

## **A History of State Action: The Politics of AIDS in Uganda and Senegal**

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Amidst the AIDS epidemic that is causing such destruction in Sub-Saharan Africa, two countries stand out for their progress in battling HIV – Senegal and Uganda. The two ‘success stories’ represent very different kinds of success– that is, one where early intervention kept HIV/AIDS under control and the other where concerted action in the context of a full-blown epidemic has seen early signs of stabilisation and even reduction of prevalence and incidence of the virus. This chapter examines the recent history of the fight against AIDS in both countries and suggests that central state action has been pivotal to the progress achieved to date.<sup>1</sup>

The first two sections of the chapter examine contrasting patterns of the epidemic in the two countries and the gains made in fighting the virus. Section three explains the reasons why political leaders at the highest level of the state in both countries engaged early in the fight against HIV/AIDS. The fourth section examines the relationship between the state and societal actors, particularly religious groups and non-governmental organisations (NGOs) in launching the fight against HIV/AIDS. In the final section, I reflect on the lessons from these two ‘success stories’ in relation to the prescriptions for fighting the virus currently being promoted on the international stage.

### **Contrasting Patterns of the Epidemic in Uganda and Senegal**

In Uganda the first cases of HIV appeared among people from the southwestern region of Rakai and it is believed that the virus established itself among high-risk groups there and in Kampala by the late 1970s.<sup>2</sup> Economic collapse and social dislocation, and new economic activities including the proliferation of the smuggling trade, contributed to the spread of the virus. While some young women turned to the sex trade, many more found themselves increasingly engaged in transactional sex as a matter of everyday survival. The spread of the virus seems to have followed the trade and communications routes from the African east coast to the centre of the continent. Long-haul truckers removed from home, with plenty of money to spend, led to the proliferation of bars and brothels along their routes as people sought income-generating activities. The increased sexual activities of men in this industry, both with multiple partners along these routes and with commercial sex workers (CSW) whose trade

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<sup>1</sup> Research was undertaken in Uganda and Senegal during January 2003, while archival work continued over the next ten months.

<sup>2</sup> See Tony Barnett and Alan Whiteside, *AIDS in the Twenty-First Century: Disease and Globalisation* (Houndmills: Palgrave Macmillan, 2003), chapters 4 and 5.

was entirely unregulated, likely accelerated the spread of the virus. Sexually transmitted infections (STIs) were widespread and mostly untreated throughout these communities.<sup>1</sup>

The southwestern region also experienced the movement of armies, when Ugandan rebel fighters and invading Tanzanian forces overthrew the government of Idi Amin in 1979. Warfare and the movement of soldiers probably contributed to the spread of the virus through an increase in violence against women, trading sex for survival, increased levels of casual sex among multiple partners and unsafe parenteral and blood transfusion practices. The combined effects of social, political and economic disruption and war created conditions for the virus to pass from high-risk groups – truckers, soldiers and commercial sex workers – into the general population. The highest levels of infection were reported in urban areas, in rural areas along trade routes, and in districts beset by conflict and war.<sup>2</sup> The decade of state collapse destroyed health care systems in the country. Also, with a predominantly Christian population, male circumcision was less widely practiced than it is in Muslim communities and this may have aggravated the spread of the virus.<sup>3</sup>

In Senegal, the virus was kept under control from the start by a combination of social, political and historical factors, as well as the particular epidemiological characteristics of the virus in West Africa. The first six cases of HIV were diagnosed in 1986. Senegalese researchers found this to be a different and less virulent strand of the virus, HIV-2, which may in fact have had an impact on slowing down the development of HIV-1, also present in the country.<sup>4</sup> However, beyond this basic ‘epidemiological advantage’, a number of other factors were important to the control of the virus in the country. While Senegal remains among the poorest countries in Africa, it has experienced relative political stability since independence in 1960, a factor that has limited abrupt displacement among the population, allowed the maintenance of traditional and local institutions and organisations and kept violent conflict to a minimum.<sup>5</sup>

In terms of public health, there were two important moves made by the Senegalese state that probably played a pivotal role in limiting the spread of HIV later. First, the urban areas of Senegal, the key trading ports, had, since French colonial times, a highly regulated commercial sex industry. In 1969, the state passed legislation securing the legal status of prostitution. Commercial sex workers of 21 years and older registered with the state and there was a general surveillance and treatment of STIs among them from the early 1970s under the Bureau of Venereal Diseases. A national programme to fight STIs was also launched in 1978, well before the appearance of HIV/AIDS, initially to work mainly with CSWs. Second, the colonial government had established the first blood bank in 1943 and, as early as 1970, the state had launched a policy of safe blood transfusions, controlling for immunological and infectious risks.<sup>6</sup>

<sup>1</sup> On the role of STIs see, UNAIDS, ‘Consultation on STD Interventions for Preventing HIV: What is the Evidence?’ (Geneva: UNAIDS and WHO, May 2000).

<sup>2</sup> Uganda AIDS Commission, *The National Strategic Framework for HIV/AIDS Activities in Uganda – 2000/1 to 2005/6* (Kampala: Uganda AIDS Commission, 2000), 9.

<sup>3</sup> On circumcision see: D.W. Cameron, et al. ‘Female to male transmission of human immunodeficiency virus type 1: risk factors for seroconversion in men’, *Lancet* 2 (1989), 403-07; and, Daniel Halperin and Robert Bailey, ‘Viewpoint: Male Circumcision and HIV Infection: 10 Years and Counting’, *Lancet*, 354 (1992), 1813-15.

<sup>4</sup> HIV-2 has been shown to be either less pathogenic or to have a longer latency period. Raymond A. Smith, ed., *Encyclopaedia of AIDS: A Social, Political, Cultural and Scientific Record of the HIV Epidemic* (London: Penguin, 2001), 327.

