Community (SADC) institutional structure and the global advocacy network formed by ICASO. ICASO is one of five NGO representatives at the UNAIDS' Programme Coordinating Board tasked with guiding this organ's response to the global HIV and AIDS epidemic.

From the above it is clear that at their respective levels of political engagement these advocacy organisations perform similar institutional tasks as well as sharing the same values and policy concepts with regards to the epidemic. This was important in trying to establish entry points into the government's policy decision-making processes. ICASO has been instrumental in working as an unofficial supervisory body of the national governments' commitment to United Nations General Assembly Special Session on HIV/AIDS (UNGASS). In Botswana BONASO sends periodic reports to ICASO detailing the progress and problems faced by the government. They facilitate the coordination of NGO programmes on HIV and AIDS in order to "enhance their role and impact the programme delivery level" (BONASO website, accessed 14 August 2010). This in turn helps to feed into the above-mentioned transnational networks that have helped to embed into the domestic structure of Botswana the principles that were discussed and agreed upon at the UN's global meetings on HIV and AIDS.

The Merck Foundation has been an influential contributor to the formulation and the implementation of projects it supports in Botswana namely ACHAP. Merck refers to their relationship as "a unique program developed with and led by the Government of Botswana, ACHAP is one of Sub-Saharan Africa's oldest, most successful public-private partnerships" (Bill and Melinda Gates Foundation Press Release 24 August 2010). Dr Donald de Korte is ACHAP's

project leader and is the former managing director for Africa and CEO of Merck's subsidiary in South Africa (Wharton global website, accessed 27 August 2012). Merck has been active in donating ARVs for the appropriate treatment programmes developed by the government of Botswana. "Partnership programs must build local capacity, demonstrate a measurable impact on the epidemic, be cost-effective, appropriate to the setting in which they are delivered, and sustainable beyond the life of the partnership (Merck website, accessed 27 August 2012). A key strength of ACHAP has been the ability to fully integrate with the government's strategy, as well as to harness private-sector expertise in support of national efforts to address the HIV and AIDS epidemic. All ACHAP projects are planned and developed through extensive consultation with all relevant government Ministries. It is also significant that for programmes to be accepted, they must fit into the strategic goals of the National Strategic Framework (NSF) for HIV and AIDS 2003-2009 (interview, Chief Research Officer NACA, 7/3/08).

Merck's choice of Botswana as a beneficiary of their programme was strategic. Aside from the fact that Botswana was reeling from the effects of the HIV and AIDS epidemic, it had a stable government in place that was friendly towards the West and Western institutions. Merck's strategy was to donate its branded ARV drugs in order to avoid the issues caused by locally manufactured drugs or the importation of generic drugs.²³ Botswana accepted the terms imposed by Merck, unlike other developing countries, which had campaigned strongly for an increase in access to cheaper generic drugs (interview, Senior Health Officer AIDS Expert SADC, 5/3/08).

Unlike South Africa, the government of Botswana had still not registered the generic substitutes of Nevirapine nor the fixed dose combination of Zidovudine and Lamiduvine, which are manufactured by pharmaceutical companies based in India (Druce et al., 2004:17). The funding provided by the Bill and Melinda Gates Foundation and Merck is attached to strict limitations on the government's autonomy in framing its policies regarding HIV and AIDS treatment. One of the conditions for the funding was that the government of Botswana would use only imported drugs and not manufacture or procure generic options. Consequently, the government took the

²³ At the inception of the agreement, Merck agreed to donate its ARV medicines - STOCRIN[®] (efavirenz) and CRIXIVAN[®] (indinavir sulfate) - to Botswana's national ARV treatment programme (Masa) for the duration partnership. In November 2008 Merck expanded its donations to include ATRIPLA[®] (efavirenz 600 mg/emtricitabine 200 mg, tenofovir disoproxil fumarate 300 mg) and ISENTRESS[®] (raltegravir) (www.merckresponsibility.com/priorities-and-performance/access-to-health/community-investment/public-and-private-partnerships/achap/home.html, accessed 27 August 2012).

approach not to register generic drug substitutes. This is a clear example of how their autonomy in framing their own policies was limited. Furthermore, if the government failed to adhere to the restrictions of the funding agreement, they risked the funding being cut. Therefore, the fear of losing the funding may have been a limiting factor in itself. This influenced the power dynamics in the public policymaking process involving the government and the influential international stakeholders in favour of the latter.

5.7 Policy processes and power dynamics – engagement between the actors

Botswana has been an active supporter of and openly receptive to the UN agencies, for example, UNDP and UNAIDS had since the mid-1990s been pioneers in the global securitisation of the HIV and AIDS epidemic. These UN agencies have played a significant role in assisting the government Ministries and other state organs to help them develop policies and programmes in order to strengthen their formulation and implementation of the policies.

The Second Medium Term Plan (MTP II) demonstrated a shift in policy framing with the adoption of a more comprehensive transnational approach. This required the inclusion of a coalition of actors working under one coordinating authority. This shift in the policymaking process was in line with events playing out in the international arena. For instance, the UNDP released its seminal report on human security in 1994. In 1996 the UN created its own multi-sectoral coordinating agency, the Joint United Nations Programme on HIV/AIDS (UNAIDS). UNAIDS was a key influential actor in Botswana in its planning and development of the MTP II.

Consultations with the multilateral agencies influenced the government in framing its policies and activities. In addition to the cooperation with the government, the UN agencies have also worked closely with other sectors and actors. UNICEF, for example, has been very active in the HIV and AIDS civil society-related projects since the early 1990s²⁴. Also, in a number of “programming workshops”, the UNDP created a forum to bring together high-ranking officials from several Ministries, NGOs, the private sector as well as international partners. The aim of these meetings was to pass knowledge and skills on to the domestic actors involved on how to carry out their functions in the new HIV and AIDS policy system established by the MTP II. The

²⁴ It has supported various projects developed by organisations such as BONASO, the University of Botswana and the Association of Teachers Against AIDS (Ministry of Health, 1997:28-29).

Chief Economist of the UNDP's HIV and AIDS Programme, Des Cohen, and the Director of the UNDP's Regional Project on HIV and AIDS, Roland Msiska, were directly involved in the discussions which preceded the launching of MPT II (telephone interview, Senior Officer AIDS Expert UNDP Regional Service Centre JHB, 09/05/08).

Being in this elite position sharing their expertise and advice with the government proved beneficial for the transnational actors as it provided an entry point to influence the government. This is highlighted by the example of the WHO and later UNAIDS, who favoured a greater bureaucratic centralisation in coordinating an expanded HIV and AIDS response to include all actors both domestic and international. While in the planning stages of the MPT II, a WHO/UNDP-led team reviewed the existing HIV and AIDS structure found in Botswana and recommended the establishment of a supra-ministerial agency to help coordinate the overall national response. The establishment of NACA was a response to this recommendation (interview, Chief Research Officer NACA, 7/3/08).

The inception of the *Strategic Framework for HIV/AIDS (2003-2009)* strengthened and formalised the channels of communication between domestic and international HIV and AIDS actors. Several forums exist in which developmental partners work together to coordinate their activities in either a collective manner amongst themselves or in collaboration with the government. At each of these forums an opportunity arises for the government through NACA to communicate and agree to the role of each of the development partners within the National Response to HIV and AIDS. The forums are:

- i) The Donor Forum: convened by the Ministry of Finance and Development Planning and was constituted in order to consider the financial aspects of government's relations with its development partners;
- ii) The Botswana HIV/AIDS Partnership Forum: coordinated by NACA dealing with the specific technical elements of implementation of the National Response in partnership with the development partners;
- iii) The Expanded Development Forum: this is a body consisting of UN agencies and other multilateral and bilateral development partners;

- iv) The UN Theme Group on HIV and AIDS: it consists of UN agencies to help manage and coordinate their HIV and AIDS activities in Botswana. (interview, Chief Research Officer NACA, 7/3/08).

There are two key forums that provide an institutional space which helps to facilitate the promotion of persuasion methods; the Expanded Development Partner Forum and the Botswana HIV and AIDS Partnership Forum. The Expanded Development Partner Forum was formed to allow a common space where both bilateral and multilateral actors can coordinate their activities and harmonise their policies. The Botswana HIV and AIDS Partnership Forum, on the other hand, is the platform used by international organisations and bilateral donors to interact with senior government officials. The decisions made at this forum are discussed at the National Aids Council, which is chaired by the President. The advantage of this forum being chaired by the President is that it provides the transnational actors an entry point into the decision-making processes of the government. This has proved beneficial to the work carried out by the UN agencies present in the country (telephone interview, Senior Officer AIDS Specialist UNDP Regional Service Centre JHB, 09/05/08).

This entry point into the decision-making processes of the government was important for the transnational actors, as it placed them in an advantageous position since as it allowed them to present their ideas directly to the President to consider for adoption and implement. Whiteside concurs and asserts that these transnational actors also have an advantage over SADC, since the latter has very little leverage to influence the decision-making processes “as with any regional body it is made up of nations and you need to get the nations to put regional interests above national interests and this is not going to happen. When has that ever happened?” (telephone interview, AIDS Expert, University of Kwazulu-Natal, 9/5/08). This is an example of the complexity of the power dynamics in the policymaking process. Both UN-agencies and SADC could in this case be considered to be part of the political elite; however, their roles and possibilities to exert an influence were very different.

The high level of access has led to a number of comprehensive studies on the implications of the HIV and AIDS epidemic in Botswana, which have impacted on policy decision-making processes. One such example is the 2000 UNDP report, *National Human Development Report*,

which focuses on how HIV and AIDS is reducing economic growth and increasing poverty. The report encouraged public discussion on the accessibility of ARV drugs and whether the government should be responsible for providing them. Subsequently, Botswana's Minister of Health tasked the UNDP Resident Representative in Gaborone and the Deputy Governor of the Bank of Botswana to explore the financial viability of such an approach. Meetings were convened at UNDP with key stakeholders including NACA, the Ministries of Health, Finance and Development, and major insurance companies. Those consultations helped lead to the decision taken by Mogae to provide free access to ARV drugs to any citizen who needs them (UNDP, 2004).

Another example of the successful exploitation of access to the President was by UNAIDS regarding the "The Three Ones" framework in Botswana. In order to ensure more efficient working relations between the National AIDS Coordinating Agency (NACA) and the Ministry of Health, a consultative process driven by the UNAIDS Theme Group worked steadily to establish the primacy of NACA regarding the HIV and AIDS institutional architecture. This fulfilled the second key principle of the "Three Ones". When looking at the "Three Ones", it is clear that with the establishment of NACA the second principle has been achieved – "One National AIDS Coordinating Authority, with a broad-based multi-sectoral mandate". With the creation and implementation of the new comprehensive action framework for 2003-2009 and Botswana's HIV and AIDS monitoring and evaluation systems the country is moving closer to achieving the two other principles (telephone interview, Senior Officer AIDS Specialist UNDP Regional Service Centre JHB, 09/05/08).

NACA was launched in 1999 situated in the office of the President, it was tasked with co-ordinating and facilitating the country's response towards the epidemic. It is also responsible for the monitoring and evaluation of resource mobilisation. For most of the 1990s the epidemic was primarily dealt with as a health issue. The establishment of the NACA significantly changed the approach adopted by the government. For instance, potential funders were able to engage directly with NACA about funding/initiating programmes to avoid duplication of projects. This helped NACA to steer funds to under-funded projects and ensured that unfunded projects received funding (interview, the Executive Director of BONEPWA, 6/03/08). Botswana started

receiving funding from the Global Fund in July 2004²⁵. NACA, however, does not receive the money directly it is sent to the Ministry of Finance and from there it is dispensed accordingly with NACA's help (interview, Chief Research Officer NACA, 7/3/08).

In 2006 Botswana had requested US\$ 18.5 million from the Global Fund to scale up its multi-sectoral response to HIV and AIDS by strengthening and increasing the capacity of care givers, NGOs, community-based organisations (CBOs) and local communities. A Global Fund communications officer, Nicolas Demey, stipulated the full amount for this grant was set at more than US\$18.5 million but only US\$9 million has been dispensed because of Botswana's failure to justify expenditure (*Daily News* 16/08/06). The Global Fund dispenses money to a grant on a regular time frame on the basis of reports that reflect what has been achieved with the released funds. Demey said Botswana had presented certain challenges with the delayed reporting on the grant and explained that adequate reporting of activities was a requirement for each disbursement, hence only half of the total approved amount had been disbursed thus far. The grant had a two-year life span, running from 1 July 2004 to 30 June 2006. The Global Fund blamed Botswana for the delays in submitting reports implying that the complete expenditure for the initial disbursement of over P42 million that was made in 2004 (*Daily News* 27/11/06).

The Executive Director of BONEPWA refuted the above claim by the Global Fund. He claimed that the stipulated time frame given by the Global Fund made it impossible to meet the deadline for the report. Consequently, the funds arrived later than expected, placing the civil society organisations at a disadvantage. The Executive Director felt that the Global Fund could have remedied the situation. Instead of releasing funds later, a financial audit should have been carried out at this point in time (interview, the Executive Director BONEPWA, 6/03/08).

NACA's approach was not to apportion blame, believing this would be counterproductive and instead it attributed the delay to the failure of a few NGOs and CBOs failures to submit their reports. This approach by NACA may be indicative of sound foresight, as apportioning blame does not always produce a positive conclusion. Monica Tselayakgosi, an official from NACA, stated that there were significant problems with the capacity-building requirements expected of NGOs and CBOs. She claimed that these problems were greater than initially envisaged and that

²⁵ The Ministry of Finance and Development Planning was the recipients of the first grant of US\$ 18 million that was to be invested in scaling up Botswana's response to the epidemic (Global Fund, 2004 website).

the reporting mechanism proved to be unduly complex for many of the implementing partners. The Global Fund has, however, encouraged Botswana to submit proposals to fight HIV and AIDS, tuberculosis or malaria in future funding rounds, even though this grant has reached its end date (*Daily News* 16/08/06 and 27/11/06).

The position held by certain civil society actors differs from that of NACA's position regarding the Global Fund conflict. An official from BONEPWA argued that the Global Fund money was delayed in being distributed to the civil society partners. This delay meant that from the outset time was against several civil society organisations being able to carry out their projects effectively as well as meet the deadline for submitting their reports. It was also expressed that the official employed by the Global Fund based at NACA was "not adequately skilled to manage the money" (interview, Officer Project Development Worker BONEPWA, 6/03/08). As a result of bureaucratic challenges the distribution of the funds was delayed. The BONEPWA official was of the opinion that the Global Fund did not remedy the situation when there was still a chance to do so. His solution was that, "instead of giving more money, they should have stopped the funding and tried to take account of the money dispensed so far" (interview, Officer Project Development Worker BONEPWA, 6/03/08).

The BONEPWA official therefore proposed that civil society partners should be the principal recipients and not only the government in order to ease the bureaucratic constraints. In addition, he proposed that professional consultants such as KPMG should be tasked to help with the dispensing of the funding. The hope is that this will be able to keep each civil society organisation accountable for its lack of performance individually²⁶. The BONEPWA official is optimistic that "Botswana has learnt from its mistakes and will be better prepared to handle financial accountability in future" (interview, Officer Project Development Worker BONEPWA, 6/03/08).

This feeling of optimism was also elaborated on by an official from an international US NGO based in Gaborone, who stated that in her view the reason for the financial mismanagement was that "the HIV and AIDS money is gone because of mismanagement due to a lack of a proper

²⁶ Global Fund has held back \$9.5 million. Botswana had to reply by April in order to receive further funding in 2009.

accounting system available. It was not due to fraud or corruption” (interview, Senior Programme Manager with the AED Centre on AIDS and Community Health, 5/3/08). Therefore, if better capacity-building measures were implemented for the domestic NGOs to strengthen their accounting systems this perceived gap may be closed.

When examining the role of the stakeholders in the policymaking process it is evident that there are elements of the constructive thinking of the pluralist public policy theorist in the collaborative model of engagement in Botswana. However, there is also clear evidence of the kind of elitism that influences the power dynamics between the actors. More specifically in the way Western governments and transnational agencies are allowed space to become strong policy-influencing actors.

5.8 Securitisation approach and the relevant actors involved

After the failure of the Medium-Term Plans of 1989-1997 and 1997-2002, a more aggressive policy formulation strategy was necessary. This meant an increased focus on key stakeholders such as the President, leading politicians, the private sector and traditional leaders, “with a view of turning them into informed campaigners and decision makers” (UNDP, 2001:2). Therefore, the challenge for this new strategy was “through research and advocacy, engender a common consensus on the magnitude of the HIV and AIDS problem and the threat it posed to governance, the economy and the character and stability of society” (UNDP, 2001:2).

After the process of policy evaluation, through measuring programme effectiveness, it was clear that a change in policy was necessary. This change in policy came in the form of the adoption and launch of MTP II. This was significant as it demonstrated that the authors of the policy were moving towards the concept of securitising HIV and AIDS, as the concept was gaining acceptance on the international stage. As already established in chapter 2, the accepted consensus was that the HIV and AIDS pendulum had swung from politicisation to the securitisation stage. This may not be the case in future, since the disease may eventually be controlled resulting a reverse swing back to the politicisation stage.

The creation of UNAIDS was important, as it influenced various think tanks and transnational actors to begin debating the links between the state and human security regarding HIV and

AIDS. This new perspective focused on a broad understanding of security that includes not just the security of states in the face of external or internal armed threats, but also gives priority to the security of people living within states against non-military threats such as disease, environmental degradation, economic and social instability etc. Following the lead of the UN, other international organisations such as the International Monetary Fund (IMF) and the World Bank adopted the concept of human security in their policy frameworks. A number of governments soon followed suit and embraced the concept in defining their national security policies²⁷.

At the turn of the millennium a new impetus to the Botswana's HIV and AIDS response was noticed (interview, Chief Research Officer NACA, 7/3/08). While formulating the National Strategic Framework (2003-2009), in consultation with UNAIDS, the government included the initiative of mainstreaming HIV and AIDS into all of its Ministries' bureaucracies and all levels of decision-making structures. This was facilitated by the establishment of the Ministry of AIDS Coordinators (MACs), which acted as the focal point within the Ministries. At present, all Ministries have MACs, which are tasked to inform and educate about impact of the HIV and AIDS national response (NACA, 2008).

MACs were tasked to address the needs and vulnerabilities of the staff in the workplace in order to formulate internal policies and guidelines. These features were then in turn conveyed to civil servants in seminars and workshops organised by MACs. Secondly, they assessed the comparative advantages of a particular bureaucracy in adding to the coordinated national response to the epidemic. In other words, MACs are responsible for adapting the normal functions and business of the Ministries to meet the needs of the national multi-sectoral response to HIV and AIDS (interview, Chief Research Officer NACA, 7/3/08).

President Mogae launched the Strategic Framework for HIV and AIDS (2003-2009) in September 2002. This new and improved action plan represented the most inclusive and comprehensive HIV and AIDS strategy ever seen in Botswana. It incorporated the new international developments concerning the conceptualisation of the HIV and AIDS epidemic as an emergency threat, which is in line with the process of securitising an issue, where political authorities demonstrate that it as “an existential threat, requiring emergency measures and

²⁷ The human security agenda has been primarily associated with ‘middle-power’ countries as describe earlier.

justifying actions outside the normal bounds of political procedure” (Buzan et al., 1998:24). Mogae illustrated this more aggressive strategy in the foreword to the framework by stating: “Having declared HIV and AIDS a national emergency, this National Strategic Framework is my Government’s pronouncement on how we will continue to address this emergency [...] outlining an aggressive and determined response, this framework brings all the stakeholders together into the fight” (NACA, 2003). By choosing to securitise the issue Mogae fulfilled the speech-act and understood that placing “something on the security agenda persuades us of the need to furnish urgent and unprecedented responses; it signals imminent danger and is therefore given a high priority” (Wæver, 1995:63).

A vital component of the new framework was the much stronger emphasis on policies directed at providing anti-retroviral therapy. This deliberate change in policy can be attributed to the discovery and successful testing of a more efficient and less harmful combination of HIV and AIDS medicine. As a result, a plan was introduced to start a mass roll-out of Antiretroviral therapy (ART) to the public. Standard ART dosage consists of the combination of at least three antiretroviral (ARV) drugs to maximally suppress the HIV virus and stop the progression of the disease. This approach was encouraged by the US government and the international pharmaceutical companies, as it was in line with their securitisation ideals which were accepted and supported by the government of Botswana. This change in policy made Botswana one of the first African states to establish a plan, which aimed at providing ART to those infected. The possibility of the mass roll-out policy brought about a renewed impetus across all sectors of society in the fight against the epidemic.

5.9 Prevailing political culture in Botswana

During the latter part of the 1990s it became apparent that the Ministry of Health could not deal on its own with the cross-cutting nature of the disease. The election of President Festus Mogae in 1998 is a defining moment in Botswana’s national response policy to the HIV and AIDS epidemic. Mogae was very active in the National AIDS Council (NAC), which in turn breathed new life into the effort of the national response. Shortly after coming into power it became clear that Mogae was to be an important role player in the promotion of securitising the HIV and AIDS threat in Botswana.

Mogae successfully utilised the securitisation speech-act to address his audience by his use of security language and imagery when discussing the epidemic in public. Mogae's engagement in actively promoting the securitisation of the epidemic can be attributed to his acceptance of the ideas and the presence of transnational actors who helped to mould his policy decision-making. According to Vieira (2011:17), "in this respect, his sympathetic stance towards Western-based knowledge of the epidemic, coupled with the need for coherent policy prescriptions in a perceived situation of crisis, are crucial elements in explaining the successful securitisation of HIV and AIDS in Botswana".

Mogae was forceful in highlighting the epidemic as the most urgent threat facing Botswana by utilising speech-act. He was very vocal in stating that the epidemic had become a threat to the very survival of the Botswana nation. "Half, if not more of today's natural deaths are caused by AIDS [...] We stand at the crossroads of a threat to the annihilation of our nation"²⁸. According to Buzan et al., (1998:27),

It is important to note that the security speech-act is not defined by uttering the word *security*. What is essential is the designation of an existential threat requiring emergency action or special measures and the acceptance of that designation by a significant audience.

Mogae aptly coined the phrase *Ntwa e bolotse* (the war has started) to address the epidemic early on in his Presidency. Therefore, Mogae's proclamations were indicative that the speech-act would be part of the style and direction he would follow when describing the epidemic to his audience while in office. As discussed in chapter 2, in order to successfully frame something in terms of security, a securitising actor has to convince a significant audience that a specific issue constitutes an existential threat (Buzan et al., 1998:32). This was achieved through Mogae's continued use of the speech-act to convey his message across to the audience/population.

As a graduate in economics from Oxford University, Mogae joined the civil service in 1968 as a Planning Officer in the Ministry of Finance and Development Planning. He rose in quickly in the

²⁸ President Mogae in an interview with the BBC News on 07/11/2000

ranks to hold several senior positions in the government²⁹. In addition, Mogae headed several boards running key institutions such as the Bank of Botswana, Debswana and the Botswana Development Corporation. From 1976 to 1980 he worked for the IMF in Washington DC. As a result, Mogae's extensive involvement in the government and international agencies may be attributed to his closer links to international institutions than was the case with either Mbeki in South Africa or Mswati in Swaziland.

Mogae embraced the concept of securitising the epidemic at the same time as the concept was gaining acceptance internationally. This is illustrated when comparing a speech made by Mogae in 2000 with a UNAIDS assertion in 2000 about the impact of the epidemic in Botswana:

Let us as Africa take responsibility for ourselves and be true leaders in fighting the greatest threat to our development and security. Let us deal with the HIV/AIDS epidemic as an emergency and respond with measures that a crisis deserves. Let us divert resources from military expenditure to fighting the HIV/AIDS epidemic (Mogae, 2000).

The HIV/AIDS epidemic in Botswana is the deadliest emergency and the biggest social and economic crisis facing the country today. After three decades of sustained economic growth, HIV is threatening to wipe out hard won gains in social development" (UNAIDS, 2000:8).

Mogae's deliberate use of and strong emphasis of words such as "emergency", "threat" and "war" was in line with the decision taken by both the USA (Clinton administration) and the UN Security Council declaring HIV and AIDS a security threat in 2000³⁰. Waeber (1995:55) explains how such statements can work in securitisation: "By uttering 'security' a state representative moves a certain development into a specific area and thereby claims a special right to use whatever means are necessary to block it". Once an issue has been successfully securitised, there is a need for the institutionalisation of the security rhetoric. At this stage the security argument is sufficient, since the sense of urgency is implicit in the standards of behaviour, principles, policies and bureaucratic processes, established to tackle the problem. The securitisation is

²⁹ Mogae became Senior Planning Officer in 1971, Director of Economic Planning in 1972 and Permanent Secretary (PS) of the Ministry from 1975 and 1976.

³⁰ UN Security Council Resolution 1308 17July 2000

institutionalised only if the threat (either perceived or real) is resilient enough to demand that the bureaucratic procedures be put in place through the formulation and implementation of public policies to address the perceived threat. In the case of Botswana, the threat was indeed resilient enough to demand the bureaucratic procedures be implemented.

On occasion, when he felt it was necessary, Mogae adopted a more a unilateral leadership approach in his quest to securitise the epidemic. As the government works towards managing a threat, it seems only logical to redraw the lines legitimating the borders of politics and limiting civil and human rights. The state passes new laws, limitations and prohibitions, with which it limits the area of politics and widens that of security. For instance when establishing routine HIV testing in Botswana, at a time when this was not common practice in most African states, he made the controversial decision to simply ignore opposing views, which defended the confidentiality of tests. Additionally, he went as far as putting forward a more controversial proposal calling for compulsory HIV and AIDS testing for students who intended to apply for government scholarships. When questioned about this proposal, he stated, “I know it won’t be popular. But I think we are going to do it anyway” (quoted in the *Washington Times* 10/04/2004). Mogae’s actions in this instance should be analysed in the context of the situation. It is not reflective of his overall leadership style. This opinion was supported by several of the interviewees.

Several interviewees mentioned Mogae’s deliberate manner in making unilateral decisions when it was necessary, while at the same time agreeing that this was necessary in order to strengthen the efforts of the national response policy to combat the HIV and AIDS epidemic. According to an interviewee, “While we may have disagreed with some of his choices, the President was trying to help the fight against the disease” (interview, the Executive Director of BONEPWA, 6/03/08). “Mogae’s adoption of the US’s policy of opt-out was criticised for infringing on people’s human rights. However, at the time the virus was spreading unabated and tough choices had to be made” (interview, Senior Health Officer: SADC, 5/3/08).

BOTUSA/CDC was an influential actor in supporting Mogae’s 2003 decision to implement routine testing at all of Botswana’s VCT clinics. The opt-out approach which was favoured by the CDC replaced the opt-in approach. The CDC put pressure on the government to change its

policy and adopt the opt-out approach. This meant that pre-test counselling was stopped and that the patient was notified that an HIV test was to be conducted unless he or she chooses to refuse the test. This new policy meant that the patients found themselves in a semi-compulsory testing system.

ACHAP was also a keen supporter of the introduction of routine testing in Botswana. According to Whiteside (2008:112), this was important since “knowledge of one’s HIV and AIDS status and the normalisation of the epidemic are essential.” From the onset of *Masa*, a major obstacle has been the lack of ability to identify people who are HIV positive and in need of ARV treatment unless they consent. Mogae’s new policy approach allowed health workers the right to record the names of patients who had tested positive. This was not accepted without criticism from UNAIDS officials and human rights activists. Global HIV and AIDS activists saw it as an infringement of the rights of patients and PLWHA to confidentiality.

According to an interviewee, “The securitisation efforts of UNAIDS and UNDP were fairly successful as they were able to make it a priority concern for the government of Botswana by successfully raising it to the level of the President’s office” (telephone interview, Senior Officer AIDS Specialist UNDP Regional Service Centre JHB, 09/05/08). In 2000 Mogae publicly declared that the HIV and AIDS epidemic was a national emergency and the primary threat to human security in Botswana. Buzan et al., (1998:37-37) asserts that the “securitisation is only considered a success when the securitising actor is able to convince a significant audience that something constitutes a threat”. In the case of Botswana, Mogae was able to achieve this through his words and actions. As already demonstrated, Mogae played an instrumental role in leading the country’s HIV and AIDS efforts while he was chairperson of NACA and President of the country. Since the late 1990s the government has significantly increased funding for health and changed the existing policy to de-link the HIV and AIDS budget from the exclusive control of the Ministry of Health. This was done in order to ensure that funding could be released more efficiently to other sectors involved in the multi-sectoral national response (interview, Chief Research Officer NACA, 7/3/08).

In the case of Botswana, Mogae as the leader was identified by international securitising actors as an important actor. The manner in which he responded to the securitisation claim helped to determine the depth and the form of securitisation found in Botswana. Mogae’s leadership

characteristics coupled with Botswana's enabling political culture facilitated the acceptance of international securitisation actors' ideals. As shown, Mogae was able to successfully prioritise HIV and AIDS as an immediate threat. He was also able to mobilise institutions, acquire resources and make the citizens/audience aware of the negative impact of the epidemic.

In chapter 2, the three facilitating conditions necessary for a speech-act to be considered successful were discussed. Mogae complied with all three of the facilitating conditions required for the process of securitisation. He accepted and followed the recognised grammar of security. By virtue of his position as President of Botswana, as a securitising actor he was in a position of authority to pronounce on the security concerns and was able to raise the level of threat facing the population.

5.10 The USA's involvement as a key securitisation partner in Botswana

A key strategic bilateral partner in Botswana's response to the HIV and AIDS epidemic is the US government. When the US government entered the HIV and AIDS political landscape in Botswana, there was a subsequent shift in the status quo. Instead of adapting and conforming to the existing approach of multilateralism, the US government chose to introduce a more bilateral approach. This resulted in the US government developing its own policies and forming coalitions without always seeking support from the local government or multilateral agencies (interview, Senior Health Officer AIDS Expert SADC, 5/3/08). The choice to partner with the US government had less to do with ideological similarities and more to do with funding. According to an interviewee, "whoever pays for it that is the ideology you follow. It is that simple!" (interview, AIDS Expert, University of Johannesburg: 25/04/08).

The introduction of PEPFAR in 2003 saw a change in the relationship between the transnational actors and the government of Botswana. The programme brought about a new securitising actor onto the political landscape. Botswana was chosen as one of the 15 countries to benefit from PEPFAR. As a result, the US Embassy formed an interagency team comprising of BOTUSA, the US Embassy's Emergency Plan Team and USAID's Regional Centre for Southern Africa (RCSA), which was tasked with the planning and implementation of the programme in Botswana.

The most important partnership formed between the US government and the government of Botswana to deal with HIV and AIDS was the partnership between the Ministry of Health and the US Centres for Disease Control and Prevention (CDC), called the BOTUSA Project. BOTUSA's initial focus was to play a significant role in helping to extend the reach of Botswana's national TB response. With the onset of the HIV and AIDS epidemic, there was a change in focus as HIV and AIDS became a key part of its mandate from 2000. The partnership has seen BOTUSA providing training, technical assistance and the infusion of essential resources.

From 2000 BOTUSA started a phase of rapid growth brought on by the advent of the CDC's Global AIDS Programme to support prevention, treatment, care and surveillance of HIV and AIDS. The Clinton administration sought to further its own security agenda with respect to the HIV and AIDS epidemic, which had a major impact on BOTUSA's goals and its relationship with the government of Botswana. This began with William J. Clinton's Global HIV and AIDS initiative by considerably increasing funding to BOTUSA. It also did not restrict itself to only being concerned with HIV and AIDS research and financial support but also included more involvement in the formulation and implementation plans of BOTUSA. This took place at the same time as BOTUSA was rolling out a bold project called *Tebelopele* (look to the future) to develop Voluntary Counselling and Testing Centres (VCTs). These VCTs provide immediate and confidential VCT services to sexually active people aged between 18 and 49. Since 2000 the Government of Botswana and the CDC (through BOTUSA) have supported the *Tebelopele* network of VCT centres, which provide immediate, confidential VCT services for sexually active people in Botswana aged 18 to 49. By the end of 2009 the network had provided free VCT services to 650,000 visitors (NACA: Botswana - 2010 Country Progress Report).

With the formalisation of PEPFAR in 2003, and the inclusion of Botswana as one of the 15 focus countries, the US government increased its involvement in Botswana's national response from 2004. It did so by ensuring that the US Embassy took on a more central role in advancing the PEPFAR initiative. It formed an interagency team comprised of BOTUSA, the Embassy's Emergency Plan Team and the United States Agency for International Development (USAID) Regional HIV-AIDS Program (RHAP) for Southern Africa (which is based in Pretoria, South Africa.) They are both tasked with taking charge of the strategic planning and implementation of

PEPFAR in Botswana. The launch of PEPFAR in Botswana has resulted in much more funding being made available to HIV and AIDS initiatives. PEPFAR contributed approximately \$55 million to the HIV and AIDS programmes present in Botswana in 2006 alone (The Power of Partnerships: Third Annual Report to Congress on PEPFAR: 2007)³¹.

An interesting observation made while conducting the interviews was the manner in which criticism was levelled by the domestic and international stakeholders. For instance, criticism has been levelled at the US government for its ‘go-it-alone’ approach and their inability to be more amenable regarding HIV and AIDS policies between the US government and the multilateral partners. This sentiment was articulated by a BONEPWA official who referred to it as the “Donor-Recipient Relationship conflict in which the donor did not understand the local environment” (interview, Officer Project Development Worker BONEPWA, 6/03/08). This feeling was predominant amongst the domestic stakeholders interviewed. However, the international stakeholders interviewed expressed the opposite view. “The US has not put unnecessary pressure on any of its partners working in Botswana” (interview, Senior Programme Manager with the AED Centre on AIDS and Community Health, 5/3/08)³². Clearly, there remains some confusion as to the approaches adopted by certain international stakeholders and the way in which they are received by the domestic stakeholders.

In Botswana PEPFAR funding has been primarily directed at HIV-prevention programmes with a strong emphasis on abstinence and faithfulness projects more in line with the “AB” side of the “ABC” paradigm³³. It has lent its support to the Ministry of Education to help develop an abstinence-based curriculum in schools and supporting similar projects targeting vulnerable young people. This can be illustrated by the radio serial drama called *Makgabaneng* the main

³¹ As of September 30 2008 PEPFAR reports to have fulfilled its commitment to providing funding for support treatment for over 2 million people living with HIV and AIDS around the world. At the launch of PEPFAR in 2003, it was estimated that only about 50,000 people were receiving treatment for HIV and AIDS in Sub-Saharan Africa. President Bush stated on 1st December 2008 that PEPFAR currently supports treatment for more than 2 million people in Sub-Saharan Africa alone. The programme has been well supported. As of September 30 2008 nearly 9.7 million people affected by HIV and AIDS in PEPFAR’s 15 focus countries had received compassionate care, including nearly 4 million orphans and vulnerable children (<http://2006-2009.pepfar.gov/112351.htm>, accessed 26 August 2012).

³² The official interviewed was from an NGO funded by the US government.

³³ In the fiscal year 2005, of the US\$50 million budget was allocated to HIV and AIDS programmes in Botswana, the US government allocated US\$12 million to HIV prevention programmes (US Department of State, 2005).

sponsor being BOTUSA³⁴. In Botswana radio reaches the largest possible segment of the population and serves as an excellent way to transmit awareness information (Fantan, 2004). The radio programmes are based on the premise that the audience would tune into the show in order to learn more about HIV and AIDS and as a result would identify with the characters and (hopefully) imitate their behaviour. Prior to the introduction of PEPFAR to Botswana, the show carried a stronger message for sexually active young people to condomise. After the involvement of PEPFAR the show's producers have adapted dialogue and scenes, which tend to place more emphasis on "AB" and less on "C". *Makgabaneng's* managing editor, Maungo Mooki, has defended the script changes by stating the programme is a "behaviour change communication tool" rather than a serial drama or soap opera (Mooki 2004). It must be noted however, as stated by a senior SADC official that, "preaching abstinence is important but can only be taught to a sober-minded person. A disturbed person cannot be taught abstinence", (interview, Senior Health Officer AIDS Expert SADC, 5/3/08). When addressing behavioural change, it is necessary to consider cultural sensitivities to get the message across.

The relationship between the US government and the Botswana government has not been without controversy. There has been tension between PEPFAR and the Ministry of Health/ACHAP regarding the ownership of the national ARV treatment programme. The US government put forward their case that because it was actively involved in the Botswana government's national ARV programme regarding factors such as financing, training, skills transfer, they could make the claim that the rising number of patients on treatment in the country was the result of the success of PEPFAR. The Botswana government and its partners at ACHAP held a different point of view. They felt that the *Masa Programme* was their initiative because ACHAP was in charge of planning and managing the whole process as well as ensuring the everyday running of the clinics and staffing.

The tensions consequently threatened to fray the cordial relations between the two governments. This led to their entering into a dialogue to work out their differences. The government of Botswana made the US government understand that the policy decision-making processes had occurred prior to their and other donors' arrival in the country. The role of the donors was to fill in where gaps existed in the national response strategy. This understanding is beneficial to

³⁴ *Makgabaneng* means "we fall and we rise" or "rocky road".

current and future projects as it allows for sustainability and continuity. Hence, the hope is that even if the donors withdraw from the projects, the projects will continue operating. “It is imperative that ownership remains in the hands of Botswana” (interview, the Executive Director BONEPWA, 6/03/08). This is important for the continuity of future policy formulation and implementation processes for Botswana.

5.11 Conclusion

The chapter explored the effects of the reliance on multilateral and bilateral donor aid and highlighted the influence this had on the policy decision-making processes and its implementation. Among the central findings in this chapter are that unlike many other developing countries, Botswana has been less dependent on funding for their HIV and AIDS policy. In addition, as a result of historically amicable links with Western institutions Mogae’s administration adopted a securitisation view of HIV and AIDS that is in line with transnational actors such as the UN. Through declaring war (*Ntwa e bolotse*) on the HIV and AIDS epidemic, the issue was elevated to the level of the President’s office and directly to the centre of the policy decision-making structure. This is an example of a top-down approach to securitising the epidemic.

