

The South African Institute of International Affairs



# Africa's Tsunami

Turning the tide on Aids

Series editor: Elizabeth Sidiropoulos

Report 7 2011

Africa's Tsunami

Turning the tide on Aids



**The South African Institute  
of International Affairs**

**Global Best Practice**

**Africa's Tsunami  
Turning the Tide on Aids**

With contributions by

**Dianna Games and Mercedes Sayagues**

Series editor: Elizabeth Sidiropoulos

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## **Erratum**

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### **Africa's Tsunami Turning the Tide on Aids**

The country case study on Uganda was inadvertently attributed to Ms Dianna Games, while Ms Mercedes Sayagues was the actual author. Sincere apologies are extended to Ms Sayagues for this oversight.



## Editor's Note

In her opening address to the World Health Organisation (WHO) meeting in Geneva held in May 2005, the assembly's president, Elena Salgado, described the growing gap between health issues in the rich world and the poor one, especially in Africa. There, 'hundreds of millions of children, and almost as many adults, suffer needlessly from illnesses that most people in the West have never heard of.'<sup>1</sup> While it is true that HIV/Aids is NOT one of the diseases that fail to register on the agendas of the WHO and the donor community, it is particularly prevalent among the poor in Africa.

According to UNAIDS' most recent epidemic update, sub-Saharan Africa has just over 10% of the world's population, but more than 60% of all people living with HIV/Aids. About 64% of all new global infections in 2005 occurred on the continent. In 2005, 25.8 million adults and children were living with HIV/Aids in sub-Saharan Africa, compared with 24.9 million in 2003. Of those, 13.5 million were women (13.1 million in 2003). There were some 3.2 million adults and children newly infected with HIV in 2005, and about 2.4 million died of Aids.<sup>2</sup> Sub-Saharan Africa has 24 of the 25 countries with the highest levels of HIV prevalence, and orphans account for 15% of children in 11 countries in the region.<sup>3</sup>

Yet there have been some examples of good practice in dealing with the pandemic among African countries. The three case studies in this book look at the history of national Aids control programmes in Botswana, Senegal and Uganda. They examine the policy-making environment, the interaction between government and various elements of civil society, and the role that political decisiveness and leadership play in a country's coming to grips with the pandemic. The aim is to identify lessons — what worked, what did not, and what we can learn from these examples. For most of the period for which there are HIV/Aids statistics, Botswana has had the highest prevalence rate in

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<sup>1</sup> Specter, M, 'What Money can Buy', *The New Yorker*, 24 October 2005.

<sup>2</sup> UNAIDS and WHO, *AIDS epidemic update, December 2005*. Geneva: UNAIDS/WHO. 2005, p.17.

<sup>3</sup> Foster G, 'Putting faith in child care', *eAfrica*, July 2005, p.8.

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Africa. In contrast, Senegal's infection level has remained below 2%, while in Uganda national HIV prevalence peaked at more than 15% in the early 1990s before dropping steadily.<sup>1</sup>

According to the latest UNAIDS update on the epidemic, published in December 2005, the national prevalence rate in Botswana appears to be stabilising among pregnant women (between 35% and 37% since 2001). Interestingly, Botswana is by far the most affluent economy of the three, although the greatest concentration of HIV cases is in its poor rural areas. Uganda and Senegal are both very poor countries that fall under the Highly Indebted Poor Countries Initiative and have very low rankings on the human development index.

All three countries receive substantial donor funding, and work closely with international agencies in combating HIV/Aids. All three have profited from the personal involvement of their presidents, who have assisted in publicising the risks of Aids, and in defying cultural taboos against talking openly about sexual matters. (President Mogae of Botswana took a well-publicised Aids test; President Museveni of Uganda insisted that Aids issues be discussed at all levels, including village councils.)

However, despite the good intentions of all three countries, Uganda and Senegal seem to have been more successful in controlling the epidemic, partly because of the timing of their interventions. Although Senegal is a poor country and was not in a position to throw money at the problem of HIV infection, it did see an opportunity to control the epidemic. As Mercedes Sayagues explains: 'Senegal marshalled its resources to mount a swift, wide, bold and home-grown response.' Her paper examines the policies that guided the domestic campaign against Aids and suggests why it was successful.

Uganda's ABC campaign was successful in changing behaviour, but recent studies indicate that this may not be enough, and that the country needs to revitalise its HIV prevention strategy.<sup>2</sup> Botswana is experiencing difficulty in bringing about behavioural change in the population. Dianna Games highlights the two main obstacles to Aids

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<sup>1</sup> *Ibid.*, pp. 24, 25, 29. ---

<sup>2</sup> *Ibid.*, p.26.



control in the country: a cultural mindset that encourages risky behaviour and a lack of trained staff to carry out programmes.

Both Uganda and Senegal seem to have adopted a far more inclusive approach, co-opting not only religious authorities but traditional healers, the media, community organisations and people actually suffering from the disease. In this way, they have reached the public in widely assorted ways. Uganda, in particular, relied on low-tech social and personal communication to influence behavioural choices. ✓

As with all developmental challenges facing the continent, including Aids, it is not possible to reduce prevalence successfully by relying entirely on one particular actor or agency. As these case studies show, government, faith-based organisations, NGOs and communities all have a role to play in the national attempt to combat the disease, whether through input into policy-making, consultation at the grassroots level, caring for the sick or ensuring awareness of Aids even in the most remote villages.

The role of faith-based organisations and communities in dealing with the consequences of the epidemic should also not be underestimated. Clerics were very important in Senegal and were included in the government's strategy to combat the disease. Given that the public sectors in African countries have serious capacity constraints, more attention should be given by policy makers to what other actors in each African country can do to assist.

Already the private sector (especially the big multinational corporations) has begun implementing Aids prevention and treatment strategies in the workplace. South African companies, in particular, are at the forefront in this regard. At the International Conference on HIV/Aids and Sexually Transmitted Infections in Africa in December 2005, President Olusegun Obasanjo of Nigeria, who is chairman of the African Union, launched the Pan-African Business Coalition on HIV/Aids. He placed particular emphasis on the need for both the public and private sectors to work together to fight the epidemic. There are also joint efforts between Africa and the UN to develop ways of developing methods to monitor HIV/Aids for the African Peer Review Mechanism.

Some elements necessary for success include the following:

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- The state should acknowledge the existence of the epidemic early on, and recognise that decisive intervention is necessary.
- Strategies that are practical (given the resources available), effective, flexible and inclusive are required. Inclusivity ensures that communities working and dealing with Aids-related issues can use their particular experiences to make an informed input into policy making. It also ensures greater public ownership and awareness of the problem and the solution. Furthermore, donor programmes should complement the home-grown strategies.
- Strong political leadership and involvement are essential. It is far too easy to reduce the inability to tackle the problem to a lack of financial resources or capacity of one sort or another. While that is a significant constraint, the limited ability of an institution to provide treatment to all should not mean that it should not provide treatment to any. Political leaders should also convey very clear messages on the dangers posed by HIV and the actions that should be taken to prevent its spread.
- A balance should be maintained between promoting prevention and treatment. Prevention has tended to be sidelined in some cases because of a focus on increasing the number of people on ARVs. The latter is linked to the WHO's three-by-five campaign (that is, three million people on ARVs by the end of 2005, a target which has been missed).<sup>3</sup>
- Openness about sexual matters (and behaviour that exposes partners to risk) should be advocated.

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<sup>3</sup> In South Africa, a plan for comprehensive HIV and Aids care, management and treatment was adopted by cabinet in November 2003. It is estimated that ARV treatment is currently being supplied to some 150 000 people, of whom about 80 000 receive it through public hospitals. (About 550 000 need immediate treatment.) While the slow uptake in South Africa has been blamed partly on the capacity of the health services, the number of people coming forward to be tested has declined, which may be ascribed to an unwillingness among many people with HIV to be tested. Linking such plans to TB services, for example, could help to increase coverage. In contrast, Uganda has made substantial progress in expanding access to treatment. In mid-2005 it was estimated that more than one-third of people in need of ARVs were receiving them.

- Improving the cultural and economic status of women is also necessary. This is a longer-term process, but in Rwanda, for example, young women with secondary or higher education were five times as likely to know the main HIV transmission routes than were young women with no formal education.

The institutional weakness and limited human and financial capacity of most African states exacerbates the difficulties of adopting multidimensional approaches to prevent and treat the HIV/Aids epidemic. On the prevention front, there are stigmas, cultural taboos, gender inequalities and faith-based strictures which inhibit education on, and awareness of, the disease. Uncertain political leadership adds to the problem. These constraints also form part of the challenges of rolling out treatment. They are compounded by:

- the lack of medical infrastructure;
- high poverty rates, which equate to poor nutrition, which in turn results in vulnerability to opportunistic diseases;
- inadequate penetration of awareness campaigns into rural areas; and
- the expense of medication.

However, access to cheaper medication has improved in recent times, primarily through the efforts of private and public foundations and pharmaceutical companies (including those producing generic drugs). In some cases, though, higher drug costs are attributable to the imposition of tariffs on imported medicines. For example, the East African Community imposes a 10% tariff on imported medicines.<sup>4</sup>

In analysing the studies in this report, one is left with the overwhelming impression that the lists of things done and things to do can be compiled without end. The authors of these three case studies have tried to show us the result of all that activity as well as the thinking behind it. Have the programmes worked? How much was spent? Who did it affect? What should have been done instead?

The battle metaphor is used repeatedly throughout this volume. There are weapons and victories, communities are decimated, protected or sheltered, and strategies are devised using the best

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<sup>4</sup> Tren R, 'Africa's AIDS policy a barrier to treatment', *Business Day*, 17 February 2005.

intelligence gathered by trusted lieutenants who may be battle-hardened or new to combat with HIV. Though the idea of a showdown on some epidemiological battlefield is tempting, we are reminded by Sayagues' writing on Uganda that the battle, so to speak, must be won in every village and in every school, after skirmishes in Parliament and the mustering of researchers, NGOs and foreign donors. In the end, no single metaphor can explain the complex effects of the virus on our equally complex communities. There has been a recognition at the level of rhetoric of the need to combat Aids, but it is always more difficult to put those good intentions into effective practice. The experiences of the three countries examined in this report should provide some examples of good practice in fighting AIDS on the African continent.

I would like to thank the Konrad Adenauer Foundation for supporting this project, and in particular, Dr Thomas Knirsch and Ms Andrea Ostheimer. I am also grateful to my colleagues at SAIIA, in particular Mr Siphon Seakamela and Ms Nandile Ngubentombi, who both worked on the studies; to Mrs Anne Katz, our typesetter; Ms Leanne Smith, the publications manager; and Ms Pippa Lange, our external editor.

*Elizabeth Sidiropoulos*  
Series editor

# Botswana and the Fight Against HIV/Aids

Dianna Games

## Introduction

*We have had one-and-a-half decades of information, communication and education on HIV and Aids, emphasising change in sexual behaviour. Progress has been slow in the face of formidable barriers in the form of ignorance, denial and stigmatisation. Even so, there are indications that we may finally have made a breakthrough.*

President Festus Mogae<sup>1</sup>

Botswana is a country in the front line of the war against HIV/Aids in Africa. Southern Africa as a region has one of the fastest-growing infection rates in the world, and among these countries, Botswana has the highest prevalence.<sup>2</sup> In a population of around 1.6 million people, there are an estimated 350,000 infected people. When surveillance began in 1992, 18.1% of pregnant women tested positive for HIV. By 2002, this had increased to 35.4%. In terms of the country's most sexually active and economically productive sector of the population, that between the ages of 15–49, the incidence of HIV infection is stable at around 38.5%, one of the highest globally.<sup>3</sup>

The first case of HIV in Botswana was diagnosed in 1985. Since then, the numbers have been increasing rapidly. Whereas in 1989 the cumulative number of people living with HIV was 35, by 1996 it had

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<sup>1</sup> Mogae President Festus, Foreword, 'Towards an Aids-Free Generation', *Botswana Human Development Report 2000*, UNDP.

<sup>2</sup> In South Africa, Botswana's powerful neighbour, UNAIDS estimated that by the end of 2003, it had a prevalence rate of 21.5%, which, while lower than Botswana's, means 5.3 million people are living with HIV — more than in any other country in the world.

<sup>3</sup> UNAIDS, [www.unaids.org](http://www.unaids.org).

risen to nearly 4,000.<sup>1</sup> By the end of 1999, at least one in four adults in Botswana was living with the virus, and by 2003 it was estimated to be one in three. The Joint United Nations Programme on HIV/Aids (UNAIDS) estimates that about 85 people are infected with HIV every day, and one in eight babies is born with it.

Botswana, which has one of the smallest populations in Africa relative to its size, has one of the lowest growth rates (currently 0.9% per annum, as against an estimated rate of 2.8% per year in a population unaffected by Aids). As a result of Aids, the number of inhabitants in 2021 will be 29% smaller than it would otherwise have been.<sup>2</sup> Life expectancy has also been considerably reduced, from 56.1 years in 1979–1979 to 39.7 in 2000–2005. It could go below 30 years by 2010 at current rates of infection.<sup>3</sup>

Despite what appears at first sight to represent a rather dismal record for the government's fight against the pandemic, Botswana is included in the Best Practice series of reports for several reasons. One of these is that Botswana is generally considered to be the top performer on the continent in both economic and governance terms. It has had real per capita GDP growth averaging 7% for the past 30 years, and its per capita income of \$3,500 is one of the highest on the continent. Its mining sector is showing high returns, and the government is starting to diversify the economy in response to concerns that it is over-dependent on mining (which accounts for one-third of GDP and around 70% of exports). The administration continues to maintain a market-friendly operating environment and sound macro-economic policies. Botswana is politically stable and, in 2004, held a trouble-free general election which saw Mogae being returned to power.

The country's achievements have been widely acknowledged. At the 2002 World Economic Forum (WEF) meeting in South Africa, Botswana's public institutions were proclaimed to be the best in Africa in terms of their quality, low levels of corruption and respect for the rule of law. The WEF's 2003–2004 Africa Competitiveness Report

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<sup>1</sup> Botswana 2000 HIV Sero-prevalence and STD Syndrome Sentinel Survey, published by the National Aids Co-ordinating Agency, Botswana, December 2000.

<sup>2</sup> Greener R, Jefferis K & H Siphambe, 'The Macro-economic impact of HIV/Aids in Botswana', *Aids Analysis Africa*, 11, 5, University of Natal, February/March 2001.

<sup>3</sup> 'Survival: Progress and setbacks', *Human Development Report 2003*, UNDP.

ranked it number one in terms of factors such as macroeconomic policy, quality of public institutions and infrastructure; the United Nations 2003 Economic Report on Africa named it the best-performing country in Africa; and it has, for the past few years, been listed by Transparency International as the least corrupt country on the continent. Botswana has also had consistently good sovereign credit ratings from international agencies such as Standard and Poor's and Moody's, and these ratings remain stable despite the economic threat posed by the Aids pandemic.

The second reason to include Botswana in a Best Practice series is that the government acted quickly to address the HIV/Aids problem once it had been identified. However, some critics have claimed that while the administration responded quickly, the actions it took at the time did little to prevent a rapid increase in infections in the late 1980s and early 1990s. But, by the same token, Botswana has been more proactive than most countries in tackling the epidemic. It also provides a good example for other countries faced with the same problem of what means can be used to arrest the spread of infection in the early stages.

Thirdly, and in the same vein, the government has, over the last 10 years, taken comprehensive and innovative steps to arrest the infection rate; raise awareness of the perils of the virus and how it is spread; assess prevalence to better determine a course of action to halt transmission; and treat those already infected. It is the first country in Africa to have introduced antiretroviral therapy (ART) through its public health system, and also the first to offer the drugs free of charge.

An important aspect of the third point is that once the extent of the rise in infection became evident through more intensive studies and monitoring, the government quickly realised it did not have the means to deal with the problem alone. This led it to take advantage of international expertise and practice in the mid to late 1990s. It now has a range of broad-based partnerships with international organisations and with local non-governmental organisations (NGOs), and has widened the net to include a multi-sectoral approach to the issue within government itself.

As a consequence of the government's efforts, the prevalence of sexually transmitted diseases has shown a marginal decline in some

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age groups over the past two to three years. Overall, the figures are starting to stabilise, despite indications that new infections are still taking place.

That Botswana has a small population has been an advantage in fighting the spread of the disease. But the relatively low rate of urbanisation and the fact that most of the population lives in the rural areas, where it can be harder to change attitudes, have not helped the fight. Botswana's geographical size has also made access to rural areas, where there is a high infection rate, more difficult and extremely costly in terms of resources, training and so on.

The costs, in social and economic terms, to the country of HIV/Aids are potentially enormous. The pandemic is leading to the breakdown of family support mechanisms and family units, which in turn contributes towards the spread of the disease. Aids is eroding savings, which are being used to cope with expenses such as medical bills and funeral costs. It is also weakening the most economically productive people in the population and leading to a much greater financial burden on the country in terms of recruitment, training and overall productivity.

Fortunately, the country's largest source of employment outside the public sector is the capital-intensive diamond mining industry. This means that Aids deaths are likely to have a less crippling effect than in labour-intensive industries. The largest private sector employer, the diamond mining company *Debswana*, is also a world leader in tackling HIV/Aids in the workplace. It has moved swiftly to stem new infections among its workers, and to treat those already infected. (See the case study below.)

One of the strongest weapons in the battle against Aids in Botswana has been the leadership of the president, who has used public platforms both at home and abroad to spread the message that Aids is a deadly threat to the survival of his country. He has also taken an Aids test publicly to show his people that everyone is at risk, and that there should be no stigma attached to being tested for the virus.

The HIV/Aids pandemic has undermined many of the gains Botswana has made as a developing country. As Mogae says:<sup>4</sup>

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<sup>4</sup> Mogae, Botswana Human Development Report, *op. cit.*



Our social safety nets have proved equal to the worst droughts Botswana has experienced as a sovereign state. We have, to a large measure[,] overcome illiteracy, malnutrition and children's diseases and accorded our people accessible quality health service. We have reduced both the magnitude and prevalence of poverty. We have had tremendous success against livestock diseases. Compared to HIV and Aids, these challenges were minor.

However, he forecasts that apart from providing services and drugs to those already infected, what is now required of Botswana is a social revolution.<sup>5</sup>

We need to refrain from behaviour that aids the spread of HIV. This includes intergenerational sex between adults and minors, unprotected sex, maintaining multiple sexual partners and failure to get timely treatment for sexually transmitted diseases. All sexually active people need to go for voluntary HIV testing and counselling. There is also an urgent need to address the structural determinants of the epidemic — poverty, gender inequality and socio-cultural beliefs — with greater resolution. I urge Botswana not to allow culture and religion to be encumbrances.

## **The Government's Role in Fighting HIV/Aids**

As already noted, Botswana's first case of Aids was reported in 1985. The following year, the public health service began screening blood to eliminate the risk of HIV transmission through blood transfusions. In 1989, the government upgraded its programme to a second-stage response by introducing the first Medium Term Plan (1989–1993). The initial phase entailed prevention of HIV transmission through sexual and other means, the strengthening of diagnostic management and infection control, and the introduction of epidemiological surveillance and monitoring.

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<sup>5</sup> *Ibid.*

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| <b>Age-specific prevalence rates among pregnant women (%)</b> |              |              |              |              |              |              |
|---|--------------|--------------|--------------|--------------|--------------|--------------|
| <b>Year</b>   | <b>15-19</b> | <b>20-24</b> | <b>25-29</b> | <b>30-34</b> | <b>35-39</b> | <b>40-44</b> |
| 1992  | 16.4         | 20.5         | 19.4         | 16.5         | 13.5         | 9.3          |
| 1993  | 21.8         | 27.1         | 24.2         | 16.8         | 13.3         | 9.4          |
| 1994  | 20.7         | 31.5         | 30.2         | 18.0         | 11.8         | 8.0          |
| 1995  | 32.4         | 34.8         | 32.6         | 33.5         | 11.1         | 15.0         |
| 1996  | 27.2         | 40.9         | 34.0         | 32.0         | 25.0         | 20.0         |
| 1997  | 28.0         | 41.4         | 41.0         | 33.3         | 39.0         | 23.1         |
| 1998  | 28.6         | 42.8         | 45.2         | 38.2         | 33.3         | 23.9         |
| 1999  | 21.5         | 38.7         | 43.3         | 42.0         | 33.3         | 25.5         |
| 2000  | 25.3         | 41.0         | 52.6         | 49.6         | 41.9         | 34.9         |

Source: STD/Aids Unit, Ministry of Health

In 1992, the government began detailed surveillance for HIV/Aids, targeting pregnant women attending antenatal clinics and male patients being treated for sexually transmitted diseases (STDs). Since then it has participated in a number of major sentinel surveys to determine both the prevalence of HIV/Aids and other STDs. Also in 1992, the government renamed its Sexually Transmitted Diseases Unit the Aids/STD Unit to refocus its efforts. However, it has been criticised for not providing specific funding to the Unit to combat HIV/Aids. Plans to control the disease received little financial support, despite the evidence that infections were spreading rapidly.<sup>6</sup> For example, HIV prevalence among pregnant women grew from 23.7% to 42.7% in Francistown from 1992-1999, and from 14.9% to 37.1% in Gaborone during the same period.<sup>7</sup> Similar increases were observed in other parts of the country surveyed during 1999; prevalence in Chobe rose to 50.8%.

<sup>6</sup> Ntseane D, 'HIV/Aids spending in Botswana', *Idasa Aids Budget Unit Research Reports*, February 2002.

<sup>7</sup> Botswana 2000 HIV Sero-prevalence and STD Syndrome Sentinel Survey, Botswana Government's Aids/STD Unit, December 2000.

In 1993, a revised National Policy for HIV/Aids was drawn up which broadened the approach to the problem. Its provisions involved the efforts of not only the health ministry but also other government departments, NGOs, and groups from the private sector and the community. The plan was dependent on the involvement of development partners and international organisations, notably UNAIDS and the UN Development Programme. The plan introduced five levels of policy: national, district, civil society, the armed forces (defence force, police and prisons service) for peer counselling, and applied research.<sup>8</sup>

Policy at the national level included establishing a focal point for co-ordination of all HIV/Aids-related projects in each ministry, and increasing policymakers' awareness of the disease and the related development needs it created. It also involved setting up management and information systems at both national and district levels to collect and analyse data for policy and programme development. The district level plan included the decentralisation of programmes to each district and then to the village context. Civil society was called in to participate in support activities, primarily through NGOs.

A second Medium-Term Plan (1997–2002), which expanded on the first one and called for political leadership and consolidation, was introduced. Its three objectives were reducing the HIV/Aids transmission rate; providing adequate care for HIV/Aids patients; and mitigating the social and economic effects of the epidemic.

