# Reflections on Ministerial Leadership: HIV/AIDS Policy Reform in South Africa

South Africa has one of the highest HIV/AIDS prevalence rates in the world. The country's response to the epidemic for a period of about eight years was hampered by misguided political leadership questioning the causality of HIV/AIDS and the effectiveness of antiretroviral therapy. This situation was finally reversed in 2009 when President Jacob Zuma was elected. This case study outlines the problem, changes and outcomes of South Africa's HIV/AIDS policy reform as follows:

- South Africa's response to its HIV/AIDS epidemic was impeded by nearly two decades of poorly informed policy, particularly under the leadership of Thabo Mbeki; believing that HIV did not cause AIDS, claiming that it was linked to social factors, and giving preference to the use of Virodene, a drug found to be highly toxic, instead of ARVs.

- As a result of these policies, the country had an adult HIV/AIDS prevalence rate of 17.3% in 2011. There were 310,000 AIDS related deaths that year and 1.9 million orphans due to the AIDS deaths. There was also a high mother-to-child transmission rate because of restricted use of freely donated nevirapine, which prevents mother-to-child transmission.

- The election of Jacob Zuma in 2008 ushered in a dramatic shift in the country's HIV/AIDS policy. He and Minister of Health, Aaron Motsoaledi, quickly implemented plans for countrywide prevention and testing, and providing ARV treatment without charge through public facilities to all who require it.

- Minister Motsoaledi introduced the HIV and AIDS Counseling and Testing Campaign in 2010 with the aim of regular HIV testing and counseling, promoting behavior change and regular condom use, providing voluntary medical male medical circumcision, scaling up syndromic management of STI and intensified prevention of mother-to-child transmission programs. Also implemented task shifting to increase the number of professionals able to test for HIV, prescribe ARVs, and administer ARV treatment.

- As a result of the newly implemented strategy, 20 million South Africans have been tested for HIV/AIDS over the past 3 years ; mother-to-child HIV transmission has decreased; life expectancy has risen; over 600,000 men have voluntarily been circumcised; the number of facilities providing ARV treatment increased significantly, as had the number of patients receiving ARV treatment; and expenditure on combating HIV/AIDS in South Africa is now the highest of any middle-income or low-income country.

On taking office in 2009, Minister Aaron Motsoaledi was faced with an immediate political priority. Reversal of the existing HIV/AIDS policy had been a part of President Zuma's election platform and there was huge domestic and international pressure for a quick change. Minister Motsoaledi tackled the

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challenge with energy and skill quickly convincing the South African public and the international community that the new government's commitment was genuine and rapidly launching highly publicized efforts to expand prevention and treatment programs. Minister Motsoaledi's efforts have transformed South Africa's HIV/AIDS management program from an international moral outrage into a global example.

## HIV/AIDS Policy Reform in South Africa – The Transformation after 2009

South Africa is one of the countries worst affected by HIV/AIDS. Historically, the HIV/AIDS response in South Africa was impeded by political leaders who questioned the science behind the causality of HIV/AIDS and the effectiveness of ARVs. However, since 2008, under the leadership of President Jacob Zuma and Minister of Health Dr. Aaron Motsoaledi, South African HIV/AIDS policy changed radically, establishing national-scale HIV prevention programs and the world's largest AIDS treatment effort leading to a five year gain in national life-expectancy.

In 2011, among South African adults aged 15-49, 17.3% were HIV-positive, more than triple the rate for the whole of sub-Saharan Africa (5.2%) and a global adult prevalence rate of 0.8%. Black South Africans, who make up four-fifths of the country's population, have been the hardest hit: 13% of their total of all ages are HIV-positive, compared with 3% of coloreds and Indians and just 1% of whites. Even thought HIV prevalence is 17.3% among the general population, it varies a lot by region. In KwaZulu-Natal, the region with the highest prevalence, just under 40% of 15-49 year-olds are living with HIV. Furthermore, there were 310,000 related deaths and 1,900,000 orphans due to AIDS. In addition, a characteristic of AIDS in South Africa is the close link with the prevalence of tuberculosis. Current HIV/TB co-infection rates exceed 70%, with TB being the most common opportunistic infection among them. Due to late detection, poor treatment, management and failure to retain TB patients on treatment, drug-resistant forms of TB (DR-TB), have increased significantly.

