

HIV/AIDS POLICY IN AFRICA: WHAT HAS WORKED IN UGANDA AND WHAT HAS FAILED IN BOTSWANA?

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Abstract: A comparison of HIV/AIDS policies in Botswana and Uganda is revealing. It helps to highlight the kinds of policies that are necessary to come to terms with the pandemic in Africa, where it is already a public health disaster. It is argued that the promotion of condoms at an early stage proved to be counter-productive in Botswana, whereas the lack of condom promotion during the 1980s and early 1990s contributed to the relative success of behaviour change strategies in Uganda. Other important factors included national and local-level leadership, the engagement (or alienation) of religious groups and local healers and, most controversially, procedures of social compliance. We end with a call for more draconian measures than are currently envisaged. Copyright © 2004 John Wiley & Sons, Ltd.

Since the early 1990s there have been indications from Uganda that HIV prevalence and rates of new infection have been stable or in decline. During the same period rates in Botswana have rapidly increased. On the face of things, this is all rather strange. The governments of the two countries introduced HIV/AIDS awareness campaigns at about the same time, have been open to advice from international experts and have welcomed external assistance. Moreover, control programmes might have been expected to work more effectively in Botswana than Uganda. In the late 80s, Uganda was widely viewed as the worst HIV/AIDS affected country in the world. It was also very poor and only just beginning to recover from decades of political upheaval. It had a relatively large population of over 20 million, divided into numerous different language groups. It had extremely limited public health and education systems, high levels of illiteracy and low life expectancy. By contrast, Botswana had enjoyed decades of stable government and high economic growth. It had a small population of around one million, virtually all of which spoke Setswana, a much higher literacy rate and an effective public health service.

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Life expectancy was similar to that in rich countries. One might have thought that here HIV/AIDS could be contained. This paper asks why it was not? How is it possible that within 10–15 years life expectancy at birth in Botswana dropped below that in Uganda?¹ Drawing upon our experiences of living and working in Uganda and Botswana since the HIV/AIDS pandemic began, developments and policies in the two countries are compared and various insights are gleaned, some of which counter still prevalent assumptions and assertions.²

PROBLEMS WITH THE DATA

First something needs to be said about the figures. Policy documents and many academic publications on the HIV/AIDS pandemic cite data from countries to describe trends without any interrogation of how this information has been collected. This can be very misleading. Data may not be collected in the same way and, even when they are, they may mean something different. The main method for collection of national HIV trends is through anonymous surveillance at static clinics. In Botswana this method is probably as accurate as it is possible to be in an African context. Ninety-five per cent of women are estimated to attend antenatal clinics (Republic of Botswana, 1997). HIV prevalence rates are therefore likely to be a good estimator of young adult prevalence. The overall adult rate will, of course, be lower, because older people will have escaped the main danger of infection. Rates in Botswana are also assessed by anonymous testing of men at sexual health clinics and by some population studies. These have tended to show that the antenatal surveillance is a strong indicator of overall trends. Since the end of the 1990s, national prevalence of HIV infection for the adult population (15–49) has been estimated at around 40 per cent (UNAIDS).

In Uganda, monitoring at antenatal clinics is much less accurate. Most of the surveillance sites are in the south of the country and in urban areas, but most of the population lives in rural areas (over 80 per cent) and have only limited access to formal health care provision. The 1990 census reported that less than 40 per cent of women consulted a trained medical worker in the course of pregnancy.³ Antenatal surveillance is therefore biased towards the urban and southern part of the country, and probably also towards a self-selecting sample of relatively affluent and educated women. Uganda, however, has also been the site of two of the best population studies undertaken in Africa. These have provided detailed information about behaviour patterns and rates of infection in the southwest of the country dating back to the end of the 1980s.

