PUBLIC ADMINISTRATION AND DEVELOPMENT

Public Admin. Dev. **24**, 19–30 (2004)

Published online in Wiley InterScience
(www.interscience.wiley.com) **DOI**: 10.1002/pad.306

THE POLITICS OF ACTION ON AIDS: A CASE STUDY OF UGANDA

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SUMMARY

This article examines the political dimensions of Uganda's progress in bringing a generalised HIV/AIDS epidemic under control. The article documents the history of the political processes involved in Uganda's battle against HIV/AIDS and analyses the complexities of presidential action and the relation between action at the level of the state and that taken within societal organisations. By the mid-1980s, Uganda was experiencing a full-blown epidemic, the virulence of which was connected with social dislocation and insecurity related to economic crisis and war. Political authorities faced the same challenge as other regimes experiencing the onslaught of AIDS in Africa. The epidemiological characteristics of HIV and AIDS—transmission through heterosexual activities, with a long gestation period, affecting people in the prime of their productive life—meant that action required wide-reaching changes in sexual behaviour, and the educational activities to achieve this, as well as relatively complex systems to monitor the virus and control medical practices (blood supplies, injection practices, mitigating drug delivery). The centralist character of the Museveni regime was crucial not only to mobilising state organisations and foreign aid resources, but also to ensuring significant involvement from non-state associations and religious authorities. The Ugandan experience demonstrates that there is a tension between the requirements for systematic action that a strong public authority can deliver and the need to disseminate information requiring a degree of democratic openness. The President was able to forge a coalition behind an HIV/AIDS campaign in part because the virus largely ignored the privileges of wealth and political power. With the development of antiretroviral therapy and the access that the wealthy can gain to these drugs, this basis for the broadest possible coalition to fight HIV/AIDS may be weakened in the future. Copyright © 2004 John Wiley & Sons, Ltd.

INTRODUCTION

By the end of 2002, some 29.4 million people, or 70% of all those living with HIV/AIDS world-wide, were in sub-Saharan Africa, which accounted for 70% of new infections and some 77% of all those who died due to the virus (UNAIDS, 2002a). By 2002, life-expectancy in sub-Saharan Africa averaged 47 years, when it would have averaged 62 years without AIDS, destroying the hard-won gains in prolonging life that figure so centrally in our notion of human development (UNAIDS, 2002b, p. 44). While the implications of the AIDS crisis are devastating, some countries in Africa have made progress fighting the pandemic.

This article examines the experience of one such country, Uganda, where a generalised epidemic has been brought under control. Prevalence of HIV as measured by surveys of women attending antenatal clinics appears to have peaked in the early 1990s and declined through the decade, remaining stable from 2000 until now.[1] Most spectacularly, in one urban surveillance site, Mbarara in western Uganda, prevalence was recorded at 30.2% in 1992 and had fallen to 10.6% by the end of 2001.[2] The data on actual levels of infection in Uganda as everywhere else are imprecise, but the US Census Board/Joint United Nations Programme on HIV/AIDS (UNAIDS) after analysing all available information suggested that overall national prevalence probably peaked at about 15% in 1991

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[1]For overall accounts of success in Uganda see Putzel (2003), Hogle (2002) and UAC (2000). On the problems associated with measures of prevalence, see Putzel (2003, pp. 15–16), Parkhurst (2000 and 2001) and Hogle (2002, p. 2).
[2]Uganda STD/AIDS Control Programme, 2002, p. 5, Table 1. Two other sites record a similar drop, Nsambya and Rubaga.

and had fallen to approximately 5% by 2001 (Hogle, 2002, p. 6). Ugandan sources suggest a national prevalence of 6.1% by year-end 2001, and DFID Uganda reported the most recent figure for 2002 at 6.5%.[3]

In this article I analyse the political dimensions of Uganda's success in fighting HIV/AIDS. It is based in part on a much more expansive report on governance and HIV/AIDS within a comparative case study on Uganda and Senegal (Putzel, 2003). Here, I delve more deeply into the still very imperfectly documented history of the political processes involved in Uganda's battle against HIV/AIDS, the complexities of presidential action and the relation between action at the level of the state and that taken within societal organisations.

Political analysis and HIV/AIDS

While social scientists, especially in the French language, have been carrying out significant work on HIV/AIDS (Becker *et al.*, 1999), there has been very little research on HIV/AIDS and governance and political scientists have hardly begun to touch the issue.[4] What exists so far has focused on the impact of the epidemic in terms of greater demands placed on government services and the erosion of government capability through AIDS-related deaths.[5] More work must be done in this area both to enable leaders to plan for these impacts and to convince political authorities of the urgency to act *before* the full impact hits. Much of the discussion about government action to date has been limited to descriptive accounts of measures taken and progress made to achieve targets in surveillance, prevention and care, and treatment.[6] In this article I focus less on how HIV/AIDS will affect governance than on *how governance can have an impact on the epidemic*.

