

**Governance and AIDS in Africa:
Assessing the International Community's "Multisectoral Approach"***

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Abstract

This paper analyses the international community's response to HIV/AIDS in Sub-Saharan Africa. The paper begins with an exploration of the political and epidemiological dimensions of the crisis. It then outlines the main parameters of an "organisational template" elaborated and imposed on developing countries by the World Bank, UNAIDS and the Global Fund to fight AIDS, Malaria and Tuberculosis. The template is evaluated based on an assessment of its implementation and focusing on key political issues, including the role of state leadership in organising a multisectoral response and in mobilising religious and associational sectors. The author argues that the organisational template misinterprets the experience of countries that have achieved some success in fighting the virus, and that it is overly influenced by the "post-Washington consensus", which brings together neoliberal prescriptions with prescriptions promoting popular participation and the defence of human rights. The AIDS crisis provides new opportunities for reviving public health sectors and creating an ethos of public service within the public sector and the medical profession, but also forces policy-makers to confront difficult trade offs between individual rights and the public good.

Keywords: acquired immunodeficiency syndrome, human immunodeficiency virus, civil society, NGOs, Uganda, Senegal, Malawi

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INTRODUCTION

The AIDS crisis has already reversed much of the progress made in development over the past half century in different parts of Sub-Saharan Africa. By the end of 2003, UNAIDS¹ estimates that some 25 million people were living with HIV/AIDS, two-thirds of all reported cases, while 3 million more people were infected and 2.2 million died of AIDS during the course of that year (UNAIDS, 2004, p.30). The most devastating statistics relate to declines in life expectancy in countries that have generalised epidemics. In seven African countries with HIV prevalence greater than 20 percent, average life expectancy, which would have been 62 years without the virus, has dropped to only 49 years. In Swaziland, Zimbabwe and Zambia, in the absence of antiretroviral therapy, life expectancy of people born in the decade beginning in 2004 will be only 35 years (UNAIDS, 2004, p.42). For both physiological and social reasons, women are hit by the virus, even more severely than men and, because its transmission in Africa is mainly through heterosexual relationships, people in the most productive years of their lives are the hardest hit as the epidemic destroys human capital across the continent. The crisis has exponentially expanded the numbers of orphaned children in every African country experiencing an epidemic.

In 2001, Catherine Boone and Jake Batsell berated the political science profession for a failure to engage with the epidemic.² They called for comparative analysis that could explain differential state responses to the crisis, systematic analysis of the role of non-governmental organisations in fighting the virus, and study of the role AIDS is playing in stoking North-South tensions and the way it is affecting international regime formation. Most, tellingly they argued that the AIDS crisis played a role in eroding “the 1990s ‘Washington consensus’ on neoliberal growth strategies in Africa” and highlighted the “need for public goods” that only governments can provide. To some extent, this paper addresses all these questions, but focuses most clearly on the extent to which the international community’s response to AIDS breaks from past development paradigms. I draw largely on evidence from the experience of two countries in Africa that have achieved considerable success in fighting the epidemic – Senegal, where state action contributed to pre-empting AIDS from developing into a full-blown epidemic, and Uganda, where state action appears to have contributed to bringing the epidemic under control.³

My analysis suggests that Boone and Batsell may have been overly optimistic about the extent to which the AIDS crisis is contributing to a break from neoliberal

¹ The Joint United Nations Programme on HIV/AIDS was launched by six UN organisations and succeeded the World Health Organisation’s (WHO) Global Programme on AIDS in January 1996.

² A search of titles and keywords in the *American Political Science Review* through the International Bibliography of the Social Sciences and JSTOR, suggests that not a single article has ever been published on HIV/AIDS.

³ See Putzel (2003) for an account of the course of the epidemic in the two countries.

precepts in the development strategies being advanced by the World Bank and the international donor community. In part this relates to the wider issue of the nature of the “post-Washington consensus” that has emerged in the Bank and among bilateral donors. Stiglitz (2002:53) described the “Washington Consensus” as a commitment of the international development community to the three pillars of “fiscal austerity, privatization and market liberalization”.⁴ The consensus was articulated in regard to Africa in the World Bank’s Berg Report published in 1979, which charted the course for almost two decades of structural adjustment in Africa (World Bank, 1979).

As the problems of implementing liberal reforms contained in the structural adjustment programmes of the 1980s and early 1990s became evident, the World Bank and other international actors, pressured by criticisms from the NGO community, began to lay out a new approach to development that placed greater emphasis on poverty reduction and the participation of civil society organisations. While the new thinking accorded greater attention to the regulatory role of the state (World Bank, 1997), the principal prescriptions of neoliberal reform contained within the Washington Consensus remained intact (Hildyard 1998). The “post-Washington Consensus”, somewhat of a misnomer since the Bush administration came to power, appeared to be a confluence of the agendas of the liberalisers at the Bank and other international organisations with the advocates of popular participation, global civil society and the defence of human rights within the NGO community.⁵ Both share a deep skepticism of the state and a devotion to individualism. The new consensus included NGOs and the advocates of global civil society as partners with private entrepreneurs and corporations in the development process.⁶ Today, this is best understood as a consensus around a multilateralist agenda shared widely within the international development community, but somewhat at odds with the Bush administration in Washington. The organizational template elaborated by the Bank and others to deal with AIDS can best be understood as an application of this “post-Washington consensus”.