One of these studies, funded by the UK's Medical Research Council in Masaka district, has monitored 10 000 people living in a cluster of 15 villages from 1989. Results from the

¹Life expectancy at birth for 2002 has been assessed at 43 for Uganda and 38 for Botswana (http://www4.worldbank.org/afr/stats/adi2004/adi_2004_ch01.pdf)

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³Even in Rakai District—where HIV/AIDS was first diagnosed in Uganda—only 23 per cent of pregnant women deliver in health centres (New Vision, 2003).

first five-year follow up showed little change in overall seroprevalence (from 8.2 per cent in 1990 to 7.6 per cent in 1994). However, there was a highly significant drop noted among males aged 13–24 years (from 3.4 to 1.0 per cent), and a less dramatic drop among females of the same age cohort (from 9.9 to 7.3 per cent). This was the first report of a decline in HIV-1 prevalence among young adults in a general population in sub-Saharan Africa with high overall HIV-1 prevalence (Mulder *et al.*, 1995). During the same period, similar declines were noted from the other population study in the neighbouring (and more highly infected) Rakai district. More recent results have shown that these declines have been sustained. Perhaps, most significantly, the ten-year follow up of the Masaka study found continued declining prevalence among young adults (Mbulaiteye *et al.*, 2002).

Thus, the very optimistic overall assessment of declining HIV-1 incidence and prevalence in Uganda is based on these results from Masaka and Rakai, and the data from mainly urban ante-natal clinics in the south of the country. The extent to which these data reflect overall national rates of infection is open to question. Very little is known about HIV/AIDS in the north of the country. Moreover, even the data that are available do not correspond with the often-cited decline in Uganda's overall adult seroprevalence from around 30 per cent to less than 10 per cent. Such a decline has only been observed at one antenatal clinic—Mbarara (Parkhurst, 2002, p. 2). There is, in fact, no evidence that overall prevalence ever reached 30 per cent. A more likely estimate is that it peaked at around 12 per cent in the early 1990s. Nevertheless, there is certainly evidence that there has been a decline in both incidence and prevalence at several locations, and overall rates have not exploded in the way that they have in southern Africa over the last fifteen years.

The most commonly given reasons for the relatively positive HIV/AIDS situation in Uganda are that the Government acted quickly and was open to assistance from international agencies. Yet the Government of Botswana did much the same. So what made Uganda different? No one knows the answer to this question for certain. What is clear, however, is that formal public health interventions were of marginal importance during the crucial years of the late 1980s and early 1990s, and that they have subsequently been less important than is regularly claimed. In this respect, looking a little more closely at what failed to work in Botswana is revealing.

HIV/AIDS POLICY IN BOTSWANA

Botswana is in many ways an exceptional African state. It has a small and relatively cohesive population. It has been a constitutional democracy since independence, and has benefited from effective institutions of governance. It is also rich in African terms, with a GNP per capita in 1999 of almost \$4000 US dollars. After the discovery of diamonds in the early 1970s, Botswana quickly developed its mining capacity, which grew to 38 per cent of GNP by 1998. In both the mining companies, Debswana and Bamangwato Concessions, Government shares equity in the company. Substantial reserves were built up throughout the 1980s and 1990s, while at the same time there was a substantial expansion of public services. Educational provision was extended with universal primary and secondary education and the development of a tertiary sector. Hospitals and clinics were built and provide effectively free treatment. Welfare provision was put into effect for the old, destitutes and to provide famine relief—a persistent problem in this drought stricken region. From the point of view of many commentators, Botswana has reaped the benefits of a responsible and far-sighted leadership.

The Government of Botswana also recognized the problem of AIDS soon after the first cases were diagnosed in the country. A one-year national emergency plan was set up in 1987, and this was followed by a series of 5-year strategic plans (Heald, 2002). WHO, USAID and various international NGOs collaborated with the Ministry of Health in setting up programmes aimed at disease surveillance and control. HIV/AIDS awareness was promoted in attempts at changing sexual behaviour. The first national campaign in 1988 used radio messages, car bumper stickers and T shirts to get the message across (Ingstad, 1990). However, by the mid-90s, education campaigns were no longer pursued with so much vigour, and by the end of the decade, when one of us (Suzette Heald) was working in the country, there was minimal public discussion of the problem. All one saw around in the capital, Gaborone, were white vans with Lovers Plus condoms emblazoned on the side and a large billboard which proclaimed that 'Avoiding AIDS is as easy as ABC—Abstain, Be faithful, Condomise'. There was surprisingly little understanding or awareness of what was happening. HIV/AIDS was a topic shrouded in stigma and silence at all levels of society. Part of the problem seems to have been with the health promotion campaigns themselves, a point that can be illustrated by reflecting on the implications and resonance of the ABC billboard.⁴

Sex education campaigns are always difficult and controversial, and not just in Africa. To be effective, they have to be seen as credible and they require responsiveness to the particular sensitivities of the target groups. In Botswana, neither was the case. The very speed of Government response to the threat meant that people had to believe in the health promotion messages before they had any experience of the disease in their own lives,⁵ and this was not helped by the fact that the ABC slogan was in English. Not surprisingly, people were sceptical about what they were being told, and AIDS became known as the 'radio disease'. Many were also offended by the campaign. In Botswana there is a deep-seated unwillingness to talk openly about sex, partly due to rules of respect that lie at the heart of family and kinship structures, which limit communication across generation and sexual divides. These attitudes were brushed aside by public slogans such as the 'as easy as ABC' message.