It has already become amply clear to the international community that the character of leadership at the highest levels of government has been decisive to diverse outcomes in confronting this epidemic. We hear a great deal about 'political will' and about prime ministers or presidents needing to personally take the lead in fighting HIV/AIDS. However, 'political will' has always been an elusive concept—a type of black box—'you have it or you don't'. If analytical insights with wider application are to be gained from an examination of President Museveni's political leadership in fighting AIDS, it is necessary to ask what ideas shaped his decisions to act early, what incentive structure existed that permitted action and what type of coalition emerged that may have allowed presidential leadership to overcome opposition to action on AIDS.

The model, which is promoted almost as an organisational template to confront AIDS in developing countries employed by UNAIDS, the Global Fund to fight AIDS, Malaria and Tuberculosis (GFAMT) and the World Bank, suggests that in addition to presidential/prime ministerial leadership, successful action requires the full involvement of civil society, decentralised and democratic government organisations, and wide participation of all government agencies on an equal footing (Putzel, 2003). An examination of the politics of early action on HIV/AIDS in Uganda, suggests at the very least, that the Ugandan experience often referred to as an application of this model, diverges considerably from these prescriptions.[7]

In the next section I briefly trace the characteristics of the epidemic in Uganda. The third section provides a contribution, by no means definitive, to documenting the political history of HIV/AIDS action in Uganda still largely unwritten despite the passing of almost two decades. Here I undertake an anatomy of what is usually labelled as the political will underpinning Uganda's success in fighting HIV/AIDS. The following section looks at the relationship between the central state and the non-governmental sector in launching the campaign against AIDS. In the conclusion, I distil the lessons from the Ugandan experience, which may be relevant in places where weaknesses in political leadership and/or the state have made action on HIV/AIDS more difficult.

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[3]Uganda STD/AIDS Control Programme (June 2002), p. 5 and communication from Angela Spilsbury, DFID, Uganda, 10 April 2003.
[4]Noteworthy here is the important article by Boone and Batsell (2001) laying out the unmet challenge HIV/AIDS poses to political science.
[5]Among the more important contributions are Barnett and Whiteside (2003), chapter 12 and de Waal (2001a,b, 2002a, 2003).
[6]The prime example related to our case study is Hogle (2002). Much of what is published by other agencies on these governance dimensions remains of a prescriptive and non-analytical character (Hsu, 2000; UNDP, 2001). Other work on governance focuses on HIV/AIDS and local government (Mbere, 2002), or discussions of how one might measure better governance as it relates to HIV/AIDS (Altman, 1999; Patterson, 2000).
[7]Putzel (2003) provides a systematic assessment of the application of this model while this article explores in more depth the political foundations of action in Uganda.

THE PATTERN OF THE EPIDEMIC

The first cases of HIV appeared among people from the southwestern region of Rakai and it is believed that the virus established itself among high-risk groups there and in Kampala by the late 1970s (Barnett and Whiteside, 2003, chapters 4 and 5). Economic collapse and social dislocation, and new economic activities including the proliferation of the smuggling trade, contributed to the spread of the virus. Young women turned to the sex trade and the spread of the virus seems to have followed the trade and communications routes from the African east coast to the centre of the continent. Long haul truckers away from home, with plenty of money to spend, gave rise to the expansion of bars and brothels along their routes as people sought income generating activities. The increased sexual activities of men in this industry with commercial sex workers (CSW) whose trade was entirely unregulated and with multiple partners along their routes likely accelerated the spread of the virus. Sexually transmitted infections (STIs) were widespread and mostly untreated throughout these communities.

The southwestern region also experienced the movement of armies, when Ugandan rebel forces and invading Tanzanian forces overthrew the government of Idi Amin in 1979. Warfare and the movement of soldiers contributed to the spread of the virus through an increase in violence against women and trading sex for survival, as well as casual sex among multiple partners. The combined effects of social, political and economic disruption and war created conditions for the virus to pass from high-risk groups—truckers, soldiers and commercial sex workers—into the general population. The highest levels of infection were reported in urban areas, in rural areas along trade routes, and in districts beset by conflict and war (UAC, 2000, p. 9).

The decade of state collapse decimated health care systems in the country. Also, with a predominantly Christian population, male circumcision was less widely practiced than it is in Muslim communities and this may have aggravated the spread of the virus.

By the mid-1980s, Uganda was experiencing a full-blown epidemic. The most salient epidemiological characteristics of HIV and AIDS implied that this is a disease which has no cure and is transmitted through mainly heterosexual activities, requiring behavioural change among the sexually active population (Putzel, 2003). It is a disease that has a long gestation period and one that presents particularly heavy burdens on women who are both physiologically and socially hit even harder than men. Its rapid spread has been connected with social dislocation and insecurity related to economic crisis and war, which had enormous impact on patterns of personal behaviour.

THE SOURCES OF POLITICAL LEADERSHIP ON HIV/AIDS

When the first evidence of AIDS was confirmed in Africa in the mid-1980s, the continent was in the midst of severe economic decline (Mosley *et al.*, 1991). State organisations were experiencing the dislocating processes of radical programmes of structural adjustment and many had collapsed or existed under severe strains of war and growing violence (Duffield, 2001). Many African leaders looked on warnings of an emergent epidemic, emanating from international organisations and the international medical community, as yet another assault on Africa, threatening to undermine incipient efforts at economic recovery, by discouraging investment and decimating tourism.[8] In December 1985, Kenya was the first sub-Saharan African country to report AIDS cases to the World Health Organisation, before it went into what a pioneering journalist in this area said was 'severe denial' in the following year (Hooper, 1990, p. 162).