<sup>5</sup> Karine Delaunay, ‘Le Programme national de lutte contre le Sida au Sénégal: entre prévention et normalisation sociale,’ in M.E. Gruénais, ed., *Organiser la lutte contre le Sida: Une étude comparative sur les rapports Etats/société civile en Afrique (Cameroun, Congo, Côte-d’Ivoire, Kenya, Sénégal)* (Paris: ANRS, 1999).

<sup>6</sup> ONUSIDA, Groupe thématique ONUSIDA/Sénégal, *Lutte contre le Sida: Meilleures pratiques, l’expérience sénégalaise* (June 2001).

Certain social characteristics may also have contributed to preventing the spread of the virus. With 95 percent of the population Muslims, male circumcision is widespread and fairly strong mechanisms of social control over the sexual activities of young women were perpetuated despite significant negative economic pressures and rapid cultural change.<sup>1</sup>

This then was the pattern of the epidemic in the two countries. By the mid-1980s, Uganda was experiencing a full-blown epidemic, while Senegal was positioned, as a result of early identification of the virus, to head off the epidemic

### **Achievements in Uganda and Senegal**

Although, Uganda's fight with HIV/AIDS is far from over, progress in fighting the epidemic has stood in sharp contrast to many other Sub-Saharan African countries.<sup>2</sup> The first cases of HIV were identified in Uganda in 1983 and thereafter the number of reported cases expanded exponentially. Prevalence as measured by surveys of women attending antenatal clinics appears to have peaked in the early 1990s and declined through the decade, remaining stable from 2000 until now. Most spectacularly, in one urban surveillance site, Mbarara in western Uganda, prevalence was recorded at 30.2 percent in 1992 and had fallen to 10.6 percent by the end of 2001.<sup>3</sup> Overall adult national prevalence probably peaked at about 15 percent in 1991 and had fallen to 5.1 percent by 2001 and 4.1 percent by year-end 2003.<sup>4</sup> Especially important has been a marked decline in prevalence observed among young (15-19 year old) pregnant women.<sup>5</sup>

Significant achievements were made in the development of the 'health infrastructure' to deal with the epidemic. In 1987 Uganda's Ministry of Health established four sentinel surveillance sites in hospitals with antenatal clinics, which expanded by the end of 2002 to 20, distributed to be representative of the whole country. Since 1986 the health services have also documented AIDS cases, which provide valuable insights for the fight against the virus, though the relatively small proportion of cases documented reflects the large number of people living with AIDS who still lack access to full health services.

By 2000, the Uganda Blood Transfusion Services (UBTS) claimed that screening was almost universal and blood safety increased to 90 percent. In 1990 the AIDS Information Center (AIC) was established to provide voluntary testing and counselling and expanded to four urban areas by the middle of the decade. As of 2000, some 400,000 people had been tested,<sup>6</sup> still far too few. Since 1994, new programmes were initiated for the diagnosis and treatment of STIs. However, Uganda lags far behind Senegal in developing diagnosis and treatment.<sup>7</sup>

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<sup>1</sup> Joseph R. Oppong, "A Vulnerability Interpretation of the Geography of HIV/AIDS in Ghana, 1986-1995", *Professional Geographer*, 50, 4 (November 1998), 444.

<sup>2</sup> For a comprehensive account of Uganda's progress in fighting HIV/AIDS see, Janice A. Hogle, ed., *What Happened in Uganda? Declining HIV Prevalence, Behaviour Change and National Response*, Projects, Lessons Learned Case Study (Washington, D.C.: USAID, September 2002) and Uganda AIDS Commission, *The National Strategic Framework*.

<sup>3</sup> Uganda STD/AIDS Control Programme, *HIV/AIDS Surveillance Report* (June 2002), p. 5, Table 1. Two other sites record a similar drop, Nsambya and Rubaga.

<sup>4</sup> Hogle, *What Happened in Uganda?*, p. 6. UNAIDS, Table of country-specific HIV and AIDS estimates and data, end 2003 (Geneva: UNAIDS, July 2004).

<sup>5</sup> On the problems of prevalence statistics, see, Justin Parkhurst, "The Crisis of AIDS and the Politics of Response: The Case of Uganda," *International Relations* 15/6 (2001), pp. 69-87, and Hogle, *What Happened in Uganda?*, 2.

<sup>6</sup> Uganda AIDS Commission, *The National Strategic Framework*.

<sup>7</sup> Hogle, *What Happened in Uganda?*

There is considerable evidence that campaigns around individual behaviour have been effective. Women surveyed reported that condom use increased from 1 percent in 1989 to 16 percent in 2000, with the comparable figures reported by men increasing from 16 percent in 1995 to 40 percent in 2000.<sup>1</sup> By the mid-1990s, two in every three people surveyed were able to cite at least two ways to protect against HIV. Some 57 percent of women and 64 percent of men reported that they had sex with one or fewer partners and the median age of first sexual encounter among girls increased by six months between 1989 and 1995.<sup>2</sup>

In Senegal, since surveillance began, prevalence of HIV has remained at about 1 percent among pregnant women attending antenatal clinics and between 15 and 30 percent among registered CSWs at the sentinel survey sites, with an increasing trend over time.<sup>3</sup> Prevalence observed among young women (15 to 25 years old) is three to four times less than women 25 years or older.

Senegal was quick to build on its established 'health infrastructure' to meet the challenge posed by HIV/AIDS. The World Health Organisation assisted Senegal in establishing its sentinel surveillance system in 1989. From surveillance sites in four districts, the system expanded to cover 10 out of the country's 11 districts by early 2003.<sup>4</sup> Surveys of 'social behaviour' were launched in 1997 and a 'second generation' surveillance system was launched in 2001, with the aim of expanding surveillance to all regions and which includes a survey of sexual behaviour among high risk groups including the military, migrants, seasonal workers and 'mobile workers' (truckers, fishermen, etc).<sup>5</sup> When Senegal launched its HIV/AIDS campaign in 1986 it worked quickly to reinforce its earlier progress in securing blood supplies, ensuring what is claimed to be 100 percent safety in its blood banks and transfusions meeting international standards.