It was argued that Botswana’s elitist political and social structures helped external actors to gain access to the domestic policy decision-making process as a consequence of the political environment and a rather weak civil society. These factors helped to create the internal conditions for Botswana’s acceptance of international thinking on the HIV and AIDS epidemic. The government of Botswana’s approach to include development partners and international organisations in their policy implementation processes was beneficial for the policy decision-making processes, as skills and expertise were shared allowing more efficient reframing of policies to be formulated. It was also found that a closer working relationship between domestic NGOs and the government through the MTP II proved beneficial. This may be an element of constructivism as expressed in pluralist public policy theory. Consequently, it is fair to say that in Botswana the public policy process has elements of both elitism and pluralism.

Finally, the chapter examined the processes and dynamics around the securitisation of HIV and AIDS in Botswana. It was found that Mogae’s openness and acceptance of the securitisation

discourse pursued by influential securitising actors led to the successful securitisation of the HIV and AIDS epidemic in Botswana.

Chapter 6: Policy Issues, Processes and Framing around HIV and AIDS in South Africa

6.1 Introduction

According to a UNAIDS (2011) report, an estimated 5.6 million South Africans were living with HIV and AIDS in 2009, the highest number of people in any country of the world. In the same year, it was estimated that 310,000 South Africans died of AIDS-related causes, indicative of the huge number of lives that the country has lost to AIDS over the last three decades (UNAIDS 2010). South Africa experienced a difficult public policy formulation period dealing with the HIV and AIDS epidemic under the presidency and administration of Thabo Mbeki. His response to the threat of the HIV and AIDS epidemic, widely criticised, has become a permanent part of Mbeki's presidency and political legacy.

This chapter focuses on the framing of HIV and AIDS public policy and the processes and factors associated with it in South Africa. This helps to explain the way policy has been formulated and adopted, or the lack of policy formulation, as part of the national response policy to the HIV and AIDS epidemic in South Africa. The role of relevant stakeholders such as state, non-state domestic HIV and AIDS actors, and multilateral and bilateral agencies in attempting to influence the framing of policy and the decision-making processes is examined. This chapter also explores the national response to HIV and AIDS in South Africa in the light of three main theoretical approaches to public policy, namely pluralism, elitism and statism. Focussing on these theoretical perspectives can help explain the power dynamics between the actors and the way the HIV and AIDS policy was framed. Finally, the chapter examines the processes and dynamics around the securitisation of the HIV and AIDS epidemic in the country. It is argued that the prevailing political environment meant that transnational securitising actors had limited access to higher-ranking decision-making structures hence, limiting their persuasive influence to promote the securitisation approach.

The responsibility of certain transnational actors – notably the UN agencies and the US government – is analysed to ascertain the extent of their persuasion efforts as promoters of the securitisation discourse in the policy decision-making processes. It is argued that South Africa's political leadership, centred primarily on Mbeki, created an environment clouded in suspicion

towards foreign actors leading to the rejection of international role players and their ideas. The prevailing political climate was characterised by a tense working relationship between state and non-state actors. This tense working relationship impacted on the framing of policy processes impacting on the HIV and AIDS national response policy in South Africa. This tense power dynamic emerged because South Africa's political and social structures prevented external actors access to its domestic policy decision-making process. Another contributing factor was a strong civil society vastly experienced in political activism. This environment meant that little political space and access were available for non-state actors to exert much influence on the policymaking processes. It is also pointed out that as a result, domestic HIV and AIDS stakeholders had to resort to the judicial route to gain access to the policymaking structure in order to influence their policies.

The contention is that Mbeki, as a key securitising actor, focused on an elite of a few trusted individuals who were influential in the way that policy issues and problems were framed and how these issues were placed onto the national policy agenda. It is argued that Mbeki's reluctance to conform to the prevailing understanding of the HIV and AIDS epidemic resulted in the securitisation discourse pursued by influential international securitising actors having less influence on the policy-framing processes. This consequently led to a lesser degree of securitisation of the HIV and AIDS epidemic in South Africa.

The chapter starts by providing a brief overview of the dimensions of the HIV and AIDS epidemic in South Africa. It looks at different socio-economic characteristics of South Africa and how the HIV and AIDS epidemic has impacted on the country. This is followed by an overview of the policy responses to the epidemic. Here the early efforts to address the epidemic are discussed as well as the processes leading to a change in approach to the policy decision-making process. The third part of this chapter examines factors that influenced this policy decision-making process. The three main factors identified are: firstly, the political leadership under President Thabo Mbeki; secondly, international and domestic criticism of the South African government's policy approaches; and finally, the transnational actors. The next part of the chapter explores the role of the relevant stakeholders. The focus of this section is on examining the relationships and power dynamics between the domestic non-state actors, transnational actors and the South African government. The section following that deals with the securitisation

approach adopted in South Africa. It discusses the prevailing political culture in South Africa and also the US government as a key-securitising partner.

6.2 Dimensions of HIV and AIDS in South Africa

The HIV and AIDS epidemic spread faster in South Africa than in any other country in the world. Between 1990 and 2003 HIV prevalence in South Africa increased dramatically and the country fell by 35 places in the Human Development Index. The first recorded case of AIDS in South Africa was diagnosed in 1982³⁵. It is reported that there are an estimated 5.7 million people living with HIV in South Africa, with approximately 3.2 million women and 280,000 children (ages 0-14) (UNAIDS Fact Sheet, July 2008). According to the UNAIDS 2008 Report, South Africa is recorded as having the highest absolute number of people infected with HIV in any country in the world³⁶. HIV prevalence among women attending antenatal clinics was 29 per cent in 2006. Among adults (ages 15-49) HIV prevalence was 18.3 per cent in 2006. Additional evidence points to a significant decline in HIV prevalence among young people (below age 20), where prevalence was 13.7 per cent in 2006 compared to 15.9 per cent in 2005. There is significant variation in HIV prevalence by province, ranging from the highest at 39.1 per cent in KwaZulu-Natal to 15.1 per cent in Western Cape (UNAIDS Country Sheet, July 2008).

AIDS is one of the leading causes of death in contemporary South Africa. According to World Bank statistics, the average life expectancy in South Africa is about 51 years, whereas without the epidemic it is estimated that it would have been 64 years instead³⁷ (World Bank, South Africa Country Brief, April 2012). Hospitals are struggling to cope with the high number of HIV-related patients that they have to care for. In 2006 the Health Economics and HIV and AIDS Research Division (HEARD) of the University of KwaZulu-Natal estimated that HIV-positive patients would soon account for approximately 60-70 per cent of all medical expenditure in South African hospitals. AIDS patients generally tend to stay in hospital longer than other

³⁵ The first two cases of HIV and AIDS were brought to the public's attention after the death of two South African Airways (SAA) flight stewards: Ralph Kretzen and Charles Steyn who died on 26 August 1982 and 1 January 1983 respectively.

³⁶ Certain media sources have claimed that India may have surpassed South Africa in the total number of people infected with HIV. However, according to the UNAIDS 2008 Report, India is estimated to have only 2.4 million Indians living with HIV.

³⁷ According to Statistics South Africa, the life expectancy of South Africans has increased to 59.6 (57.7 for males and 61.4 years for females).

patients, because it takes them so much longer to recover from opportunistic diseases. According to the Human Science Research Council (HSRC) President Olive Shisana, “HIV-positive patients stay on average four times longer in hospital than non-HIV patients” (Palitza, 2006:1).

At the time when the first cases of HIV were being reported in the 1980s South Africa was embroiled in a mass state-sponsored violence against the resistance movements, which in turn created political instability and social disorder in the townships. This environment and created the ideal conditions whereby the disease could progress and spread relatively unabated (Whiteside and Sunter, 2000:62). South Africa’s transition from apartheid to a democratic dispensation was hailed globally as a ‘miracle’ and led to Archbishop Desmond Tutu coining the phrase the “Rainbow Nation”. However, the reality in South Africa since the mid-1990s has been that of a society that had been burdened by harsh dividing factors such as political violence, forced migration, racial exclusion and family strife. These factors helped contribute to the explosive growth of the HIV and AIDS epidemic experienced in South Africa (Fourie, 2005:85).

South Africa experienced a significant increase in HIV prevalence during the period between 1993 and 2000, during which time the government of the day was focusing on the major political changes playing themselves out in the political arena. After the transition from the apartheid regime to a fully democratic state, South Africa found itself in a political dilemma. In order to address the urgent political, economic and social inequalities, certain other areas were inadvertently overlooked. One important area was the health sector, where HIV was rapidly becoming more widespread. With hindsight, it is likely that adopting a sustained plan of action during this time could have reduced the severity of the epidemic (telephone interview, Senior Officer AIDS Specialist UNDP Regional Service Centre JHB, 09/05/08).

The first societal group affected by the disease was white male homosexuals. However, as the virus continued to spread unabated, it soon impacted on all societal groupings. Recent trends indicate that currently the HIV and AIDS epidemic is severely impacting on young heterosexual Africans and the economically disadvantaged in the population. Young females continue to bear the brunt of the epidemic as they continue to have the highest prevalence rates in the population. Because this group makes up a substantial percentage of the population, HIV and AIDS can potentially have a very serious impact on social development (Whiteside and Sunter, 2000:58).

Terreblanche (2002:44) agrees by noting that black South Africans were more vulnerable to HIV as a result of the legacy of apartheid. Terreblanche also notes the massive misdistribution of health and other resources, and adds that as long as “comprehensive, coordinated and effective policies for alleviating poverty and preventing AIDS are not implemented, poor health and AIDS will remain an important and ominous poverty trap leading to the further pauperisation of especially the poorer half of the population”.

Nelson Mandela’s government inherited a public health system with huge discrepancies. The healthcare facilities found in the former white urban areas were well equipped and modern. At the same time, the healthcare facilities intended for the black population, located mainly in rural areas, lacked both equipment and capable staff. This posed a significant challenge for the new government, as it had to ensure not only that healthcare facilities were coordinated and run in a uniform manner but that the healthcare facilities were accessible to all. This task proved difficult to remedy in the short term because of the sheer enormity. Another challenge for the new administration was disputes occurring between the newly appointed officials and the representatives from the former regime, which did not support the organisational change, leading to an extended period of bureaucratic semi-paralysis, which impacted negatively on the efficiency and availability of services in all public sectors (Strode and Grant, 2004).

6.3 Observable policy responses

6.3.1 Early efforts to address the epidemic

In response to the HIV and AIDS epidemic, the apartheid regime convened a conference to address the potential threat it posed for the country. Consequently, in 1987 AIDS was included in the official South African list of communicable diseases. In the same year the first black South African was diagnosed with AIDS (McNiel, 2012).

From the late 1980s South African health professionals and civil servants employed in public healthcare facilities became more aware of the threat posed by HIV and AIDS. At that point in time government intervention was particularly inconspicuous (Furlong and Ball, 2005). The political leadership at the time found that they had more urgent threats to deal with, namely the economic sanctions against the regime, the political isolation imposed by the international

community, the ever-present threat of hostility from the neighbouring state, widespread social unrest in the black townships and the guerrilla campaign promoted by the ANC (Furlong and Ball, 2005:131).

From 1987 onwards reports from the South African Medical Research Council pointed out that there was a significant rise in heterosexual transmission among the African mining population and other black communities. The apartheid regime had recognised and understood that the disease was a real public health threat to the black population as a whole. As a result of its racist policies, however, the regime did little to address the threat. Fourie (2005:142) sums this up by saying that “the ‘gay plague’ had become the ‘black death’ - an untimely addition to the greater National Party pathology of a ‘swart gevaar’ (black danger)”. At the same time certain influential voices among the ANC cadres accused the apartheid regime as well as Western governments of artificially producing the virus to decimate blacks (Fourie, 2005:96). PW Botha and his administration were focused on protecting and maintaining the apartheid system instead of prioritising a disease that seemed to affect mainly the African population.

From 1989 a change in the political landscape occurred. On the political front a change in the leadership of the National Party (NP) brought FW de Klerk to power. This ushered in the start of a more inclusive participatory political environment in the country, with the inclusion of the formerly banned liberation parties and their input and involvement in public policy debates. This shift in policy led to a milestone meeting in March 1990 between the NP regime and the ANC leaders meeting for the first time in order to discuss the effects and impact of HIV and AIDS in South Africa. Following this meeting, a joint request for funding and technical assistance was submitted to the WHO’s HIV and AIDS Global Programme (Furlong and Ball, 2005:132). A working relationship had already been established between the South African Department of Health and the WHO. They provided assistance by establishing eleven HIV and AIDS training, information and counselling centres (ATICCs) in South Africa. However, the NP regime continued with its discriminatory agenda in the way HIV and AIDS policies were implemented. According to Furlong and Ball (2005:133), the ATICCs were strategically located, “where they served almost exclusively whites; only in mid-1993 was one for Soweto approved”.

The first national antenatal survey was conducted in 1990 to test for HIV and the results showed that 0.8 per cent of pregnant women were HIV positive (Whiteside, 2003). The number of people

in South Africa living with HIV at this time was estimated to be between 74,000 and 120,000 people. Antenatal surveys have subsequently been carried out annually. The government's first significant response to HIV and AIDS came about through a consultative effort involving the ANC, the Department of Health, and a variety of representatives from civil society and the business sector (Fourie, 2005). The outcome of the consultative body was the establishment of a national body for all HIV and AIDS activities, the National AIDS Convention of South Africa (NACOSA), in 1992.

NACOSA was established to develop more comprehensive policies for dealing with HIV and AIDS. The NACOSA plan was endorsed by a wide range of social actors, namely religious groups, trade unions, civil society and the private sector (Vieira, 2006:224). The purpose of NACOSA was to bring together a wide range of actors from different sectors of society to develop a cohesive response to the crisis. This represented the first time that the main policy decision-makers in the South African HIV and AIDS arena assembled. AIDS organisations and activists celebrated the perceived commitment of the new government to tackling the disease (Fourie, 2005). The meeting that established NACOSA was succinctly described as “an unusual show of national unity at a time of complex and sensitive political negotiations, well before an election date for a democratically elected government had been decided” (Nattrass, 2004:42).

In August 1994 President Mandela³⁸ accepted “The National AIDS Plan for South Africa” launched by NACOSA. According to McNeil (2012:2), “the Plan focused on prevention of HIV through public education campaigns, reducing transmission of HIV through appropriate care, treatment and support for the infected, and mobilising local, provincial, national and international resources to combat HIV and AIDS”. An interviewee stated that at this point in time the government thought that the HIV and AIDS epidemic was still controllable and manageable (interview, Senior Researcher - AIDS Expert, the Centre for Conflict Resolution, 23/4/08). The Mandela administration showed a willingness to actively engage in efforts to manage the effects posed by the epidemic. It was clear that, unlike the previous regime, the new government acquired a more comprehensive knowledge of both the medical and socio-economic effects that HIV and AIDS could have for the South African population (Schneider, 1998:6). It

³⁸ While Mandela was an important actor in South Africa's early national HIV and AIDS response policies, his role falls outside of the timeframe of this thesis.

has been noted that reports released by the ANC indicated that they had detailed projections showing that the threat posed by the HIV and AIDS epidemic was a major concern to public health in the country (Butler, 2005:593).

The change in the political arena, coupled with the policy shift created a more favourable environment for a new policy direction to deal with the threat posed by the epidemic. The inclusion of all the different actors in the planning and deliberations phase led to the drafting of South Africa's first comprehensive public strategy on HIV and AIDS. This is in line with the constructivist thinking of the pluralist and elitist theories on public policy. The Cabinet officially adopted the National AIDS Plan (NAP) in October 1994. Following the adoption of the NAP, the Department of Health created a designated Directorate of HIV and AIDS and Sexually Transmitted Diseases. The NAP had identified the multi-dimensional impact of the epidemic and the need for a multi-sectoral partnership to be formed with the aim of creating a more effective response towards the epidemic.

With the support of the government and the wide range of HIV and AIDS stakeholders in place, the key objective was to try and contain the HIV prevalence level and to lower it over time. However, this commitment was not enough to stem the high HIV prevalence rates for women attending antenatal clinics. In 1994 the HIV prevalence rate was 7.6 per cent and, instead of decreasing or even stabilising, it spiralled out of control with an exponential increase of over 300 per cent to 24.5 per cent by the year 2000. According to Whiteside and Sunter (2000:119-20),

There were major flaws in the NACOSA plan - not in the contents, which are still valid today, but in the lack of attention to process and the failure to acknowledge the realities of the social, political and economic situation in South Africa at the time. In effect, there was no 'reality-check', a fundamental principle of good planning.

In an interview with the BBC in 2003 Mandela admitted that during the run up to the 1994 elections, "I wanted to win and I didn't talk about AIDS" and that once he was President he "had not time to concentrate on the issue" (*BBC News*, 02 March 2003).

6.4 Changes in the policy decision making environment

As the 1990s drew to a close, clear divisions between competing paradigms arose in the public policy debates on HIV and AIDS in South Africa. The NGO sector and some parts of the health establishment were more aligned to UNAIDS, while, the ANC leadership developed its own interpretations and policy recommendations for the epidemic.

In 1997, three years after the implementation of the NAP, it was clear that the necessary tools to contain the spread of the epidemic were lacking. Furthermore, there were no attempts to try to amend the Plan so that it could be more effective (telephone interview, Senior Officer AIDS Specialist UNDP Regional Service Centre JHB, 09/05/08). A national review of South Africa's HIV and AIDS response to the epidemic entitled *Review the Past, Plan the Future, Work Together*, was released in the same year. The review highlighted the need for the following:

- Political leadership and public commitment;
- Meaningful involvement of people living with HIV and AIDS in policy formulation;
- Responses to be interdepartmental and intersectoral;
- Widespread capacity building; and
- An urgent address of human rights abuses and the reduction of stigmatisation

(Department of Health 1997, *Review the Past, Plan the Future, Work Together*)

After the review the government implemented several important changes to address the problems of interdepartmental responsibility. An important decision taken was to elevate it to the office of the Deputy President who took over the responsibility for the strategy as a whole. Also, it was agreed to establish an Inter-Ministerial Committee (IMC) on HIV and AIDS. The IMC was tasked to facilitate better co-ordination between the departments and to strengthen their political commitment towards the epidemic. The first IMC was headed by then Deputy President Thabo Mbeki (*The Presidency*, press release, 1 December 2006).

In 2000 the government established the South African National AIDS Council (SANAC) to develop and oversee a multi-sectoral approach to the HIV and AIDS epidemic (Furlong and Ball, 2005:128). Establishing a single HIV and AIDS coordinating agency was in line with the UNAIDS approach set out in the second key principle of the "Three Ones". "One National AIDS

Coordinating Authority, with a broad-based multi-sectoral mandate” (UNAIDS, Fact Sheet 2004).

SANAC is the highest body that advises the government on various issues relating to HIV and AIDS. Its key functions include: advising the government on HIV and AIDS policy; mobilising resources for the implementation of AIDS programmes; monitoring the implementation of the Strategic Plan across all sectors of society; advocating for the effective involvement of sectors and organisations in implementing programmes and strategies, and recommending appropriate research. SANAC is assisted by the provincial AIDS Councils in the implementation and definition of AIDS programmes at district, municipality and community levels (SANAC website, accessed 27 September 2013). As noted by Strode and Grant (2004:14), “SANAC had to replace the AIDS Advisory Council, as it was not a multi-sectoral body and only made up of technical experts”.

SANAC is composed of the Deputy President, nine Executive Committee members³⁹ tasked to manage urgent matters and to oversee the implementation of HIV and AIDS programmes, and a plenary body of 33 members (16 from government and 17 from civil society) representing the different governmental departments, members of civil society and five technical task teams (SANAC website, accessed 27 September 2013)⁴⁰. SANAC was initially scheduled to convene on a monthly basis. However, in 2002 the members agreed that meetings would be held quarterly instead.

Even though SANAC’s inception was welcomed by all, and it had a far-reaching agenda, it was unable to fulfil expectations that it would become the leading HIV and AIDS institutional body in South Africa (Schneider, 1998). Since its inception SANAC meetings have been infrequent and irregular, which hindered the effective fulfilment of the body’s mandate as concerns to be addressed accumulated⁴¹. SANAC was described as “one of the most unproductive bodies of this kind in Southern Africa” (Vieira, 2006:227). A major criticism levelled was the fact that the

³⁹ According to SANAC website these comprise of five Cabinet Ministers, a member of the National Association of People Living with HIV/AIDS (NAPWA), a representative of the women’s sector of civil society, a representative from the hospital sector and a representative from COSATU.

⁴⁰ The technical task teams are comprised of experts in prevention; care and support; information, education, communication and social mobilisation; research, monitoring, surveillance and evaluation; and legal issues and human rights.

⁴¹ Strode and Grant (2004) note that in 2002 SANAC met only three times.

Department of Health was the sole agenda-setter for all SANAC meetings. According to Strode and Grant (2004:23), “the current structure has allowed the Department of Health to dominate SANAC. The SANAC’s Secretariat was placed within the Department of Health and they effectively set the agenda for all meetings; this meant that other sectors (namely members of civil society) were not given equal opportunity to place issues on the SANAC agenda”. This in turn prevented other SANAC members from including issues for discussions (Strode and Grant, 2004:23). This shows that the Department of Health sees its role within SANAC in line with elitist theories on public policymaking.

Strode and Grant (2004:23) elaborate by adding that “SANAC is not accountable to anyone; it does not report to any structure and its minutes and proceeding are kept confidential”. Also SANAC members were not full-time paid staff, since participation in SANAC was on a voluntary basis. This was undoubtedly a contributory factor affecting the commitment of members and their obligations to SANAC. Furthermore, the government showed signs of scepticism about mainstreaming knowledge about the epidemic, as SANAC excluded chief researchers and NGOs, the Medical Research Council and the Medicines’ Control Council (Butler, 2005:594). Finally, former Deputy President Jacob Zuma was appointed the first Chairperson of SANAC. Most interviewees were in agreement that he did not show the necessary leadership skills required, which resulted in several shortcomings under his tenure. One interviewee stated, “SANAC almost never met and there was a definite lack of civil society participation” (interview, Senior Manager, Centre for the Study of AIDS, 01/08/08).

According to the HIV/AIDS and Sexually Transmitted Infections (STI) Strategic Plan for South Africa 2007-2011, the shortcomings of SANAC had to be addressed. This resulted in SANAC undergoing major changes at the end of 2006. The newly empowered SANAC would operate on three levels by means of:

- A high level council, meeting twice per annum, chaired by the Deputy President;
- Sector level co-ordination – with sectors taking responsibility for their own organisation, strategic plans, programmes, monitoring and reporting to SANAC;
- Programme level organisation – led by the social cluster of the government; and
- SANAC would be allotted with a Monitoring and Evaluation Unit.

(HIV and AIDS and STI Strategic Plan for South Africa 2007-2011)

The new changes developed to strengthen the work and the position of SANAC, can be also attributed to the pressure and influence from non-state actors which helped to change the policymaking dynamics in South Africa. These changes resulted in the important change brought about by the new SANAC. This was done by investigating the roles of the principal policymaking actors and domestic and international policy-influencing actors in the national response policy present in South Africa. Also it highlighted the discursive processes that featured in shaping the policy-framing in the country that led to this important shift in policy.

6.5 Factors that influenced the policy making process

i) Political leadership

Thabo Mbeki's Presidency was marked by periods of stark conflict and periods of partnership with HIV and AIDS stakeholders (Heywood, 2004:3-4). During the period under review South Africa experienced a rapid increase in the number of new HIV infections. This section will examine the roles played by Mbeki and his Minister of Health Manto Tshabalala-Msimang in influencing the policy decision-making processes.

Frank Chikane⁴² writes about Mbeki's association with the HIV and AIDS epidemic in South Africa:

It loomed so large that some cannot see anything else that he did during his presidency. A mention of the name Mbeki anywhere in the world is associated with the HIV/AIDS matter, and many have no memory about HIV/AIDS before he fired that shot in October 1999. That was the moment which changed the whole discourse (*The Star*, 26 October 2010).

Much of the increased centralisation in the ruling party and in high-level policy institutions took place during Mbeki's presidency, which influenced the HIV and AIDS policy decision-making process (Vieira, 2006). This can be seen as following elitist theory on public policy, where the role players with access to the policymaking process are narrowed to a few influential actors. An example of this is that after the establishment of SANAC in 2000, the President moved the policy decision-making process from this structure to the office of the Presidency. Mbeki

⁴² Frank Chikane was the Director-General in the President's office 1999-2009.

motivated the creation of policy-planning clusters, each coordinated by the Presidency, “thus usurping the Cabinet’s ability to mobilise knowledge across government” (Butler, 2005:600). This move effectively removed all Cabinet’s responsibility to Parliament concerning HIV and AIDS planning and implementation programmes. Mbeki has been accused of the “appointment of unelected officials who are loyal to [him] but lack political weight and constituencies, [and this] has reduced internal debate over AIDS policies” (Patterson, 2006:36). In his understanding of the epidemic, Mbeki can therefore be said to view the epidemic “as posing an existential threat” thus “justifying the use of extraordinary measures” (Buzan et al. 1998:21).

Mbeki’s many years in exile influenced his leadership style, as he stands in contrast with the leaders of both the unions and the civil society bodies who remained in South Africa and engaged in the domestic liberation struggle (*The Telegraph*, 20 September 2000). Apartheid agents repeatedly attempted to penetrate and infiltrate the exile movement. The hierarchical military discipline required for an exile guerrilla movement meant that policy decision-making was only focused only on a few trusted individuals (Patterson, 2006:36).

Steven Friedman (2004:239) contends that the exiles’ rise to power in 1999 has coincided with the “diminution of democratic practice within the ANC”. In terms of public policy theory, this strengthened the position of the elite few. Several of Mbeki’s closest allies are from his time spent together in exile. In 2005, out of the 30 cabinet ministers, 17 had spent time together in exile. One such ally was the Minister of Health, Manto Tshabalala-Msimang who had been a loyal supporter of Mbeki since they both went into exile in 1962. She was an ardent supporter and defender of Mbeki. She challenged donors who questioned South Africa’s ARV policies and echoed the assertion that ARVs are toxic, and she clashed with civil society organisations on many occasions (Patterson, 2006:39). According to an AIDS expert, “her unwavering support for Mbeki must be the reason for her reappointment as Minister in 2004 despite her unpopularity” (telephone interview, Senior Officer AIDS Specialist UNDP Regional Service Centre JHB, 09/05/08).

The creation of the Presidential Advisory Panel was justified as a means to learn more about the unique nature of the HIV and AIDS strain found in Africa. This opinion influenced Mbeki’s speeches. which were indicative of his struggle with the complexity of HIV and AIDS and its

relationship to poverty. Mbeki's critics were not convinced by the scientific rationale for the creation of such a panel. According to Natrass (2004:49-50) the appointment of the Panel

made it impossible to follow scientific principles in adjudicating between rival theories. By giving dissident websites equal status with the Medical Controls Council (MCC), South Africa's political leadership propelled AIDS policy making into a scientific dark age. Under these conditions, 'true statements' could not be established and, in the end, policymaking was determined by power. Initially, that power vested entirely with the state president.

On 3 April 2000 Mbeki wrote a controversial five page letter addressed to world leaders asserting his views on the HIV and AIDS issue. He stated that

Not long ago, in our country people were killed because the established authority believed that their views were dangerous and discredited. We are asked now to do precisely the same thing that the racist Apartheid tyranny we opposed did, because, it is said there exists a scientific view that is supported by the majority, against which dissent is prohibited (Mbeki, 2000).

The manner in which Mbeki encouraged and defended AIDS denialism has been widely examined. Mbeki has not expressly or publicly ever denied a link between HIV and AIDS, but he did not publicly affirm that HIV does in fact cause AIDS. According to Heywood (2004:7), "Instead, he has left a paper trail of his questions about HIV and hints about his sympathies with the denialists, the impact of which can be traced through what was not done by his government as well as what was questioned and resisted". According to Whiteside (2008:88-89), Mbeki's denialist sympathies can be explained by several factors, including the social stigma surrounding the origins of HIV and AIDS and sexuality, and the fact that the early messages about HIV and AIDS came from the apartheid government, which was known to use scientific explanations to further its racial theories⁴³.

Mbeki's message was a cause of confusion that resulted in the slow and at times confusing framing of policy responses adopted by his administration. According to Statistics South Africa, death certification shows more than 1,5 million deaths between the ages 0-49 and more than 2

⁴³ For the more detailed list refer to Whiteside, "HIV/AIDS A Very Short Introduction" (2008:88-89).

million new infections occurred under Mbeki's leadership. Furthermore, as a direct consequence life expectancy was dropping every year Mbeki was in office (*Mail and Guardian*, 27 September 2008).

Mbeki's personal views influenced the manner in which his government addressed the epidemic. This resulted in various government representatives arguing that deep-rooted social problems such as poverty and exclusion led to the immunodeficiency experienced by many black South Africans instead of HIV and AIDS. According to Vieira (2006:228), "the government's questioning of the efficiency of AIDS drugs also fundamentally impacted the collective imagery of South Africans". In each of the case studies, leadership figures are very important, therefore, Mbeki's and his Minister of Health's views regarding ARVs greatly influenced the population's reasoning about whether they should take the drugs or not.

By questioning the scientific knowledge pertaining to the epidemic, this helped to reinforce scepticism and denial, which prevented the necessary behavioural change needed in South African society, which negatively impacted on policy responses. The sending of mixed signals was very confusing to both government structures as well as the South African public at large. The South African government believed that HIV and AIDS was a side effect of decades of exploitation, underdevelopment and racism. Whereas, this contrasted with the securitisation emphasis of the international securitising actors, asserting that there would be very little that the South African government could do in the short-term to fight it. The solution to the AIDS problem rested in the formulation of long-term policies addressing social ills such as poverty, malnutrition, and poor socioeconomic conditions.

Mbeki's stance to remove or lessen the sense of urgency, which was strongly advised and promoted by international securitising actors led to the confusion and hampered the government response policies. According to Vieira (2006:237), "Mbeki decided to fight two powerful adversaries at the same time: the epidemic itself and the international and domestic actors promoting its securitisation"⁴⁴. To accurately pin down Mbeki's position is rather difficult because one is not certain if he is actually using the denialist approach, in order, to legitimise his

⁴⁴ Mbeki demonstrated this behavior in March 2001, in spite of strong international pressure; Mbeki rejected appeals to declare HIV and AIDS a national emergency. Also, later in September, the South African government blocked the publication of a report from the Medical Research Council, which stated that AIDS was the leading cause of death in South Africa (Copson, 2004:4).

opinion and challenge the international community or even if he truly believed that HIV and AIDS are separate issues. However, what must be noted is the impact of decision-makers' ideas and deep-rooted values in shaping South Africa's understandings and responses to the HIV and AIDS epidemic. By fully understanding both the political and ideological environment wherein the epidemic took hold in South Africa, will help to understand how the interpretations of and the responses towards the epidemic were influenced by this prevailing environment.

ii) Domestic and international criticism of the South Africa government's policy approaches

From April 2002 in the wake of vociferous international and local criticism, Mbeki made the decision to distance himself from the AIDS denialists. Mbeki instructed Tshabalala-Msimang to write letters to the denialists instructing them not to use his name when signing letters or documents. Several denialists had signed "Member of President Mbeki's AIDS Advisory Panel" in dissident literature (Vieira, 2006). The South African government released a report which stated that Mbeki "will refrain from expressing his personal views in public and will instead reiterate the official position when questioned on AIDS" (Makhanya, 21 April 2002).

Later in 2002 the South African High Court passed a judgement that ordered the government to make the drug Nevirapine available to pregnant women to help prevent mother-to-child transmission of HIV. Despite international drug companies offering free or cheap antiretroviral drugs, the government was hesitant to accept the free drugs to provide treatment for people living with HIV (interview, Senior Manager, Centre for the Study of AIDS, 01/08/08). In November 2003 the government approved a plan to make antiretroviral treatment publicly available. Cabinet approved an ambitious antiretroviral treatment roll-out to an estimated 53,000 people by the end of March 2005. The judgement passed by the court was a result of a lawsuit filed by a local NGO, the Treatment Action Campaign (TAC), against the Minister of Health and nine Provincial Health MECs. Zackie Achmat the founder and chairperson of the TAC, explained the reasons the TAC took the government to court in 2001:

Our government has ignored science, economics, morality, good planning, good governance and the law for more than five years on this issue. We've organised,

marched, presented petitions and government has ignored every decent plea for them to do something. That's why we've taken this step. (Achmat, 22 August 2001).

Following the decision by the government to provide ARV therapy to people living with HIV, Tshabalala-Msimang began advocating for the promotion of alternative methods for the prevention and treatment of HIV and AIDS such as eating garlic, lemon and beetroot. During the 2006 International AIDS Conference held in Toronto, Canada, Tshabala-Msimang opened the South African exhibition stall by displaying vegetables such as beetroot and garlic. She intended to promote natural remedies in the treatment of AIDS, but this backfired and generated a flurry of negative criticism of South Africa's national HIV and AIDS response policy. Criticism of the government's response to AIDS heightened, with UN Special Envoy Stephen Lewis attacking the government as being "obtuse and negligent" at the Conference (interview with Fox, 18 August 2006).

This very public attack by Lewis on the South African government in addition to a combination of factors, already listed, influenced the shift in policy change towards the national HIV and AIDS response. The public rebuke of the South African government expedited the government's announcement of a draft framework to tackle HIV and AIDS and it pledged to improve antiretroviral drug access. Civil society groups were optimistic about this change in policy and are of the opinion that this marked a turning point in the government's response (interview, Senior Researcher AIDS Expert, the Centre for Conflict Resolution, 23/4/08).

While the South African government's defensive attitude seemed to ease slightly, it still remained reluctant to accept international guidelines agreed by national governments at multilateral forums of negotiations. For example, in 2006 at the UN High Level Meeting on HIV/AIDS, "South African diplomacy worked hard to reverse the UNGASS Declaration of 2001 with regards to the goal of universal access to treatment" (Vieira, 2006:230). While at the same time the government also lobbied against the proposal of setting clear targets for national governments in the areas of prevention, care and treatment (Vieira, 2006:230). These actions were indicative of the confrontational mentalities, which guided the policy preferences of the principle decision-makers in the South African government at that time regarding HIV and AIDS.

By the end of March 2006 there were 134,473 people accessing the government's ART programme of HIV-suppressing drugs, with an estimated additional 80,000 people receiving ARTs through private medical treatment and the non-governmental sector. Since 2006 the Health Ministry has led the country's extensive antiretroviral (ARV) roll-out programme. According to statistics from 2008, there were more than 480,000 people receiving ARTs, making South Africa's programme one of the biggest in the world (Henry J. Kaiser Family Foundation, October 2008).

In response to the public relations disaster created by Tshabalala-Msimang at the International AIDS Conference in Toronto, Former Deputy President Phumzile Mlambo-Ngcuka became the new chair of SANAC replacing Zuma - much to the relief of civil society as, according to one interviewee, Zuma's lifestyle choices had negatively impacted on the office (telephone interview, AIDS Expert, HEARD (University of Durban), 9/5/08). After assuming the chair of SANAC, Mlambo-Ngcuka stated that measures would be implemented to strengthen it and to mend relations with NGOs working in the field. This "underscored the need to take concrete steps to mend relations and raise the level of interaction between government and stakeholder groupings" (SA Government press release, 18 September 2006). The shift in policy-framing was the foundation necessary to establish better working relations between the state and non-state actors. From the perspective of the non-state sector, this heralded a new era in the South African government's national HIV and AIDS response (telephone interview, Senior Officer AIDS Specialist UNDP Regional Service Centre JHB, 09/05/08).

In March 2007 the South African government proposed a five-year plan that aimed to reduce the number of new HIV cases in the country by 50 per cent by 2011, and to provide at least 80 per cent of HIV-positive people with access to antiretroviral treatment (South African government press release 2007). The plan was presented at a two-day conference held in Gauteng. Several of the interviewees believed that the conference was successful, as it created a platform to bring together a wide range of influential HIV and AIDS stakeholders from various fields such as politics, business and HIV and AIDS advocates to debate methods needed to implement the Plan (South African government press release 2007).

To achieve its targets, the Plan stressed the importance of empowering women, the need to encourage people to test regularly for HIV and to increase efforts to promote behaviour change among the country's youth. This proposal was unanimously approved by Cabinet two months later. South Africa's new AIDS Plan was praised by UNAIDS Executive Director Dr Peter Piot, who stated that South Africa was well placed to lead Africa into a new phase in responding to the disease. According to Piot, "Failure to reach the ambitious, but necessary goals would be a collective failure on all our parts. You have a better chance than any other country in the region to deliver on AIDS. If you can't, who can?" (UNAIDS, 6 June 2007).

In January 2008 following many years of uncertainty and negative criticism, the Policy Committee of the National Health Council adopted new guidelines for the Prevention of Mother to Child Transmission (PMTCT). At the heart of the new policy is the addition of a second antiretroviral drug, AZT, for pregnant women with HIV and their babies, to complement the current treatment of Nevirapine only. This addition of AZT demonstrated that the criticism was an influencing factor which led to a significant change in policy formulation and implementation by the government as both of these drugs were a source of great tension between the government and non-state stakeholders.

Finally, at the 2008 International AIDS Conference in Mexico City, Mexico it was clear that South Africa was a much-changed participant. All the previous negative criticism had forced the country to reframe policies and launch a new reframed National Strategic Plan (NSP) and a revamped National AIDS Council. South Africa was also given credited for the adoption of new Prevention of Mother to Child Transmission guidelines. These enabled pregnant mothers in South Africa to receive improved dual therapy, which it hoped would save future lives. The Deputy Head of SANAC, Mark Heywood, captured the mood by declaring that, "compared to Toronto, we are in a completely different political environment around AIDS" (*Mail and Guardian*, 7 August 2008). The positive outcome of the 2008 International AIDS Conference may suggest that South Africa was losing its image as the world's AIDS pariah (interview, Senior Manager AIDS Expert, Centre for the Study of AIDS, 01/08/08). This demonstrates how as a response to the criticism the South African government reframed its narrow elitist approach to public policy-framing.

iii) Transnational actors

As was common for Southern African states, South Africa initially accepted the international guidelines for action, which prescribed a variety of HIV and AIDS policies, strategies and the development of specific institutions to deal with the epidemic (Johnson, 2004:108). The UNAIDS has been very influential in introducing certain institutional innovations relating to the way in which the South African government manages its relationship with its international partners. This can best be illustrated by the government's approach to the "Three Ones" principles, when the Department of Health established a Donor Communication Forum (DCF) in 2000. This forum is tasked with coordinating activities to ensure avoiding duplication of programmes by donors, multilateral agencies and NGOs. This has been beneficial to the South African government as it has created a communication link between government and international partners, which enables a better developed and more synchronised response to the epidemic (telephone interview, Senior Officer AIDS Specialist UNDP Regional Service Centre JHB, 09/05/08). In addition, by means of funding from UNDP and the local AIDS Theme Group, the Department of Health has been able to develop a useful database (Donor Matrix) aimed at monitoring donors' financial commitment to HIV and AIDS response in South Africa (Ndlovu, 2005:1).

