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Leah Gilbert [a]
[a] Department of Sociology, University of the Witwatersrand

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'UPSTREAM/DOWNSTREAM' – LOCATING THE 'SOCIAL' IN HEALTH PROMOTION AND HIV/AIDS IN SOUTH AFRICA?

Leah Gilbert
Department of Sociology
University of the Witwatersrand
Leah.gilbert@wits.ac.za

ABSTRACT

Strengthening HIV prevention remains an urgent global health priority. The problem is that 'advancement' in HIV prevention often stands for the development of biomedical technologies or interventions. Theories and practices of health promotion have been advocating a shift from a biological/medical preventive focus to a more social one; from the level of individuals to organisations, communities and broader social policy. It seems, however, that in practice a real shift in the desired direction remains an elusive goal. This article explores HIV/AIDS health promotion efforts in South Africa, focusing on the traditional dichotomies of bio–social; individual–society and downstream–upstream, in order to draw attention to associated complexities that should be taken on board. Relying on evidence from South Africa (past and present), the main thesis in the article demonstrates the limitation of these efforts, and argues for a more comprehensive approach along a flexible continuum of options, with a focus on the 'social'. The main argument advanced here, rests on the premise that there is a lack of fit between the forces that shaped the epidemic and efforts to prevent its rapid spread, despite the existence of an adequate sociological understanding of these forces. A model based on the critique developed in the article is presented as a 'way forward', suggesting solutions along a flexible 'continuum of options' that take the 'social' on board. While the focus of the article is on HIV/AIDS, the insights offered in the final thesis and the way forward should prove useful for health promotion efforts in dealing with other health problems as well.

Keywords: health promotion, HIV/AIDS, structural interventions, upstream/downstream

INTRODUCTION

The latest report on the global AIDS epidemic (UNAIDS 2011: 5) claims that 'HIV prevention programmes are working' and that 'the decline in new HIV infections over the past 10 years is linked to changes in behaviour ... and increased knowledge of HIV'. However, the report reiterates that with two new HIV infections occurring for every

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individual who starts on antiretroviral treatment, strengthening HIV prevention remains an urgent global health priority. The problem, as stated by Adam, is that 'advancement in HIV prevention, as represented in major international policy documents, often appears largely as a question of the development of biomedical technologies or interventions, such as vaccines, microbicides, pre-or post-exposure prophylaxis or circumcision' (2011: 3). Furthermore, Kippax and Holt (2009: 1) maintain that 'an increasing tendency to neglect the social sciences in HIV prevention, treatment and care has been noted, following what might be regarded as an intense period of "biomedicalisation" of the HIV response'.

In a recent report, 'State of Social and Political Science Research Related to HIV', prepared for the International AIDS Society, Kippax and Holt (ibid: 4) concluded that HIV/AIDS social-sciences researchers believe 'maintaining a critical perspective on developments within the HIV field [is] seen as an important but risky endeavour in a field dominated by biomedical research', yet at the same time there was agreement that 'building bridges between social science, public health and biomedicine was seen as a priority'. This article, in its aim, engages in such a 'risky endeavour' by further interrogating the hidden questions posed in its title, in an attempt to contribute to 'building these bridges'. Before this can occur, there is a need to revisit the main conceptual frameworks that form the basis for the review and discussion to follow.

Understanding the problematic *interface between medicine and public health* and the place of *health promotion* within this complex relationship is necessary in order to shed light on the main perspective of this article. The conservative medicine-based public health is still dominant in many countries, despite being criticised as outmoded and resistant to change. It is characterised by a paradigmatic reliance on the 'medical model' (Gilbert et al. 2010) and its structure as a sub-division of 'medicine' or 'health sciences'. An alternative model is advanced by McKinlay and Marceau (2000: 27–28), where public health is seen as a 'socio-political activity' that is 'multi-disciplinary in nature' and 'extends into all aspects of society'. In this model the key words are 'health' (not 'medicine') and 'society' (not 'individual') – ideas which are echoed in many current public health messages (Satcher 2010). These two concepts of public health are clearly different, as reflected in their philosophies and structural arrangements. Consequently, the nature of health promotion, as a component of public health, will no doubt also reflect these differences.

Medical sociologist Irving Zola's '*upstream–downstream*' metaphor provides a useful framework for thinking about how we typically address the goal of improved health and wellbeing. Zola describes modern medical practice as follows:

> ... sometimes it feels like this. There I am standing by the shore of a swiftly flowing river and I hear the cry of a drowning man. So I jump into the river, put my arms around him, pull him to the shore and apply artificial respiration. Just when he begins to breathe, there is another cry for help. So I jump into the river, reach him, pull him to shore, apply artificial respiration, and then just as he begins to breathe, another cry for help. So back into the river again, reaching,

> pulling, applying, breathing and another yell. Again and again, without end, goes the sequence. You know, I am so busy jumping in, pulling them to shore, applying artificial respiration, that I have no time to see who in the hell is upstream pushing them in. (cited in McKinlay 1979: 9)

In this metaphor, 'downstream endeavours' include bio-medical interventions that focus on individual pathology and deal with the diagnosis and treatment of the disease after it has manifested. It has been argued that the achievements linked to these efforts are 'futile and short term' (McKinlay 1979: 9), despite responding to the immediate needs of certain groups. In contrast, 'upstream endeavours' focus on aspects of our social and physical environments that are conducive (or not) to good health and wellbeing. Upstream interventions typically concentrate on changing or minimising aspects of those environments that are health damaging, and/or enhancing aspects of our social and physical surroundings which are associated with health. This approach, with its emphasis on the promotion of health and the prevention of disease in larger groups in society, has been favoured as the long-term, lasting solution.