A behaviour survey conducted in 1997 by the AIDS Control for International Development/Sénégal drew on baseline data from 1993, and documented significant progress in promoting individual behaviour change: 90 percent of those targeted by educational programmes could identify at least two methods of prevention; between 1993 and 1997, the proportion of the population reporting having sexual relations with at least one casual partner was cut in half; in 1997, 70 percent of respondents said they had used a condom at their last sexual encounter with a casual partner; between 1993 and 1997 there was an 80 percent increase in the number of people who said they were able to gain access to condoms; and there was an increase over the period in the number of people who used the health services for STI treatment. Also there was a marked rise in the number of young girls who had not had sex and a rise in the number of boys who had used condoms consistently. Sales of condoms increased sharply between 1995 and 2000.<sup>6</sup>

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<sup>1</sup> For a less optimistic view of progress in condom use see, Uganda Ministry of Finance, Planning and Economic Development, 'Uganda Participatory Poverty Assessment Process' National Report (final draft) (Kampala: MFPED, December, 2002). This may be a reflection of the reluctance shown by President Museveni to emphasise condom use. The NRM published guidelines in the late 1980s that acknowledged condoms 'can reduce the chance of getting AIDS' but warned how ineffective they were. *National Resistance Movement Guidelines for the Control of AIDS: Action for Survival* (Department of Information and Mass Mobilisation, NRM Secretariat, printed with assistance from UNICEF, no date).

<sup>2</sup> Uganda AIDS Commission, *The National Strategic Framework*.

<sup>3</sup> See ONUSIDA, *Lutte contre le Sida* – much more comprehensive than the English account published two years earlier, UNAIDS, *Acting early to prevent AIDS: The case of Senegal*, UNAIDS Best Practice Collection, UNAIDS/99.34E (Geneva: UNAIDS, June 1999).

<sup>4</sup> Interview with officials from Family Health International, established in Senegal since the 1970s, 23 January 2003.

<sup>5</sup> *Bulletin Epidémiologique de Surveillance du VIH/SIDA: 1999, 2000 et 2001*, 9 (March 2002).

<sup>6</sup> ONUSIDA, *Lutte Contre le Sida*, 18-19.

## National and Central Leadership

In analysing the progress made in bringing or keeping HIV/AIDS under control in Uganda and Senegal, it has become commonplace to celebrate the role of 'political leadership' in both countries. However, the 'quality of leadership' is an elusive factor. Some will be better leaders than others and leadership involves a complex set of determinants: intelligence and vision; charisma (the ability to inspire); rhetorical and organisational skills; openness to innovation; willingness to take risks, make hard choices and set priorities; accessibility of ideas and information; and luck. These factors of course played a role in both Senegal and Uganda, though arguably the personality of the leader was more important in Uganda and the nature of the leading organisation, the Parti socialiste, was decisive in Senegal. Analytically, there were three factors that provided the context for strong leadership in both countries.

First, leaders faced an incentive structure that meant they had nothing to lose and everything to gain from taking concerted action to fight the epidemic. Within months of taking power in 1986, Uganda's new president Yoweri Museveni sent his first Minister of Health, Dr. Ruhakana Rugunda, to the World Health Assembly in Geneva where he announced the HIV epidemic facing the country.<sup>1</sup> While some in Uganda recoiled in the face of international press coverage of the epidemic, by the end of his second year in power Museveni succeeded in uniting his National Resistance Movement government behind a full-blown campaign on AIDS. Early evidence that HIV/AIDS was pervasive in the armed forces was one reason Museveni was keen to act quickly. Furthermore, because Uganda's economy was devastated by years of misrule and warfare, Museveni had more to gain from attracting international assistance to fight AIDS than he had to lose in tourism revenue and investment by acknowledging the extent of the epidemic.

UNICEF was present when Museveni launched the National Committee for the Prevention of AIDS, in Kampala in October 1986 and, in January 1987, the World Health Organisation (WHO) sent a mission to lay the groundwork for cooperation with the government. In February a WHO team assisted in drawing up a five-year action plan on AIDS, which was published on 2 April 1987. This laid the basis for a donor conference organised by the Ministry of Health and WHO in May 1987 and the launching of the first AIDS Control Programme in Africa.

In Senegal, the conditions under which President Diouf accorded high-level national attention to HIV/AIDS were very different.<sup>2</sup> Senegal was not facing a full-blown epidemic when the government decided to act. Professor Souleymane Mboup and other university-based researchers had heard about the disease in 1983 and decided to undertake research in Senegal in collaboration with foreign academics. They discovered a virus in 1984-85 that was distinct from that found in Europe - HIV2 - and this discovery quickly gained international recognition for Mboup's team. This had a pivotal effect on the course of action taken by the national government. When the first six cases of HIV were identified in 1986, Mboup went to the then Director of Health, where he joined with Dr. Ibra Ndoye who had been working on STIs among commercial sex workers. A triumvirate was formed between Ndoye, Professor Awa Coll-Seck who was working on infectious diseases with the Ministry of Health, and Mboup and they met with President Diouf.

The President was won over to the idea of a campaign very quickly. Mboup had already gained international fame and medical experts from the developed world were coming

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<sup>1</sup> I have reconstructed the history of Museveni's engagement with HIV/AIDS in much more detail in, James Putzel, 'The Politics of Action on AIDS: A Case Study of Uganda', *Public Administration and Development* 24, 1 (February 2004), 19-30.

<sup>2</sup> This is based on an interview with Professor Souleymane Mboup, Dakar, 24 January 2003.

to Senegal. Work on HIV/AIDS was seen as something that added value to, rather than detracting from, Senegal's international reputation. USAID made it clear they would provide support. On 29 October 1986 the government launched the Comité National Pluridisciplinaire de Prévention du Sida (Multi-disciplinary National Committee for the Prevention of AIDS – CNPPS).