The paper is based on fieldwork undertaken in Uganda, Senegal and Malawi, originally in the context of consultancy work for the Department for International Development of the UK government, reflective work undertaken for the UNAIDS Africa AIDS Scenarios project and further research in the archives of national governments and international organisations.

The first section of the paper examines the political and epidemiological dimensions of the HIV/AIDS crisis to offer an analytical prism through which to examine the actions of the international community. The second section outlines what I call the “organisational template” elaborated and imposed on developing countries by the international donor community as a condition for receiving funds to fight the epidemic. The third section critically evaluates the template in light of the experience of its implementation, focusing on the key political dimensions of the fight against HIV/AIDS. In the conclusion I offer a reflection on the political dimensions of the

⁴ The “Washington Consensus” was a phrase coined by Williamson (1990) to refer to ten policy issues around which the powerful in Washington DC (the US government and the international financial organizations) could agree. Williamson not only presented a much more nuanced assessment of the consensus than Stiglitz describes, but also demonstrated his own distance from some of its precepts.

⁵ This current is best represented by Kaldor et al (2003) and Beck (2003).

⁶ See Putzel (forthcoming) for a fuller exposition of the post-Washington consensus.

battle against AIDS and call for a more flexible and nuanced approach by the donor community.

POLITICAL AND EPIDEMIOLOGICAL DIMENSIONS OF HIV/AIDS

The lack of attention to the AIDS crisis within the political science profession is particularly striking as the epidemic is a quintessentially political issue. One explanation for the failure to engage with the disease may be the general perception that it is a health issue best left to medical experts. However, it is likely the failure to engage is related to the complexity of the epidemic that defies easy modelling, standardised interpretations or uniform policy responses.

Designing public policies in response to the epidemic must begin from understanding the epidemiological characteristics of the virus and their relationship to basic social, economic and political conditions. Key epidemiological facts include: the long-gestation of the virus; its transmission in Africa primarily through heterosexual encounters; the fact that women are physiologically more susceptible to contracting the virus than men; and the observation that different strands of the virus (HIV-1 and HIV2) progress to AIDS at different rates (and possibly that dominance of HIV-2 inhibits the more virulent HIV-1).

We know that key social practices and conditions affect the spread of the virus and therefore need to be brought into the realm of public policy debate. These can be considered in two categories:

(1) *issues directly related to sexual activities:*

- the prevalence of sexually transmitted diseases accelerates the transmission of the virus
- male circumcision almost certainly slows it down
- female genital mutilation likely accelerates transmission
- a younger age of first sexual contact accelerates transmission
- having multiple sexual partners accelerates the spread of the virus – particularly if they are casual partners.

(2) *more basic social-economic-political conditions that appear to influence patterns of sexual activity:*

- the inferior position of women in society combines with physiological vulnerability to make women even more susceptible than men to the virus and accelerates transmission;
- unregulated commercial sex markets particularly in urban areas, migrant areas, along transport routes and among displaced people, accelerate transmission;
- patterns of work and trade more generally influence the rate of transmission;
- patterns of war and violence influence the rate of transmission;
- patterns of religious affiliation influence patterns of transmission; and
- patterns of poverty and inequality form the bedrock on which all the above affect how HIV/AIDS spreads through a population.

These basic facts mean that HIV/AIDS necessitates the inclusion into direct public policy debate issues that were formerly either matters left to families or religious organisations (most of what we have called issues directly related to sexual activity), or those considered beyond the pale of public policy either because they fall within the realm of illegality (commercial sex work and patterns of violence), or those that have been seen as determined by market activities or political processes beyond policy (most of the social and economic conditions mentioned above as well as issues of violence and war).

The tensions involved in developing a response to the epidemic form the very “stuff of politics”. Sketched out in Figure 1, the epidemic forces analysts and policy-makers to deal with the major dichotomous tensions in the organisation of, and forms of action promoted by, public administration, between approaches that are: governmental and non-governmental, medical and non-medical, centralised and decentralised, directive and participatory, multilateral and unilateral and state driven and market driven.