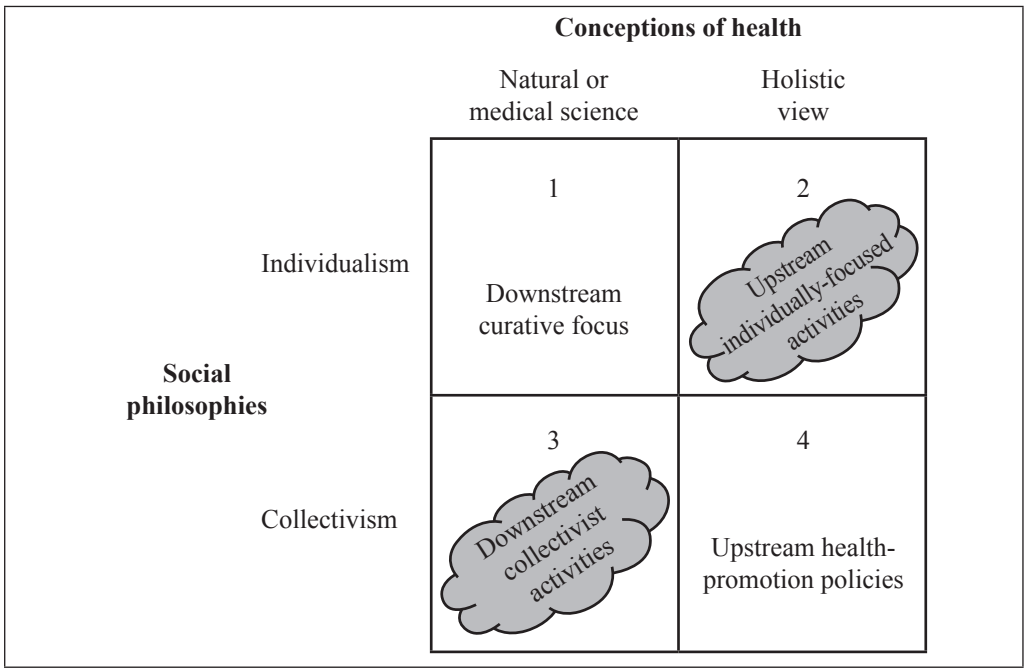

Figure 1: Different social philosophies and conceptions of health produce different public health activities
Adapted from: McKinlay and Marceau (2000a: 27)

McKinlay and Marceau's (2000a) conceptualisation, as depicted in Figure 1, is useful for understanding the differences in these approaches as emanating from different social philosophies. The South African experience of HIV/AIDS suggests that there are

reasonable grounds to add a level of complexity to this analysis, by filling in the original 'empty cells' in Figure 1 with two further options, based on two examples:

1. A *collectivist activity* that is taking place 'downstream', such as civil society's efforts to force the South African government to provide ARVs in the public sector (Nattrass 2007); and
2. An *individually orientated activity* that is leading 'upstream' in the long-term, such as the provision of micro-financing to impoverished women in rural areas (Pronyk et al. 2006).

This model, as a tool for analytical clarification, lends itself to the refinement introduced by McKinlay and Marceau (2000b), by adding the option of '*midstream*' in regard to individually focused prevention efforts. It also facilitates the presentation of the 'way forward' along a flexible continuum of options at the end of this article.

The position of health promotion in relation to these two extreme interpretations calls for further contemplation. This is aided by Lucas and Lloyd (2005), who trace the path of health promotion activities. They focus particularly on how these paths are informed, and the manner in which they have shifted away from an understanding of health (and by association health promotion theory and activities) as solely removing or stemming the presence of disease in an individual's body, towards a more nuanced view of health as a state of physical, emotional, spiritual, sexual, social, psychological and societal wellbeing. Nevertheless, Lucas and Lloyd argue that in assessing the current models of health promotion, it is apparent that the emphasis still resides in biomedical theories and practices. Furthermore, in designing programmatic interventions (despite cooperation and consultation with communities) there are few attempts to truly account for and address the social-health-related concerns of the community, as expressed by members (ibid.).

Consequently, the conceptual framework of health promotion is rooted in the critique of the 'downstream' approach of the hegemonic bio-medical curative model with its devotion to 'saving drowning swimmers' and the development of an alternative 'upstream' approach that aims to 'tackle the forces that push them into the river' (WHO 1986). Yet, despite publicly declared claims of health promotion (Clark 2010; MacDonald 1998) a closer analysis, based on the actual activities undertaken as part of 'health promotion', indicates that most activities can be best described as 'health education' or interventions aimed at 'behavioural changes' on an individual basis remaining 'midstream'.

Thus, instead of tackling the bigger forces that (according to the Psycho-Socio-Environmental model) 'manufacture pathology' (Gilbert et al. 2010) and impact on the size of the 'diseased' river, it merely provides people with the knowledge on how to avoid falling into a rising river and how to swim once they are in danger of being swept away. With regard to HIV/AIDS, this would include the emphasis on ABC preventative messages (as is the policy in South Africa), the potential use of microbicides, male

circumcision, as well as antiretroviral treatment. The latter offers a 'life-line' to those already infected, and is currently being considered as routine prevention for special 'high-risk-groups', according to recent studies (Donnell et al. 2010). A point needs to be made: classifying these endeavours as *not* being 'upstream' is not a judgement about their effectiveness as preventive measures, but is rather an analytical tool to distinguish between different forms of interventions – in particular, attempting to draw attention to more comprehensive 'upstream' interventions advocated here.

In a critical analysis of the challenges facing the field of health promotion, Antonovsky (1996) argues against the use of the 'dichotomous' approach, in favour of a conceptualisation of health and disease as a 'continuum', by advocating a salutogenic orientation (Lindstrom & Eriksson 2006). The idea of a flexible 'continuum of options' that incorporates the wider social dimensions of health and disease and targets larger social groups will indeed be incorporated into the development of the final 'way forward' as a response to the critiques raised.

It is within this conceptual framework that the article aims to explore HIV/AIDS health promotion efforts in South Africa, focusing on the traditional dichotomies of bio–social, individual–society and downstream–upstream, in order to draw attention to the associated complexities that should be taken on board. Note that the purpose is not to offer a comprehensive analysis of various health-promotion initiatives, but rather to reflect on them in order to construct a general thesis.

Relying on evidence from South Africa (past and present), the main thesis in the article demonstrates the limitation of these efforts, and argues for a more comprehensive approach along a flexible continuum of options, with a focus on the 'social'. A deliberate attempt is made to keep the 'social' as an expansive concept that allows for open and creative interpretations at various levels of interventions (Ljungdalh & Moller 2011), without the potential constraints of a more specifically prescribed framework. This is done with the full knowledge that the lack of specificity and failure to explain 'the social' might problematise its usage in public health and health promotion. The aim in this article is also to add to a wider understanding of the meaning of the 'social' as a 'cause' of disease (ibid.) and to show why a strong and real emphasis on the 'social' in all interventions throughout the disease trajectory is an essential condition in successful efforts to reduce HIV/AIDS prevalence in South Africa.

THE SOUTH AFRICAN HIV/AIDS EPIDEMIC IN A HISTORICAL CONTEXT

There is growing consensus that the magnitude and development of the HIV/AIDS epidemic in South Africa are rooted in the country's political and social structure (Gilbert 2008; Marks 2008). In explaining the scope and course of the epidemic, as it has unfolded in the South African context, it is useful to employ a historical perspective to explain the ways in which health promotion responses have failed to fully capture the social aspects of the epidemic. Upon analysing the history of sexually transmitted diseases (STDs) in

South Africa, it is evident that the health promotion responses adopted to tackle sexual health were instituted in a downstream fashion, and were unable to effectively address the wider 'social' nature and experience of sexual health in the country. This is seen specifically in assessing Jeeves and Jolly's (2009) explanation of the similarities in health promotion responses to HIV currently, and STDs in the 1940s and 1950s.

Using the lessons learnt from the past, the main argument advanced in this article rests on the premise that there is a lack of fit between the forces that shaped the epidemic and efforts to prevent its rapid spread, despite the existence of an adequate sociological understanding of these forces (Rehle et al. 2009). Notwithstanding the fact that this understanding is not complete, and further research is needed to provide a more nuanced perspective.