Second, in both countries, leaders based their decisions about HIV/AIDS on medical evidence. Senegal was fortunate to have within its senior medical establishment one of the world's leading researchers on HIV/AIDS, Dr. Mboup. This was a reflection of the fact that the country had a significant tradition of medical research and teaching, an inheritance from Dakar's position at the heart of French colonial Africa.<sup>1</sup> The Ministry of Health included, in its senior ranks, highly skilled medical practitioners and researchers and, importantly, a relatively long-established programme of research and treatment of sexually transmitted infections (STI).<sup>2</sup> The Socialist Party, which had ruled the country since independence, had a highly educated cadre at the centre, who respected the work of the Senegalese academic and scientific community, which itself was in close communication with the scientific community in France and Europe. When Mboup and his colleagues approached the President, Diouf was quick to launch state action.

In Uganda in late 1983, a team of foreign and domestic medical experts began investigating the first reports of a strange wasting disease, which local people had labelled 'Slim'. Within two years, they had gathered conclusive evidence of the presence of HIV/AIDS. However, political authorities and officials in the Ministry of Health under the 'second regime' of Milton Obote were in as much a state of denial about AIDS as elsewhere in Africa. They were too preoccupied with holding on to power to undertake any serious action on HIV before the end of 1985.<sup>3</sup> When Museveni's National Resistance Movement came to power, the new president gave his support to the crusading young doctors and ordered the medical bureaucracy to make HIV/AIDS a priority. The donor community supported a huge research effort in which Museveni was said to have taken a personal interest.<sup>4</sup>

Third, the impact of high-level political commitment to fight against HIV/AIDS and the all-out educational campaigns launched in both Uganda and Senegal created a situation where the epidemic was put beyond partisan politics. While Museveni faced many criticisms from opposition forces, all publicly admired the role he played in mobilising the nation around the epidemic and none put the government's commitment to the fight against HIV/AIDS into question. In Senegal, even the radical change of administration in 2000, when Abdoulaye Wade became the first opposition candidate in the nation's history to win the Presidency, did not alter the central government's commitment to fight the epidemic. In fact, the team heading work on HIV/AIDS was retained in its entirety (while strengthened and encouraged to somewhat redefine its role). No one could occupy high office in either of these countries without demonstrating a commitment to continue the fight against the virus.

In Uganda, unity behind the HIV/AIDS campaign was achieved in part due to the overwhelming presence of President Museveni and his military organisation, given the context of the guerrilla war he had won. Museveni also left little room for open political

<sup>1</sup> See Charles Becker, *La recherche sénégalaise et la prise en charge du sida: Leçons d'une revue de la littérature* (Dakar: Réser-Sida, 2000).

<sup>2</sup> Charles Becker and René Collignon, 'A history of sexually transmitted diseases and AIDS in Senegal: Difficulties in accounting for social logics in health policy', in Philip W. Setel, Milton Lewis and Maryinez Lyons (eds), *Histories of Sexually Transmitted Diseases and HIV/AIDS in sub-Saharan Africa* (Westport: Greenwood Press, 1999), 65-96.

<sup>3</sup> See Putzel, 'The Politics of Action on AIDS', for a detailed account of the early work on HIV/AIDS in Uganda, including the role of foreign doctors who were an early casualty of a nationalist.

<sup>4</sup> Edward Hooper, *Slim: A Reporter's Own Story of AIDS in East Africa* (London: Bodley Head, 1990), 214.

dissent once the NRM government adopted a policy.<sup>1</sup> There were few families in the country, including the families of most major political actors, who were not affected by HIV/AIDS. In Senegal, it was the prestige of the country's lead role in research on HIV/AIDS that helped build political consensus behind the campaign. Ibra Ndoeye, the public face of the campaign in Senegal, never joined a political party, ensuring that his work would not become partisan and maintaining his access to whoever held political authority.<sup>2</sup>

### **The state took the lead in mobilising society**

In both Uganda and Senegal state leadership was essential to making progress in the fight against HIV/AIDS, despite the dominant discourse advocating a major role for non-governmental, religious organisations and other non-state actors in the fight against the epidemic promoted by agencies like UNAIDS, the World Bank and the Global Fund to fight AIDS, Malaria and Tuberculosis (GFAMT).<sup>3</sup> The central state was largely responsible for initiating action in non-governmental sectors in both countries, played a major role especially through ministries of health in both countries in promoting the infrastructure to deal with the epidemic, and laterally holds the key to problems of scaling up the response to the epidemic and ensuring that decentralised action actually materialises.

While Uganda and Senegal have had great success in involving both religious sectors and non-governmental organisations, essential to ensuring the development of multiple messages to effect behaviour change and to provide care for the ill, it was leaders of the central state who acted first to rally the nation behind the fight against HIV/AIDS. They had the knowledge and the connections with the international community, but most importantly, the authority to convince a diversity of social groups to organise around HIV/AIDS. The central government in each case encouraged existing associations to take up work on the epidemic and helped to form new organisations for that purpose.

The dissemination of information and education of the public at large has been of central importance in effecting sexual behaviour change in both countries. Like in most parts of the world, fostering open discussion about sexual behaviour touches on matters deeply personal and closely linked to specific moralities, values and religious beliefs. Early on in their campaigns political leaders in both countries saw the necessity of involving religious leaders and organisations. Not only were they needed to help influence the population, but governments needed to ensure that they would support, rather than oppose, efforts to discuss the epidemic. Because AIDS was initially linked in the rich developed countries to homosexual behaviour and injecting drug users, and even in Africa was initially linked to promiscuous sexual behaviour, enormous stigma was attached to the disease. No efforts of surveillance, prevention or care and treatment could be made without fighting stigma and religious leaders were recognised as playing an essential part.