In 1999, a pilot project for the prevention of mother-to-child HIV transmission was started. This was later expanded into a nationwide programme. In 2000, the first Tebelopele Voluntary Counselling and Testing (VCT) centre was opened, the first of 15 such facilities planned by the government. It also introduced a community home-based care programme and a TB prevention programme for HIV-infected people. Botswana was one of the first African countries to provide the latter. Many innovative education and awareness communication strategies were introduced, such as the 100-episode Makgabeng radio drama

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<sup>8</sup> Ntseane D, *op. cit.*

series focusing on HIV/Aids issues, which is designed to inform listeners and bring about behavioural change.<sup>9</sup>

At the political level, the National Aids Council (NAC), chaired by the president, and its secretariat, the National Aids Co-ordinating Agency (NACA), were established in 2000. These bodies were given responsibility for co-ordinating a multisectoral national response to the pandemic. District Multisectoral Aids Committees were also established.<sup>10</sup>

Although the government had acknowledged HIV/Aids as a national emergency by the late 1990s, and had thrown its full support behind initiatives to deal with it, there had been no decline in the severity of the epidemic by 2001. Mogae, in his 2001 budget speech, declared it to be 'the most serious challenge facing our nation and a threat to our continued existence as a people'.

At the beginning of 2002, the government began its anti-retroviral drug therapy (ART) programme (see details below), in partnership with international organisations. In 2002/03, of the \$45 million the government earmarked for HIV/Aids expenditure, more than half was allocated to ART expenses.

In 2003, NACA, in collaboration with the government's Aids/STD unit, the Botswana Project, District Health teams, the World Health Organisation (WHO) and the Botswana Harvard Partnership released the Second Generation HIV Surveillance Report.<sup>11</sup> The findings include the following:

- in the key 15–49 age group, more women than men were found to be infected;
- the highest prevalence was in the 25–29 year old age group, at about 50% for the three years up to 2003;
- the lowest rates were in the women's 15–19 year old age group, in which infections had peaked in 1995, decreased over the next four years and remained stable after 1999;

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<sup>9</sup> *Ibid.*

<sup>10</sup> *Ibid.*

<sup>11</sup> See The African Comprehensive HIV/Aids Partnerships (ACHAP) website on [www.achap.org](http://www.achap.org) for details.

- in the 20–24 year old age group, HIV prevalence reached its highest point in 1998, declined the following year and has remained unchanged since 1999;
- there has been a steady increase of infection in the 25–49 year old group since 1992, although the rate appears to have stabilised since 2000;
- HIV prevalence in pregnant women was reported to be levelling off, showing a slight decrease from 36.2% in 2001 to 35.4% in 2002;
- the first sexual act encounter was reported as generally occurring at 19 years for boys and 18.7 years for girls;
- general awareness of HIV/Aids was reported to be at more than 90%, although this had not translated into changes in sexual behaviour;
- the highest concentration of people suffering from the disease occurs in Gaborone, Kweneng East, Serowe/Palapye, Francistown and Tutume;
- there is no relationship between the level of education and HIV prevalence;
- there is little variation in HIV incidence between employment categories, because in five districts it was highest among those with regular employment while in seven other districts it was highest among the self-employed; and
- the occurrence of infection was essentially the same in urban and rural areas.

NACA attributes the high HIV/Aids prevalence in Botswana to the following social factors.

- **High levels of sexually transmitted infections:** The prevalence of STDs increases vulnerability to HIV.
- **Family and communal disruption:** People are often separated from their families for extended periods. This is due to the extreme scarcity of skills in various parts of the country, and the consequent forced relocation of government staff and company employees to rural areas to improve efficiency.
- **High mobility:** Many Batswana possess more than one home (they can have up to four residences) and circulate between them,

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particularly over long weekends. The presence of different sexual networks in each of these locations could increase the likelihood of infection.

- **Disintegration of traditional family patterns:** The majority of pregnant women in Botswana are single (almost 80% of HIV-infected pregnant women surveyed in 2001 by NACA were unmarried, and 12% of these were students), which indicates that many Batswana have short-term relationships and have more than one sexual partner.
- **Violence and sexual abuse:** The incidence of rape and domestic violence, including marital rape, is increasing.
- **Lack of recreational facilities:** Not many active youth recreation programmes exist. This means that there is a higher chance that young people (and Batswana generally) will spend leisure time involved in risky behaviour, such as visiting bars, drinking, and having unprotected sex.
- **Availability of alcohol:** Low alcohol prices combined with lenient law enforcement regarding the sale of spirits to minors, makes it easy for the young to buy and consume alcohol, which in turn leads to other forms of high-risk behaviour.
- **Denial:** Despite the high rate of infections, only a handful of people have publicly acknowledged being HIV positive. There is still a major social and moral stigma attached to the condition.

Although condoms have been widely advertised and are commonly available, the public's response is not as good as it could be. Some research suggests that condom use is as high as 85%, but that it is random and not routine, which to some degree defeats the purpose. The government, in partnership with the African Comprehensive HIV/Aids Partnerships (ACHAP), now plans to install 10,500 condom dispensers that will provide free condoms to the public. However, this will not be effective unless people use them every time they have intercourse. A survey published in a research report in 2003 found that 32.8% of women surveyed always ensured a condom was used, 41.6% sometimes did, and the highest number (43.9%) never did.

Among the men who took part in the survey, 23% always used one, 33.7% sometimes used one and 39% never did.<sup>12</sup>

The government recently introduced a country-wide plan that makes testing for HIV part of routine medical screening for all people entering the public health care system (see details of the 'opt out campaign' below). The main aim was to destigmatise HIV testing by making it normal and routine practice rather than something apart, which might single out the person taking it or arouse suspicion in the person's family or friends. But it is also a major step toward obtaining more information about people's HIV status, which will then make it possible for treatment or preventative measures to be introduced. Currently, it is estimated that only about 100,000 of the country's inhabitants have been tested.

## **Public–Private and International Partnerships**

The government has relied increasingly on partnerships with, and support from, development partners and international organisations to help it fight the pandemic. Their contributions cover a wide range, from training and counselling to providing infrastructure and ARVs. According to one research report, between 1997 and 2004, development partners will have invested about \$44 million in HIV/Aids-related programmes. Most of this funding was pledged or used in 2002.<sup>13</sup>

The government's most important partners are listed next.

- **The United Nations** is heavily involved in the country's overall HIV/Aids programme through a number of its agencies including UNAIDS, the UN Development Programme (UNDP), the UN Population Fund, UNICEF and the WHO. The Botswana government and the UNDP signed the HIV/Aids Programme Support Document in 1997. It was evaluated in 1999 and given an extension for

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<sup>12</sup> Botswana 2003 Second Generation HIV Surveillance Report compiled by NACA, the government's STD/Aids Unit, the Botswana project, District Health Teams, the Botswana Harvard Partnership and the World Health Organisation.

<sup>13</sup> Nteane D, *op. cit.*

completion in 2002. The programme supports both the National Policy on HIV/Aids introduced in 1993 and the second phase of the national multi-sectoral plan launched in 1996.

- The **Africa Comprehensive HIV/Aids Partnership** is a collaborative public–private partnership between the Botswana government, the Merck Company Foundation and the Bill and Melinda Gates Foundation. In 2000, the Gates Foundation announced that it intended giving \$50 million to Botswana’s battle against Aids. The aim of the donation was to strengthen the primary health care system in the country. The contribution was matched by the pharmaceutical manufacturer Merck & Co, through the Merck Foundation. The latter’s contribution includes the provision of two kinds of ARV for the duration of the initiative. The \$100 million partnership effort is being co-ordinated with the government of Botswana.<sup>14</sup> The programmes aim to strengthen local capacity, improve health care infrastructure, transfer technical skills, and introduce prevention measures such as disease awareness and education, which will also help reduce the stigma attached to the infection.
- The **Botswana–Harvard University Partnership** runs a National STDs and Research Centre focusing on the prevention of mother-to-child transmission, the treatment of Aids and the development of a vaccine. It has a research laboratory in Gaborone and is also involved in training health care workers. Established in 1998, the programme costs about \$1 million a year.
- The **Baylor College of Medicine**, based in Texas, and the pharmaceutical company **Bristol-Myers Squibb** have funded a \$9.7 million centre for children with Aids in Gaborone.
- Other participants in the campaign against Aids include **BOTUSA**, a partnership between Botswana and the Centre for Disease Control and Prevention (CDC) in the US, the European Commission, the German Technical Co-operation Agency, the Swedish International Development Agency and China.

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<sup>14</sup> ‘Gates Foundation gives \$560m to Botswana Aids battle’, 10 July 2000, [www.gatesfoundation.org](http://www.gatesfoundation.org).



- The European Commission and UK Department for International Development provide support for regional programmes that also benefit Botswana.

There are also a number of global funding initiatives which include Botswana in their programmes. The most notable among these is the commitment made by President George Bush to spend \$15 billion over five years (2004–2008) to fight HIV/Aids. Of this sum, \$10 billion is new money. This is to be spent in 15 countries worldwide, selected, according to the US, on the basis of HIV infection rates and the institutional capacity of individual countries to deliver care. Of these, 12— Botswana, Cote d'Ivoire, Ethiopia, Kenya, Mozambique, Namibia, Nigeria, Rwanda, South Africa, Tanzania, Uganda and Zambia. — are in Africa.

Botswana is also likely to benefit from other initiatives such as the Global Fund, which was set up to fight Aids, tuberculosis and malaria. The Fund was formed as an independent public–private partnership after the G8 Summit in Genoa in 2001, at the suggestion of the UN Secretary-General, Kofi Annan. By October 2003, it had approved \$2.1 billion in funding, to be disbursed in stages. The Clinton Presidential Foundation has set up a deal with the UN, UNICEF and the World Bank to enable developing countries to buy generic drugs from five companies at reduced prices negotiated by the Foundation. This arrangement is also likely to benefit Botswana.

## **Botswana's Anti-Retroviral Programme**

Currently, ARVs are being dispensed in Botswana to more than 34,000 people, of whom 27,000 are acquiring them through the public health system. Another 7,000 receive them through private means such as medical aids or private payments. The cost of diagnostics ranges from \$500 to \$1,500 per patient per year, depending on what treatment they receive and how ill they are when they begin such treatment. HIV positive children qualify for ARV treatment, as do people with a CD4 count<sup>15</sup> below 200 or an Aids-defining illness.<sup>16</sup>

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<sup>15</sup> A measure of the strength of the immune system.

### **Global Best Practice**

The first HIV care ward was set up in the Princess Marina hospital in Gaborone. There are now 29 centres across the country that dispense treatment (on a monthly basis), and another three are to be built by January 2005. The next phase in the new fiscal year (2004/05) is the roll-out of ARVs to community clinics, which currently provide only screening and follow-up services to stable patients.

As mentioned above, the Merck–Gates programme, under ACHAP, is funding a portion of the ARV roll-out, and Merck provides two kinds of ARV to be used in government-run programmes. To date, that partnership has spent \$12–15 million on the ARV programme, although the government is funding 90% of the total amount being spent. The costs of the first few years of roll-out are much higher when the expenses involved in setting up infrastructure to dispense the drugs are taken into consideration. This, according to at least one report, pushes up the cost of ARV provision to around \$7,000 per patient per year. However, while the amounts of money involved are enormous, the government has anticipated this aspect from the outset, and has planned for the programme to be sustainable despite the costs.

Over the long term, the government is hoping for reductions both in the prices of available drugs and in the numbers needing them. However, it has said that it is committed to the programme and will review its financing mechanisms on a regular basis. It is also repositioning its health services model towards primary care, changing its former emphasis on donors and highly trained staff to a focus on developing skills in lower-level staff who can act as care-givers. This is a cheaper way of using resources, and is more feasible as a long-term option in the local context.<sup>17</sup>

But those involved in rolling out the programme say that what is at issue is much more than the cost of the drugs themselves, and getting people to register with the available treatment programmes. The other side of the story is the need to develop capacity, both in terms of staff training and counselling and in terms of building infrastructure suitable for the provision of services to HIV positive people.

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<sup>16</sup> Interview, Ernest Darkoh, Director, Botswana Anti-Retroviral Programme.

<sup>17</sup> Darkoh, *op. cit.*

Botswana is the second African country to have adopted such an extensive ARV programme, and the first to offer ARVs free through its public health system. Only in June 2004 did Uganda start to offer free ARV medication to people with Aids.<sup>18</sup> Uganda, on the other hand, ran one of the first pilot ARV programmes in Africa, a two-year project between 1998–2000, which aimed to find out how such an initiative could be set up and carried out in a resource-poor country. In terms of the study, the 399 patients involved paid for their treatment and bought their drugs at negotiated reduced prices. At the end of the two years, the patients were reported to have shown good adherence to treatment. Their virological and immunological responses to ARVs were similar to those found in Western countries. The Ugandan Ministry of Health has since incorporated the essential elements of the scheme into its National Strategic Framework for HIV/Aids. At the end of 2003, out of 110,000 people needing treatment, the Ugandan Ministry of Health claimed that 25,000 were being treated. The Ministry's aim is to increase this to 47,500 by the end of 2005.

## **Economic Impact**

Botswana's economic growth over several decades, and its success in addressing poverty, malnutrition and unemployment means that it has been less hard hit by the HIV/Aids crisis than might have been expected. It has been balancing its budgets without external assistance since the early 1970s; and between 1970 and 2003 it has experienced annual economic growth of around 7%. In 2002/03, real GDP grew at 6.7%. Its mining sector is booming, and concerted efforts are being made to diversify the economy.

But research has shown that, notwithstanding its strong economy, Botswana will not escape serious economic fallout because of the scale of the epidemic. One study, conducted by the Botswana Institute for Development and Policy Analysis (Bidpa) in 2000, forecast that the economy, in the decade to 2010, would be 31% smaller than it would have been had the disease not afflicted the country (although growth

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<sup>18</sup> AVERT, *op. cit.*

## **Global Best Practice**

would still take place).<sup>19</sup> The report predicted that HIV/Aids would reduce GDP growth by 1.5% a year, and that there would be a 12–17% rise in wages for skilled workers resulting from a shortage of such labour.

The Bidpa survey also estimated that up to one-half of all households in Botswana were likely to have at least one infected member, while a quarter could expect to lose an income earner. There would also be a rapid increase in the number of very poor and destitute households, with an 8% fall in the per capita incomes of national households, and a growth of 5% in the number of people living in poor households. Again, the report projected that in addition to a drop in income, poorer households would also have to support an extra four dependants as a result of HIV/Aids. Spending on recruitment, training, health, support for Aids orphans<sup>20</sup> and destitution-relief by the government was expected to rise by 15%. The Bidpa survey estimated that government expenditure would increase by between 7% and 18% in the next decade because of the social and economic effects of Aids.

In addition, since GDP is projected to be 20% lower after 10 years than it would have been had the Aids pandemic not occurred, the revenues from both the Southern African Customs Union (SACU) and income and sales taxes would be expected to decline by a similar amount. The resulting deficit pressure is also likely to reduce interest income from the Bank of Botswana by about 24% at the end of 10 years, according to the report. The net result is that government revenues are expected to be about 10% lower after 10 years than they would have been. Combined with the finding that expenditure will be an average of 12% higher, we may conclude that Aids will have an impact on the government budget equivalent to a reduction in revenue of over 20%.<sup>21</sup>

There are some positive advantages for Botswana when its situation is compared with that of most other African countries. Firstly, it has a high level of domestic savings, which will help to mitigate the

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<sup>19</sup> 'Macroeconomic Impacts of the HIV/Aids Epidemic in Botswana', Botswana Institute for Development Policy Analysis, May 2000.

<sup>20</sup> The UNDP estimates that by 2010 there will be between 159,000 and 214,000 Aids orphans in Botswana. See <http://www.unbotswana.org/bw/undp/hiv aids.html>.

<sup>21</sup> *Ibid.*

deleterious effects of the pandemic on investment and, in turn, on economic growth. In the past 10 years, gross domestic saving has been more than 40% of GDP, while gross investment has been below 30%. Secondly, production in Botswana is more capital- than labour-intensive, particularly in the diamond mining industry; therefore, the effects of a loss of employees are likely to be less damaging than for many other countries. Again, Debswana has adopted innovative ways of tackling both the spread of the virus and containing its effects. This means Botswana's main source of revenue is less likely to be vulnerable to the effects of HIV/Aids than other sectors, which may be much more severely damaged, possibly undermining the government's attempts at diversification.

However, although investment is not expected to be directly undermined by the pandemic in terms of eroding savings, the investment climate could be altered by increasing uncertainty in the private sector over the availability of skilled labour; reduced profits due to high recruitment and training costs; and the rising levels of crime that could arise if Aids orphans are not provided for.<sup>22</sup>

Analysts suggest that the key areas of focus for the government should be growth in skilled labour, investment and productivity. Policy efforts should be directed at maintaining investor confidence, particularly in the private sector. The government may also need to collaborate with the private sector to share training costs, and encourage firms to plan ahead to counter possible losses of highly-trained employees.

Although the private sector as a whole has been slow to introduce workplace initiatives sufficient to combat the spread and effects of HIV/Aids, the situation has improved over the past few years, partly as a result of the awareness programmes introduced by the government in 2000. A number of companies now offer Aids ARV awareness courses and treatment to employees. There is also a heightened consciousness of the need to re-examine training and skills issues in preparation for a possible rise in deaths among key members of the work force.

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<sup>22</sup> Greener R, Jefferis K & H Siphambe, 'The Macroeconomic impact of HIV/Aids in Botswana', *op. cit.*

## **Global Best Practice**

One of the companies that exemplifies best practice in its HIV/Aids employee programme is Debswana (see box). Others that have been singled out as having exemplary workplace programmes are Barclays, the Botswana Power Corporation and the Botswana Telecommunications Corporation.

### **Debswana – Corporate best practice in the fight against HIV/Aids<sup>23</sup>**

Debswana, the diamond mining company, which is Botswana's largest employer after the government and has 6,500 staff members, is a global leader in the fight against the HIV/Aids pandemic in terms of corporate policy. It has introduced a proactive and enlightened workplace strategy to counter the impact of the virus on such issues as productivity and staffing.

Debswana, which was the first company in the world to issue ARVs free to its employees, was recognised as a 'global benchmark' company in the UNAIDS case study on private sector response to HIV/Aids that was published in September 2002. A number of leading companies have sought Debswana's advice on how to stem the spread of HIV/Aids in their workforces.

The death rate from Aids-related causes among Debswana's workers increased steadily from 1996–2000. Since then it has declined, as the company's efforts have begun to bear fruit. The company's campaign against HIV/Aids began in 1988/89 after the first cases were recorded at the Jwaneng mine hospital in 1987.

The company realised it needed to act quickly if it wanted to hold back the tide of HIV/Aids. As a result, in 1991/92, it employed full-time HIV/Aids Programme Co-ordinators at its Jwaneng, Orapa and Letlhakane mines and in 1996, launched its Aids Management Workplace Policy.

While HIV/Aids programmes originally fell under the company's health and safety guidelines, an institutional audit identified the need to develop a separate strategy for HIV/Aids, in order to give it greater attention.

A task team was put together to develop a programme, which was included in overall corporate strategy in October 2000. In 2001, the 1996 Aids Management Workplace Policy was revised to encompass its ART programme. The drugs are also available to the (legally married) spouses of employees.

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<sup>23</sup> See [www.debswana.com](http://www.debswana.com).

**Debswana — Corporate best practice in the fight against HIV/Aids  
(continued)**

The company says its policy is clear: There should be no discrimination against infected employees; nor should there be pre-employment testing. It also emphasises the importance of education and information dissemination through support structures such as home-based care providers, counsellors and peer educators.

***Prevalence studies***

Between 1996 and 1999, the company began to experience the effects of increased levels of disease and mortality attributable to HIV/Aids among its workforce. A significant percentage of retirements due to ill health over this period, 40% in 1996 and 75% in 1999, were Aids-related.

The percentage of deaths attributable to Aids in 1996 was 37.5%; in 1997 it was 48.3%; and in 1999, 59.1%. The company therefore decided to determine the level of HIV incidence among its employees to assist in planning risk-reduction strategies. A saliva test survey, conducted among 75% of the work force, showed that 28.8% of the company's 5,261 employees were infected with the virus.

A second survey, in which 74% of the workforce participated, was conducted at seven Debswana sites in June/July 2001. The prevalence rate was found to be 22.6%. The third survey (56% participation) was conducted in June 2003 at the six Debswana operations, and combined with a blood test survey (38.8% participation). The prevalence rate as determined by the saliva tests was 19.8%, and by the blood tests, 20.1%.

The company subsequently identified six strategic focus areas for action. These were:

- *epidemic containment*, a strategy for preventing new infections among employees and their families, with a specific focus on young people and the community;
- *economic impact containment*, a strategy for minimising the financial burden on the company through proactive planning for the various HIV/Aids-associated impact indicators such as deaths, absences due to illness and retirements due to ill-health, accompanied by targeted succession planning, particularly in core jobs;

**Debswana — Corporate best practice in the fight against HIV/Aids  
(continued)**

- *living with Aids*, a strategy for minimising the effect on employees living with the disease, which included ARV treatment;
- *stakeholder engagement*;
- *evaluation measurement and monitoring*, a strategy for the regular evaluation of the effectiveness of the company's HIV/Aids programmes and the measurement and monitoring of HIV/Aids impact indicators; and
- *communication*, a strategy to support the HIV/Aids programmes and to improve awareness of these and other initiatives, both internally and externally.

The company also has a contractor strategy in terms of which all companies wanting to do business with Debswana are required to actively support its HIV/Aids policies. This enables it to have some influence outside its immediate sphere.

ACHAP is supporting efforts by The Botswana Business Coalition on HIV/Aids (BBCA) and the Botswana Confederation of Commerce Industry and Manpower (BOCCIM) to develop an HIV/Aids Unit to support companies who are interested in developing programmes and policies, pooling resources, sharing their experiences and applying existing government programmes in the workplace. The objective is to help small and medium-sized businesses in Botswana to follow best practices established by their larger counterparts, and to develop effective in-house programmes of their own.<sup>24</sup>

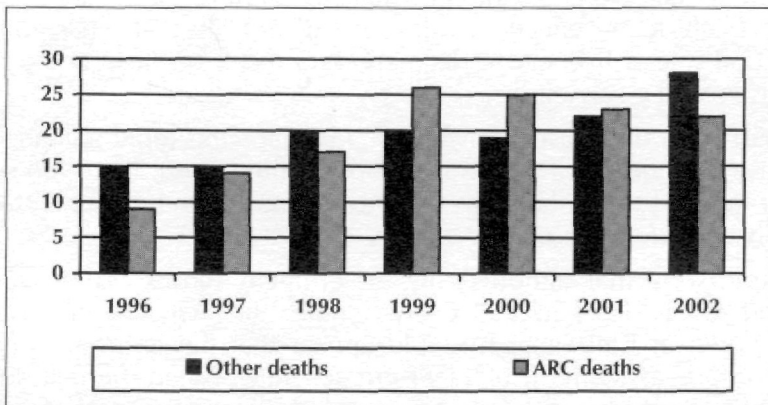
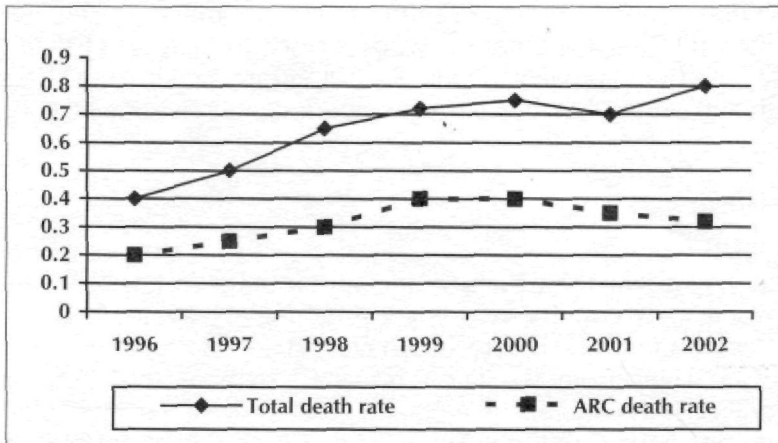
Botswana is also supporting the Global Business Council on HIV/Aids and its 'opt out' campaign, launched in February 2004, which calls for a dramatic increase in HIV testing and counselling services. This changes the focus of current approaches towards HIV testing (which regards it as a strictly voluntary procedure) to one in which individuals are routinely offered HIV tests, although they have the option of refusing.