Fittingly, Rehle et al. (2009: 16) discuss the current mainly '*social*' drivers of the HIV/AIDS epidemic in South Africa, which include 'culture and social norms, stigma and denial, poverty, labour-related migration, gender-based violence including rape, concurrent multiple sex partners and age mixing patterns' as well as untreated sexually transmitted infections (STIs) and low levels of male circumcision in the population. Yet, at the same time they acknowledge that there are many shortcomings in the strategies aimed at impacting the infection rate through *individual behavioural prevention* efforts. They rightly emphasise that little progress has been made in altering the structural and social forces that drive the epidemic and render particular categories of people more vulnerable to infection than others.

Borrowing Marks' (2002) phrase, Walker et al. (2004: 60–61) describe South Africa's experience with HIV/AIDS as 'an epidemic waiting to happen' and state that the nation's 'complex social history [which is] fraught with conflict and characterised by sweeping change' has contributed to the country's status as a 'high risk situation'. Using Kark's assessment of the syphilis epidemic in the 1940s to show how this earlier epidemic parallels the current HIV/AIDS epidemic, they demonstrate that economic deprivation, social inequality and political changes in the society all shape the course and outcomes of epidemics. The authors also highlight the necessity of accounting for the social environment in trying to tackle the HIV/AIDS epidemic in meaningful and concrete ways. Confirming the assertion by Lucas and Lloyd (2005) that insufficient attention is paid to those factors and structures that constrain individual choice and behaviour changes, despite individuals' adequate knowledge of the risks and harms involved. This can be attributed to misunderstanding that occurs in relation to the local context in which the health promotion intervention is being applied and the broader socio-political agenda and ideology which may stand in tension with one another. The statement made by Jeeves and Jolly (and many others), that if prevention campaigns are to effectively and concretely achieve their aims, they need to understand the 'complex socio-cultural contexts in which young people interpret HIV/AIDS messages while playing out their sexual identities' (2009: 273) supports this line of reasoning.

While the author fully agrees with this statement, the thrust of this article goes beyond the need to acknowledge the 'social' when planning intervention programmes,

to the assertion that health promotion/public health interventions can improve people's health in the long term only if they concurrently tackle larger social forces and engage in truly 'upstream' endeavour. In similar vein, Lindstrom and Eriksson (2006:243) state that 'there is a need to look for long-term sustainable strategies and to build capacity for healthy public policies'.

A retrospective reflection on the activities and achievements of Kark's team in the 1940s, in curtailing the spread of STDs and decreasing infant mortality (Cassel 1955), brings to light the main failure of the approach taken at the time. Despite attempts to recognise the 'social', their focus was on the clinical prevention of disease in the community. Kark et al. (1949) identified 'wider social forces' as being responsible for the so-called 'community syndrome', thus acknowledging the 'social' drivers of the epidemic. There is, however, little evidence to suggest that a real attempt was made to intervene on the macro-level, and thus to impact in 'upstream' ways on the 'community syndrome' – an option that might have yielded more long-term results. It is acknowledged that in the historical context in which Kark and his colleagues were working, it was probably not feasible to do anything meaningful to alter the physical and structural environment that shaped South Africa at that time. This notwithstanding, the result was that their achievements were sadly reversed with the termination of the programme, while 'social' conditions remained the same or worsened. Some 40 years later, with the outbreak of the HIV epidemic, the same 'social' scenario facilitated its rapid spread. While acknowledging their short-term successes (with the wisdom of hindsight) it seems logical that a different approach, with a stronger emphasis on the 'upstream', could have impacted the spread of HIV today, which underscores the limitations of the approach taken. Relying on the notion of 'sociological plausibility', as suggested by Auerbach et al. (2011), it is possible to argue that although there is no 'hard' data to substantiate this notion, employing historical and sociological deductive skills should be sufficient to support this logic and learn from it, rather than to repeat similar mistakes.

This 'tough order' argument may attract the criticism that impacting on the spread of HIV/AIDS in South Africa means curing all social ills first, and, as this is impossible, concentrating efforts to change what is possible as it can be more tangibly achieved. Nonetheless, being aware of the dangers of advancing this argument in its simplistic form, it is imperative to pursue the proposal that the long-term success of HIV preventive efforts depends on our ability to understand and intervene in the specific social contexts in which it flourishes, and to harness the 'social' at all levels of the disease trajectory without shying away from tackling the impossible. For this reason, clarification is needed on a range of issues, as addressed in the subsequent section.

COMPLEXITIES AROUND THE MEANING AND INTERPRETATION OF THE 'SOCIAL'

As indicated earlier, despite a more comprehensive understanding of the factors contributing to the spread of HIV, there is general consensus that HIV prevention has

been dominated by 'individual level behavioural interventions that seek to influence knowledge, attitudes, and behaviours' (Gupta et al. 2008: 764). It has been suggested that the popularity of preventive efforts at this level of the individual derives from its congruence with the traditional medical model, despite its limited success. Evidence suggests that the success of an individually orientated intervention increases when it addresses the broader structural factors that shape or constrain individual behaviour, such as poverty, gender, policy and power (Coates et al. 2008). This supports the argument made here that despite these interventions being preventative, they have limited short-term value mainly due to being individualistically centred and motivated.

The practise of focusing on the individual at risk, with the emphasis on behavioural strategies, was dealt a blow when a recent systematic review concluded that behaviour change programmes have little impact on the incidence of HIV amongst girls and women in poorer countries (McCoy et al. 2010). This again suggests that a different approach is needed to concretely and effectively address the epidemic in innovative ways. Therefore, in keeping with the expansive notion of the 'social', and without further explicating the meaning of all the 'social' attributes that play a central role in health generally and in the epidemic in particular, it is important to highlight their complexity and the difficulty of addressing them. Focusing on a few major 'social' drivers might provide additional insights that will help explain why aspects of the 'social' are sometimes mentioned (but mostly overlooked) in health promotion efforts.

Gender is commonly regarded as an important factor in peoples' health, with a vast volume of literature devoted to gender inequalities and the ways to overcome its (still) devastating outcomes in the form of increased morbidity for women (Kuhlmann & Annandale 2010). It is widely acknowledged that women are the main carriers of the burden of HIV/AIDS in South Africa (Gilbert & Selikow 2011; Gilbert & Walker 2002). Despite increasing emphasis, of late, on the development of gender-sensitive technologies, Jewkes (2009: 37) claims they are 'unlikely to make much difference because they will not address the underlying construction of masculinities and femininities that makes such interventions necessary in the first place'. She strongly argues that 'broader transformative programmes that link promoting gender equality, economic and social empowerment and preventing sexual risk taking are also needed' (ibid.). These types of interventions are supportive of the need for a socially focused upstream approach, with the spotlight on gender, as promoted in this article. The main claim is that women's (and men's) perceptions of themselves, their relationships and sexuality, have been shaped by the 'social' such as the historical legacy of apartheid in the form of poverty, poor educational attainment, lack of opportunity and high youth unemployment. Therefore, these issues should be targeted in any attempt to make a difference. Although these macro-social factors are difficult to tackle, Jewkes (ibid.) maintains – in line with the main argument presented here – that 'structural change that strengthens economic opportunities for women and men is of vital importance'. The success of programmes such as Intervention with Microfinance for AIDS & Gender Equity (IMAGE) provides evidence to support this claim (Hargreaves et al. 2010).