In Uganda, President Museveni sought out leaders of the Christian community and urged his officials to avoid antagonising them. Initially, the President's own opposition to the

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<sup>1</sup> Putzel, "The Politics of Action on AIDS".

<sup>2</sup> Ndoeye address to a World Bank workshop, Dakar, 21 January 2003.

<sup>3</sup> The Joint United Nations Programme on HIV/AIDS (UNAIDS) was established in 1996 by six UN agencies to follow on from the work of the World Health Organization's Global Programme on AIDS, originally established in 1987. The Bank launched a Multi-country AIDS Programme (MAP) in September 2000. See, World Bank, "Multi-Country HIV/AIDS Program". Project Appraisal Document, Report No: 20727 AFR. (Washington, D.C.: World Bank, 14 August 2000). The Global Fund was established in 2002. See, Global Fund, 'The By-laws of the Global Fund to Fight AIDS, Tuberculosis and Malaria' (Geneva: Global Fund, 2002). For a critical assessment of the international effort see, James Putzel, "The Global Fight Against AIDS: How adequate are the National Commissions", *Journal of International Development*, 16 (2004), 1129-1140.

promotion of condoms helped to reassure Christian leaders. From very early on church leaders were invited onto the national committees charged with fighting the epidemic. One reason the traditionally conservative churches were won over to the coalition to fight the epidemic was the extent to which their own clergy and parishioners were touched by the epidemic. Inventive actions were taken, as when the star singer, the late Philly Bongole Lutaaya, came out openly as HIV positive and organised a concert in the Namirembe Cathedral, in the very early years of the campaign.<sup>1</sup> People took the word of clergy members to heart due to their positions of authority in communities. Like in politics, crucial to the mobilisation of the religious groups was the early involvement of respected leading members of the clergy, like the late Bishop Yona Okoth who provided the space within the church for AIDS activists to operate. Canon Gideon Byamugisha played an enormous role in breaking down prejudice both within the church and in Christian communities, when he revealed that his wife had died of AIDS and that he discovered after her death his own HIV positive status.<sup>2</sup> Church organisations have provided subsidies to people to have their status checked and have trained clergy and lay members in counselling. They could reach far into the rural communities, perhaps where even the NRM could not.<sup>3</sup>

In Senegal, President Diouf and leaders of the National Committee also worked hard to involve traditional religious leaders of the majority Muslim community, which makes up some 95 percent of the population. Traditional religious leaders command enormous influence in the country.<sup>4</sup> The government began by encouraging a survey among religious leaders, carried out by an NGO, which found that most had very poor information about the virus. On this basis a process of negotiation was undertaken. The Muslim NGO, Jamra, (not known for its tolerance having waged Islamist campaigns against drugs and ‘perversions’ in the past) worked with the highest Islamic officials in the country and the major schools of Islamic thought. The most controversial issue, as in Uganda, concerned the use of condoms and like in Uganda, religious leaders did not support the use of condoms, but were won over to a position where they would not oppose either government or private sector efforts to promote condom use. A clear example of the way multiple messages were employed to achieve behaviour change came with the publication of *Guide Islam et Sida*, which while disseminating the basic facts on the epidemic, emphasised how Islamic teaching could help in preventing the spread of the virus.<sup>5</sup> Religious leaders became particularly involved in treating those succumbing to AIDS. The Catholic Church came on board much later,<sup>6</sup> finally participating in a conference in Dakar organised by the NGO *Sida-Service* in 1996 (though *Sida-Service* itself was involved before this).

International donors and international religious communities played an important role in winning over local churches and mosques. The World Council of Churches produced a pamphlet as early as 1987 entitled *What is AIDS?*, which had an important influence in local

<sup>1</sup> J. Azabo, ‘Lutaaya has AIDS’, *New Vision* 4/72 (13 April 1989), 1.

<sup>2</sup> See his writings: *Am I My Brother's Keeper: Reflections on Genesis 4:9* (Kampala: Ecumenical Association of Third World Theologians – Uganda Chapter, 1998); *AIDS, the Condom & the Church: Are Science and Morality Exclusively Antagonistic?* (Kampala: Ecumenical Association of Third World Theologians – Uganda Chapter, 1998); *Breaking the Silence on HIV/AIDS in Africa: How can religious institutions talk about sexual matters?* (Kampala: Tricolour Designers & Printers, 2000).

<sup>3</sup> Interview, Canon Gideon Byamugisha, 7 January 2003.

<sup>4</sup> Leonardo Villalón, *Islamic Society and State Power in Senegal: Disciples and citizens in Fatik* (Cambridge: Cambridge University Press, 1995).

<sup>5</sup> Comité National de Lutte contre le Sida, Association Nationale des Imams et Oulémas du Sénégal, ONG Jamra, *Guide Islam et Sida: Recueil de Sermons et Conférences* (n.d.).

<sup>6</sup> As late as 1994, Charles Becker berated the silence of the Church. ‘L’église et le sida en Afrique’, *Afrique & Parole* 39 (February 1994), 2-4; also in *Perspectives missionnaires* 27, 66-76. In Uganda the Church joined the multisectoral organisations only in 1995.

church circles in Uganda. USAID was instrumental in assisting church and mosque leaders to organise a conference in 1991 to learn about and commit to the fight against HIV/AIDS.