Figure 1: Political tensions in responses to HIV/AIDS epidemic

Political Administrative			Political Philosophical		
Government	↔	Non-governmental	Collective	↔	Individual
Medical	↔	Non-medical	Coercion	↔	Persuasion
Centralised	↔	Decentralised	Duties	↔	Rights
Directive	↔	Participatory	Public	↔	Private
Unilateral	↔	Multilateral	Secular	↔	Religious
State	↔	Market	Science	↔	Myth

The epidemic also forces a consideration of tensions in the most fundamental philosophical dimensions underlying government and political action between: the individual and the collective; coercion and persuasion; duties and rights, private and public, secular and religious and science and myth. Action around HIV/AIDS requires engagement with each side of these dichotomous dimensions, finding a balance between them at any given moment, and adjusting that balance given changing endowments, capacity and epidemiological, social and economic conditions. It is not surprising that the epidemic has eluded political analysis, nor that international agencies have fallen back on ideologically driven templates to deal with the complexities involved. Those templates inevitably tend to universally endorse one side of these dichotomies and tend to hopelessly attempt to construct a normative policy package where “all good things go together”, in the hope of avoiding the thorny trade-offs, particularly in political philosophical dimensions, that must inevitably be engaged with in a public health crisis.

One of the most important insights to have been gained in work to counter the epidemic is that due to the complex factors driving the spread of HIV/AIDS in the first place, a response cannot be confined to the medical profession and thence the call for multi-sectoral approaches that would address the medical, social, economic and political aspects of efforts to control the epidemic. In the process of elaborating a multi-sectoral response, there has been a tendency to minimise and secondarise the medical dimensions that remain centrally important in any fight against disease.

In Figure 2, I offer a heuristic “three dimensional” (function, actor, time) model to depict the main domains of intervention necessary to the fight against HIV/AIDS. Four types of intervention are outlined: surveillance, prevention, care and treatment and addressing long-term causes and impact. I have listed the types of actions distilled from the experience of effective campaigns under two broad categories of ‘medical/technical’ and ‘social, economic and political’ and indicated those that involve *both* dimensions. I have laid out the spectrum of action in this way specifically to highlight the *continued importance of the medical/technical aspects* within a multi-sectoral approach. This can be seen by the *number of measures that overlap the two categories* (the middle column in bold).

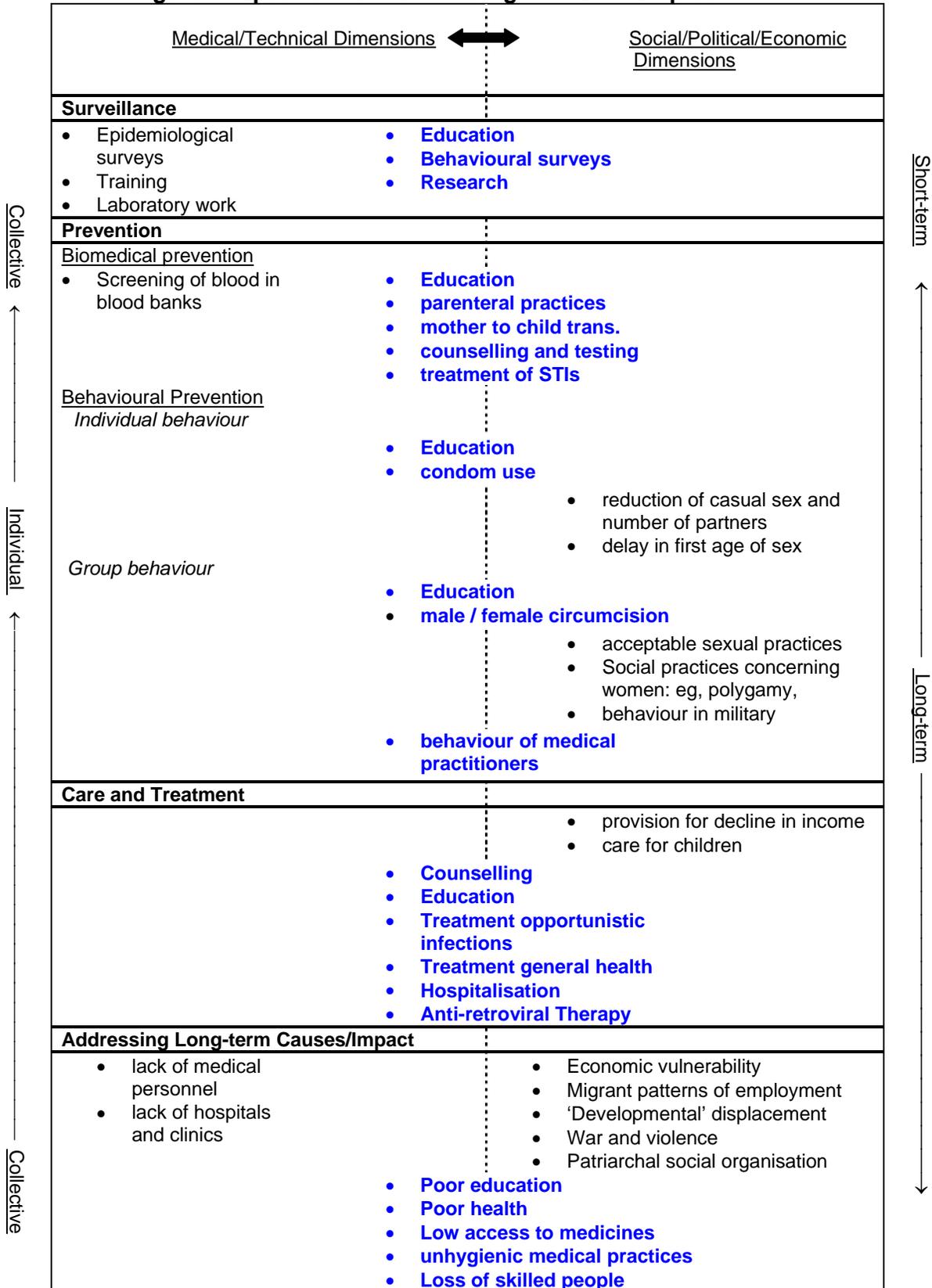
At the core of any effort to fight HIV/AIDS must be the establishment of systems of *Surveillance* to monitor the spread of the virus, the onset of AIDS, the epidemiological characteristics of the virus in its social and geographical setting and the behavioural characteristics of the population hit by the virus. This comprises a complex set of activities that are expensive, requiring technical sophistication and long-term commitment of personnel and resources.