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<sup>24</sup> See [www.achap.org](http://www.achap.org).



Debswana death rates 1996–2002



ARC: Aids-related causes of death

Source: Debswana

### *Global Best Practice*

The Council claims that the new model shifts the burden of establishing a person's HIV status from the individual to the health and community service providers, thus removing much of the fear and responsibility felt by a person who decides to take an HIV test. The success of the campaign depends on a strong signal from the public health authorities that they strongly recommend everyone take the test.

### **Conclusion**

After examining the evidence, the author believes it is fair to say that Botswana as a country is doing everything it can to deal with the HIV/Aids pandemic. The results have yet to be really felt, although there are signs from the latest research, such as the 2003 Second Generation HIV Surveillance Report, that prevalence rates across all age groups have stabilised. This is particularly notable in the younger age groups, from 15–24 years, at which concerted efforts at prevention through education and awareness have been directed because they are more likely to be effective. But it is still not clear at what point the infection rate will begin to decrease as a result of these broad-based, inclusive and costly efforts.

Apart from the reasons given by NACA for the rapid spread of the disease (outlined in a previous section of the paper), there are several other factors that explain why the programme has not so far shown the results one could reasonably expect.

The **first** is that although the government moved to contain the spread of the virus in 1987, a year after the first case of Aids was discovered in Botswana, it would appear that the criticisms of those early efforts as being insufficient are accurate. When the first detailed surveillance study was done in 1992, prevalence was already high. What have now emerged as two of the key objectives—creating awareness of the virus and encouraging behaviour change—were not central to the early campaign. Even now, with the government, private sector, NGOs and international agencies co-ordinating a massive programme of treatment and education, the rate of new infections remains high.

The **second** is that despite the very directed and widely disseminated efforts of the past five years or so, there is still too little evidence of behavioural change. It appears that people at risk remain caught up in issues of tradition (including a tendency to visit traditional healers rather than doctors, which takes them out of the testing loop), religion and fear. The stigma of being infected is still strong, even though it is slowly being eradicated. Many people believe that if they are likely to be given a 'death sentence' they would rather not know whether they are HIV positive or not. And even though ARVs can make a dramatic difference to the life expectancy of those who are HIV positive, it is still only a minority of those infected who have access to the drug at present.

Women, who are the worst hit by the virus, have been particularly disadvantaged by the fact that many men refuse to be tested or to use condoms, and also forbid the mothers of their children to feed babies on formula, insisting on breastfeeding. However, health practitioners have reported that as people become more open about HIV/Aids and accept testing as routine, women have also become more assertive about insisting on their male sexual partners being tested as well. Although the use of condoms has increased, those involved in counselling say there is still a stigma attached to their use, because they were introduced at the same time as a dreaded unknown disease and therefore have negative associations with it. Also, many of those who knew of Aids thought of it as a homosexual disease (as it was in the early stages in western countries), and did not want to be associated with such behaviour.

The **third** main reason for the continuing spread of the virus is a lack of capacity to carry out the government's programmes, which lessens their effectiveness. It is increasingly clear that the problem is not about money but about having sufficient numbers of trained staff to offer services that range from health care to administration (of the increasing number of testing and treatment centres) to counselling. Gaborone's Princess Marina Hospital is one of the biggest HIV centres in the world, and is responsible for dispensing drugs and advice to more than 6,000 people. The staff cannot keep up with the demand from these patients, let alone treat those with other illnesses. Even as Botswana negotiates with countries such as Cuba for doctors, their own medical

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practitioners are being drawn away by other countries.<sup>25</sup> Their citizens' fear of testing also means that many people arrive at the clinics and hospitals only when they are already critically ill, a further drain on resources and manpower.

The lack of capacity has also affected the provision of a range of services at the village and district levels. It has been difficult to get the district committees to function properly, for reasons which include insufficient training, focus and funding. The implementation of the government's service policy appears to be directed at the national level, in the hope that it will have a trickle-down effect.<sup>26</sup>

Botswana, at this stage, has probably done as much as it can to prevent the spread of HIV and manage the consequences of infection and illness. It provides widespread education and awareness campaigns, condom distribution and education; strategies to prevent mother-to-child transmission; increasing numbers of voluntary testing facilities that also offer counselling; and free ARV therapy for growing numbers of infected people. Its good fiscal policies and its international partnerships have enabled the government to find the resources to tackle the problem head-on. Of particular importance is that the fight is being conducted through the public health systems, to which everyone has access, and that the campaign is being led from the front, that is, by the president. There appears to be a strong political will to get to grips with the problem, and this commitment from leadership is important to success.

Another key element in Botswana's approach to the crisis has been the acknowledgement by the government that the public sector did not have all the skills and technical expertise necessary to address such a problem. It therefore brought in the expertise of development partners (although arguably it would have done so sooner had it anticipated how rapidly infections would spread). The government's new approach to testing, although also late in coming, is likely to bolster the government's efforts to ascertain the HIV status of the population. Now that ARVs are an option for increasing numbers of people, the government believes there is little reason for people to fear knowing

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<sup>25</sup> Hale B, 'The missing medics in Botswana's Aids battle', *BBC News Online*, 21 November 2003.

<sup>26</sup> Ntseane D, *op. cit.*

their status, even if the result is knowing they are HIV positive. 'It is critical that the current testing paradigms change and become much more proactive, as we now have services and medications available. We are still generally caught up in the pre-ARV mindset', said a health official.<sup>27</sup>

In an interview, President Mogae stressed:<sup>28</sup>

The ideal of an Aids-Free Generation requires a return to basics for Batswana. We are not a promiscuous society. We do not condone the sexual abuse of children. We have a tradition of respect for marriage and good family life. We must therefore unite in returning to these values and impose tough sanctions on those who persist with anti-social behaviour. Our response to the epidemic must be anchored firmly on respect for human rights and the dignity of the human person. *Otherwise, stigma and denial will continue to frustrate our efforts.*

Despite its successes and the sophistication of its prevention and treatment methods overall, Botswana needs to build on its successes and keep up the momentum. Otherwise, there is a danger that an even higher prevalence rate could threaten the country.

The government's vision is to have no new infections in the country by 2016. It is relying to a large extent on the fact that nearly half of the population is below the age of 18, and the argument that behavioural change in this generation could be the pivot for reversing the direction of the country's HIV crisis. Unless there is a major alteration in the attitude of the general population to risky behaviour, this is not likely to happen. There is only so much the government, its development partners and the private sector can do to stem the tide. The rest is up to the people of Botswana.

The country provides an important example to other countries. It suggests what they can do and what can be improved in their fight against HIV/Aids. It is also key in another respect. Botswana is one of the richest countries in Africa, and it has a relatively small population. It also has major international and private sector support, and strong government commitment to fighting the pandemic. If it cannot succeed, where does this leave the rest of the continent? Dr Howard

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<sup>27</sup> Interview with Darkoh.

<sup>28</sup> *Op. cit.*

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Moffet, superintendent of Princess Marina Hospital, sums it up.<sup>29</sup> 'We have no choice. With all the benefits that we have and all the resources that we have been given, we have to succeed. If we fail, I think there will be little hope for the rest of Africa.'

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<sup>29</sup> *BBC News Online, op. cit.*

# **A Genuine Concern for Public Health: The Government of Senegal's Response to the Threat of Aids**

Mercedes Sayagues

## **Introduction**

Since the late 1980s, Senegal has maintained a stable and low HIV prevalence of 1.4%, one of the lowest rates in sub-Saharan Africa. This translates into 80,000 HIV positive (HIV+) people among its estimated population of 10 million. This West African country is widely praised as a success story in Aids prevention on the continent.

Yet Senegal is a poor country, with a GDP of under \$600 per person. Although it was in economic distress during the 1980s, it did not receive massive injections of foreign aid, so it could not throw money at the problem of HIV infection. But, in 1986, seeing an opportunity to control the epidemic, Senegal marshalled its resources to mount a swift, broad, bold and home-grown response. This paper examines the policies that guided the domestic campaign against Aids, and suggests why it was successful.

A number of political, social, religious and cultural factors already prevalent in Senegal interacted with policy to limit the spread of HIV:

- conservative norms for sex, that is, low levels of premarital and extramarital sex;
- relatively mature age at marriage and first sexual experience for girls;
- universal male circumcision (which reduces the risk of HIV transmission);
- a generally low level of alcohol consumption;
- social and religious cohesion, a history of co-existence and tolerance among different religious and ethnic groups, and a strong grassroots associative movement; and

### ***Global Best Practice***

- political peace, stability and respect for human rights.

In the first years of the epidemic, the majority of infections belonged to the VIH-2 strain (HIV in French), which is less virulent, less infectious and takes longer to develop into Aids than VIH-1. Infection with VIH-1 has now overtaken VIH-2.

The success of Senegal's strategy to counteract the spread of the epidemic had numerous strands. The country's political leaders recognised the problem early and faced it honestly. High-level commitment started at the top, with President Abdou Diouf, and was underpinned by the sustained provision of public funds for prevention, care, and (later) ARV treatment. Also, the national policy response was based on the advice of scientists and doctors, not on fear, emotion or prejudice. Another vital component was the country's multi-sectoral approach, an acknowledgement that the health sector needed to seek strategic alliances with NGOs, faith-based and community groups. The Aids authorities quickly reached out to religious leaders and civil society in general.

Through dialogue and negotiation, Aids officials and Muslim and Catholic leaders reached a tacit agreement on the use of condoms. Clerics would recommend abstinence and fidelity and would not oppose the government's promotion of condoms. The latter would be publicised in a modest manner, and stress responsible sexual behaviour. Social mobilisation tapped into the strong civil society movements (such as religious and political groups, sports and cultural clubs, women and youth groups, village and neighbourhood associations) that already existed in Senegal. Literally hundreds of groups now teach awareness and prevention of the disease. 'STOP SIDA' (Aids in French) became a national goal.

In October 1986, the government established the engine room of its anti-Aids campaign — the *Comite National Pluri-disciplinaire de Prevention du SIDA* (CNPS or the National Multi-Disciplinary Committee to Prevent Aids). Located in the Ministry of Health, the CNPS comprised doctors, scientists, biologists, sociologists, and representatives of all ministries and NGOs. (Later, people living with HIV/Aids — PLAs — were also included.)



The CNPS identified several interventions that could prevent HIV from breaking out of the high-risk groups into the general population. These included:

- ensuring a safe national blood supply from 1987;
- providing reliable sentinel surveillance to monitor the spread of the epidemic from 1988;
- bringing about an immediate expansion of programmes to control sexually transmitted diseases (a window for HIV infection);
- regulating prostitution and requiring registered sex workers to undergo regular health check-ups (at which time they also received Aids information and condoms) when they were being treated for sexually transmitted diseases;
- promoting the use of condoms without offending religious sensibilities;
- providing broad-based information and awareness campaigns in schools, the mass media and at the grassroots level;
- mounting campaigns against traditional practices that help spread Aids, such as female genital mutilation, which was banned by law in 1999;
- developing local research and expertise on HIV/Aids; and
- providing antiretroviral treatment (ART).

Senegal was the first country in sub-Saharan Africa to start its own programme of ARV treatment with public funds in 1998. At the time, conventional opinion was that such programmes were not feasible in Africa.

The National Aids Strategic Plan of 2002–2006 includes decentralisation (the extension of the programme into the rural regions) and increasing the number receiving free ART from 2,000 patients in 2004 to 7,000 by 2006. (The latter figure represents half of those who need treatment.)

The change in the scale of the provision of ART requires specialised training for health personnel, improvement of the administrative capacities of various services in the regions, and more participation by communities and people living with HIV/Aids.

Improving home-based care and orphan support are also priorities, although these are not being attended to at the expense of prevention.

## **Overview of Senegal's Economy, Political Situation and Development**

Senegal is a poor country, with an annual per capita GDP of under \$600. More than half of its nearly 10 million population live in poverty, according to the government's 2002 *Poverty Reduction Strategy Paper*.<sup>1</sup> One-quarter of the people are undernourished, and three-quarters live on less than \$2 a day.<sup>2</sup>

In the first 20 years after independence, the government of Senegal pursued an inward-looking economic strategy that was marked by heavy state intervention, expansionary monetary and fiscal policies, regulation of the private sector, price and trade controls and the multiplication of state enterprises.<sup>3</sup> By the beginning of the 1980s, the overvaluation of the CFA franc, a series of droughts, and deterioration in the terms of trade had led to mounting fiscal deficits and a general economic downturn.

In 1979, Senegal adopted trade liberalisation, deregulation, and structural adjustment programmes supported by the World Bank and the International Monetary Fund (IMF). This change in economic policy had mixed results. It produced some economic growth in the first few years, but did not succeed in trimming state expenditure, diversifying the economy or encouraging the emergence of a dynamic private business sector. Some early reforms intended to liberalise internal trade restrictions and domestic price controls were reversed. High levels of debt accumulated, and these were made worse by the appreciation of the CFA franc. The World Bank commented: 'Real

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<sup>1</sup> *Poverty Reduction Strategy Paper*, Government of Senegal, 2002.

<sup>2</sup> *Idem*.

<sup>3</sup> Senegal, *Country Profile 2003*, The Economist Intelligence Unit, UK, 2003.

economic growth was highly erratic and net per capita income declined between independence and 1994'.<sup>4</sup>

In 1994, Senegal agreed to an enhanced structural adjustment facility with the IMF. In the same year, the devaluation of the CFA franc from 50 to 100 to the French franc produced, on the one hand, riots in Dakar to protest the sharp increase in prices, and, on the other, a sudden improvement in the country's international competitiveness. This initially benefited Senegal's exports, but failed to bring about any substantial or sustained growth in that sector. Between 1995 and 2000, Senegal's annual average export growth in dollar terms was 3%.<sup>5</sup>

The construction, transportation and chemicals sectors expanded and were able to offer more employment. Tourism experienced sustained growth. However, manufacturing offered fewer jobs, while agriculture and fishing declined. The world price for groundnuts, the country's main cash crop, remained low. Fishing suffered from stock depletion, while rain-fed cultivation of both cash and subsistence crops was severely affected by poor weather and drought in both 1997/98 and 2000.

After the devaluation, Senegal posted six years of real economic growth, averaging 5%, allowing real per capita income to rise by more than 2%.<sup>6</sup> Over the same period, the population increased by an average of 2.8%. This means that the country's improved economic performance had little impact on poverty, especially in the rural areas, where incomes plummeted.

The *Poverty Reduction Strategy Paper* of 2002 reported that while 57.9% of Senegalese were poor in 1994, the percentage in 2001 was 53.9%, 'an outcome both disappointing and surprising'.<sup>7</sup>

A study of the effects of 20 years of structural adjustment found that '[l]ow or stagnant economic growth, a deterioration in some social indicators and only modest improvements in others has characterised

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<sup>4</sup> Senegal. *Policies and Strategies for Accelerated Growth and Poverty Reduction*. A country economic memorandum. Dakar: World Bank, 2003.

<sup>5</sup> *Idem*.

<sup>6</sup> *Id.*

<sup>7</sup> *Poverty Reduction Strategy Paper, op. cit.*, 2002.

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the period of structural adjustment'.<sup>8</sup> Meanwhile, the debt ratio ballooned even though 13 rescheduling arrangements had been made with the Paris Club of bilateral creditors since 1981. In 2002, the country's external debt accounted for 70% of GDP and more than 200% of the country's export revenues.<sup>9</sup>

| <b>Socio-economic profile</b>  |                               |
|--|-------------------------------|
| Area   | 196.722 sq. km                |
| Population (estimate for 2002)   | 10 million                    |
| Administrative division  | 11 regions and 33 departments |
| GNI per person (Atlas method)  | \$500                         |
| Illiteracy   |                               |
| Women  | 56.1%                         |
| Men  | 28.5%                         |
| Primary completion rate (total) (% age group)  | 44.1%                         |
| Fertility rates (births per woman)   | 4.9                           |
| Population growth (annual %)   | 2.3                           |
| Population under 20 years old  | Nearly 60%                    |
| Life expectancy at birth   |                               |
| Women  | 53 years                      |
| Men  | 51 years                      |
| More than 60% of people live in the rural areas and earn a livelihood in agriculture. Fishing and tourism are the country's other main sources of revenue  |                               |
| Source: <a href="http://www.worldbank.org">http://www.worldbank.org</a> ; <a href="http://www.worldbank.org">www.worldbank.org</a> (country at a glance); <a href="http://www.devdata.worldbank.org/external/CPRofile.asp">www.devdata.worldbank.org/external/CPRofile.asp</a> |                               |

<sup>8</sup> Dembele DM, *Senegal, Debt and Destruction: A Study of Twenty Years of IMF and World Bank Policies*. London: World Development Movement, 2003.

<sup>9</sup> Dembele DM, *op. cit.*

In 2000, Senegal entered the Heavily Indebted Poor Country (HIPC) Initiative, which should reduce its debt by \$850 million over the next decade. The purpose of this programme is to provide debt relief over a period in exchange for the debtor government's commitment to spending the resources made available on agreed purposes (such as poverty reduction, health, education and fighting Aids).

### ***Political overview***

At the time of its gaining independence in 1960, Senegal became a republic, with Leopold Sedar Senghor of the Socialist party as its first president. Senegal was a de facto one-party state, albeit with entrenched civil liberties, until 2000. The process of moving towards a multi-party system began in 1974, with the recognition of the first two political opposition parties. Four parties participated in the 1978 legislative elections. The shift towards political pluralism deepened after 1981, when Senghor retired and his prime minister, Abdou Diouf, succeeded him. Diouf and the Socialist Party swept to victory in the legislative and presidential elections in both 1983 and 1988, although in the second of these, allegations of electoral fraud sparked riots in Dakar.

In 1991, Diouf formed a government of national unity that included opposition leaders like Abdoulaye Wade, of the *Parti Democratique Senegalais* (PDS). Popular support for the Socialist party eroded during the 1990s. It was also undermined from within by splits in the party itself. The 1993 elections, which were won by Diouf, were tainted by allegations that the poll was flawed. Alarmed at the loss of voters, the ruling party changed the electoral laws for its own benefit. In consequence, the opposition boycotted the first senate elections, which were held in 1999.

In the presidential elections of 2000, Wade won the second round of voting. For the first time since independence, an opposition party assumed power. Wade formed a coalition government which was

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described in a United Nations Development Programme (UNDP) report as establishing a political climate of openness and dialogue.<sup>10</sup>

In the legislative elections of 2001, with a high voter turnout of 67.4%, the PDS won the majority of seats, while the Socialist Party retained only 10. A new constitution was adopted after a referendum held in 2001. Voter turnout was 65%, and nine out of 10 citizens voted for the new text, which gives greater powers to Parliament but continues to favour a strong executive.

## ***Development overview***

In 2004, Senegal ranked 157<sup>th</sup> out of 177 countries in the Human Development Index (HDI). Its rating for 2002 was 0.437.<sup>11</sup> Illiteracy is high, at 56.1% of women and 28.5% of men. School enrolment at primary level is 58.3% (with girls representing 40% of pupils) and 9% at secondary level, below the average for sub-Saharan Africa. More than half of the people of Senegal are poor. One-quarter suffer from chronic malnutrition.

A sustained effort to redirect resources toward improved primary health care took place in the 1980s. Using social mobilisation and community participation to assist its effort, the government introduced a package of priority programmes to address childhood diseases. This initiative achieved an impressive reduction in child mortality by an average of 3.8% per year. This progress slowed down in the 1990s when the public health care effort became fragmented and less well-funded. Child mortality rates have not improved since.

Low spending on health care throughout the 1990s meant that only 40% of the population had access to health services. More than half of the country's medical personnel are concentrated in Dakar and Thies,

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<sup>10</sup> *Rapport Annuel du Coordinateur Resident*, UNDP, 2001.

<sup>11</sup> The Human Development Index measures human progress in terms of life expectancy, educational attainment, and income per capita expressed in Purchasing Power Parity. The index ranges from 0 to 1, with 1 reflecting higher levels of development. *Human Development Report 2004*. New York: United Nations Development Programme, 2004.

with the result that 43% of the country's health workers care for the 76% of the population that lives outside the main towns.

In 2001, the UN formally ranked Senegal among the world's 49 least developed countries owing to its low per capita GDP, weak human resource base and low level of economic diversification.<sup>12</sup>

## **Senegal's Response to the Threat of Aids**

Senegal is considered to be an Aids prevention success story in Africa. The government's bold and rapid response to HIV infection was so effective that today Senegal has a stable HIV prevalence rate of 1.4%, one of the lowest in sub-Saharan Africa. Senegal started its campaign against Aids in 1986, even though it experienced an acute economic crisis throughout the 1980s and 1990s.

How did Senegal do it?

The Senegalese government did not wait until it was faced with a full-blown epidemic. In 1986, when the first four cases of Aids were identified in Senegal, a team of three respected scientists and doctors requested a meeting with President Abdou Diouf to persuade him that it was in Senegal's interest to act decisively to contain the epidemic.<sup>13</sup> Professor Souleymane Mboup had earned international recognition in 1984 when he isolated HIV-2, a different strain of the virus to that already known. Dr Ibra Ndoeye had researched STDs among sex workers, and Professor Awa Coll-Seck had worked on infectious diseases for the Ministry of Health. All three enjoyed the respect of the government. At their meeting with the president, they argued that Senegal had nothing to lose and everything to gain from an aggressive campaign to halt the spread of Aids. The opportunity to control the epidemic might be lost unless the government acted promptly. They argued that acknowledging and fighting Aids would build Senegal's image as a country that cared for its people, and establish it as a continental leader on issues of public health. They added that local

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<sup>12</sup> *Senegal Country Profile*. London: The Economist Intelligence Unit, 2003.

<sup>13</sup> Putzel Dr J, 'Institutionalising an emergency response: HIV/Aids and governance in Uganda and Senegal,' London 2003. Interviews with USAID and CNLS in Dakar, April 2004.