The South African government's initial response to the epidemic was significantly lacking due to poor political leadership, AIDS denialism and failure to provide comprehensive AIDS treatment and prevention programs. This situation lead to large scale protest by civil society in South Africa and from the international community. By 2008 the government recognized the need to change course. This policy sea change did not gather full momentum until the election of President Jacob Zuma in May 2009 and the appointment of Minister of Health Dr. Aaron Motsoaledi. Over the past three years, South Africa has become a model for comprehensive HIV/AIDS management.

**Background**

The first attempt to formulate a post-apartheid response to AIDS in South Africa began with the launch of the National AIDS Committee of South Africa (NACOSA) in 1992 following consultations between the African National Congress (ANC), the National Party government and civil organizations. This in turn led to the National AIDS Plan in 1994. Since then, the government's policy evolved to formulating the HIV/AIDS and Sexually Transmitted Disease Program in 1996; the establishment of the South African National Aids Council in 2000; and, in the same year, the compilation of the country's comprehensive National HIV/Aids and STI Strategic Plan for 2000-2005. Despite all these initiatives, there was barely any progress in the HIV/AIDS response. This can be attributed to a history of prevarication of HIV/AIDS by top political leadership.

In 1996, Deputy President Thabo Mbeki, under President Nelson Mandela, was a major actor in the Virodene saga, a significant event in South Africa's HIV/AIDS history. At the time, a group of academics of the University of Pretoria claimed they had found the cure for AIDS through a vaccine called Virodene, a drug the Medicines Control Council warned was dangerous and toxic. Mbeki, a staunch supporter of "Africans finding African solutions", became the chief champion of Virodene. He thought it would be the perfect platform from which to launch his vision of an African Renaissance, led by South Africa. Tests by independent scientists, however, found Virodene could be highly toxic and could cause severe liver damage. In 1999, Mbeki was elected President of South Africa and in his first address to the nation, Mbeki declared HIV/AIDS "everyone's problem" and emphasized how the country needed to face AIDS to save the youth, its education and the country's economy.

After his initial unambivalent stance, Mbeki's approach changed dramatically by June 1999 when he declared his support for the view that HIV does not cause AIDS. Throughout his nine-year tenure as South Africa's President, Mbeki aligned his views with what have been termed "dissident" scientists, a group of scientists who denied the conventional theory that the HIV virus caused AIDS and that anti-retroviral drugs could save the people who tested positive for it. During this period Mbeki began to argue that HIV and AIDS were linked to social factors such as poverty, malnutrition and poor health care. Mbeki stubbornly continued to embrace this position even as the evidence against it became overwhelming. While Botswana and Namibia, South Africa's neighbors, provided anti-retrovirals to the majority of its citizens infected by HIV, South Africa under Mbeki failed to do so. President Mbeki also restricted the use of freely donated nevirapine in the prevention of mother-to-child transmission of HIV.

As a result, ARVs were unavailable to patients in state clinics and hospitals, whether rape survivors or health care workers who had accidentally been exposed to the virus. The impact of this policy was severe, both in terms of avoidable loss of life and the long-term damage to HIV/AIDS education efforts in South Africa. The only state-funded HIV/AIDS program was the provision of ARVs to pregnant women for Preventing Mother to Child Transmission (PMTCT). From the late 1990s, a series of protests and marches driven by civil society and religious groupings led to a Constitutional Court challenge to oblige the government to provide ART to HIV-positive mothers in an effort to prevent mother-to-child transmission. In July 2002 the Constitutional Court ruled that the government had a constitutional duty to provide AIDS drugs to pregnant women to prevent transmission of HIV to their babies. The Government was forced to comply with the Court ruling, but there was no change in general HIV/AIDS policy by the Mbeki administration.

By the time President Mbeki left office in September 2008 studies estimate that upwards of 330,000 AIDS-related deaths could potentially be attributed to Mbeki's recalcitrance on HIV/AIDS. In addition, an estimated 35,000 babies were born with HIV by not implementing a mother-to-child transmission prophylaxis program using nevirapine before being compelled to by the Constitutional Court.

While South Africa has a sophisticated infrastructure, a well-developed private sector and a stable macro-economy, the high prevalence of HIV/AIDS partly explains why South Africa has not achieved some targets for MDGs related to outcomes such as employment, income levels, and life expectancy. Realizing the severity of the HIV/AIDS pandemic as a local and global health emergency as well as a development emergency, the new South African government of Jacob Zuma elected in May 2009 and Minister of Health Aaron Motsoaledi moved quickly to implement effective measures to combat the epidemic.