I have divided *Prevention* activities between those that can be understood as biomedical activities and those that relate to activities directed at changing sexual behaviour and practices. Because there is no vaccine for HIV/AIDS and because the spread of the virus in Africa has been overwhelmingly through heterosexual sex, immediate intervention has focused on efforts to promote behavioural change in the population at large. I highlight those aspects of behavioural change that are directed towards individuals, where most of the educational and informational work has been targeted up to now, and those aspects that are related to the behaviour of groups, where change must address deeply rooted institutions, particularly informal institutions relating to prevailing norms and values. This dimension has received much less attention in policy discussion and analyses to date.

As the epidemic begins to reach its full impact, demands for *Care and Treatment* will continue to expand and become increasingly complex. Even in countries like Uganda and Senegal, where the fight against HIV/AIDS is more advanced than elsewhere, governments, private sector actors and associations are only beginning to face up to the challenges to care for People Living with HIV/AIDS. But developing this dimension of interventions is as important to success in prevention work as it is in dealing with the devastating impact on the lives of individuals, families, communities, work places and nations. Few people will choose to get a test and those who know their status may do little to change their behaviour if no care or treatment is available. The rolling out of antiretroviral represents a fundamental shift in this regard and if access to effective treatments can be sustained over time this will not only prolong life, but significantly increase incentives for testing and contribute in a major way to prevention and to building a strong political constituency in favour of further action.

The last category of interventions, *Addressing the long-term causes and impact* of HIV/AIDS comprises deeply rooted structural features of the epidemic and has received mainly lip-service from all quarters. I have tried to avoid a statement of these factors that is all-inclusive of the world’s ills, but instead to underline those structural dimensions that appear to be directly contributing to the depth of the

Figure 1: Spectrum of Action to fight HIV/AIDS Epidemic



pandemic and that are most severely affected by its impact. Given the scale of the HIV/AIDS crisis, a comprehensive response must begin to explicitly address these deeper problems.

The AIDS crisis puts into question the basic propositions of the post-Washington consensus, forcing a reconsideration of the role of the central state, of non-market forms of health care delivery, of directive and sometimes coercive measures needed to secure health as a public good. But it is not as straightforward as replacing one side of the dichotomous dimensions outlined above with the other, because the crisis requires too, new forms of participation, innovative partnerships to actually have an impact on social norms of behaviour and to meet the demands of mitigation from an epidemic that is causing such destruction to not only health, but also the social and economic fabric of communities and polities.

IMPOSING AN ORGANISATIONAL TEMPLATE⁷

In 1999, after publicly admitting that it had been all too slow to react to the HIV/AIDS crisis in Africa, the Bank launched a new AIDS Campaign Team for Africa (ACTAfrica) and a new strategy to confront the crisis (World Bank, 1999a 1999b). The new strategy of the Bank was prompted by a concern that the international donor community and African governments were not responding fast enough, not getting resources to the communities and families living and experiencing the epidemic, not working with non-governmental and private sector organisations, and were still leaving much of the response to officials responsible for health care and to the medical profession. The Bank's message was clear: HIV/AIDS was not only a health crisis, but a *development* crisis. The new strategy was based on mobilising strong political commitment from the highest level of government to launch a multisectoral response involving "sectoral ministries, religious and cultural leaders, civil society, people living with HIV/AIDS [PLWHA], women's groups, youth groups, NGOs, CBOs, [and] the private sector" (World Bank, 1999b, p.46).