The role of *culture* in shaping health and illness behaviour is widely discussed in sociological and public health literature, and is often considered in health promotion programmes (Gilbert et al. 2010). Leclerc-Madlala et al. (2009: 22) assert that 'making HIV prevention more effective in South Africa will require approaches that are better attuned to the cultural specificities of the people concerned'. They further argue that 'thus far, there has been little evidence of any serious attempt to do this either at the level of HIV/AIDS policy-making or programming in South Africa'. They emphasise the lack of attention given to macro-social factors in health-promotion efforts, calling for a more focused upstream endeavour: 'There remains a need to engage more directly with the sociocultural factors that make our local communities so exceptionally vulnerable to this disease' (ibid.). This call sits comfortably as one component within the wider ambit of the 'social' advocated in this article. These sociocultural factors are addressed in on-going programmes such as 'Stepping Stones' (Jewkes et al. 2007), loveLife (2012), as well as those presented by The Soul City Institute for Health & Development Communication (Soul City 2012).

The *Political Economy of Health* (PEH) framework – which maintains that community-based inequalities such as class, ethnicity, race or gender create a 'risk environment' that facilitates the spread of HIV – was used as a conceptual point of departure in a national study conducted in Malawi by Feldacker et al. (2011). The researchers found that social, economic and physical risk environments disproportionately influence the health outcomes of the poor and most vulnerable. Since the direct relationships found between community factors and individual HIV status are *not* mediated by individual HIV risk behaviours, their study provides motivation for expanding HIV prevention efforts beyond individual risk behaviours, to a consideration of the community factors that may drive the epidemic. However, they add that 'because community factors do not *cause* HIV, the *mechanisms* by which these community factors affect HIV remain unidentified' (ibid: 723). Despite providing additional evidence to support the main argument made here, their study raises a pertinent conceptual question with regard to the role of the 'social' in the 'causation' of HIV, its 'measurability' and therefore its successful inclusion in health promotion programmes that need to be monitored and evaluated.

It is no doubt challenging for public health interventions to engage in the 'social', as explored earlier, and it requires *political will* on behalf of the whole establishment, as a lack of political will is usually cited as a barrier to effective 'upstream' public health and health promotion (Wouters et al. 2010). This is exacerbated in the context of HIV/AIDS in South Africa, with the added complexity of political interference in the form of 'AIDS denialism' and a lack of willingness which presents a missed opportunity to embrace the 'social' (Nattrass 2007; Nattrass & Kalichman 2009).

On an abstract level, attempts to explain people's vulnerability to HIV infection have relied on the *psycho-socio-environmental model of health and disease* by recognising the impact of social, economic, political and environmental factors (Gilbert et al. 2010).

This, in turn, has stimulated interest in and discussions about 'structural approaches to HIV prevention', i.e. in looking at 'upstream approaches' in health promotion that pay attention to the 'social'. Despite this consciousness there is, however, no dispute that 'progress in the use of structural approaches has been limited' as argued by Gupta et al. (2008: 764). They make the connection between structural factors and the risk of HIV, concluding that 'HIV prevention efforts cannot succeed in the long-term without addressing the underlying drivers of HIV... . HIV programmes therefore need to incorporate structural approaches.' Gupta et al. (ibid.) voice their concern about the 'lack of conceptual and technical consensus on definition and implementation and methodological challenges in the assessment'. The main problem here is in a heavy reliance on the paradigmatic dominance of the medical model, as reflected in the use of language and methodology even when discussing 'structural social factors' (that do not easily lend themselves to simplification and reduction) as 'measurable indicators'. In this regard, Horton (2008: 421) admits: 'The uncomfortable truth seems to be that there is no effective, reliable and comprehensive monitoring or evaluation of HIV-prevention programmes'. He notes that this is mainly due to a lack of measurable and reliable indicators. Notwithstanding the need to monitor interventions, this statement supports the argument advanced in this article and further problematises the lack of attention afforded to the 'social' in HIV promotion, since it is complex and difficult to find indicators that effectively measure long-term social interventions.

An interesting idea offered as vindication for the lack of incorporation of structural factors such as gender, income inequality and social marginalisation, is introduced by Gupta et al. They maintain that 'social' factors are difficult to change, in addition to being viewed as long-term initiatives that belong 'within the purview of broader economic and social development ... rather than within the scope of HIV prevention' (2008: 764). This highlights the ways in which public health activities are publicly disassociated from broader developmental goals that fit within the 'upstream' approach. This contradicts most declarations of the 'New Public Health' (Gilbert 1995; Tulchinsky & Varavikova 2009), therefore the position adopted here, as developed in the 'way forward', is that for health promotion as part of public health to succeed, it has to align its goals with wider developmental and 'social' agendas generally and particularly in the case of HIV/AIDS in South Africa.

CRITICAL CHALLENGES

South African health education campaigns to control STDs during the 1940s, as well as current interventions to halt the spread of HIV, lend themselves to critical interpretation. Most local studies illustrate the difficulties of changing people's behaviours in the current social and cultural milieu (Rohleder et al. 2009). Despite this evidence, most programmes and scientific studies remain focused on individualistic behaviours. Without downplaying their contribution to curbing the spread of the epidemic, a real shift towards an emphasis on 'social system contributions' (McKinlay 1993) ought to

take place, in order to effect substantial and lasting benefits while acknowledging the enormity of such a task.

According to McKinlay (ibid: 110), 'some critics view public health interventions, especially those at the individual level, as futile because they "decontextualise" the ways in which at-risk behaviours are generated and sustained'. Padian et al. (2008: 595) add that the 'compartmentalisation of prevention strategies into those that are biomedical, behavioural, and structural is artificial. Even a simple and successful biomedical strategy has the potential to alter individual behaviour and has to be scaled up in ways that affect structural institutions such as the health care system. Hence an integrated approach will inevitably be needed' – an idea that corresponds with those advanced here.

Tomlinson et al. (2009: 217) point out that 'every magic-bullet solution to HIV/AIDS has thus far failed' and maintain that 'if prevention efforts continue to be focused on individual behaviour change (a one-dimensional approach), HIV/AIDS is likely to remain an intractable problem in southern Africa, and the search for the magic bullet will continue'. They cite the recent excitement about male circumcision as an example, and argue that the quest for the magic bullet is at the heart of why structural interventions have not properly been investigated locally. Similarly, Bertozzi et al. (2008: 842) acknowledge that the past 25 years of HIV prevention have been characterised by 'islands of success and a sea of failures'. They have not abandoned all hope of finding a 'magic bullet', but urge nations to 'start designing and implementing prevention programmes that can succeed without one' (ibid.).

