



SCIENCE SEALS MBEKI/MSIMANG'S AIDS IGNOMINY



Professor Nicoli Nattrass, Director of UCT's AIDS and Society Research Unit.

The first systemic empirical analysis of AIDS leadership in 82 affected countries, conducted by a University of Cape Town (UCT) health economist, concludes that South Africa's infamous but until-now anecdotal reputation for poor leadership is fully justified.

When it comes to the difference between actual and predicted HAART coverage, South Africa is more than twice below the quantum used as a scientific benchmark to label a country as performing 'below expectations'. It is four or more times worse than Russia,

Among countries that should have been able to achieve higher levels of both HAART and PMTCT coverage (given their individual contexts), South Africa languishes at the bottom of the table alongside Uruguay, Trinidad and Tobago.

Zambia and Zimbabwe and more than twice as bad as the Ukraine. Only Latvia is worse.

Published in the *Journal of Public Health* in September,¹ the study's primary controls were for levels of development (GDP per capita), external funding support, scale of the epidemic, other health-related demands and politico-institutional capacity (political stability, being an established democracy and percentage of births attended by skilled personnel).

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According to the study author, Professor Nicoli Nattrass, Director of UCT's AIDS and Society Research Unit, these four countries have the resources and capacity to achieve 'substantially higher' levels of coverage. Once all

other possible factors had been ruled out, the only conclusion left was that a lack of political will and leadership were to blame.

Ironically, her findings coincided with the two most influential South African AIDS leaders, Health Minister Manto Tshabalala-Msimang and President Thabo Mbeki, losing their jobs – for reasons totally unrelated to their controversial leadership in the local pandemic.

World's longest ARV rollout a denialist 'smokescreen'

The research should finally put to rest the repeated, beguiling selective and disingenuous official counter to international condemnation of the government's erstwhile anti-AIDS ideology that South Africa has the world's longest rollout of ART.

Nicoli introduces her study by saying that despite an unprecedented mobilisation of resources since 2003 (Global Fund to Fight AIDS, TB and Malaria and the US President's Emergency Plan for AIDS Relief (Pepfar)), the epidemic continues to outstrip attempts to rein it in. Last year 2.1 million people died of AIDS and 2.5 million became infected with HIV, bringing the global total of people living with HIV to 33.2 million.

'Part of the problem is that as foreign assistance flows into AIDS-affected countries, inadequacies at the national level have become apparent, placing the spotlight on government leadership on AIDS.'

The author of one of the most comprehensive books yet on the ARV treatment 'struggle' in South Africa,² Nattrass wanted to probe whether reputations (good or bad) for AIDS leadership were deserved, or whether they simply reflected differential capacities and constraints. She began by framing the question of leadership



explicitly within the context of what was 'possible and reasonable to expect', choosing HAART, and to a lesser extent PMTCT rollout, as measures of policy. These had the most widely reported outcome variables available.

One of the multiple factors she used when considering country-specific characteristics likely to impact on HAART coverage (beyond the immediate control of governments), was that Global Fund and Pefar funds were distributed to a wide variety of NGOs and CBOs not necessarily in agreement with national policy on AIDS.

SA's sorry tale of inefficiency

A memorable controversy in South Africa was when KwaZulu-Natal landed the first Global AIDS Fund millions while Pretoria missed the application deadline. Tshabalala-Msimang furiously insisted the funds be distributed nationally or 'returned' because KZN had failed to use her hastily assembled and then Global Fund-required 'country co-ordinating committee'. The Global Fund has since stopped relying only on governments to distribute funds and turned to the corporate and NGO sectors for help.

The SA government *faux pas* had a disturbing sequel earlier this year when the health department failed to appoint a grant management team of six dedicated staff members by

the required deadline of 16 March to qualify for an R80 million Global Fund instalment aimed at 'behaviour change communication'. This put 13 of the country's biggest HIV/AIDS charities at risk of running out of money and may force the retrenchment of up to 100 vital HIV prevention campaign workers. Last year, Health Director-General, Thami Mseleku, failed to meet the tender contract renewal deadline for a major local AIDS prevention campaign, effectively putting it on ice for several months.

Other controls in Natrass' study included the total HIV-positive population, adult HIV prevalence rates and the number of disability-adjusted life years lost due to non-AIDS-related reasons, plus demographic factors. She used the percentage of births in the presence of a skilled health professional as an indicator of the reach of the health sector.

Using HAART coverage as the key indicator of commitment to combatting AIDS showed that Brazil, Cambodia, Mexico, Namibia, Thailand, Uganda and, to a lesser extent, Cuba and Rwanda, had performed 'better than expected', given their institutional characteristics, demographic challenges and levels of development. Natrass concluded that these countries' reputation as 'poster children for good AIDS leadership was thus probably well deserved'.

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Botswana, which has universal HAART coverage, was assessed to be performing 'as expected' but, 'alarming', performed below expectations when it came to PMTCT coverage, something that suggested urgent further research.

Natrass cautioned that HAART coverage was 'but one indicator' of the wide range of policy responses necessary for combatting AIDS. 'It tells us nothing about the characteristics of country-level programmes which may have relevance for clinical outcomes and the development of drug resistance,' she added.

Chris Bateman

1. Natrass N. *J Public Health* 2008 (E-pub ahead of print).
2. Natrass N. *Mortal Combat: AIDS Denialism and the Struggle for Antiretrovirals in South Africa*. Cambridge: Cambridge University Press, 2007.