Until the epidemic appeared in Africa, AIDS, which had earlier been identified in the United States and Europe, had been associated with homosexuality and intravenous drug use and thus was marked by stigma. With the first evidence suggesting that the virus may have originated in Africa, many Africans felt that the rush of scientists and journalists to investigate the virus in their countries would all too easily feed into prejudices and discrimination

[8]A conference on 'AIDS in Africa' convened in late November 1985 in Brussels, which brought together 700 scientists (50 from 16 countries in Africa), focused in part on the issue of the origin of AIDS and led to a serious backlash from African political authorities who charged the scientific community with racism and threatened to bar research on the virus (Gray, 1985; Nelson, 1985; Raeburn, 1985a,b).

with deep roots in the colonial period. In the view of one journalist who worked with PANOS, one of the first international NGOs to campaign on AIDS in Africa, this was precisely what happened.[9]

It is in this context that the early action by President Museveni to both acknowledge the presence of HIV/AIDS and to launch a concerted campaign of action to prevent and control the spread of the virus must be assessed.

Crusading role of medical researchers

Political authorities and officials in the Ministry of Health under the 'second regime' of Milton Obote were in as much a state of denial about HIV/AIDS as elsewhere in Africa.[10] People began dying in Uganda's Rakai district of a strange 'wasting disease', which by 1982 became known as 'Slim', but no one yet associated the evidence with what would later be recognised as HIV. In late 1983 and early 1984, a team of Ugandan and foreign doctors including Dr David Serwadda, who was working at the Uganda Cancer Institute in Mulago National Referral Hospital and Dr J. Wilson Carswell, a British surgeon with long experience in the country, had observed repeated evidence of Kaposi's sarcoma (KS) among young patients—all from the Rakai district.[11] They knew of the work of another expatriate doctor in Zambia, a cancer surgeon Anne Bayley, who had documented similar evidence of KS in 1983 and suspected a link with the virus that was causing such a stir in North America. By mid-1984, Serwada and Carswell reported their suspicions to Dr Sam Okware, an epidemiologist who served as secretary to the Ministry of Health's Disease Surveillance Sub-Committee, but his initial reaction was that this was not possible, since a disease of homosexuals was unlikely to be present in Uganda. Serwadda and Carswell quietly sent blood samples drawn from patients with KS to Robert Downing at the Centre for Applied Microbiological Research, at Porton Down, in the UK. By October 1984, Downing reported back that the samples tested positive for Human T-cell Lymphotropic Virus (HTLV-III), as HIV-1 was originally labelled.

In the meantime, Dr Anthony Lwegaba, a district medical officer in Rakai, was observing the impact of Slim, particularly on traders and smugglers in Kasensero and Lukunyu. By November 1984, he had submitted a report to the Ministry of Health raising the possibility that this disease was linked with the epidemic affecting homosexuals in North America (Hooper, 1990, p. 256). This led to newspaper reports and in January 1985, President Obote ordered the Disease Surveillance Sub-Committee to investigate. The mission from the Ministry reported that the illness in Kasensero was due to poor sanitation. Apparently it was Dr Carswell who, at his own expense, sent a selection of the blood samples collected by the team to Downing at Porton Down. When he reported back that the samples had tested positive for HTLV-III, Carswell was appointed to the Disease Surveillance Sub-Committee and chaired a Clinical Committee on AIDS.[12] In June 1985, Carswell, profiting from a visit to the country by Anne Bayley and Robert Downing, organised a team to conduct a study in Masaka and Rakai, which sampled all households, discovering that only sexually active people had the disease.[13] Their report became the first authoritative study on HIV/AIDS in the country and was published in the British medical journal, *The Lancet* (Serwadda *et al.*, 1985).

The doctors involved in discovering HIV/AIDS in Uganda were either foreigners or junior practitioners and political authorities were too preoccupied with holding on to power in a regime that was crumbling, to undertake any serious action on HIV before the end of 1985.[14]

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[9]Judith Marissy (1988) wrote a self-critical article citing her own contribution to the origins debate published in the *Lagos Guardian* in early December 1985. See also Sabatier (1988).

[10]The following is based on interviews with Dr David Apuuli, Director General of the Uganda AIDS Commission (9 January 2003), Sam Okware, Ministry of Health (10 January 2003), Dr Jesse Kagimba, Presidential Adviser on HIV/AIDS (11 January 2003) and, Schoofs (2000) and Bakyawa (2003).

[11]Kaposi sarcoma (KS), a slow-growing tumour of blood vessels that was associated with death from other causes, was first discovered in Austria in 1872 among men of Jewish and Mediterranean ancestry. Cases of a particularly aggressive form of KS were increasingly identified in Africa in the 1950s and 1960s among young people. It is now known to affect some 18–40% of people with AIDS (Smith, 2001, pp. 406–407).