After earlier difficulties in the working relationship between the South African government and transnational actors such as UNAIDS, the relationship gradually improved. This was demonstrated in 2007, when a joint UN Team on AIDS was consolidated as a common platform for the coordination and delivery of technical assistance to the HIV and AIDS national response. Through the team, the UN collectively supported the development of the National Strategic Plan 2007-2011 (NSP), the costing and a Monitoring and Evaluation (M&E) Framework.

Also UNAIDS took a leading role in several activities in partnership with the South African government, namely,

- i) Serving in the national task teams for the development of the NSP and the Monitoring and Evaluation Framework;
- ii) Part of the writing team of the NSP, in collaboration with the Department for International Development (DFID);

- iii) Supported the national AIDS council to prepare the national report to UNGASS for 2008;
- iv) Supported the Department of Health in the analysis of data for the 2006 ANC survey and preparation of the 2007 survey.

According to Vieira (2006:243), the relationship between the government and the transnational actors regarding the HIV and AIDS programmes is based on a kind of “cautious cooperation”. This is to say that there are well-established bilateral and multilateral means of resource allocation and technical assistance among organisations such as the DIFD, UNICEF, Global Fund, UNAIDS, UNDP, USAID/PEPFAR and others. There remains a high reliance on public sector funding for the South African HIV and AIDS response, which resulted in strengthening the government’s own domestic policies at the expense of the agenda of international donors (Vieira, 2006). South Africa receives only about 40 per cent of HIV and AIDS funding from donors. The South African government has been significantly increasing its share of funds allocated for HIV and AIDS programmes since 2000, which resulted in lesser dependence on donor funding (Ndlovu, 2005). According to Cloete (2000), many developing world countries find themselves trapped in a cycle of international debt. This in turn does not only reduce the decision-making autonomy of the developing countries’ governments, but also makes them more vulnerable to policy prescriptions from international aid agencies. However, because of South Africa’s relative economic strength this was not the case. This is important, as it influenced the power dynamics between the South African government and international donors in South Africa’s favour.

During the interviews an important thread emerged regarding the institutional relationship between transnational donors and the South African government. Most of their interaction seemed confined to the lower ranks of political authority and there was very little, if any, contact with top-level decision-makers. For example, a senior officer at the UNDP stated that while they had interaction and collaborative activities with the South African Department of Health, they have experienced difficulty in making contact with higher-ranking decision-makers (telephone interview, Senior Officer AIDS Specialist UNDP Regional Service Centre JHB, 09/05/08). This is a consequence of Mbeki’s narrow elitist approach to public policy framing, protecting his political elite from external influence. As a result, transnational actors had to find alternative

means to introduce their ideas into the South African domestic policymaking structure and tilt the power dynamics in their favour. They chose to link up with like-minded domestic actors such as some provincial governments⁴⁵ and opposition members in the national parliament. They also utilised the judicial route by supporting local NGOs taking the government to court as was in the case of TAC.

6.6 Role of relevant stakeholders

By the end of the 1990s a change was noticeable in the working relations between the state and non-state actors, which meant that the non-state actors' involvement in HIV and AIDS policymaking had decreased (telephone interview, AIDS Expert, HEARD (University of Durban), 9/5/08). Reasons for the strained relations experienced between state and non-state actors are wide-ranging. After 1994 there was a major influx of former civil society activists taking up positions in the government, or who forged formal alliances with it (interview, Senior Researcher AIDS Expert, the Centre for Conflict Resolution, 23/4/08). The growing authoritarian tendencies of the South African government, under the leadership of Mbeki, led to a very low tolerance of policy positions contrary to those of the government (Johnson, 2002:222). Also within the government, the decisions taken about the AIDS policy were carried out on a political level removed from bureaucrats and top civil servants (Johnson, 2004:121).

6.6.1 Politics and differing priorities - political space for domestic non-state actors in South Africa

Prior to 1994 the ANC had started working closely with the first few NGOs involved in the HIV and AIDS field. The leading NGOs at the time were the AIDS Consortium (a membership-based organisation bringing together a network of over 1,000 AIDS service organisations), the AIDS Law Project, the National Progressive Primary Health Care Network (NPPHCN) and the National Association of People Living with AIDS (NAPWA). These organisations were at the forefront in responding to the epidemic, choosing to focus their response policies on human rights, non-discrimination and dignity concerns. The good working relations between the NGOs and the ANC allowed many successful initiatives to be launched, such as the Charter on HIV and AIDS and Human Rights (1992), later endorsed by the first ANC administration, and a Code of

⁴⁵ This point will be elaborated on later in the chapter.

Good Conduct on HIV/AIDS in the Workplace. This was turned into policy during Mandela's Presidency (Heywood, 2004:2).

It is surprising that a country such as South Africa with such a long history of mass mobilisation was slow in creating a mass social movement against HIV and AIDS. A senior AIDS expert from the UNDP expressed his views on the lack of a mass social movement against HIV and AIDS. According to this interviewee,

I cannot understand why there are not more riots and marching against the government's action taken over the disease as currently being seen and experienced in Africa and the rest of the world against the high food prices. Even an extremely militarised environment like Somalia, people rioted against the increase in food prices (telephone interview, Senior Officer AIDS Specialist UNDP Regional Service Centre JHB, 09/05/08).

He argued that South Africa had shown great capacity to organise itself to fight an enemy. Under the apartheid system people were able to organise themselves in an environment where there was no democracy and they could not talk to one another openly. However, in a democratic South Africa there seems to be a lack of agreement by relevant actors on the HIV and AIDS epidemic. "I don't see this level of social mobilisation in the case of HIV and AIDS in spite of the impact it has on both the individual and community level (telephone interview, Senior Officer AIDS Specialist UNDP Regional Service Centre JHB, 09/05/08).

By the end of the 1990s, NGO involvement in HIV and AIDS policymaking had started to steadily decline⁴⁶. There are many non-state organisations specialising in the HIV and AIDS field in South Africa⁴⁷. They were active in monitoring the government's implementation of policies as well as being securitising actors with regards to the politics of HIV and AIDS in South Africa. This thesis narrows its focus on the analysis of organisations concerned primarily with issues pertaining to lobbying and advocacy while also ensuring that people living with HIV and AIDS have their rights protected and that the government upholds its constitutional obligations in providing health care and social assistance to them. As a result, three organisations

⁴⁶ The reasons for this deterioration in the exchanges between the state and non-state actors were varied and complex and it not the aim of this thesis to discuss them in detail.

⁴⁷ According to the AIDS Consortium, it operates as a membership-based organisation that brings together a network of over 1000 Community Based Organisations and individuals, locally, nationally and internationally.

were identified as particularly influential in fighting for the rights of people living with HIV and AIDS. They acted as an alternative voice outside of the state's spheres of decision-making, namely National Association of people living with HIV and AIDS (NAPWA), The AIDS Consortium, The AIDS Law Project and its further upshot, the Treatment Action Campaign (TAC). The TAC has assumed the domestic leadership and gained international recognition for its work. For this reason, the rest of this section will focus on the important role played by the TAC in influencing South Africa's policy decision-making process.

The TAC was formed in 1998, with the objective of "campaign[ing] for greater access to treatment for all South Africans by raising public awareness and understanding about issues surrounding the availability, affordability and use of HIV treatments" (TAC website, accessed 20 September 2013). The TAC became the largest HIV and AIDS actor in South Africa. Heywood (2004:13) believes this is because it is the only organisation that was prepared to robustly and unapologetically challenge AIDS denialism, which resulted in souring relations between the TAC and the government and consequently further decreasing the TAC's influence on the policymaking process. However, the TAC has been relatively successful in utilising both mobilisation campaigns and the legal system in order to further its cause. It has also been successful in being able to embrace international discourses of human rights and human security as a means to gain national and international support for its cause (interview, AIDS Expert, University of Johannesburg (UJ), 25/04/08).

Heywood (2004) believes that the actions of the TAC may have encouraged Mandela to start demanding that the government lead a proper response to the HIV and AIDS epidemic. In July 2000, in his closing speech at the 13th International AIDS Conference in Durban, South Africa, Mandela, while not coming out in direct opposition to Mbeki, for the first time questioned the actions of his successor. Speaking on behalf of "the ordinary people of the continent and the world – and particularly the poor who, on our continent, will again carry a disproportionate burden of this scourge" he requested "that we proceed to address the needs and concerns of those suffering and dying. And this can only be done in partnership" (Conference Media Release 2000).

6.7 Policy power dynamics – engagement between the state and domestic actors

In 1998 Mbeki defended his Minister of Health's decision to stop providing Zidovudine (AZT) to HIV-positive pregnant women. By the end of the 1990s Mbeki and Tshabalala-Msimang claimed that the drugs were toxic and questioned the motives of the manufacturers. Mbeki chose not to address his critics, but instead went on the offensive and labelled them "sell-outs" to Western drug companies. He claimed that the drug companies were financing the TAC, who had demanded ARV access in order to create demand for the companies' products (*The Star*, 31 January, 2000). Mbeki also chose to accuse the US Central Intelligence Agency (CIA) of promoting the view that HIV causes AIDS with the intention that African countries would purchase US produced ARVs (*Agence France-Press*, 6 October, 2000).

The TAC challenged the government in various ways, most notably the already mentioned lawsuits and the 2003 campaign for ARVs. They also successfully used civil disobedience, for example, illegally smuggling in generic ARVs for its own pilot treatment programmes. The TAC has been able to use the media for its own benefit. The confrontational strategies were effective partly because the TAC was able to set the media agenda by issuing timely press releases containing medical arguments for ARVs and it referred journalists to scientific experts for comments. By utilising these tactics, the TAC acted as a knowledge broker, thereby challenging the role of the government as the centre of policy expertise (Mbali, 2005:45). Most of the interviewees agreed that the policies used by the TAC helped to further their cause at the expense of the government's image in dealing with the HIV and AIDS epidemic.

The relationship between the TAC and the government experienced extreme highs and lows. Although initially excluded from SANAC, the TAC managed through their efforts to garner support from several council members by 2004. This show of support proved useful, as it led to several TAC members being consulted and included in the task team established to study the financial costs of the ARV roll-out in 2002. The TAC understood that in order to achieve their aim of treatment, they had to work in conjunction with the government, because without them the ARV roll-out would not work sufficiently (telephone interview, AIDS Expert, HEARD (University of Durban), 9/5/08).

After the initial tensions between the state and non-state domestic actors, a welcome thawing in relations occurred. The appointment of Mark Heywood in 2007 as the first deputy chair for SANAC was a key sign of the change, as Heywood came from the civil society sector. World AIDS Day 2008 proved to cemented the unprecedented show of unity between the South African government and the domestic non-state actors and the international AIDS community coming together to combat the HIV and AIDS epidemic collectively for the first time (UNAIDS, 2008). An insight offered during the interview process regarding the state-non-state power dynamic in the HIV and AIDS activist community, is the need for a balanced approach (telephone interview, AIDS Expert, HEARD (University of Durban), 9/5/08). Following this logic, the policy-framing process should be open to both state and non-state actors, allowing for a more constructivist approach to public policymaking and moving away from the narrower elitist approach that had prevailed in South Africa.

6.8 Politics and differing priorities - political space for international non-state actors in South Africa

During the apartheid period South Africa was excluded from the WHO and did not participate in the intensive HIV and AIDS planning in the mid-1980s (Iliffe, 2006:72). This changed in 1990, when the NP regime and the ANC leadership jointly requested the WHO's assistance. This joint call for assistance led to the international organisation's entry into the South African HIV and AIDS arena and enabled them to take a more proactive role. This move was very much in line with the changing political changes taking place South Africa at the time.

When Mandela came to power, the WHO's Global Programme on AIDS (GPA) was already engaged in sending technical support personnel to help in the implementation of NAP. This was the beginning of a more consultative and participatory decision-making process, which led many to believe that all domestic and international HIV and AIDS stakeholders would work together in a constructivist response to the epidemic.

At the same time, as already discussed in chapter 4, on the international front there was the securitisation move that led to the creation of UNAIDS in 1996. UNAIDS has become a key securitising actor by promoting and furthering the current predominant view that link HIV and AIDS and security. This resulted in the international community advocating for countries to

adopt a multi-sectoral approach towards the epidemic, which was to be coordinated by a single body placed at the top of the national policymaking structure. The government was in support of this new policy and looked to be moving towards its implementation (Johnson, 2004:108). As to be expected, in the early stages of the NAP the lack of locally trained personnel created a situation in which foreign experts especially from the WHO and UNAIDS, became influential advisors to the government. Even though the environment may have been sufficiently accommodating to allow international actors access to South Africa, the reality of the day was that South Africa was undergoing a political transition. This meant that the international agencies, including UNAIDS, were confronted with a state bureaucracy undergoing a process of extensive restructuring.

As of 2000 the institutional format for coordinated action amongst international development agencies, multilateral bodies, donor states and the South African government was set out in the “The Three One’s” framework. SANAC was the coordinating authority in the country in addition to being South Africa’s Country Coordinating Mechanism (CCM) to the Global Fund. In April 2002 the Global Fund authorised a grant of \$72 million to be used over two years on programmes covering HIV and AIDS and tuberculosis. Due to the high HIV prevalence in KwaZulu-Natal it was decided that this province would be the first beneficiary (Baleta, 2002).

However by June 2002 the relationship between the government and the multilateral organisations had become more strained. The government had attempted to stop the Global Fund’s grant to KwaZulu-Natal, accusing the province of bypassing the national government when submitting its application. The Minister of Health claimed that the proper procedure to be followed was for the issue to have been discussed at SANAC before being submitted to the Global Fund. In response, the Kwazulu-Natal provincial government replied that the reason they applied directly to the Global Fund was because the government still had to establish a CCM at the time of the application⁴⁸. A year later, after continued strained working relations, a final agreement was reached between the South African government and the Global Fund in August 2003 (Ndlovu, 2005:12-13). The issue was finally settled after the Global Fund agreed that the National Treasury would act as the main recipient of the money and that SANAC would coordinate the implementation proposals.

⁴⁸ A month later in July 2002, SANC was chosen as South Africa’s CCM to the Global Fund.

The US government has been an important development partner for South Africa as far as the HIV and AIDS epidemic is concerned. USAID is the largest bilateral donor and second largest overall donor in South Africa after the European Union, which works in the areas of HIV and AIDS, capacity building, civil society, governance and environment (USAID Country Fact Sheet 2006). Through USAID and the CDC, the US government has aided the South African government in developing primary health care structures. From 2000 the Clinton Global Initiative on AIDS directed large amounts of funding to South Africa's struggle against the HIV and AIDS epidemic. Currently, the US government is the largest bilateral donor to South Africa's health sector. For instance, under the PEPFAR, a total of US\$100 million in financial support was given in 2004, with the majority of it allocated for programmes related to HIV and AIDS prevention, care and treatment (US Department of State, 2005:9).

Even with the considerable backing by the US government in supporting South Africa's HIV and AIDS initiatives, the bilateral relations between the two countries have experienced periods of discontent. A major reason for the tense relationship was the pharmaceutical manufacturers, with the backing of the US government, lobbying for a South African law enacted in 1997 enabling the government to import and produce generic substitutes of patented drugs. In 1997 the Department of Health passed the Medicines and Related Substances Control Amendment Act (Medicine Act). The Act enabled the government to parallel import ARVs from third countries instead of paying exorbitant fees to large pharmaceutical firms in exchange for the drugs (Fourie, 2005:183). The respective South African governments have followed a policy cutting the costs of branded drugs by advocating for the local manufacturing of cheaper generic drugs. This advocacy by the government has benefitted the South African economy, while also boosting the local drug industry, making it the largest in Africa (telephone interview, Senior Officer AIDS Specialist UNDP Regional Service Centre JHB, 09/05/08). In addition, the legislation also enabled the government to activate compulsory licensing that would transfer pharmaceutical technologies to local manufacturers, making it cheaper to produce locally (Bond 2001:156).

6.9 Policy power dynamics – engagement between the state and international Actors

After 1999 the HIV and AIDS policy environment had become highly politicised in South Africa resulting in strained working relations with UNAIDS (telephone interview, Senior Officer AIDS

Specialist UNDP Regional Service Centre JHB, 09/05/08). The Donor Matrix had shortcomings which impacted on the government's ability to accurately record the donor funding entering South Africa from international partners. It failed to provide a reliable guide to donor spending in the country, since it was based on donor commitments over an extended period as opposed to the actual allocation and disbursement of the money. Thus the lack of adequate control created a loophole which allowed international donors to exploit the system for their own purposes. This loophole enabled them to deal directly with the local government structures and NGOs, therefore bypassing the structures of the national government. Since donors direct their funds to service providers and research institutes, the government does not collect comprehensive information on these resources (Ndlovu, 2005:4). The fact that the funds could have been accessed more easily by allowing intended programmes to be implemented or to continue operating may have been considered a step in the right direction towards a more effective national response to the HIV and AIDS epidemic, but the government did not view it in this way. Instead this only helped to strengthen the government's belief that they were being undermined by international agencies promoting their own agendas. According to an interviewee, "what was necessary were better communication channels between government and the international agencies to help them both achieve their goals" (interview, Senior Researcher AIDS Expert, the Centre for Conflict Resolution, 23/4/08).

With the end of the Pharmaceutical Manufacturers Association of South Africa (PMA) lawsuit, it was anticipated that both parties would want to find common ground to work towards the same goal. This was not to be as in December 2004 the ANC published a strongly worded attack on the US government health officials, accusing them of "treating Africans like 'guinea pigs' in order to promote AIDS drugs" (ANC, 2004). The attack by the ANC was related to the controversy over the drug Nevirapine. The article stated that Dr Edmund Tramont, Chief of the US National Institutes of Health (NIH), who led the project in Uganda, "[...] entered into a conspiracy with a pharmaceutical company to tell lies to promote the sales of Nevirapine in Africa, with absolutely no consideration of the health impact of those lies on the lives of millions of Africans" (ANC, 2004). It also claimed, that "upon learning of the potential lethal side effects of Nevirapine, President Bush and his administration did nothing to stop the shipment and usage of the drug in Africa. They must be held accountable for their inaction (ANC, 2004).

The perceived efforts of the US government to safeguard the interests of the pharmaceutical industry were interpreted by the ANC leadership as an imperialist plot against the millions of Africans in need of the life-saving drugs. The US government's continued support of the pharmaceutical industry was thus viewed by the ANC leadership as being part of a strategy that prioritised the economic interests of the pharmaceutical companies ahead of the lives of Africans who were in dire need of the life-saving drugs. It was interpreted as resembling the colonial system of imperial Britain in which state power ensured an environment suitable for companies to exploit the locals and benefit at their expense. Therefore pushing for the local production of generic versions of the ARV drugs may be interpreted as a symbolic effort to break the hegemony of Western capitalism and science by transferring essential medical skill to Africans, thus promoting African and self-empowerment.

When examining the role of the stakeholders in the policymaking process it is evident that during Mbeki's presidency there was an elitist approach to the public policy-framing process. This was influenced by the centralisation of power within the ANC and the government, and as a consequence the power dynamics between the political elite and non-state actors were clearly in the favour of the political elite. However, after responding to international criticism of their HIV and AIDS policies, and because of a strong civil society sector in the country, there was a shift in policy framing allowing non-state actors more access to the policy decision-making structures.

6.10 Securitisation approach and the relevant actors involved

i) President Thabo Mbeki

Despite the serious threat posed by HIV and AIDS, Mbeki and his close advisers, including his Minister of Health, constantly defied the mainstream international approaches to the epidemic. Mbeki linked the epidemics' spread to poverty and the deep-rooted legacies of the apartheid regime. He also claimed that HIV and AIDS are not related and that Pharmaceutical Companies, who are backed by powerful states, are exploiting (one could also say securitising) the epidemic exclusively for achieve financial gain (*The Economist*, 21 February 2002). As highlighted earlier, instead the South African government took a more radical stance instead, openly accusing the US-backed pharmaceutical companies of exploiting the suffering of impoverished Africans.

Mbeki's leadership role can be used to explain a need for the securitisation process in a country where the spread of HIV represented a real and existential threat to the entire population. Elbe (2006:132) argues that in the case of South Africa securitising HIV and AIDS would not imply removing it from the political sphere and shifting it into the security sphere, "but instead to shift it out of its non-politicised status and to begin a proper politicisation of the issue". In 2000, Mbeki refused to consider HIV and AIDS as an urgent matter; instead he claimed that since the main cause of the spread of the virus was extreme poverty, efforts should therefore be taken to tackle the latter rather than the former (*BBC News*, 14 October 2008). Even though there is a correlation between extreme poverty/inequality and the spread of HIV, this is a disease which affects all social classes. As a result, it is problematic to regard poverty alone as the main underlying cause of HIV.

Chikane (2010) asserts that a major flaw in Mbeki's approach was that he tended to articulate his concerns to the public too quickly without the necessary foresight and consultation. According to Chikane (2010), if Mbeki was a researcher and had done research on these drugs and published his research findings, this would have been normal and maybe accepted by the public at large. However as the leader of South Africa he exposed himself to attack, "so his views would have consequences for the use of the drugs in the rest of the developing world". This flaw may have been a contributory factor in South Africa's framing of policies as well as the associated processes in the national response policy towards the epidemic.

What Mbeki and his supporters initially failed to recognise is that securitisation on a national level may have been able to overcome the problem of scarce medication available for the population. By framing HIV and AIDS as a security threat to the population, it is in fact possible for developing countries to overcome the restrictive and expensive patents that protect most of the ARV medication. These patents, which are protected under the legislation of the World Trade Organisation (WTO), impede poorer countries from producing generic ARVs therapies and other medicines in general at lower prices (Elbe, 2006:133). However, by appealing to the 'security exceptions' included in these patents, developing countries are able to invoke the *raison d'état* to overrule these legal agreements, increasing the domestic production of medication or importing it from other countries at more competitive prices (Elbe, 2006).

When examining the language used by Mbeki in explaining his views on the HIV and AIDS epidemic, it is evident he draws from the human security discourse. Human security emerged as a way to link various humanitarian, economic, and social issues in order to alleviate human suffering and assure security. As a result, Mbeki ensured that poverty coupled with the legacy of apartheid, was blamed for many of the social ills in the country, and was the driving force for his advocacy. In essence, Mbeki's emphasis was primarily on the poverty and social ills unleashed by the epidemic, while ignoring the viral aspect. This meant that Mbeki failed to get the full message across to his audience. It was communicated so ineffectively that it became a failure which hampered the policy decision-making processes in South Africa regarding the response policies aimed at addressing the HIV and AIDS epidemic. According to an interviewee, "By Mbeki taking the virus out altogether, he really shot himself in the foot. If he had kept it and said the virus thrives in conditions of severe poverty which is the real underlying factor that really would have won him praise (interview, AIDS Expert, University of Johannesburg (UJ), 25/04/08).

While Mbeki failed to fully embrace the concept of using speech-act during his tenure, he did at times adopt a more security-orientated language approach by referring to the "escalating HIV and AIDS pandemic" as a "pressing crisis" (Chikane, 26 October 2010). Chikane (2010) defends this approach by arguing that Mbeki's speeches were used instead for purposes of highlighting the challenges of the epidemic while meetings were held to further raise awareness. Mbeki failed to go as far as Mogae and Mswati in his efforts to fully adopt the speech-act to securitise the HIV and AIDS epidemic and as a result the South African case study is indicative of a failed securitisation attempt. At this stage the security argument would have been enough, but in the case of South Africa it failed since there was no sense of urgency therefore securitisation was not implicit in the standards of behaviour, principles, policies and bureaucratic processes which were required to tackle the problem.

Chapter 2, discussed how three facilitating conditions were necessary for a speech act to be considered successful in the process of securitisation. Mbeki failed to comply with all three of the facilitating conditions required for the process of securitisation. He remained hesitant to fully accept and follow the recognised grammar of security regarding the HIV and AIDS epidemic. By virtue of his position as President of South Africa, as a securitising actor he was in a position of

authority to pronounce on the security concerns however, he was not willing to fully raise the level of threat facing the population.

ii) Domestic actors -Treatment Action Campaign

As already set out in chapter 2, according to Buzan et al. (1998:40), “a security actor is someone, or a group, who performs the security speech-act”. These actors can come from political leaders, bureaucracies, governments, lobbyists and pressure groups. Based on this definition, TAC can be considered a securitising actor in South Africa. The TAC proceeded by combining the international representation of the epidemic as a human rights as well as a security concern by using strong images related to the anti-apartheid struggle. It also utilised other key strategies such as adopting language as a means to help securitise the epidemic. This was successful, as it allowed the TAC to successfully construct a speech-act that drew on the long-term sensitivities of the South African society. By adopting a human rights perspective, TAC ensured that any stigma that may have been created through the securitisation would be included and addressed. Additionally, it also campaigns against “the view that AIDS is a ‘death sentence’” (TAC website, accessed 30 January 2013). The TAC used traditional anti-apartheid human rights slogans for its national campaigns, for example, the “Defiance Campaign” and the “Civil Disobedience Campaign”. Acharya (2004:248) asserts that, “while the initiative to spread transnational norms can be undertaken either by local or foreign entrepreneurs, diffusion strategies that accommodate local sensitivity are more likely to succeed than those who seek to supplant the latter”.

The TAC’s ability to successfully utilise social mobilisation methods was very important in promoting its cause. The amount of actual time spent in the communities through door-to-door campaigns brought the organisation closer to the realities of the people they sought to assist. This approach helped to sustain and strengthen their grassroots relations as people become more familiar with the organisation, its aims and objectives, thereby expanding their audience reach. According to Buzan et al. (1998:32), a condition for a securitising move is that, “the social conditions regarding the position of authority for the securitising actor that is, the relationship between the speaker and the audience and thereby the likelihood of the audience accepting the claims made in a securitising attempt”. Therefore, because of its social mobilisation approach, the TAC was able to be in a position to meet the above condition. The TAC’s use a social mobilisation strategy allowed the organisation to gain access to local news and information about

challenges affecting the targeted communities, while at the same time ensuring that the organisation's name became known and familiar to the communities, and make them more willing to accept the securitising attempt.

Interestingly, when examining the methods the TAC used to confront the government about its inaction regarding the security threat posed by the HIV and AIDS epidemic, it becomes evident that the organisation employed similar persuasion strategies to those adopted by the liberation movements during the apartheid era (interview, Senior Researcher AIDS Expert, the Centre for Conflict Resolution, 23/4/08). During the apartheid era it was the norm for transnational actors to work in unison with resistance groups in South Africa and those in exile to apply pressure on the apartheid state (Black, 1999). The TAC's language and action strategies were based on the international norm of racial equality, within a broadening human rights perspective, which was then applied to the particular context of South Africa (Klotz, 1995:44). This strategy was advantageous as it placed the TAC in a position to promote the need for the epidemic to be securitised and led to it being a persuasive agent of change.

The TAC, having learnt from the liberation experiences of the ANC, also built up a multifaceted system by forming partnerships with both state and non-state actors on different levels of both political and social interactions. The TAC makes use of various strategies depending on whether it is interacting with international actors or domestic actors. Internationally, the TAC actively pursued a policy of interacting at global AIDS conferences and other multilateral meetings with international organisations and other transnational NGOs that share similar interests and opinions. Domestically, it shared information, carried out mass mobilisation campaigns and liaised with other activist organisations of PLWHA. When challenging the government, it made use of the political and justice systems available in South Africa. The TAC's campaigns have drawn strongly upon a human rights discourse, with international support from agencies such as UNAIDS. Some scholars are of the opinion that a change in approach may be necessary as a more multi-faceted approach is needed to successfully combat the epidemic (interview, AIDS Expert, University of Johannesburg (UJ), 25/04/08).

From the late 1990s the TAC participated intensively in transnational advocacy networks, which succeeded in influencing domestic change in South Africa. An important victory for the TAC, which influenced the prevailing opinion among donors, the governments and the UN system

itself, was establishing the view that therapy with ARVs was far too complex for health systems in the Third World and that prevention campaigns were more cost effective than treatment (Heywood, 2004). This success achieved by the TAC resulted in international actors being re-socialised with new ideas regarding more effective responses to the epidemic. The TAC also began pressuring several governments, including the South African government, to apply national HIV and AIDS plans that emphasise the importance of the provision of treatment to people infected with HIV. All of this made the TAC an important securitisation actor in the case of South Africa.

The South African government had previously strongly opposed most efforts by both domestic and international pressure groups to change its HIV and AIDS policies. This hard stance led to the TAC seeking legal recourse against the government. As a direct result of the court action, a new comprehensive plan for the roll-out of ARVs was formulated and successfully implemented. In an attempt to raise doubts about the growing legitimacy and credibility of the TAC, Mbeki and his administration sought to use ideological arguments as a means to undermine the TAC. For instance, regarding the provision of Nevirapine, the government accused TAC of representing the interests of the pharmaceutical companies as opposed to the interests of the South African people. Heywood (2004:9) asserts that, “in 2000 it is alleged that Mbeki told the ANC parliamentary caucus that TAC was a front for drug companies, and had successfully ‘infiltrated’ the trade union movement”. The government accused the TAC of representing the interests of the pharmaceutical companies at the expense of the South African population, which proved not to be the case (telephone interview, Senior Officer AIDS Specialist UNDP Regional Service Centre JHB, 09/05/08).

The TAC has been able to carry out its dual strategy with great effect for several reasons. Firstly, it acquired the organisational strength to be able to either challenge and/or to cooperate with the government. Secondly, it was financially independent from the government and therefore had no obligation to the government. Thirdly, through its global networking the TAC has created supportive alliances that have mobilised global public opinion and provided funding. Finally, the TAC has skilfully built what its leaders term “moral consensus” on ARV treatment.

The TAC proved very effective in pressuring the government through both political and judicial routes. Because the TAC’s campaigns adopted a human rights approach, this drew support from

international actors such as UNAIDS. As highlighted, TAC's use of language differed somewhat from the more straightforward state security approach of other securitising actors such as the US government. TAC has therefore, strategically constructed a speech-act which appealed to the long term sensitivities of the South African society. According to Buzan et al, (1998:27), "It is important to note that the security speech-act is not defined by uttering the word security. What is essential is the designation of an existential threat requiring emergency action or special measures and the acceptance of that designation by a significant audience".

The TAC has adopted the moral argument "that no one should die from AIDS because of a lack of affordable treatment, since there are available medicines that are proven to be effective," which has indeed been a powerful motivator for action (Patterson, 2006:125-126). The TAC has used this moral argument against the government to great effect. Since the ANC was the party that liberated South Africa, it had acquired a great moral stature. When the TAC made the point that the ANC government had failed HIV-positive citizens, many of whom are black, coupled with the fact that government continued to argue that access to treatment was too expensive, the government lost ground on the moral argument (interview, Senior Researcher AIDS Expert, the Centre for Conflict Resolution, 23/4/08). Therefore, the TAC's strategy was in line with the basic premise that to successfully frame something in terms of security, a securitising actor has to convince a significant audience that a specific issue constitutes an existential threat (Buzan et al, 1998:32).

TAC complied with two of the three facilitating conditions required for the process of securitisation that were discussed in chapter 2. TAC accepted and followed the recognised grammar of security. However, by virtue of it being a non-state actor it was not in a position of authority to pronounce on the security. However, TAC was able to successfully raise the level of threat facing the population.

iii) The USA as a key-securitisation actor in South Africa

As mentioned earlier, in 1997 the Pharmaceutical Manufacturers Association of South Africa (PMA) sued the South African government over the new legislation related to the Medicine Act. The court case continued over three years and resulted in intense international and domestic lobbying, but the PMA dropped its lawsuit in 2001. The US government acting on behalf of the

pharmaceutical industry, resisted all attempts by the South African government to defend the legality of South Africa's position at the World Trade Organisation (WTO) (Bond, 1999). Furthermore, since the introduction of PEPFAR to South Africa, USAID has insisted that the South African government adopt a policy of using the financial assistance of the US government to buy branded ARVs from US pharmaceutical companies as opposed to buying cheaper non-branded generic drugs from other countries. Unlike Botswana, South Africa was strongly opposed to this option. The intention behind this US strategy was essentially a skilful manoeuvring tactic guaranteeing that the aid money would eventually be redirected back into the US economy. A criticism directed at PEPFAR's investment in HIV and AIDS treatment was that it sought to help restore the global image of the USA. Former US President George Bush's 2003 State of the Union address makes the point, while talking about HIV and AIDS, that in order to address emergencies, countries often require outside help and that the US has the experience and expertise to offer help,

[Maintaining] human dignity has been part of our history for a long time. We fed the hungry after World War I. This country carried out the Marshall Plan and the Berlin airlift [...] It's nothing new for our country. But there's a pandemic which we must address now, before it's too late.

In accordance with its broader HIV and AIDS securitisation strategy, as promoted by PEPFAR in 2003, the US government established its own system of aid provision in South Africa. This resulted in all US HIV and AIDS programmes being integrated into PEPFAR under the control of USAID/CDC and the American Embassy in Pretoria. Approval of funds for the implementation of plans was subject to the US Global Aids Coordinator at the State Department in Washington and PEPFAR's projects being managed by the US Ambassador in Pretoria (US Department of State, 2005). The US representatives in South Africa refrained from engaging directly with the pre-existing multilateral mechanisms already in place to coordinate the work of international partners. Instead, they chose to deal bilaterally with over 200 partners in the public, private and non-profit sectors (US Department of State, 2005).

In the case of South Africa, the US did not have much access to the South African national structure of the policy decision-making process. Unsurprisingly, and because of the tense HIV and AIDS policy environment, Mbeki and his Cabinet closed ranks in order to shield themselves

from any interference by external and domestic actors whose views were contrary to those of the government. However, this proved beneficial to PEPFAR as it facilitated its broad strategies of avoiding national coordinating to achieve its objectives, and meant that it was in a position to rapidly mobilise groups as well as being able to address concerns at the grassroots level (interview, Senior Researcher AIDS Expert, the Centre for Conflict Resolution, 23/4/08). This in turn led to a response by the government, with the then Minister Tshabalala-Msimang calling for PEPFAR to be more closely integrated into the government structures that deal with external funding matters. The Minister stated that South Africa “had not asked for PEPFAR’s assistance” and that the Ministry’s coordination efforts to support South Africa’s response to HIV and AIDS epidemic should not be at risk of duplication or of unaccountable initiatives by international partners (Aidsmap, 23/06/2006).

Regarding the HIV-prevention policies promoted by PEPFAR’s “ABC” approach, they were not readily accepted in South Africa. The only organisations promoting this approach are a number of Christian groups operating in South Africa that are financed by the US government⁴⁹. The majority of civil society groups and the government departments dealing with HIV and AIDS in South Africa have adopted a more pragmatic approach of using multilateral agencies (interview, AIDS Expert, University of Johannesburg (UJ), 25/04/08). Therefore, regardless of the funding offered by PEPFAR, most have rejected the US government’s moralistic approach to HIV and AIDS prevention by continuing to focus on awareness campaigns and on the distribution of condoms as part of their response to the epidemic.

From 2003 the US government, represented by CDC in South Africa, has been a keen advocate of the introduction of the routine or ‘opt-out’ HIV testing in the public health care system. However, because of the sensitive nature of the issue, voluntary counselling and testing (VCT) continues to be the accepted policy in order to promote the protection of individual human rights. The protection of human rights of people testing positive for HIV has always been an important factor in South Africa’s response to the epidemic⁵⁰. The majority of the interviewees were in

⁴⁹ This still applies presently in 2013.

⁵⁰ The Constitution of South Africa has enshrined the rights of people living with HIV and AIDS and the Bill of Rights makes any discrimination action against them illegal.

agreement that this should remain the status quo as it supports the fight against the HIV and AIDS epidemic.

Interestingly, however, a leading AIDS expert believes that the South African human rights approach is misleading and a better option should be found by marrying the human rights approach with the public health approach in South Africa. There seems to be a bit of momentum in that direction but it is not enough. South Africa's strong liberal constitution means that it is only natural to follow a human rights approach, but this stops short of providing a holistic solution. The human rights approach may have run its course and the response strategy should perhaps move on to a more pragmatic intervention as in public health (interview, AIDS Expert, University of Johannesburg (UJ), 25/04/08).

6.11 Conclusion

The HIV and AIDS epidemic in South Africa is fuelled by several factors such as poverty, gender inequalities, and social and racial exclusion. Walker et al. (2004:19), stress that "the spread of the disease is also influenced by personal choices, political responses and cultural factors." South Africa is an economic and political power in the region with a strong economy and stable democracy with relatively efficient social infrastructure in place. However, South Africa has struggled to achieve similar success in combating HIV and AIDS than countries with much lower levels of socio-economic development.

This chapter found that the political leadership in their framing of policy the political leadership was influenced by the controversial denialists. This was coupled with the urgent need to address the legacy of social injustices left by the apartheid regime. As a result the government's response was a degree of inaction and a slow response to the HIV and AIDS epidemic from key policy decision-makers. According to Anderson (2000:7), even the failure to formulate a policy will become policy since "inaction becomes a public policy when officials decline to act on a problem".

Also, the chapter indicated and discussed the causes, extent and implication of this suspicion by the government about the true intentions of the Western governments and the interests of international pharmaceutical companies operating in South Africa. This suspicion led to the

rejection of international thinking on the HIV and AIDS epidemic, and influenced the policymaking processes accordingly.

It was argued that the leadership, under the direction of Mbeki, drew on the advice of a few trusted individuals. This left little space for non-state actors in the policy formulation structures. The ability of domestic and international securitising actors to exert an influence on key policy decision-makers was therefore limited. The relationship between the government and domestic non-state actors was at an all-time low in the late 1990s. In an attempt to remedy this, the TAC used the judicial route as a means to influence the policymaking process. This was illustrated by the court ordering the government to provide the AIDS drug Nevirapine to prevent mother-to-child transmission.