Reactions to condom use were particularly intense, and a factor causing the campaigns to be ignored or actively opposed by church groups and many parents and elders. In local terms, condom promotion seemed to encourage 'immorality'—something that was seen as all too prevalent, and as being exacerbated by the opportunities afforded by rapid economic growth. Nor was this necessarily a misinformed perception. A Government survey in 1992 reported an increase in condom use among its young urban respondents and also an increased rate of partner change (Republic of Botswana, 1994). In addition, condom promotion fuelled an alternative discourse of AIDS, bedded in Tswana beliefs and understandings, which held the condom an agent not in the control of the disease but rather in its very origin and spread.

In this discourse AIDS is seen—if it is seen at all—not as a new disease but as an old one. It has been interpreted by the population—and diviners and prophets of new spirit churches—as a manifestation of old 'Tswana' illnesses, acquiring new virulence because of the disrespect for the mores of traditional culture, or to these illnesses having mutated as they have 'mixed' together. At the level of experience this is of course right. AIDS

⁴For more detailed discussion of the following points, see Heald, 2002, 2003.

⁵The British campaign, also of 1988, met similar difficulties and ones which have served since to undermine credence in Government health campaigns in areas of sexual health. The difference is that the British population at that time did not have any significant level of HIV infection. The tragedy is that Botswana did.

manifests itself not as a new disease but as a mass of familiar afflictions. In Botswana, these ailments are associated with pollution caused by the breaking of sexual taboos—*meila*. These taboos control reproductive life and are linked to a coherent bio-moral model, concerned with the flow of bloods, not only within the person but also between persons. In this model, sexual intercourse has special value, not only as procreative, but because it sets up a flow of bloods between sexual partners, which is health-giving. Stopping this flow is seen as a possible cause of affliction with the blood becoming ‘hot’. From this point of view, use of a condom is dangerous in itself. The Government’s following of an exclusively western model fuelled suspicion, which the exclusion of diviners, healers and churchmen from the campaigns did nothing to ameliorate. Two parallel discourses existed, one official and one non-official, and this latter in the absence of any recognition had the potential to take on decidedly political overtones. Setswana interpretations opposed Segkoa (white) ones, and were linked to a critique of modernization and to the government itself (Heald, 2002).

Nor did the situation change radically as rates of infection soared. In the late 1990s HIV/AIDS continued to be referred to as the radio disease (referring back to the first radio campaign of 1988) and few people could tolerate the idea of testing and even fewer to admit to having been infected. It was said that only seven people had come out publicly as HIV positive. The links between HIV, condoms and immorality remained strong and the stigma attached to infection was considerable.

There was surely also a financial element underlying these developments. By the mid-1990s, the international agencies had largely withdrawn from Botswana, taking the view that, given the wealth of the country, their resources could be better deployed elsewhere. Botswana was then left to fund almost all of its HIV/AIDS control programmes, making them a much more immediate drain on national resources than has been the case in other African countries. Moreover, the economy of Botswana is not dependent on a large labour force, and it is even uncertain if high mortality rates will affect growth. In 2003, a study cited by the government claimed that, if HIV continued to spread at the current rate, then there would be a 32 per cent reduction in economic growth by 2010 (Republic of Botswana, 2002, p. 3). Others, however, are more sceptical (e.g. Bonnell, 2000, p. 2), and with good reason.