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research on HIV was internationally recognised as of the highest standard, and that donors like the United States Agency for International Development (USAID) would be willing to give support.

The President agreed. By the end of October, the *Comite National Pluridisciplinaire du Prevention du VIH-SIDA* (CNPS), located in the Ministry of Health, was operational. It was one of the first in Africa. Led by Professor Mboup, it comprised doctors, scientists, biologists, sociologists, and representatives of all ministries and NGOs. (Later, people living with Aids were included.) The CNPS designed the national policy, which took the form of the *Programme National de Lutte contre le SIDA et Maladies Sexuellement Transmises* (National Programme for the Fight against Aids and STDs—PNLS). The PNLs fell under the responsibility of the Directorate for Hygiene and Sanitary Protection in the Ministry of Health.

The CNPS worked through committees at regional and departmental levels (at the time, 10 regions were subdivided into 30 departments).

## **The Work of the CNPS**

Government played a central role in funding, policy-making, planning, implementing the response and seeking allies in the campaign to control the spread of HIV infection. The multisectoral mandate of the PNLs also required it to work with other ministries and with civil society. It was therefore able to address the specific needs of particularly vulnerable groups.<sup>14</sup>

- **Women.** The Ministries for the Family and for Social Development, NGOs and women's groups worked together to reduce women's vulnerability through prevention campaigns, education, economic empowerment, the promotion of use of the femidom (female condom) among sex workers and rural women, prevention of mother-to-child transmission of HIV, and care of Aids orphans.
- **Young people.** The aim of the Ministry for Youth, NGOs and youth groups was (and is) to try to keep young people informed about HIV/Aids so that they might remain uninfected. For example, the

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<sup>14</sup> *Strategic Plan 2002–2006.*



*Projet Promotion des Jeunes* (Youth Promotion Project) runs 10 information centres.

- **Workers.** The Ministry of Labour provided programmes aimed at Aids prevention in the workplace, in collaboration with trade unions and the business sector.
- **School children.** With the support of the teachers' union, Aids prevention programmes were integrated with staff management training and included in the curricula for primary and secondary students. Outside the formal education system, a literacy programme for women and girls, which has 200,000 participants in all regions, teaches Aids prevention in the eight national languages
- **Members of the armed forces.** Awareness programmes specifically designed for the military resulted in a low HIV prevalence among personnel in uniform, including peacekeepers.

Traditional healers were also included in the national effort to contain the Aids epidemic by giving them training in symptom recognition, understanding of sexual transmission of infection, the promotion of safe practices and methods of Aids prevention. This has equipped them to help their communities.

## **The PLNS**

The national programme had both action and research components, which enabled those involved to measure the epidemic, reduce transmission of infection, co-ordinate research, provide psychosocial and medical care and help people acquire both theoretical and practical knowledge about HIV/Aids. Working with the Joint United Nations Programme on HIV/Aids (Unaids), the PLNS adopted a number of effective strategic approaches for Senegal.

## ***Safe blood***

The first blood bank in Senegal was set up by the French colonial administration in 1943. In 1970, one decade after independence, the country designed a policy to ensure safe blood transfusions. The blood

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stores in the bank were regularly screened for infectious diseases like syphilis and hepatitis B. To prevent HIV transmission through contaminated blood, the health authorities reviewed the system used by the blood bank in 1987, and intensified the screening of blood donations.

Today, more than 25,000 blood donations are screened every year. *The Centre National de Transfusion Sanguine* (CNTS) provides supervision and quality control, and supplies reagents for HIV testing to peripheral and regional blood banks. According to USAID, a key partner in this area, the national and regional blood banks have adequate equipment and trained personnel.<sup>15</sup>

## ***Sentinel surveillance for HIV***

A reliable surveillance system was needed to monitor the spread and evolution of the epidemic among both high-risk groups and the general population, and to measure the effectiveness of interventions by the authorities. The first of these was set up in 1989 in four regions, with support from the World Health Organisation (WHO). In 2002 it expanded to all 10 regions, and in August 2003 was extended to the newly-created region of Matam in the north-east.

Regular sero-epidemiological surveys have been carried out since 1989. Five groups are routinely tested: pregnant women at antenatal clinics, registered commercial sex workers attending the STD centres, men attending STD centres, TB patients and all hospital patients treated for infectious diseases.<sup>16</sup> (In Matam, however, tests are done only on pregnant women.)

Senegal's surveillance system and the data that it elicits are considered reliable by the WHO and Unaid, although there is room for improvement. For example, laboratory equipment is ageing, quality control needs to be tightened and the surveillance system itself should be reoriented to track high-risk groups (like truck-drivers and fishermen) more effectively.

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<sup>15</sup> *HIV/Aids in Senegal*. A USAID Brief, 2002.

<sup>16</sup> *Strategic Plan 2002–2006*.

Funding has been provided since 1994 by USAID/FHI (Family Health International). The US-based Centre for Disease Control also became a contributor in 2001.<sup>17</sup>

## **Control of Sexually Transmitted Diseases**

STD control is a key element of prevention because the presence of such diseases increases the risk of HIV infection. STDs are transmitted, like HIV, through unprotected sex, and are a good example of how sexual behaviour can put both partners at risk.

Senegal has a history of STD control dating from colonial times. Its programme for the management of STDs has already entered its fourth decade. The Bureau of Venereal Diseases was created in 1978 and placed under the *Direction d'Hygiene et de la Protection Sociale* (Directorate for Hygiene and Social Protection) in the Ministry of Health. In the same year, well before Aids was identified in Senegal, the Bureau launched a national STD programme that integrated STD care into regular primary health services. Senegal was one of the first countries in Africa to do so.<sup>18</sup>

Because the CNPS regarded STD control as a health priority, it set up a special group to monitor projects, examine constraints on the effectiveness of the existing interventions, and draw up elaborate national guidelines for the prevention and treatment of STDs. A baseline survey identified the needs. This was followed by intensive training of health staff in STD management, and the mounting of mass public awareness campaigns which emphasised the importance of prevention, early detection and treatment of such diseases. Subsequent surveys found that public awareness of STD prevention and the need for partner notification had risen sharply after these interventions.<sup>19</sup>

In 1994, Senegal introduced 'syndromic' management of STDs, which is based on clinical observation and saves not only laboratory costs and time, but improves service quality. Pregnant women are

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<sup>17</sup> *FHI Annual Report 2003*, USAID, 2002.

<sup>18</sup> *Strategic Plan 2002–2006*.

<sup>19</sup> Unaid 1999, *op. cit.*

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routinely tested and treated for syphilis at antenatal clinics. The same services are offered to registered sex workers at the centres for STDs. There are 14 of these in Senegal, at least one in each region, and more in districts with high concentrations of sex workers, like the capital and the tourist and trade hubs.

Between 1991 and 1996, the prevalence of the main types of STDs decreased significantly among pregnant women and sex workers.<sup>20</sup> Among pregnant women in Dakar, syphilis and gonorrhoea were halved (to less than 5%). Among sex workers, gonorrhoea and trichomonas decreased by two-thirds, syphilis by one-third.

These clinical findings have been confirmed by demographic and health surveys. In a national survey conducted in 1997, only 1% of men reported having experienced STD symptoms in the previous year. In a survey restricted to the capital during the same year, 2.3% of men reported STD symptoms.

## **Monitoring of commercial sex workers**

Prostitution has been recognised and regulated in Senegal since colonial times, especially in the urban areas and around the port of Dakar. After independence, the state continued this policy (which was officially formulated in 1970).

Although not fully legal, prostitution is regulated. Sex workers over 21 years old are required to register with the state and obtain a card allowing them to practise their profession. They are also obliged to undergo regular quarterly health check-ups at STD centres. These centres also provide care for, and advice on, STDs, family planning counselling and so on. Some 2,000 sex workers are registered, about half of them in Dakar, the capital.<sup>21</sup> Many have joined support groups and operate as sex educators. However, the system has its limitations. Some experts estimate that only 20% of all sex workers are registered.<sup>22</sup>

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<sup>20</sup> *Strategic Plan 2002–2006*; CNLS; and Unaid 2000.

<sup>21</sup> Interview with Dr Ly, Division du SIDA et MST, Dakar, April 2004.

<sup>22</sup> *Ibid.*

The long-established relationship between sex workers and the health services provided an entry point through which the national authorities could monitor the spread of HIV among them, and provide both Aids education and condoms. This approach has resulted in high rates of condom use among sex workers and their clients.

A national survey in 2001 found that a greater proportion of registered sex workers were tested for HIV infection than members of the general population: seven out of 10 sex workers in Dakar, and nine out of 10 in other regions. Among unregistered sex workers, less than half in Dakar and less than 40% in other regions had been tested.<sup>23</sup>

The most difficult individuals to reach are under-age, occasional and migrant sex workers. To encourage members of this group to use the health services, Aids activists from the NGO Association for Women at Risk of Aids (AWA) are lobbying for a reduction from 21 to 18 of the legal age for registration of sex workers. AWA also conducts information briefings with police (to reduce harassment of sex workers) and with health staff (to make clinics more welcoming to them). In one prevention programme, registered sex workers act as outreach educators both for their colleagues and their clients, supplying information and condoms at markets and bars. Another project targets groups of men whose work involves constant travelling from place to place, such as fishermen, traders and truck-drivers.

## **Condom use**

Condom promotion is a major component of Senegal's strategy, even though advocacy is carried out discreetly in order not to offend religious sensibilities. Male and female condoms are distributed free by the government to sex workers and patients at the MST (STD) centres, the armed forces and young people. In 1988, the number of condoms distributed, including both free supply and sales, was 800,000. The figure jumped to seven million in 1997 and just under 10 million in 2000.<sup>24</sup> In 2001, in USAID-supported social marketing programmes alone, 3.6 million condoms were sold through 2,200 sales points. The

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<sup>23</sup> *HIV/Aids Behavioural Surveillance Survey Senegal*. 2002.

<sup>24</sup> *Strategic Plan 2002–2006; Unaided 2000, op. cit.; Usaid 2002, op. cit.*

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number increased to four million in 2003. Surveys show increased condom use among certain groups. It remains low among married couples, but in casual sex relationships it has risen dramatically. In Dakar, 67% of men and 45% of women reported that they had used a condom in their most recent 'risky' sexual encounter. Condom use is higher among those divorced, separated or widowed, and rises with education and age.<sup>25</sup>

Condom promotion among sex workers has been very effective. Ninety-seven percent say they use a condom with regular clients, and 99% with casual clients. However, condom use decreases to 60% with regular partners who are not clients.

One-third of sexually active young people claim they used a condom the first time they had sex. More than 70% used a condom when they had intercourse with a new partner.

### **The Introduction of ISSARV**

Senegal was the first country in sub-Saharan Africa to introduce a home-grown, publicly-funded programme to provide antiretroviral treatment (ART) through the state health services in 1998. Known as the *Initiative Senegalaise d'Acces aux ARVs* (Senegalese Initiative of ARV Access — ISAARV), the pilot project aimed to prove that the provision of ART was feasible in a poor African country, at a time when conventional wisdom held that ART was too expensive and logistically complicated to be provided by developing countries.

The obstacles to universal provision of ART included:

- the price of medicines, which was extremely high in relation to the resources of both the state and the population;
- the international consensus, which promoted prevention rather than treatment in developing countries; and
- the lack of any international institution that was prepared to fund such treatment.

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<sup>25</sup> Unaid 1999, *op. cit.*

The idea was to start quickly but modestly, to adopt a pragmatic approach to programme design, and to expand as the feasibility, accessibility, acceptability and efficacy of the programme and the government's means allowed it.

At about the same time (1998), Brazil began to provide ARVs through its public health system. Uganda and Côte D'Ivoire too launched ART pilot projects in the framework of the WHO/Unaid Drug Access Initiative, with technical support from Unaid.

### ***The preparatory stages***

The uniqueness of ISAARV was not only that the government bought the drugs with public funds, but that Senegal negotiated discounts of up to 90% from the pharmaceutical companies Glaxo Wellcome (now GlaxoSmithKline), Merck Sharp and Dome, Bristol Meyer Squibb, and Boehringer. In 1998, the government assigned FCFA250 million for the purchase of ARVs and for the clinical and biological monitoring of an initial 50 patients. Government funding almost tripled over the next three years as the programme expanded. Political support became even stronger than before after the election of President Wade in 2000.

The research component of ISAARV received French funding through Project Sidak, which helped to structure the programme by producing documents on planning, programming, monitoring and evaluation. At a later stage, the EU, the International Development Association and the Global Fund for the Fight against Aids, TB and Malaria also donated funds to extend the programme.

Partly owing to budgetary constraints and partly to ensure flexibility in an environment in which scientific information and drug prices changed quickly, the ISAARV did not set up a specific vertical structure. Instead, it was placed under the *Conseil National Pluridisciplinaire du Prevention du VIH-SIDA* (CNLS). It operated through the Ministry of Health and three health facilities in Dakar during its initial phase.

The ISAARV aimed to treat those in medical need, regardless of their financial means. However, in 1998, and in spite of discounts from the pharmaceutical companies, the price of ARVs was still too high to be

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completely covered by the state. Patients were therefore asked to contribute according to their means.

After 2000, as the price of ARVs plummeted owing to international lobbying by the Clinton Foundation and other organisations, the ISAARV provided free drugs and increased the number of patients under treatment. By 2002, 90% of ISAARV patients were being provided with free drugs. In December 2003, President Wade announced that ARVs would be supplied free to both Senegalese citizens and foreign residents.

In 2000, the CNLS announced the transition of the programme from the pilot phase to a five-year national plan. This involved providing additional training for health professionals, upgrading health facilities and ensuring a constant supply of drugs. More ART centres were opened in Dakar. The first provincial ART site opened in Kaolack in December 2001.

By 2004, with support from the World Bank and the Global Fund, the ISAARV had become decentralised and had a presence in the main hospitals in each of the 11 regional capitals. At the time of writing, about 2,000 patients in Senegal receive free ARVs. By 2006, the programme expects to reach 7,000 people, or 46% of those in need of treatment.

An evaluation of the first three years of the ISAARV programme concluded that the treatment had a biological and clinical efficacy comparable to that of similar projects in the North. It also reported high levels of adherence by patients to the drug regime and competence in the medical team. The programme had also proved its ability to adapt to changes in scientific findings relating to ARVs, and had experienced no stock disruptions.

Expansion will involve reinforcing local capacities, training health professionals on VCT and ART, ensuring a constant supply of ARVs, finding ways of bringing down the associated medical costs, and boosting community participation.



## Restructuring in 2001

In December 2001, the structure of the national Aids response was reorganised by presidential decree. The CNPS was replaced by the *Conseil National de Lutte contre le SIDA* (CNLS), a supra-ministerial body, chaired by the Prime Minister. The Minister of Health was to be vice-chair. This meant that the administrative heart of the Aids response moved out of the Ministry of Health and into the ambit of the Prime Minister's authority. After 16 years at the helm of the CNPS, Professor Mboup left. The former head of the PNLS, Dr Ibra Ndoye, became Executive Secretary.

The CNLS has 30 members: representatives of 10 key ministries, donors, NGOs and other civil society organisations, the private sector, and people living with HIV. It meets once every six months and is responsible for:

- advocacy, strategic direction and policy co-ordination;
- mobilisation of financial, human and physical resources;
- oversight of implementation plans; and
- provision for the legal and ethical aspects of the fight against HIV/Aids.

The CNLS implements its mandate through the National Executive Secretariat, whose Secretary reports to the Minister of Health.

The reorganisation brought a period of disarray. The channels for funding, planning and implementation changed overnight. All ministries were expected to implement Aids programmes in their own sectors, whereas previously the Ministry of Health had co-ordinated both their efforts and civil society's contributions.

Analysts claim the reason for the change was to meet the criteria to qualify for \$30 million in funding from the World Bank's Multi-Country HIV/Aids programme (MAP2).<sup>26</sup> The World Bank requires recipient countries to have a supra-ministerial body to co-ordinate and

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<sup>26</sup> Project Appraisal Document (...) for a HIV/Aids Prevention and Control Project in support of the second phase of the US\$500 million Multi-Country HIV/Aids Program (MAP@) for the Africa Region, World Bank, December 2001.

oversee the state's Aids response. The reasoning is that having such a high-level committee will ensure both political commitment and sufficient authority to push the Aids agenda forward and disburse World Bank funds wisely.

Decentralisation of Senegal's Aids programme was overdue. However, in their haste to proceed, the CNLS set up new regional and departmental councils that were staffed by officials with a poor understanding of what good practice for Aids entails. Also, the sudden availability of World Bank funds for local community-based Aids interventions prompted groups with little or no experience to submit project proposals. A cottage industry of project-proposal ghostwriters has emerged, and professional NGOs complain that there is no control of these interventions at local level.

A group of five NGOs has set up an *Observatorium* to analyse work in the Aids sector, including that of the CNLS, and to suggest improvements. Dialogue being the Senegalese way of doing things, there is hope that the new mechanism will be incorporated without detriment to Senegal's existing programmes.

## **Results in 2002<sup>27</sup>**

Unusually for a state in sub-Saharan Africa, Senegal maintains a low and stable HIV prevalence rate of 1.4% in the 15–49 age group.<sup>28</sup> Between 1989 and 1997, prevalence did not exceed 1.6% among pregnant women and 3.6% among STD patients, but rose to between 15% and 30% among registered sex workers.<sup>29</sup>

- **Pregnant women:** HIV prevalence in this group has remained low and stable since the late 1990s, with an average of 1.2% in the sentinel sites, and 1% in Dakar since 1989. In 2002, the highest rate

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<sup>27</sup> All data from *Bulletin Sero-epidemiologique No. 10 de Surveillance du VIH*, July 2003, CNLS, *Ministere de la Sante, de l'Hygiene et de la Prevention, Division de la Lutte contre le SIDA/IST, Bureau de Surveillance Epidemiologique*, and Usaid/FHI/CDC. These results were published in mid-2003.

<sup>28</sup> *Strategic Plan 2002–2006*.

<sup>29</sup> BSS, 2001.

was 2.9% in Kola and the lowest was 0.2% in St. Louis. Pregnant women under 25 years old show lower HIV prevalence rates than older women in general. The exception is the new sentinel site in Kolda, where prevalence was higher among younger women (3.7% as against 2.2%).

- **Sex workers:** HIV prevalence ranges between 5.1% in Mbour to 28% in Kaolack and Ziguinchor. In Dakar, which has the highest concentration of sex workers, the incidence remains stable at 19.4%.
- **TB patients:** HIV prevalence ranges from 14.8% in Kaolack to 3.2% in Mbour, with an average of 10% nationwide.<sup>30</sup>
- **Hospitalised patients:** HIV prevalence ranges from 7.8% in Tambacounda and Thies to 37% in Dakar, possibly because the capital is the referral centre for Aids patients.

Although the less virulent HIV-2 strain was more common between 1986 and 1989, since 1989, infection with HIV-1 has been rising. In 2002, HIV-1 infection was from two to 10 times higher than HIV-2 in the sentinel sites.

Projections based on prevalence rates estimate that in 2003 there were 80,000 people infected, of whom 77,000 were adults aged 15–49. The gender ratio is 1.3, or nine men infected for every seven women.<sup>31</sup> Senegal is unusual in this respect, for in almost every country in sub-Saharan Africa prevalence rates are higher among women than men, and on average, women account for 58% of those infected.<sup>32</sup>

Since the beginning of the epidemic, 30,000 people with Aids are estimated to have died, leaving 20,000 children orphaned. (The United Nations Children's Fund, Unicef, defines an orphan as a child under 18 who has lost either its mother or both parents.)

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<sup>30</sup> TB is the most common opportunistic infection among HIV+ people. About 40% of HIV+ people seeking health care in Dakar have TB. It is estimated that only half of TB cases are detected by the public health system; of these, only half are successfully treated. The new Aid plan seeks to improve TB control. World Bank MAP II, 2001.

<sup>31</sup> *Strategic Plan 2002–2006*.

<sup>32</sup> *Accelerating Action against Aids in Africa*. Geneva: Unaid, 2003.

## Factors Contributing to Senegal's Success

### *The role of political leadership*

The experience of Senegal proves what global research suggests: that political commitment is the most important element in any effective HIV/Aids strategy. The support given by the government to the CNPS was driven by a genuine concern for public health. Senegal's response was all the more striking in the present context of high-level denial in Africa that Aids is a threat that must be faced. In July 1992, Senegal was the driving force behind the HIV/Aids declaration by African heads of state at the 28<sup>th</sup> ordinary session of the Assembly of the Organisation of African Unity (OAU), held in Dakar.<sup>33</sup> Confirming 'the gravity and the urgency of the problem' (Aids), the Declaration called for 'the mobilisation of the entire society' and all leaders against the disease.<sup>34</sup>

We should no longer defer to susceptibilities and we should speak frankly about the way to prevent Aids .... We must encourage traditional and religious chiefs to do the same in order to protect their communities against Aids.

Today, this thinking is common currency. Every leader and every national Aids commission expresses similar sentiments. But in 1992, a time of widespread apathy in government circles over HIV/Aids in Africa, it was a ground-breaking statement. Another innovation proposed by Senegal in the OAU was that the problem of Aids should be taken beyond the bio-medical model of the disease, and dealt with as a social and political issue that required broad-based participation and ownership. The OAU Declaration that resulted was the official expression of Senegal's HIV/Aids policy, and marked the launching of a new phase in its strategy.

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<sup>33</sup> *Longue Quete d'un Dialogue: L'expérience du Projet AidsCap au Senegal dans l'implication des Leaders d'opinion dans la Lutte Contre le SIDA*. Dakar: AidsCAP/ACI, 1997.

<sup>34</sup> (OAU Declaration, July 1992, own translation.)

This new approach had been crystallising since the late 1980s as the designers of the Aids programme moved beyond controlling the response through bureaucratic and health interventions. Instead, they sought to involve a range of actors, build co-operation on the basis of shared goals, and develop strategic alliances, most notably with leaders of the Muslim community, but not exclusively.

### ***The contribution of science***

As already noted, a major factor in the government's commitment to Aids prevention was the authority and prestige of local scientists in the field. Senegal has a long history of medical research and teaching that dates from colonial times. Senegalese scientists have trained at research institutions and universities in France and the United States. The isolation of HIV-2, a different strand of the virus, by Professor Souleymane Mboup and his team the year before, had garnered international accolades. Also, Senegalese scientists, working with foreign epidemic specialists started monitoring HIV and STDs among sex workers in 1985. They developed new and cheaper methods of conducting HIV studies and providing STD treatment. For example, Senegal pioneered the cheaper syndromic approach to STDs which is a main component of current Aids prevention. In a mutually reinforcing relationship, local expertise attracted international funding for research and training in Aids and STDs. The country has engaged in a number of productive partnerships with overseas research centres, particularly in France, and in 1985 an inter-university convention on joint research was signed by institutions in Dakar, Harvard, Limoges and Tours.