As a result of the tense HIV and AIDS policy environment, the TAC adopted a strategy of linking up with transnational actors to exert external pressure on the South African government. It was demonstrated that the TAC's action took the form of lobbying and communicating directly with the international community at various international gatherings such as Global AIDS Conferences and at the UN General Assembly's Special Meetings on HIV and AIDS. These strategies proved useful to the TAC, as they provided the organisation with an opening access to and influence the framing of policy.

It was argued that South Africa's narrow elitist political and social structures restricted external actors from gaining access into the domestic policy decision-making structure. This was due to the centralisation of power within the ANC and the government under Mbeki's presidency as well as the suspicions about Western influence. In response to this, the international actors aligned themselves with like-minded domestic non-state actors. Unlike in Botswana, South Africa had a strong civil society opposing the government's HIV and AIDS policy responses and that was prepared to use the judicial system to influence policy formulation and implementation. After criticism from international and domestic actors the South African government opened up its policymaking processes to include non-state actors. Although this is still mainly an elitist approach, the access to the policymaking process has widened and now includes elements of constructivism.

The chapter examined the processes and dynamics around the securitisation of HIV and AIDS in South Africa. It was found that Mbeki's suspicion of foreign securitising actors led to reluctance to accept the securitisation discourse. This led to the unsuccessful securitisation of the HIV and AIDS epidemic in South Africa. It was also found that as a result of the tense political environment, transnational actors had limited access to high-ranking decision-making structures, hence limiting their persuasive influence to promote the securitisation approach. At the same time the TAC also made a securitisation attempt through the use of securitisation speech-acts. Although they managed to reach a wide audience, their securitisation attempt was constrained because of their lack of access into the policymaking structure. This is interesting as it is an example of a bottom-up approach to securitising the epidemic.

Chapter 7: Policy Issues, Processes and Framing around HIV and AIDS in Swaziland

7.1 Introduction

Swaziland holds the unenviable distinction of having the highest HIV-prevalence in the world at 26.3 per cent (USAID Swaziland Country Profile, October 2010). The consequences of the epidemic are becoming more apparent and are reflected in deteriorating socio-economic indicators⁵¹. This situation has unfolded slowly and unobtrusively since the early 1990s. As is the case with Botswana and South Africa, Swaziland too finds itself in “the global epicentre of the epidemic” (Hwedie 2001:55). Early reporting by UNICEF on HIV and AIDS in Swaziland indicated that “even if no new infections [occur] after 1999, infection levels will remain high through at least 2010 [and] deaths will not level off until after 2020” (UNICEF, 1999:13). Currently, infection levels remain relatively high.

This chapter focuses on the framing of policy and the processes and factors associated with it in Swaziland. Examining the public policy discourse on HIV and AIDS should reveal how public policy on HIV and AIDS was framed. A central part of this is looking at the policymaking dynamics and what factors influenced them. The chapter further explores the role of relevant stakeholders such as state, non-state domestic HIV and AIDS actors, and multilateral and bilateral agencies in attempting to influence the policy decision-making processes in Swaziland in the roles of policymaking actors and policy-influencing actors. Finally, the chapter examines the processes and dynamics around the securitisation of the HIV and AIDS epidemic in the country. It is argued that because of the political environment transnational securitising actors initially had limited access to higher-ranking decision-making structures, since there were social and cultural barriers to overcome. This severely limited the persuasive influence of these actors in promoting the securitisation approach. However, once the political space for the acceptance of the securitisation discourse pursued by influential securitising actors was created, the securitisation of the HIV and AIDS epidemic in Swaziland became possible and was eventually partially successful.

⁵¹ For a more comprehensive review of these socio-economic indicators see, “The Socio-Economic Impact of HIV/AIDS in Swaziland” by Whiteside et al, 2006.

As in Chapters 5 and 6, the roles of certain transnational actors - notably the UN agencies and the US government - are analysed to ascertain the scope of their persuasion efforts as promoters of the securitisation discourse in the policy decision-making processes. It is argued that Swaziland's political leadership under King Mswati III created a political environment that was initially not very open to the acceptance of international actors and their ideas. This approach had elements of elitist public policy theory, in which only a trusted elite is part of the policymaking discourse. The prevailing political environment created a tense working relationship for state and non-state actors. As a result, this tense relationship impacted on the framing of HIV and AIDS policy and processes in Swaziland. However, it will also be demonstrated that despite the tense political environment the domestic and international HIV and AIDS actors were able to find and create a political space, which gained them access to, and to some degree influence over, the policymaking processes. For the purposes of this study political space will be defined as "the presence of allies and support groups; the availability of meaningful access points in the political system" (Brockett, 1991: 254).

It is also argued that Mswati's leadership and lifestyle choices sent many confusing signals. This in turn affected and influenced the process of how policy issues and problems were framed and how these issues were placed on the policy agenda. The fact that Mswati is a traditionalist practising polygamy caused tensions with international HIV and AIDS actors as this practice did not fit neatly into their generic global awareness campaigns.

Swaziland reveals a few of Cloete's (2000) characteristics of developing countries, such as a low per capita income, an agriculture-dependent economy and a large rural population. Swaziland is heavily dependent on donor aid. It is argued that this dependence on donor aid led to the creation and opening of access points in to the political system for non-state actors and exert some influence on the policymaking structures.

7.2 Dimensions of the HIV and AIDS epidemic in Swaziland

Swaziland ranks as a lower-middle-income country, approximately 75 per cent of the population are employed in some form of subsistence farming and 60 per cent of the population live on less than the equivalent of US\$1.25 per day (UNDP, 2008). Swaziland has experienced several years of wavering economic growth, which has been exacerbated by the economy's failure to aid job

creation to meet the rate of new job seekers entering the market. The emergence of the HIV and AIDS epidemic coupled with slow economic growth placed a heavy strain on the government's ability to provide much-needed social services, such as health care and education (*UNAIDS Epidemic*, 2009).

With an estimated adult prevalence of 26.3 per cent, Swaziland has the world's most severe HIV and AIDS epidemic, posing a serious challenge to the country's economic development. Since Swaziland's first AIDS case was reported, the epidemic has spread across all parts of the country. According to *UNAIDS Epidemic Update 2009*, average Swazi life expectancy fell by half between 1990 and 2007, in great part due to the epidemic. Approximately 190,000 people in Swaziland are HIV positive, including 15,000 children under the age of 15 (*UNAIDS Epidemic Update 2009*).

After visiting Swaziland in February 2010, UNAIDS Executive Director Michel Sidibe presented a report estimating that three in every 100 people in Swaziland will be infected with HIV every year, leading to an expected 18,000 new infections each year by 2012 (UNAIDS, February 2010). While he praised prevention of mother-to-child transmission initiatives, he expressed the view that much progress still to be made. According to the *UNAIDS World AIDS Day Report 2011*, overall rates of new HIV infections in Sub-Saharan Africa appear to have peaked in the late 1990s, and HIV prevalence seems to have declined slightly (UNAIDS, 2011).

As a consequence of the HIV and AIDS epidemic, approximately 10 per cent of all households in Swaziland are now headed by children and 60 per cent of the country's population lives below the poverty line (UNICEF 2005). The probability of a young Swazi aged 15 today reaching the age of 50 is 28 per cent for males and 22 per cent for females (Patterson, 2006:45). Swaziland has not been very successful in curbing new infections. At the end of 2007 there were approximately 190,000 people living with HIV, including 15,000 children aged 0-14. HIV prevalence for the 15-24 age group remained steady at 39.4 per cent between 2002 and 2004, and levelled off at 34.6 per cent in 2006 (UNGASS Swaziland Country Progress Report 2007).

The deaths of many adults left behind a youthful population in Swaziland. Many children are orphaned and left in the care of grandparents. If there are no grandparents, they are left to fend for themselves in child-headed families. Increasing economic decline may push Swaziland into

further poverty or economic migration, potentially escalating the scale of the epidemic. This huge scale of AIDS-related illnesses and deaths is weakening the government's capacity to deliver adequate healthcare and other essential services, with serious consequences for food security, economic growth and human development (Patterson, 2006).

7.3 Observable policy responses

7.3.1 Early efforts to address the epidemic

Swaziland's first HIV-positive case was reported in 1986. According to the WHO, the government has "demonstrated a high level of political commitment to fight HIV and AIDS since the start of the epidemic" (WHO, Swaziland Country Profile 2005). The government responded almost immediately by establishing the National AIDS Prevention and Control Programme (NAPCP), later renamed the Swaziland National AIDS/STI Programme (SNAP), with support from the WHO's Global Programme on AIDS (GPA). The aim of the programme was to develop policies, and to coordinate and strengthen the national response policy on the HIV and AIDS epidemic. As was the norm in most countries in the late 1990s, a standard package of HIV and AIDS interventions was implemented. In addition, from 1992 SNAP was tasked with conducting the sentinel surveillance of HIV prevalence every two years.

The first interventions took the form of the Short-Term Plan (1986-1988), which later evolved into the Medium-Term Plan (1989-1992). Both these plans focused primarily on awareness programmes which provided information and education on HIV and AIDS, promoted condom usage, attempted to manage the spread of sexually transmitted infections, and ensure safe blood screening. While these plans were strategically aimed at providing valuable information about the disease, the message failed to resonate sufficiently with the nation. The disease soon spread exponentially across all sectors of Swazi society. An interviewee believed that the reason for the failure was that while the intervention did indeed raise awareness about the disease, it failed to adequately address behavioural change concerns (interview, UNAIDS-Social Mobilisation and Partnership Advisor, Swaziland, 14/04/08). The plans were flawed because they did not adequately address the issue of behaviour change which is a key driver for limiting the spread of the disease.

According to Whiteside (2003:6), the government's initial response to the HIV and AIDS epidemic was in line with international norms, and "indeed in many cases has gone beyond them". He illustrates his point by recalling a meeting led by the NAPCP in 1993 calling for the Cabinet to make a firm commitment to fight the disease. This was significant as it led to Swaziland being credited as being one of the first countries to include and make mention of HIV in its national development plans. Additionally, the government was the first to commission a study on the socio-economic impact of the HIV and AIDS epidemic; more importantly a senior government official was open about his HIV status and the need for behaviour change as early as the mid-1990s (Whiteside, 2003:6). While this may have been true of the initial policy response initiatives, today Swaziland has one of the highest HIV rates in the world.

During the first few years of the epidemic in Swaziland it was reported that there was a steady increase in incidence from the first reported HIV and AIDS case to over 150 in 1993. HIV surveillance was introduced in 1992 and by that time 3.9 per cent of pregnant women tested were HIV positive (Government of the Kingdom of Swaziland, Policy Document on HIV/AIDS and STD Prevention and Control, 1998:1). In order to formulate and implement a more efficient policy response, the HIV and AIDS national policy was restructured in 1993. The restructuring included the formulation and development of the National Strategic Plans of 1994-1997 and 1998-2000.

In February 1999 two key events took place, which represent turning points in raising the Swazi population's awareness levels of the full impact of the disease and the government's approach to containing the spread of the disease. Firstly, UNICEF published a report in the *Times of Swaziland* newspaper on the likely long-term impact of the epidemic, focusing on the projected number of children who will be orphaned as a result of the disease. Secondly, shortly afterwards, Mswati declared the HIV and AIDS epidemic a national disaster and the Crisis Management and Technical Committee (CMTC) was established to lead the formulation and implementation of a new national response policy on the epidemic. This was Mswati's first attempt at securitising the epidemic. As already discussed in chapter 2, in order to successfully frame something in terms of security, a securitising actor has to convince a significant audience that a specific issue constitutes an existential threat (Buzan et al., 1998:32). By his declaration, he was fulfilling part of the speech-act requirement for the securitisation process.

According to the Copenhagen School, for the securitisation process to be initiated, there must be an “existential threat requiring emergency action” to be identified, and a significant part of the audience must accept that account (Buzan et al., 1998:27). The type of threat requires a political actor to build a persuasive case for securitising the threat. Mswati, in his position as the absolute ruler, was indeed such a political actor who had access to the entire population and the power to have his message conveyed to a significant part of the population/audience.

The CMTC developed the National Strategic Plan for 2000-2005. This focused on improving health services; changing behaviour by means of mass media outlets, schools and workplaces; and minimising the future impact of the epidemic, especially for vulnerable groups such as orphans (Swaziland National Strategic Plan for HIV/AIDS 2000-2005). These two events proved instrumental in heightening the population’s awareness of the disease, while at the same time it demonstrated the government’s resolve to intervene more aggressively by reframing, formulating and implementing new public policy programmes to help curb the spread of the virus (interview, UNAIDS - Social Mobilisation and Partnership Advisor, Swaziland, 14/04/08). This highlighted part of the policymaking dynamics as related to the HIV and AIDS epidemic by presenting the roles of the principal policymaking actors in Swaziland.

While early successes may have been experienced and can be described as being constructive initiatives to help combat the disease, they unfortunately did not translate into reduced infection numbers. Several of the interviewees expressed the view that previous response attempts by both the Health Ministry and non-state HIV and AIDS actors lacked a unified and multi-sectoral dimension in addressing the epidemic, which resulted in programmes being hampered and hence limited successes. Similar to Botswana and South Africa, Swaziland’s government saw a need for a more inclusive approach along the lines of constructivist theories of pluralism and elitism. The low success rates of the government’s initial policy approaches towards the epidemic necessitated the change in the government’s policy-making processes, leading to new policies being formulated and implemented as part of the new national response policy.

7.4 Changes in the policymaking environment

The continuing rise in HIV prevalence led to a process of policy evaluation, which in turn necessitated new policy formulations as part of the national response to the HIV and AIDS

epidemic in Swaziland. A state's political and social culture and the prevailing socio-economic conditions will have a significant impact on what will be deemed important societal issues (Anderson 2000:45). The government recognised HIV as an important societal issue. Importantly, the government also realised that the epidemic was not only a health problem, but also a development problem that had social, economic and cultural implications (interview, Director of NERCHA, Swaziland, 11/04/08). As a result, the new policy decisions formulated focused on three key areas, namely prevention, care and support, as well as on impact mitigation. Swaziland's then Prime Minister, Barnabas Sibusiso Dlamini, stated on 1 February 1999, "If we don't act fast and resolutely, the spread of HIV and AIDS through our nation will be [...] as nerve gas in a gentle breeze" (UNICEF 1999:13). This declaration by the Prime Minister is further proof of government representatives acting as securitising actors to bring the danger/emergency of the epidemic to the attention of the wider audience. According to Buzan et al., (1998:27) "It is important to note that the security speech-act is not defined by uttering the word security. What is essential is the designation of an existential threat requiring emergency action or special measures and the acceptance of that designation by a significant audience".

Several of the interviewees concurred that with the adoption of the new policy approach the government was indicating a better understanding of the impact of the disease on the society as whole. In order to achieve better success rates, there was a need to reframe the policy response, which led to a more decentralised multi-sectoral approach. This included the addition of multiple sectors of government departments and relevant non-state entities. This approach seeks to encourage greater collaboration among the different partners contributing to Swaziland's national response policy to address the HIV and AIDS epidemic. This is in line with the constructivist elements of elite theory on public policy, where a select elite influences the policymaking. In Swaziland, as was demonstrated in the other two cases, there was an increased understanding of the need to open up to allow for a wider inclusion of policymaking actors, leading to this change in policy response.

Having identified the shortcomings of earlier policy approaches, the focus of the new NSP was to frame policy around specifically targeting behaviour change in conjunction with continued focus on awareness programmes. Social messages were disseminated through national media in schools and workplaces in order to improve health services and minimise the future impact of the

epidemic, especially for vulnerable groups such as orphans (Swaziland National Strategic Plan for HIV and AIDS 2000-2005, 2000).

In September 2000 the CMTC developed the Swaziland National Strategic Plan for HIV and AIDS 2000-2005, which was Cabinet approved. In November 2001, the Ministry of Health and Social Welfare (MOHSW) published a policy document on HIV and AIDS and STI prevention and control. The key objectives of the policy were to:

- maintain a sustained political commitment at all levels for HIV and AIDS prevention and control;
- expand the national response to the HIV and AIDS epidemic by strengthening and maintaining a multi-sector approach;
- improve coordination of HIV and AIDS prevention and control activities at all levels;
- increase the capacity of women, youths and other vulnerable or disadvantaged groups (for example, disabled persons, sex workers and street children) to protect themselves against HIV and AIDS and STIs;
- safeguard the human rights of people living with HIV and AIDS; and
- promote HIV and AIDS-related research and surveillance activities.

(Report on the 8th HIV Sentinel Survey, Swaziland Government, Ministry of Health and Social Welfare, Mbabane, 2001).

The government announced that the year 2000 and beyond “will be the time of delivery” for HIV and AIDS policy in Swaziland (Swaziland National Strategic Plan for HIV/AIDS 2000-2005). This assumption is based on the fact that in the year 2000 HIV prevalence was 34.2 per cent for pregnant women in Swaziland (WHO Country Factsheet, 2004). This bold statement was necessary considering that all previous national policy response efforts were largely ineffective (interview, AIDS Specialist William J Clinton Foundation Swaziland (formerly with Ministry of Health and NERCHA) 11/4/08). This was evidence of the principal policymaking actors actively seeking to make policy changes to better address the epidemic.

7.5 Factors that influenced the policy making process in Swaziland

7.5.1 King Mswati III, the traditionalist - prevailing cultural values and practices

From the interviews conducted it became clear that customs and traditions play a vital role in the fight against HIV and AIDS, since they are important factors in encouraging social cohesion and building strong communities. However there is a feeling that Mswati's behaviour sent mixed messages relating to customs and traditions, which are rooted in gender inequality. The sending of mixed signals was also experienced and highlighted in the South African case study because of Mbeki's actions. In each of the case studies, leadership figures are very important, therefore, Mswati sending mixed signals regarding the HIV and AIDS policies prevented the necessary behavioural change needed in Swazi society which negatively impacted on policy responses. This gender inequality has been a main contributing factor to the spread of HIV in the country. By adopting policies which combined traditional and modern approaches, according to Whiteside (2005:121), "there is a tendency for political, economic and cultural leaders to say, 'Do as I say, not as I do' in Swaziland. Typically, older men advocate abstinence and fidelity, but their behaviour contradicts this". Thus, in a country where political power is centralised in the monarch and his chosen administration, the opportunities and political space available for other organisations to counter the confusing mixed messages are limited.

In order to overcome the heavy burdens faced by women and children, it is essential that the ingrained traditions and customs prevailing in Swaziland are addressed (telephone interview, UNDP – RSC Johannesburg, RSA, 8/5/08). These factors are significant challenges that face the political leadership as it seeks to curb the rampant spread of HIV. Swazi culture has a long and strong polygamous tradition that encourages males to enter into polygamous marriages with as many wives as they are able to sustain financially. This led to confusion in early HIV and AIDS prevention posters which in most countries promoted "Sticking to One Partner". In Swaziland this had to be adapted since polygamy is socially accepted, with Mswati marrying several wives. The posters had to use a less than catchy message, "Be Faithful in your polygamous Family" (Whiteside, 2008:44). The issue of polygamy is not as pronounced in South Africa⁵² and to even

⁵² Although in South Africa some political and traditional leaders have polygamous families, including Jacob Zuma.

a lesser degree in Botswana. Therefore, this is a unique factor that must be addressed by the principal policymaking actors in Swaziland when formulating the necessary policies.

Mswati's polygamous lifestyle has drawn criticism from both domestic and international stakeholders. Mswati has 13 wives⁵³, each with a retinue, a palace and the use of a fleet of luxury vehicles. It was reported that about \$30 million of the government's 2009 budget was set aside for "royal emoluments" (*New York Times*, 07/02/2009)⁵⁴.

According to one interviewee, "the monarch must set a better example regarding concurrent sexual relations. People look at him and say that if the king is doing it, it is not wrong. What they are not realising is that the king [most probably] has a full-time medical team to make sure all the wives are tested" (interview, UNAIDS Social Mobilisation and Partnership Advisor, Swaziland, 14/2/08).

This viewpoint is disputed by another interviewee who claimed that, "polygamy is not wrong per se. Unfaithful polygamy relationships are wrong. The King would therefore be hypocritical to talk of sexual faithfulness or issues as such due to the fact that he has so many sexual partners" (interview, AIDS Specialist William J Clinton Foundation Swaziland (formerly with Ministry of Health and NERCHA) 11/4/08).

According to a 2008 UNDP report, when one sexual partner in a polygamous relationship is HIV-positive and the sex is unprotected, this practice becomes an important driver of the epidemic (UNDP's Swaziland Human Development Report for 2008).

An interviewee expressed that,

Mswati could still give a positive message regarding the issue of polygamy by emphasising the need for a faithful polygamous relationship. By not raising the issue you think that he is avoiding dealing with it, therefore, the King should be more vocal on this issue. More importantly, in a polygamous society where you have social support for multiple concurrent partnering, i.e. a polygamous system, you are not going to have

⁵³ This was the reported number of wives of Mswati at the time the study was conducted.

⁵⁴ Forbes.com recently listed Mswati as the world's 15th wealthiest monarch, estimating his fortune at \$200 million, <http://www.forbes.com/global/2008/0901/038.html>

successful interventions if you don't address these systemic issues (interview, AIDS Specialist William J Clinton Foundation Swaziland (formerly with Ministry of Health and NERCHA) 11/4/08).

Mswati's authority and legitimacy does not derive from constitutional powers or popular election, but from family lineage and traditional rule. Because of the fundamental weakness of formal political institutions in Swaziland such as the legislature and the judiciary means that the monarch becomes an important actor in the fight against HIV and AIDS. Whiteside (2005:120) argues that Mswati's response record on HIV and AIDS is mixed. Even though in Swaziland there are formal HIV and AIDS institutions, centralisation of decision-making power within the monarchy impedes the government's attempts to combat the HIV and AIDS epidemic successfully. Also, Mswati's autocratic rule has led to policy decisions made with limited input from non-state actors, which resulted in a lack of transparency and minimal influence from non-state actors. It can be argued using elitist theory on public policy that in Swaziland, because of the nature of Mswati's rule, the elite with policy-influencing powers is smaller than in the other two cases, which are also elitist. According to an interviewee, "the monarchy does not always show political commitment as it is not always outspoken on the epidemic, neither does it praise the positive work that has been done by actors in the field" (interview, AIDS Specialist William J Clinton Foundation Swaziland (formerly with Ministry of Health and NERCHA) 11/4/08).

Since Mswati plays such a central role in Swaziland's political system, which provides very little political space for other actors, his actions are key in the framing of policy and processes regarding decision-making in the HIV and AIDS national response policy. Mswati's leadership skills regarding the empowerment of women and making them less vulnerable to HIV remain questionable and even entirely lacking. For example, an important Swazi cultural event is the holding of the annual Reed Dance. Thousands of young virgins dance bare-breasted and the King chooses a new wife from among them. However, this custom has caused a public outcry against the royal house. In November 2002 a mother filed a lawsuit to prevent Mswati from marrying her 17-year old daughter, whom he had identified at the Reed Dance. Mswati responded by claiming that the mother had "no respect for tradition," since Swazi custom allows the King to choose wives from among the thousands of dancing maidens (Rana, 2004:1). Mswati's public rejection of the lawsuit severely undermined the independence of the Swazi judiciary in being

able to preside fairly over cases involving the government and AIDS actors. Mswati's apparent disregard of human and women's rights were denounced by Amnesty International and several other international organisations (Amnesty International Report 2005: Swaziland, 25/05/2005).

Mswati was also criticised for his choice of such a young bride, as it occurred so soon after his own rule banning all girls under the age of 18 from participating in any form of sexual intercourse. The law declared that all Swazi girls were expected to wear a bundle of bright traditional tassels, known as an *Umcwasho*. The tassels signified celibacy and hung around the back of the neck and below the shoulders, like a pair of floppy ponytails, warding off potential suitors. If a couple is found guilty of contravening the law, the offender is liable to pay a fine in the form of a cow. Mswati has claimed that the *Umcwasho* policy was implemented as a preventive measure to counter the spread of HIV and AIDS (Meldrum, 2005). By disregarding his own law, Mswati was criticised for setting a poor example for his people and more specifically the youth who are vulnerable⁵⁵. Possibly in response to all the criticism by local HIV and AIDS activists, international journalists and donor officials, or because Mswati finally realised that more was needed than simply reviving a dormant tradition to help curb the HIV and AIDS epidemic, he abandoned the *Umcwasho* custom in August 2005 (*The Independent*, 23/08/05).

Mswati's shortcomings have been clearly highlighted. However, he has also shown a willingness to adopt a more proactive leadership role in Swaziland's HIV and AIDS policy response. This he displayed by participating in several HIV and AIDS awareness campaigns which were carried out domestically, regionally and internationally. Mswati also travelled extensively to obtain funding for the many AIDS orphans and programmes linked to orphans in Swaziland (BBC News, 04/12/01). A major initiative he undertook was a fundraising tour of the USA for a project called the Royal Initiative to Combat AIDS (RICA). Through this project, Mswati appealed to several American musicians, entertainers and artists to record an album called *Songs for Life*. The proceeds of the album were to be used for setting up a fund to help the fight against HIV and AIDS in Swaziland as well as in the SADC region⁵⁶. Mswati's actions in this regard reinforce the view expressed by an interviewee that as long as Mswati and the work of his government was

⁵⁵ In an attempt to rectify his actions and set a better example, Mswati later paid the fine for breaking the tradition.

⁵⁶ The success of the project has so far not been evaluated.

not questioned, he would support most initiatives aimed at combating the epidemic (interview, AIDS Specialist William J Clinton Foundation Swaziland (formerly with Ministry of Health and NERCHA), 11/4/08). This was an important finding by the non-state actors since it availed them more political space to operate within. Importantly, with the access to more political space, this also helped to empower the non-state actors with more autonomy to carry out their work and pursue securitisation ideals without the fear of being targeted by government agents.

It is rather difficult to accurately gauge what the majority of the Swazi population truly feel about the monarchy. In Swaziland the majority of the population reside in rural areas. Most of the rural population are dependent on the goodwill of the Chiefs, who are answerable to Mswati, for their livelihoods and land occupation. Swazi society is deeply traditional and throughout history people have venerated their monarchs as rulers ordained by God, fathers and protectors of the nation and custodians of culture (Corrigan, 2008:2). Swazi royalists have promoted this belief, to the extent that clergy who support them have condemned democracy as anti-Christian. However, the mystique seems to be unravelling as Swaziland has experienced unparalleled levels of discontent with the royal house.

7.5.2 Prevailing political and social gender bias society

At a UN conference in 2001 Mswati remarked that “my people are dying. They are dying before their time, leaving behind their children as orphans, and a nation in a continuous state of mourning”⁵⁷. This speech by Mswati revealed that he was in agreement with the global securitising actors at the time about the reality of the impact of the HIV and AIDS epidemic.

In this instance, Mswati complied with all three of the facilitating conditions required for the process of securitisation, as discussed in chapter 2. He accepted and followed the recognised grammar of security. By virtue of his position as King of Swaziland, and absolute ruler, as a securitising actor he was in a position of authority to pronounce on the security concerns and was able to raise the level of threat facing the population. However as will be revealed later, Mswati

⁵⁷ Mswati’s opening comments at the 2001 UN General Assembly Special Session on HIV and AIDS. Swaziland is an absolute Monarchy ruled by King Mswati III. He has been the absolute ruler since the onset of the HIV and AIDS epidemic in Swaziland.

was not always in agreement with the recognised grammar of security when he perceived it to attack his cultural norms and traditions.

While King Mswati's remarks are valid, it is important to understand that the disease affects all sectors of Swazi society differently. The role of the head of government is important in the institutional agenda setting and agenda building process (Fourie, 2005:7). Mswati's reaction was similar that of Mogae in Botswana, who accepted and understood the impact of the epidemic and was prepared to act while Mbeki in South Africa remained hesitant to fully accept the impact of the epidemic. Public problems tend to affect a substantial number of people with further consequences for people who are not directly involved (Anderson 2000:88). However, the mortality rate differs significantly between different sectors of society. The effects of HIV and AIDS on a population "depends on who the individuals are, their place in society and the resources they, their households, communities and societies have available" (Barnett and Whiteside, 2002:182). In the African context women, children, migrants and the poor tend to be more susceptible to the effects of the disease. In the case of Swaziland, women and children bear the brunt of the effects of the epidemic (Patterson, 2006:44).

In Swaziland the law has traditionally been shown to favour men at the expense of women (Patterson, 2006:45). This point is well demonstrated by examining the different definitions of adultery applicable to men and women. For instance, for women adultery is defined as voluntary sexual intercourse between a married woman and a man other than her husband while for a man, sexual intercourse between a married man and an unmarried woman or girl does not constitute adultery. In fact, sexual relationships between a married man and his younger, unmarried sister-in-law are considered acceptable (Kasenene 1993:113-114). This means that for a man adultery occurs only in the context of sexual intercourse with a married woman. Thus the struggle to combat the HIV and AIDS epidemic in Swaziland is played out in a country where moral and legal traditions permit males more leeway in their sexual behaviour at the expense of female liberties. These cultural assumptions act as an impediment to the kinds of learned behaviours required to contain the impact of the epidemic (Daly, 2001:25).

The lack of equal rights for women in Swaziland has also been a key factor in ensuring that women remain in a condition of dependence in their society. Swazi law allows regional chiefs (with the approval of the King) to maintain their own tribal traditions. These include a vast

system of unwritten laws and customs, whose eventual documentation will require extensive and painstaking research (Rweyemamu, 1990). For instance, a married woman was considered a dependent minor for as long as her husband was alive and if she relied on her in-laws for her livelihood. If she becomes a widow, she would become a dependent of her grown son, or of her husband's brother, or of the chief if there was no other male sponsor. In addition, women were not allowed to obtain a passport, open a personal or business banking account, move from one tribal region to another, purchase a car, buy land or a home without securing the approval of the sponsor (e.g., husband, father, brother, or chief) (Women and Law in Southern Africa Research Trust, 1998:167). Divorce is not a viable option and it affects only unhappily married women, since men have recourse to multiple marriages. Only as recently as February 2010 did the High Court of Swaziland rule that some married women will be allowed to register property in their own name. It has been five years since the new Constitution granted women equal status (*IRIN news*, February 2010).

In October 2002 Mswati summoned the editors of *The Times of Swaziland* newspaper, the country's only independent newspaper, to a meeting with his royal advisors. Mswati warned them that it would be unpatriotic to publish a UNDP report, *Gender focused responses to HIV/AIDS: The needs of women infected with and affected by HIV/AIDS*, which suggested cultural practices were fuelling the spread of HIV and AIDS. Mswati demonstrated contradictory ideals towards the HIV and AIDS epidemic, at the above mentioned 2001 UN General Assembly Special Session on HIV and AIDS, he agreed with and accepted the recommendations made by the international securitising actors that more focused policies were needed to address the epidemic. However, when the required policy responses appeared to challenge his cultural norms and traditions, Mswati was quick to defend his kingdom's cultural norms and traditions even at the expense of well-intended response policies to deal with the epidemic. This again impacted negatively on the country's policy making processes.

This particular UNDP report stated that some age-old Swazi customs intended to keep girls chaste before marriage, such as, for instance, arranged marriages, society's approval of multiple sexual partners for men and widow inheritance, placed more people at risk of infection. "The Swazi society expects women to be subordinate and submissive; allows men to have multiple

sexual partners; and polygamy, which exposes women to HIV infection, is legal in the country,” (UNDP, 2002).

Daphne Mthembu, an advisor to the Swaziland branch of Women in Law in Southern Africa (WLSA) observed that the lack of acceptance by Mswati of the idea that cultural practices may contribute to the spread of HIV and AIDS is one of the obstacles to the eradication of stigma and the discrimination of people living with AIDS. In response to the government’s efforts to stifle any debate regarding the UNDP report, Mthembu noted the following, “If our leaders deny that having multiple sexual partners or inheriting a widow whose husband might have died of HIV and AIDS may lead to new infections then campaigns to encourage people infected with the disease to come out in the open would come to naught” (Mthembu quoted in Nyathi, 2002).

Swaziland’s leadership has also been criticised by Special HIV and AIDS Envoy to Africa Stephen Lewis, for the way in which it has dealt with the epidemic.

The kingdom’s leadership was too slow to recognise the threat of HIV and AIDS on people’s lives and their response may have come rather too late for the kingdom to overcome the crisis it was faced with. Leadership must take a leading role in addressing the spread of the epidemic. There are a lot of things that are contributing to the spread of the epidemic and that includes those customs that renders women minors while it exposes them to the epidemic (*Agence France-Presse*, 21/03/04).

Swaziland is an example of how weak political institutions and patriarchal attitudes affect women’s vulnerability to the HIV and AIDS epidemic (interview, Regional Programme Manager PACT, Southern Africa, 10/4/08). This in turn negatively impacts on the success of policies targeted at addressing this serious concern. Since women tend to be more vulnerable to the effects of the epidemic it is necessary to ensure that the principal policymaking actors formulate and implement the required policies to strengthen the response policies to tackle the epidemic.

7.5.3 Neopatrimonialism

As already established in chapter 2, neopatrimonialism is linked to statism. The form of neopatrimonialism present in Swaziland stems from the centralisation of political power, which has impacted on the policy decision-making processes in the country. This approach can be

linked to the theory of statism, which describes the viewpoint in public policy that a government should control either economic or social policy or both to some degree (Levy, 2006:469). Sharing elements with elite theory, statism notes that elites may be positioned in state agencies where they influence public policy to advance their own political agendas. Swaziland is an example of this process in operation. Mswati's spending habits demonstrate Patrick Chabal and Jean-Pascal Daloz's (1999:160) argument that neopatrimonial state leaders engage in consumption and not production: "Ostentation remains, and is likely to remain, one of the chief political virtues in Africa".

For his 36th birthday in 2004 Mswati was accused of spending US\$600,000 on new vehicles, accommodation and food (*The New York Times*, 17/04/04). The following year his birthday party budget allegedly increased to US \$1.7 million (*iol news*, 11/04/05). The same year the Swazi Federation of Trade Unions called for and organised a two-day strike over the monarch's expenses (International Crisis Group Policy Briefing, 2005:7). The lack of accountability creates a space for corruption to take hold and grow, which in turn may prove detrimental to the efforts entailed in the policy response to the HIV and AIDS epidemic.

In 2008 to honour Mswati's 40th birthday and the nation's 40th year of independence, a new 15,000-seat stadium was built and a fleet of sedans was ordered to transport the visiting dignitaries. The cost was estimated to be several million dollars (*The New York Times*, 05/09/08). Mswati's spending habits led to much disapproval throughout the country. However, because of his position, his unilateral spending habits were beyond accountability. Frustration levels heightened over Mswati's costly celebrations and the discontent was demonstrated by the first time all-women protest against the royal shopping trip as part of the 40-40 celebrations. The protestors claimed that the money should have been used for anti-retroviral drugs instead of the celebrations (Guerin, 2008).

Patterson (2006:48) asserts that "high neopatrimonialism will have a negative impact on AIDS efforts because state leaders will divert resources from AIDS programmes to patronage." She also argues that "neopatrimonialism will drive donors from providing needed funding to fight AIDS" Patterson (2006:48). The Coordinating Assembly of Non-Governmental Organisations (CANGO) reported a general decline in grant aid extended to the country over the last few years. In Swaziland there is a definitive contrast in spending habits between expenditure on the royal

family and expenditure on health issues, which demonstrates the negative effect of neopatrimonialism for the citizens' general welfare. In 2004 Mswati spent \$14 million on new palaces for each of his wives, \$2.8 million for luxury homes for relatives, \$11 million for palace building programmes and \$45 million for a private jet. At the same time the government allocated only \$30.8 million for all national health services (International Crisis Group Policy Briefing, 2005:9-10). While it is true that it is impossible to directly link corruption to low spending on health services, it does however give some insight into that fact that the upkeep of the royal household is prioritised.

Swaziland finds itself in a rather difficult position in that it continues to record poor economic performance indicators, a high incidence of poverty, recurring drought and famine, and the adverse impact of the HIV and AIDS epidemic. Because these harsh conditions are present in Swaziland, one would assume that there would be a willingness by donors to come to the aid of the country, but several donors have demonstrated a reluctance to become more involved there. According to media reports, "Accessing funds for development has remained a serious challenge for NGOs in Swaziland, as donors continue to shun the country" (*IRIN News*, 18/01/07). According to an interviewee, "Swaziland's blame should go to the donors. Swaziland does not get a lot of support from donors because of a non-HIV and AIDS political environment" (telephone interview, UNDP – RSC Johannesburg, RSA, 8/5/08). As a result of this donor apathy, CANGO has advocated for better working partnerships between civil society and the government, as it is believed that this would reassure donors and encourage them to assist and operate more willingly in Swaziland.

Neopatrimonialism coupled with Mswati's personal behaviour has led to a situation where some donors are less eager about participating in the national response policy to deal with the HIV and AIDS epidemic in Swaziland (interview, AIDS Specialist William J Clinton Foundation (formerly with Ministry of Health and NERCHA) 11/4/08). This point is highlighted by the fact that from 2005 Swaziland received only \$15 million of a \$50 million grant from the Global Fund. Also, Swaziland was not considered to be one of the focus countries under the PEPFAR programme, despite its high HIV prevalence rate. In 2003 the UK's Department for International Development (DFID) decreased its overall assistance to Swaziland from 3.1 million Pounds in 1999 to 907,000 Pounds. The Canadian International Development Agency (CIDA) followed

suit and decreased its funding between 1999 and 2003 (CIDA, 2005). Mswati spent almost the same amount of money on his birthday celebrations in 2005 as the UK gives in aid to Swaziland. This led to DFID officials rethinking their aid pledges to Swaziland (*Sunday Telegraph*, 16/02/05). A multilateral donor official conceded: “There is no question that unfavourable reports about the country are making Swaziland a harder sell” (Hall, 2004:1). The above highlights the negative consequences of Swaziland’s neopatrimonial system, which may hamper the national response policy effort. Regardless of how well intended the HIV and AIDS policies are, this political culture may deter donors. Neopatrimonialism negatively affects policy decision-making processes, especially development projects, and is responsible for the misuse of donor aid and state budgets. Because of Swaziland’s neopatrimonial system, this impacts both on existing and potential donors. It can be assumed that the donors do not want to fund or be perceived as funding the extravagant lifestyle of Mswati at the expense of the Swazi population.