The three main sources of income for Botswana are tourism, cattle and diamonds. The tourism industry is mainly focused on the upper end of the market and is centred on the sparsely populated northwest. The cattle industry also does not employ large numbers, as the animals are not managed intensively. In turn, the diamond industry only employs 6300 people, of whom only 26 per cent are considered critical workers (mainly in technical cadres and taking around five years to train). So long as these sectors are protected, the economy will continue to grow, and will grow much faster in per capita terms as AIDS mortality increases. In this context it can be noted that an outbreak of cattle lung disease in the mid 1990s was dealt with swiftly and efficiently—and that no expense was spared. \$50 million was immediately allocated to its eradication and the programme was placed under the President’s direct authority. Similarly, a considerable investment was being made to control foot and mouth disease in 2003–04. Action has also been taken to deal with the effects of HIV/AIDS on the diamond industry. Mandatory testing of the workforce was introduced in 2000. No one was sacked and ARV treatment has been provided to workers and spouses, with the industry paying 90 per cent of the bill.

It would seem reasonable to conclude that there have been perverse economic incentives at work with respect to Botswana’s national HIV control programmes—and

these have not gone away with the changes that have occurred in Government policy (notably the increased engagement from the president's office since Mogae took over from Masire in 1997). Botswana is now trying to lead the continent in the provision of mass access ARV treatment. An index of the success of this programme is that HIV prevalence will escalate as more people survive, and treatment will have to be provided on a permanent basis. At present, Merck pharmaceuticals and other companies are providing many of the drugs free of charge or at cost, and Botswana is also receiving considerable support for HIV treatment from the Gates Foundation and other western donors. But these 'public-private' initiatives are not permanent arrangements and, even with this assistance, the Botswana government is providing most of the HIV/AIDS programme funds (exactly how much is hard to assess, but probably around 70 per cent of the total).⁶ Understandably, there has been a great deal of interest in this national ARV programme in Botswana, and talk about it acting as a model for other African countries to emulate. However, the financial incentives to act vigorously are by no means straightforward, and there remains enormous public resistance to health initiatives.

The ARV programme began in 1999 with high hopes, initially with the intention that by the end of 2002, 19 000 people would be on treatment. In the event 'take off' has proved much slower. It soon became apparent that despite Botswana's well-developed primary health care structure, it did not have the testing facilities, nor the ability to rapidly staff and maintain the infrastructure to supply ARVs on the scale intended. In April 2003, more than two years after the inception of the programme, fewer than 5000 people were receiving ARV treatment and only 10 000 by the end of that year.

Visiting the country in July 2003, we found that the problem was not just the need for infrastructure but the extreme reluctance people were still showing to come forward for testing. Just as it had been in the 1990s, and despite the prominence of the ARV programme, AIDS is still a 'silent' disease that continues to be understood in terms of local, bio-moral knowledge. This is crucial because the only way that the ARV programme can work to reduce rates of transmission (one of its major aims) is to encourage testing. Nor did public education seem any more effective. Travelling around the more densely populated part of the country we found signs beside the main roads relating to cattle disease control, but very few about HIV/AIDS. True, bus shelters were decorated with posters in both Setswana and English. However, whichever project had put them up had clearly moved on, because the transparent acrylic sheets which protected them had become opaque and cracked, making it hard to read what they said. Off the main roads we found almost nothing, and this was true even in Government offices. Indeed, the situation in mid 2003 seemed to be one of bureaucratic paralysis. Suddenly there were a wide array of different kinds of donors and a bewildering multitude of overlapping programmes, each with their own acronym. A National AIDS Coordinating Agency had been set up to facilitate a multi-sectoral response but, as elsewhere in Africa (Putzel, 2003), it introduced yet further complexity to an already over-burdened and complex bureaucratic structure. Moreover, the connection of this bureaucracy with the daily life of ordinary people seemed minimal.

⁶The public-private partnership between Merck Pharmaceuticals, the Bill and Melinda Gates Foundation and the Botswana Government was formed in 2001 with finance from the private sector committed for five years.. The Government expected to pick up the whole tab at the end of the programme. Currently, President Mogae estimates that the Government's increased spending on HIV/AIDS is about 70 million dollars a year, 70 per cent of the total expenditure (speech by President Mogae, 30 November 2003, Washington DC. allafrica.com/stories/200311300081.html).