The Bank provided the reigning interpretation (shared by UNAIDS and bilateral donors) of what "successful national HIV/AIDS programs" have had in common, laying out "what works":

- government commitment at the highest level and partnerships with civil society and the private sector at all levels;
- investing early in prevention efforts;
- cooperation and collaboration among those most affected by the epidemic, religious and community leaders, NGOs, researchers and health professionals, and the private sector;
- decentralised and participatory approaches to bring prevention and care programs to national scale;
- a forward-looking, comprehensive, and multisectoral response, which addresses the socio-economic determinants that make people vulnerable to infection and targets prevention interventions and care and treatment support to them;

⁷ This section and the first two parts of the next are largely taken from Putzel (forthcoming).

- community participation in government policymaking as well as design and implementation of programs especially people living with HIV/AIDS, NGOs, civil society, and the private sector. (World Bank 1999b, pp.22-23).

They identified a, “core set of interventions that have been proven on a small scale to change behaviour, to reduce the risk of HIV transmission, and to be cost-effective”: changing behaviour through communication; making STI diagnosis and treatment available and affordable; treating opportunistic infections; making condoms affordable and accessible; ensuring safe blood supply; making [voluntary counselling and testing] VCT available and affordable; and preventing mother to child transmission” (World Bank, 1999b, p.23).

Equally the Bank presented the reigning interpretation in the donor community of “what does not work”, including:

- expecting health-oriented national AIDS committees to lead without sustained and high-level government support;
 - centralised programs, led by ministries of health, primarily focusing on the health aspects of the epidemic;
 - inadequately targeting interventions to small sections of populations at increased risk;
 - designing programs without community involvement.
- (World Bank, 1999b, pp.23-24).

This understanding formed the basis of the “organisational template” that has come to dominate the international drive against HIV/AIDS in the developing world. Within a year, the Bank had designed the Multi-Country AIDS Programme (MAP), as a special facility within its concessional lending arm, the International Development Association (IDA), to deliver resources quickly to countries that demonstrated a willingness to develop an “extended” response (World Bank, 2000a, 2000b). The programme was launched under a rather broad interpretation of the Adaptable Program Lending facility, to allow ACT*africa* flexibility and speedy approval of national proposals for MAP funding.⁸ In order to get the Bank Board to approve such flexibility there had to be strong conditionality for projects receiving MAP funding. The MAP programme appraisal document laid out the “eligibility requirements”:

- “**evidence of a strategic approach to HIV/AIDS**” demonstrated by the adoption of a “coherent national, multisectoral strategy and action plan for ...prevention, care and treatment ...developed through a participatory approach”, or at least evidence that the process was underway;
- “**a high-level HIV/AIDS coordinating body** such as a national HIV/AIDS council or equivalent has been established to oversee the implementation of the strategy and action plan” with “broad representation of key stakeholders from all sectors, including PLWHA”;

⁸ On the Adaptable Lending Program (ALP) introduced by the Bank in 1997, see World Bank (2000c, p.8).

- **government has agreed to “channelling grant funds for HIV/AIDS activities directly to communities, civil society and the private sector”** and has in place “effective financial management ...and procurement” measures;
- **“government has agreed to use and fund multiple implementation agencies, especially community-based and non-governmental organizations”**. (World Bank, 2000b)

The sizable funds available under the MAP gave the Bank considerable clout to push the organisational template, but the pressure on countries to adopt its main precepts was considerably increased with the launching of the Global Fund to fight AIDS, Malaria and Tuberculosis (GFAMT),⁹ in January 2002. Conditions that had to be met to receive resources from the Global Fund included:

- proposals must be submitted from and administered by a **“Country Coordinating Mechanism”** that is “broadly representative of all national stakeholders in the fight against the three diseases”, and it should be gender balanced and generally include actors from: the academic/educational sector; government; NGOs and community based organisations; people living with HIV/AIDS, TB and Malaria; the private sector; religious and faith-based organisations; and multilateral and bilateral development partners based in the country;
- proposals should take into account human rights and reducing stigma and discrimination; and
- proposals should be developed in a participatory (Global Fund, 2003a, 2004a).

The World Bank based its organisational template on examples of best practice. In so far as Africa was concerned, the Bank referred mainly to the experiences of Uganda and Senegal (World Bank, 1999a, p.2, 1999b, pp.19,21,58, 2000a, p.5, 2000b, pp.9, 26). The Global Fund appeared to simply incorporate these prescriptions of the Bank modified by the further elaboration of the principles of multisectoralism, participation, decentralisation and public-private partnerships current in UNAIDS discourse and that of the international donor community more generally.