Based on the consensus in the literature, the main claim is that in order to achieve this goal the focus needs to shift to a truly holistic upstream approach, with the emphasis on the 'social'. However, this implies taking a long-term view and a comprehensive approach that takes into consideration complex ideological and moral questions such as gender imbalances, poverty alleviation, the role of the state in the private lives of citizens, and violence against women. Needless to say that 'the challenges for research of this nature are substantial, not least of which is that of how to control for and measure multi-level interventions, but these are challenges worth facing' (Tomlinson 2009: 218) – a sentiment fully endorsed here, that will be imported into the considerations on the 'way forward'.

Examining the global history and challenges of HIV prevention, Merson et al. (2008: 487) point out many shortcomings of the global response as far as prevention is concerned, concluding that 'HIV must remain one of the world's top health and development priorities … and the mistakes of the mid-1990s … must not be repeated'. However, they continually refer to the 'need for reliable evidence-based research [a key component of the bio-medical discourse] to better guide the selection of available behavioural and structural interventions in specific areas or populations' (ibid.). This conclusion uses language borrowed directly from the bio-medical paradigm, indicating its continuing hegemony even within public health (Gilbert 1995) which is the subject of critique in this article. This is done despite citing data that show the association

between higher levels of HIV infection in poor countries and socio-economic status in relation to other health issues (Merson et al. 2008: 483) and acknowledging the need to 'build comprehensive, sustainable, nationally owned responses that are vital to the ultimate control of this pandemic' (ibid: 487).

Piot et al. analysed the complexity of HIV prevention, in an attempt to learn valuable lessons in creating more effective prevention programmes. They attribute the failures of certain efforts to a range of factors, among which is the fact that 'an appreciation of macro-level political, demographic, and economic changes is rarely used' (2008: 845). The authors reiterate that 'unless responses take changing social and cultural context into account, they will miss their mark' (ibid.). This, again, supports the call to pay more attention to the 'social' and to modify the understanding of the 'upstream' approach accordingly.

CONCLUSION – THE WAY FORWARD

Despite many official calls, supporting Piot's point that '[u]ltimately, we need to come to terms with addressing the underlying social drivers of HIV/AIDS ... prevention work takes the longest time, is largely outside of health services and has no "quick win"' (ibid: 857), most health promotion efforts do not take it as far as it needs to go. This is exemplified by a recent South African budget speech, where the Finance Minister announced an increase in the budget to combat AIDS: during the next financial year, about 30 per cent of the allocation will be channeled to HIV prevention efforts (Bodibe 2011). Although this is a welcome move, it highlights the shortcomings of local health promotion efforts: despite all the talk about 'structural interventions', no direct budget and no direct monetary action are channelled in that direction. Rather, the focus remains on specific *bio-behavioural interventions* (condoms, HIV counselling and testing, mother-to-child transmission, STI and tuberculosis (TB) prevention) within the traditional framework, as critiqued here. The fact that the Department of Health does not take the lead in implementing structural interventions, once again highlights the detachment of health promotion initiatives from the wider developmental agenda that focuses on the 'social'.

As argued, health promotion efforts have a better chance of success if their leaders and implementers advance a wider 'social' vision. On a speculative note, the argument here is that if that had happened in South Africa at the onset of the epidemic, its spread would have been positively different.

The latest Marmot Review of social inequalities relies on a useful conceptual model of the social determinants of health (2010: 4). Based on this comprehensive model, the key messages of the report are that in order to reduce inequalities in health outcomes, the focus needs to be on the social determinants responsible for those inequalities. Similar logic is used with regard to HIV/AIDS, in support of the adoption of a *social ecological framework* (UNAIDS 2011) which is based on the *psycho-socio-environmental* model of health and disease mentioned earlier (Gilbert et al. 2010). In the case of HIV, as with

general health, the individual's behaviour and health outcomes are shaped by a range of factors on different levels, as presented in Figure 2. Efforts to reduce HIV must therefore take cognisance of the various levels and address these factors in their entirety.

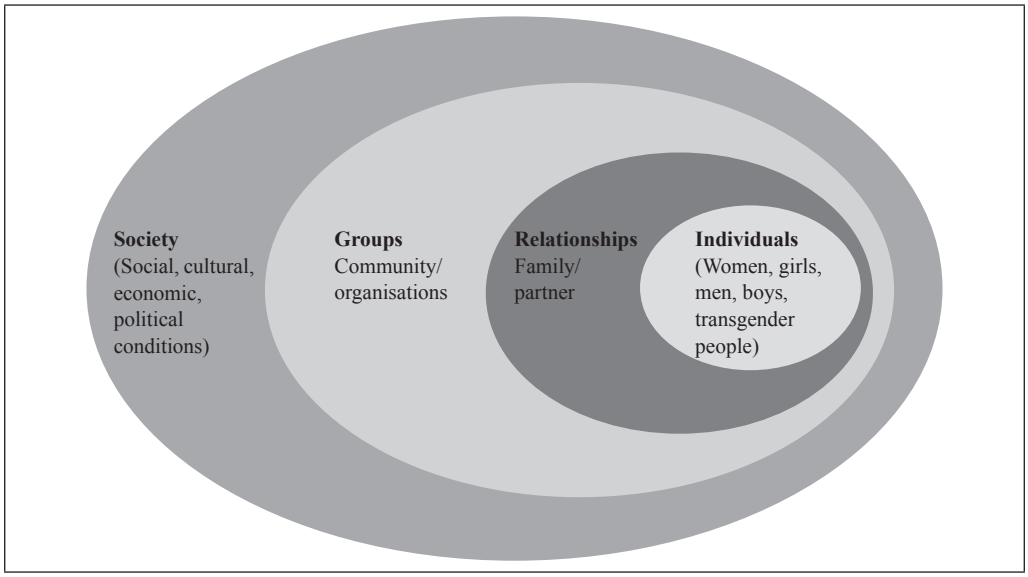

Figure 2: A social ecological framework
Source: UNAIDS (2011: 15)

The 'multi-level explanation', a conceptual framework borrowed from McKinlay and Marceau (2000a), provides a useful analytical tool since it encourages a multi-disciplinary approach and integration of different levels. It also acknowledges that different actions are required, depending on the level of explanation being focused on. No doubt if the ultimate goal is to affect the 'social' in the epidemic, public health efforts need to focus on integrated and relevant 'structural interventions' along the continuum of the disease trajectory that corresponds with the main drivers of the epidemic. The solutions can thus be placed at various social levels (Auerbach et al. 2011; McKinlay 1979):

1. Individuals and underlying risk-behaviours – strategies aimed at changing behaviours and providing individual prevention technology;
2. The family and its social networks, as linked to general health status, as well as how these facilitate the spread of the virus, testing, treatment and care – harnessing and enabling the positive aspects;
3. Organisations and broader social institutions such as neighbourhoods and community structures, and their effects in the social distribution of pathology and 'at-risk behaviour' – mobilisation of communities to change gender norms and impact on youth sexual culture;

4. The broader political-economic spectrum, and how these more remote forces are aetiologically involved in the onset of disease – national leadership to affect legal reform and improve environmental and social conditions, as well as health-social movements for change.