One of the new strategies to complement the ARV programme was called 'total community mobilisation'. This, as with so much else in Botswana, was designed as a top down intervention. An army of field-officers were to undertake door-to-door visits, and to talk at various community gatherings and hold workshops. During colonial times, local level government in Botswana had remained largely in the control of the *dikgotla* (sing. *Kgotla*), the 'traditional' structure of chiefs and their associated councils. Since Independence, in 1966, as state control has become increasingly centralised, their power has been considerably eroded. Nevertheless, the basic structure of the *dikgotla* remains, with councils at all levels, from the sub-ward up to the ward, village, tribe and thence to the house of chiefs. It runs both in parallel with government bureaucracy and is incorporated into it, or rather side lined by it. *Dikgosi* (chiefs) still sit everyday in their courts and are paid a Government stipend but their powers of independent action are curtailed.

In addition to a hereditary chief or headman, each village now has a range of elected village committees (including one for AIDS), who report to village chief and council but also, and more importantly, to the Village Development Committee and thence to government offices higher up the hierarchy. But the wheels of the bureaucracy grind exceedingly slowly. At village level, the speed and effectiveness of village committees is limited by the necessity for meetings to be funded by sitting allowances, and the same goes for committees at other levels. Yet, chiefs can no longer act independently of this committee structure, nor committees independently of higher approval. In 2003, we heard of two cases where chiefs wanted to put up their own HIV/AIDS posters in their *kgotla*—but permission had to go up to NACA (the National Aids Coordinating Agency) and then come down. In over two years in one case, and in over three in the other, no such authorization had come down. But these chiefs were exceptions. We did not see much sign of those few we visited in 2004 wanting to act. When interviewed, they said HIV was an external problem, with people who had been working in the town coming back to die, and not an internal one. And, to questions about controlling sexuality in the village, the standard response was that no one had any control over the young anymore and if they attempted to discipline a young man for seducing girls in the village, they would run the risk of having Human Rights lawyers from the cities on their backs.

During the past year, there have been major new developments explicitly designed to break the silence and denial and to make the ARV programme effective. President Mogae has been at the forefront here, as he was with the introduction of the ARV programme itself. In October 2003, he backed a full testing programme, recommending that it become routine in all Government health facilities.⁷ In a series of speeches, he has been determined, as he puts it, 'to make Batswana face up to the disease'. He has also suggested that civil society, including church groups, become more involved.⁸ The importance of such a move comes out clearly when comparisons are made with Uganda.

HIV/AIDS POLICY IN UGANDA

Although it is often ignored, a crucial point in assessing HIV/AIDS policy in Uganda is that the epidemic is significantly older than in Southern Africa. This is important for two

⁷The ARV programme had relied on establishing stand alone testing and treatment centres, largely funded by the Global Fund. Of these, four were operational in mid-2003 and a further six centres were opened by end of 2003. This new directive, which came into effect on 1 January 2004, presumably means that testing facilities will now also be available in village level clinics.

⁸See for example BBC, 2003: 'Botswana Aids stigma persists', and IFSC, 2004: 'Mogae defends AIDS testing'.

reasons. First, it is reasonable to expect that HIV/AIDS, like any other epidemic, will run a natural course. Its virulence within a particular population will decline over time. How long this will take with HIV/AIDS is unknown, but it is possible that the declines in infection rates noted in parts of Uganda may reflect such a trend. Second, a disease locally referred to as 'slim' had already been causing deaths for some time in southwest Uganda before those infected were diagnosed as having HIV/AIDS in 1982–83. This meant that by the time that the national HIV/AIDS programme was underway in 1987–88, experience of AIDS-like symptoms and excessively high mortality was widespread in some places. Particularly in the south of Uganda, people were well aware that something was wrong. Thus, unlike the population of Botswana, there was evidence to back up the early awareness and behavioural change campaigns.

Those campaigns proved to be very effective. It is hard to show that they directly changed behaviour, but they did quickly increase awareness of the disease in Kampala and southern parts of the country. As in Botswana, the symptoms of AIDS were often incorporated into local bio-moral interpretations of affliction, but the diversity of Ugandan society mitigated against the kind of widely believed and cohesive alternative explanation of the disease found in Botswana. Various, relatively small-scale cults of affliction emerged, but there was less resistance to the formal public health care messages.

The messages themselves were also different to those used in Botswana. The slogans used included 'love faithfully' and 'zero grazing'. The latter referred to the technique of tethering a cow or goat to a post, so that it would eat grass in a circle. There was little reference to condoms.⁹ In the early years of his presidency, Museveni was involved in an informal alliance with the, traditionally Catholic, Democratic Party. Partly for this reason, but also partly because of his own beliefs and attitudes, condoms were not vigorously promoted. Indeed, Museveni and other ministers made speeches denouncing condoms as un-African and raising doubts about their efficacy as a form of protection. Over the years this line has been toned down, but Museveni maintains that the success of his government's programme has been to do with the promotion of 'family values'¹⁰—a position that makes him rather popular with certain Republican politicians in the US.