As Senegal developed its anti-Aids programmes, North-South funding enabled the local researchers to pursue pilot initiatives on Aids prevention and the provision of ARV. Today, Senegal shares its expertise by training managers of Aids and ARV programmes and laboratory technicians from neighbouring countries.<sup>35</sup>

The CNLS identified several axes of research: the clinical and biological disciplines; social and behavioural sciences; immunology; bacteriology; and virology. The roots of the campaign against Aids in

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<sup>35</sup> *Strategic Plan 2002-2006, op. cit.*

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science and research shaped the form it took, making its strategies flexible. New information about Aids, its treatment and impact was incorporated as the campaign evolved. Supplying accurate medical and scientific evidence to all actors, from mullahs to sex workers, was considered a priority because Aids officials believed that a clear understanding of the disease was an essential element in an effective response.

The research component not only underpinned the interventions made but also played an integral part in the CNLS's strategy. For example, the up-to-date information provided by the medical researchers to the government helped it to negotiate with pharmaceutical companies to reduce the price of ARVs in 1998.

## **Mitigating Factors Unique to Senegal**

The combination in Senegal of political, social and cultural factors shaped an environment that assisted in keeping the epidemic under control.

- Universal male circumcision is performed well before puberty. This is associated with hygienic practices before and after sex. Of 27 studies on male circumcision in Africa, 21 showed that circumcision reduces by half the risk of HIV transmission for men because the removal of the foreskin makes the exposed skin of the glans thicker and more resistant to infection by HIV and STDs arising from abrasion during sex.
- Following Islamic principles, levels of alcohol consumption in Senegal are low. Consequently, there is little alcohol abuse.<sup>36</sup>
- Ninety-five percent of Senegal's population is Muslim. Therefore, most people accept Islamic teachings on women's and men's sexuality.
- Conservative norms regarding sex prevail. In accordance with Islamic precepts, polygamy is legal. Nearly half of the women share a husband, but extra-marital sex is rare. A survey in Dakar found that

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<sup>36</sup> *HIV/Aids Behavioural Surveillance Survey Senegal 2002*, Dakar: Senegal Ministry of Public Health, Family Health International, Centres for Disease Control, *Cabinet d'Etudes et de Recherches*, 2002.

married women rarely have sexual partners other than their husbands. Only 12% of married men reported having had sexual partners other than their wives.

- The average age at first marriage for females in Senegal is older than in other African countries. This is particularly the case for educated women. Those who have a secondary or tertiary education are, on average, virgins for six years longer than the norm in Africa. Such women marry around the age of 28, 10 years later than uneducated women do. Half of the girls who have not attended school are married by the time they are 18.
- The average age at which the first sexual encounter takes place is higher in Senegal. A Behavioural Surveillance Study made in 2001 found that the average age for the start of sexual activity was 17 among female students, 15 for male students, and 16 for those not at school. Among young women aged 15–21, only 4% of female students in Dakar and 12% in the regions had had sex, compared to 20% of female vendors in Dakar and 16% in the regions. Sexually active young people of both sexes generally reported having had one partner or a small number of partners during the previous year.
- Senegal has strong social cohesion, a history of peaceful co-existence and tolerance among different religious and ethnic groups, and a vigorous grassroots culture of associations (such as religious or women's or young people's groups).
- The country also enjoys political stability and democracy, and has experienced four decades of peace.

## **Resource Allocation**

In 1986 Senegal was in dire straits economically, but between 1992 and 1996, according to Unaid, the government, helped by donors, invested nearly \$20 million in Aids prevention. It also gave up revenue by removing a tax on condoms that had quadrupled the price for consumers.

Given the relatively low numbers of people infected (an estimated 80,000), health officials, activists and MPS constantly debate the share

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of the available human and financial resources that should be devoted to HIV/Aids. Some argue that malaria is a bigger problem than HIV, because it affects 70% of children under five, and half of all pregnant women,<sup>37</sup> but receives far less attention and funding.

A study of state HIV/Aids expenditure between 1998 and 2002 was done to determine whether the HIV/Aids programmes have led to massive absorption of Ministry of Health resources to the disadvantage of expenditure on other equally serious diseases.<sup>38</sup> Vinard, Ciss, Taverne, Ly and Ndoye did this by looking at funding channelled through the PNLS (excluding financial assistance dedicated to research projects or given directly to NGOs). The researchers acknowledge the complexities of studying Aids funding. Among the obstacles were 'striking gaps between promised investment and actual spending in this highly mediated field' and complex joint funding operations that lead to some amounts being counted twice. However, according to the PNLS budget, public funding of Senegal's programme rose from FCFA400 million in 1998 to FCFA 2,475 million in 2002. During this period, the proportion of the overall health budget allocated to the PNLS rose from 2.2% to 8%. This must be read in context, however, because total health spending also increased to 9% of the Ordinary Expenditures budget. In real terms, in 2002, the health budget increased by more than 20% while the PNLS budget doubled, according to the study. The exceptional increase in the PNLS budget occurred during the implementation of the pilot phase of the public programme of ARV treatment (ISAARV).

The overall rise in the health allocation to 9% of the government's total budget was a step toward Senegal's meeting the commitment made by African nations at the Abuja Summit of April 2001. The Abuja Declaration described Aids as 'a State of Emergency in the continent'<sup>39</sup> and required signatory governments to devote 15% of their national budgets to health.

However, Vinard and his fellow researchers found that, in spite of a tripling in purchases of ARVs and reagents for ISAARV, the share of the

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<sup>37</sup> Unicef, 2003.

<sup>38</sup> Vinard P, Ciss M, Taverne B, Ly A & I Ndoye, Analysis of HIV/Aids Expenditures in Senegal: From Pilot Project to National Programme, Dakar, 2002.

<sup>39</sup> OAU Declaration, *op. cit.*, para.22.



cost met by the PNLS declined from 52.5% to less than 40%, because more funding was allocated to other activities. Therefore Aids treatment did not expand to the detriment of governmental attention to other diseases.

### ***External sources of funding***

Senegal has consistently shown strong national commitment to addressing the epidemic. In general, foreign aid for Senegal has not targeted its Aids programme specifically, possibly because of the country's low HIV prevalence, but there are exceptions. The largest donor to Senegal's Aids programme is the US (through USAID), followed by Canada, Germany and France. Admittedly, this contribution was substantial. However, foreign funding for the PNLS decreased from 75.4% in 1998 to 62.1% in 2001, while total spending on health increased from 23% to 34% during the same period.

Another important aspect is the part played by the population's spending on health through user fees and payment systems. Citizens contributed 15% to total expenditure on health and 1% of the PNLS's spending in 2001.

Vinard and his co-authors concluded that, for the period examined (1998–2002), 'The fight against Aids in Senegal is not artificially sustained by foreign aid'.

### **Changes in Senegal's Aids Strategy after 2003**

Major changes, both institutional and programmatic, were introduced in 2003. These changes included institutional reorganisation, the roll-out of a nationwide ARV treatment programme (already discussed in a previous section), and the opening of new voluntary testing centres in the country regions.

The changes are outlined in the new *Strategic Plan 2002–2006* (extended to 2007 because of delays in finding funding) and its budget. The executive secretary of the CNLS, Dr Ibra Ndoeye, estimated the cost of the new plan at \$100 million. The decentralisation and extension of

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ARV treatment is funded chiefly by the World Bank, the Global Fund for Aids, TB and Malaria, and the state.

The Strategic Plan 2002–2007, because it is far more ambitious,<sup>40</sup>

does not simply represent a change of scale but also implies a profound modification of spending, in its relative place within the different state budgets and in the funding structure. ... The challenges are of a different order. They include the training of health personnel, the administrative capacities of the different services, the place of the private sector and the degree of dependency on foreign aid.

The distribution of donors has changed, and is now far more concentrated. The World Bank will finance 41% of the Plan and the Global Fund nearly 16%. Aid from other donors is decreasing in relative value, while dependency on the World Bank is rising sharply. In absolute value, funding for Aids by France and Germany is increasing twofold and threefold respectively. Canada and the UN maintain stable levels, and the contribution of the EU is decreasing. The state's share of the funding will decrease from 37% in 2002 to 13.5% for the entire period covered by the Plan. However, this could change, because state commitments are put to the vote annually. Also, because the prices of drugs continue to fall and generic medicines enter the supply chain on a larger scale, the original costing estimates are unlikely to remain constant.

Until now, Senegal has run its Aids programme with relative independence, but the qualitative changes in scale and philosophy introduced by the new Strategic Plan represent a new phase in the response.

## **Those Involved in the Domestic Response to Aids**

Apart from the efforts by the government and the medical establishment, Senegal mobilised a plurality of actors from civil society, among them religious leaders, whose endorsement of the national programme gave it added credibility. The involvement of people who could influence public opinion made broad social

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<sup>40</sup> Vinard P, Ciss M, Taverne B, Ly A & I Ndoye, *op. cit.*

participation possible. Cross-sectoral dialogue that could reach into, and involve, communities at the grassroots level was, and still is, the backbone of the Senegalese Aids strategy.

### ***Senegal's religious background***

The strategic partnership entered into between the government and both Muslim and Catholic leaders is a unique feature of Senegal's response to Aids, because the relationship between faith-based organisations and Aids has been problematic in almost every other part of the world. The reason is that Aids information campaigns intended to bring about behaviour change necessarily address such issues as sexuality, marriage, family and gender relations, which are normally shaped by moral, religious and cultural values. Often, religious leaders object to what they consider an infringement on their domain.

Many faith-based groups are also uncomfortable with two of the basic components of Aids prevention — sex education for young people and the promotion and availability of condoms. They fear such programmes will encourage early sexual activity, promiscuity and sex outside marriage, even though objective evidence indicates otherwise. Another factor in the reluctance of religious authorities to endorse Aids prevention is that in the initial stages of Aids (the 1980s), it was associated with homosexual men and injecting drug users. When transmission through heterosexual sex was finally acknowledged, Aids became associated in the minds of religious groups with loose morals, adultery and sin. Sufferers from the disease therefore tended to be branded as moral outcasts. Moreover, frank discussion of sex and sexuality is not a traditional practice in Africa.

These factors prevented an honest, open, public discussion of the disease, and perpetuated the stigma attached to it.<sup>41</sup>

The fear of offending powerful religious constituencies has created gridlock in some national governments, and for good reason. Conservative lobbies have shown that they can obstruct everything from family life education to condom promotion if they choose.

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<sup>41</sup> 'Acting Early to Prevent AIDS: The Case of Senegal,' Unaid, Geneva 1999

Yet religion has the power to reach large numbers of people, to influence their behaviour, and involve them in moral causes. Religion shapes the norms that guide people's sexual and reproductive behaviour, and can therefore channel the ways in which people not only interpret Aids prevention messages but react to the presence of Aids in their midst. It was therefore vital to the success of the Senegalese campaign that the religious leaders should not remain ignorant, distant, or, in a worst-case scenario, opposed to the campaign against Aids.

As previously noted, religion is a vital element of Senegal's social cohesion. Ninety-four percent of Senegalese are Muslim; there is a small but active Catholic church (representing 4%), and a tiny percentage are animists. The different religions have a history of peaceful co-existence, inter-faith dialogue and strong information exchange among their followers.

Most rural and urban Muslims belong to religious *confreries* (brotherhoods). Through their associations (*dahiras*) and Koranic schools (*daaras*), the *confreries* provide Islamic theological and moral education, mutual help and security.<sup>42</sup>

The influence of the Catholic Church is greater than its numbers would suggest, because it provides about one-third of the country's health services through its network of 62 rural and urban health clinics, and also runs many schools for both Christian and Muslim students. Institutionally well organised, the Catholic community is also able to respond to crises quickly.

### ***The involvement of religious groups in the national aids control effort***

In 1986–87, when media reports appeared on the 'killer disease, the plague of the century,' the first reaction of both Muslim and Catholic clerics was to condemn infected people as sinners, and to attempt to scare people into abstinence and fidelity.

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<sup>42</sup> Engelberg G & M Ndiaye, *Etude Aupres des Leaders et Decideurs de Politiquesur les Questions Relatives a l'epidemie du VIH/SIDA*. Dakar: AidsCAP, 1994.

However, officials involved in the national Aids campaign realised that public condemnation of Aids would work against the interests of public health because it reinforced the stigma associated with the disease, and would drive the epidemic underground. In an atmosphere of prejudice and ostracism, prevention, testing, care and treatment cannot succeed. Another danger was that religious leaders were likely to oppose the efforts of the Ministry of Health and NGOs to promote safer sex through the use of condoms and the teaching of Aids prevention in schools.

Starting in 1987, the PNLS and health officials organised HIV/Aids briefings for Muslim leaders, most notably for the Islamic NGO Jamra. The first aim of the health experts was to provide accurate scientific information as the basis for a clear understanding of the disease and its impact on communities. Having done this, they offered an analysis of the roles each religious grouping could fulfil in complementing the national effort to halt the spread of Aids and deal with its effects.

A tacit agreement was reached: religious leaders might not endorse condom use outside marriage, but would not oppose it. Condom promotion campaigns would not use brash, sexy, 'in your face' Western-style marketing, but would promote responsible sexuality and mention abstinence and faithfulness. The religious leaders, for their part, would encourage abstinence before marriage, fidelity between spouses, and compassion and support for both those infected and those affected. This agreement ensured that ordinary people received a variety of Aids prevention messages that covered a wide range of different values and types of behaviour.

### *Jamra's contribution*

The conservative Islamic NGO Jamra<sup>43</sup> is a Koran-inspired anti-drug and anti-prostitution campaigner, perceived among Muslims as a legitimate actor because its work was based on orthodox Islamic teachings. Jamra developed close links with all the *confreries* and Islamic schools of thought. It controlled an estimated 30,000 mosques, which were each served by at least two imams, and therefore provided

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<sup>43</sup> *Jamra* is a stone that pilgrims at Mecca throw to ward off the devil (*chayton/ idris*).

a gateway to the Muslim community. Since 1982, Jamra had campaigned against drug abuse and prostitution, arguing that these are 'social ills that should be eradicated'. At first, it regarded Aids as another social ill, and therefore condemned infected people as sinners, blamed sex outside marriage, and opposed the use of condoms.

The PNLIS organised workshops for Jamra staff, led by respected Aids scientists and health officials. In February 1989, the PNLIS and Jamra signed an official protocol entrusting the latter with conducting Aids awareness campaigns among Muslim communities. It was also charged with structuring the Muslim response through its links with the National Association of Imams and the highest echelons of Islamic leadership. Jamra staff and health officials briefed imams, khalifes, preachers and traditional authorities across the country. Slowly, the perception of HIV/Aids changed among Muslim clerics. At a meeting in 1991, top Islamic leaders were deeply moved when they heard their first *temoignage* (testimony) from an HIV+ person.

A 'Community Train' staffed by volunteers conducted Aids prevention programmes in Dakar in 1992. Later, other volunteers criss-crossed the whole country in buses to carry the campaign into the more remote regions. In 1995, Jamra published the *Guide Islam et Sida*,<sup>44</sup> the purpose of which was 'to contribute to promote healthy behaviour in sexual matters, namely, fidelity among couples, abstinence and the fight against sexual debauchery'. In French and Arabic, the Guide gives factual information about HIV/Aids, and explains how living according to Islamic principles can prevent the spread of the virus. It also contains a variety of opinions and teachings inspired by the Koran. They range from calls to support and not discriminate against HIV+ people, to advice against female circumcision, wife inheritance, anal sex and intercourse during the menses. Use of condoms by married couples is allowed.

In the late 1990s, imams and mullahs supported a grassroots-inspired drive to stop female circumcision. The Society of Women against Aids in Africa (SWAA) in Dakar reports that rural imams now support its efforts to promote use of the female condom among married couples,

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<sup>44</sup> *Guide Islam et Sida, Jamra. Dakar: Ministere de la Sante et de l'Action Sociale, 1995.*

because they have ruled that a wife has the right to protection from both infection and re-infection.

In addition to its continuing work against drug abuse and prostitution, Jamra supports people living with HIV and Aids orphans. 'Religion has to do with humanity and with love for all God's creatures,' noted Imam Ousmane Gueye, president of the National Network Islam/Aids/Education and permanent secretary of the National Association of Imams and Ulemas of Senegal. 'What is sinful is to turn a blind eye to people with Aids, we must help them'. Since 1987, he has been an indefatigable campaigner, and is a popular figure on radio and TV.

The conference 'Aids and religion: The responses of Islam', held in March 1995, was attended by the highest ranks in the religious and political hierarchy. These were the khalifes from the *confreries*, President Diouf and the ministers of Health and Social Action. Organised by Jamra and attended by 260 Islamic leaders, this conference provided a meeting-point for science, tradition and religion. At its conclusion, the conference delegates adopted resolutions that synthesised Islam's position on many issues. In particular, it declared that Aids is not a divine punishment for sin, and that a married couple can use a condom if one of the spouses is sero-positive.

### *The SIDA service*

The Catholic Church joined the national response later than the Islamic groups, but it quickly became a major player. Initially, the hierarchy and, most prominently, Cardinal Hyacinthe Thiandoum, archbishop of Dakar, spoke of Aids as a disease of sinners and opposed condom use. However, a group of Catholics — nuns, doctors, teachers, health staff and students who worked at the Association of Catholic Private Health Clinics — became active campaigners for Aids prevention, citing the Christian values of solidarity and compassion. In 1991, they set up a multidisciplinary group to provide Aids information and raise awareness of Aids in Catholic schools. Eventually this turned into SIDA Service, an NGO that specialises in Aids prevention, voluntary testing

### **Evaluation of the co-optation of religious groups**

Some critics argue that, in order to garner the support of Islamic leaders, the Senegalese government appeared to endorse Islamic messages. For example, *Guide Islam et Sida* was a joint publication of Jamra and the CNLS. These critics feel that a secular government should distance itself from the conservative opinions and taboos of faith-based groups. 'Moralising discourses reinforce stigma', argued Dr Bernard Taverne, a medical anthropologist at the *Institut de Recherche et Developpement* in Dakar. From a feminist perspective, one could argue that the prevention messages put out by both Muslims and Catholics reinforce the strong social control of female sexuality exerted in Senegal. Family, neighbourhood and other social institutions watch over women. 'The value of virginity is cultivated among young women and reinforced by traditional ceremonies that praise the control of sexuality', Dr Khoudia Sow, of the Aids Division at the Ministry of Health and Prevention, asserted.

One consequence is early marriage for girls. To protect them from the double risk of premarital sex — losing virginity and exposing themselves to infection — daughters are married off early. In an unpublished study, Dr. Sow noted that female identity in Senegal is predicated on childbearing, family-caring, and the values of *mugn* or perseverance, and *sutura* or modesty. Their combination results in female submission. Aids prevention messages can be grafted onto this pattern of desirable female behaviour. Both the Muslim and Catholic faiths preach abstinence, chastity and faithfulness as 'moral hygiene'. Dr Sow pointed out that messages designed to promote condom use among sex workers refer to sexual pleasure. For the general population, however, the appeal is directed towards moral and sexual hygiene. This dichotomy corresponds to collective representations of female sexuality — good woman, bad woman. Yet the question remains: Could religious leaders have been persuaded to participate in Aids prevention on any other terms?

In the words of A. Latif Gueye, a former president of Jamra:<sup>45</sup>

We hail the prudence, ... the pedagogy shown by the National Committee for the Fight Against Aids, which started by engaging religious leaders in order to develop a strategy that would not hurt their sensibilities, a strategy that our NGO describes as 'the moral condom'.

This was Senegal's winning combination: to get religion on the side of public health through dialogue, seeking collaboration instead of confrontation.

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<sup>45</sup> *Actes du Premier Colloque International SIDA et Religion*, Dakar, November 1997.



and counselling (VCT), and in the care and treatment of HIV-infected people.

The founding members agreed on the need to persuade the leaders of the church to change their attitude. Between 1992–1993, they visited each bishop and archbishop to discuss Aids. The young Catholics also discussed their activities with government officials. As it had done with Jamra, the PNLs briefed the Catholic hierarchy on Aids. A conference under the rubric ‘Aids and Religion: the responses of Christian churches’, held in January 1996, provided an opportunity for representatives of the science, public health and religious sectors of Senegalese society to exchange information and views. In the recommendations made at the end of the conference, the bishops requested that each of the seven dioceses of the Catholic church establish a SIDA Service unit.

Today, each diocese has a SIDA Service committee with several *antennes* (outreach points), making 19 overall. Their activities include prevention, VCT, care and support for people with Aids, and the supply of condoms to sero-discordant couples. SIDA also started the first free VCT centre in Dakar in 2000, and now runs eight of the 12 VCT units in the regions. It started providing ART in 2004.<sup>46</sup>

SIDA Service also organises training sessions on Aids for the benefit of priests, nuns and other religious staff who, in the course of their social work, see people from all denominations. The training helps religious staff to assist those infected and their families, and to deliver more informed sermons and messages on the subject of Aids. SIDA Service has also been active in bringing other Christian denominations into the campaign against Aids. The colloquium ‘SIDA and Religion: the response of Christian churches,’ held by the Service in January 1996, was attended by all the bishops of Senegal and by representatives of Protestant churches, Cardinal Thiandoum, the Grand Imam of Dakar and the Health Minister. In the closing declaration, the

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<sup>46</sup> To avoid the stigmatisation of its clients, the original SIDA Service in Dakar dropped SIDA from its name and became the *Centre de Promotion de la Sante Cardinale Hyacinthe Thiandoum* (Centre for the Promotion of Health). This shows the change in the Cardinal’s thinking about HIV/Aids.

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Christian churches expressed their determination to fight Aids in the name of human and spiritual solidarity.

In November 1997, Dakar hosted the First International Conference on Aids and Religion, sponsored by Unaid and the EU. Another milestone was the launch in May 1999 of the *Alliance des Religieux et Experts Medicaux contre le SIDA* (Alliance of religious leaders and medical experts against Aids). It comprises Jamra, the Association of Imams of Senegal, SIDA Service and the CNLS. The Alliance conducts Aids prevention and training for its members, and organises national and international conferences. For example, in December 2002, SIDA Service organised a three-day workshop on 'Aids and Religious, Priest and Lay Vocations' for the Episcopal Conference.

### ***The involvement of civil society***

The involvement of civil society and the community movement in particular was another of the components of Senegal's Aids policy.

Well before the country became aware of Aids, Senegal had a tradition of active community groupings. It was common for people to join associations and groups for culture or sports, for women or for young people. Other organisations were based on ethnic, religious or political allegiances. These connections between people are an integral part of Senegal's closely interwoven human ecology.

The involvement of civil society in the national response to Aids went through different stages as the epidemic grew, as thinking about Aids evolved, and as NGOs negotiated the role they could play.

In the first phase, the PNLN launched information campaigns through the mass media. However, it understood that these had limited reach, and therefore were unlikely to bring about changes in behaviour. The public health experts at the helm of the PNLN realised that bringing in community-based organisations (CBOs) and NGOs would ensure much wider and deeper access to the public mind, involve a more sustained effort and encourage wider participation.