Some religious organisations have been major providers of health care and education in the absence of public authorities' ability to do so. While claims have been made that religious organisations have provided health care more cost-effectively than public organisations (a 'religious premium' on lower wage costs),<sup>1</sup> some of these tend to evaporate when it is noted that the government wage costs include a lunch allowance, as one consultant pointed out. There is a tendency to turn necessity into a virtue in this respect, particularly with aggressive faith-based initiatives in some of the donor countries.<sup>2</sup>

In both Uganda and Senegal, as some religious AIDS activists themselves said, the state had to take the lead not only to ensure a plurality of faith groups could be involved, but also to ensure that the messages of these groups came as supplements to secular public health messages and information.<sup>3</sup> Some secular activists felt uncomfortable that government was putting its name to publications, which while constructive in mobilising members of religious communities, at the same time in citing the Qu'ran still spoke of God's instruction, 'don't go anywhere near sex outside of marriage. In reality this is a depraved act and a detestable road' adding 'If men transgress this divine warning, depravity will develop on land and sea as a result of their own sins'.<sup>4</sup> Others suggested that it was not enough to get traditional and religious leaders not to oppose the HIV/AIDS campaign and government promotion of condom use, but felt that secular government and non-government leaders needed to put pressure on the religious sector to discard old taboos and prejudices.

As with religious organisations, the associational sector (NGOs, community based organisations and professional associations) has been a pivotal player in both Uganda and Senegal's HIV/AIDS campaigns, particularly in getting messages on behaviour change to communities and in providing counselling and care and treatment to HIV positive people and people living with AIDS. However, the central state was pivotal, not only in creating the space for the associational sector to act, but in initially mobilising the sector around HIV/AIDS.

In Uganda, despite the hegemony of the National Resistance Movement on the political scene, President Museveni and his cadres saw the importance of NGOs to their general reconstruction efforts after coming to power in 1986 and created a favourable environment for them to grow. The international donor community was instrumental in providing funding for the NGO sector from the earliest days of the Museveni regime. In 1988, The AIDS Support Organisation (TASO) was founded by people living with HIV/AIDS and members of their families.<sup>5</sup> TASO was instrumental in the elaboration of the 'multisectoral approach' in Uganda and a pioneer in promoting voluntary counselling and testing as well as piloting the use of antiretroviral therapies in the country.

<sup>1</sup> Ritva Reinikka and Jakob Svensson, 'Working for God? Evaluating service delivery of religious not-for-profit health care providers in Uganda' (preliminary draft), October 2002.

<sup>2</sup> Christian fundamentalist groups in the United States have become particularly active lobbyists in relation to foreign assistance programmes in the HIV/AIDS sphere.

<sup>3</sup> Interviews with activists in Kampala and Dakar, January 2003.

<sup>4</sup> Comité National de Lutte contre le Sida, Association Nationale des Imams et Oulémas du Sénégal, ONG Jamra, *Les Principes médicaux, coraniques et bibliques que tout croyant doit lire, savoir et appliquer* (n.d.), p. 14. "Dieu a dit dans le Saint Coran « n'approchez point la fornication. En vérité c'est turpitude et quel détestable chemin » " (Verset 32-Sourate 17). Si les hommes passent outre cet avertissement divin, la turpitude se développera sur terre et sur mer du fait de leurs propres péchés".

<sup>5</sup> The AIDS Support Organisation, 'Operational Strategy and Plan of Action, January 1999 to December 2002' (Kampala: TASO, April 1999).

In Senegal, President Diouf's Socialist Party reached out to the associational sector to educate organisations about HIV/AIDS and to encourage the formation of new organisations to deal with the epidemic. International NGOs contributed as well, with the group, Environment et développement en Afrique (ENDA) playing a central role right from the start, working with government from the top-down to establish associational activity. NGO activists themselves remember how it was the state that called associations together, that met with local women's organisations and told them about HIV/AIDS and urged them to develop activities.<sup>1</sup> Once organisations like the Society for Women and AIDS in Africa (SWAA) were established they worked on a genuinely voluntary basis with little financial support from the state or international sources during their first decade.<sup>2</sup> By early 2003 there were hundreds of associations involved in HIV/AIDS work, many of which were affiliated to the International Council of AIDS Service Organizations (ICASO), whose president locally sat in the CNLS and whose regional headquarters was established in Dakar hosted by ENDA.<sup>3</sup>

There is a particular dimension of NGOs' role in HIV/AIDS work, which is likely to ensure continued mobilisation and activity within civil society, unlike in many other dimensions of NGO work – that is, the organisations of People Living with HIV/AIDS (PLWH). Sustained bottom-up activity is now being promoted by these organisations. The promotion, involvement and financing of organisations of PLWH is pivotal to all dimensions of action, from prevention through care and treatment, including the many difficult issues related to rights and ethics.

Nevertheless, the central state's role remained strategic. In both Uganda and Senegal, the campaigns against HIV/AIDS were launched in an environment of health service reforms involving both the decentralisation of service delivery and the privatisation of service providers – or at least the arrival of private providers to compete with those in the public sector. The Global Fund and the World Bank, as well as many bilateral donors, especially USAID, were deeply involved in the development of decentralised delivery of resources for HIV/AIDS.

In Uganda, President Museveni was adamant about pushing resources out to the districts even if it meant some funds would be lost. Early efforts by the World Bank to transfer funds directly to the district level floundered and project funding reverted to the Ministry of Health. However, when the Bank launched its Multi-country AIDS Program, new efforts were made to set up District HIV/AIDS Committees, mirroring the structure of the national AIDS commission. Capacity at the district level remained woefully inadequate, however, especially as decentralisation proceeded very rapidly.<sup>4</sup> Despite aspirations to develop a multisectoral approach at the local level, this seemed often to exist in name only.

Senegal has a long experience of highly centralised government. However, in 1991 the government created a district level health system, with a further transfer of authority to local governments in 1996. By the year 2000, roughly 44% of HIV/AIDS funding went to the centre, 15% to the regional level and an impressive 41% to the district level, which demonstrated a genuine effort to ensure money reached the operational level.<sup>5</sup> The pattern of the distribution of funding, however, was determined by donor zoning requirements rather than relative needs between the districts. This was a problem that appeared to be shared in

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<sup>1</sup> Interview, Aminata Touré, UNIFEM, Dakar, 23 January 2003.