7.5.4 Funding concerns

As discussed above, reluctant funding from donors has proved problematic in Swaziland. As a result, the National Emergency Response Committee on HIV AND AIDS (NERCHA) has had to develop mechanisms to deal with any funding issues. A key reframed policy decision made was to encourage civil society members to source funding for their own projects “as we don’t want them to become over-reliant on us to fund them” (interview, Senior AIDS Officer NERCHA, Swaziland 11/4/08). Once an organisation has successfully sourced funding, it is required to inform NERCHA about the type of activity intended to be funded. This process allows for unfunded activities in the NSP to be identified and promoted more easily so, as to be addressed at a later date (interview, Senior AIDS Officer NERCHA, Swaziland, 11/4/08). NERCHA has therefore provided a platform for civil society to participate actively in the national response policy in terms of access to funding (interview, Ministry of Health: In Charge of the National Referral Laboratory at the Mbabane Government Hospital: Swaziland, 10/04/08). This policy was implemented so that funding remains monitored but not regulated thereby allowing the domestic stakeholders and the donors to collaborate without much interference.

This initiative by NERCHA to encourage civil society organisations to source their own funding was another important breakthrough. It helped further empower and reinforce civil society

autonomy. This allowed them to partner with like-minded international securitising actors and act as their conduits to help spread their securitisation ideals. Therefore, by sourcing their own funding it provided them a higher degree of authority as they became less dependent on state funding. This created a situation whereby they were in a better positioned to try and influence the policymaking processes.

A shortcoming regarding the funding environment is the unintended bureaucracy, which ends up being a major obstacle in the distribution of the funds. The NGOs claimed that the way in which the funding takes place does not allow it to trickle all the way to the grassroots communities who are in dire need of the funding and programmes. According to an interviewee,

This process does not help because people who set up an organisation stop the money from trickling all the way down as the money gets used up mainly for administrative purposes. It has been suggested that donors should develop a culture of tracing funds from top to bottom and training PLWHA to trace funding from the proposal development to implementation from the secretariat down to the grassroots level (interview, Regional Co-ordinator Shiselweni Region, SWANEPWA, Swaziland, 11/04/08).

It was hoped that implementing this process would ensure that the funding would filter all the way down to the grassroots level where it is urgently required. Training PLWHA to efficiently trace the funding builds capacity both in terms of being able to absorb the funds and also to implement and successfully carry out their programmes.

Even though funding might not be channelled directly through the government, it is still coordinated through NERCHA. For example, the William J Clinton Foundation funds paediatrics as this has been cleared by NERCHA since it is one of the activities in the NSP (interview, AIDS Specialist William J Clinton Foundation Swaziland (formerly with Ministry of Health and NERCHA) 11/4/08.) The interviewee shared her experience that funding directly to an organisation took place because no good mechanism was in place for funnelling the money through government channels. As a result, the interviewee is of the opinion that it is more efficient for donors to fund domestic organisations directly. This resulted in the international donors gaining access points into the domestic policymaking structures as they were able to exert influence over the domestic non-state actors in order to receive funding.

An interviewee from NERCHA stated that funding is sent to the applicant organisation directly. This is a standard mechanism of regulation – with the NSP a National Action Plan (NAP) is devised and it identified areas of concern that need funding. The donors are asked to identify areas from the Plan that they intend supporting. Therefore, this is a means of self-regulation which ensures that all areas of concern are sufficiently covered by all donors and relevant HIV and AIDS stakeholders. Thus, the areas of concern not covered by donors will be identified and additional funding can be sourced specifically for the unfunded activities (interview, Senior AIDS Officer NERCHA, Swaziland, 11/4/08).

Some HIV and AIDS activists as well as some donors have been critical of NERCHA's policy implementation regarding budget spending programmes. Critics have questioned the reasons behind NERCHA's spending large amounts of money on new community centres for orphans while community-based programmes already exist. Further criticism directed at NERCHA included resisting ARV's until 2004, its bureaucratic foot-dragging tendencies in negotiations with the Global Fund, as well as not doing more to educate traditional leaders about ARV treatment (*allAfrica.com*, 06/12/05). Commenting on the criticism, a Senior NERCHA official stated that NERCHA has learnt from these projects and they have taken it upon themselves to seek out their own projects, which will enable the organisation to carry out its programmes more efficiently (interview, Senior AIDS Officer NERCHA, Swaziland, 11/4/08).

7.6 Politics and differing priorities - political space for domestic non-state actors in Swaziland

7.6.1 Role of relevant stakeholders

CANGO was formed in 1983 and has a membership of 70 associated NGOs covering a wide range of social issues such as; child abuse, population control, women's empowerment and the elderly; groups devoted to the welfare of ex-prisoners, traditional healers, youth and orphans; and social service organisations such as the Boy Scouts and the Salvation Army. An HIV and AIDS Consortium was established within CANGO. The consortium is made up of all NGOs involved in activities related to HIV and AIDS, and its goal is to coordinate and solicit funds for HIV and AIDS activities. The first organisation of people living with HIV was established in 1993, and currently there are a number of such organisations in the country.

CANGO has been allowed to operate within the political space, since it has chosen a strategy which differs from that of Swaziland's trade unions and banned political organisations in that it seeks dialogue and partnership rather than adopting a confrontational approach towards the government (interview, UNAIDS - Social Mobilisation and Partnership Advisor, Swaziland, 14/04/08). Several of the interviewees mentioned that because of the nature of the political environment in Swaziland this approach worked best even if it meant taking longer to get the desired outcome.

However, a serious shortcoming on the part of the NGOs has been a lack of capacity in most of the organisations. According to an interviewee,

A problem we face is that organisations that we work with have no basic infrastructure in place such as staff, offices, computers etc., and yet the donors expect miracles. The irony is that the donors want these types of organisations to be funded, yet there is limited flexibility in their required outcomes (interview, Regional Programme Manager for the Southern Africa HIV and AIDS Prevention Programme - PACT: 10/4/08).

An official from UNAIDS shared the above opinion and agreed that in most countries civil society works in partnership with the government in its HIV and AIDS national response strategies. "However, the quality of the people that comprise the civil society representation can be a problem as experienced in Swaziland" (interview, Regional Programme Manager for the Southern Africa HIV and AIDS Prevention Programme - PACT: 10/4/08).

According to CANGO's Executive Director Emmanuel Ndlangamandla,

A strong and sustained civil society voice is required to address national challenges. Through effective citizen participation in governance, monitoring of national strategies, policies and programmes, and engaging policy and legislation, NGOs and civil society could effectively lobby the government to address challenges (*IRIN News*, 18/01/07).

Although Ndlangamandla makes a valid point, the monarchy continues to be suspicious of NGOs, which are known to be critical of the government, which hampered the nation response policy. Ndlangamandla's point regarding the monarchy was supported by several of the interviewees. While agreeing that Mswati does not look too favourably on NGOs, who are

deemed too critical of the government, there was consensus that he has shown a readiness to be more open to supporting NGOs that dealt only and specifically with HIV and AIDS concerns and not issues critical of the government. A key finding drawn from the interviewees regarding political space was that civil society actors felt that the government showed a bias towards certain NGOs. According to Amos Ndwandwe, who works as a counsellor for an HIV and AIDS NGO (which he declined to identify), “It has been building for some years. The deeper Swaziland sinks into poverty, hunger and AIDS, and the more dependent we become on non-governmental organisations, the more hostile government officials, like MPs and some chiefs, come to NGOs” (Norwegian Council for Africa, 1 October 2009).

According to an interviewee, the government tends to question the agendas of NGOs they perceived as suspicious, and it questions the intentions of their funders as they are more often than not foreign based (interview, AIDS Specialist William J Clinton Foundation Swaziland (formerly with Ministry of Health and NERCHA) 11/4/08). This was in conflict with NERCHA since it actively encouraged NGOs to source their own funding for their programmes. This situation created an environment in which the political space for NGOs in the country was limited, which directly impacted on their influence to shape policy and influence the country’s leadership to accept their ideas. This is in line with statist theory on public policy. The NGOs responded to the lack of political space by stating that their sole interest is to help benefit the Swazi people and not too meddle in local or national politics (interview, AIDS Specialist William J Clinton Foundation Swaziland (formerly with Ministry of Health and NERCHA) 11/4/08).

In an important move to appear more progressive, the government tacitly ceded the handling of certain critical humanitarian situations over to civil society, for example dealing with the food crisis and engaging in the national response to HIV and AIDS (interview, UNAIDS - Social Mobilisation and Partnership Advisor, Swaziland, 14/04/08). This meant that more political space was freed up which benefitted and strengthened the policy decision-making formulation processes in the country as it became more inclusive of all relevant actors that were previously excluded because of (perceived) political differences. However, as discussed earlier, civil society actors have experienced a drop in donor support, which has detrimentally affected their activities

and ability to implement programmes. According to Ndlangamandla, “some of the NGOs have scaled down their programmes, whilst others are closing shop” (*IRIN News*, 18/01/07).

7.6.2 Weak civil society

Because of its history and political landscape, Swaziland does not have a long history of vibrant social movements. There have been instances where a nascent social movement seemed to be taking root but the absolutist political status quo it did not always allow it to prosper. Recently, there have been positive changes noticed with the growth of more organisations being established to deal with social concerns (interview, Regional Co-ordinator Shiselweni Region, SWANEPWA, Swaziland 11/04/08).

According to CANGO, “the country’s weak civil society voice, coupled with citizen apathy, made glaring the fact that the Swaziland government and the private sector lacked an effective civil society partner for the country to effectively address these daunting challenges” (*ReliefWeb Report*, 18/01/07). CANGO blames Swaziland’s weak civil society which it believes is hampering efforts to adequately address the humanitarian crisis in the country (*IRIN News*, 18/01/07). CANGO itself however, fails to address the failures of government to also play its part in addressing the humanitarian crisis facing Swaziland. CANGO’s position may be based on the fact that openly challenging the government may have repercussions.

However as expressed earlier, while traditionally civil society in Swaziland was relatively weak two important occurrences took place to challenge this status quo. Firstly, civil society actors made the realisation that they could access more political space if they focused solely on humanitarian and HIV and AIDS issues and not issues targeting the government or Msawti directly. The outcome of this was the freeing up of more political space, which meant that more civil society actors were able to become a part of and able to exert a degree of influence over the policymaking processes in Swaziland on HIV and AIDS issues. Secondly, NERCHA permitted civil society organisations to source their own funding for their programmes. This situation opened up a conduit through the domestic non-state actors’ access, for international non-state actors, to influence and access the policy decision-making structure in Swaziland. This also allowed the international securitising actors to spread their ideals through this process that had previously been closed or rather difficult to access.

7.7 Policy power dynamics – engagement between the state and domestic actors

In December 2001 NERCHA was established, in line with the promotion of the “Three Ones” principles, and replaced the CMTC. NERCHA was elevated to the Office of the Prime Minister. Situating it in the office of the Prime Minister showed a renewed determination and a reframing of the understanding of the urgency of the need to deal with the epidemic (interview, the Director of NERCHA, Swaziland, 11/4/08). It was tasked with converting the CMTC’s national strategic plan for HIV and AIDS into an action plan. NERCHA was also tasked with coordinating and mobilising resources for an expanded and coordinated national response in the country. In addition, it promoted a wider and more inclusive multi-sector involvement of all HIV and AIDS stakeholders. Dye (1995:23) states that pluralists support the idea that the conduct of politics in society begins with the interaction among groups, with the latter constituted of “individuals with common interests”.

NERCHA has been instrumental in conducting research in addition to working with multilateral donors to help develop HIV and AIDS policies (Whiteside, 2005:98). The NERCHA committee attained council status by an act of Parliament. The key objectives of the council are to coordinate and facilitate:

- the achievement of preventive behaviour towards the transmission and contracting of HIV and AIDS;
- the provision of comprehensive and appropriate care and support for people infected and affected by HIV and AIDS;
- the minimisation of the impact of HIV and AIDS on society;
- the monitoring and evaluation of services as well as measuring the impact of HIV and AIDS on the Swazi people;
- the mobilisation of financial and technical resources, including the management and allocation of these to implementing agencies; and
- the periodic review and updating of HIV and AIDS-related policies and guidelines.

(Policy Document on HIV AND AIDS and STD Prevention and Control, Ministry of Health and Social Welfare, Swaziland Government, 2001)

According to an AIDS expert, NERCHA is strong with good leadership⁵⁸ in place and capable of carrying out its objectives, and it has worked closely with the Global Fund and UNAIDS (interview, AIDS Expert, University of Johannesburg (UJ), 25/04/08). “That cooperation is fairly unique and constructive” (interview, AIDS Expert University of Johannesburg: 25/04/08). NERCHA carried out policy agenda-setting processes that created an environment within which donors and NGOs seeking funding were able to work together. This led to the promotion of further interaction between the government and non-state stakeholders working together to combat the epidemic. According to an interviewee, “there is political commitment in the fight against HIV and AIDS in Swaziland” (interview, Director of NERCHA, Swaziland, 11/4/08) which if maintained, will strengthen the HIV and AIDS national response policy effort.

In 2003 the Ministry of Health and Social Welfare (MOHSW) launched the Emergency Care and Treatment Implementation Plan to provide free antiretroviral therapy (ART) to people living with HIV and AIDS. This reframed policy decision brought about a significant increase in the number of health facilities in the country, which rose from 3 in 2003 to 17 in 2005. This was in line with the global securitising actors call for securitisation of the HIV and AIDS epidemic as it permitted the purchase of cheaper generic AIDS drugs. Swaziland experienced financial difficulties and as a result the ability to purchase the generic AIDS drugs was a benefit brought about by the securitisation of the epidemic. Also, unlike the situation in South Africa, Swaziland was not opposed to the provision of patented AIDS drugs. Presently, international sources still cover the majority of Swaziland’s HIV response at 60 per cent in 2010, up from 55 per cent in 2009, while domestic funding remains at around 44 per cent (UNAIDS, 2012, March). According to the 2007 WHO/UNAIDS/UNICEF report, *Towards Universal Access*, 42 per cent of HIV-infected people in Swaziland are receiving treatment. However, a UN report released in December 2008 revealed that revised projections indicated that twice as many HIV-positive Swazis are in need of ARV drugs than initially predicted (UNAIDS, 2008).

While there were certain successes, several factors led to Swaziland’s ARV programme failing to meet its objectives. As a result of financial constraints the government hospital in Mbabane, the capital city’s main ARV distribution point, periodically runs out of the drugs (interview,

⁵⁸ The interviewee expressed his faith in the leadership qualities and capabilities of NERCHA’s Director Dr Derek von Wissel.

Ministry of Health Official: In Charge of the National Referral Laboratory at the Mbabane Government Hospital: Swaziland, 10/04/08). In 2007, 8,000 patients, almost a quarter of all patients on ARVs, disappeared from the ARV treatment programme. A survey conducted by the MOHSW found that irregular drug shortages were not the only reason; a lack of health facilities distributing the drugs and inadequate adherence counselling were also obstacles to patients staying on treatment (*IRIN Plus News*, 3/12/08). An ARV therapy coordinator at SNAP claimed that “the distance to hospitals was given as the main reason people became defaulters (stopped taking their drugs). They either couldn’t get to the ARV distribution centres at hospitals in the towns, or they didn’t have money for transport” (*IRIN Plus News*, 3/12/08).

In an attempt to resolve the problem, a reframed policy decision was made to decentralise ARV drug distribution from a small number of provincial hospitals to 196 clinics across the country. Once patients were deemed stable, which takes place after about six months on ARV treatment, they are referred from a provincial hospital to their local clinic. It was estimated that about 185,000 of Swaziland’s one million population were HIV positive, while only about 30 000 were receiving ARV treatment at the time (UNGASS Swaziland Country Report 2008).

While many international donors appeared to be reluctant to sponsor programmes in Swaziland, in January 2005 Bristol-Myers Squibb announced the construction of Swaziland’s first paediatric HIV and AIDS centre to provide care and treatment to children living with HIV and AIDS, and to provide support to the families. This proved that while donors may have been reluctant to donate they preferred to sponsor programmes such as these where no actual money was handed over in the process. Also in 2005, under the supervision of NERCHA, the first National Strategic Plan was reviewed by a broad group of national stakeholders. Based on this review, a new National HIV and AIDS Strategic Plan for 2006-2008, a National HIV and AIDS Action Plan, and the National Multi-sectoral HIV and AIDS Policy were developed in 2006 to help coordinate the policy for the national response. NERCHA identified six key priority areas to be covered in the new national response plan: prevention; care and support; impact mitigation; communications; monitoring and evaluation; and management and coordination.

In 2006 the government announced that as a result of these successful efforts there was a slight decline in Swaziland’s HIV prevalence rate among pregnant women, which had dropped from 42.6 per cent in 2004 to 39.2 per cent. NERCHA’s Director, Dr Derek von Wissel, proclaimed in

2006, “We are cautiously optimistic that our prevention strategies are beginning to take hold” (*IRIN News*, 5/12/2006). However, this decline in percentage has not been maintained and a recent study by the government referred to in the media has claimed that about 42 per cent of pregnant women in Swaziland are HIV positive, a 3 per cent increase from 2008. The report also stated that the increase in 2008 was partly because more women were taking life-prolonging ARV medication (USAID: Swaziland, October 2010)

In essence, the events described above can be attributed to the process of framing and reframing of policymaking which was necessary for strengthening the national response policy to address the HIV and AIDS epidemic in Swaziland.

7.8 Domestic cooperation

Several NGOs and community based organisations (CBOs) dealt solely with HIV and AIDS issues⁵⁹, while others started mainstreaming HIV and AIDS within their core programmes⁶⁰. The Churches United Against HIV and AIDS in Eastern and Southern Africa Ambassadors of Hope Programme is one faith-based programme seeking to establish PLHWA support groups within churches. At the municipal level, the Alliance of Mayors Initiative for Community Action on AIDS at the Local Level (AMICAALL) and NGOs have carried out programmes which have resulted in the establishment of youth organisations (UN AMICAALL Partnership Programme, December 2005).

According to the UNGASS Swaziland Country Report 2008, civil society members in Swaziland believe that their involvement in the national policy response to the HIV and AIDS epidemic has improved over the years, but scored its involvement as 40 per cent in 2007, the same score as in 2005. This may be attributed to the freeing up of political space for these actors. Civil society organisations are involved in the activities of the Global Fund, since they are members of the Country Coordinating Mechanism. However, civil society has very limited involvement in non-Global Fund-supported activities. To establish a more meaningful and effective involvement on

⁵⁹ These include The AIDS Support Centre, Swaziland AIDS Support Organisation (SASO) and Hospice at Home.

⁶⁰ Examples include amongst others, World Vision, Save the Children Fund, Lutheran Development Services, Africa Cooperative Action Trust, Caritas, Council of Swaziland Churches, Baphalai Swaziland Red Cross, Swaziland Action Group Against Abuse (SWAGAA), Umptapo Women’s Resources Centre and Save Our Souls.

an on-going basis in the national response, civil society members have recommended the following:

- i) They should be included in the overall policy and planning processes at all times, since they are responsible for a reasonable bulk of the response in home based care (HBC), care and support, clinical care, information, education and communication (IEC), and BCC programmes;
- ii) They should have more targeted representation in decision-making forums, whether at the local, regional or national level;
- iii) They should be more involved in technical forums or working groups, such as research committees, planning and budgeting committees and committees developing guidelines (UNGASS Swaziland Country Report 2008).

An important development in the country has been the formation of several PLWHA organisations. The first organisation formed by and for PLWHA, was the Swaziland AIDS Support Organisation, established as early as 1993. Several other organisations have been established such as Swazis for Positive Living (SWAPOL), Women Together and Imphilo Isachubeka (Life Goes On). In 2004 the International Community of Women Living with HIV opened a regional office in Swaziland.

After analysing the interviews, a finding was that several interviewees mentioned the need for the formation of a mass social movement to support and strengthen the national response policy to deal with the HIV and AIDS epidemic. According to the Director of NERCHA, there is an urgent need for a social movement to mobilise the population to do their part in helping to confront the epidemic (interview, the Director of NERCHA, Swaziland, 11/4/08). According to an interviewee,

Get the grassroots working - creating a social movement. Most of the population lives in the rural areas, but you find the implementers operating from the semi-urban areas mainly. If we could have a social movement who will help. People should not always wait for someone to come and help them. They need to get up and mobilise themselves so

they can better understand the impact of the disease on their communities (interview, UNAIDS - Social Mobilisation and Partnership Advisor, Swaziland, 14/2/08).

The interviewees expressed an explicit need to get the grassroots population empowered. This is so that they will be able to demand the service they are entitled to receive. In this way they may be able to put pressure on their local government structures to be provided with better health facilities and access to medicine.

We believe that grassroots groups, which for years have focused on particular social ills, have garnered expertise and experience that would be valuable in national policymaking, and the execution of those policies. But NGOs are frustrated by this feeling – it's more than a feeling, actually – that government does not see them as equal partners (*IRIN News*, 18/01/07).

The interviewees' use of the term 'social movement' suggests they see a social movement as both organised or unorganised/spontaneous mobilisation and collaboration for a specific purpose. An interviewee stated that to further strengthen the national response policy, it was necessary to get the grassroots working by creating such a social movement where everyone is committed to be contributing to the national response policy (interview, UNAIDS – Social Mobilisation and Partnership Advisor, Swaziland, 14/2/08). Additionally, another interviewee stated that awareness programmes must be implemented educating the population to understand that complaining and establishing a mass social movement against the HIV and AIDS epidemic is not an attack against the King. "A mass social movement enables a forum to be created to formulate better strategies to tackle the impact of the epidemic, thus creating the political space needed for this emergency as opposed to merely criticising Mswati's rule" (interview, AIDS Specialist William J Clinton Foundation Swaziland (formerly with Ministry of Health and NERCHA), 11/4/08). Therefore, as highlighted earlier, in order to address the concerns related to perceived attacks on the King, it is necessary to ensure that HIV and AIDS programmes do not include criticism of Mswati as this will hamper the successful implementation of such programmes.

7.9 Politics and differing priorities – political space for international non-state actors in Swaziland

By adopting a more progressive reframed policy approach towards the HIV and AIDS epidemic, the government opened the political space for domestic and international HIV and AIDS stakeholders to operate within Swaziland in support of the national response policy. However, this new approach by the government was open to abuse by certain organisations, which sought more political space and access into the policymaking processes than what was made available to them. For instance, from the interviews conducted it was mentioned that Medicins Sans Frontieres (MSF), who had arrived recently in Swaziland and been very vocal and raised concerns about the HIV and AIDS emergency that exists in the country. This has resulted in calls of resistance to MSF's perceived aggressive methods. Their approach cannot be explained away by simply stating that MSF does not understand the culture of the Swazi people. According to an interviewee, "you can work with people to get things working. You cannot arrive and think your way is always the correct or only way. Or even that the locals are being too slow and they cannot wait for the locals to catch up before implementing their own programmes" (interview, AIDS Specialist William J Clinton Foundation Swaziland (formerly with Ministry of Health and NERCHA) 11/4/08).

As a result, MSF is experiencing more problems trying to get things done. The interviewee asserts that,

Most organisations know that they have to get along to be able to get the work done. It depends on the organisation and how long they have been in the country. Even the ones who seem to be doing very little are in effect the ones getting the most done. MSF needs to learn this ... there is a right approach (interview, AIDS Specialist William J Clinton Foundation Swaziland (formerly with Ministry of Health and NERCHA) 11/4/08).

Having learnt from similar experiences, since HIV and AIDS was declared a national disaster, all the UN agencies assistance has moved from their traditional mandate to focusing on HIV and AIDS as part of the joint programming of the United Nations Country Team (UNCT). The UN agencies WHO, UNDP, UNICEF, FAO, WFP, UNESCO, UNFPA and the UNAIDS Secretariat are members of the UN Theme Group on HIV and AIDS in Swaziland and convene monthly

meetings. The Inter-Agency Technical Working Group comprising of HIV and AIDS focal persons from each agency meets weekly. In 2002 the UN Theme Group membership was extended to include other development partners, donors and NERCHA, who meet quarterly. More recently, the Ministry of Health and Social Welfare was also incorporated into this group (UNAIDS at Country Level Progress Report, 2004:90). This was an important initiative by the international securitising actors as it gave them access to influence the policymaking structures and processes in the country. This helped these securitising actors to influence and set the HIV and AIDS policy agenda in Swaziland. The UN Theme Group has supported the government of Swaziland in the development of several national frameworks and policies for the improved management of the national response towards HIV and AIDS, advocacy activities, training and capacity-building initiatives, research, and increasing availability and accessibility of HIV and AIDS services (UNDP Swaziland Country Profile, 2009).

Several examples highlight the times when the UN Theme Group jointly undertook programmes in Swaziland such as the funding of initiatives specifically targeting adolescents in the country. The focus areas included capacity development of youth NGOs, provision of youth-friendly services, orphans care, and support for people living with HIV and AIDS as well as community mobilisation. The UN agencies involved in this initiative were UNDP, UNICEF, WHO and UNFPA. Each of the agencies undertook activities in line with their corporate mandates. Building on this experience, UNDP, WHO, UNAIDS, UNFPA, FAO, WFP, and UNESCO in collaboration with their partners are currently developing joint programmes in the areas of HIV and AIDS prevention; impact mitigation; care, support and treatment; and Management of the National Response (UNDP: Swaziland Country Profile, 2009).

UNAIDS has long been an important partner in the national response policy addressing the epidemic in Swaziland. The role that UNAIDS performs at country level is no different from its role at the global level. UNAIDS is a facilitator working in conjunction with the government which retains the role of implementer (interview, UNAIDS - Social Mobilisation and Partnership Advisor, Swaziland, 14/2/08). It has been influential in providing technical support to NERCHA to advocate for the importance of having a national Monitoring and Evaluation (M&E) Plan that would not only help monitor and evaluate the actions that have already been financed, but also to support Swaziland's in dealing with donors. In partnership activities with NERCHA and Support

to International Partnership Against AIDS in Africa (SIPAA), UNAIDS has facilitated a rapid assessment of organisations of people living with HIV by PLWHAs themselves. In addition, UNAIDS has provided a technical assistant in order to support the government in its preparations for the Global Fund proposals applications. UNAIDS speaks about a multi-sectoral approach which involves all relevant stakeholders and not necessarily of a security approach (interview, UNAIDS - Social Mobilisation and Partnership Advisor, Swaziland, 14/2/08).

Responding to a call in March 2003 by the UN Secretary-General for a renewed commitment and a reinvigorated campaign to challenge the HIV and AIDS crisis the UNCT gathered and developed a six-month emergency plan of action. The gathering concluded that the UNCT should identify certain areas where it would be able to support NERCHA so as to form closer working relations in order to address the threat posed by the HIV and AIDS emergency. Interestingly, there have been calls for the HIV and AIDS crisis not to be treated as an emergency any longer. “The whole managing by crisis should stop. HIV and AIDS is not an emergency it is here already. We must deal with it and accept it so that we can move sufficiently forward as opposed to playing catch up all the time” (interview, Ministry of Health: In Charge of the National Referral Laboratory at the Mbabane Government Hospital: Swaziland, 10/04/08).

When developing its yearly plan of action on HIV and AIDS in support of the national policy response strategy, the UN Theme Group identified five priority areas; antiretroviral therapy, orphans and vulnerable children, food security and nutrition, communication, and capacity building and replenishment. The process is carried out in consultation with its cooperating partners (UNAIDS Swaziland Country Level Progress Report, 2004:90). With the inclusion of more securitising actors in the policy decision-making process the international securitising actors found an access point into the decision-making structure which they were able to exert a degree of influence over.

7.10 Policy power dynamics – engagement between the state and international actors in Swaziland

The UN has encountered several challenges in the course of carrying out its work in Swaziland. A factor such as depleted human resources, especially in the health sector, is a major challenge. A depleted health sector means that it may become very difficult to provide the much-needed

health care to the population. This opinion is echoed by an interviewee, who stated that if the infrastructure is not sound, then the work carried out cannot be expected to be sound (interviewed, Regional Co-ordinator Shiselweni Region, SWANEPWA official, Swaziland, 11/04/08). The on-going food shortages have added to the burden of the humanitarian crisis aggravated by the HIV and AIDS epidemic. The high percentage and ever-increasing of number of orphans and vulnerable children also requires special attention. According to an interviewee, “Only 24 per cent of children are growing up in a dual-parent household” (interview, the Director of NERCHA, Swaziland, 11/4/08). Finally, there is a need for an overall communication strategy as part of the national response policy to include more relevant information on antiretroviral therapy for the general public. According to an interviewee,

You cannot isolate one element as more important than the other but nutrition alone does not cure aids while at the same time ARVs without food kills. Furthermore, wording ARVs as poisonous is negligent as it is toxic but with proper nutrition it works. Religious people must not merely pray for you, they need to pray for you and the ARVs to work (interview, the Director of NERCHA, Swaziland 11/4/08).

There have been claims that the US government has taken too much credit for the success of HIV and AIDS programmes in Swaziland. According to an interviewee, “donors still want the credit. Just attend the meetings and you will see that credit has been taken” (interview, Ministry of Health: In Charge of the National Referral Laboratory at the Mbabane Government Hospital: Swaziland, 10/04/08). This approach by the donors has strained the working relations with both the government and domestic AIDS stakeholders, which impacts negatively on policy.

In order to motivate domestic stakeholders, it is important for them to receive the necessary recognition for their successes as motivation and encouragement. According to a UNAIDS official, this “used to be the norm but there is a change that is taking place amongst the donors and they are recognising the need to give credit where it is due” (interview, UNAIDS - Social Mobilisation and Partnership Advisor, Swaziland, 14/2/08). Recognition of work carried out is important and strengthens working relationships between international and domestic non-state actors.

NERCHA has raised a concern regarding the coordination efforts in the national response policy. According to an interviewee, “coordination is a problem; we are trying very hard to coordinate”. It becomes more difficult when, “USG [the US government] will not reveal their figures to NERCHA so the coordination problem is not just with local civil society” (interview, the Director of NERCHA, Swaziland, 11/4/08). At the end of the year the US government figures are requested, but they are not always released. All the relevant stakeholders want better coordination channels, yet at the same time they do not want to be coordinated. He added that the problem with coordination is that “trying to coordinate is like herding cats, not sheep. They don’t all go in one direction” (interview, the Director of NERCHA, Swaziland, 11/4/08).

UNAIDS was instrumental in initiating the move from the Expanded Theme Group to a Partnership Forum. This Partnership Forum includes HIV and AIDS stakeholders from NGOs, the private sector, faith-based organisations, people living with HIV, the media, youth groups and key government Ministries (UNAIDS Country Level Progress Report, 2004:91). The UNAIDS office has been sharing best practices documents, position papers and publications with its partners in the country. NERCHA’s intention to open a resource centre/library was supported by UNAIDS in principle as well as the provision of essential materials.

UNAIDS has continued to report on the severity of the serious human resource problem experienced throughout the country. The Ministry of Health is burdened as trained nurses leave the country for better opportunities on a continuing basis. Thus there is a problem regarding capable personnel required to implement the formulated policies. Several of the interviewees suggested that local community representatives should be utilised to carry out such work. According to an interviewee, “the people on the ground know better than people looking in from outside. Listen to the actual needs of the locals before you offer help” (interview, Regional Co-ordinator Shiselweni Region, SWANEPWA, Swaziland, 11/04/08). This will help empower the local people to become more actively and productively involved to support and strengthen the national response policy.

The WHO has also been a very influential actor in the fight against the HIV and AIDS epidemic in Swaziland. The Ministry of Health and Social Welfare remains the lead actor in delivering HIV-prevention, care and treatment services. The WHO has provided technical support for developing clinical guidelines for HIV care and treatment, voluntary counselling and testing,

human capacity building, drug procurement and supply management (WHO Swaziland profile, December 2005). The health workforce was comprehensively analysed in 2004 with support from the WHO. Also strategies to strengthen the human resource base were identified, as well as ensuring that the existing health workforce is utilised to its optimum, recruiting and retaining additional health professionals and inspiring leadership and motivation among workers.

As illustrated above, the most important priority of the strategy, according to the Ministry of Health and Social Welfare, is to build the capacity of “rural health motivators” - primary health care workers. According to an interviewee, “the people of the country understand the problem/impact better than outsiders” (interview, UNAIDS - Social Mobilisation and Partnership Advisor, Swaziland 14/2/08). Health workers are being trained with support from the WHO, using the Integrated Management of Adult and Adolescent Illness (IMAI) strategy. Swaziland has a relatively good infrastructure of roads, electricity and water and community networks, which can be beneficial for the national response policy.

Lastly, the WHO was also influential in the evaluation of the Health Sector Response Plan for HIV and AIDS for 2003-2005 and for further developing a health sector response plan for 2006-2008. Because of its extensive experience, the WHO expressed its intention to help the government by providing continued support in strengthening the mechanisms for procuring and supplying drugs to fight the epidemic. Additionally, the WHO will support the development and implementation of a countrywide information, education and communication strategy, which will target the general public and specific groups, including health workers, people living with HIV and AIDS, teenagers, schoolchildren and the mass media. It is hoped that having a better education and communication policy strategy in place will encourage a change in sexual practices and behaviour.

7.11 Securitisation approach and the relevant actors involved

7.11.1 Domestic securitising actors - NERCHA and SWANEPWA

As already set out in chapter 2, according to Buzan et al. (1998:40), “a security actor is someone, or a group, who performs the security speech-act”. These actors can come from political leaders, bureaucracies, governments, lobbyists and pressure groups. According to this definition, both

NERCHA and SWANEPWA can be considered securitising actors in Swaziland. As Swaziland's key HIV and AIDS policy decision-making body, NERCHA is an important securitising actor in leading the national policy response strategy for dealing with the HIV and AIDS epidemic. Interestingly, NERCHA's emblem is a short-range close-contact Swazi fighting spear with the caption *Nation at War*. This deliberate use of security imagery symbolises the fact that Swaziland is at war with the epidemic. This is in line with basic premise of this thesis, that is, to successfully frame something in terms of security, a securitising actor has to convince a significant audience that a specific issue constitutes an existential threat (Buzan et al., 1998:32). This is done through the action of speech-act which NERCHA was able to achieve through the use of security imagery. This is similar to the approach demonstrated by NACA in Botswana utilising the imagery and language of wartime security.

An important civil society AIDS securitising actor in Swaziland is the Swaziland National Network of People Living with HIV and AIDS (SWANEPWA) which is an umbrella organisation established for PLWHA in 2004. The organisation provides free ARV drugs provided through the Global Fund and the government of Swaziland (interview, Regional Co-ordinator Shiselweni Region, SWANEPWA, Swaziland, 11/04/08). SWANEPWA has been instrumental in promoting the approach of making donors realise that "people on the ground know better than people looking in from outside. Listen before you offer help" (interview, Regional Co-ordinator Shiselweni Region, SWANEPWA, Swaziland, 11/04/08). SWANEPWA positions itself as the voice for all people living with HIV and AIDS, while also striving to improve the quality of life for these people. SWANEPWA position as an umbrella body allowed the organisation to reach a wider audience of the society.

Importantly, SWANEPWA's efforts helped in decentralising the ARV treatment to the communities, so that people do not have to travel so far to health centres for treatment, as many are poor and unemployed (interview, Regional Co-ordinator Shiselweni Region, SWANEPWA, Swaziland, 11/04/08). This thinking was in line with thinking of international actors, namely UNAIDS, which promoted the decentralisation of ARV treatment to the communities. This was an important contribution that influenced and persuaded role players to reframe the policymaking processes in Swaziland, leading to the decentralisation. The objective of SWANEPWA is to strengthen support groups at community level so they can become self-

sufficient advocates on their own at various community levels. This strengthened their position to access help from the government directly in a more decentralised system of the government. The involvement and participation of communities in providing care and support to people living with HIV and orphans in Swaziland has been heralded as a prime example of ‘best practice’ within the AIDS response (interview, Director of NERCHA, Swaziland, 11/4/08).

At a meeting with the Prime Minister Themba Dlamini, UNAIDS’s Peter Piot applauded the excellent examples in Swaziland of where the decentralisation of the HIV and AIDS national response policy by using local community structures has helped reach the people most in need and at risk of succumbing to the epidemic. Piot encouraged Swaziland to continue to build on these positive experiences to ensure future successes and explained that, “Swaziland is a country facing extreme challenges, with high HIV prevalence levels - but the country has shown that by decentralising the response, more people can be reached and engaged, with the community becoming a central force of the response” (UNAIDS, 01/05/07).

In chapter 2, three facilitating conditions were necessary for a speech-act to be considered successful were discussed. Both NERCHA and SWANEPWA complied with some of the facilitating conditions required for the process of securitisation. Both actors accepted and followed the recognised grammar of security. But they were both were not in a position of authority to pronounce on the security concerns. However, more importantly, they were able to raise the level of threat facing the population.

7.11.2 The USA as a key-securitisation actor in Swaziland

As in Botswana and South Africa, the US government is a very important bilateral actor in Swaziland, with bilateral relations dating back to independence in 1968. The USA is Swaziland’s largest bilateral donor in that it provides one-third of the Global Fund’s total contributions. For the fiscal year of 2008 Swaziland received \$8.33 million through the US Agency for International Development (USAID), for essential HIV and AIDS programs and services (USAID Swaziland HIV/AIDS Health Profile, 2008). USAID programs in Swaziland are implemented in collaboration with the US President’s Emergency Plan for AIDS Relief (PEPFAR).

In order to be in line for PEPFAR's overarching goal of treating two million people with HIV and AIDS, a country must have a large number of HIV-positive people. Even though Swaziland has very high HIV prevalence rates, it was excluded because of its relatively small population (UNAIDS, 2004:191). Although Swaziland is not one of PEPFAR's 15 focus countries, it does benefit from the bilateral assistance. According to a NERCHA official, "Swaziland is a non-PEPFAR country yet we are benefiting from it" (interview, Senior Planning Officer NERCHA, Swaziland 11/4/08).