[12]Included in this Committee were some of the key figures who were involved with early work on HIV/AIDS in the country: Roy Mugerwa, Nelson Sewankambo, Fred Kigozi and Richard Goodgame, and they wrote a report, 'AIDS in Uganda' which analysed 65 cases all admitted to Mulago Hospital between October and November 1985 and was published in *Health Information Quarterly* in early 1986 (Hooper, 1990, p. 82).

[13]The team also included David Serwadda, Nelson Ssewankambo and Roy Mugerwa.

[14]Of course, it must be acknowledged that Obote's regime was decimated by the civil war and could not concern itself with much more than security. All public services including health had been destroyed by the long period of unrest from the first uprising against Amin, through the second Obote regime.

Museveni's early action in the face of a nationalist backlash

This changed after Museveni's National Resistance Movement took power in January 1986. The severity of HIV/AIDS was driven home to Museveni even before he came to power.[15] As early as February, the new Health Minister, Dr Ruhakana Rugunda, elevated Okware to head the Disease Surveillance Sub-Committee and it began meeting on a bi-monthly basis. In May, Museveni sent Rugunda to the World Health Assembly in Geneva where he announced the HIV epidemic facing the country.[16] Shortly after his return Rugunda gave an interview to the newly founded state-owned newspaper, *New Vision*, announcing that AIDS was widespread and the government was purchasing new screening equipment and launching a public education campaign (UPI, 1986). In remarks that made him stand out from most African politicians at the time, Rugunda said, 'There is no national pride whatsoever in hiding the prevalence of AIDS . . . If anything, in my view, you objectively destroy the standing and pride of your country if you hide such a problem' (Hardin, 1986).

The international media's attention to AIDS in Africa cut two ways. On the one hand the flurry of reporting from the end of 1985 helped to focus donor attention on the mounting evidence of what appeared to be an emerging catastrophic epidemic; on the other hand, discussion about the origin of AIDS and its rampant spread through prostitution and sexual promiscuity, drew the ire of African politicians. Despite the Museveni government's early acknowledgement of the epidemic, throughout 1986, there was a growing unease with the manner in which the epidemic in Uganda was being reported in the international press (Hooper, 1990, pp. 103, 117).[17] While Health Secretary Rugunda had been outspoken in May, by late June, the government's newspaper ran an article entitled, 'Press Overplaying AIDS Scare' (1986), citing Okware as saying, 'The mass media has overdramatised the AIDS scourge . . . The figures given by the press in recent weeks are clearly overstrenced [sic]', and arguing that AIDS was being misdiagnosed for other common diseases with the same symptoms like typhoid fever and chronic malaria.

Nevertheless, in September 1986, when the foundations of the new regime had been firmly consolidated, Museveni appeared to take a personal interest and a direct role in stepping up government efforts to fight the epidemic. Later, he claimed that he was prompted to take new action when he learned that, of 60 officers that he sent to Cuba for high-level military training, 18 (or 30%) had tested HIV positive.[18] Rugunda arranged for Okware and his Sub-Committee to brief the President on the state of the epidemic and the President responded by upgrading the Sub-Committee to establish the National Committee for the Prevention of AIDS (NCPA), publicly launched at Kampala City Hall in October 1986. International participation included UNICEF, but surprisingly not the World Health Organisation. Foreign doctors like Carswell, who had played a key role in the Sub-Committee, were not included in the NCPA.

Carswell and the other foreign doctors who had been instrumental in drawing attention to the virus were constantly sought out by international journalists for comments (Harden, 1986a,b; Raeburn, 1986a,b,c; Reuters, 1986; Williams, 1986). Carswell clearly saw the international press as a vehicle to attract more foreign assistance to fight the virus, but also felt at the time that the new government was still being far too complacent (Hooper, 1990, p. 349). Throughout 1986 he spoke to journalists, often with a candour that caused ranker among the authorities. In February, an issue of the *Health Information Quarterly* was published documenting the severity of the epidemic,

[15]In a speech to the '9th International Conference on AIDS and sexually transmitted diseases (STDs) in Africa' (10 December 1995) in Kampala, Museveni said he first heard of AIDS on the radio while fighting in the bush and it was only discussed as a disease of homosexuals. But, in 1984, when he heard an Italian specialist explain that it did not affect only homosexuals he called his men together and told them there was a danger (Nau, 1995). According to one of his advisers, Museveni was listening to a BBC report from Zambia.

[16]The World Health Organisation's annual meeting took place during 1–15 May 1986.

[17]Writing in 1991, Boyd (1991), who had been very close to Museveni's government, reflected the reigning sentiments when she explained why she had not previously spoken about AIDS, 'I have sought in the past four years to encourage people to look at Uganda outside of the Western-media image of Uganda, equated with AIDS and Idi Amin, images that made it the pariah of the international world, and to look at Uganda's new and hopeful programs for real development'.