<sup>2</sup> Interview with Mbaye Maniang Diagne, Valérie Mouley Omar and Nafi Sar, SWAA, Dakar, 24 January 2003.

<sup>3</sup> ICASO was later replaced by COSSEN (Conseil des organisations de lutte contre le Sida au Sénégal), which was closely linked to CNLS and major community organisations, like ENDA, undertook successful action to get a hold of more resources. Personal communication from Charles Becker, November 2004.

<sup>4</sup> Interviews with Sam Okware and Elizabet Madra at the Ministry of Health, 9-10 January 2003.

<sup>5</sup> Cheikh Mbengue and Allison Gamble Kelly, 'Funding and Implementing HIV/AIDS Activities in the Context of Decentralization: Ethiopia and Senegal', Abt Associates for Partnerships for Health Reform and USAID (February 2001).

Uganda, underlining the need for central government to establish clear criteria so that funds could reach districts on the basis of need and epidemiological evidence rather than due to particular political connections.

In Senegal the central state had to play a key role in training local actors and ensuring they had the financial resources to carry out their work. As of 2000, apart from Dakar, no regions received funds for HIV/AIDS from local authorities. However, over the next few years USAID began working with local government units to provide a 'full package' of support for HIV/AIDS related work. Interestingly it required local governments to raise tax revenues to finance, at least partially, campaigns against the virus as a condition for funding, something also advanced by the World Bank's MAP.<sup>1</sup>

In both countries, health officials – even those deeply involved with, and supportive of, decentralisation measures – were worried about the rigid requirements imposed by the Bank and the Global Fund in terms of decentralising resources. This is because capacity at local levels of government remained terribly unequal and generally inadequate. Senegal's experience seems to demonstrate that appropriate medical expertise can best be developed first at the centre and, with training and increasing resources, be incrementally devolved to district and sub-district levels. In early 2003, the NGO community itself, generally supportive in principle of efforts to get resources out of Dakar and down to the communities, argued that the framework offered by the Bank and Global Fund was inadequate (and was hardly discussed with the NGO sector).<sup>2</sup> One NGO leader said that surveys conducted demonstrated that HIV/AIDS was fourth or fifth on the agendas of local governments. Interestingly, he argued that a strong centre was needed to demonstrate to local governments why AIDS is important. At the same time, he argued for national level involvement of NGOs to ensure that resources would actually reach the associational sector at the local level.

In Uganda, when Museveni came to power in 1986, what had once been an efficient and well run health service had long since virtually collapsed. The issue was not one of privatisation, as the narrow base of health service delivery after years of war, political instability and economic decline had wrecked the public sector. What health care existed was almost entirely private. NGOs and church related organisations were encouraged to deliver health care as efforts were made to reconstruct the public sector. Cost-sharing (patient fees), long practiced at least informally through the payment of bribes and the like, was tolerated by the Ugandan government but never endorsed as policy by Museveni. In 2001 it was abolished in what some claim was a blatantly political move by the President to gain support before elections. While the abolition of cost-sharing led to some short-term difficulties in supplying adequate drugs to meet demand, evidence emerged pointing to an expansion in the use of government health services.<sup>3</sup> Others suggest that cost-sharing was never a deterrent to the use of public services, but rather people were deterred by 'misconduct on the part of health workers, as well as perceived poor quality of service, including the dispensing of pain killers no matter what ailment one was suffering from'.<sup>4</sup>

Clearly, there are compelling reasons in the fight against HIV/AIDS to have an integrated health system, at least as a goal. In Uganda, it was the fight against AIDS which

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<sup>1</sup> Interview with USAID officials, Kampala, 8/01/2003.

<sup>2</sup> Interview with Baba Goumbala, Alliance Nationale Contre le Sida, Dakar, 24/01/2003.

<sup>3</sup> Uganda Ministry of Finance, Planning and Economic Development, 'Uganda Participatory Poverty Assessment Process' National Report (final draft) December, 2002 and Uganda Ministry of Health, 'The Effects of Abolition of Cost-sharing in Uganda: Report on the Findings for 2001', WHO and MOH Uganda (June 2002).

<sup>4</sup> F. Golooba Mutebi, "Decentralisation, Democracy and Development Administration in Uganda, 1986-1996: Limits to Popular Participation", *Ph.D. dissertation*, London School of Economics and Political Science, University of London, 2000.

provided the opportunity to develop a centralised system for monitoring disease.<sup>1</sup> The requirements of surveillance of the epidemic, of providing experienced counselling and testing facilities, of ensuring safe blood supplies and parenteral practices, of treating opportunistic infections and developing antiretroviral therapy in the future, all militate towards greater integration in approaches to public health, rather than dispersal to systems of private providers.

### **Conclusion: Assessing ‘success’ in light of international prescriptions**

Identifying Uganda and Senegal as ‘success stories’ in the fight against HIV/AIDS, in no way means that the battle to control the epidemic is over in either country. Uganda still faces a high HIV prevalence rate and in those parts of the country still at war we have no knowledge of how high that is and very little if anything is being done to control the epidemic. In Senegal two particularly worrying trends have emerged: first, a declining trend of HIV-2 has been matched by a rising trend of HIV-1, and while women once constituted a minority of those infected, they now are the majority.<sup>2</sup> In both Uganda and Senegal efforts to promote behaviour change have remained largely directed at individual behaviour. While significant progress has been made in dealing with behaviour in the armed forces in both countries, much less has been done to address the institutional barriers blocking change in the behaviour of other groups, addressing structural features like women’s position in society or patterns of migration to secure livelihoods.