The fierce and personalized debates that have been going on in the US about the use of condoms in global HIV control has meant that what actually happened in Uganda has been less important than what needs to be asserted for political purposes.¹¹ It is certainly the case that some people used condoms if they could obtain them. Similar sorts of people had been using condoms in the early 1980s to protect themselves from venereal diseases. But during the 1980s availability was very limited, and most of those wanting to use them were educated and lived in urban areas. In rural areas, where more than 80 per cent of Ugandans live, few people would have seen or used one. As late as 1991, donated condoms were being kept in stores in Entebbe because of government resistance to their distribution. This

⁹Ironically, the ABC message is often attributed by enthusiastic observers to the programme in Uganda, but in point of fact, the campaign was pioneered elsewhere (including Botswana), and not used in Uganda until the later 1990s.

¹⁰See for example 'Museveni denies condoms reduced HIV in Uganda', Abstinence Clearing House <http://abstinence.net/library/index.php?entryid=583> (accessed 05/02/04); Museveni condemns condom distribution to pupils, *New Vision*, May 2004 <http://www.newvision.co.ug/D/8/12/360669> (accessed 04.08.04). Museveni's wife, Janet, is even more explicit, particularly in the link between behavioural change and religion. See her 'Christain faith and Uganda's story', a talk to the South African Christain Leadership Assembly, July 2003 www.africanenterprise.org.za/sacla/talkjanetmuseveni.htm (accessed 05.02.04).

¹¹For a review of these bitter debates among anthropologists see *AIDS and Anthropology Bulletin*, 2003; Green, 2003, 2004.

subsequently changed, and by mid decade there were rural condom distribution points in some rural areas, but there was little evidence that they were being widely used.

In June 1996, one of us (Tim Allen) visited Rakai District. This is where the first group of Ugandans were diagnosed as having been infected with HIV/AIDS (in 1982/3) and, not surprisingly, it had become the focus of numerous aid and research projects. There were condom distribution points along some roads, and local council officers talked about encouraging people to use them. At the little port at Kasensero a local council chairman was receiving a small stipend for HIV/AIDS awareness promotion, and was doing his best to make condoms available to the fishermen and the small group of local women who were selling them services. There were misunderstandings at first, he claimed, but now condoms were 'going like hot-cakes!' Interviews with women, however, told a different story. Both here and further inland, many claimed that they had only heard of them. Others said that they killed people when they became stuck inside the woman, or that they had heard that the best thing to do was to use many of them at the same time.¹²

Discussions with staff working for NGOs and medical research projects in the area confirmed that promoting the use of condoms was proving very different. The first results of the epidemiological surveillance in neighbouring Masaka district had just been published. The co-author of the articles that presented the results was the late Dan Mulder of the London School of Hygiene and Tropical Medicine. He had also been in charge of running the project, and had lived in the area for over five years. In his view condoms were unlikely to have been a major factor in the declining incidence among young people. The decline had already started before condoms had become available, and when they had, they were not available in sufficient quantities nor was there much evidence that they were being used appropriately in the population as a whole. For Mulder and his team, the key factor was probably a decline in casual sex, and specifically the later age of first sexual intercourse for girls. In Mulder's view this had occurred because of the widespread awareness of the disease as a result of the public education campaigns.¹³

An important aspect of these campaigns in Uganda was that they involved a variety of institutions and individuals, both inside and outside of the government sector. The President himself, government ministers and public health workers made speeches, but musicians,¹⁴ local and international NGOs, chiefs, Christian and Muslim groups, and local councils were also involved. In the north of the country, where Tim Allen was living in the late 1980s and early 1990s, it was the latter two that were most important.¹⁵ In Moyo District knowledge of HIV/AIDS became widespread in 1989 when two prominent local men died.¹⁶ They made statements before dying about how they had become infected by

¹²These interviews were taped by Tim Allen in 1996 and included in an Open University radio programme on AIDS in Uganda broadcast by BBC Radio 3 and 4. Since the late 1990s condom promotion has increased in Rakai District, nevertheless a recent survey concluded that only 12 per cent of men and less than 10 per cent of women consistently use a condom (New Vision, 2003). However, in Kampala and some other urban areas it is likely that condom use has become a more significant factor in limiting transmission.