[18]Museveni said, at the conference of the Non-Aligned Movement held in Harare during 1–6 September 1986, Cuban President Fidel Castro told him of the tests and suggested he had a major problem in his country, after which Museveni said he spoke to his doctors (Nau, 1995) (this report of his speech suggested the soldiers were sent to Cuba for testing rather than training). *The Economist* in March 1987 reported that, 'A team of Cuban doctors recently completed a two-month survey of AIDS infection in the army: unofficial preliminary results are that one soldier in three is infected'.

which was followed by the publication of articles in the international press. A series of articles in London's *Guardian* by Peter Murtagh (1987a,b,c) published in early February 1987 led to a significant backlash within the Museveni government.[19] Murtagh wrote of an escalating epidemic pointing to Uganda as the site of origin of the virus spreading into Kenya and discussing problems of rampant prostitution along trading routes involving Ugandan women. He reported conditions were unhygienic in clinics and action fell far short of requirements to stem the tide of the virus, while churches, especially the Catholics, opposed programmes to promote condom use. Murtagh reported Carswell's observations that the virus was spreading exponentially and most unfortunately cited the doctor as saying, 'Next year we'll see the apocalypse ... Come back to Kampala then ... there'll be plenty of parking space' (Murtagh, 1987b). In early February, Carswell's home was attacked and his cook and gardener were beaten to death, with rumours that the attackers were soldiers in uniform (Hooper, 1990, p. 156).

Less than a week later, Wanume Kibedi (1987a), Uganda's Permanent Representative to the United Nations, published a two-page spread in the government newspaper with a stinging attack on journalists and those who were talking to them. He condemned 'those who should have known better' for alarmist articles and statements on AIDS 'making sweeping generalisations that are not supported by any scientific evidence'. He refuted one by one what he said were myths that AIDS started in Africa, that African countries were not reporting cases, that the virus is out of control and killing millions and that it is spread by promiscuity. Kibedi wrote that he had spoken to Rugunda who assured him, 'that the claims about the extent of AIDS in Uganda were much exaggerated' and said malaria, TB and diarrhoea were a 'far greater menace than AIDS'.

In January 1987, the World Health Organisation (WHO) had sent a mission to lay the groundwork for cooperation with the government. In February, as Kibedi and others were rebuffing 'exaggerations' about AIDS, a second WHO team arrived, including Robert Downing who had played a role in identifying the presence of the virus in the country. The team assisted in drawing up a short-term response and a medium-term five-year action plan (Ochan, 1987).

Carswell was unceremoniously expelled from the country on 1 April (Hooper, 1990, pp. 103, 117, 172, 287) just the day before the five-year action plan drawn up by government officials and the WHO team was published. The plan formed the basis for a donor conference organised by the Ministry of Health and WHO in May 1987 and the launching of the first AIDS Control Programme (ACP) in Africa, which was based within the Ministry of Health. Donors pledged $ 6.9 million to fund it through its first year, with $ 14 million for the following four years (Hooper, 1990, p. 184). At the conference Jonathan Mann, the crusading head of WHO's AIDS programme, appeared to use the occasion to distance WHO from debates about 'African origins' of the virus. He congratulated the NRM government for its openness and stressed its role in fighting what was, not an African, but a *global* threat, 'Since the NRM government is taking a major role internationally to find a solution to this global threat the WHO will help Uganda in its efforts against AIDS'.[20]

The president's stance on HIV/AIDS

Throughout 1987, Hooper (1990, p. 269) argued that the NRM was slow to develop cooperation with the National Committee for the Prevention of AIDS.[21] The first major public intervention by President Museveni reported in the government-owned newspaper, *New Vision*, came two months after the donor conference, at the end of July 1987, at an assembly in Masaka, one of the earliest and worst affected areas of the country (UNA, 1987).[22] The paper did not report another major speech until November 1988, when Museveni addressed a National Seminar on the draft UN Convention on the Rights of the Child (Amooti, 1988). The third major speech reported in the government press was delivered on World AIDS Day held in Kampala on 1 December, and it was on this occasion that the

[19]Murtagh was introduced to Carswell through PANOS, where Renee Sabatier had been undertaking research on AIDS since 1984. Communication from James Deane, PANOS UK (18 July 2003).
[20]The donor meeting was held during 21–22 May ('AIDS Meeting Starts' 1987).
[21]It was only toward the end of the decade that the NRM (n.d.) published its own guidelines for the control of HIV/AIDS.
[22]This is based on a comprehensive review of the government owned paper *New Vision* between 24 June 1986 and 25 June 1989. While some numbers were missing from the collection at Howard University's Moorland Spingarn Research Center, Washington DC, the review nonetheless allowed an assessment of the emphasis placed on HIV/AIDS by the government over time.

President appeared to put to rest any ambiguity in the government's position, making it clear that the fight against HIV/AIDS was a national priority (*New Vision*, 1988).[23] In these three speeches, the President raised the key themes that would characterise most of his future interventions on AIDS and shed considerable light on his own stand in fighting the epidemic—the ideas that informed his leadership on AIDS.