To this end, the PNLs provided information, training and the political opportunities for civil society to become its partner and ally in prevention. 'Only by allying itself with NGOs and grassroots movements of youth, women, religion and others was the PNLs able to achieve a multiplier effect and long-term sustained action,' said Dr Abdelkader Bacha, an HIV/Aids co-ordinator at Environment and Development in Africa (ENDA).

Senegal's First Strategic Plan (1986) identified several areas to which civil society organisations could contribute. These were surveillance; ensuring a safe blood supply; ethics and law; and information, education and communication (IEC).

The second phase of NGO involvement developed as the social and economic implications of Aids became more fully understood in the early 1990s. These were pivotal years for Aids interventions all over the world.

A growing malaise became discernible among NGOs working in the field of HIV/Aids in both the North and South. Many activists felt that the NGOs supplied a great deal of volunteer work at the community level, but were excluded from the decision-making and the funding allocations of Aids programmes. This newly critical attitude called for the greater and more meaningful involvement of civil society.

Across the world, the unprecedented social response generated by Aids took the disease out of the strictly medical realm, and made it a development issue. Reflecting the shift in emphasis, the theme for International Worlds Aids Day in 1992 was 'community involvement'. This set the tone for greater participation by civil society, and put pressure on the medical community and decision-makers to adopt a more holistic approach. Donors, aid agencies, NGOs and activists lobbied Aids officials to allow NGOs to become more fully involved in higher-level planning. Even though Aids officials in Senegal had called on NGOs to mount public campaigns for Aids prevention before 1990, the country's NGOs had to lobby hard to be allowed to participate in policy formulation.

This is the background against which Senegal's NGO-government partnership at all levels was formally initiated. It has intensified ever since. Starting in 1992, Environment and Development in Africa (ENDA) joined forces with AFRICASO, the African chapter of the

Toronto-based International Council of Aids Services Organisations (ICASO). Having AFRICASO in Dakar helped local and continental lobbying and networking, although the organisation was institutionally weak and dependent on ENDA for many years. The PNLS invited AFRICASO to join it as member in 1992. NGO activists joined medical experts and public health experts in formulating policies, policy and strategies. They contributed on-the-ground experience and fresh thinking.

Many NGOs and churches are active in the fields of health and development in Senegal. Unaid estimates that at least a quarter of all NGOs are involved in health-related activities, from vaccination campaigns to rubbish collection.<sup>47</sup> Their contribution became crucial when the public health services deteriorated during the economic crisis of the 1980s and early 1990s. Today, hundreds of big and small NGOs, CBOs and special-interest groups conduct awareness and education activities for Aids prevention. A few specialised NGOs provide counselling, testing, support, care and treatment. 'The response to the epidemic was grafted onto Senegal's extraordinary social tissue, its lively and dynamic social architecture, and it worked', said Gary Engelberg, the director of Africa Consultants International.

By enlisting civil society groups, the government pulled together the key elements for a successful response — social mobilisation, local activism, community participation and identification with the effort.

Several NGOs based in Senegal were instrumental in developing new thinking about the epidemic.<sup>48</sup> Because they had legitimacy, competence, professionalism and credibility in the field of Aids, they were well positioned to become fully-fledged partners of the PNLS. The work of two faith-based organisations, Jamra and the SIDA Service, has already been described. Three other NGOs played a particularly prominent role.

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<sup>47</sup> Unaid, 1999.

<sup>48</sup> Mbodj F & B Taverne, *L'impact des Traitements Antiretroviraux dans le Paysage Associatif Senegalais*. Paris: ANRS, 2002.

## ENDA

The international NGO Environment and Development in Africa has worked in Senegal since 1972, deploying 20 teams dedicated to different tasks. ENDA developed an early interest in Aids, and in 1988 published a book that suggested for the first time that Aids be approached as a development issue and not merely a health problem. Because of its long-standing presence in Senegal as a development agency, its good links with donors, and its cutting-edge thinking on Aids, ENDA was well placed to lead the NGO response in Senegal. In 1986 it set up a special Aids unit, and in 1991 launched a programme to build community focal points and reinforce the ability of communities to respond to Aids in a positive spirit. ENDA was an early partner of the PNLs, and lobbied strenuously for the national Aids authorities to broaden the areas of involvement for NGOs beyond information, education and communication (IEC) and World Aids Day.

## *The SWAA*

The Society for Women against Aids in Africa (SWAA), created in Harare in 1988, established an office in Dakar in 1989. The SWAA became the advocate of the gender dimension of the epidemic. In particular it raised awareness of the vulnerability of women and children to HIV/Aids. Women's vulnerability is rooted in socio-economic inequalities that are gender-based. For example, fewer girls than boys are sent to school, with the result that only one-third of females over 15 are literate. Girls' school enrolment is rising, but at present less than half of school-age girls complete primary education.<sup>49</sup>

The SWAA obtained the support of many eminent women, such as Elizabeth Diouf and Vivianne Wade (the wives of presidents Diouf and Wade), and quickly developed a highly visible national and international profile. The organisation specialises in Aids advocacy, prevention, and skills building among workers and communities at the grassroots level. It

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<sup>49</sup> Senegal at a Glance, [www.worldbank.org](http://www.worldbank.org).

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also provides medical and psychosocial care for HIV+ women and children.

In one project, the SWAA identified 60 networks of women's groups in four regions, including the capital. Its activities include reinforcing the groups' knowledge about HIV/Aids and sexually transmitted infections (STIs), promoting the use of the female condom, and making it available with support from local religious and community leaders.

Because of advocacy by SWAA and other groups, the harmful traditional practice of female genital mutilation or circumcision is now declining as a result of a combined political and social effort to end it. A grassroots campaign brought about a public renunciation of the practice in more than 200 villages before the law banning circumcision was approved in 1999.

### ***The ANCS***

The *Alliance Nationale Contre le SIDA* (National Alliance against Aids/ANCS) was set up in 1995 to support community-based efforts to counter Aids. These include prevention and anti-discrimination efforts, the care and support of infected people and of those affected by Aids, the provision of various forms of technical support to groups, and the fostering of co-operation and agreement among different actors in the Aids sector.

The ANCS is supported both technically and financially by the London-based International HIV/Aids Alliance. It provides a source of funding that is unconnected with the government and the PNLs. The ANCS aims to assist civil society's efforts to deal with Aids. Its advantages are that it is more flexible than the cumbersome mechanisms of bilateral or UN donors, and more transparent, since the main local NGOs sit on its board. One-third of the ANCS's funding is devoted to the care of people living with HIV; the rest is allocated to prevention and awareness activities. The ANCS has also encouraged the creation of support groups for HIV+ people in the provinces, and supports prevention work with street children, homosexual men and drug users.

The ANCS has more than 100 member associations. Since its inception it has funded the activities of more than 800 groups and has boosted community involvement in the field of Aids.

Another NGO, the local *Synergie pour l'Enfance* (Synergy for Children) has worked with HIV+ women and children since 1996. It provides VCT, medical care and support for orphans.

Besides these highly professional NGOs, hundreds of smaller groups have also joined the move to control Aids. Their main contribution has been in the fields of advocating behaviour change, building solidarity and fighting discrimination against those affected.

### *Other actors*

With faith-based groups and NGOs involved in the national response, the Senegal government's attention turned to other actors: community leaders, the media and Parliament. In 1996, a drive to engage opinion-makers in the fight against Aids was launched. The objective was to support policy dialogue across sectors and to equip a variety of leaders with the information and tools needed to mobilise their communities.<sup>50</sup>

The Aids Control and Prevention project (AidsCAP) was funded by USAID through Family Health International, a partner of CNLS, and implemented by Africa Consultants International (ACI). In 1996–97, ACI organised seven workshops for NGO staff members and six for 250 leaders in four regions. The latter represented a cross-section of communities: political parties, trade unions, young people's and women's groups, elders and chiefs. The ACI-designed training manual used in the workshops described the epidemic, analysed its impact at different socio-economic levels, and encouraged participants to identify different types of actions and interventions with which they could help to halt the spread of Aids in their communities.

The training not only motivated leaders to act but broke down taboos that prevented the open discussion of Aids. Bringing a cross-section of

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<sup>50</sup> Longue Quete d'un Dialogue: L'expérience du Projet AidsCAP au Senegal dans l'implication des Leaders d'opinion dans la Lutte Contre le SIDA. Dakar: AidsCAP/ACI, 1997.

### **Aids activism – North and South**

In Senegal, as in most of Africa, civil society joined the response to Aids as a partner, in most cases at the invitation of the national authorities. This situation is at odds with the Western mainstream media's representation of Aids activists as adversaries of governments and pharmaceutical companies. This discrepancy arises from the different ways in which civil society has engaged with national campaigns against Aids in the North and in the South.

In the North, civil society groups are independent, autonomous, have their own funding and operate in an environment in which laws and courts and multi-party democratic systems are functional. They often adopt an adversarial or challenging role *vis á vis* government and health services, to put pressure on them to act. For example, they have demanded anti-discrimination measures, improved medical care and, when it became available, ARV treatment.

The situation is different in Africa, where the relationship between the government, the health services and civil society has evolved along different lines. The very concept of civil society is relatively new, barely a decade old in many countries that were ruled by one-party regimes until recently. Many of these governments failed to respond to the epidemic until civil society nudged them into action. But, as the authorities realised the magnitude of the problem, national anti-Aids programmes relied on civil society groups, first for prevention campaigns, then for counselling, home-based care, and ARV treatment support.

Today, in most African countries, associations of people living with HIV have government support (although one must acknowledge the constraint this puts on their autonomy). The exception is South Africa. There, because of its unique characteristics (a highly developed and politicised civil society, a progressive constitution, an effective judiciary and President Thabo Mbeki's denial and downplaying of the epidemic), the pressure group, Treatment Action Campaign, has adopted a vocally adversarial role towards the government.

In the rest of Africa, as in Senegal, collaboration rather than outright confrontation has marked the partnership of NGOs and national Aids authorities. It is a delicate balancing task for NGOs and CBOs to develop sufficient financial and intellectual autonomy to criticise decisions taken by national Aids bodies. In Senegal, with such a high-powered national Aids team, the tension between partnership, autonomy and co-option is ever present.



leaders and other interested parties together enabled them to work out how they could support each other's efforts. Once the AidsCAP project ended, the FHI continued to support lobbying and policy dialogue in the private sector, the media, Catholic religious staff, and NGOs promoting prevention among commercial sex workers, transport operators and fishing folk.<sup>51</sup>

### ***The media, public debate and HIV/Aids***

The media are a powerful force against HIV/Aids because they shape public opinion, generate discussion, channel information, influence attitudes and behaviour, and are able to whip up support or opposition to issues. 'In each successful response to Aids in the world, a vibrant, professional, free and independent media ... played an important role,' claimed Thomas Scalway of the Panos Institute in a study that analysed 20 years of communication strategies used to publicise Aids issues.<sup>52</sup>

Starting in 1986, the government launched information campaigns carrying health warnings through posters, brochures and pamphlets, radio, TV and print. The media quickly put Aids on their agenda and took part in the national dialogue among the different socio-political and religious constituencies. In particular, they provided a forum for debates between religious leaders and health officials, and for the airing of religious perspectives on Aids. For example, since the mid-1990s, national TV and radio have broadcast messages on HIV/Aids from the General Khalifes of the Tidiane and Layenne brotherhoods, the Catholic Cardinal and the health minister.

As occurred elsewhere, during the first 15 years of the epidemic, HIV/Aids coverage came in two flavours: advisory information to assist prevention, or the reporting of dramatic, doom-and-gloom stories. People infected with HIV were routinely portrayed or referred to in a stigmatising way. These forms of coverage did not mention that the

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<sup>51</sup> *Rapport Annuel des Activites 2003*. Dakar: Family Health International/CNLS//USAID/CDC, 2003.

<sup>52</sup> *Missing the Message: 20 years of Learning from HIV/Aids*. London: Panos, 2003.

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prevalence of HIV/Aids in Senegal was low because it would have made the message less dramatic.<sup>53</sup>

The first training workshop on Aids matters for journalists took place in June 1995 and was organised by AidsCAP. Ten journalists from state-owned and private media (print, TV and radio) attended. The objectives of the workshop were:

- to increase the journalists' understanding of the epidemic;
- to teach them to use research results about behaviour in their writing, and address different target audiences; and
- to help them establish links with NGOs and community leaders, to publicise the prevention activities of different communities.

Since 2000, a training programme developed by Africa Consultants International and funded by the FHI has trained some 150 journalists, including women broadcasters from community radio stations.

A regional workshop for newspaper and radio editors from Senegal, Burkina Faso, Mali, Côte d'Ivoire and Mauritania, held in November 2001, resulted in a ten-point declaration of principles and guidelines for reporting on HIV/Aids. These included the need for:

- confidentiality and anonymity;
- respect for people living with HIV;
- the use of non-derogatory language;
- presentation of HIV/Aids as a development and not merely a medical issue;
- a special effort to highlight women's vulnerability and identify practices that increase it; and
- journalists' responsibility, as public educators, to give accurate information and warnings about risky behaviour and cultural practices, and to promote dialogue and solidarity.

Between 2002 and 2003, a team of journalists and Aids activists published a monthly media bulletin and information guide called *SIDA Media Flash*. It was sent to more than 400 journalists in Senegal and

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<sup>53</sup> Interview with journalist and media consultant Tidiane Kasse, editor of *Sida Media Flash*.

West Africa. The bulletin contained small news items, advice, story ideas, lists of sources, examples of good stories, guidelines, bibliography and Internet resources.

The events organised for the annual World Aids Day, Women's Week and Youth Week against Aids also generate considerable media coverage.

The challenge for the media now is to provide a forum where a plurality of voices, especially those of HIV+ people, can be heard, and where discrimination against HIV+ people is addressed. They can also act as watchdogs for the ARV rollout and the associated massive injection of donor funds. They should be ready to spur the government on should it ever become complacent about the need to continue the fight against HIV/Aids.

### Media messages

A nationwide survey<sup>54</sup> found that one-third of male and female high school and university students aged 15–21 acknowledged that changes in their behaviour in order to reduce the risk of HIV infection were attributable to the messages they had seen on TV. The latter was also the most important medium for young people in the informal sector, female vendors and male apprentices aged 15–21.

Radio was the second most important medium. It was named by 10% of the students and 21% of female vendors as having influenced their behaviour.

Other channels for dissemination of information about Aids were school lessons, awareness campaigns, parents and printed messages such as brochures.

Among registered sex workers, the second most important cause of behaviour change, after TV, was the talks given by the *Institut d'Hygiene*. Radio messages took third place.

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<sup>54</sup> *HIV/Aids Behavioural Surveillance Survey Senegal 2002*, Senegal Ministry of Public Health, Family Health International, Centres for Disease Control and Cabinet d'Etudes et de Recherche.

## **Conclusion: The Challenges Ahead**

The CNLS has embarked on an ambitious Strategic Plan for 2002–2006, which includes establishing centres in the regions and expanding ART provision. Prevention programmes, building up home-based care and orphan support are other priorities.

Due to the country's high population growth (2.4%),<sup>55</sup> the number of its inhabitants is expected to reach 16 million in 2020, nearly double what it was in 2000. The urban population is expanding faster, at 4% per year, and should reach nine million in 2020. This means large cohorts of young people will become sexually active, and that the increase in urbanisation is likely to be accompanied by cultural and behavioural changes.

Already, the average age at which the first sexual encounter takes place is dropping. At 15, 16% of girls have had sex. More than half have done so by 18. Young women with tertiary education marry nearly 10 years later than girls who did not attend school, but this also increases the likelihood that they will have pre-marital sex.<sup>56</sup>

Senegal cannot rest on its laurels. Its Strategic Plan recognises that 2006 may be its last opportunity to contain the epidemic. Consequently, one of its two main broad goals is 'to capitalise on achievements by maintaining HIV prevalence among the total population [at] under 3% in 2006'. The other is 'to significantly improve the quality of life of PLAs, their families and orphans', in the medical, economic and social spheres.

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<sup>55</sup> *Senegal Country Profile*. London: The Economist Intelligence Unit, 2003.

<sup>56</sup> *Strategic Plan 2002–2006*.

# Uganda: Controlling the HIV/Aids Epidemic

Dianna Games

## Introduction

Uganda, situated in East Africa and straddling the equator, is a landlocked country, more than 800km from the Indian Ocean. It has fertile soils, regular rainfall, and rich copper, cobalt, gold, phosphate and limestone deposits. Another major source of income is fishery.

After gaining independence in 1962, the country was riven by civil strife until 1986. Since then, Uganda has recorded 16 years of economic recovery and growth. In the first years after the civil war ended, GDP grew at 2.3%. In the 1990s, growth averaged an impressive 6% every year, just below the national target of 7%. The economic reforms undertaken (which included macro-economic stabilisation, currency reform, freeing producer prices on export crops and improving civil service wages), backed by substantial donor support (13–14% of GDP), led to low inflation, stable exchange rates and market-determined prices. These reforms, coupled with socio-political stability, have laid the foundation for Uganda's economic growth and structural transformation.<sup>1</sup>

In the past three years, growth has stagnated at 5%. The reasons for this include drought, external trade shocks (such as low prices for coffee, the main export crop), a decline in tourism after 11 September 2001, civil strife in the north and west, corruption and HIV/Aids. Also, private investment has grown slowly, despite the government's efforts at liberalisation.

Agriculture is the traditional mainstay of the country's economy, although its contribution to GDP fell from 53.8% in 1990 to 42% in

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<sup>1</sup> United Nations Development Programme (UNDP), 2002.

2000.<sup>1</sup> The main crops are coffee, cotton, tobacco and tea. Half of agricultural production comes from subsistence farmers — the sector of the population most affected by HIV/Aids. Coffee accounts for 25–30% of all exports. Because of a fall in global market prices, coffee export earnings fell from \$400m in 1994/95 to \$84m in 2001/02.<sup>2</sup> Uganda was the first country eligible for debt relief under the Heavily Indebted Poor Countries Initiative in 1998.<sup>3</sup>

Assuming full delivery of HIPC assistance, Uganda received debt relief equivalent to \$347 million and \$656 million in net present value terms under the original and the enhanced frameworks, respectively.

Yet Uganda's external debt was \$3.4 billion by 2000, according to the World Bank. The country's debt remains unsustainable. The ratio of foreign debt to GDP has remained above 50% since 1992/93. The ratio of total aid to GDP has ranged from 10–20% between 1992/93 and 2000/01, while that of debt service to GDP averaged 67.76% between 1992 and 2001.<sup>4</sup> Tax revenues increased from less than 7% of GDP in 1991 to 12% in 2001. Public expenditure remains relatively high, at about 20% of GDP. Donors finance an annual average of 52% and 80% of recurrent and capital budget respectively.<sup>5</sup> The government spends nearly 25% on education and health (according to the 2004/5 budget).

Despite its relative economic success, Uganda is one of the world's poorest countries in terms of income and human development. Its GDP (or GNI) per capita (\$260) is lower than the median for both sub-Saharan Africa (\$460) and all poor countries (\$430).<sup>6</sup> Uganda's Human Development Index rating rose from 0.338 in 1997 to 0.507 in 1999, but dropped to 0.449 in 2001 owing to high child mortality, Aids-related deaths and the associated lower life expectancy (43 years in 2002).<sup>7</sup> However, national household surveys report that the

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<sup>1</sup> World Bank, 2004.

<sup>2</sup> Country Profile, The Economist Intelligence Unit, 2003.

<sup>3</sup> USFC, p.47.

<sup>4</sup> UNDP, *op. cit.*

<sup>5</sup> *Ibid.*

<sup>6</sup> USCF, *op. cit.*

<sup>7</sup> UNDP, *op. cit.*

percentage of people living below the national poverty line fell from 56% in 1992 to 44% in 1997 and 35% in 2001.<sup>8</sup>

Overall, 96% of the poor live in the rural areas. In the war-ravaged north, 66% of the people are poor. Poverty among households headed by females or the elderly is higher in the north and east, and is associated with land shortages and low levels of education.

Uganda has the world's youngest population. In 2000, the median age was 15.1 years. Fifty-one percent of the population is below the age of 15 (as compared with 44% in sub-Saharan Africa). It also has the world's 10<sup>th</sup> highest annual population growth, at 3.4%.<sup>9</sup>

However, the country has shown significant improvement in human development since 1986. This includes a reduction in child malnourishment from 25% in 1995 to 22.8% in 2001. In 2000, 57% of the population had access to potable water, compared with 20% in 1990. Two-thirds of adults were literate in 2000, compared with only half in 1990. As a result of the provision of free primary education, school enrolment jumped from 2.6 million in 1996 to 6.9 million in 2001 and 7.4 million in 2002.<sup>10</sup>

However, two critical indicators, those of infant and maternal mortality, have remained unchanged over the past decade, and stand at 88 per 1,000 and 505 per 100,000 live births, respectively. Uganda ranks 13th in the world among countries with the highest maternal mortality rates. Malnutrition rates also remain high, with a 39% stunting rate.<sup>11</sup> (See the development indicators given in the tables below.)

## **Political Background**

Uganda gained independence from Great Britain in 1962. A prosperous colony, its economy was based on agriculture and a developing industrial sector. However, political and ethnic violence,

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<sup>8</sup> *Ibid.*

<sup>9</sup> Unicef, 2004.

<sup>10</sup> UNDP, *op. cit.*

<sup>11</sup> Unicef, *op. cit.*

instability and coups in 1966 and 1971 followed. General Idi Amin's rule (1971–1979) was particularly incompetent and brutal, and was attended by gross atrocities. Some 300,000 Ugandans were murdered. Amin summarily expelled the 70,000-strong Asian community, and the economy and infrastructure collapsed.

Amin was overthrown by a group of Ugandan exiles backed by the Tanzanian army. A former Ugandan head of state, Milton Obote, was voted president in rigged elections in 1980. Obote's army committed massive human rights abuses, and razed part of the countryside trying to stamp out an insurgency.

A small rebel group, the National Resistance Army (NRA), led by Yoweri Kaguta Museveni, fought Obote. A military coup deposed Obote in 1985, but the new rulers continued abusing human rights and killing civilians. The NRA waged war until it seized Kampala in 1986 and Museveni took power. The NRA became the National Resistance Movement (NRM) in its civilian form.

Museveni brought socio-political and economic stability to the country through a home-grown system of one-party grassroots democracy based on local councils. He banned political parties on the grounds that, being aligned with the country's ethnic and religious faultlines, they bred ethnic hate and division. In 1995, Uganda adopted a constitution which provided for the establishment of a Parliament of 214 elected and 91 appointed members. Candidates would stand as individuals under the NRM umbrella. In the first presidential elections held in 1996, Museveni won 76% of the vote. Laws restrictive of media freedom were relaxed that year, resulting in a lively and varied coverage of events, but the ban on political parties remains.

Between 1996 and 2000, high-level corruption and meddling in the war in the Democratic Republic of Congo (DRC) have tarnished Museveni's and the NRM's hitherto good reputation. In 2003, Transparency International ranked Uganda as the 17<sup>th</sup> most corrupt country in the world. Donors increasingly demand accountability and a return to full democracy as conditions for a continuation of their support.