¹³The interview with Dan Mulder was taped in 1996 and used in an Open University radio programme on AIDS in Uganda broadcast by BBC Radio 3 and 4.

¹⁴Including Phil Lutaaya, one of the best known Ugandan musicians, who announced that he was HIV positive in 1989.

¹⁵For detailed discussion of the points made about northern Uganda see Allen, 1988; 1989; 1991(a); 1991(b); 1992; 1994(a); 1994(b); 1994(c); 1996; 1997.

¹⁶In August 1991, a survey of around 1400 informants in Moyo District found that more than 90 per cent had heard of AIDS, about 30 per cent knew of someone with AIDS and over 60 per cent believed that 'sex with many people' was a cause of transmission (Schopper, 1991).

having sex outside of marriage, and they exhorted people to not follow their example. Catholic priests read these out at church services.

Also very active in promoting behavioural change were the local councils. Museveni's government introduced these councils in 1986. Initially, they operated in parallel with the civil service, but have subsequently been absorbed into it. Whereas in Botswana, years of efficient, centralised government has led to a systematic dis-empowering of local councils, in Uganda precisely the opposite occurred. Although members of these locally elected bodies were originally not paid salaries or stipends, they were able to make informal charges for their services. Most importantly, they derived their authority directly from the President, and were supported by the army. They were also given a great deal of latitude in deciding how to operate. They were supposed to act as advocates for their people at each level of the administration, collaborate with aid agencies and monitor security. In Moyo District, and in many other parts of Uganda they become active in promoting awareness of HIV/AIDS, often putting up their own health promotion posters. In some cases they also became active in not just promoting behavioural change, but in enforcing it.

A suggestion that is sometimes made about HIV/AIDS rates in Uganda is that they escalated during the years of civil war before Museveni came to power in 1986, and have declined as a consequence of the return to peace. A recent World Bank report mentions this almost as a matter of fact (World Bank, 2003, p. 47). There are obvious problems with this argument: first, there has been continuous military activity and civil war in parts of Uganda since 1986 and second, several countries in southern Africa, including Botswana, have not been affected by war but have much higher rates of infection. However, there may be something here worth considering. It was perhaps not the end of fighting in some parts of Uganda that helps explain declining rates, but the modes of establishing or re-establishing communal life.

The local councils introduced under Museveni are directly elected. Most groups in Uganda primarily trace descent in the patrilineal line and are patri-local (i.e. the wife comes to live at her husband and father-in-law's home). Marriage is a process whereby the lineage status of a woman undergoes a process of transition involving the production of children and the transfer of bridewealth to her father and brothers. In the Uganda of the early 1980s there was a great deal of population displacement and it had also become very difficult to provide bridewealth. This had many effects, including increasing instability of marriage. In the later 1980s, the new local councils become involved in trying to stabilise this situation, often by re-asserting patriarchal interests. In Moyo District, councils tried to control activities of young people at dances, monitor the movement of certain women (and occasionally certain men), and mediate in various kinds of disputes. These disputes often related to payments of bridewealth, or to the sexual activities of women for whom no bridewealth had been paid. In some instances the councils were prepared to act forcefully, for example by expelling certain individuals from a neighbourhood. They also became involved in hearing cases where someone, usually a woman, was accused of *inyinya* (witchcraft/poisoning). On a number of occasions they executed a person found guilty, sometimes with the active support of soldiers stationed in the vicinity. Once news about HIV/AIDS started to spread, such activities appeared to have presidential and church support, and to be in the interests of public health. Indeed, the term *inyinya* started to be used for people, mostly women, who might be infected.

There was similar witch-cleansing in neighbouring Arua and Gulu Districts during the late 1980s and early 1990s. At one point the Arua Diocese Catholic newsletter reported the removal of witches from one location and even printed the names of those who had been

accused. Elsewhere it may be that local council approaches were less extreme. Nevertheless, their involvement in regulating behavioural change was a widespread phenomenon. It could be readily observed in Rakai District, where local council officials made no secret of what they were trying to do, and could even be seen in parts of greater Kampala. In many places local council officers were also able to secure funds for their 'health promotion' campaigns from aid agencies. For example, the local council officer at Kasensero mentioned above, who was trying to ensure that fishermen used condoms with sex-workers, was receiving a stipend from the French NGO, *Medecine Du Monde*.