First, he *listened to and valued scientific and medical knowledge*. As we have seen, from the moment he took power and even in the bush before he came to power, Museveni put great stock on expert knowledge. In Masaka, in what may have been a response to the views expressed by Kibedi and others, he explained that research had demonstrated that the disease had reached epidemic proportions in some parts of the country. He warned the people against associating AIDS with witchcraft, which he said would deter them from taking measures and changing sexual behaviour and argued that they should avoid unprofessional medical treatment. In December 1988, he appeared to resolve the tension that had existed in his government with his call for all-out action, but this time he echoed Kibedi (who had made yet another major criticism of media reporting in June 1988)[24] warning journalists that they could derail national efforts to combat AIDS with 'such irresponsible converage [sic] of stories and claims'.

Second, he *favoured public delivery of health care and the regulation of private providers*. In Masaka he said the government would look after orphans of AIDS victims and said he had asked the Ministry of Health to develop a programme. At World AIDS Day he called for improvement in ensuring safe blood transfusions and said he was perturbed by mushrooming private clinics, which lack facilities and called for their closure. He said traditional healers should only operate with approval from the MOH.

Third, he simultaneously called for *protection of the rights of women and children and advanced a socially conservative agenda*, which while rejecting superstitions and abusive family practices, at the same time called for a revival of traditional values. In November 1988, Museveni called for protection of children under 21 from sex abuse by adults and said minors should be barred from sexual activity. He pointed to the problem of extortionate bride wealth demanded by the parents of girls and said parents should be kept from selling their children. He announced that the government would be preparing another law on extra marital relationships. In Masaka he had earlier argued that couples should have an AIDS test before marriage. On World AIDS Day, Museveni said Resistance Committees (RCs) should revive traditional codes of morality, warning that those who knowingly spread AIDS should face criminal charges. He said that 'a very effective way' to deter prostitution and adultery were old corporal punishments, 'We should emulate the social behaviour of our ancestors which forbade immorality and irresponsible communal sexual life styles'.

Fourth, Museveni argued for an *all out campaign to educate the public*. In November he said an extensive and systematic health campaign needed to be taken down to the village level through the organisation of seminars, as posters, radio and television would not reach the rural areas. At World AIDS Day he said that public education had to be carried out by all officials not just those working on health and argued against ostracising sufferers and pleaded for more counselling. He said an aptitude test on AIDS knowledge should be taken by all public officials, and famously eliminated any further ambiguity among NRM and government officials about the attention AIDS deserved saying, 'All ministers, RCs, Senior Government officials must inform the people how to stop the spread of AIDS, at all meetings without exception'.[25]

The sources of 'political will'

A review of the political history of AIDS in Uganda suggests that Uganda faced many of the same pressures as other African countries confronting the AIDS epidemic and the government's adoption of a full-blown campaign

[23]Hooper (1990, p. 359) suggests Museveni may have been influenced by preliminary results of the first comprehensive sero-survey, which had likely become available to him by that time.

[24]In a statement to the US House of Representatives on 30 June to back up Uganda's request for additional assistance for its AIDS programmes, Kibedi (1988) outlined the commitment and progress of the NRM government in fighting AIDS and once again berated the international media, 'Unfortunately some outside journalistic interests exploited the policy of openness, making trips to Uganda for the purpose of writing sensationalist stories about the AIDS outbreak'. He said the world got the impression that Uganda is awash with AIDS, which, he argued, was not true.

[25]However, on many subsequent occasions, Museveni's own keynote speeches did not mention AIDS. Surprisingly there is no mention of HIV/AIDS in Museveni (1997).

was not unproblematic. Although the personal attributes of Museveni played a role in the process, four factors emerge out of this history that help to explain what gave rise to successful central leadership in the fight against HIV/AIDS.

First, Museveni shunned the mythologies associated with HIV/AIDS and *listened to expert medical advice*. The NRM government was influenced as other governments on the continent, by the negative imagery about AIDS in Africa even to the point of expelling doctors like Carswell who had played a pivotal role in discovering the virus in the country. Nevertheless, in the end, the administration supported Ugandan doctors and the health professionals in the MOH and based their decisions on medical and scientific evidence.

Second, the *incentive structure* that the government faced meant that overall it had little to lose and everything to gain by taking early action on HIV/AIDS. The legacy of the civil war and the role of the international donor community were pivotal in this respect. When Museveni's NRM took power in 1986 the country had been devastated by war. Unlike in countries like Kenya, the new administration did not have to face the same dilemma over the economic impact of a decision to openly recognise the virus as there was no tourism to speak of and investors had long stayed away from the chaotic Ugandan economy. What is more, the donor community, at least from early 1987, when the WHO and US experts helped to design the ACP, held out the prospects of providing significant assistance if the government demonstrated commitment to a campaign against AIDS.

Third, the impact of the high-level political commitment to fight against HIV/AIDS and the all-out educational campaign, both clinched by December 1988, created a situation where the *epidemic was put beyond partisan politics*. While the international media focus on AIDS in the country raised nationalist resentment, it not only drew the donor's attention to the gravity of the situation, but also played a role in making it illegitimate for political authorities to oppose the emerging drive among the medical profession, the Ministry of Health and the President's office to launch an all-out campaign. While Museveni faced many criticisms (though no serious challenges) from opposition forces, all publicly admired the role he played in mobilising the nation around the epidemic and none put the government's commitment to the fight against HIV/AIDS into question. No one could occupy high office without demonstrating a commitment to continue the fight against the virus.