On July 30 2008 PEPFAR was re-authorized to the amount of \$39 billion for HIV and AIDS bilateral programmes and contributions to the Global Fund. This is evidence of the continued commitment by the US government to fight the global HIV and AIDS pandemic. By working in partnership with host nations, the new initiative will support antiretroviral treatment for at least 3 million people, prevention of 12 million new HIV infections, and care and support for 12 million people, including 5 million orphans and vulnerable children (USAID Swaziland: HIV and AIDS Health Profile, September 2008). The PEPFAR team comprises of several US government agencies, namely USAID, the Department of Health and Human Services/Centres for Disease Control and Prevention (HHS/CDC), the Department of Defence, the Peace Corps, the Department of State (DOS), and the Department of Labour (USAID Swaziland: HIV AND AIDS Health Profile, September 2008).

The PEPFAR programme carries out activities in all the regions of Swaziland and is organised around four main technical areas: prevention, care and treatment, human capacity development, and strategic information. By working in close collaboration with and by utilising the particular technical expertise of each agency, the PEPFAR programme is working to implement a sustainable, evidence-based, results-oriented programme (USAID Swaziland: HIV and AIDS Health Profile, September 2008).

USAID administers the bulk of the PEPFAR funding, followed by the CDC and the Department of State (DoS). USAID programme and technical support focuses on prevention, human capacity development, NGO capacity building, and strengthening of health systems. USAID also provides significant technical assistance to the development and management of ART and patient monitoring systems in order to assist Swaziland in adhering to the requirements set out by the Global Fund (USAID Swaziland: HIV AND AIDS Health Profile, September 2008).

In 2003 the Peace Corps volunteers were reintroduced to Swaziland after a nine-year absence. The current Peace Corps/Swaziland programme, namely Community Health Project, focuses primarily on the HIV and AIDS threat to the country. It provides assistance in the execution of two components of the HIV and AIDS national response policy; risk reduction and mitigation of the impact of the disease. Volunteers travel throughout the country spreading their ideas and act as securitising agents to encourage the youth to adopt appropriate sexual behavioural changes in line with their policies. They also work with children orphaned by the HIV and AIDS pandemic and they are active in assisting in capacity building for NGOs and CBOs. The fact that they are able to carry out their work and spread their ideas throughout the country provides the volunteers with an opportunity to introduce their securitising ideas, often persuading sections of the population to adopt their values.

The USAID Regional HIV and AIDS Program, based in Pretoria, South Africa, provide technical and program management assistance to the PEPFAR programmes in Swaziland. The US government has laid claim to being responsible for several successful HIV and AIDS initiatives carried out by USAID and PEPFAR in Swaziland. The successes include:

- A computerised system implemented to manage and monitor antiretroviral drugs (ARVs) at ART sites, which enabled the Global Fund to lift its moratorium on the use of Global Fund resources to purchase ARVs and TB medicines for Swaziland Government programmes;
- A successful family-centred care model for the prevention of mother-to-child transmission of HIV, which has resulted in a rapidly increasing number of individuals who receive HIV counselling and testing;
- Assistance in collaboration with the CDC on the National TB Programme (NTP). Policy, operational guidelines/standard operating procedures, laboratory services, in-service training, and programmatic and surveillance information systems for infection control planning and extensively drug- and multidrug-resistant TB have all been upgraded. The NTP has evolved from a weak organisation at risk of losing Global Fund allocations to one now regarded as a fairly strong part of the overall programmatic response to HIV and TB in Swaziland;

- Support for the Swaziland National AIDS Programme in the area of HIV testing and counselling. The organisations have been at the forefront of scaling up policy, technical guidance, service delivery, and training for national HIV testing and counselling scale-up. The US government has provided very substantial assistance in the roll-out of Swaziland's provider-initiated counselling and testing plan while maintaining important focus on outreach and client-initiated counselling and testing;
- Support for the Swaziland Action Group Against Abuse's programme "Reducing Gender-Based Violence as a Cause and Consequence of HIV AND AIDS," which reached more than 5,980 people in 67 communities, while also promoting men's involvement in the prevention of HIV infection and gender-based violence;
- Support for HIV and AIDS prevention, palliative care, and orphans and vulnerable children support grants to local and international NGOs and faith - and community-based organizations, designed to facilitate the efficient flow of grant funds and to deliver capacity-building services to organizations contributing to the fight against HIV and AIDS.

(USAID Swaziland: HIV and AIDS Health Profile, September 2008)

In an attempt to counter critics challenging them, the US government partners took a policy decision that changed the format of their meetings. The new policy implemented was that all relevant stakeholders, including the government, were invited for the purpose of outlining and coordinating their strategic plan for the year. This forum raised awareness amongst the participants of the activities planned for the year. This was important, as it strengthened the coordination process and created an opportunity for all actors present at the meeting to identify whether there were any overlapping programmes so that this could be addressed accordingly (interview, AIDS Specialist William J Clinton Foundation Swaziland (formerly with Ministry of Health and NERCHA) 11/4/08). This initiative by the US government partners has been influential in supporting the objectives set out in the NSP. This process allows the relevant HIV and AIDS stakeholders an opportunity to ensure that more of the objectives are met so as to avoid duplication of programmes. This forum also allowed them to share their ideas and to try persuading the participants to accept them. The meeting provided a conduit for getting their ideas and or policies through to all relevant actors.

7.12 Criticisms of PEPFAR activities

PEPFAR has been criticised for its strict adherence to its policies with very little flexibility for change. This has allowed them to become influential securitising actors who because of their funding power, were in a position to successfully promote their policies. A major criticism was raised because of the Anti-Prostitution Pledge, which states that anyone receiving money from PEPFAR must sign a declaration stating that they do not support prostitution and sex trafficking, while at the same time institutions seeking funds must also agree not to work with any of these affected groups. This is highly problematic as these women remain at the forefront of the epidemic. Formulating policies aimed at offering support to the affected groups creates an awareness conduit for introducing them to more efficient prevention methods available. As a result, some organisations refused PEPFAR funding on the grounds that they feel strongly that in order to effectively fight the HIV and AIDS epidemic, you need to work with all affected groups in the country (interview, Regional Programme Manager PACT, Southern Africa, 10/4/08).

A key finding from the interview process was that PEPFAR's funding practices have left some programmes without funding at crucial stages of their implementation. PEPFAR tends to provide only a one-year grant. However, at times it may provide a two-year grant but with only one-year of the grant being guaranteed, while funding for the second year will be released depending on the performance of the organisation. This affects organisations that are staffed and operated primarily with PLWH since they have a very high fringe benefit cost (medical benefits) as might be expected. They are also often more inexperienced organisations based in the rural areas, yet they are given the same one-year grant often at the same grant level. The reality is that if their staff costs as a result of the high fringe benefits are 20-30 per cent higher than the staff costs of another organisations, they will not be able to carry out as many programmes and activities, which in turn means their results will naturally reflect a lower achievement, yet they are judged on the same criteria (interview, Regional Programme Manager PACT, Southern Africa, 10/4/08). Consequently, this impacts directly on the vital work carried out by these important organisations working to support the HIV and AIDS national response policy. Unless the organisations' proposed initiatives are for a one-year grant, it makes it more difficult to obtain a second-year grant.

In 2006 PEPFAR announced that it would no longer fund an HIV and AIDS programme in Swaziland that offered subsidised male circumcision in an attempt to prevent the spread of the disease (Kaiser Daily HIV and AIDS Report October 2006). This decision was taken despite the outcome of a study conducted in South Africa and published in the *PLoS Medicine Journal* (November 2005), which claimed that “male circumcision provides a degree of protection against acquiring the HIV infection, equivalent to what a vaccine of high efficacy would have achieved”. USAID claimed it was unaware of the programme, which goes against US policy supporting the study of male circumcision but not programmes providing the procedure. According to a USAID statement (2006), “There will be no further circumcision performed with US government funds until the PEPFAR Scientific Steering Committee reviews data from on-going clinical trials and considers any recommendations on male circumcision from the normative international agencies”. As a result, the circumcision programme stalled due to a lack of funding.

Finally, PEPFAR was also criticised for not incorporating food packages as part of its initiatives. According to the WFP, 69 per cent of Swaziland’s population live below the poverty line. One interviewee stated, “grassroots issues also need to be dealt with. Social determinants need to be addressed before you can help sufficiently. A one-size-fits-all approach does not work!” (interview, UNAIDS - Social Mobilisation and Partnership Advisor, Swaziland 14/2/08). Therefore, in order to have a more effective national response policy it is important to address poverty as a social determinant. An interviewee made the point, “PEPFAR does not do food packages. How can you give ARVs on an empty stomach?” (interview, Regional Programme Manager PACT, Southern Africa, 10/4/08).

7.13 Conclusion

The HIV and AIDS epidemic is fuelled by several factors such as high levels of poverty, gender inequalities and cultural practices such as polygamy, which is still practised widely in Swaziland. While Swaziland was relatively quick to respond by taking action against the rising HIV prevalence rate, cultural norms continue to hinder the implementation of the national policy response. Women and children bear the brunt of the epidemic in Swaziland.

This chapter found that in the framing of policy the political leadership was influenced by the social and cultural norms practised in Swaziland. These mixed messages resulted in a degree of inaction, which hampered effective policymaking by key policy decision-makers. Also, the fact that Mswati is the absolute authority meant that he controlled the availability of any meaningful access points in the political system in the country. Therefore, in overcome this obstacle, domestic and international HIV and AIDS stakeholders created a space within the political environment by dealing specifically with humanitarian concerns. Mswati's absolutist rule helped to create the internal conditions for the initial rejection of international thinking on the HIV and AIDS epidemic. However, this rejection was replaced with a more collaborative relationship when domestic and international HIV and AIDS stakeholders were able to define their political space with in which to operate. This defines the national HIV and AIDS response policy currently. Despite this, neopatrimonialism and Mswati's lifestyle choices have resulted in donors shying away from funding the national response and institutions in Swaziland.

It was argued that opening up Swaziland's political and social structures helped external actors to gain some access to the domestic policy decision-making process. This resulted in more acceptance of international thinking regarding the HIV and AIDS epidemic. The government of Swaziland's approach to include development partners and international organisations in their policy implementation processes was beneficial for the policy decision-making processes, as skills and expertise were shared and this in turn allowed more efficient policy formulation.

Finally, the chapter examined the processes and dynamics around the securitisation of HIV and AIDS in Swaziland. It was found that the capacity of domestic and international securitising actors to exert any influence on key decision-makers was limited since the political space provided was regulated and determined by Mswati. Hence the political environment limited their persuasive influence to promote the securitisation approach fully. Because there was a degree of political space made available, this resulted in the partial acceptance of the securitisation discourse pursued by influential securitising actors which in turn, led to the partially successful securitisation of the HIV and AIDS epidemic in Swaziland. In Swaziland the decision-making remained top-down, however, the non-state actors were able to create a political space, which positioned them to influence the policymaking processes to a certain degree.

Chapter 8 Conclusion

8.1 Introduction

This study explores the dimensions and institutional processes related to HIV and AIDS public policy formulation in Botswana, South Africa and Swaziland after the securitising move by UNAIDS and the Security Council in 2000. Two strands of theoretical literature were reviewed; literature on public policymaking processes and dynamics, and literature on the securitisation of the HIV and AIDS epidemic in the international domain.

The study focuses on the political environment and the process of policy making. It also seeks to identify the factors that influenced the framing of HIV and AIDS policies in the three Southern African countries. Each of the case studies shows how unique factors influenced the policy decision-making processes. It also shows how, in line with McInnes and Rushton (2010), it is not fruitful to speak of an issue being securitised as a simple binary equation. The empirical findings in this study showed that outcomes of the policymaking processes for HIV and AIDS revealed differing degrees of securitisation in the different case study countries.

The thesis demonstrates that the securitisation of HIV and AIDS has gradually become part of the collective understandings informing a global community of HIV and AIDS actors. All three countries are party to this community through participation in international forums. The US and the UN are the two main established securitising actors globally, although whether or not they are successful securitising actors has become increasingly contested (McInnes and Rushton, 2010). Seemingly, the global community agreed that securitising the HIV and AIDS epidemic would be beneficial in terms of generating political action. However, this study found that these benefits appear more complex and nuanced with a number of potential downsides being highlighted (McInnes, 2010:16).

It was demonstrated that the global HIV and AIDS community supported the securitisation norms lead by the US government and the UN. However, despite sharing the view that the epidemic had to be securitised, divisions appeared led by the US government and UNAIDS respectively, concerning the appropriateness of the measures used to achieve it. This led to the global securitising actors being positioned into two separate, and at certain times, opposing sides.

It is argued, that this influenced the domestic policymaking structures and also the daily running of national governments. These three countries, all at the epicentre of the epidemic, found themselves subjected to pressures calling for the securitisation of HIV and AIDS. This study examines the different processes and outcomes that took place because of the penetration of transitional HIV and AIDS securitisation norms into the domestic political arena of Botswana, South Africa and Swaziland.

The study illustrates that there is an increasing need for a body of scholarship to address the significance of HIV and AIDS as security threats. The securitisation perspective of the Copenhagen School is examined to explain the rise and diffusion of the discourse around HIV and AIDS as a security issue and the related securitisation of public policies. It is argued that HIV and AIDS has moved along, Buzan et al.'s (1998), spectrum ranging from nonpoliticised to politicised and finally securitised. This movement occurred through the use of public policy processes and framing of the HIV and AIDS epidemic as a security threat. The politicised stage brought the issue of HIV and AIDS on to the public policy stage that required action from government. Without the politicised stage, its continued movement along the spectrum may have been limited. Therefore, a link does exist between the framing of public policy analysis and securitisation approaches as each can be found on the same spectrum but at different points. The argument can be made that depending on the movement of a particular issue along the spectrum, public policy processes (the politicised stage) can lead to a particular issue becoming securitised.

The study sought to find a link between the framing of public policy and the securitisation process. It showed that the HIV and AIDS epidemic can be considered a security threat, but this is dependent on how the disease is framed. Speech-act theory was examined to demonstrate how HIV and AIDS were constructed as a security threat by actors through language, by framing it as an existential threat. The framing of the disease was important as it stems from both the public policymaking and the securitisation processes. The securitisation of the HIV and AIDS epidemic becomes institutionalised, since the epidemic is resilient enough to demand that bureaucratic procedures come in to play.

This study demonstrated that states highly affected by the HIV and AIDS epidemic were subjected to the same, or at least similar, external pressures to securitise the HIV and AIDS epidemic. As a result, the global HIV and AIDS securitising actors had a variable impact on the

domestic decision-making structure and in the daily activities of national governments. Based on this assumption, the study investigated different processes and outcomes which resulted from the penetration of transnational HIV and AIDS securitisation norms into the domestic political setting of the three countries under review.

This concluding chapter assesses the findings of the three empirical case studies in the light of the research questions and theoretical propositions discussed earlier in the study. The guiding questions for the study were:

- a) What public policies were designed to combat the HIV and AIDS epidemic in the three cases?
- b) What are the similarities and differences in the adoption of international HIV and AIDS ideas in the approaches of Botswana, South Africa and Swaziland?
- c) What are the roles of principal policymaking actors as well as domestic and international policy-influencing actors? And what are the power dynamics between these actors?
- d) What were the discursive processes that featured and shaped policymaking (the securitisation dynamics)?
- e) To what degree was the HIV and AIDS epidemic securitised in the respective countries?

8.2 Major findings from each of the case studies - summary

8.2.1 Botswana – successful securitisation

Botswana is an example of a developmental state with a top-down system of state-society relations. This political environment meant that the formation of an autonomous and outspoken civil society sector remained limited. Since Botswana experienced a relatively smooth transition from colonial rule, this laid the foundation for a political environment promoting cordial relations between Botswana and the former colonising power, as well as the acceptance of Western ideas and transnational HIV and AIDS securitising actors.

With Botswana's centralised system of decision-making coupled with a state-sponsored and dependent civil society sector, President Festus Mogae became a key actor in the policy decision-making process. Mogae's open support of global securitisation ideals influenced the domestic policy response to HIV and AIDS. This led to Mogae being identified by both international and domestic HIV and AIDS securitising actors in an attempt to gain access to influence the policy decision-making process. His acceptance of the securitisation approach was widely accepted by domestic HIV and AIDS actors. For this reason, under the leadership of Mogae, Botswana's attempt to securitise the HIV and AIDS epidemic can be considered successful. Botswana can therefore be considered a success story for international attempts to securitise HIV and AIDS in states with extremely high HIV and AIDS prevalence rates.

In chapter 2, it was discussed that three facilitating conditions were necessary for a speech-act to be considered successful for the process of securitisation. Mogae complied with all three of the facilitating conditions required. He accepted and followed the recognised grammar of security. By virtue of his position as President of Botswana, as a securitising actor he was in a position of authority to pronounce on the security concerns and was able to raise the level of threat facing the population. Therefore, his attempts at speech-acts according to the tool can be considered successful.

The role played by transnational HIV and AIDS actors was important, as they transferred their ideas to domestic actors. This took the form of advocacy networking carried out at multinational forums, in partnership with the government, where they were able to embed their principles and policies relating to HIV and AIDS in domestic processes (Vieira, 2006:267). In the case of domestic non-governmental organisations (NGOs), they were more inclined to follow government policy since the government sponsored much of their programmes. As a result they were not in a position to influence the policy decision-making structures.

It was found that more influential securitising actors such as the US government, international donors and UNAIDS fared better in their attempts to access and influence the policy decision-making structures than domestic NGOs. For instance, even though being supported by the US government, faith-based organisations were also important securitising agents as they operated at the grass-roots level and were able to promote the moral agenda of transnational Christian organisations. However, because of Botswana's state-dominated domestic structure, the number

of entry points into the policymaking structures was limited. This situation limited their influence over top decision-makers, unlike the more influential roles played by the US government, international donors and UNAIDS.

The study also found that Mogae's administration revealed a preference for the securitisation principles and policy ideas supported the US government. Unlike South Africa, as part of Botswana's national response policy it adopted a treatment plan, which included the provision of patented HIV and AIDS drugs. Mogae's approach of resisting generic ARVs was in line with that of the US government and international donors. This was discussed in chapter 5, where the public-private partnership between the Bill and Melinda Gates Foundation, the US pharmaceutical Merck and the government of Botswana through ACHAP, was instrumental in the government's national response policy to adopt a treatment plan based on branded HIV and AIDS drugs.

Significantly, in 2003 Botswana's national response policy included the controversial opt-out routine HIV testing in all its public health facilities. This new policy addition drew criticism from HIV and AIDS civil society bodies concerned with the human rights of PLWHA for the perceived unilateral form of monitoring HIV. The routine HIV testing stems from a recommendation of the US CDC, without the support of UNAIDS and other important transnational HIV and AIDS actors. After it became clear that the initial national response policy, which focused primarily on prevention⁶¹ was not attaining the expected results, the US-sponsored "abstinence and faithfulness" (AB) plan was introduced into the revamped national response policy in an attempt to curb the spread of HIV among the population.

These examples support the findings of the study which suggest that the persuasion strategies of the US government may have been more effective in Botswana as opposed to the approach of other transnational HIV and AIDS actors. The long-term collaboration that was formed between the US CDC and Botswana's Ministry of Health was important in building very strong institutional and knowledge-based links between the governments of Botswana and the US in the area of public health. Also, unlike in South Africa, Botswana's openness to engage in negotiations with a wide range of international actors proved beneficial as it resulted in the

⁶¹ This early government strategy was in line with the WHO/UNAIDS programme of sexual education in combination with the widespread distribution of condoms.

establishment of partnerships such as ACHAP. Finally, because of Botswana's economy and political stability, this setting attracted wealthy US donors such as the Bill and Melinda Gates Foundation which invested large sums of resources in supporting the government's response to the epidemic.

8.2.2 South Africa – unsuccessful securitisation

South Africa remains the economic and political power in the region with a relatively efficient social infrastructure in place. However, this study has shown that even with strong institutions in place, South Africa has struggled to achieve similar success rates in dealing with HIV and AIDS compared to countries with much lower socio-economic development. Walker et al. (2004:19), stress that "the spread of the disease is also influenced by personal choices, political responses and cultural factors". The South Africa case study demonstrates that the HIV and AIDS epidemic is fuelled by several factors; including poverty, gender inequalities and social and racial exclusion.

In South Africa the HIV and AIDS epidemic led to an increase in state-society tensions. These tensions became heightened mainly under Mbeki's presidency since he controversially chose to question Western scientific knowledge about the epidemic. Also, the rape charges brought against the first chair of the National HIV and AIDS Council, Jacob Zuma in 2006, displayed a cultural mismatch between local understandings of the epidemic and the accepted mainstream scientific knowledge (Vieira, 2006:273). In addition, Minister Tshabala-Msimang's continued public support for the unconventional methods of HIV and AIDS treatment and prevention caused tensions domestically and internationally. These factors made it difficult for the securitisation efforts of transnational actors to successfully convince the government's policy decision-makers of the urgent need to address the epidemic.

Important transnational securitising actors such as the US government and UNAIDS faced difficulties in their attempts to penetrate the South African structures of policy decision-making on HIV and AIDS. UNAIDS has made more noticeable progress. This is illustrated by the UNAIDS Theme Group, which was able to slowly create more multilateral channels with the aim of improving communication between the government and international partners, as evident in the establishment of the Donor Communication Forum (DCF) in 2000. However, while there

may have been noticeable progress, these channels did not lead to engagement with the government's top leadership, but only with lower levels of policymaking structures. This lack of effective communication undermined the securitisation attempts or speech-act practises of the international securitising actors in South Africa.

The degree of suspicion about the intentions of Western governments and about the real interests of international pharmaceutical companies operating in South Africa impeded the fostering of good working relations. This was evident in the suspicion about PEPFAR programmes in South Africa. The US government's continued support of the pharmaceutical industry was viewed by the ANC's ruling elites as part of a strategy that prioritised the economic interests of the pharmaceutical companies ahead of the lives of Africans who were in dire need of the life-saving drugs. For instance, as discussed in chapter 6, the US government's backing of the Pharmaceutical Manufacturers Association (PMA) in the court case against the South African government affected bilateral relations regarding HIV and AIDS policies.

The South African government also showed resistance towards the US recommendations concerning HIV prevention and testing. In the case of South Africa, the "AB" strategy was supplanted by a more pragmatic view of UNAIDS and its partners. At the time of the formulation of the nation response policy, the gender imbalances in South Africa would create significant barriers to abstinence of woman and girls. Regarding HIV testing, the US/CDC's lobby for the introduction in South Africa of routine semi-compulsory testing has also been rather unsuccessful because of the government's and TAC's strong emphasis on the individual human rights of the South African population.

On the other hand, transnational advocacy networks have been more successful than other securitising actors in being promoters of policy change. The Treatment Action Campaign (TAC), an HIV and AIDS NGO, adopted a strategy, which aligned its political agenda to that of its transnational counterparts. This alignment was important and produced significant results as it forced the government to reconsider certain policy decisions. For example, in 2002 the TAC sued the government for refusing to roll-out ARV treatment even though there was the option of the cheaper generic drugs. This led to the government being forced by the South African Constitutional Court to provide HIV and AIDS drugs through the public health system. The TAC was also influential in ensuring that the government was embarrassed and exposed its failed

policies to the wider international community. As a result, in 2002 Mbeki distanced himself from the views of the so-called dissidents. It can be claimed that this decision was because of pressure and sustained criticism by the transnational-domestic mobilisation led by the TAC. By continuing to shame and criticise Mbeki's response to the epidemic, the TAC was able to embarrass the government on the international stage. While at the same time gaining ground on opposing the South African government's response policies.

This chapter also examine the incidences of speech-act which were tested against the three facilitating conditions are necessary for a speech-act to be considered successful for the process of securitisation. Mbeki failed to comply with all three of the facilitating conditions required. He remained hesitant to fully accept and follow the recognised grammar of security regarding the HIV and AIDS epidemic. By virtue of his position as President of South Africa, as a securitising actor he was in a position of authority to pronounce on the security concerns however, he was not willing to fully raise the level of threat facing the population. Therefore, his attempts at speech-acts can be considered unsuccessful.

On the other hand, the TAC complied with two of the three facilitating conditions required for a successful speech-act in the process of securitisation. TAC accepted and followed the recognised grammar of security. However, by virtue of it being a non-state organisation it was not in a position of authority to pronounce on the security. Although importantly, TAC was able to successfully raise the level of threat facing the population. Therefore, TAC's attempts at speech-acts can be considered more successful.

8.2.3 Swaziland – partially successful securitisation

Swaziland remains the last absolute monarchy on the continent, with King Mswati III firmly in control of the policy decision-making process. In Swaziland the HIV and AIDS epidemic led to an increase in state-society tensions. Swaziland's HIV and AIDS epidemic is fuelled by several factors including poverty, gender inequalities and cultural practices such as polygamy which is still practised widely in Swaziland. Swaziland's initial response policy to the rising HIV prevalence rate was relatively quick. However, this initial response policy was hindered as a result of existing cultural norms in the country; polygamy, gender inequality and the accepted

sexual practices of young men all proved to impede the implementation of the national response policy on the HIV and AIDS epidemic.

Several factors in Swaziland's political environment impacted on the policy decision-making process, namely the prevailing political and social gender bias, Mswati's promotion of traditional customs and culture, and the high levels of neopatrimonialism. These factors influenced and hindered the policy decision-making process in Swaziland.

It is argued that Mswati held contradictory ideals towards the HIV and AIDS epidemic. This was best demonstrated at the 2001 UN General Assembly Special Session on HIV and AIDS, when he agreed with and accepted the recommendations made by the international securitising actors that more focused policies were needed to address the epidemic. However, when the necessary policy response appeared to challenge his cultural practices, Mswati was quick to defend his kingdom's cultural practices against any perceived challengers.

In Swaziland there is limited space for both the domestic and international securitising actors to exert any influence on key policy decision-makers. This stems from the fact that Mswati in his capacity as absolute ruler ensures that he controls and manages the political space available to prevent potential opposition parties' access to it. However as discussed in chapter 7, while traditionally civil society in Swaziland was relatively weak, two important occurrences took place to challenge this status quo. Firstly, civil society actors realised that they could access more political space if they focused solely on humanitarian and HIV and AIDS issues and not issues targeting the government or Mswati directly. By freeing up more political space this meant that more civil society actors were able to become part of and exert a degree of influence over the policymaking processes in Swaziland on HIV and AIDS issues. Secondly, NERCHA permitted civil society organisations to source their own funding for their programmes. This situation opened up a conduit through the domestic non-state actors' access for international non-state actors to exert influence and access the policy decision-making structure in Swaziland. This also allowed the international securitising actors to persuade and spread their securitisation ideals through this process that had previously been closed or rather difficult to access.

After the realisation was made regarding the opening of political space available to non-state actors, this led to gaining key access points into the HIV and AIDS policy-making structure.

This newfound access point to the policy decision-making process led to the government establishing a single coordinating HIV and AIDS coordination body, NERCHA. This in turn led to the formulation of new more effective collaborative policies to be included in the national response policy. NERCHA was instrumental in ensuring that international donors conformed to and complied with the objectives set out in the NSP. This was important, as it strengthened relations between state and non-state actors as well as ensuring an end to the duplication of HIV and AIDS programmes.

Domestic NGOs were relatively weak coupled with a lack of adequate capacity and skilled staff. However, actors such as SWANEPWA were able to persuade the government to increase its participation and include non-state actors in the national response policy. This was achieved through decentralisation and empowering grassroots-level civil society efforts, which widened the scope of PLWHAs who could to be supported. This policy change was important in the country's national response policy as it empowered communities and provided them with more access into the policy-making structures.

The role of international actors such as the US government's PEPFAR programme proved to be problematic at times. This was due to the stringent conditions attached to their programmes, which defined only certain sectors of society that the programmes would fund and support. The US-sponsored "abstinence and faithfulness" (AB) plan proved problematic since it clashed with the cultural norms of polygamy. The government also showed resistance towards the US recommendations concerning HIV prevention. In the case of Swaziland, as was the case in South Africa, the "AB" strategy was supplanted by a more pragmatic view of UNAIDS and its partners. At the time of the formulation of the nation response policy, the gender and cultural imbalances in Swaziland created significant barriers to abstinence of women and girls.

Although the relationship between the government and the international agencies was tense, there were important collaborative initiatives such as the establishment of the UN Theme Group. This body was influential in providing support to the government in the development of several national frameworks and policies for the improved management of the national response policy on HIV and AIDS, advocacy activities, training and capacity-building initiatives, research, and the increasing availability and accessibility of HIV and AIDS services (UNDP Swaziland Country Profile, 2009). This establishment of this structure created an additional access point for

the international actors to the country's policy-making structures and achieved some successful policy decision-making change in the country.

It was also found that, of the three case studies, Swaziland was most in need of donor aid. However, it appears that certain donors remain reluctant to fund activities in the country. This reluctance may be attributed to neopatrimonialism and Mswati's personal spending habits. According to an interviewee, "Swaziland does not get a lot of support from donors because of a non-HIV and AIDS political environment" (telephone interview, UNDP – RSC Johannesburg, RSA, 8/5/08). Neopatrimonialism negatively affects policy decision-making, especially development projects, and is responsible for the misuse of donor aid and state budgets. Because of Swaziland's neopatrimonial system, this impacts both on existing and potential donors as it is fair to assume that the donors will not want to fund or be perceived as funding the extravagant lifestyle of Mswati at the expense of the Swazi population.

In response to the reluctance of donors, CANGO and NERCHA have been instrumental in finding means to overcome this obstacle. A key reframed policy decision made was to encourage civil society to source funding for their own projects, thereby appealing to donors on their own and not in partnership with government. This policy has proved beneficial to domestic actors in sourcing funding for their activities.

When examining the incidences of securitisation speech-acts, Mswati complied with all three of the speech-act facilitating conditions required for the process of securitisation. He accepted and followed the recognised grammar of security. However, he took exception if that grammar was perceived to attack his country's cultural identity. By virtue of his position as King of Swaziland, as a securitising actor he was in a position of authority to pronounce on the security concerns and was able to raise the level of threat facing the population. Therefore, his attempts at speech-acts were partially successful.

On the other hand, both NERCHA and SWANEPWA complied with some of these facilitating conditions. Both securitising actors accepted and followed the recognised grammar of security. But, neither was in a position of authority to pronounce on the security concerns. However, they were in a position to help raise the awareness level of the threat facing the population. Therefore, their attempts at speech-acts according to the speech-act tool can be considered more successful.

8.3 Results and the implications for the theory

A general empirical finding of this thesis which has strong theoretical implications is that similar international pressures for the socialisation of international ideals can lead to very dissimilar results in terms of domestic policy outcomes. Therefore, differences found in the domestic social, political and cultural structures of all three case studies were proved to be essential elements in understanding their responses to the securitisation of HIV and AIDS. For purposes of this study and in line with Buzan et al.'s (1998) definition of securitising actor, the term security actor was used broadly to encompass anyone or organisation that shows agency because this made it easier to compare and contrast their roles in the policy making process. This was done in conjunction with the speech-act tool to verify the success of their speech-act attempts. The use of this speech-act tool placed the analyst in a better position to assess the degree to which they were successful as securitising actors. This study has highlighted several important implications for both public policy and securitisation theory. Pluralism has been useful to the study as it highlights the fractured nature of political power as was observed in the case study countries. From the examples of the case studies it was demonstrated that the decision-making was top-down in each of the countries. However, in all three cases there were varying degrees of political space for HIV and AIDS policy-influencing actors. These policy-influencing actors used this space to either conceptualise policy problems related to the epidemic; to seek alternative approaches, and to influence the public agenda.

Fourie (2005:246) asserts that the position of non-state actors should not “be overemphasised in terms of their power to implement essentially good AIDS policies”. As shown in chapters 5, 6 and 7, the state still remained the most important policy agent in each of the countries under review, even though transnational actors have been influential. Their influence can be illustrated through the lens of elite theory and statism, which show how other key sectors of the AIDS community were fairly successful in ensuring that the agenda-setting capacity was widened to beyond that of only the governments.

The case studies revealed that depending on the differences found in the domestic structures of states, international approach can be fundamentally accepted in the case of Botswana, rejected in the case of South Africa, or partially accepted in the case of Swaziland. While it can be argued that the proposed securitisation of HIV and AIDS may not be a good international approach

because of the fact that it is an extreme measure found outside the realm of normal politics, however, its proponents find it a necessary approach because of the magnitude of the challenges posed by the epidemic.

Drawing from the findings in the case studies, it was revealed that the differences in the domestic structures of each state determined the level to which international approaches were accepted or not. The study also found that the transnational actors chose to align themselves with domestic actors that shared similar priorities regarding the HIV and AIDS epidemic. In the case of South Africa, in the face of ever growing civil society and transnational mobilisation, some members of the political leadership, found at the provincial level of decision-making, realised a need to question the prevailing HIV and AIDS policies formulated and implemented by the national government. This realisation was not felt at national government level which led to the continued fiercely resist HIV and AIDS social mobilisation. As a result in South Africa, the TAC adopted a dual strategy to organise mass protests in the country, while at the same time the organisation also raised international awareness about the situation in the country. The TAC's next move was to resort to the judicial system, using a human rights law suit to achieve their goals. Only then did the government move towards the implementation of a nationwide HIV and AIDS treatment plan. What the South African case study revealed was that instead of engaging in direct argumentative practices with opposing ANC leaders, rather, the domestic HIV and AIDS organisations sought alternative forms of social pressure that moved beyond the limits of the domestic arena of decision-making.

In Botswana and Swaziland, on the other hand, there was no strong social movement to exert such pressure on the state. In their case, the ruling elites would engage directly with the securitisation speech-acts of the US, UNAIDS and other transnational HIV and AIDS actors with distinct differences in the outcomes of socialisation.

In the case of Swaziland, the lack of a strong domestic civil society sector in an absolute monarchy meant that the domestic and transnational actors had to develop a strategy to find a space for them to operate within the political environment. This was accomplished by ensuring that their policies dealt specifically with humanitarian concerns covering HIV and AIDS issues and did not appear critical of the King. Once this political space was occupied, it presented transnational actors and domestic non-state actors with more access to promote their

securitisation approaches to the relevant policy decision-makers in the country. Also, being given the opportunity to source their own funding by NERCHA also gave them more autonomy to run their programmes. However, this option provided the donors with the ability to influence the domestic HIV and AIDS organisations to align themselves with their ideals.

In Botswana the civil society sector was heavily dependent on the government for financial support as well as policy guidance. Botswana has a highly centralised decision-making system. This led to a situation in Botswana where domestic HIV and AIDS organisations tended to be more reactive than proactive in their approach towards influencing the national response policy. Consequently, the government had a fairly autonomous capacity allowing them to negotiate the entry of transnational actors and their securitising approaches towards the HIV and AIDS epidemic.

Owing to its economic and political strength, the US government became a strong factor in each of the case studies and their acceptance to this government's ideas. As a result, it was seen that the huge economic incentives of PEPFAR indeed did influence policy decision-making in Botswana, South Africa and Swaziland. However, this was not the decisive factor in any of the countries accepting the US government's HIV and AIDS policies. For instance, Botswana, who it appeared needed the PEPFAR money least, was interestingly the country that adhered most with the policy influences of the US government. South Africa, also a PEPFAR recipient chose to denounce the perceived interference of the US government's economic interest in Africa and actively resisted any interference. Swaziland, which was found to need the funding the most, provided political space for the issues related to HIV and AIDS as long as this did not interfere with Mswati's rule. In addition, the high levels of neopatrimonialism and Mswati's lifestyle choices have resulted in some donors shying away from funding the national response policy in Swaziland.

An interesting finding in the case studies is the roles of the domestic non-state policy-influencing actors. In South Africa the TAC uses the legislative route in order to influence policy, whereas in Botswana and Swaziland, the non-state domestic actors have less of an influence over the policy decision-making. In contrast, the UN as an international actor has influenced policy in all three countries, from setting the precedent on public policymaking related to HIV and AIDS with the

establishment of UNAIDS to elevating the issue onto the security agenda through the UN Security Council meeting in 2000.

The unfolding of the policy processes and dynamics related to the HIV and AIDS epidemic in the countries under review has added to the on-going securitisation debate in international relations. As was discussed in chapter 2, the Copenhagen School led by Buzan and Weaver have attempted to provide a theoretical foundation which sets out the processes necessary for an issue to become securitised. A shortcoming in their efforts has been in not actually demonstrating when or how a speech-act moves a particular issue from the realm of normal politics to that of an existential threat. Vieira (2006:282) claims that this is because the authors “concentrated mostly on meta-theoretical assumptions about the inter-subjective security articulations between securitising actors and their audiences”. They did not focus on the actual empirical circumstances which strengthen the claim for the success of a securitisation attempt. This study has therefore helped to expand the capacity of the securitisation theory to empirically understand the way in which states and audiences absorb and respond to the securitisation claims of the securitising actors. This was done by examining the tool to help study incidences of speech-act in each of the case study countries. For a speech-act to be successful three facilitating conditions are required in the process of securitisation:

- It must follow the recognised grammar of security;
- It must come from an actor in position of authority to pronounce on security (the state);
- That it helps if the object can be generally said to be threatening.

This tool was useful as it made it possible to for the incidences of speech-acts in each of the case study countries to be tested against it. It therefore, helped in the final assessment of whether the domestic securitisation approach was successful, unsuccessful or partially successful.

Chapter 2 used the analogy of a pendulum to best describe how issues are moved from the realm of politicisation (normal politics) to that of securitisation (emergency) and back. The inadequate understanding of the actual mechanisms whereby securitisation attempts are internalised by domestic actors and their response to such attempts remains a constraint on securitisation

analysis. The different securitisation approaches examined in each of these case studies have therefore widened the scope of the securitisation research agenda by expanding the focus of the study to also include the audiences of securitisation.

Also, the study addressed McInnes' (2010:14) claim regarding the limitations of available empirical research related to the securitisation processes in different countries. McInnes (2010:14) argues that "there has been little work which has demonstrated a comparable impact on the policies adopted by other countries, nor do the security policy institutions in other countries appear to have seized on the issue to the same extent". This thesis has expanded and contributed to address this limitation in the literature by demonstrating the securitisation processes, policies adopted and influence of security policy institutions in each of the three states in Southern Africa: Botswana, Mozambique and South Africa.