However, when, in 2000, the government held a referendum on whether a multi-party system should be adopted, the opposition faction



within the NRM boycotted it, and a mere 51% of voters participated. The result of the ballot was overwhelming support for the one-party system, as exemplified by the NRM.

In 2002, the government passed a new law which lifted some restrictions on political parties. Analysts do not consider this enough to ensure effective campaigning of parties other than the NRM for the next general elections, which are to be held in 2006.

Museveni's last legal term in office ends in 2005, although he has not indicated that he will step down when that time comes. The president and the NRM still command wide support, although it is diminishing. The opposition parties are fragmented. Even so, Ugandans increasingly demand their full political rights.

Since the mid-1990s, attacks by two rebel movements, the Lord's Resistance Army (LRA) in the north, and the Allied Democratic Forces (ADF) in the west, have resulted in the massive displacement of communities. More than 1.5 million people in the north have been driven from their homes. The ADF has been contained, but not the brutal LRA, which operates from bases in southern Sudan. Renewed fighting in 2002 'has precipitated a swift deterioration of an already strained humanitarian situation'.<sup>12</sup>

## **The Epidemiology of Aids in Uganda**

Uganda experienced nearly 20 years civil strife after 1966. This period of instability created conditions that have helped the spread of Aids: poverty, hunger, insecurity, displacement, and the collapse of the country's health services. There was also the forcible violation of women by roaming soldiers. Stability returned when Museveni seized power in 1986.

The first two cases of Aids in Uganda were identified in 1982 in a fishing village on Lake Victoria. First known as 'Slim' because of the wasted bodies of its victims, the disease quickly became a national epidemic. A population-based national sero-survey held in 1987/88

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<sup>12</sup> Northern Uganda, Unicef, *op. cit.*

revealed an overall infection rate of 6–8%.<sup>13</sup> By 1992, national prevalence based on sentinel site surveillance was peaking at just over 20%. Among pregnant women attending antenatal clinics at the main urban hospitals, the incidence was 24–35%.<sup>14</sup>

Transmission of infection is heterosexual in 84% of new cases, mother to child in 14%, and related to use of unsafe blood and blood products in 5%. Determining the incidence of infection in intravenous drug users and men who have sex with men requires more research, according to the Uganda Aids Commission (UAC).<sup>15</sup>

By the end of 2001, the government estimated that the cumulative number of Aids deaths was 950,000 and that 1,050,000 people were living with HIV.<sup>16</sup> For the year 2002, the Ministry of Health released the following figures: 70,170 new infections; 73,830 new Aids cases; and 75,290 deaths from Aids.<sup>17</sup> Aids is the leading cause of death for people aged 15–49 in Uganda.<sup>18</sup>

## **The Response to the Aids Pandemic**

### ***Institutional arrangements***

In 1986, Museveni set up within his office a National Aids Prevention and Control Committee, which comprised representatives of government and civil society. Museveni chaired its monthly meetings. Also in 1986, Uganda launched its National Aids Control Programme (NACP), the first in Africa. Operating under the Ministry of Health

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<sup>13</sup> UNDP, *op. cit.*

<sup>14</sup> These are government/Uganda Aids Commission figures. The US Census Bureau/Unaid estimates that national prevalence peaked at 15%. Data before 1995 was patchy because there were few sentinel sites, and these were concentrated in towns. Also, until 2002 Unaid always made lower estimates than the government, World Bank and UNDP. Now they have harmonised the figures they publish.

<sup>15</sup> UAC, 2003.

<sup>16</sup> MoH; UNDP, *op. cit.* 2002; and UAC, *ibid.*

<sup>17</sup> STD/ACP Surveillance unit projection, 2003.

<sup>18</sup> UNDP, *op. cit.*

(MoH), with support from the World Health Organisation (WHO), the NACP developed a five-year plan for the period 1987–1992. This involved a strong mass prevention campaign, sero-surveillance, improved blood safety, and the mobilisation of civil society. Government bodies, like the Ministry of Defence, were encouraged to start their own Aids programmes. The churches, traditional healers and schools were involved in disseminating information and counselling. People were encouraged to take voluntary tests to establish their sero-status, and condom use was widely promoted.

In 1990, a Task Force consisting of government officials, donors and other actors worked out the modalities for a multisectoral approach. In 1992, the United Aids Commission was established by an Act of Parliament, and a multisectoral approach adopted. In 1993, the UAC developed HIV/Aids Policy Guidelines.

Although located in the President's Office, the UAC's mandate is not clear. Its relations with line ministries have led to a disappointing performance. For example, several reviews noted that the UAC duplicated work done by line ministries, blurred co-ordination and implementation, and tended towards bureaucratic enlargement.<sup>19</sup>

By 2000, the UAC in its existing institutional framework was unable to co-ordinate the complex national response to new issues (such as treatment, Aids orphans, home-based care), a larger number of actors and increased funding requirements. A review of the UAC led to the adoption in March 2002 of a new format, the Partnership.<sup>20</sup>

The UAC aligns partners according to the current National Strategic Framework (NSF), the first of which was developed in 1997 and revised in 2000. The latest, 2001–2006, was amended in 2003 to accommodate the rollout of mass antiretroviral treatment (ART).

### ***Co-ordination through the partnership***

The Uganda HIV/Aids Partnership is the UAC's mechanism for national co-ordination. It operates as a formal, representative forum for

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<sup>19</sup> 'Final report: Uganda Aids Commission Review', Unaid, September 2001.

<sup>20</sup> United Aids Commission/Unaid 2004

discussion, information sharing, consensus-building, joint planning and mutual support for all stakeholders in the national response to HIV/Aids. It aims to minimise wasteful duplication, to pool efforts for scaling up the response to the pandemic, and, as the advisory body to the UAC, to provide it with clear leadership and guidance on harmonisation.

In the past, the UAC dealt with different actors individually, which was neither effective nor transparent. This new mechanism consolidates sectors, brings them together in monthly meetings, and goes beyond the classic 'government and donors partnership', which often excludes less vocal and less well-organised constituencies such as civil society groups, people living with Aids (PHAs) — referring to those actually suffering from the disease, representatives of the business sector, and even agencies of the United Nations. The Partnership is expressly structured to ensure the influence of PHAs at every level.<sup>21</sup>

The Partnership consists of four structures:

- a Partnership Committee;
- self-co-ordinating entities (SCEs);
- a Partnership Forum; and
- the Partnership Fund.

The Partnership Committee, chaired by a UAC Commissioner, involves key stakeholders and meets monthly. The Ministry of Health, Ministry of Finance, Planning and Economic Development, UAC and the UN Thematic Group/Unaids have permanent seats on the Committee. Other members are representatives of SCEs, which include line ministries, district authorities, Parliament, UN and bilateral donors; PHA networks; the private sector; international and national NGOs; faith-based organisations; the media; youth; arts and culture lobbies; and the research community. Each SCE elects a representative to attend the Partnership Committee meetings who provides a link between its constituencies and the Committee. Representatives give feedback both ways: from committee meetings to constituencies and vice versa.

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<sup>21</sup> See organogram, additional information in booklet *The Uganda HIV/Aids Partnership*, October, 2002.

In the Partnership, representatives are chosen collectively by their peers and are accountable to them. This method improves on the ad-hoc appointment of one well-positioned NGO to serve as the sole representative of civil society.

One beneficial effect is that, in order to liaise with the UAC effectively, the various entities have organised and strengthened their constituencies. Some use existing co-ordination structures. For example, the Inter-religious Council of Uganda, comprising the four institutionalised religious communities (Christian, Catholic, Muslim and Orthodox) represents faith-based organisations. National NGOs chose as their representative the Uganda Network of Aids Service Organisations (UNASO). PHAs set up their own national forum.

The Partnership Forum meets once a year or more often if necessary, and is open to all those involved in the national response to HIV/Aids.

The Partnership Fund, which is sponsored by the partners, covers co-ordination costs for the scheme and for SCEs such as PHAs, and provides technical assistance. This pooling of funds is intended to encourage joint ownership, which is the essence of the Partnership.

### **People living with HIV/Aids**

Uganda pioneered the involvement of people living with Aids (PHAs), first in prevention, then in advocacy and lobbying, and now at the top decision-making level, and in policy analysis and monitoring. This has been done through their participation in the Partnership Forum. The Ministry of Health (MoH) recognises PHAs as its key partner in improving understanding of treatment and, hence, of adherence to the therapeutic regime.

PHAs became prominent in the late 1980s, when a musician, an army major, and an Anglican priest, among others, disclosed their HIV positive status publicly and became well-known activists. They gave a human face to the epidemic, lobbied for PHA rights, and reduced the stigma associated with the disease.

The National Forum of PHLA (People Living with HIV/Aids) Networks and Associations dates from 2002. One of its major aims is to provide peer support and the sharing of experiences and lessons learnt among PLHA networks and associations.

#### **Care and support**

Very early on, Uganda developed the concept of care for PHAs, refined it as new thinking emerged, and placed it at the centre of the response to HIV/Aids.

The basic concept is that with support and appropriate medical and psychosocial care, PHAs can live longer, with greater dignity and without stigma. Community-based support for understanding and continuing with treatment is a key element of today's ART rollout.

The holistic concept of home-based care (HBC) developed as hospitals became overstretched because of the number of patients with Aids-related illnesses. HBC considers the needs of patients, families and carers. Under the supervision of medical personnel, families, communities and trained lay workers provide care, psychosocial and material support, and counselling to patients and their families at home.

The first groups to respond to this need were two Catholic hospitals in Masaka district, followed by the Aids Support Organisation (TASO). Hundreds of HBC schemes are run by NGOs, community-based organisations, churches and PHA networks throughout the country. This helps relieve pressure on medical facilities and ensures proper care for PHAs. The main providers of biomedical care are government, faith-based health institutions and specialised NGOs, notably TASO.

### **Support for research**

From 1986, Museveni supported local research efforts, which were funded by the international community. Museveni's close connection with medical experts, his faith in their advice, and growing national pride in local research and expertise informed a rational anti-Aids response that was based on scientific advice, not on prejudice and fear. Research helped Uganda to develop local and appropriate solutions to the epidemic.

Many national and international institutions conduct research on HIV/Aids in Uganda. Among them are the Uganda Virus Research Institute, the Academic Alliance for Aids Care and Prevention in Africa, Makerere University, the Joint Clinical Research Centre, the Uganda Medical Research Council Programme, the Mulago, Nsambiya and Mengo hospitals and the Mildmay Palliative Centre. 'Understanding the dynamics, etiology and epidemiology of Aids has been a major concern for Uganda,' says the UNDP.<sup>22</sup>

Antiretroviral drugs (ARVs) were introduced in 1992 through clinical trials at the Joint Clinical Research Centre (JCRC). Uganda was the first African country to participate in a vaccine trial in 1999. Two other vaccine research projects (UVRI and the International Aids Vaccine/Walter Reed Project) are under way.

Epidemiological and laboratory studies, and socio-economic research in the country cover a wide range of concerns. These include the basic science and natural history of the disease, trends, the use of modern and traditional medicines in clinical and cohort studies, the socio-economic impact of the disease, and evaluation of interventions.

In 1993, the UAC established the National Aids Documentation and Information Centre, a national information clearing house that provides technical assistance to researchers.

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<sup>22</sup> UNDP, *op. cit.*

## **Donor support**

Uganda, partly because of its early openness, and partly because of its later success, has enjoyed high levels of donor support. 'The level of resource mobilisation has been unparalleled, although still inadequate....[due to] strong advocacy and persuasion of partners by policy leaders and other partners'.<sup>23</sup>

Estimates of donor support are made problematic by the multiple sources of funding, incomplete or divergent statistics, difficulties in distinguishing between expenditure on HIV/Aids and reproductive health, and so on.

Most donors concentrate on thematic areas: the EU on blood safety since 1986, the United Nations Population Fund (UNFPA) on adolescents, while a few focus on districts (for example, the *Deutsche Gesellschaft für Technische Zusammenarbeit* (GTZ) funds comprehensive programmes in Bundibugyo and Kabarole.<sup>24</sup>

The US Aids Agency for International Development (USAID)/ Centre for Disease Control (CDC) study estimated that total donor support for Aids-related interventions in Uganda between 1989–1998 was around \$180 million, or 70% of total expenditure on HIV/Aids.<sup>25</sup>

A 2001 report by the African Medical and Research Foundation (AMREF)/Uganda Aids Commission (UAC) found that between 2000 and 2001 donors gave \$43.7 million, to be spent on care and support (27.7%), prevention (18.8%), capacity-building (16.2%), voluntary counselling and testing (VCT) (12.1%) and HIV testing (11.4%).

Starting in 2001, with increased funding from World Bank Missions for Africa Programme (MAP) (\$47.5m for 2001–2006), the Global Fund (\$36m for 2002–2004, \$70.2m for 2004–2006) and the United States (\$97m in 2004), Uganda has seen an enormous inflow of funds, mainly to scale up ART provision. Government economists are

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<sup>23</sup> UAC 2004.

<sup>24</sup> For a list of key donors and financing see [www.theglobalfund.org/earch/docs/13UGDH\\_full.pdf755\\_](http://www.theglobalfund.org/earch/docs/13UGDH_full.pdf755_).

<sup>25</sup> Marum E & E Madraa, *The Role of donors in empowering an effective national response to AIDS*, International Aids conference report, 2000.



concerned that the sudden inflows could destabilise the macro-economy, lead to higher inflation and cause the real exchange rate to appreciate, which could damage the country's export competitiveness.<sup>26</sup>

In terms of resources, Uganda's response to Aids is heavily donor-dependent. But the core elements of its response were developed and refined locally. These include openness, culturally appropriate messages, cross-sectoral co-operation, Aids education at schools, the involvement of religious institutions, women and young people, VCT, and home-based care-giving (HBC).

### ***Institutional capacity-building***

Since 1987, Uganda, with the help of donors, has introduced capacity-building programmes at national, district and community levels. The first government department to benefit was the MoH in such areas as blood safety, epidemiology, sexually transmitted infections (STIs), and information, education and communication (IEC). Donors supported the UAC, first with salaries, technical training, and logistics, and later with technical support for epidemiology, finance and planning. Equipment, training and technical support were provided to the Aids Control Programmes established in 1993 in 11 selected ministries. Since 1987, the MoH has trained district officials and health and extension workers, to help them launch local campaigns to prevent the spread of Aids.

These programmes have boosted the competence of those engaged in the fight against Aids at all levels. The downside is the constant loss of trained and competent government staff as they move to NGOs and international agencies, which offer better salaries

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<sup>26</sup> UNDP, *op. cit.*

### ***The multisectoral approach***

In 1992, the UAC developed a country-specific Multisectoral Approach to the Control of Aids (MACA), predicated on the idea that HIV/Aids goes beyond being merely a health problem. The multisectoral approach calls for HIV/Aids issues to be integrated as a cross-cutting and cross-sectoral issue into all development policies to support programme implementation. The main features of MACA were:

- to accept the responsibility of all Ugandans to be actively involved in Aids control activities in a co-ordinated way, from the various administrative and political levels to the grassroots level;
- to address not only HIV/Aids prevention but also to respond to and manage all perceived consequences of the epidemic; and
- to enable both sectors and individuals to respond in ways that were both effective and sustainable.

MACA had five goals: to stop the spread of HIV infection; mitigate the adverse effects of the epidemic on the country's health and socio-economic well-being; strengthen the national capacity to respond to the epidemic; establish a national database on HIV/Aids; and improve the national capacity to conduct research on Aids

In 1993, the UAC developed a National Operation Plan and National Aids Control Policy Proposals, which were revised in 1996, to put MACA into practice. The proposals addressed 34 issues in the five thematic areas of prevention, care, mitigation, research and capacity building.<sup>27</sup> Vision 2025, the long-term projection for the country, regards HIV/Aids as a development issue. So does the medium-term Poverty Eradication Action Plan (PEAP), the overarching national strategy for development adopted in 2000. The NSF for HIV/Aids is an integral part of PEAP. This implies that HIV/Aids programmes take priority in budgetary allocations, that resources are channelled directly to local communities, and that HIV/Aids work benefits from debt relief savings.<sup>28</sup>

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<sup>27</sup> *Ibid.*, UAC, 2004)

<sup>28</sup> UNDP, *ibid.*

A multisectoral approach has two elements. The **first** is the cross-ministerial participation of all sectors of government, 'mainstreaming' HIV/Aids into all government programmes. Mainstreaming is defined as the integration of HIV/Aids matters into ministerial/sector programmes at all stages, including budget, mandate, planning, policy, implementation, and monitoring and evaluation (M&E). The process of mainstreaming should include sensitisation towards, and impact evaluation of, the effects of Aids in all planning.

The **second** element is a partnership between government agencies, donors and civil society organisations (NGOs, churches, the private sector and so on). Although the second element has been very effective in Uganda since the 1980s and is widely credited with Uganda's unique and successful response, the first has been less successful. The involvement of all government ministries started in earnest after 2000, partly because two major donors, the World Bank and the Global Fund, require supra-ministerial Aids bodies and a comprehensive multisectoral approach by government.<sup>29</sup> The first ministries to develop their own HIV/Aids programmes were health, education and defence in 1988, under the MoH's National HIV/Aids Control Programme. In the 1990s, sector policies in education, social development, local government and health integrated HIV/Aids issues into their policies and plans. But 'collectively, the different policies have been inadequate, with some irrelevant provisions and gaps'.<sup>30</sup>

According to UAC documents,<sup>31</sup> prioritising HIV/Aids across ministries remains problematic. Many sector plans focus narrowly on prevention, care and treatment. For example, condom distribution and VCT/ART may be supplied only to ministry staff. Alternatively, the ministry officer responsible for HIV/Aids policy may be a junior employee with little clout.

However, all ministries, except the Ministry of Finance, Planning and Economic Development (MFPED) and the President's Office have developed strategic plans relating to the National Strategic Framework (NSF). Common elements include staff sensitisation, condom

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<sup>29</sup> Interview with HIV/Aids adviser, World Bank, Kampala.

<sup>30</sup> The UNDP and UCSF have studies that describe in detail the plans and interventions of each ministry.

<sup>31</sup> UAC, 2004.

### ***Global Best Practice***

distribution and training in counselling skills. Implementation of the strategic plans/ frameworks has started in most ministries, although many need funding, technical and logistical support and facilitation to reach full implementation. Few ministries have M&E plans. All ministries have designated focal point officers, but their workload is heavy, and lack of budget lines for HIV/Aids is a constraint on the actualisation of programmes. Also, co-ordination between the ministries, for example, the President's Office with the Ministry of Gender, is poor.

### **The Policy Framework**

One of Uganda's paradoxes is that it developed an effective Aids response without an overarching policy on HIV/Aids. Its only framework was provided by the HIV/Aids Policy Guidelines developed by the UAC in 1993, which did not go through the process of approval by Parliament. The driving forces were political will and stewardship, openness, the empowerment of people, the mobilisation of many players, and the insistence on keeping HIV/Aids on the public agenda.

However, because both Aids and funding have become more complex after 2000, an overarching policy is needed for the UAC, and also to enable ministries and sectors to align their interventions more closely. Ideally, it will provide a strong and supportive legal and policy environment with relevant legal and administrative instruments, and contain provisions to avoid discrimination; protect the rights of PHAs, orphans and vulnerable children; and promote VCT, HBC, condoms, and Aids education. Uganda's policy on Aids orphans is based on community care, with orphanages as the last resort. Family reunion, foster care and independent living in groups under adult supervision are preferred options for Uganda's estimated 2.2 million children who have lost their parents to Aids. The new policy is expected to be ready for tabling by the end of 2004.

## Decentralisation

In 1992, Uganda introduced a decentralisation policy by starting with a pilot project in terms of which the UAC established District Aids Co-ordination Committees (DACCS) in all 39 districts. A government review a decade later found that most DACCS were ineffective. The reasons were limited consultation, scarce resources, unclear mandates, a lack of guidelines, and an absence of HIV focal point officers. DACCS performed best in districts that received UNDP funding, and ceased to be effective when that support came to an end.<sup>32</sup>

The Local Government Act of 1997 devolved political, financial and administrative powers to the districts, which at that time numbered 56. These decentralised powers included many Aids-related services: health, education, social development, and welfare.

In 2001, the district HIV/Aids co-ordinating structure was revised. It consists of a District Aids Task Force (DAT), chaired by the district chairperson, which provides political guidance, advocacy and strategic direction; and a District HIV/Aids Committee (DHAC), led by the chief administrative officer, which ensures co-ordination, implementation and management of all Aids initiatives. Lower-level structures of a similar kind operate in each constituency, sub-county, parish and village. The persons involved include representatives of government, civil society, NGOs, PHAs, faith-based groups and the private sector.<sup>33</sup>

A 2002 UNDP study claims:

decentralisation has empowered local communities to demand increased HIV/Aids services, such as VCT, orphan support, and enhanced community participation in planning and implementing HIV/Aids interventions.

However, district performance is uneven. Some work well, usually where there are strong NGOs and donors, as has already been noted. Others require policy guidance and capacity-building to design appropriate Aids interventions. Many are donor-dependent and devote few or no local resources to Aids.

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<sup>32</sup> Guidelines for district HIV/Aids co-ordination, UAC, October 2002.

<sup>33</sup> Organogram available, UNDP, *op. cit.*

### ***Global Best Practice***

A review of decentralisation by stakeholders recommended that:<sup>34</sup>

- the NSF should be widely publicised in districts so that its goals are known and adopted;
- the DATs should be helped to develop an integrated district plan to which donors can contribute, rather than having donors imposing their own priorities;
- the efforts of all stakeholders, including donors and NGOs that tend to bypass bureaucratic district structures, should be harmonised;
- transparency, accountability and information sharing within the district should be improved, to reduce the risk that power and resources can be controlled by a few officials;
- the competence and information of Aids advisors at village level should be improved, especially as regards new developments like ARV treatment;
- consultation with, and participation of, all stakeholders should be encouraged, especially NGOs, CSOs and PHAs, so that all actors work together;
- the office of the HIV/Aids focal person should be institutionalised and made a full-time commitment, and not simply added to other functions;.
- a checklist for M&E should be developed and integrated with existing systems; and
- the complexity of the structures (two large committees, DAT and DAC, replicated down to village level) could be simplified by merging the two into one smaller body with sub-committees.

### ***The involvement of sectors of civil society***

Among the influential players that were already present in civil society and were co-opted into the national effort to combat Aids were the faith-based organisations and the traditional healers.

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<sup>34</sup> Unaso, May 2004.

The population of Uganda is 66% Christian and 16% Muslim, while 18% hold indigenous beliefs. Religious institutions run some health and education services and are very influential. Museveni reached out to Catholic and Protestant bishops, and urged his officials to work with religious institutions. Representatives of the various religions were members of the first Committee, and then of the UAC.

In 1989, the Anglican Church held a concert at Namirembe Cathedral which featured the musician Philly Lutaaya, the first openly HIV-positive celebrity to be recognised in Uganda. In a statement in 1989, Catholic bishops declared that Aids was not a divine punishment; endorsed Aids education for young people; recommended stable and faithful relationships; promoted compassion and solidarity; and encouraged those infected with HIV to form support groups.