Finally, there was clearly a *firm coalition* behind the President's HIV/AIDS campaign. By the time Museveni brought the NRM out forcefully behind a full-blown campaign at the end of 1988, there were few families in the country, including the families of most major political actors, who were not affected by HIV/AIDS. As time went on, everyone knew someone who had died as a result of the virus and the images of its impact, at least in the urban areas, were pervasive. Doctors could not cure their own brothers and, money and privilege was no shield to the virus.

Unity behind the HIV/AIDS campaign was achieved in part due to the overwhelming presence of President Museveni and his military organisation, given the context of the guerrilla war he had won. Museveni also left little room for open political dissent once the NRM government adopted a policy.[26] The centralised character of the NRM regime proved decisive in ensuring the successful implementation of the AIDS Control Programme.

CENTRAL LEADERSHIP TO ENSURE SOCIETY'S INVOLVEMENT

It was leaders of the central state who acted first to rally the nation behind the fight against HIV/AIDS. They had the knowledge and the connections with the international community, but most importantly, the authority to convince a diversity of social groups to organise around HIV/AIDS. The central government encouraged existing associations to take up work on the epidemic and helped to form new organisations. The centralist authority of the NRM, once it came on board, and the military organisation on which it was based, also made quick dissemination of the message about HIV to every village possible. It was Museveni's military organisation that in 1988 implemented the first national sero-survey to take place in Africa.

[26]Kanyeihamba's (2002, pp. 267–268.) account of 'correct politics' provides some insight.

Religious organisations and the fight against HIV/AIDS

Because progress in fighting the HIV/AIDS epidemic is so dependent on changing risky sexual behaviour, the dissemination of information and education of the public at large is all important. In Uganda, like in most parts of the world, fostering open discussion about sexual behaviour touches on matters deeply personal and closely linked to specific moralities, values and religious beliefs. Early on in the campaign political leaders saw the necessity of involving religious leaders and organisations. Not only were they needed to help influence the population, but the government needed to ensure that they would be part of, rather than in opposition to, efforts to discuss the epidemic. Because AIDS was initially linked in the west to homosexual behaviour and injecting drug users, and even in Africa was initially linked to promiscuous sexual behaviour, enormous stigma was attached to the disease. No efforts of surveillance, prevention or care and treatment could be made without fighting stigma and religious leaders were recognised as playing an essential part.

President Museveni sought out leaders of the Catholic and Protestant majority Christian community and urged his officials to work with them and to avoid antagonising them. Initially, the President's own socially conservative positions and opposition to the promotion of condoms helped to reassure Christian leaders. From very early on church leaders were invited onto the national committees charged with fighting the epidemic. One reason the traditionally conservative churches were won over to the coalition to fight the epidemic was the extent to which their own clergy and parishioners were touched by the epidemic.[27] Inventive actions were taken, when the late star singer Philly Bongoley Lutaaya came out openly as HIV positive and organised a concert in the Namirembe Cathedral, in April 1989 (Azabo, 1989). People took the words of clergy members to heart due to their positions of authority in communities. Like in politics, crucial to the mobilisation of the religious groups was the early involvement of respected leading members of the clergy, like the late Bishop Yona Okoth who provided the space within the church for AIDS activists to operate. Canon Gideon Byamugisha (1998a,b, 2000) played an enormous role in breaking down prejudice both within the church and in Christian communities when he revealed that his wife had died of AIDS and that he discovered after her death his own HIV positive status. Church organisations have provided subsidies to people to have their status checked and have trained clergy and lay members in counselling. They could reach far into the rural communities, perhaps where even the NRM could not.

International donors and international religious communities played an important role in winning over local churches and mosques. The World Council of Churches produced a pamphlet as early as in 1987 entitled *What is AIDS?*, which had an important influence in local church circles in Uganda. USAID was instrumental in assisting church and mosque leaders to organise a conference in 1991 to learn about and commit to the fight against HIV/AIDS.

Some religious AIDS activists themselves said, the state had to take the lead both to ensure a plurality of faith groups could be involved, but also to ensure that the messages of these groups came as supplements to secular public health messages and information.

The role of NGOs and the associational sector

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

Despite the hegemony of the NRM on the political scene, President Museveni and his cadres saw the importance of NGOs to their general reconstruction efforts and created a favourable environment for them to grow. The international donor community was instrumental in providing funding for the NGO sector from the outset. At the end of 1987, The AIDS Support Organisation (TASO) was founded by people living with HIV/AIDS and members

[27]Interview with Rev Gideon Byamugisha (7 January 2003).

of their families (TASO, 1999). TASO was a pioneer in promoting voluntary counselling and testing as well as piloting the use of antiretroviral therapies in the country.[28]

In most domains of development work, NGO activity is heavily dependent on foreign funds and difficult to sustain over the long-term. However, there is a particular dimension of NGOs' role in HIV/AIDS work, which is likely to ensure continued mobilisation and activity within civil society—that is, the organisations of People Living with HIV/AIDS (PLWH). Since the number of people living with the virus will continue to grow, these organisations play an essential role in care and treatment and coping with the hardships inflicted by AIDS. In Uganda, the NGO sector has been almost entirely dependent on donor funds with even long-standing organisations like TASO receiving 100% of their funding from abroad until very recently.