The findings on Botswana, South Africa and Swaziland showed they can be considered as displaying successful securitisation, unsuccessful securitisation and partially successful securitisation respectively. This leads to the important finding that instead of an issue being securitised or not, an issue may be partly securitised, with different actors and audiences positioned at varying points along a spectrum of securitisation. The empirical findings in each of the political arenas for the countries under review contributed to a more comprehensive understanding of the securitisation process, allowing the role of the audiences of securitisation and their social context to be increased. This study has also made a contribution to the existing knowledge, because of the author's 'real world' study of securitisation. Since the study of securitisation tends to be highly theoretical, this study adds a unique empirical dimension to the existing literature. This is done by demonstrating the degree to which the HIV and AIDS epidemic was securitised at the national level of all three case study countries.

The study highlighted that the results of a securitising move are not homogenous. It also revealed that some actors have more willingly accepted HIV and AIDS as a security issue than others. McInnes (2010:17) argues that this variation may be a reflection of the disease itself, "that its effects are not homogenous but diverse depending on context; but it also suggests that different actors (often at the level of ministries or even individuals) were more easily persuaded than others."

The study helped to identify the domestic conditions which proved to either facilitate or impede the successful pendulum swing of HIV and AIDS from the area of politicisation to that of securitisation. It was possible to identify four main factors that played a role in this movement:

- i) The type of prevailing state-society relations;
- ii) The nature of state institutions and the system of the policy decision-making process;
- iii) The long-term values and principles which define the political culture of each country; and
- iv) The personal characteristics of key leaders in government.

Table 8.1 below synthesises the key findings of the study.

Table 8.1: Analytical Factors and Case Studies Findings

	State-Society Relations	State Institutions and Policy Decision-making Process	Relationship between Transnational HIV and AIDS Actors and the Pre-existing political and Social Cultures	Political Leadership towards HIV and AIDS after the Securitisation Move	Outcome
Botswana	Collaborative with weak civil society	Strong and centralised	Close	Assertive	Successful Securitisation
South Africa	Contentious with strong civil society	Strong and centralised	Distant	Erratic	Unsuccessful Securitisation
Swaziland	Collaborative on Humanitarian Issues with weak civil society	Strong and centralised at first leading to more decentralised approach	Initially Confrontational	Confident	Partial successful Securitisation

8.4 Issues for Further Research

The study has demonstrated that HIV and AIDS represent an area of contention in the specific case studies. This was because of the failure to move policy from the formulation stage to full implementation. The reasons behind the policy failures may require further research as it was not the aim of this thesis to evaluate the policies themselves. It was found that in the case of Swaziland a more decentralised approach to policy implementation has yielded better results. Therefore, additional research could be carried out on finding ways for both state and non-state actors to cooperate better for more efficient policy implementation. Also when formulating policies and programmes, it is important to remember that each country presented displayed different cultural and social characteristics, which in turn require HIV and AIDS programmes

and policies to be formulated in a more country-specific way since cultural practices are different in each of the case studies.

In the Southern African context HIV and AIDS remains a taboo subject in most cultures because of the social patterns and norms associated with sexual and political interaction. This has led to policies being formulated that are too socially and culturally generic which then fail to resonate with the intended audience. Further research may be carried out on this issue to ensure that any future policy decision-making processes speak more to the social and cultural aspect of the society concerned.

Regarding the securitisation approach, future in-depth research on real world securitisations as in the case studies presented would be useful. The study has been useful as it may help close the gap between scholarly knowledge in this field and that of government's policymaking processes because of the agency aspect brought by the researcher. It is hoped that the study will prove helpful in laying the foundation for future research on securitising other global non-traditional security threats such as climate change, water insecurity, energy insecurity and food insecurity. Thus the study may provide future researchers and policy-makers with some leverage to formulate and implement more progressive policies when necessary.

As the three countries are all in the SADC region and are equally affected by the epidemic, it is assumed that a regional securitisation response would be more beneficial. However, the study found that SADC as the regional body was not an important factor in the securitisation process in member countries. This was mainly because SADC identified the HIV and AIDS epidemic primarily as a health issue. It has not moved the issue from normalcy to securitisation. It was found that within the SADC region individual member states have moved towards some stage of securitisation, but not collectively. Therefore future research could be carried out on analysing the possible impediments facing the regional organisation seeking to securitise not only HIV and AIDS but other socio-economic issues too.

8.5 Conclusion

Each case study presented unique and similar factors that influenced the policymaking process. This process in turn revealed that the policymaking dynamics led to different degrees of securitisation of the HIV and AIDS epidemic in Botswana, South Africa and Swaziland.

Bibliography

Primary Sources

African Comprehensive HIV/AIDS Partnerships (ACHAP) (2004) *Review of Activities*, Gaborone.

African Comprehensive HIV/AIDS Partnerships (ACHAP) (2005) *New Focused Strategy: ACHAP Announces Additional Support*, Newsletter 5, August 2005.

African Comprehensive HIV/AIDS Partnerships (ACHAP) (2005) *Decentralisation of HIV Testing: ACHAP Keeps its Promise*, (Newsletter 6, December 2005) Gaborone: ACHAP Available at <http://www.achap.org/programme/treatment> accessed on 04 October 2013.

Achmat, Z. (2001) *Address to the Aids in Context International Conference on HIV/AIDS*. Johannesburg, University of Witwatersrand.

Amnesty International (2005) *Amnesty International Report 2005: Swaziland*, 25/05/2005. Available at www.amnesty.org accessed on 13 January 2006.

Annan, K. (2000) *Address by Kofi Annan to the Security Council on The Situation in Africa: the impact of AIDS on peace and security*, delivered 10th January 2000.

Annan, K. (2004) "Foreword by the United Nations Secretary-General", in *A More Secure World: Our shared responsibility*, New York: United Nations.

AMICAAL (2005) *Working Together at the Local Level. Swaziland – A Mini Case Study*. Available at <http://www.amicaall.org/sz/publications.html> accessed on 04 October 2013.

Avert: *History of HIV & AIDS in South Africa*. Available at <http://www.avert.org/history-hiv-aids-south-africa.htm> accessed on 04 October 2013.

Avert: *HIV & AIDS in Botswana*. Available on <http://www.avert.org/hiv-aids-botswana.htm> accessed on 04 October 2013.

Avert: *HIV & AIDS in Swaziland*. Available at <http://www.avert.org/hiv-aids-swaziland.htm> accessed on 04 October 2013.

BONASO (2006) *Annual Report*, Gaborone. Available at www.bonaso.org.bw accessed on 14 August 2010.

MOFAIC. *Botswana, UK relations benefit both*, Ministry of Foreign Affairs and International Cooperation. Available at http://www.mofaic.gov.bw/index.php?option=com_content&view=article&id=654:botswana-uk-relations-benefit-both&catid=8&Itemid=95 accessed on 24 September 2013

CANGO. Website <http://www.cango.org.sz/>. Accessed 15 June 2012.

Coovadia, H. *Presentation at the Republic of South Africa Embassy*, Oslo, Norway. October 2007.

Dikeni, S. and Burger, D. (2002) *South Africa Yearbook 2002/2003* Pretoria: Government Communication and Information System.

Drimie, S. (2002) *The Impact of HIV/AIDS on Rural Households and Land Issues in Southern and Eastern Africa*. FAO: Corporate Document Repository, Economic and Social Development Department. Available at <http://www.fao.org/wairdocs/ad696e/ad696e00.htm#Contents> accessed on 04 October 2013.

Dr Hussein, A. *Statement at the Twenty-Sixth Special Session of the United Nations General Assembly on HIV/AIDS*, delivered 27th June 2001.

Global Fund (2005a) *Current Grant Commitments and Disbursements*. Geneva: Global Fund.

Global Fund (2005b) *The Global Fund to Fight Aids, Tuberculosis and Malaria – Pledges*. Geneva: Global Fund.

Global Health Policy. Available at <http://kff.org/global-health-policy/>. Accessed on 04 October 2013.

Government of the Kingdom of Swaziland (2006) *Draft National Multisectoral HIV and AIDS Policy. A Nation at War with HIV and AIDS*. Available at

http://gametlibrary.worldbank.org/FILES/113_National%20HIV%20Policy%20-%20Swaziland.pdf. Accessed on 04 October 2013.

HIV/AIDS Crisis Management and Technical Committee, Swaziland (2000) *Swaziland National Strategic Plan for HIV/AIDS 2000-2005*. Available at http://www.ilo.org/wcmsp5/groups/public/---ed_protect/---protrav/---ilo_aids/documents/legaldocument/wcms_174729.pdf. Accessed 04 October 13.

IASC (2003) *Guidelines for HIV/AIDS Interventions in Emergency Settings*. Geneva and New York: IASC.

Korte, D. (2012) *Profile*, Wharton Global. Available at www.whartonglobal.com/africa/donald_korte.asp. Accessed 27 August 2012.

Mankahlana, P. (2000) *Building a Monument to Intolerance*, Release from Mr Parks Mankahlana, Head of Communications, 23 March 2000.

Mbeki, T. (2000) *Speech of the President of South Africa at the Opening Session of the 13th International AIDS Conference*. Durban. Available at <http://www.virusmyth.net/aids/news/durbspmbeki.htm>. Accessed on 04 October 2013.

Mbeki, T. (2000) "Letter to World Leaders" In *New African* 397:18-20.

Mbeki, T. (2000) *State of the Nation Address at the Opening of Parliament, Cape Town, 04 February 2000*. Available at <http://www.info.gov.za/speeches/2000/000204451p1001.htm> accessed on 07 October 2013.

Mbeki, T. (2005) *Statement by former President Mbeki during the annual State of the Nation Address in 2005*. Available at <http://www.info.gov.za/speeches/2005/05021110501001.htm>. Accessed on 30 September 2013.

Merck (2013) *ACHAP*. Available at <http://www.merckresponsibility.com/focus-areas/access-to-health/community-investment/public-private-partnerships/achap/>. Accessed on 27 August 2012.

- Ministry of Foreign Affairs & International Cooperation, Botswana (2011) *Botswana, UK Relations Benefit Both*. Available at http://www.mofaic.gov.bw/index.php?option=com_content&view=article&id=654:botswana-uk-relations-benefit-both&catid=8:latest&Itemid=95. Accessed 04 October 2013.
- Ministry of Health, AIDS/STD Unit (1997) *Botswana HIV and AIDS Second Medium Term Plan – MTPII (1997 – 2002)*. Gaborone: Ministry of Health.
- Ministry of Health, AIDS/STD Unit (2004) *Masa Antiretroviral Therapy – Rolling- Out ARV Therapy in Botswana*. Gaborone: Ministry of Health.
- Ministry of Health, AIDS/STD Unit (2004) Access for All: The Masa Programme – Providing All Batswanas with Access to Care and Treatment, In *Masa Newsletter 9*, June/July 2004. Gaborone: Ministry of Health.
- Ministry of Health, AIDS/STD Unit and WHO (2004) *Report of the Study on Stigmas and Stigmatisation Associated with HIV/AIDS in the Health Sector in Six Selected Districts in Botswana*. Gaborone: Ministry of Health and WHO.
- Ministry of Health, AIDS/STD Unit (2005) A New Dawn for Botswana. In *Masa Newsletter 14*, April 2005. Gaborone: Ministry of Health.
- NACA (2002) *Ntwa e Bolotse, Botswana’s War Against HIV/AIDS Surveillance – A Technical Report*. Gaborone: NACA.
- NACA (2003) *Ntwa e Bolotse: World AIDS Day Special Issue, Winning the War Against HIV/AIDS*. Gaborone: NACA.
- NERCHA (2007). *Preliminary Report: Swaziland Demographic and Health Survey 2006-2007*. Available at <http://www.nercha.org.sz/document/preliminary-report-swaziland-demographic-and-health-survey-2006-2007>. Accessed on 04 October 2013.
- OAU (2001) *Abuja Declaration on HIV/AIDS, Tuberculosis and Other Infectious Diseases*. Abuja: OAU.

PEPFAR (2007) *The Power of Partnerships: Third Annual Report to Congress on PEPFAR*. Available at <http://www.pepfar.gov/press/c21604.htm>. Accessed on 04 October 2013.

PEPFAR (2008) *World AIDS Day 2008: Celebrate Life! 2008*. Available at <http://2006-2009.pepfar.gov/112351.htm>. Accessed on 04 October 2013.

Piot, P. (2001) *AIDS and Human Security*. Speech Given at the United Nations University, Tokyo, 2 October 2001. Geneva: UNAIDS.

PSI. Available at <http://www.psi.org/botswana>. Accessed on 04 October 13.

Treatment Action Campaign (TAC). Available at <http://www.tac.org.za/>. Accessed on 04 October 13.

The Henry J. Kaiser Family Foundation (2012) *Financing the Response to AIDS in Low- and Middle-Income Countries: International Assistance from Donor Governments in 2012*. Available at <http://kff.org/global-health-policy/report/financing-the-response-to-aids-in-low/> accessed on 04 October 13.

The Presidency, South Africa (2006). *The Restructuring of the South African National AIDS Council (SANAC): Record of Agreement*. Available at <http://www.doh.gov.za/docs/pr/2006/pr1201b.html>. Accessed 04 October 13.

The Bill and Melinda Gates Foundation, available at <http://www.gatesfoundation.org/>. Accessed on 04 October 2013.

The Bill and Melinda Gates Foundation (2010) *Merck Provides New Funding to Fight HIV/AIDS in Botswana*. Available at <http://www.gatesfoundation.org/press-releases/Pages/merck-provides-new-funding-to-fight-hiv-in-botswana-100824.aspx> accessed on 04 October 13.

The South African National AIDS Council (SANAC). Available at <http://www.info.gov.za/issues/hiv/sanac.htm> accessed on 29 January 2013.

UNAIDS/WHO (2002) *AIDS Epidemic Update 2002*. Available at http://www.unaids.org/en/media/unaids/contentassets/dataimport/publications/irc-pub03/epiupdate2002_en.pdf. Accessed on 07 October 2013.

UNAIDS (2004) “*Three Ones*” *Key Principle, Coordination of National responses to HIV/AIDS. Guiding Principles for National Authorities and Their Partners*. Available at http://www.unaids.org/en/media/unaids/contentassets/dataimport/una-docs/three-ones_keyprinciples_en.pdf. Accessed on 04 October 2013.

UNAIDS (2004), *A Joint Response to HIV/AIDS and Security. Fact Sheet 1*. Geneva: UNAIDS.

UNAIDS (2005) *On the Front Line: A Review of Policies and Programmes to Address HIV/AIDS Among Peacekeepers and Uniformed Services*. UNAIDS: Geneva.

UNAIDS (2005b) *Donor Contribution Table 1995 – 2005*. Geneva: UNAIDS.

UNAIDS (2006) *Report on the Global AIDS Epidemic*. Available at http://data.unaids.org/pub/EpiReport/2006/2006_EpiUpdate_en.pdf. Accessed on 04 October 2013.

UNAIDS (2007) *South Africa AIDS Conference*. Available at <http://www.unaids.org/en/resources/presscentre/featurestories/2007/june/20070606saaidconference/>. Accessed on 04 October 2013.

UNAIDS (2008) *Expenditures by Finance Sources and Spending Category, Botswana 2007*. Available at http://data.unaids.org/pub/Report/2008/rt08_bot_en.pdf. Accessed on 04 October 2013.

UNAIDS Epidemic Update (2009) *AIDS Epidemic Update December 2009*. Available at http://www.unaids.org/en/media/unaids/contentassets/dataimport/pub/report/2009/jc1700_epi_update_2009_en.pdf. Accessed on 07 October 2013.

UNAIDS (2009) *East and Southern Africa*. Available at <http://www.unaids.org/en/regionscountries/regions/easternandsouthernafrika/>. Accessed on 04 October 2013.

UNAIDS (2010) *UNAIDS Report on the Global AIDS Epidemic 2010*. Available at <http://www.unaids.org/globalreport/>. Accessed 04 October 2013.

UNAIDS (2010b) *Unite for Universal Access: Overview brochure on 2011 High Level Meeting on AIDS*. Available at <http://www.unaids.org/en/aboutunaids/unitednationsdeclarationsandgoals/2011highlevelmeetingonaids/> Accessed on 04 October 2013.

UNAIDS (2011) *UNAIDS World AIDS Day Report 2011*. Available at <http://www.unaids.org/en/resources/presscentre/pressreleaseandstatementarchive/2011/november/20111121wad2011report/> Accessed 04 October 2013.

UNAIDS (2012) *Swaziland Country Report on Monitoring the Political Declaration on HIV and AIDS*. UNAIDS. Available at [http://www.unaids.org/en/dataanalysis/knowyourresponse/countryprogressreports/2012countries/ce_SZ_Narrative_Report\[1\].pdf](http://www.unaids.org/en/dataanalysis/knowyourresponse/countryprogressreports/2012countries/ce_SZ_Narrative_Report[1].pdf) Accessed 04 October 2013.

UNAIDS (2013) *Getting to Zero: HIV in Eastern and Southern Africa*. UNAIDS: Regional Report 2013.

UNAIDS (2013b) *Special Report - How Africa Turned AIDS around*. UNAIDS Special Report.

UNAIDS (2013c) *Country Report, Botswana*. Available at <http://www.unaids.org/en/Regionscountries/Countries/Botswana/>. Accessed on 04 October 2013.

UNAIDS (2013d) *Country Report, South Africa*. Available at <http://www.unaids.org/en/regionscountries/countries/southafrica/>. Accessed on 04 October 2013.

UNAIDS (2013c) *Country Report, Swaziland*. Available at <http://www.unaids.org/en/regionscountries/countries/swaziland/>. Accessed on 04 October 2013.

UN AMICAALL Partnership Programme (2005) *From Advocacy to Action*. UN AMICAALL Partnership Programme with support from UNAIDS December 2005.

UNDP (2002) *Human Development Report 2002*. New York: Oxford University Press.

UNDP (2008) *Human development indices – Human and income poverty (Population living below national poverty line (2000–2007))*. United Nations Development Programme. 28 November 2008.

UNFPA (2001) *Botswana Struggles to Overcome the Worst AIDS Rate in the World*, April 2001. Available at <http://web.unfpa.org/focus/botswana/struggles.htm>. Accessed on 07 October 2013.

UNGASS (2001) *Declaration of Commitment on HIV/AIDS: Global Crisis – Global Action* (Twenty-Sixth Special Session of the General Assembly). New York: United Nations.

UNGASS (2008). *Botswana UNGASS Country Report 2008*, Available at <http://www.safaid.net/content/botswana-ungass-country-report-2008>. Accessed on 07 October 2013.

UNGASS 2008. *South Africa Country Report 2008*, Available at <http://www.eldis.org/go/countryprofiles&id=39246&type=Document#.UIOY30v8JMs>. Accessed on 07 October 2013.

UNGASS (2008). *Swaziland Country Report 2008*. Available at http://data.unaids.org/pub/report/2008/swaziland_2008_country_progress_report_en.pdf. Accessed on 07 October 2013.

UN General Assembly (2006) *Resolution Adopted by the General Assembly: Political Declaration on HIV/AIDS* (87th Plenary Meeting 2 June 2006). New York: United Nations.

UNICEF (2009) *Eastern and Southern Africa*. Available at http://www.unicef.org/esaro/5482_HIV_AIDS.html. Accessed on 04 October 2013.

UNSC (2000) *The Impact of AIDS on Peace and Security in Africa* (4087th Security Council Meeting, 10 January 2000), New York: United Nations.

UNSC (2000b) *Resolution 1308 (2000) on the Responsibility of the Security Council in the Maintenance of international Peace and Security: HIV/AIDS and International Peace Keeping Operations* (4172nd Meeting, 17 July 2000) New York: United Nations.

USAID (2008) *Swaziland HIV/AIDS Health Profile, 2008*.

USAID (2010) *Swaziland Country Office*. Available at

http://sa.usaid.gov/southern_africa/node/94. Accessed 12 September 2013.

U.S. Department of State (2003) *President Speaks on Fighting Global and Domestic HIV/AIDS*.

Washington: U.S. Department of State.

U.S. Department of State (2004) *AIDS Poses a Challenge to Global Community*. Washington:

U.S. Department of State.

U.S. Department of State (2013) *US Relations with Botswana*. Available at

<http://www.state.gov/r/pa/ei/bgn/1830.htm>. Accessed 04 October 2013.

U.S. Department of State (2013) *US Relations with South Africa*. Available at

<http://www.state.gov/r/pa/ei/bgn/2898.htm>. Accessed 04 October 2013.

U.S. Department of State (2013) *US Relations with Swaziland*. Website:

<http://www.state.gov/r/pa/ei/bgn/2841.htm>. Accessed 04 October 2013.

WHO (2000) *The 3 by 5 Initiative*. Available at <http://www.who.int/3by5/countryprofiles/en/>.

Accessed 04 October 2013.

WHO (2005) *WHO Adds More New Products to its List of Pre-qualified HIV medicines*.

Available at <http://www.who.int/mediacentre/news/notes/2005/np26/en/>. Accessed 04 October 2013.

WHO (2013) *Botswana*. Available at <http://www.who.int/countries/bwa/en/>. Accessed 04

October 2013.

WHO (2013) *South Africa*. Available at <http://www.who.int/countries/zaf/en/>. Accessed 04

October 2013.

WHO (2013) *Swaziland*. Available at <http://www.who.int/countries/swz/en/>. Accessed 04

October 2013.

WHO/UNICEF/UNAIDS (2011) *Progress Report 2011: Global HIV/AIDS Response*. Website:

http://www.who.int/hiv/pub/progress_report2011/en/index.html. Accessed 04 October 2013.

Zuma, J. (2000) *Statement in Parliament by Deputy President Jacob Zuma on HIV/AIDS*. Available at <http://www.polity.org.za/html/govdocs/speeches/2000/sp0419.html>. Accessed 27 August 2012.

Secondary Sources

Acharya, A. (2004) "How Ideas Spread: Whose Norms Matter? Norm Localisation and Institutional Change in Asian Regionalism." In *International Organisation* 58 (2):239-279

Ala J. (1997) "Gender Biases: Stumbling Blocks to effective Development Policies," *Discussion Paper in International Relations* 1 (4): 12.

Alimonti, J.B., Ball T.B. and Fowke K.R. (2003) "Mechanisms of CD4+ T lymphocyte cell death in human immunodeficiency virus infection and AIDS." In *J. Gen. Virol.* 84 (7): 1649–1661.

Alker, H. (2005) "Emancipation in the Critical Security Studies Project." In Booth, K (ed.) *Critical Security Studies and World Politics*. Boulder, Colorado: Lynne Rienner.

Allen, T. and Heald, S. (2004) "HIV/AIDS Policy in Africa: What has Worked in South Africa and What has Failed in Botswana?" In *Journal of International Development*, 16: 1141 – 1154.

Altman, D. (2008) "State Fragility, Human Security and HIV", in Foller, M. and Thorn, H. (eds.), *The Politics of AIDS – Globalization, the State and Civil Society*. Palgrave Macmillan, Houndmills.

Anderson, J. (2000) *Public policymaking*. Boston: Houghton Mifflin Company.

Austin, J.L. (1962) *How to do Things With Words*. Oxford: Clarendon Press.

Axworthy, L. (2001) "Human Security and Global Governance: Putting People First". In *Global Governance*, 7 (1): 19-23.

Ballard, R., Habib, A. and Valodia, I. (eds.) (2006) *Voices of Protest: Social Movements in Post-Apartheid South Africa*. Pietermaritzburg: UKZN Press.

- Baleta, A. "Global Fund dispute in KwaZulu-Natal", In *The Lancet Infectious Diseases*, 2 (9): 510, September 2002.
- Balzacq, T. (2005) "The Three Faces of Securitization: Political Agency, Audience and Context." In *European Journal of International Relations*, 11 (2): 171 - 202.
- Barnett, T. and Prins, G. (2006) "HIV/AIDS and Security: Fact, Fiction and Evidence." In *International Affairs*, 82 (2): 360.
- Barnett, T. and Whiteside, A. (2002) *AIDS in the Twenty-First Century: Disease and Globalisation*. Basingstoke: Palgrave Macmillan.
- Bartels, B. (2003) *HIV/AIDS, State Capacity, and Security in Africa*, Presented at the Workshop and Political Theory and Policy Analysis, Indiana University 02 – 05 May 2003.
- Bauer, G. and Taylor, S.D. (2005) *Politics in Southern Africa: State and Society in Transition*. Boulder and London: Lynne Rienner Publishers.
- Baylis, J. (2005) "International and Global Security in the Post-Cold War Era." In *The Globalization of World Politics*, eds. J. Baylis and S. Smith. Oxford: Oxford University Press.
- Becker, H.S. (1998) *Tricks of the Trade: How to Think About Your Research While You're Doing It*. Chicago: University of Chicago Press.
- Behrman, G. (2004) *The Invisible People: How the US Has Slept Through the Global AIDS Pandemic, The Greatest Humanitarian Catastrophe of Our Time*. New York, London, Toronto and Sydney: Free Press.
- Bialobrzeska, M. (2007) *Managing HIV and AIDS in Schools in Diverse Contexts*. Draft paper presented at the TEP Conference 28 – 29 May 2007. Available at http://www.cepd.org.za/files/CEPD_TEP_SAIDE-SystemsforManagingHIV-AIDS.pdf. Accessed on 07 October 2013.

- Black, D. (1999) "The Long and Winding Road: International Norms and Domestic Political Change in South Africa." In *The Power of Human Rights: International Norms and Domestic Change*, Risse, T., Ropp, S.C, and Sikknik, K. (eds.). Cambridge: Cambridge University Press.
- Boas, M. (2001) Liberia and Sierra-Leone: Dead Ringers? The Logic of Neopatrimonial Rule, In *Third World Quarterly*, 22 (5): 697 – 723.
- Bogdan, R.C: and Biklin, S.K. (1998) *Qualitative Research for Education: An Introduction to Theory and Methods*. (3rd ed.) Boston: Allyn and Bacon.
- Bond, P. (1999) Globalisation, Pharmaceutical Pricing, and South African Health Policy: Managing Conformation with US Firms and Politicians. In *International Journal of Health Series* 29 (4): 765-792.
- Bond, P. (2000) *Elite Transition: From Apartheid to Neoliberalism in South Africa*. London: Pluto Press.
- Bond, P. (2001) *Against Global Apartheid: South Africa Meets the World Bank, IMF and International Finance*. Landsdowne: UCT Press
- Booth, K. (ed.) (2005) *Critical Security Studies and World Politics*. Boulder, Colorado: Lynne Reiner Publishers.
- Boutros-Ghali, B. (1995) *An Agenda for Peace*. New York: United Nations.
- Bratt , D. (2002) Blue Condoms: The Use of International Peacekeepers in the Fight Against AIDS. *International Peacekeeping*, 9 (3): 67-86.
- Brockett, C. (1991) The Structure of Political Opportunities and Peasant Mobilisation in Central America, *Comparative Politics* 23 (3): 253-274.
- Brocklehurst, H. (2010) Child Soldiers. In Collins, A. *Contemporary Security Studies*. 2nd edition. Oxford University Press, (448-462).
- Burns, R.B. (1997) *Introduction to Research Methods*. (3rd ed.) Australia: Longman.

- Buse, K., Hein, W. and Drager, N. (eds.) (2009) *Making Sense of Global Health Governance: A Policy Perspective*. Basingstoke, UK: Palgrave Macmillan.
- Butler, A. (2005) "South Africa's HIV/AIDS Policy 1999 – 2004: How can it be Explained?" In *African Affairs*, 104(417): 591 – 615.
- Buzan, B., Kelstrup, M., Lemaitre, P., Tromer, E., and Wæver, O. (1990) *The European Security Order Recast. Scenarios for the Post-Cold War Era*. London: Pinter.
- Buzan, B. (1991) *People, States and Fear: An Agenda for International Security Studies in the Post-Cold War Era*. London: Lynne Rienner Publishers.
- Buzan, B., Wæver, O. and Wilde, J. (1998) *Security: A New Framework for Analysis*. London: Lynne Rienner Publishers.
- Chabal, P. and Daloz, J.P. (1999) *Africa Works: Disorder as Political Instrument*. Bloomington: Indiana University Press.
- Chen, L. et al., eds. (2003) *Global Health Challenges for Human Security*. Cambridge: Harvard University Press.
- Cloete, F. (2000) Public Policy in More or Less Developed States. In Cloete, F. and Wissink, H. (eds.) *Improving Public Policy*. Pretoria: Van Schaik Publishers.
- Cobb, R. and Elder, C. (1983) *The Political Uses of Symbols*. New York: Longman.
- Cohen, L. and Manion, L. (1994) *Research Methods in Education*. (4th ed.) London: Routledge.
- Collins J. and Rau B. (2000) *HIV/AIDS and Failed Development*, Africa Policy Information Centre Working Paper, March.
- Cook, T. and Campbell, D. (1979) *Quasi-experimentation: Design and Analysis Issues for Field Settings*. Boston: Houghton Mifflin.
- Cooper, A.F., Kirton, J.J., and Schrecker, T. (eds.) (2007) *Governing Global Health: Challenge, Response, Innovation*. Aldershot, UK: Ashgate.

Copson, R.W. (2004) AIDS in Africa. *CRS Issue Brief for Congress IB10050*. Washington: Congressional Research Service, The Library of Congress.

Creswell, J.W. (2003). *Research design: Qualitative, quantitative, and mixed methods approaches*. (2nd ed.) Thousand Oaks: Sage.

Daly, J. (2001) "AIDS in Swaziland: The Battle from Within" *African Studies Review*, 44 (1): 21-35.

Davids, Y.D. (2010) *Explaining Poverty: A Comparison Between Perceptions and Conditions of Poverty in South Africa*. Stellenbosch: PhD Thesis, Stellenbosch University.

Davies, S. (2010) *Global Politics of Health*. Cambridge, UK: Polity.

Decosas, J. (1998) "Labour Migration and HIV Epidemics in Africa." In *AIDS Analysis Africa* 9(2), August/September.

DeWaal, A. (2003) "How Will HIV/AIDS Transform African Governance?" In *African Affairs* 102(406): 1-23.

Dror, Y. (1968) *Public Policymaking Re-examined*. New York: Intext Educational Publishers.

Druce N., Kgatlwane, J., Mosime, O., and Ramiah, I. (2004) *Impact of Public-Private Partnerships Addressing Access to Pharmaceuticals in Low and Middle Income Countries – Botswana*. Geneva: Initiative on Public-Private Partnerships for Health.

DuToit, P. (1995) *State Building and Democracy in Southern Africa: Botswana, Zimbabwe and South Africa*. Washington D.C.: US Institute of Peace.

Dye, T. (1995) *Understanding Public Policy*. Englewood Cliffs: Prentice Hall.

Eberstadt, N. (2004) "The Future of AIDS." *Foreign Affairs*, 81 (6): 22-33.

Elbe, S. (2001) *HIV/AIDS and the Security Sector in the Southern African Region*. Unpublished Manuscript.

Elbe, S. (2002) "HIV/AIDS and the Changing Landscape of War in Africa." In *International Security*, 27 (2): 159 - 177.

Elbe, S. (2003) *Strategic Implications of HIV/AIDS*. Adelphi Paper 357. London: International Institute for Strategic Studies.

Elbe, S. (2005) "AIDS, Security, Biopolitics". In *International Relations* 19 (4): 403 – 419.

Elbe, S. (2006) "Should HIV/AIDS be Securitized? The Ethical Dilemma of Linking HIV/AIDS to Security." In *International Studies Quarterly*, 50 (1): 119-144.

Elbe, S. (2010). "Health and Security." In: Collins, A. *Contemporary Security Studies*. 2nd edition. Oxford University Press, (414-427).

Emmers, R. (2010). "Securitization." In: Collins, A. *Contemporary Security Studies*. 2nd edition. Oxford University Press, (137-151).

Floyd, R. (2007) "Human security and the Copenhagen school's Securitization approach: Conceptualising human security as a securitising move" *Human Security Journal*, 5: (38-49).

Fourie, P. and Schönteich, M. (2001) *Die, the Beloved Countries: Human Security and HIV/AIDS in Africa*. Pretoria: ISS.

Fourie, P. and Schönteich, M. (2001) "Africa's New Security Threat: HIV/AIDS and Human Security in Southern Africa." In *African Security Review* 10 (4).

Fourie, P. (2005) *One Burden Too Many: The Political Management of HIV/AIDS in South Africa, 1982 – 2005*. Johannesburg: PhD Thesis, University of Johannesburg.

Friedman, S. (2004) "South Africa: Building Democracy After Apartheid." In *Democratic Reform in Africa: The Quality of Progress*. Gyimah-Boadi, E. (ed.). Boulder Colorado: Lynne Rienner Publishers.

Friedman, S. and Mottiar, S. (2004) *A Moral to the Tale: The Treatment Action Campaign and the Politics of HIV/AIDS*. Paper for the Centre for Policy Studies. Durban: University of KwaZulu-Natal.

Furlong, P. and Ball, K. (2005) “The More Things Change: AIDS and the State in South Africa, 1987 – 2003.” In Patterson, A.S. (ed.) *The African State and the AIDS Crisis*. Ashgate: Aldershot.

Galea P. and Chermann J.C. (1998) “HIV as the cause of AIDS and associated diseases.” In *Genetica* 104 (2): 133-142.

Games, D. (2006) “Botswana and the Fight Against HIV/AIDS.” In *Africa’s Tsunami. Turning the Tide on AIDS*. Sidiropoulos, E. (ed.). The South African Institute of International Affairs. Global Best Practice Report No. 7.

Garrett, L. (2005) “The Lessons of HIV/AIDS”. In *Foreign Affairs*, 84 (4): 64.

Garrett, L. (2007) “The Challenge of Global Health.” In *Foreign Affairs* 86 (1): 14–38.

Gigleux, V. (2011) *Non-Traditional Security Issues: Should HIV/AIDS be Securitized?* Available at <http://www.e-ir.info/2011/08/10/non-traditional-security-issues-should-hiv-aids-be-securitized/>. Accessed on 03 October 13.

Glesne, C., & Peshkin, A. (1992). *Becoming qualitative researchers*. Thousand Oaks: Sage.

Godsäter, A. and Söderbaum, F. (2008) *The Role of Civil Society in Regional Governance: The Case of Eastern and Southern Africa*. Paper for GARNET Annual Conference, Bordeaux, 17 – 19 September 2008.

Good, K. (1996) Towards Popular Participation in Botswana. *Journal of Modern African Studies* 34 (1): 53-77.

Gorard, G. (2004). *Combining methods in educational and social research*. Berkshire: Open University Press.

Grmek, M.D. (1990) *History of AIDS: Emergence and Origin of a Modern Pandemic*, New Jersey: Princeton University Press.

Grindle, M.S. and Thomas, J.W. (1991) *Public Choices and Policy Change: The Political Economy of Reform in Developing Countries*. Baltimore, Maryland: Johns Hopkins University Press.

Gündüz, Z. (2006) *The HIV/AIDS Epidemic –What’s Security got to do with it?* Available at <http://sam.gov.tr/wpcontent/uploads/2012/02/ZuhalYesilyurtGunduz.pdf>. Accessed on 07 October 2013.

Guss, D.A. (1994) “The acquired immune deficiency syndrome: an overview for the emergency physician, Part 1”. *J. Emerg. Med.* 12 (3): 375–384.

Hadingham J. (2000) “Human security and Africa: Polemic opposites.” In *South African Journal of International Affairs*, 7(2), Winter 2000, Johannesburg.

Haftendorn, H, (1991) “The Security Puzzle: Theory-Building and Discipline-Building in International Security.” In *International Studies Quarterly* 35(1): 3-18.

Hall, J. (2004) “Swaziland women secure right of land ownership”. *African News*, March 2002. Available at http://web.peacelink.it/afrinews/72_issue/p6.html. Accessed on 07 October 2013.

Ham, C. and Hill, M. (1993) *The Policy Process in the Modern Capitalist State*. New York, Harvester Wheatsheaf.

Harman, S. (2012) *Global Health Governance*. Abingdon, UK: Routledge.

Harvey, C. and Lewis, S. (1990) *Policy Choice and Development Performance in Botswana*, Macmillan, London UK.

Heald, S. (2002) “It’s Never as Easy as ABC: Understandings of AIDS in Botswana.” In *African Journal of AIDS Research* 1 (1): 1 – 10.

Heinecken, L. (2000) “AIDS: The New Security Frontier.” In *Conflict Trends*. 3 (4): 12-15.

Heinecken, L. (2001) “Strategic Implications of HIV/AIDS in South Africa.” In *Conflict, Security and Development* 1 (1): 109-113.

Heineman, R. Bluhm, W., Peterson, S. and Kearny, E. (2002) *The World of the Policy Analyst – Rationality, Values and Politics*. New York and London: Chatham House Publishers.

Held, D and McGrew A. (eds.) (2002) *Governing globalization: power, authority and global governance*. Cambridge: Polity Press.

Hertz, J.H. (1957) “Rise and Demise of the Territorial State.” In *World Politics* 9 (4).

Heywood, M. (2003) “Preventing Mother to Child HIV Transmission in South Africa: Background, Strategies and Outcomes of the TAC case against the Minister of Health.”, *SA Journal on Human Rights*, 19 (2).

Heywood, M. (2004) “The Price of Denial”. *Mimeo*.

Holm and Darnolf (2000) “Democratising the Administrative State in Botswana.” In *The Uncertain Promise of Southern Africa*, Bradshaw, Y. and Ndwega, S. (eds.). Bloomington: Indiana University Press.

Hunter, S. (2003) *Who Cares? AIDS in Africa*, New York: Palgrave Macmillan. Also published under the title *Black Death: AIDS in Africa*. London: Palgrave.

Hwedie, O (2001) “HIV/AIDS and the Politics of Domestic Response: The Case of Botswana.” In *International Relations*. 15 (6): 55-68.

Illiffe, J. (2006) *The African AIDS Epidemic: A History*. Athens, Oxford and Cape Town: Ohio University Press, James Currey and Double Storey.

Ingstad, B. (1990) “The cultural construction of AIDS and its consequences for prevention in Botswana”. In *Medical Anthropology Quarterly* 4 (1): 28-40.

International Crisis Group. (2004) HIV/AIDS as a Security Issue in Africa: Lessons from Uganda, Executive Summary and Recommendation. In *ICG, Issues Report N°3*: 1-18.

International Crisis Group (2012) “Implementing Peace and Security Architecture (II): Southern Africa.” In *Africa Report N°191*.

Jahn, E., Lemaitre, P. and Wæver, O. (1987) *Concepts of Security: Problems of Research in Non-Military Aspects*. Copenhagen Papers n. 1. Copenhagen: Centre for Peace and Conflict Research.