In the HIV/AIDS programmes of both countries, ‘care and treatment’ has been recognised as the biggest challenge, yet, in both, the means to deal with mounting numbers of People Living with HIV/AIDS are woefully inadequate. Despite education campaigns, stigmatisation remains a major problem in communities and workplaces. Outside of hospitalisation, care and treatment is being carried out by the non-governmental sector, which faces huge deficits in terms of skilled personnel and funds.<sup>3</sup>

It must also be said that even in these ‘success stories’, very little has been done to address the long-term causes and impact of the epidemic. This obviously poses challenges far beyond the capability of single nation-states and it is unlikely that substantial progress can be made in this area without a transformation of the international efforts to fight the epidemic. Thus far, international agencies have focused much of their attention on attempting to promote campaigns for individual behaviour change in the countries hardest hit by HIV/AIDS. With the development of antiretroviral therapy and the access that the wealthy can gain to these drugs, the basis for the broad political coalitions that were built to fight HIV/AIDS in both countries may be weakened in the future.

The international community has advocated a model of response to HIV/AIDS, which is centred on developing a ‘multi-sectoral’ effort to fight the epidemic, involving all branches of government and a wide cross-section of religious and non-governmental organisations. While this orientation recognises the social character of the epidemic and rightly breaks from thinking about HIV/AIDS as a purely medical problem, it is important not to lose sight of the key role that the state has played in successful battles against HIV/AIDS.<sup>4</sup>

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<sup>1</sup> Jim Holt of the World Health Organisation in 1987 said, ‘We are using AIDS in order to establish an effective surveillance system for Uganda, and one that will operate for measles, cholera and other such diseases as well’ (cited by Hooper, 1990, 254).

<sup>2</sup> *Bulletin Epidémiologique de Surveillance du VIH/Sida* (March 2002).

<sup>3</sup> Interview, Baba Goumbala, Alliance Nationale Contre le Sida, Dakar, 24 January 2003.

<sup>4</sup> For an assessment of the problems in the international community’s approach see, James Putzel, ‘Institutionalising an Emergency Response: HIV/AIDS and Governance in Uganda and Senegal’. Report submitted to the Department for International Development, UK Government, London (May, 2003) and Putzel, ‘The Global Fight Against AIDS’.

The kind of 'health infrastructure' required to mount a battle against the epidemic - including establishing surveillance systems, providing clean blood supplies, securing parenteral practices in health delivery, providing adequate testing facilities, ensuring treatment of STIs and regulating the activities of commercial sex workers - requires the full involvement of the medical profession and the consolidation of the public health system. This can only be done, in the medium to long term, through the consolidation of central and local organisations of the state.

It is clear that a central state response only works where the state's reach extends deeply down to local communities. In different ways, in both Uganda and Senegal, the central state has incorporated local and traditional leaders in systems of hierarchical authority.<sup>1</sup> There is some evidence in both countries that local communities, which had little access to income generating activities of any kind, engaged in the fight against the epidemic as a means of gaining access to funds and employment opportunities provided by the state for that purpose. In other words, the state's leverage in promoting successful AIDS campaigns was related to the impoverishment and dependence of local communities. Effective behavioural change, in rural areas at least, may have been achieved through the reinforcement of control over young women by traditional authorities.<sup>2</sup>

In Senegal, the government's early response is one reason why the epidemic was arrested in its tracks. While the Parti socialiste was often criticised for over-centralisation and, while much of the discourse about achieving the kind of behavioural change that is necessary to slowing transmission of HIV/AIDS is geared towards mobilising 'civil society', it was the Parti socialiste's centralist character that allowed it to reach down through the associations to every corner of the country and that was responsible for the early awakening of the nation to the danger posed by the virus.<sup>3</sup> In a similar way, in Uganda, the centralist authority of the National Resistance Movement, and the military organisation on which it was based, also made quick dissemination of the message about HIV to every village possible.<sup>4</sup> It was Museveni's military organisation that in 1988 implemented the country's first national sero-survey.

The benefits of the central state's role on all these fronts clearly can best be achieved where leadership is provided by a political party, rather than dependent entirely on the beliefs and abilities of individual leaders. In Senegal, the culture and programme of the Parti socialiste was more important to positive action than the person of President Diouf. In Uganda, and in Senegal since the election of Wade, action on HIV/AIDS has been determined by the individual leadership of populist presidents. To be sustained over time gains must be institutionalised both within party programmes and within the organisations of the state. One of the most precarious aspects of the many successes Uganda has achieved in development since 1986 is the overwhelming reliance on the personal attributes of the President on one hand, and the role of foreign donors on the other. Moves by Museveni in 2003-04 towards multi-party competition potentially appear as an antidote to over-reliance on the person of the

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<sup>1</sup> Leonardo Villalón, *Islamic Society and State Power*, especially chapter 3, has painted a fascinating portrait of the manner in which the Senegalese state relates to local communities. Tim Allen and Suzette Heald argued in similar terms about the relationship between authorities in Kampala and local communities in rural Uganda. See Tim Allen and Suzette Heald, 'HIV/AIDS Policy in Africa: What has Worked in Uganda and what has Failed in Botswana?', *Journal of International Development*, 16 (2004), 1141-1154.

<sup>2</sup> Tim Allen and Suzette Heald, 'HIV/AIDS Policy in Africa'.

<sup>3</sup> The most articulate members of the NGO community recognise this. Interviews with Aminata Touré (UNIFEM) and Baba Goumbala (ANCS) in Dakar, January 2003.

<sup>4</sup> However, the NRM was slow to develop cooperation with the National Committee for the Prevention of AIDS. See Putzel, "Politics of Action on AIDS".

president and may open the way to greater institutionalisation of gains both within the NRM and within state organisations.

While a multi-sectoral approach and the involvement of a diversity of social organisations and associations was essential to progress in both countries, this was made possible through strong central state leadership. Of course, in countries where there is an absence of strong central leadership, the burden of organising a response to HIV/AIDS must be borne by organisations in society. But just as NGOs and community based organisations can never provide for the military security of a country, neither can they provide for security from an epidemic like HIV/AIDS. It is difficult to imagine how sustained progress can be made in protecting a population against the virus if central leadership is lacking.