THE ORGANISATIONAL TEMPLATE IN PRACTICE

Many of the propositions about how governments might organise a successful fight against the epidemic put forward by the World Bank and UNAIDS in the late 1990s were based on sound evidence. Successes in Uganda and Senegal involved strong political leadership, right from the top of government. The epidemiological and social character of the virus meant that any successful fight to control its transmission required action far beyond the health sector, necessitating a mobilisation of action

⁹ The Global Fund is a non-profit foundation established in Geneva to act as a clearing house for donor funds and is administered by the World Bank (Global Fund, 2002). It was set up in 2002, with an initial pledge of 2.1 billion dollars. The initiative was first born in the US House of Representatives where there was a proposal to set up a Global AIDS and Tuberculosis World Bank trust fund. On the urging of the Secretary General of the United Nations at the UN General Assembly Special Session on HIV/AIDS (June 2001), a proposal was adopted to endorse a “Global Fund” followed by an endorsement from the G-8 in July 2001. The initial board of the Fund met in January 2002 (Copson and Salaam, 2002).

across government departments and the enlistment of a wide variety of non-governmental actors, including religious authorities, traditional leaders and community associations.

However, the demand from the Bank and other donors that all countries should establish a national commission to lead the battle against HIV/AIDS as a condition for accessing funds significantly misrepresented the experience of such Commissions, even in Uganda and Senegal where success had been achieved in fighting the epidemic. The problem lay in confusing political leadership with particular forms of organisation and in attempting to identify a “technical fix” for what was primarily a political challenge. Promoting the model tended to obscure the need to significantly reinforce the capacity of health sectors to be able to respond to the crisis, to underestimate the role the state and leading political parties within it played to mobilise the associational and religious sectors, and to ignore real tensions between democratic, decentralised and rights based agendas on the one hand, and the imperatives of confronting a public health emergency on the other.

The early experience organising government action

The first country to establish a National AIDS Commission was Uganda and the World Bank was involved from the start.¹⁰ When President Museveni decided to launch a nation-wide effort to fight HIV/AIDS in 1986 he formed a National Committee for the Prevention of AIDS (NCPA) within his office and chaired by himself. At the same time a National AIDS Control Programme was established in the Ministry of Health (MoH). Between 1987 and 1990, the NCPA held monthly meetings chaired by the President and attended by the major donors. By 1988, the NCPA included representatives from the most concerned national government ministries, all the major religions in the country and the NGO community, particularly the path-breaking NGO, the AIDS Support Organization (TASO), set up by people living with HIV/AIDS at the end of 1987.

This innovation of Museveni’s - establishing a Committee within the President’s Office – inspired the idea within the Bank that governments could duplicate what was achieved in Uganda through establishing national commissions or councils involving all “stakeholders”. However, this ignored the fact that most of the resources, the support for other ministries’ action, and the organisation of a systematic campaign against the virus in Uganda was lodged within the Ministry of Health. The NCPA did not set up a parallel structure to government but operated within the existing organisational framework of government.

During the first four years of the campaign, the Ministry of Health, assisted by the World Health Organization, developed the nuts and bolts of Uganda’s fight against the epidemic through the National AIDS Control Programme. The Ministry of Health’s National AIDS Control Programme was the centrepiece of the government’s efforts to fight the epidemic and quickly became bigger than the rest of the MoH. It was tasked with health education, the establishment of a blood bank and the

¹⁰ This account is based on interviews with major players in the National Committee and the subsequent Uganda AIDS Commission. For a more thorough exploration of the history of action in Uganda see Putzel (2004a) and Parkhurst (2002).

development of care for people suffering from AIDS, especially treatment of opportunistic diseases. By 1988, it had helped to launch major programmes on HIV/AIDS within the Ministry of Education and in the Ministry of Defence and had launched work with NGOs like TASO. The MoH worked closely with the WHO to develop the National AIDS Control Programme and established six units: (1) epidemiology in charge of surveys; (2) monitoring and evaluation; (3) information, education and communications; (4) care for people living with AIDS, especially in relation to opportunistic infections; (5) STD management; and (6) infection control and precautions, such as the use of condoms.

By 1990, at the urging of the World Bank, an initiative was launched to formalise and reproduce the coordinating role that the President's national committee had undertaken since 1987. The President set up a team to form a Commission that would be housed under the Office of the President and would include 11 Cabinet Ministers, as well as religious organisations and NGOs. The mandate of the new Commission would be to coordinate responsibilities for fighting the epidemic among ministries through joint planning, to undertake monitoring and evaluation work and to share information. By 1992, the Uganda AIDS Commission (UAC) was established, but right from the start it experienced problems (WHO et al, 1992). The enabling legislation was unclear about its mandate and the relation of the UAC with other central ministries within the government. The Ministry of Health was seen as merely the 'technical arm' of the UAC. By 1997, when initial funding was exhausted, the donors were disappointed with the UAC's performance and it was folded back under the authority of the MoH and remained moribund.