**Situation Analysis**

Minister Motsoaledi brought strong leadership and high energy to his position. He quickly won over civil society and re-energized the public health sector. Minister Motsoaledi's fervor for improving service delivery has uncovered the inefficiency of how health facilities and programs had been run prior to his coming to office– from the administration level and service delivery to the supply of essentials. Considering HIV/AIDS, he quickly put in motion programs for countrywide prevention, detection and immediate treatment with ARVs for all the people who tested HIV positive. In the first year of his tenure, Minister Motsoaledi was tireless in his efforts to mobilize all sectors of society in support of a dramatically ramped up national campaign to prevent and treat HIV/AIDS. Most notably, Minister Motsoledi's passion mobilized other key political leaders, and with the support of President Zuma, also mobilized the public take up the campaign against HIV/AIDS. It was not long before local and international studies referred to the revolution Minister Motsoaledi had brought about in health in South Africa, especially in HIV/AIDS.

**Strategy**

The fight against HIV/AIDS has been a major focus for Minister Motsoaledi from the beginning of his appointment. The cornerstone of the new strategy to combat HIV/AIDS was the HIV and AIDS Counseling and Testing (HCT) Campaign, launched in 2010. The HCT campaign aimed to scale up the integrated prevention strategy based on: regular HIV testing and counseling, promoting behavior change and condom usage, providing medical male circumcision, scaling up syndromic management of STI and intensified prevention of mother-to-child transmission (PMTCT) programs. Another aim of the HCT Campaign is that people should know their status early. This was done by massively scaling up HCT services in public and private facilities, homes, workplaces and public spaces, followed by the administration of ARVs. Some 500,000 people were tested for HIV in the first six months of the HCT campaign. According to statistics on the HCT campaign, 65% of the people who participate and want to know their HIV status are women, 5% are children and only 35% are men. Minister Motsoaledi also announced that comprehensive reproductive health education would be introduced in government schools, including family planning and sexuality education, HIV counseling and testing should be happening in schools.

Scientific evidence showing that male circumcision reduces the risk of sexual transmission of HIV from women to men by 60% prompted the South African government to include voluntary medical male circumcision (VMMC) as an integral part of its HCT campaign. As such, the campaign offers all men aged 15-49 voluntary medical circumcision at public health facilities. In April 2010, KwaZulu-Natal became the first province to offer VMMC services at public clinics, a region where male circumcision is not traditional. The scale-up of VMMC to all nine provinces has meant that South Africa (along with Kenya and Zambia) ranked one of the highest globally, in terms of number of circumcisions performed. In 2009, 9168 men were circumcised and in 2010 this increased to 121,117 and subsequently to 347,973 in 2011.

The impact of HIV/AIDS on children has been vast as well, but since 2009 South Africa has had one of the sharpest declines in new infections among children. In 2011, more than 95% of pregnant women with HIV received treatment to prevent the infection of their child (20). Yearly infections in children have dropped from 56,500 in 2009 to 29,100 in 2011. In 2009, around 30% of pregnant women were HIV positive, demonstrating the need for South Africa to deliver effective PMTCT programs. South African guidelines for PMTCT issued in 2008 were heavily criticized for not meeting World Health Organization recommendations. In 2010 South Africa released new PMTCT guidelines, more in line with WHO recommendations. In South Africa's guidelines HIV-positive pregnant women are advised to start

treatment when their CD4 count drops below 350 cells/$mm^3$; all pregnant women who test HIV-positive will begin receiving treatment at 14 weeks rather than in the last term of pregnancy. In addition, HIV-positive women are advised to receive antiretroviral drugs postpartum. The latest National Strategic Plan aims to reduce MTCT to less than 2% at six weeks after birth and less than 5% at 18 months by 2016.

In addition, in May 2010, South Africa implemented task shifting. Under task-shifting, nurses, rather than doctors, can initiate antiretroviral therapy; lay counselors, rather than nurses, can carry out HIV tests, as well as provide support for orphans usually done by social workers; and pharmacy assistants, rather than pharmacists themselves, can prescribe ARV drugs. It is believed task shifting vastly increases the access points to treatment and care by reducing the 'bottlenecks' in the system created by a lack of staff able to perform certain tasks. Minister Motsoaledi approved the new regulations, which allow a person who is not a healthcare provider (such as a counselor who has received training in taking blood) to do so. In 2011 it was announced that the number of nurses trained to administer ARVs has increased from only 250 nurses in early 2010 to 2000 nurses in May 2011.