The options for potential interventions would clearly differ according to the level, but would be placed along a flexible continuum in relation to each other, with the emphasis on the 'social' as the common thread.

These conceptual models can be used as a framework for the way forward that encourages the targeted inclusion of the 'social' at all levels of health promotion and leads to the ultimate adoption of an 'upstream' approach. The challenge for social scientists working in health promotion is to invigorate research efforts in order to provide

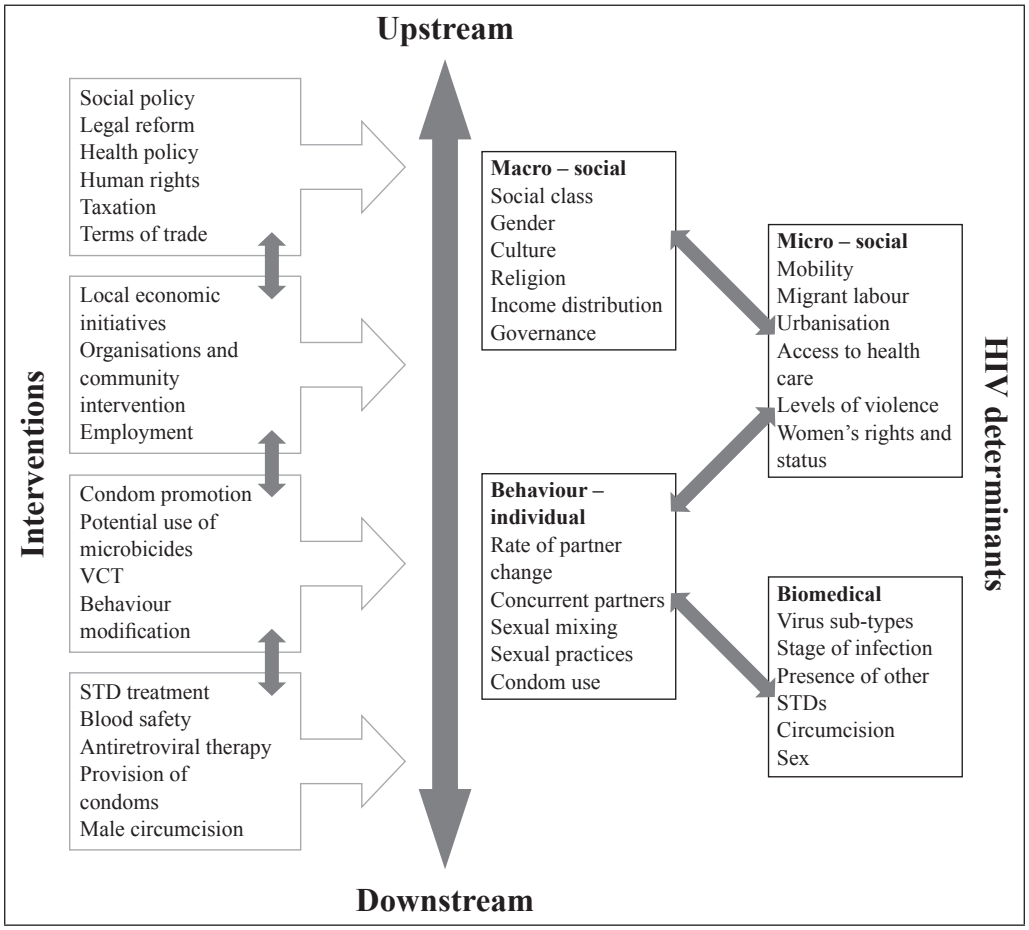

Figure 3: The way forward (2002)
Adapted from: Barnett and Whiteside

a more nuanced understanding of the 'social' and its practical translation in the context of health promotion – a task that is beyond the scope of this article which, as indicated earlier, uses a more conceptually expansive notion of the 'social' for the purpose of focusing on its problematic location in public health and health promotion. Although it is not the intention to provide specific examples at each level, as illustrated in Figure 3, it is hoped that the ideas presented here might stimulate further, more specific research and analysis.

The idea of a continuum of options should be adopted as a flexible strategy that does not exclude the potential synergies that might exist between interventions operating at different levels. It should also acknowledge the cyclical nature of the processes involved.

Prevention programmes could be improved mainly because the behavioural theories they are based on do not address the fact that risky health behaviour and HIV transmission are 'social events' shaped by more than individual psychological and behavioural factors, according to Coates et al. (2008). For this reason they advocate 'a multilevel approach that encompasses behavioural strategies', arguing that 'behavioural HIV prevention needs to be integrated with biomedical and structural approaches and treatment for HIV infection' (ibid: 669). This should be taken one step further, by linking it to the proposed 'continuum of option' at various levels with a greater emphasis on the 'social' (Figure 3).

If the multi-level continuum of options (see Figure 3) which takes the 'social' on board at specific points of the disease trajectory as well as at specific levels of the 'downstream–upstream' is seriously adopted, there can be a macro implementation via initial focus on the individual, while taking a long-term 'social' view. The brief socio-historical analysis of STDs and efforts to curb the spread of HIV/AIDS in South Africa supports this case. Hypothetically, if the health education efforts that went into eradicating STDs in the 1940s had included attempts to deal with the specific macro-social factors that contributed to their spread, and had met with even partial success, different, less accommodating grounds would have been created with the appearance of HIV 40 years later. Whiteside, in linking HIV/AIDS with the 'development agenda', maintains that the disease is a long-wave event with long-term implications. He therefore argues that despite the fact that 'all southern African leaders are aware of the threat HIV/AIDS poses to their populations ... what they do not seem to understand is the adverse effects it will have on development, nor do they seem to appreciate that responding to the disease requires long-term actions' (ibid: 208).

Most encouraging is the renewed interest in what is now termed '*combination prevention*' by the global planning community (Auerbach et al. 2011). According to UNAIDS this approach offers the best prospects for addressing the documented weaknesses in HIV prevention and for generating significant, sustained reductions in HIV incidences in diverse settings. Combination prevention focuses on biomedical, behavioural and structural strategies, and its programmes operate on different levels (e.g., individual, relationship, community, societal) to address the specific, but diverse

needs of the populations at risk (Kurt et al. 2011; UNAIDS 2011). According to Auerbach et al. (2011: 1), this development is based on growing consensus among researchers, programmers and policy makers, that after three decades of the epidemic, 'it is time to shift from an "emergency" approach to a long-term response'. However, since the idea itself in not new (Gilbert et al. 2010), but nevertheless has not been implemented on a wide scale, it might run the risk of remaining in the realm of unfulfilled plans, despite its hopeful outcomes.