In Senegal, the other country from which the World Bank drew inspiration, there was a similar experience, where Presidential action led to an early effective campaign, but one that relied heavily on the existing structures of government and the expertise of the health sector.¹¹ Right from the start of Senegal's campaign against the HIV/AIDS virus there was recognition of the need to mobilise far beyond the health sector to fight the epidemic. Shortly after the first cases of HIV were diagnosed, on 29 October 1986, the government established the Comité National Pluridisciplinaire de Prévention du VIH/SIDA (the National Multidisciplinary Committee for the Prevention of HIV/AIDS – CNPS). The Committee immediately began to elaborate the Programme National de Lutte contre le VIH/SIDA (the National Programme of Struggle Against HIV/AIDS – PNLs). The CNPS objectives included developing surveillance systems, reducing the rate of transmission of the virus, ensuring blood transfusion safety, promoting education and information to influence sexual behaviour, assisting in care of the sick, improving the already robust treatment of sexually transmitted infections and coordinating research activities on HIV/AIDS.

While the Committee fell under the authority of the Ministry of Health, it worked in close and constructive collaboration with other key ministries with support from the WHO. It worked with the Ministry of Women, Children and the Family to put in place community services, with the Ministry of Education for a programme in

¹¹ This account is based on interviews and speeches from the major actors involved in the original National Committee, those in the CNLC, donor personnel and Senegal CNLC (2003a, 2003b) and UNAIDS (2001). For a more indepth analysis of the patterns of the epidemic and the response of Senegal, see Putzel (2003).

schools, which in 1990 established its own internal committee for nationwide education on HIV/AIDS, and with the Ministry of Work and Employment on a major programme of prevention in the workplace and for the protection of the rights of workers living with HIV/AIDS. From 1987, the CNPS worked with religious and political leaders to get them involved in the campaign. Unlike in Uganda, the National Committee maintained a stable leadership and strong cooperation was achieved across the government and with non-governmental actors.

Thus, the early experience of the two African countries cited as positive role models provided significant evidence of the need for a “multisectoral” approach involving all branches of government and cooperation with non-governmental actors. However, this was *not* achieved through the establishment of stand alone AIDS commissions. Instead, it required active leadership at the highest levels of the state and expert action from *within* the ministries of health that helped to underpin efforts in other ministries.

The renewed thrust to establish national AIDS commissions

Given the early negative experience of the Uganda AIDS Commission, its revival in 1999 came as a surprise to many involved in HIV/AIDS work. Under pressure from the World Bank, Museveni decided to re-launch the Commission and place it back under the authority of the Office of the President. The revival of the UAC caused considerable confusion and infighting between ministries over funds. By making all ministries co-equal members of the UAC, the MoH was somewhat marginalised, despite the fact that all other ministries called on it for support to their own HIV/AIDS programmes. A great deal of overlapping and duplication of work became evident. Successive evaluations of the Uganda AIDS Commission have found that it tended unsuccessfully to duplicate what line ministries, especially the Ministry of Health, could do better; it tended constantly to engage (poorly) in implementation even though it was mandated largely to facilitate and coordinate; and it tended to veer (inefficiently) towards bureaucratic enlargement (UNAIDS, 2002).

In Senegal where the Comité National Pluridisciplinaire under the Ministry of Health had so successfully led the campaign against HIV/AIDS, many were stunned when, on 10 December 2001, the Conseil National de Lutte contre le VIH Sida (CNLS) was created by Presidential decree. The government announced that it would be chaired by the Prime Minister with the Minister of Health as vice-chair and would include representatives of the key ministries, NGOs and civil society, people living with HIV, development partners (donors) and representatives of local communities and community and religious associations.¹² The move to form the CNLS appears to have been hastily undertaken to comply with the World Bank organisational template, in order for its proposed ‘HIV/AIDS Prevention and Control Project’ to gain access to IDA funds under the second phase of the MAP that was to come before the Bank’s board on 17 January 2002 (World Bank, 2001).

¹² Ministries included in the CNLS: Health, Hygiene and Prevention; Education; Youth; Defence; Family and National Solidarity; Social Development; Public Sector, Work, Employment and Professional Organisations; Foreign Affairs; Tourism; and Infrastructure, Equipment and Transport.

What ensued according to both long-time participants in the fight against HIV/AIDS in Senegal, as well as donor officials who had experience working with the CNLS, was a period of confusion and a battle between ministries over funds. The new Conseil National not only fomented discord between ministries, but also demanded that these ministries simply channel the new funds to local multisectoral initiatives. Various NGOs had long had relationships with specific ministries and developed specialised programmes for women or youth or in the military, or with the private sector. One of the leaders since the start of the campaign commented, "Why change a winning team?"

While the actions to launch national commissions were disruptive in countries where the HIV/AIDS campaigns had made progress, they appeared to be devastating in other countries where progress was slow or non-existent. Malawi had a National AIDS Control Program lodged in the Ministry of Health since 1987, but it made little progress in engendering a multisectoral response despite major efforts in that direction supported by the donor community throughout the first half of the 1990s. A strategic planning unit was established by the NACP in 1998 and its work was funded by UNDP. This process led to the elaboration of a new national strategic framework for confronting the epidemic in 1999 and then, in preparation for securing a MAP programme from the World Bank, the launching of a stand-alone National AIDS Commission in 2001 (Munthali and McDonnel, 2000).