In 1989, the Islamic Medical Association of Uganda (IMAU), comprising more than 300 Muslim medical personnel, sponsored a national Aids education workshop, which was followed by others held in the districts. By 2004, IMAU had trained imams at 1,000 mosques in 13 districts (out of an estimated 6,000 mosques) to act as Aids educators in their communities, introducing Aids topics at prayers, weddings and funerals. (Being volunteers, they are rewarded by gifts such as a bicycle or a goat.) IMAU has called for 'Jihad Nafs' on Aids, describing it as 'the struggle of the soul to prevent infection and to care and support those infected and affected by HIV/Aids'.<sup>35</sup>

Condom promotion was a source of friction between the government and the faith-based organisations in the 1980s, but was resolved through a tacit agreement. The government would recommend condom use, while the religious leaders would neither oppose nor promote it. By the mid-1990s, resistance to the concept was fading. At the end of 2003, Muslim authorities accepted condom use within marriage.

In 2001, Christians and Muslims came together in Community Action to Protect Children from Aids (CAPCA). Local council and religious leaders are trained in how to mobilise and educate their communities to use services that prevent mother-to-child transmission

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<sup>35</sup> IMAU Strategic Plan 2004–2008

(PMCT). Since 2002, CAPCA has trained 750 volunteers in Kampala. These emissaries have reached nearly half a million men and women by means of sermons, group talks and home visits. Another 690 are being trained in the Wakiso district.

Another influential force is represented by traditional healers. Traditional and Modern Health Practitioners Together against Aids (THETA), set up in 1992, has two lines of work: evaluating traditional herbal medicines to treat opportunistic infections, and training healers as Aids educators and counsellors. Training can take the form of a three-day workshop or a two-year certified course on STI/Aids counselling and education. THETA and the MoH regularly train healers and traditional midwives. In 1995, THETA opened a Resource Centre for Traditional Medicine and Aids.<sup>36</sup>

### ***Anti-retroviral treatment***

Uganda led prevention efforts in the 1990s, and today it leads in treatment. At present, of the estimated 100,000–150,000 people who need ART, 23,500 receive it. All main public hospitals in the 11 regions provide free ART, albeit to small numbers. Countrywide, 54 ART sites have been accredited, 26 of which are operational. The national target is to have 60,000 people on ART by the end of 2005. Both non-profit and government institutions provide anti-retroviral (ARV) drugs. The public health sector uses fixed-dose generics, while a few NGOs and faith-based groups use brand drugs supplied by the US President's Emergency Aid Plan for Aids Relief (PEPFAR) programme.

In 2001, the provision of ART on a large scale became possible when ARV prices started to fall and international funding for drug treatment became available. Uganda prepared for this new phase of the response by appointing a Task Force to develop guidelines for using ART. In 2002, Uganda produced a three-phase plan to scale up its small ART programme, which had begun in 1997 as part of the Unaided/WHO Accelerated Drug Access Initiative. Several non-profit health providers like the Job Creation and Retention Programme (JCRP), Mildmay, Uganda Cares and others also offered small-scale ART initiatives.

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<sup>36</sup> 'Ancient remedies, new disease', *Unaided Case Study*, Geneva, 2002.



The extended three-phase plan involved training staff, procuring drugs, ensuring a steady supply chain for ARVs, and procuring and distributing equipment. The government recruited 2,000 additional health workers in one year. Although it does admit that the numbers fall below the needs because national budget ceilings do not allow for more recruiting. Aids activists are lobbying Parliament to lift those ceilings.

## The Results of the Government's Intervention

### *HIV prevalence*

After 1992, the prevalence of Aids fell steadily. It stabilised in 2000, and in 2004 it was 6.4%.<sup>37</sup> This sharp decline in new infections is unique in the world.

Among pregnant women, all sentinel sites have recorded a drop in incidence of infection.<sup>38</sup> In some urban sites the percentage of HIV positive mothers almost halved from 1990–95, according to the WHO, in a study that confirmed the effectiveness of Uganda's surveillance procedures.<sup>39</sup> For example, the average prevalence for Kampala sites peaked at 29.4% in 1992, and declined to 11.4% in 1999 and 9.9% in 2001.<sup>40</sup> The drop has been most dramatic among young pregnant women aged 15–19, who represent relatively recent infections. At Nsambya hospital in Kampala, the incidence of HIV infection in this group was 28.5% in 1991, 8.2% in 2001 and 5% in 2002. The overall weighted antenatal clinic prevalence was 6.5% in 2001, ranging from 4.2% in rural areas to 8.8% in towns.<sup>41</sup> Antenatal clinic data is supported by the Uganda Demographic and Health Survey (UDHS), the Medical Research Council/Uganda Virus Research Institute

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<sup>37</sup> Unaids, *op. cit.*

<sup>38</sup> MoH, 2003.

<sup>39</sup> WHO/Unaids, 1998.

<sup>40</sup> MoH/SR, 2003.

<sup>41</sup> MoH/Surveillance Report, 2003.

(MRC/UVRI) cohort prevalence study and the VCT service is run by the Aids Information Centre.

Among high-risk groups, HIV rates among patients with STIs at Mulago hospital in Kampala halved within 12 years.<sup>42</sup> However, sex workers still have unacceptably high levels of infection (over 30%). The HIV/Aids Surveillance Report warns that they need 'specific intervention urgently'.<sup>43</sup>

Overall, HIV prevalence is declining in the urban areas and stabilising in the country districts. The most marked drop in infection rates is to be found among young people. 'There is consensus in the global HIV/Aids community that there has been a robust decline in HIV prevalence in Uganda, related to several factors'.<sup>44</sup>

A large and vibrant network of NGOs has also emerged to deal with gender-related Aids issues. The National Association of Women's Organisations of Uganda is their overall co-ordinating body. The National Community of Women Living with Aids (NACWOLA) has developed and lobbied for the adoption of a gendered approach to Aids. Among many bright ideas, NACWOLA pioneered the concept of Memory Boxes to help families prepare for the loss of members.

## **Prevention**

In a May 2003 report, the Global HIV Prevention Working Group, convened by the Bill and Melinda Gates and Kaiser Family foundations, referred to Uganda's approach as 'combination prevention':

A key finding from Uganda's experience is that no single factor or intervention can adequately explain the country's extraordinary progress in reversing its potentially catastrophic epidemic. Uganda's success underscores the effectiveness of a combination of proven approaches to HIV prevention: Aids awareness campaigns, community mobilisation, targeted behaviour change programs — encouraging delayed initiation of sex, mutual

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<sup>42</sup> MoH, 2001.

<sup>43</sup> MoH/SR, *op. cit.*

<sup>44</sup> *Country Aids Policy Analysis Project*. Garbus and Marseille: UCSF, 2003.

monogamy, and condom use — voluntary counselling and testing, and treatment of STDs.

Prevention started with information. The first anti-Aids message publicised in 1986 featured a traditional warning by drums every 15 minutes on radio and TV, alerting the nation to the dangers of Aids.

### **Role of the media in the campaign against Aids**

The media, especially Radio Uganda, which broadcast programmes in 13 local languages, helped reduce the stigma associated with Aids through extensive coverage of the first people to admit HIV positive status openly in the late 1980s. It created a space in the public sphere for discussion about Aids. An explosion in the number and variety of media took place in Uganda after liberalisation in 1994 — for example, from two radio stations then to 80 today. The newly gained freedom translated into vibrant and extensive HIV/Aids coverage. The media denounced Aids-spreading traditional practices, such as wife inheritance, female circumcision and rape, on the grounds that they increased women's vulnerability. They challenged conservative attitudes to sex, kept Aids on the public agenda and became lobbyists for human rights and cheap access to treatment for people with Aids.<sup>45</sup>

The MoH, the Health Press Association, Makerere University and others also provided special training in HIV/Aids reporting to journalists.

In the five years that followed, IEC campaigns focused on the explanation of heterosexual transmission of HIV and sought to bring about behavioural change in society. The messages sent out by the IEC campaigns were: Aids kills but is preventable; casual sex is risky; love carefully; delay sex; and have fewer casual partners.

Museveni led by example. He went around to villages explaining that Aids is a killer disease caused by a virus, not by witchcraft or angry ancestors, and is preventable. He created a space for intervention and in doing so set the stage for other actors promoting prevention. Government officials, NGOs, faith-based groups, schools, musicians, chiefs and health staff participated. One UNDP-sponsored project trained 15,000 skilled people in Aids education and community mobilisation.

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<sup>45</sup> Bkyawa J, *Learning from Communities: The Media and HIV/Aids*. Kampala: Makerere University of Public Health, 2003.

Several studies note that Uganda's approach to IEC relied less on high-tech media interventions and more on low-tech social and personal communication, what USAID calls 'non electronic mass communication — community-based, face-to-face, and culturally appropriate'.<sup>46</sup> Such personal communication networks can be more effective than mass media campaigns in transmitting Aids knowledge because they personalise risk, are more convincing, and therefore produce real behaviour change.<sup>47</sup> Many Ugandans add that the actual death toll caused by Aids reinforced prevention messages.

By 1995, knowledge of the disease among Ugandans was just under 100%. Eight out of 10 people knew that a healthy person can have HIV, and were aware of mother-to-child transmission. Six out of 10 knew that having fewer sexual partners and being faithful were ways to reduce the risk of infection. In all areas of knowledge linked to prevention there were significant gains.<sup>48</sup> Prevention emphasised the ABC approach — abstinence, be faithful, use condoms — with more emphasis on A and B: delay the first sexual encounter and stick to one partner. Condoms gained importance after 1995, after prevalence had declined. In the mid-1990s, the IEC messages broadened to include caring for and accepting people with Aids.

According to Edward Green, 'The lesson from Uganda is that a balanced integrated approach that provides a range of behavioural options is what works best'.<sup>49</sup>

### ***Changes in sexual behaviour***

By 1995, compared with men in other African countries with high Aids prevalence, Ugandans were less likely to have multiple sexual partners, and more likely to be married and be faithful. Boys under 19 were less likely to have had sex.<sup>50</sup> In a 2001 survey, only 12% of

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<sup>46</sup> Usaid, *op. cit.*

<sup>47</sup> Stoneburner R & D Low-Beer, Presentation to USAID, 2002.

<sup>48</sup> UDHS, 1995.

<sup>49</sup> Green EC, *Rethinking Aids Prevention: Learning from Successes in Developing Countries*. Praeger Publishers, 2003.

<sup>50</sup> Unaid, 1998.

married men and 2% of married women reported having had sexual relations out of marriage (in contrast with 1995, when just over half of men and women had only one partner).<sup>51</sup> Among unmarried young people aged 15–19, eight out of 10 had not had a sexual partner in the previous year. The median age at which the first sexual encounter takes place has been rising, especially among males. In 1995 it was 17.6 years for men and 16.1 years for women aged 25–29, whereas in 2001 it was 19.4 and 16.8, respectively. Condom use has risen steadily, especially when intercourse is with casual partners. Fewer people report engaging in paid sex. By 1997, the number of people exchanging sex for money in Kampala and Jinja had halved.<sup>52</sup>

Some experts argue that the decline in Uganda's HIV prevalence rate is attributable to factors other than behaviour change. These include:

- **The natural course of the epidemic.** Prevalence does not increase indefinitely. Following the initial spread of HIV there is likely to be a fall in the incidence.<sup>53</sup>
- **The high mortality rate resulting from Aids-associated illness.** The number of Aids deaths is greater than the number of new infections, which causes HIV rates to drop.
- **Weak surveillance in rural areas.** Most sentinel sites are in urban areas, although 88% of Ugandans live in the rural districts. There are few sites in the war-ravaged north.
- **The lower fertility rate attributable to Aids.** This reduces the number of HIV positive women at ante-natal clinics, especially those with long-standing infections.

However, Unaid's argues that these factors are unlikely to distort data significantly. It finds 'a plausible link' between the fall in HIV prevalence and behavioural data showing increased adoption of safer sex practices among young people.<sup>54</sup>

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<sup>51</sup> MoH/SR, *op. cit.*

<sup>52</sup> UNDP, *op. cit.*

<sup>53</sup> Unaid's/Trends, 1999.

<sup>54</sup> 'A measure of success in Uganda', Unaid's, 1998.

## **Lessons Learned**

### ***Strong political leadership***

President Yoweri Museveni's leadership on Aids was early, bold, and maintained over 18 years. Museveni had heard of Aids while still a rebel leader fighting in the bush in 1984/85, and had warned his commanders about it. Once he had assumed power in 1986, he was galvanised into action when the Cuban president, Fidel Castro, warned him, at the Non-Aligned Movement conference in Harare, that 18 of the 60 Ugandan military officers sent for training in Cuba had tested HIV positive. Museveni took the fight against Aids as his personal patriotic mission and persuaded both his immediate circle and the nation to follow suit.<sup>55</sup>

The President personally carried out education campaigns countrywide, encouraged open debate, called for the provision of timely, accurate information by technical people and urged political leaders to put Aids high on the agenda.

Museveni declared Aids a priority from village level to the highest echelons. He demanded that officials involved themselves in the fight against the disease. Political legitimacy in Uganda became linked to the response to Aids. Support rippled outwards through the government's machinery, with varying levels of commitment and efficiency. This meant that, as the epidemic developed, the response was coherent, systematic and persistent, as Putzel points out,<sup>56</sup>

Four key aspects of central leadership, seldom pointed to in the literature about HIV/Aids, emerge as pivotal in the fight against the epidemic:

- minimisation of negative incentives and maximisation of positive — leaders have nothing to lose and everything to gain;
- leadership is based on scientific advice;
- fighting HIV/Aids becomes a test of political legitimacy; and
- central leadership ensures society's involvement.

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<sup>55</sup> UNDP, *op. cit.*

<sup>56</sup> UAC, 2004; Putzel J, *Uganda/Senegal Study*.

## ***Openness***

Museveni set the tone, defying cultural and religious taboos against public discussion of sex and sexuality. 'Despite considerable criticism, the President and sectors of his government persisted, exhibiting considerable courage'.<sup>57</sup> Openness encouraged public debate, broke down taboos on discussing sex and sexuality in formal and informal fora, and encouraged tolerance and acceptance of HIV positive people. It sensitised communities, mobilised international support and enabled officials, politicians and civil society to address Aids.<sup>58</sup>

## ***Community mobilisation***

Uganda's response was first and foremost a community-based response. In 1986, Uganda lacked drugs, clinics, doctors, free and broad-based media and international funding. It mobilised what it had — its human resources, its social and political capital. Several Ugandan commentators note that, as they emerged from 20 years of civil strife, people trusted Museveni as a peace-building leader and wanted to prevent further damage to their disrupted communities. The fight against Aids, packaged as a 'patriotic duty' of communities, brought the nation together: Aids was an enemy everyone could agree on.

## ***Ownership***

The broad national partnership of many actors encouraged a sense of ownership at many levels. Uganda's response might have been donor-dependent, but it was not donor-driven. Crucially, its locus was individual responsibility. It hinged on self-control and self-empowerment — people as agents of change. 'Most important has

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<sup>57</sup> World Bank, *Uganda HIV/Aids Case Study*, 2003.

<sup>58</sup> UNDP, *op. cit.*

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been ... the acceptance by Ugandans that the focus of control of HIV/Aids lies with themselves and not with third parties'.<sup>59</sup>

## ***Creating an enabling environment***

NGOs were free to operate and receive foreign funding directly. It was easy to register and operate an NGO in the 1980s and 1990s. Many of these NGOs — the Aids Information Centre (AIC), The Aids Support Organisation (TASO), the JCRP, IMAU — have become global models of best practice. In September 2003, 2,500 NGOs were working on Aids in Uganda. civil society organisations (CSOs) provide 80% of VCT and 90% of post-test counselling and care.

## ***Innovation and adaptation***

Uganda innovated, starting with the candid admission (highly criticised by other African ministers) by the MoH, at the WHO General Assembly in Geneva in 1986, that Uganda had an Aids problem and needed international help. The state encouraged non-state actors to try out new ideas. For example, it started Africa's first free VCT in 1990 through the AIC, when VCT as a prevention strategy was unheard of. The Aids Support Organisation (TASO), formed in 1987 by people infected and affected, also involved PHAs as stakeholders.

## **Conclusion: The Challenges Ahead**

Although its record of Aids intervention can be regarded as a relative success, Uganda faces a number of constraints that hamper its efforts. These range from circumstantial to socio-economic, cultural and institutional factors.

**First**, the population of Uganda is largely rural and poverty-stricken. A very great number of internally displaced people live in the north of

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<sup>59</sup> Coutinho, *Situation Analysis of HIV/Aids in Uganda and the Role of VCT*. Kampala, 2003.



the country. (These two factors mean that those who are most vulnerable to the disease are least likely to benefit from information, surveillance and intervention.) There is also a demographic bias in favour of the very young. This also poses problems for appropriate information, education and counselling activities.

**Second**, the government faces the problems created by massive donor dependence and its obligations to service its foreign debt. This limits the resources available for social spending, and in particular the government's ability to provide anti-retroviral drugs to all who need them. It also means that the country's public health system is weak, leading to organisational and operational weaknesses. These are also partly attributable to a lack of formal legislation to guide policy on Aids, in particular laws protecting the rights of people living with Aids, and of Aids widows and orphans. At the institutional level there is poor co-ordination of Aids-related programmes, both between donors and aid agencies, and between government services and those carrying out national programmes at the district level. As a result, communities increasingly carry the burden of care for people suffering from the disease. Other deficiencies are weak programmes for the control of STIs and the lack of a new IEC programme for young people.

**Third**, cultural barriers to Aids information, prevention and care remain formidable. Some of these are religious, but they also include traditional beliefs that encourage fatalism, and the secondary status accorded to women. The latter means that women are particularly vulnerable to behaviour that results in HIV infection. Another factor is the social and cultural stigma associated with HIV positive status. There are also many myths and misconceptions related to the use of condoms.

However, given these obstacles, Uganda's track record in Aids control and prevention becomes even more impressive.

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## Select Glossary

|          |  |
|----------|--|
| ACHAP    | African Comprehensive HIV/Aids Partnerships                    |
| ACI      | Africa Consultants International                               |
| AFRICASO | African Council of Aids Services Organisations                 |
| AIC      | Aids Information Centre  |
| Aids     | Acquired Immunodeficiency Syndrome                             |
| AidsCAP  | Aids Control and Prevention Project                            |
| AMREF    | African Medical and Research Foundation                        |
| ANCS     | <i>Alliance Nationale de Lutte contre le Sida</i>              |
| ARV      | Antiretroviral Drugs   |
| AZT      | Zivovudine (an ARV)  |
|          |  |
| BBCA     | Botswana Business Coalition on HIV/Aids                        |
| Bidpa    | Botswana Institute for Development and Policy Analysis         |
| BOCCIM   | Botswana Confederation of Commerce Industry and Manpower       |
| BSS      | Behavioural Surveillance Survey                                |
|          |  |
| CAPCA    | Community Action to Protect Children from Aids                 |
| CBO      | Community-Based Organisation                                   |
| CDC      | Centre for Disease Control                                     |
| CFA      | Senegal's national currency, the French Zone Franc             |
| CHU      | <i>Centre Hospitalier Universitaire</i>                        |
| CNLS     | <i>Conseil National de Lutte contre le SIDA</i>                |
| CNPS     | <i>Comite National Pluridisciplinaire de Prevention du VIH</i> |
| CNTS     | <i>Centre National de Transfusion Sanguine</i>                 |

### **Select Glossary**

|           |   |
|-----------|---|
| DACCS     | District Aids Co-ordination Committee                       |
| DAT       | District Aids Task Force                                    |
| DHAC      | District Aids Committee                                     |
| ENDA GRAF | <i>ENDA Groupe de Recherche Action Formation</i>            |
| ENDA      | <i>Environnement et Developement en Afrique</i>             |
| FHI       | Family Health International                                 |
| GDP       | Gross Domestic Product                                      |
| HBC       | Home-based Care   |
| HDI       | Human Development Index                                     |
| HIV       | Human Immunodeficiency Virus                                |
| ICASO     | International Council of Aids Services Organisations        |
| IEC       | Information, Education and Communication                    |
| IMAU      | Islamic Medical Association of Uganda                       |
| IRD       | <i>Institut de Recherche et Developpement</i>               |
| ISAARV    | <i>Initiative Senegalaise d'Access aux Anti-retroviraux</i> |
| JCRP      | Job Creation and Retention Programme                        |
| M&E       | Monitoring and Evaluation                                   |
| MACA      | Multisectoral Approach to the Control of Aids               |
| MAP       | Missionaries for America Programme                          |
| MAPII     | MultiCountry HIV/Aids Programme II                          |

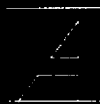
|          |  |
|----------|--|
| MFPED    | Ministry of Finance, Planning and Economic Development   |
| MRC/UVRI | Medical Research Council/Uganda Virus Research Institute |
| NAC      | National Aids Council                                    |
| NACA     | National Aids Co-ordinating Agency                       |
| NACP     | National Aids Control Programme (Uganda)                 |
| NACWOLA  | National Community of Women Living with Aids             |
| NGO      | Non-governmental Organisation                            |
| NSF      | National Strategic Framework                             |
| OAU      | Organisation of African Unity (now African Union)        |
| PDS      | <i>Parti Democratique Senegalais</i>                     |
| PEAP     | Poverty Eradication Action Plan                          |
| PEPFAR   | US President's Emergency Aid Plan for Aids Relief        |
| PHA      | People Living with Aids                                  |
| PLA      | People Living with HIV/Aids (also PWA or PLWA)           |
| PMCT     | Prevent mother-to-child transmission                     |
| PNLS     | <i>Programme National de Lutte contre le SIDA</i>        |
| PTME     | <i>Programme de Transmission Mere Enfant</i>             |
| SACU     | Southern African Customs Union                           |
| SCE      | Self-co-ordinating Entities                              |
| SIDA     | <i>Syndrome Immuno-Deficience Acquise</i> (AIDS)         |
| STDs     | Sexually Transmitted Diseases                            |
| STI      | Sexually Transmitted Infections                          |

**Select Glossary**

|        |  |
|--------|--|
| SWAA   | The Society for Women Against Aids in Africa             |
| TASO   | Aids Support Organisation                                |
| THETA  | Traditional and Modern Health Practitioners Against AIDS |
| UAC    | Uganda Aids Commission                                   |
| UDHS   | Uganda Demographic and Health Survey                     |
| UNAIDS | Joint United Nations Programme on HIV/Aids               |
| UNASO  | Uganda Network of Aids Service Organisations             |
| UNDP   | United Nations Development Programme                     |
| UNICEF | United Nations Children's Fund                           |
| USAID  | US Agency for International Development                  |
| VCT    | Voluntary Counselling and Testing                        |
| WEF    | World Economic Forum                                     |
| WHO    | World Health Organisation                                |

The series examines a number of country case studies with the aim of assessing their potential applicability in the African development context.

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