This point relates to a further contrast between Uganda and Botswana. No one doubts that high AIDS mortality affects economic well-being in Uganda. It is a mostly rural population and, unlike Botswana, its main exports require agricultural labourers. It also does not enjoy Botswana's social security system. So there are economic incentives at all levels of society to contain the epidemic. But this of course is also true of several other African countries, such as Kenya or Tanzania. What has set Uganda apart, at least until recently, is donor aid involvement. The Uganda Government has probably never had to contribute more than 10 per cent of the costs of the HIV/AIDS programmes because Museveni has been outstandingly successful in securing and sustaining international assistance. Apparent success in containing the epidemic has resulted in a continuous flow of finance, and not just for senior government officials. Resources have been distributed all over the country, often by NGOs working closely with the local councils. This has meant that, unlike Botswana, there are direct, institutionalised economic incentives to engage with HIV/AIDS projects on a day-to-day basis.

CONCLUSION

While expressing some scepticism about HIV/AIDS data, we have found that reviewing experiences in Botswana and Uganda is revealing. We have noted that the control programmes in the two countries need to be assessed in the context of the local epidemiology of HIV/AIDS. The fact that it is a more mature epidemic in Uganda has, amongst other things, affected when the population became aware of excess mortality. It may also be the case that the forms of HIV-1 prevalent in Botswana are more virulent than those in Uganda.¹⁷ However, it is unlikely that this alone explains the divergent trends.

We have suggested that a crucial factor explaining the failure of early programmes in Botswana and the relative success of programmes in Uganda relates to condom promotion. In Botswana, condom promotion provoked antipathy from church groups, local healers, parents and chiefs. In Uganda, the fact that condoms were not initially introduced, and also the president's negative attitude towards them, played a part in the social acceptance of sexual behavioural change messages. The very groups so alienated in Botswana became actively involved in Uganda. Other important factors leading to divergent outcomes have included economic incentives, and leadership both at national and local level. That Museveni was so vocal about the problem and inspired local council officers to become involved in dealing with it was probably crucial. It helped initiate exactly the kind of 'total community mobilization' to which the Government of Botswana now aspires, but seems

¹⁷The strain of the virus prevalent in Botswana is HIV-IC—a strain known to be particularly virulent. It is also possible that non-sexual modes of transmission (notably unsafe medical practices) may have been different in the two countries. However he have no space to discuss this controversial issue here.

(after years of developing a strong executive arm of government) to have so little capacity to initiate.

More controversially, we have also argued that social constraint has been a key aspect of what has occurred. It seems to us that human rights activism linked to HIV/AIDS in Botswana has hindered public health measures. Botswana has followed the accepted line in HIV intervention with its stress on voluntarism, confidentiality, gentle persuasion and encouragement. Only now, with the population facing meltdown, are more coercive measures being advocated and even then in the face of intense opposition from outside agencies. In parts of Uganda, on the other hand, sexual-behavioural change has been regulated by local groups, and in some instances violently enforced. It is not our contention that the extreme measures observed in northern Uganda should become a model to be emulated in HIV/AIDS control. However, such events illustrate the point that human behaviour rarely changes because of health education alone. Change is facilitated when information is linked to procedures of compliance.

High hopes have been expressed for the new ARV schemes. However, even for these to work, there is a need for fundamental changes in actions and attitudes. This fact is recognised by Botswana's current President, Festus Mogae. We applaud his lead: people should have to opt out of testing procedures rather than voluntarily opt into them, and adequate facilities to make this possible should be a funding priority.¹⁸ Africans need to know if they are positive, and compliance and constraint must become a major component in HIV/AIDS policy initiatives. In this region of the world the pandemic has been allowed to become a public health disaster. It urgently demands appropriately tough responses to bring it under control.¹⁹

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¹⁸Only an estimated 6 per cent of Africans have access to voluntary testing (Global HIV Prevention Group, 2003, p. 10).

¹⁹De Cock *et al.* (2002) have put forward a cogent case for the acceptance of measures used for other infectious diseases, including sexually transmitted ones, such as widespread testing, partner notification and the tracing of contacts. See also de Waal, 2003.

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