These ideas feed into the discussion about the nature of public health and provide a good example for deliberations on the myth of a value-free public health. McKinlay and Marceau (2000b: 760) maintain that 'public health can never be an entirely objective "value free" enterprise'. Their assertion that 'to disregard the socio-political determinants of health is to relegate public health once more to the prevention and promotion of risk behaviours (which are mere epiphenomena)' (ibid: 761) resonates with the thesis advanced here, and also supports the proposed way forward.

Without downplaying the complexity of a truly 'social' intervention, it is hoped that this article makes a contribution to current debates, by shedding further light on the complexities associated with locating the 'social' in health promotion. This, to avoid falling into the potentially debilitating trap of 'having to cure South Africa' before attempting to control the HIV/AIDS epidemic. While the focus of this article is on HIV/AIDS, the insights offered in the final thesis and the way forward, should prove useful for health promotion efforts in dealing with other health problems as well.

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REFERENCES

Adam, B.D. 2011. 'Epistemic Fault Lines in Biomedical and Social Approaches to HIV Prevention.' *Journal of the International AIDS Society*, 14(Suppl. 2): S2.

Antonovsky, A. 1996. 'The Salutogenic Model as a Theory to Guide Health Promotion.' *Health Promotion International*, 11: 11–18.

Auerbach, J.D., Parkhurst, J.O. & Caceres, C.F. 2011. 'Addressing Social Drivers of HIV/AIDS for the Long-Term Response: Conceptual and Methodological Considerations.' *Global Public Health*, 1–17: iFirst article.

Barnett, T. & Whiteside, A. 2002. *AIDS in the Twenty-First Century.* Hampshire: Palgrave Macmillan, 76–77.

Bertozzi, S.M., Laga, M., Bautista-Arrendoro, S. & Coutinho, A. 2008. 'Making HIV Prevention Programmes Work.' *Lancet*, 372: 831–844.

Bodibe, K. 2011. 'Prevention to Get Major Boost in New Budget.' *Health-e*, 23 February.

Cassel, J. 1955. 'A Comprehensive Health Program among South African Zulus.' In B.D. Paul (ed.). *Health, Culture, and Community.* New York: Russell Sage Foundation, 15–41.

Clark, A. 2010. *The Sociology of Health Care.* London: Longman-Pearson.

Coates, T.J., Richter, L. & Caceres, C. 2008. 'Behavioural Strategies to Reduce HIV Transmission: How to Make them Work Better.' *Lancet*, 372: 669–684.

Donnell, D., Baeten, J.D., Kiarie, J., et al, for the Partners in Prevention HSV/HIV Transmission Study Team. 2010. 'Heterosexual HIV-1 Transmission after Initiation of Antiretroviral Therapy: A Prospective Cohort Analysis.' *Lancet*, 375: 2092–2098.

Feldacker, C., Ennetta, S.T. & Speizer, I. 2011. 'It's not Just Who You Are but Where You Live: An Exploration of Community Influences on Individual HIV Status in Rural Malawi.' *Social Science & Medicine*, 72: 717–725.

Gilbert, L. 1995. 'Sociology and the "New Public Health" in South Africa.' *South African Journal of Sociology*, 26: 1–10.

Gilbert, L. 2008. 'Public Health and Health Professionals in the Times of HIV/AIDS.' *South African Sociological Review*, 39: 301–316.

Gilbert, L. & Selikow, T.A. 2011. '"The Epidemics in This Country Has the Face of a Woman": Gender and HIV/AIDS in South Africa.' *African Journal of AIDS Research*, 10: 325–334.

Gilbert, L., Selikow, T.A. & Walker, L. 2010. *Society, Health and Disease in a Time of HIV/AIDS.* Johannesburg: Macmillan.

Gilbert L. & Walker, L. 2002. 'Treading the Path of Least Resistance – HIV/AIDS and Social Inequalities: A South African Case Study.' *Social Science & Medicine*, 54: 1093–1110.

Gupta, G.R., Parkhurst, J.O., Ogden, J.A., Aggleton, P. & Mahal, A. 2008. 'Structural Approaches to HIV Prevention.' *Lancet*, 372: 764–775.

Hargreaves, J., Hatcher, A., Strange, V., Phetla, G., Busza, J., Kim, J., Watts, C., Morison, L., Porter, J., Pronyk, P. & Bonell, C. 2010. 'Process Evaluation of the Intervention with Microfinance for AIDS and Gender Equity (IMAGE) in Rural South Africa.' *Health Education Research*, 25(1): 27–40.

Horton, R. 2008. 'Putting Prevention at the Forefront of HIV/AIDS.' *Lancet*, 372: 421–422.

Jeeves, A. & Jolly, R.J. 2009. 'Sexually Transmitted Infection and Public Health in South Africa: Educational Campaigns for Prevention, 1935–1948 and 1999–2008.' *Social Theory and Health*, 7: 264–283.

Jewkes, R. 2009. 'HIV and Women.' In P. Rohleder, L. Swartz, S.C. Kalichman & L.C. Simbayi (eds.). *HIV/AIDS in South Africa 25 Years on – Psychosocial Perspectives*. New York: Springer, 27–40.

Jewkes, R., Nduna, M., Levin, J., Jama, N., Dunkle, K., Wood, K., Koss, M., Puren, A. & Duvvury, N. 2007. 'Evaluation of Stepping Stones: A Gender Transformative HIV Prevention Intervention.' MRC Policy Brief. Pretoria: Medical Research Council (MRC).

Kark, S. 1949. 'The Social Pathology of Syphilis in Africans.' *South African Medical Journal*, 23: 77–84.

Kippax, S. & Holt, M. 2009. *The State of Social and Political Science Research Related to HIV: A Report for the International AIDS Society*. Sydney: International AIDS Society, 1–58.

Kippax, S.C., Holt, M. & Friedman, S.R. 2011. 'Bridging the Social and the Biomedical: Engaging the Social and Political Sciences in HIV Research.' *Journal of the International AIDS Society*, 14(Suppl. 2): S1.

Kuhlmann, E. & Annandale, E. 2010. *Handbook of Gender and Healthcare*. London: Palgrave.

Kurth, A. Celum, C., Baeten, J., Vermund, S. & Wasserheit, J. 2011. 'Combination HIV Prevention: Significance, Challenges and Opportunities.' *Current HIV/AIDS Reports*, 8(1): 62–72.

Leclerc-Madlala, S., Simbayi, L.C. & Cloete, A. 2009. 'The Sociocultural Aspects of HIV/AIDS in South Africa.' In P. Rohleder, L. Swartz, S.C. Kalichman & L.C. Simbayi (eds.). *HIV/AIDS in South Africa 25 Years on – Psychosocial Perspectives*. New York: Springer, 13–25.