Media

Behavioural change can occur only when there is a plurality of messages that combine to reach the majority of the population. While government-controlled media can disseminate uniform information, it is only when there is a plurality of media sources that people tend to listen and trust what they hear. In Uganda, when still in private practice, Dr Elioda Tumwesigye, who by 2003 was head of the Parliament's standing committee on HIV/AIDS, teamed up with privately-owned Capitol Radio, the first independent FM station, to offer a programme on health matters and HIV/AIDS. He said this was made possible with the liberalisation of the media in 1994 and nine years later there were some forty programmes that discussed health issues over the airwaves.[29] Even government buys time on private radio for its own HIV/AIDS advertisements. Interestingly, however, one study reporting survey data from the mid-1990s argued that awareness of HIV/AIDS in Uganda leading to behaviour change was achieved more through social/personal networks than through mass media (Stoneburner *et al.*, 2002). Nevertheless, especially in the 1990s, the media often pushed public debate faster than the government was initially comfortable with.[30]

The central state played a key role in mobilising and shaping non-governmental interventions on AIDS. At the same time, the NRM's decision to allow the operation of private media organisations contributed in an important way to ensuring that information about the need for behaviour change reached large numbers of people.

CONCLUSION: POLITICS AND HIV/AIDS

Uganda faced many of the problems that other African countries confront in relation to HIV/AIDS and even after the Museveni government came to power with an early commitment to fight the epidemic, it took a full two years before a full-blown presidential led campaign was launched. The president's role of course was underpinned by his own charisma and particular abilities, but there is still much to learn from the Ugandan experience for other countries where leadership may be less decisive.

The first step in confronting the AIDS epidemic was a move from a situation of war and disorder to a condition of relative security. It is doubtful that any significant progress could have been made in fighting the epidemic without securing the peace. This is underlined by the fact that in the areas where the Museveni regime is still engaged in combat, little is known about the prevalence of HIV and virtually no action is being taken to stem the spread of the virus.

While efforts to move away from exclusively biomedically determined priorities are necessary to progress in confronting the virus, the medical profession and the public health authorities nevertheless play a crucial role in dealing with the epidemic. The importance of making decisions on scientific evidence is underlined by the apparent dilemma that faces leaders who can see much more immediate and widespread causes of death in diseases like malaria and tuberculosis. Especially in the early stages of an epidemic, leaders will only be convinced to invest resources and attention to HIV if they understand the epidemiological characteristics of the virus (its long period of latency, the way it can spread throughout a population and its incurability) and the way it will interact with other diseases like malaria and TB. Waiting to take action on HIV/AIDS until there is evidence of AIDS-induced deaths,

[28]Interview with Dr Alex Coutinho, Director TASO, 11 January 2003.
[29]Interview, 6 January 2003.
[30]Communication from James Deane, PANOS UK (18 July 2003).

will allow the virus to reach epidemic proportions. The single most important characteristic of Museveni's positive leadership was that he was guided, in the end, by medical evidence about HIV/AIDS.

The incentive structure faced by the President was such that there was little to lose and everything to gain in launching a campaign on HIV/AIDS. The international community, despite the antagonism spun by some of the reporting in the press, played a pivotal role in shaping this incentive structure, both by providing resources to a committed government and by shaping the grounds of legitimacy faced by the government at home and abroad.

It is clear that the centralist character of the NRM regime was crucial not only to mobilising state organisations and foreign aid resources, but also to ensuring significant involvement from non-state actors. In Uganda, the absence of effective political competition in the late 1980s allowed the President a relatively free hand to spearhead a nationwide campaign on HIV/AIDS without needing to be overly deferential to potential opponents of the strategy. Programmes such as compulsory testing for new recruits to the armed forces received some criticism, but nevertheless have been important in ensuring against the further proliferation of the virus in this high-risk group. There is a tension between the requirements for determined and systematic action that public authority and a command structure can deliver and the need to disseminate information widely and through multiple belief systems requiring a degree of democratic openness and a free media.

While it is fashionable at the beginning of the 21st century to see all things 'democratic' as unquestionably 'good', the experience of fighting the HIV/AIDS epidemic in Uganda, as elsewhere, calls for a more nuanced understanding of the role of democratic organisations and institutions. In large measure, it was Museveni's socially conservative approach that won over church organisations to participate in the AIDS campaign. To be sure, if leadership is lacking and state organisations are weak, the associational and religious sectors may be alone in promoting AIDS work, but if they are to be effective over the medium term, an important part of that work needs to be devoted to repairing the state to ensure long-term action.

In Uganda, the President was able to forge a coalition behind an HIV/AIDS campaign in part because the virus largely ignored the privileges of wealth and political power. With the development of antiretroviral therapy and the access that the wealthy can gain to these drugs, this basis for the broadest possible coalition to fight HIV/AIDS may be weakened in the future.

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