The commitment of the current government and Minister Motsoaledi is further demonstrated through a new National Strategic Plan on HIV/AIDS and TB for the period 2012 – 2016. This Strategic Plan will integrate HIV and AIDS and TB in the same strategic plan and will outline a 20-year vision of the country in the fight against the double scourges of HIV/AIDS and TB.

**Outcomes**

- According to government statistics, 20 million South Africans have been tested for HIV/AIDS since the HCT campaign was launched in April 2010, exceeding the target of 15 million.

- The rate of mother-to-child HIV transmission at 6 weeks has been reduced from 8% in 2008 to 3.5% in 2010 and down to 2.7% in 2011. The latest National Strategic Plan aims to reduce MTCT to less than 2% at six weeks after birth and less than 5% at 18 months by 2016.

- Life expectancy has risen from 56.5 years in 2009 to 60 years in 2012.

- The medical male circumcision program is under way and is doing very well. South Africa has circumcised 600,000 people who were not circumcised before the program was launched. The number of circumcisions performed in 2010 placed South Africa among the highest globally, along with Kenya and Zambia. The province of KwaZulu-Natal is aiming to circumcise at least two million males by 2015.

- There were only 490 ARV treatment sites in February 2010. By the end of 2012, this number increased to 3,000 facilities, which were well equipped to initiate ARV treatment. It was estimated that 1.7 million people were on ARVs in 2012 compared to approximately 920,000 in 2009, an approximate 75% increase in just 2 years. The State is hoping that by 2015, the number of people on treatment will reach 2.5 million. The ARVs have been called the 'Lazarus drug' because people rise up and walk.

- Expenditure on HIV/AIDS increased to $1.3 billion in 2012, the highest by any low-and middle-income country.

| | 2006 | 2007 | 2008 | 2009 | 2010 | 2011 |
|---|---|---|---|---|---|---|
| **HIV/AIDS indicators** | | | | | | |
| People living with HIV (million) | 4·99 | 5·27 | 5·13 | 5·35 | 5·47 | 5·58 |
| Antenatal HIV frequency (%) | 29·1% | 29·4% | 29·3% | 29·4% | 30·2% | NA |
| HIV frequency in the total population (%)[24] | 10·2% | 10·2% | 10·6%[25] | 10·4% | 10·5% | 10·6% |
| Male condoms distributed (million) | 376 | 453[28] | 284[29] | 445[30] | 492[31] | 347 |
| Female condoms distributed (million) | 3·6 | 3·3[26] | 4·3[28] | 3·6[30] | 5·0[31] | 6·4 |
| Adult medical male circumcisions[25,27] | NA | NA | 5190 | 9168 | 121 117 | 347 973 |
| Adults and children receiving antiretroviral therapy[28] | 235 000 | 382 000 | 588 000 | 912 000 | 1 287 000 | 1 793 000 |
| Antiretroviral coverage (%)[27–29] | 19% | 28% | 35% | 51%*/29%† | 64%*/39%† | 79%*/52%† |
| Deaths due to HIV/AIDS (%) | 52·3% | 51·2% | 49·2% | 46·4% | 44·3% | 43·6% |
| **Tuberculosis indicators** | | | | | | |
| Prevalence (all forms; per 100 000 people)[30] | 797 | 789 | 792 | 809 | 795 | NA |
| Estimated incidence (all forms; per 100 000 population)[30] | 940 | 948 | 960 | 971 | 981 | NA |
| Estimated number of incident cases (all forms) | 450 000 | 460 000 | 470 000 | 480 000 | 490 000 | NA |
| Case detection (%)[30] | 67% | 68% | 73% | 75% | 72% | NA |
| Treatment success of new smear positive cases (%)[30,31] | 74% | 74% | 76% | 73% | 73% | 80% |
| Death rate (per 100 000 population)[30] | 57 | 53 | 51 | 52 | 50 | NA |
| Patients with HIV co-infection[30] (%) | 59% | 59% | 59% | 58% | 60% | 65% |

NA=not available. *Eligible when CD4 <200 cells per μL. †Eligible when CD4 <350 cells per μL.

*Table 1:* **Temporal trends in the HIV and tuberculosis epidemics in South Africa**

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