Lindstrom, B. & Eriksson, M. 2006. 'Contextualising Salutogenesis and Antonovsky in Public Health Development.' *Health Promotion International*, 21: 238–244.

Ljungdalh, A.K. & Moller, J.E. 2011. 'The Social in Medicine: Social Techniques in Patient Education.' *Health* on-line-first, DOI: 10.1177/1363459311416835.

loveLife. 2012. www.lovelife.org.za (accessed 4 January 2012).

Lucas, K. & Lloyd, B. 2005. *Health and Health Promotion: 'Theory', Models and Approaches in Health Promotions – Evidence and Experience*. London: Sage.

MacDonald, T.H. 1998. *Rethinking Health Promotion – A Global Approach*. London: Routledge.

Marks, S. 2002. 'An Epidemic Waiting to Happen? The Spread of HIV/AIDS in South Africa in Social and Historical Perspective.' *African Studies*, 61: 13–26.

Marks, S. 2008. 'The Burdens of the Past.' In A. Ndinga-Muvumba & R. Pharoah (eds.). *HIV/AIDS and Society in South Africa*. Durban: University of KwaZulu-Natal Press, 37–62.

Marmot Review Team. 2010. *Fair Society, Healthy Lives: Strategic Review of Health Inequalities in England Post-2010.* London: Marmot Review.

McCoy, S.L., Kangende, R.A. & Padian, N.S. 2010. 'Behavior Change Interventions to Prevent HIV Infection among Women Living in Low and Middle Income Countries: A Systematic Review.' *AIDS Behavior*, 14: 469–482.

McKinlay, J.B. 1979. 'A Case for Refocusing Upstream: The Political Economy of Illness.' In E.G. Jaco (ed.). *Patients, Physicians and Illness.* New York: The Free Press, 9–25.

McKinlay, J.B. 1993. 'The Promotion of Health through Planned Sociopolitical Change: Challenges for Research and Policy.' *Social Science & Medicine*, 36: 109–117.

McKinlay, J.B. & Marceau, L.D. 2000a. 'Public Health Matters – To Boldly Go.' *American Journal of Public Health*, 90: 25–33.

McKinlay, J.B. & Marceau, L.D. 2000b. 'US Public Health and the 21st Century: Diabetes Mellitus.' *Lancet*, 356: 757–761.

Merson, M.H., O'Malley, J., Serwadda, D. & Apisuk, C. 2008. The History and Challenge of HIV Prevention. *Lancet*, 372: 475–488.

Nattrass, N. 2007. *Mortal Combat – AIDS Denialism and the Struggle for Antiretrovirals in South Africa*. Durban: University of KwaZulu-Natal Press.

Nattrass, N. & Kalichman, S.C. 2009. 'The Politics and Psychology of AIDS Denialism.' In P. Rohleder, L. Swartz, S.C. Kalichman & L.C. Simbayi (eds.). *HIV/AIDS in South Africa 25 Years On – Psychosocial Perspectives*. New York: Springer, 123–134.

Padian, N.S., Buve, A., Balkus, J., Serwada, D. & Cates, W. 2008. 'Biomedical Interventions to Prevent HIV Infection: Evidence, Challenges and Way Forward.' *Lancet*, 372: 585–599.

Piot, P., Bartos, M., Larson, H., Zewdie, D. & Mane, P. 2008. 'Coming to Terms with Complexity: A Call for Action for HIV Prevention.' *Lancet*, 372: 845–859.

Pronyk, P.M., Hargreaves, J.R., Kim, J.C., Morison, L.A., Phetla, G., Watts, C., Busza, J. & Porter, J.D.H. 2006. 'Effect of a Structural Intervention for the Prevention of Intimate-Partner Violence and HIV in Rural South Africa: A Cluster Randomised Trial.' *Lancet*, 368: 1973–1983.

Rehle, T., Simbayi, L., Leclerc-Madlala, S., Shishana, O., Zungu, N., Seager, J. & Peltzer, K. 2009. '*HIV/AIDS and Society*.' Report prepared for the South African Presidency. Pretoria: HSRC.

Rohleder, P., Swartz, L., Kalichman, S.C. & L.C. Simbayi (eds.). 2009. *HIV/AIDS in South Africa_25 Years On – Psychosocial Perspectives*. New York: Springer.

Satcher, D. 2010. 'Commentary: Include a Social Determinants of Health Approach to Reduce Health Inequities.' *Public Health Reports*, 125(Suppl. 4): 6–7.

Soul City. 2012. 'The Soul City Institute for Health & Development Communication.' www.soulcity.org.za (accessed 3 January 2012).

Tomlinson, M., Drimie, S., Swartz, L. & Rohleder, P. 2009. 'HIV/AIDS, Nutrition and Structural Interventions in South Arica: A Move in the Right Direction.' In P. Rohleder, L. Swartz, S.C. Kalichman & L.C. Simbayi (eds.). *HIV/AIDS in South Africa 25 Years On – Psychosocial Perspectives*. New York: Springer, 205–220.

Tulchinsky, T.H. & Varavikova, E. 2009. *The New Public Health.* London: Elsevier Academic Press.

UNAIDS. 2011. Discussion Paper: 'Combination HIV Prevention: Tailoring and Coordinating Biomedical, Behavioural and Structural Strategies to Reduce New HIV Infections. Geneva: Joint United Nations Programme on HIV/AIDS (UNAIDS)'.

Walker, L., Reid, G. & Cornell, M. 2004. 'An Epidemic Waiting to Happen.' In L. Walker, G. Reid & M. Cornell (eds.). *Waiting to Happen: HIV/AIDS in South Africa.* Cape Town: Double Storey, 60–87.

Whiteside, A. 2008. 'The Development Agenda and HIV/AIDS.' In A. Ndinga-Muvumba & R. Pharoah (eds.). *HIV/AIDS and Society in South Africa*. Durban: University of KwaZulu-Natal Press, 203–223.

World Health Organisation (WHO). 1986. *Ottawa Charter for Health Promotion*. First International Conference on Health Promotion, Ottawa, 21 November. WHO/HPR/HEP/95.1.

Wouters, E., Van Rensburg, H.C.J. & Meulemans, H. 2010. 'The National Strategic Plan of South Africa: What are the Prospects of Success after the Repeated Failure of Previous AIDS Policies?' *Health Policy Planning*, 25: 171–185.

BIOGRAPHICAL NOTE

Leah Gilbert is Professor of Health Sociology at the University of the Witwatersrand. Her research interests encompass the links between society, health, disease and the health professions and she has published widely on social aspects of dentistry, the role of pharmacy in primary health care, and medical and health care pluralism. Her current research focuses on the role of health professionals in the response to HIV/AIDS, and the associated social complexity. These themes are reflected in her latest publications on 'stigma' and the 'illness experience' of patients on ART, older women and 'Gender and HIV/AIDS'.