Jans, M.T. (2007) *A Framework for Public Policy Analysis and Policy Evaluation*. IES Research colloquium, 4 September 2007.

Johnson, K. (2002) State and Civil Society in Contemporary South Africa: Redefining the Rules of the Game. In *Thabo Mbeki's World: The Politics and Ideology of the South African President*. Eds. S. Jacobs and R. Calland. London and New York: Zed Books.

Johnson, K. (2004) "The Politics of AIDS Policy Development and Implementation in Postapartheid South Africa". In *Africa Today* 51 (2): 107 – 128.

Kasenene, P. (1993) *Religion in Swaziland*, Skotaville Publishers, Braamfontein, Johannesburg.

Kay, A. and Williams, O.D. (eds.) (2009) *Global Governance. Crisis, Institutions and Political Economy*. Basingstoke, UK: Palgrave Macmillan.

Kickbusch, I. (2002) "Global Health Governance: Some Theoretical Considerations on the New Political Space." In *Health Impacts of Globalization: Towards Global Governance*. Edited by Kelley Lee. Houndmills, UK: Palgrave Macmillan.

Klotz (1995) *Norms in International Relations: The Struggle Against Apartheid*. Ithaca: Cornell University Press.

Khun, T. (1962). *The structure of scientific revolution*. Chicago: University of Chicago Press.

Krathwohl, D.R. (1993). *Methods of educational and social science research: An integrated approach*. New York: Longman.

Leedy, P. & Ormrod, J. (2005). *A handbook for teacher research from design to implementation*. New Jersey: Pearson Education.

Levy, A.D. (1993) "Employer Considerations in Determining a Policy on AIDS." In *South African Journal on Human Rights* 9(1).

- Levy, J.D. (2006) *The State After Statism: New State Activities in the Age of Liberalization*, Cambridge, Mass.: Harvard University Press.
- Mackenzie, N. and Knipe, S. (2006) "Research Dilemmas: Paradigms, Methods and Methodology." In *Issues in Educational Research*. Vol. 16.
- MacLean G. (1998) *The Changing Perceptions of Human Security: Co-ordinating National and Multilateral Responses*. UNAC, Manitoba.
- Mac Naughton, G., Rolfe S.A., & Siraj-Blatchford, I. (2001). *Doing Early Childhood Research: International perspectives on theory and practice*. Australia: Allen & Unwin.
- Marks, S. (2002) "An Epidemic Waiting to happen? The Spread of HIV/AIDS in South Africa in Social and Historical Perspective." In *African Studies* 61 (1): 15.
- Mason, J. (2002) *Qualitative Researching* (2nd Edition), London: Sage publications.
- Mbali, M (2002) "Mbeki's Denialism and the Ghosts of Apartheid and Colonialism for Post-apartheid policy making" Presented at the University of Natal, Durban, Public Health Journal Club Seminar Paper, 3 May 2002.
- Mbali, M. (2003) "HIV/AIDS policymaking in post-apartheid South Africa." In *State of the Nation: South Africa 2003-2004*, Daniel, J., Habib, A. and Southall R. (eds.). Cape Town: HSRC Press.
- Mbali, M. (2005) "The Treatment Action Campaign and the History of Rights-Based, Patient-Driven HIV/AIDS Activism in South Africa." In Jones, P. and Stokke, K. (eds.) *Democratising Development: The Politics of Socio-Economic Rights in South Africa*. Leiden: Martinus Nijhoff.
- McCoy, D., Chand, S. and Sridhar, D. (2009) "Global Health Funding: How Much, Where It Comes from, and Where It Goes." In *Health Policy and Planning* 24: 407–417.
- McDonald, M. (2008) "Securitisation and the Construction of Security." In *European Journal of International Relations*, 14.
- McInnes, C. (2006) "HIV/AIDS and Security." In *International Affairs*, 82 (2): 315 - 326.

- McInnes, C. and Rushton, S. (2010) *HIV, AIDS and Securitisation*. Paper for 2010 International Studies Association Annual Conference. New Orleans.
- McLennan, G. (1997) *The Evolution of Pluralist Theory. The Policy Process. A Reader*. Ed. M. Hill. London and New York: Prentice Hall Harvester Wheatsheaf.
- McMillan, J., & Schumacher, S. (2006). *Research in Education*. (6th ed.) Boston: Pearson Education.
- McNiel, J. (2012) The HIV/AIDS Crisis Emerges: Responses of the Apartheid Government. *SA History website*. Available at <http://www.sahistory.org.za/topic/history-official-government-hivaids-policy-south-africa>. Accessed on 28 January 2013.
- McSweeney, B. (1996) Identity and Security: Buzan and the Copenhagen School. *Review of International Studies*, 22: 81-93.
- Mearsheimer, J. (1990) Back to the Future: Instability After the Cold War. In *International Security*, 15 (1): 5-56.
- Mearsheimer J. (2006) "Structural Realism".
Mearsheimer.uchicago.edu/pdfs/StructuralRealism.pdf
- Mertens, D.M. (2005). *Research methods in education and psychology: Integrating diversity with quantitative and qualitative approaches*. (2nd ed.) Thousand Oaks: Sage.
- Merton, R.K., Fiske, M. and Kendall, P.L. (1990) *The Focused Interview: A Manual of Problems and Procedures* (2nd ed.) New York: Free Press.
- Merton, R.K., & Kendall, P.L. (1946) "The focused interview." *The American Journal of Sociology*, 51, (6): 541-557.
- Miles, M.B. and Huberman, A.M. (1994) *Qualitative Data Analysis: An Expanded Sourcebook*. Thousand Oaks, California: Sage.

Mills, G. (2000) “AIDS and the South African Military: Timeworn Cliché or Time-bomb?” In *HIV? AIDS: A Threat to the African Renaissance?*. Ed. M. Lange. Johannesburg: Konrad Adenauer Foundation.

Mogalakwe, M. and Sebudubudi, D. (2006) “Trends in State-Civil Society Relations in Botswana”. In *Journal of African Elections*, 5 (2).

Murray, A and Parsons, N. (1990) “The Modern Economic History of Botswana” In Konczacki, ZA, Parpart, JL, Shaw, TM (eds) *Studies in the Economic History of Southern Africa*, Vol 1; The Front Line states, Frank Cass Publishers.

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

Ndlovu, N. (2005) *An Exploratory Analysis of HIV and AIDS Donor Funding in South Africa. IDASA – Budget Brief No. 155*. Cape Town: IDASA.

Neuman, (2000). *Social research methods: qualitative and quantitative approaches*. (4th ed.) Boston: Allyn & Bacon.

North, D.C. (1991) “Institutions.” In *Journal of Economic Perspectives*, 5 (1): 97 – 112.

Ntseane, D. (2002) “HIV/AIDS Spending in Botswana”. In *Idasa Aids Budget Unit Research Reports*.

Ntseane, P.G. (2004) *Cultural Dimensions of Sexuality: Empowerment Challenge for HIV/AIDS Prevention in Botswana*. Paper Presented at the International Seminar/Workshop on “Learning and Empowerment: Key Issues in Strategies for HIV/AIDS Prevention. Chiangmai, Thailand March 2004.

Nzau, M. (2011) “On Political Leadership and Development in Africa: A Case Study of Kenya.” In *Kenya Studies Review*, 3 (3).

O'Leary, Z. (2004). *The essential guide to doing research*. London: Sage.

- O'Manique, C. (2006) "The Securitization of AIDS: A Critical Feminist Lens" in (eds.) Tim Shaw and Sandra McLean, *Mapping Innovations in Human Security* Ashgate.
- Ostergard, R. (2002) "Politics in the Hot Zone: AIDS and National Security in Africa." In *Third World Quarterly*, 23 (2): 333 – 350.
- Ostergard, R. (ed.) (2005) *HIV, AIDS and the Threat to National and International Security*. London: Palgrave.
- Parsons, W. (1997) *Public Policy: an Introduction to the Theory and Practice of Policy Analysis*. Cheltenham: Edward Elgar.
- Patterson, A.S. (2006) *The Politics of AIDS in Africa*. Boulder, Colorado: Lynne Rienner Publishers.
- Peterson, S. (2002/3) "Epidemic Disease and National Security." In *Security Studies*, 12 (2): 43-81.
- Pillay, Y., White, C. and McCormick, N. (2012) "How Times Have Changed – HIV and AIDS in South Africa in 2011." In *South African Medical Journal*, 102 (2).
- Poku N., and Cheru F. (2001) "The Politics of Poverty and Debt in Africa's AIDS Crisis." In *International Relations* 15 (6): 45.
- Poku, N. (2002) "Africa's AIDS Crisis in Context: How the Poor Are Dying." In *Third World Quarterly*, 22 (2): 195.
- Prasad, P. (1997) "Systems of Meaning: Ethnography as a Methodology for the Study of Information Technologies," in A. S. Lee, J. Liebenau, and J. I. DeGross (Eds.) *Information Systems and Qualitative Research*, London: Chapman and Hall, (101-118).
- Price-Smith A. (2003) *The HIV/AIDS Pandemic as a Threat to Governance and National Security: The Case of South Africa*. Presented at the International Studies Association Annual Conference, Portland, USA, February.
- Prins, G. (2004) "AIDS and Global Security." In *International Affairs*, 80 (5): 931 – 952.

- Rana, A. (2004) "What Future Democracy?" In *Index on Censorship*, 1 (4): 56-9.
- Reeves J.D. and Doms R.W. (2002) "Human Immunodeficiency Virus Type 2", *J. Gen. Virol*, 83 (6): 1253-1265.
- Renouf, J.S. (2011) *Understanding How the Identity of International Aid Agencies and Their Approaches to Security Are Mutually Shaped*. London: PhD Thesis, London School of Economics and Political Science.
- Rollnick, R. (2002) "An African Test Case for Wide Distribution of Life-Prolonging Medicines." In *Africa Recovery*. Available at <http://allafrica.com/sustainable/stories/200210230001.html>. Accessed on 04 October 2013.
- Rook, F. (2009) "Public – Private Partnerships in the Fight Against HIV/AIDS: A Case Study of Botswana." In *SPNA Review*, 5 (1): 19 – 27.
- Rubin, H.J. and Rubin, I.S. (1995) *Qualitative Interviewing: The Art of Hearing Data*. Thousand Oaks, California: Sage.
- Rushton, S. (2007) *The Development of HIV/AIDS and Security Discourse: The Role of CSOs*. Case study for the Peter Wall Institute's London Workshop on Civil Society Organisations and Global Health Governance, October 2007.
- Rweyemamu, N. (1990) *The Swazi chief and the written law*, Mbabane, Swaziland: Websters.
- Salter, M. (2008) "Securitisation and Securitisation: A Dramaturgical Analysis of the Canadian Air Transport Security Authority", In *Journal of International Relations and Development* 11 (4): 321-49.
- Schneider, H. (1998) *The Politics Behind AIDS: The Case of South Arica*. Paper presented at the 12th World AIDS Conference in Geneva.
- Schoofs, M (200) "Flirting with Pseudo-Science", In *Village Voice*, March 15-21.
- Schram, T. (2006). *Conceptualizing and proposing qualitative research*. (2nd ed.) New Jersey: Pearson Education.

- Searle, J.R. (1969) *Speech Acts. An Essay in the Philosophy of Language*. Cambridge: Cambridge University Press.
- Seckinelgin, H., Birgirumwami, J. and Morris, J. (2010) "Securitization of HIV/AIDS in Context: Gendered Vulnerability in Burundi." In *Security Dialogue*, 41 (5): 515-534.
- Schwartzman, H. (1993) *Ethnography in organizations*, Sage Publications (Newbury Park California).
- Shell, R. (2000) "Halfway to the Holocaust: The Economic, Demographic and Social Implications of the AIDS pandemic to the Year 2010 in the Southern African Region." In *HIV/AIDS: A Threat to the African Renaissance?*. Konrad Adenauer Stifting Occasional Paper, June.
- Silverman, D. (2000). *Doing qualitative research: A practical handbook*. London, Thousand Oaks, New Delhi: Sage Publications.
- Singer, P.W. (2002) "AIDS and International Security." In *Survival*, 44(1): 145-158.
- Sjöstedt, R. (2008) "Exploring the Construction of Threats: The Securitisation of HIV/AIDS in Russia." In *Security Dialogue* 39(1): 7-29.
- Somekh, B., & Lewin, C. (2005). *Research methods in social sciences*. London: Sage.
- Stake, R. (1995) *The art of case study research*, Sage Publications, Thousand California
- Strange, S. (1995) "Political Economy and Interantional Relations." In *International Relations Theory Today*. (Eds.) K. Booth and S. Smith. London: Polity Press.
- Stritzel, H. (2005) *Towards a Theory of Securitization: Copenhagen and Beyond*. Unpublished Manuscript.
- Strode, A. and Grant, K. (2004) *Understanding the Institutional Dynamics of South Africa`s Response to the HIV/AIDS Epidemic*. Pretoria: IDASA.

Su, Y. (2010) “The Failure of the American ABC HIV Prevention Model in Botswana.” In *Studies by Undergraduate Researchers at Guelph*, 4 (1).

Tapia-Valdés, J.A (1982) “A Typology of National Security Policies.” In *Yale Journal of World Public Order* 9(10): 10-39.

Tashakkori, A., and Teddlie, C. (2003). *Handbook of mixed methods in social and behavioural research*. London: Cassell.

Taureck, R. (2006) “Securitization Theory and Securitisation on Studies.” In *Journal of International Relations and Development*, 9: 53 – 61.

Taylor, I. (2002) *Botswana’s Developmental State and the Politics of Legitimacy*. Paper presented at the conference “Towards a New Political Economy of Development: Globalisation and Governance” Sheffield: University of Sheffield.

Taylor, I. (2005) “*Growing Authoritarianism in ‘the African Miracle’: Should Botswana be Cause for Concern?*” Copenhagen: Danish Institute for International Studies, DIIS Working Paper 2005/24.

Tellis, W. (1997) “Application of a Case Study Methodology”. In *The Qualitative Report*, 3 (3).

Terreblanche, S. (2002) *A History of Inequality in South Africa 1652 – 2002*. Pietermaritzburg: University of Natal Press.

Thomas, R. M. (2003). *Blending qualitative and quantitative research methods in theses and dissertations*. Thousand Oaks, California: Corwin Press, Inc, A Sage Publications Company.

Tickner, J.A. (1992) *Gender in International Relations: Feminist Perspectives on Achieving Global Security*. New York: Columbia University Press.

Tsie, B. (1996) “The Political Context of Botswana’s Development Performance.” In *Journal of Southern African Studies*. 22(4): 599 – 616.

Ullman, R. (1983) “Redefining Security.” In *International Security* 8 (1): 129 – 153.

Van der Walddt, G. (2001) "Public Policy and Policy Analysis." In *Governance, Politics and Policy in South Africa*. (Eds.) D. van Niekerk, G. Van der Walddt and A. Jonker. Cape Town: Oxford University Press Southern Africa.

Vieira, M.A.M. deC. (2006) *Southern Africa's Response(s) to International HIV/AIDS Norms: The Politics of Assimilation*. London: PhD Thesis, London School of Economics and Political Science.

Vieira, M.A.M. deC. (2007) "The securitization of the HIV/AIDS epidemic as a norm: a contribution to constructivist scholarship on the emergence and diffusion of international norms." In *Brazilian Political Science Review*, 1 (2). Available at http://socialsciences.scielo.org/scielo.php?pid=S1981-38212007000200005&script=sci_arttext. Accessed on 04 July 2012.

Walker, L., Reid, G. and Cornell, M. (2004) *Waiting to Happen: HIV/AIDS in South Africa*. London: Lynne Rynnner.

Walt, S.M. (1991) "The Renaissance of Security Studies." In *International Studies Quarterly* 3.

Walter, M. (2006). *Social Science methods: an Australian perspective*. Oxford, New York: Oxford University Press.

Waltz, K. (2001) *Man, the State and War: A Theoretical Analysis*. New York: Columbia University Press.

Weiser, S.D., Leiter, K., Heisler, M., McFarland, W., Percy-deKorte, F., DeMonner, S.M., Tlou, S., Phaladza, N., Lacopino, V. and Bangsberg, D.R. (2006) *A Population-Based Study on Alcohol and High-Risk Sexual Behaviors in Botswana*. Available at <http://www.plosmedicine.org/article/info%3Adoi%2F10.1371%2Fjournal.pmed.0030392>. Accessed 04 October 2013.

Whiteside, A. (2005) "The economic impact of AIDS", in Abdool Karim, S. S. and Abdool Karim, Q. (eds.), *HIV/AIDS in South Africa*. Cambridge University Press, Cambridge.

Whiteside, A. (2008) *HIV/AIDS. A Very Short Introduction*. New York: Oxford University Press.

Whiteside, A., Andrade, C., Arrehag, L., Dlamini, S., Ginindza, T., Parikh, A. (2006) *The Socio-Economic Impact of HIV/AIDS in Swaziland*. Prepared by NERCHA and HEARD.

Whiteside, A. and Barnett, T. (2002) *AIDS in the Twenty First Century: Disease and Globalisation*. Houndsmills: Palgrave

Whiteside, A. and Cross, S. (2003) *Facing up to AIDS: The Socio-economic impact in Southern Africa*, New York: St Martin's Press

Whiteside, A., DeWaal, A. and Tensae, T.G. (2006) "AIDS, the Military and Security in Africa: A Sober Appraisal." *In African Affairs*. 105 (419): 2012-218..

Whiteside, A. and Sunter, C. (2000) *AIDS the Challenge for South Africa*, Cape Town: Human and Rousseau

Wiersma, W. (2000). *Research methods in education: An introduction*. (7th ed.) Boston: Allyn and Bacon.

Williams B., Gouws E., Lurie M. and Crush J. (2002) "Spaces of vulnerability: Migration and HIV/AIDS in South Africa." *In Southern African Migration Project, Migration Policy Series No. 24*, IDASA, Cape Town.

Williams, M. (1998) "Modernity, Identity and Security: A Comment on the "Copenhagen Controversy"". *In Review of International Studies* 24: 435 – 439.

Williams, M. (2003) "Words, Images, Enemies: Securitization and International Politics." *In International Studies Quarterly*, 47 (4): 511 – 531.

Wolde, M.A. (2005) *A Critical Assessment of Institutions, Roles and Leverage in Public Policy Making: Ethiopia, 1974 – 2004*. Stellenbosch: PhD Thesis, University of Stellenbosch.

Wolfers A, (1952) "National Security as an Ambiguous Symbol." *In Political Science Quarterly*, 67 (4): 481-502.

Wæver, O. (1989) *Security, the Speech Act: Analyzing the Politics of a Word (and the Transforming of a Continent)*. Paper presented at the research training seminar, Sostrup Manor.

Wæver, O. (1995) "Securitisation and Desecuritisation." In *On Security*. (Ed.) R.D. Lipschutz. New York: Columbia University Press.

Wæver, O. (1997) *Concepts of Security*. Copenhagen: Institute of Political Science, University of Copenhagen.

Wæver, O., Buzan, B., Kelstrup, M., Lemaitre, P. (1993) *Identity, Migration and the New Security Agenda in Europe*. London: Pinter.

Wæver, O., Lemaitre, P., Tromer, E., (eds.) (1989) *European Polyphony Perspectives Beyond East – West Confrontation*. London: Macmillan.

Yanow, D., Schwartz-Shea P. & Freitas, M. J. (2008). "Case Study Research in Political Science." In A.J. Mills, G. Durepos & E. Wiebe (Eds.), *Encyclopedia of Case Study Research*. Sage Publications.

Yin, R.K. (2009) *Case Study Research: Design and Methods*. Thousand Oaks, California: Sage.

Zacarias, A. (1996) *The Security Concept in Southern Africa: Prospects for the Post-Apartheid Era*. London: PhD Thesis, London School of Economics.

Zacarias, A. (1999) *Security and the State in Southern Africa*. London: Tauris Academic Studies.

Newspapers, Magazines and Internet sources

"A Political Economy of AIDS in Africa". *PCDN*, 10 November 2009. Available at <http://www.internationalpeaceandconflict.org/profiles/blogs/a-political-economy-of-aids-in> accessed 04 on October 2013.

"Activists Happy to See Manto Go". *news24.com*, 26 September 2008. Available at <http://www.news24.com/SouthAfrica/Politics/Activists-happy-to-see-Manto-go-20080926>. Accessed 04 on October 2013.

“Aids: Hogan signals new tactic”. *News24.com*, 13 October 2008. Available at <http://www.news24.com/SouthAfrica/AidsFocus/Aids-Hogan-signals-new-tactic-20081013>. Accessed on 29 January 2013.

“Africa Should Beware of Forces of Liberal Imperialism”. *The Mail and Guardian*, 07 April 2006.

“After Extinction Fears Botswana Learns to Live with AIDS”. *Terradaily*, 20 October 2007. Available at http://www.terradaily.com/reports/After_extinction_fears_Botswana_learns_to_live_with_AIDS_999.html. Accessed on 04 October 2013.

“A HOLLOWED GENERATION: Plunge in Life Expectancy; Hut by Hut, AIDS Steals Life in a Southern Africa Town.” *The New York Times*, 17 April 2004.

“Appeals ignored - TAC takes government to court”. *The South African Health News Service*, 22 August 2001. Available at <http://www.health-e.org.za/2001/08/22/appeals-ignored-tac-takes-government-to-court/>. Accessed 04 on October 2013.

Bearak, B. “In Destitute Swaziland, Leader Lives Royally.” *The New York Times*, 6 September 2008. Available at http://www.nytimes.com/2008/09/06/world/africa/06king.html?_r=0. Accessed on 04 October 2013.

“Botswana: A Risky Combination of Alcohol and Sex.” *IRIN News*, 05 November 2009. Available at <http://www.irinnews.org/report/86899/botswana-a-risky-combination-of-alcohol-and-sex>. Accessed on 04 October 2013.

“Botswana loses out” *Daily News* 16 August, 2006. Available at <http://www.olddailynews.gov.bw/cgi-bin/news.cgi?d=20060816>. Accessed on 04 October 2013.

“Controversy dogs Aids forum” *BBC*, 10 July 2000. Available at <http://news.bbc.co.uk/2/hi/africa/826742.stm>. Accessed on 04 February 2013.

“Expectations on the state of the nation address” *Daily News* 03 November, 2008. Available at <http://www.olddailynews.gov.bw/cgi-bin/news.cgi?d=20081103> Daily News. Accessed on 04 October 2013.

“Delay for Aids Drugs Case.” *BBC*, 06 March 2001. Available at <http://news.bbc.co.uk/2/hi/africa/1205388.stm>. Accessed on 04 October 2013.

“No peace for workaholic Mandela”. *BBC news*, 02 March 2003. Available at <http://news.bbc.co.uk/2/hi/africa/2808313.stm>. Accessed on 04 October 2013.

Endal, D. “Botswana’s President: Alcohol a Great Obstacle to HIV/AIDS Prevention.” *Alcohol, Drugs and Development (ADD)*, 15 December 2008. Available at <http://www.add-resources.org/botswanas-president-alcohol-a-great-obstacle-to-hiv-aids-prevention.4532054-76188.html>. Accessed on 04 October 2013.

“Flirting with pseudoscience” *Village Voice*, 21 March 2000.

Fox, M. “AIDS conference closes with blast at South Africa”. *redOrbit.com*, 18 August 2006. Available at http://www.redorbit.com/news/general/622836/aids_conference_closes_with_blast_at_south_africa/. Accessed on 04 October 2013.

“GLOBAL: Leadership determines AIDS performance.” *IRIN News*, 25 September 2008. Available at <http://www.irinnews.org/report/80597/global-leadership-determines-aids-performance>. Accessed on 04 October 2013.

“Has Swaziland turned the corner in the fight against AIDS?” *IRIN News*, 05 December 2006.

“Health Dept ahead of ARV target”. *South Africa the Good News*, 29 January 2009. Available at http://www.sagoodnews.co.za/health_and_hiv_aids/health_dept_ahead_of_arv_target.html. Accessed on 04 October 2013.

“HEALTH-SOUTH AFRICA: A Burden That Will Only Become Heavier”. Inter Press Service News Agency, 28 May 2006. Available at <http://www.ipsnews.net/2006/05/health-south-africa-a-burden-that-will-only-become-heavier/>. Accessed 04. October 2013.

“HIV/AIDS Interventions in Truck Driver Population in Southern Africa: A Review of Literature and BCC Materials”. SANAC website, 03 February 2004. Available at <http://www.sanacws.org.za/se/resource-centre/download/4d7de12a35eeb-hiv-aids-intervention-in-truck-driver-populations-in-south-a-pdf>. Accessed on 07 October 2013.

“Hogan’s stance on Aids gets thumbs up” *iol news*, 07 October 2008. Available at <http://www.iol.co.za/news/south-africa/hogan-s-stance-on-aids-gets-the-thumbs-up-1.419198?ot=inmsa.ArticlePrintPageLayout.ot>. Accessed on 04 October 2013.

“How times have changed – HIV and AIDS in South Africa in 2011”. *South African Medical Journal*, Vol 102 (02) 2012. Available at <http://www.samj.org.za/index.php/samj/rt/priniterFriendly/5284/3845>. Accessed on 04 October 2013.

“In South Africa, a dramatic shift on AIDS”, *Washington Post*, 27 October 2006.

“King Buys £450,000 Fleet of BMWs for 11 Wives.” *Sunday Telegraph*, 16 February 2005.

“Labour migration contributes to spread of HIV”. *iol news*, 14 August 2006. Available at <http://www.iol.co.za/news/africa/labour-migration-contributes-to-spread-of-hiv-1.289340#.UIKH90v8JMs>. Accessed 07 October 2011.

“Mbeki – Africa’s Challenges”. *Time Magazine*, 11 September 2000. Available at <http://content.time.com/time/world/article/0,8599,2039809,00.html>. Accessed on 04 October 2013.

“Mbeki and the HIV/AIDS Monster”. *The Star*, 26 October 2010

“Mbeki Should Apologize for AIDS Inaction, Union Leader Says.” *Bloomberg*, 30 November 2009. Available at

<http://www.bloomberg.com/apps/news?pid=newsarchive&sid=atDqsOWNRNHo>. Accessed on 04 October 2013.

“Mbeki Urged to Sack Ally over HIV Views.” *The Guardian*, 07 September 2006.

Available at <http://www.guardian.co.uk/world/2006/sep/07/southafrica.aids>. Accessed on 04 October 2013.

“Mbeti: Always use condoms”. *New24.com*, 1 December 2008. Available at

<http://www.news24.com/SouthAfrica/AidsFocus/Mbeti-Always-use-condoms-20081201>.

Accessed on 05 October 2013.

Meldrum, A. “King Comes Courting 20,000 Virgin Dancers.” *The Guardian*, 30 August 2005.

Available at <http://www.guardian.co.uk/world/2005/aug/30/aids.andrewmeldrum>. Accessed on 04 October 2013.

“Mswati plans a hearty party”. *iol news*, 11 April 2005. Available at

<http://www.iol.co.za/news/africa/mswati-plans-a-hearty-party-1.236027#.UIJ5Nkv8JMs>.

Accessed on 07 October 2013.

“Namibia - Partners working hard to maintain treatment success.” *IRIN*, 13 March 2007.

Available at <http://www.irinnews.org/report/70655/namibia-partners-working-hard-to-maintain-treatment-success>. Accessed on 4 October 2013.

“New era for S Africa Aids fight?” *BBC News* 06 October 2006. Available at

<http://news.bbc.co.uk/2/hi/7650983.stm>. Accessed on 04 October 2013.

“No Peace for workaholic Mandela”. *BBC News* 02 March 2003, Available at

<http://news.bbc.co.uk/2/hi/africa/2808313.stm>. Accessed on 07 October 2013.

“Opposition urges Khama to fight AIDS” *Mmegi News* 27 November 2008. Available at

<http://www.mmegi.bw/index.php?sid=1&aid=2&dir=2008/November/Thursday27>. Accessed on

07 October 2013.

“R50 million programme to reduce HIV amongst farm workers”. *South African The Good News*, 11 March 2009 Available at

http://www.sagoodnews.co.za/health_and_hiv_aids/r50m_programme_to_reduce_hiv_among_farm_workers.html. Accessed on 04 October 2013.

“SA’s ‘dramatic shift’ on Aids”. *South Africa info*, 30 October 2006. Available at

<http://www.southafrica.info/about/health/aids-washingtonpost.htm>. Accessed on 07 October 2013.

“Scientists Rip S. African AIDS Policies”. *Washington Post*, 6 September 2006. Available at

<http://www.washingtonpost.com/wp-dyn/content/article/2006/09/06/AR2006090600586.html>. Accessed on 04 October 2013.

“Scientists ordered to stop using President’s name.” *Sunday Times (South Africa)* 21 April 2002.

“SA Minister calls for vaccine”, *BBC News*, 14 October 2008. Available at

<http://news.bbc.co.uk/2/hi/africa/7668637.stm>. Accessed on 07 October 2013.

“South African Government Under Fire for Delaying Release of Global Fund”. *IPS News Agency*, 05 May 2003. Available at <http://www.ipsnews.net/2003/05/health-south-african-government-under-fire-for-delaying-release-of-global-funds/>. Accessed 07 October 2013.

“South Africa New Unity on AIDS”. *Southafrica.info*, 02 December 2008. Available at

<http://www.southafrica.info/about/health/aidsday2008.htm#.UIL730v8JMs>. Accessed 07 October 2013.

“Stop denying the killer bug”. *The Economist*, 21 February 2002.

“Swazi girls celebrate as king lifts ban on sex for under-18s.” *The Independent*, 23 August 2005.

“SWAZILAND: ARV programme needs to double”. *IRIN News*, 03 December 2008. Available at

<http://www.irinnews.org/report/81796/swaziland-arv-programme-needs-to-double>. Accessed on 07 October 2013.

“Swaziland: HIV Positive Swazis Take Government to Task over ARV Supply”. *allAfrica.com*, 06 December 2005. Available at <http://allAfrica.com/stories/200512060641.html>. Accessed on 04 October 2013.

“Swaziland king celebrates in style.” BBC, 6 September 2008. Available at <http://news.bbc.co.uk/2/hi/africa/7602427.stm>. Accessed on 04 October 2013.

“Swaziland: NGOs and Government on a Collision Course”. *Norwegian Council For Africa/IRINNews*, 01 October 2009. Available at <http://www.afrika.no/Detailed/18760.html>. Accessed on 04 October 2013.

“Swaziland: Reforms Long Overdue”. *Allafrica.com*. Available at <http://allafrica.com/stories/200809230586.html>. Accessed on 04 October 2013.

“SWAZILAND: Some women can now own property”. *IRIN News*, 25 February 2010. Available at <http://www.irinnews.org/report/88230/swaziland-some-women-can-now-own-property>. Accessed on 04 October 2013.

“SWAZILAND: The role of women stirs debate at the reed dance”. *IRIN News* 30 August 2005. Available at <http://www.irinnews.org/report/56096/swaziland-the-role-of-women-stirs-debate-at-the-reed-dance>. Accessed on 07 October 2013.

“SWAZILAND: “Weak” civil society hampering efforts to address crises”. *IRIN News*, 18 January 2007.

“Swaziland women secure right of land ownership.” *News From Africa*, March 2002. Available at http://www.newsfromafrica.org/newsfromafrica/articles/art_7884.html. Accessed on 04 October 2013.

“Taiwan to ignore flu drug patent”. *BBC News*, 22 October 2005. Available at <http://news.bbc.co.uk/2/hi/asia-pacific/4366514.stm>. Accessed on 04 October 2013.

“Taking the AIDS Battle Forward”. *BBC*, 16 September 2005. Available at <http://newswww.bbc.net.uk/2/hi/africa/4242530.stm>. Accessed on 04 October 2013.

“Thabo Mbeki, A Man of two faces”. *The Economist*, 20 January 2005.

The HIV/AIDS Epidemic in Southern Africa” *Henry J. Kaiser Family Foundation*, [October 2008](#). Available at <http://stepsa.org/resources/shared-documents/hiv-aids-policy-fact-sheet-pdf>.

Accessed on 04 October 2013.

“Top five challenges for new Health boss”. *Health24.com*, 03 October 2008. Available at <http://www.health24.com/Medical/HIV-AIDS/Different-political-stances/Top-5-challenges-for-new-health-boss-20120721>. Accessed on 07 October 2013.

“Trade Unions warn ANC of Rift.” *The Telegraph*, 20 September 2000. Available at <http://www.telegraph.co.uk/news/worldnews/africaandindianocean/southafrica/1356147/Trade-unions-warn-ANC-of-rift.html>. Accessed on 04 October 2013.

Troubled King Mswati, BBC News 04 December 2001. Available at <http://news.bbc.co.uk/2/hi/africa/1692217.stm>. Accessed on 07 October 2014.

“UNAIDS Executive Director Celebrates World AIDS Day in South Africa”. UNAIDS 01 December 2008. Available at <http://www.unaids.org/en/resources/presscentre/featurestories/2008/december/20081201ppwadsouthafrica/>. Accessed 04 October 2013.

“UN envoy slams Swaziland for ignoring AIDS time bomb.” *Agence France-Presse*, 21 March 2004.

“You Ain’t Seen Nothing Yet”. *The Economist*, 23 June 2005.

Appendix 1

Interview Schedule – Guiding Questions

- a) What do you perceive is the pre-dominant approach to HIV and AIDS in the countries (Botswana, Swaziland and South Africa)? Do you think HIV and AIDS also has a security aspect and if so what is it?
- b) Has the epidemic been fully securitised and to what degree?
- c) Does a sufficient political space exist for non-state actors to contribute to curbing the epidemic? What is the role of non-state actors in attempts to address the epidemic? (What is the role both implicit and explicit?)
- d) Are there conflicting approaches between domestic and regional approaches with regards to policy concerns?
- e) Is SADC as the regional body able to deal with the epidemic? If not, why not?
- f) To what extent have HIV and AIDS securitisation attempts been more successful in one domestic setting than in another? Do you think there have been successful attempts to address HIV and AIDS as a security issue?

Appendix 2

Interview Schedule – Interview List		
Name and title	Organisation	Date and Type of interview
Exploratory interviews		
Dr. Antonica Hembe - HIV and AIDS Unit Manager	Social and Human Development Directorate - Southern African Development Community (SADC)	2008/05/07 Email
Dr. Alphonse Mulumba - HIV and AIDS Senior Officer for Research	Social and Human Development Directorate - Southern African Development Community (SADC)	2008/05/09 Email and telephone
Dr. Evaristo Marowa – Country Coordinator Botswana	UNAIDS	3/3/08 Email
Mr. Mark Sterling - Regional Director for Southern Africa	UNAIDS	15/04/ 08 Email

Dr. Shivaji Bhattacharya -Senior Policy Advisor Africa Regional HIV and AIDS Team, RSC	UNDP	7/5/ 08 Email
Professor Nana K. Poku	University of Bradford	23/4/06, 8/5/06 and 12/5/06 Email
Dr. Martin R. Rupiya - Senior Researcher	Institute for Security Studies (ISS)	19/04/07 Email
Professor Pieter Fourie	University of Johannesburg	25/04/08
Ms. Angela Ndinga- Muvumba Senior Researcher	Centre for Conflict Resolution (CCR)	23/04/08
Professor Lindy Heinecken	University of Stellenbosch	24/04/08
Mr. Johan Maritz – Senior Manager	Centre for AIDS Study, University of Pretoria	26/04/08
Professor Alan Whiteside – Executive Director	The Health Economics and HIV/AIDS Research Division (HEARD) AIDS Expert, University of Durban	09/05/08 Telephone

Key Informant Interviews		
Botswana		
Ms. Kirsten Weeks - Senior Programme Manager	Academy for Educational Development (AED) Centre on AIDS and Community Health	05/03/08
Ms. Mpho Mmelesi - Chief Research Officer	National AIDS Coordinating Agency (NACA)	07/03/08
Mr. David Ngele - Executive Director	Botswana Network of People Living with AIDS (BONEPWA)	06/03/08
Dr. S.M. Kang'ethe - Project Development Worker	Botswana Network of People Living with AIDS (BONEPWA)	6/03/08
Southern African Development Community (SADC)		
Ms. Lebo Lebeso - Senior Health Officer	Social and Human Development Directorate - Southern African Development Community (SADC)	05/03/08
Col. Gerson Sangiza - Head of Defence Affairs	Organ on Politics, Defence and Security Cooperation - Southern African Development Community (SADC)	07/03/08

Dr Mokete Pherudi - Acting Head	Regional Early Warning Centre (REWC) – Southern African Development Community (SADC)	07/03/08
South Africa		
Mrs Nomajoni Ntombela Senior Advisor Maternal & Child Health and Nutrition	Academy for Educational Development (AED)	27/02/08 email 23/04/08
Dr Lemma Merid Senior Policy Advisor	UNDP	09/05/08 Telephone
Mr. Thabo Rakoloti Director Department of Health	Department of Health, South Africa	9/10/07 Email
Mr. Jacob Ntseke - Deputy Director International Health Liaison Officer	Department of Health, South Africa	10/10/07 Email
Mr. Moses Kau - Head of International Health Liaison Officer	Department of Health, South Africa	10/10/07 Email
Mr. Moeketsi	Department of Health, South Africa	10/10/07

Modisenyane - Director Africa Relations		Email
Swaziland		
Ms. Thembisile Dlamini - Social Mobilisation and Partnership Advisor	UNAIDS	14/02/08
Dr. Von Wessels - Director	National Emergency Response Council on HIV and AIDS (NERCHA)	11/04/08
Ms. Faith Dlamini - Health Sector Coordinator - HIV Prevention	National Emergency Response Council on HIV and AIDS (NERCHA)	11/04/08
Mr. Richard Walwema - Director	National Referral Laboratory at the Mbabane Government Hospital, Ministry of Health	10/04/08
Ms. Catarina Andrade Policy Advisor	William J. Clinton Foundation (formerly with the Ministry of Health and The National Emergency Response Council on HIV and AIDS (NERCHA))	11/04/08
Mr. Gavin Khumalo - Regional Coordinator Shiselweni Region	Swaziland National Network of People Living With HIV and AIDS (SWANNEPHA)	11/04/08

Ms. Kate McNally Regional Programme Manager	Pact - Southern Africa HIV and AIDS Prevention Programme	10/04/08
---	---	----------