Unlike in Uganda, where both the initial formation of a Commission in 1992 and its subsequent re-launching in 1998 left the National AIDS Control Program within the Ministry of Health in tact, in Malawi the new Commission was established by ripping the NACP out of the Ministry of Health. Personnel, vehicles and even buildings were reallocated to the new Commission, leaving the Ministry of Health in a shambles. The situation was so bad that by 2004, the government was discussing with donors the funding of an emergency programme for capacity building in the Ministry.

The problem of the organisational template imposed by the World Bank and the Global Fund (and UNAIDS) was not limited to these cases. At a meeting of the Commonwealth Ministries of Health in Africa in Entebbe at the end of 2002, there was heated discussion about the problems all ministries had encountered. In summing up priorities for action at the end of the meeting, the first priority was set as follows: 'There is need for clarification of roles, functions, coordination and implementation mechanisms of National AIDS Councils and MoH AIDS Control Programmes'. The first resolution noted 'the need for distinction between the implementation and coordination roles' of commissions and ministries of health, saying, 'the arising ambiguity could reverse progress of national responses to HIV/AIDS' and called for consultations between the national commissions, ministries of health and donors to 're-examine and further clarify roles and functions and redefine mechanisms for co-ordination and implementation' (Commonwealth, 2002, p.46 and Annex 1).

The World Bank's own evaluation of the early work funded through MAP found these problems broadly present in other experiences (World Bank, 2002b). The evaluation identified problems of Commissions duplicating the "traditional role of Ministries of Health at the national, regional, district [and]...local levels" and suggested there was a "lack of clarity surrounding the role of NAC Secs [Secretariats]... in supporting line ministries". Further, it suggested that the

Commissions and their Secretariats “do not always appear to recognize substantial work on HIV/AIDS done prior to the MAP. This has resulted in some re-inventing of the wheel and consequent alienation of some partners, particularly in Ministries of Health”. The NACs had disrupted procurement operations by Ministries of Health better equipped to continue such operations and obscured what the evaluation said was, “the central role that MOHs and their decentralized

Reports from the Global Fund (2003b) suggest that it has experienced similar problems affecting the functioning of the Country-Coordinating Mechanisms set up as the multisectoral bodies designated to manage Fund projects. In Malawi and elsewhere CCMs have been set up as yet another multi-sectoral body in addition to donor required Technical Working Groups and National AIDS Commissions. In a report to the Fund’s Board, the Executive Director noted that, the “CCMs are not performing as well as we would hope, whether in empowering the engagement of civil society or in ensuring approaches to fight these diseases that are harmonious with other efforts to improve health and reduce poverty” (Global Fund, 2003b). An evaluation of CCMs in 17 countries demonstrated that few had achieved objectives of participation aspired to and generally all had experienced severe problems (Global Fund, 2004b).

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 both Uganda and Senegal, like in most parts of the world, fostering open discussion about sexual behaviour touches on matters deeply personal and closely linked to specific moralities, values and religious beliefs. Early on in their campaigns political leaders in both countries saw the necessity of involving religious leaders and organisations. Not only were they needed to help influence the population, but the governments needed to ensure that they would be part of, rather than opposed to, campaigns against 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. It was for all these reasons that the World Bank and the Global Fund insisted that religious organisations be drafted into National Commissions and CCMs as co-equal partners.

In Uganda, 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. 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. 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 (1988, 2000a and b) 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 provided subsidies to people to take HIV tests and trained clergy and lay members in counselling. They could reach far into the rural communities, perhaps where even the NRM could not.

In Senegal, President Diouf and leaders of the National Committee also worked hard to involve traditional religious leaders of the majority Muslim community, which makes up some 95% of the population. Traditional religious leaders command enormous influence in the country. The government began by encouraging a survey among religious leaders, carried out by an NGO, which found that most had very poor information about the virus. On this basis a process of negotiation was undertaken. The Muslim NGO, Jamra, (not known for its tolerance having waged Islamist campaigns against drugs and 'perversions' in the past) worked with the highest Islamic officials in the country and the major schools of Islamic thought. The most controversial issue, as in Uganda, concerned the use of condoms and like in Uganda, religious leaders did not support the use of condoms but were won over to a position where they would not oppose either government or private sector efforts to promote condom use. A clear example of the way multiple messages were employed to achieve behaviour change came with the publication of *Guide Islam et SIDA*, which while disseminating the basic facts on the epidemic, emphasised how Islamic teaching could help in preventing the spread of the virus (Comité National, n.d.). Religious leaders became particularly involved in treating those succumbing to AIDS. The Catholic Church came on board much later,¹³ finally participating in a conference in Dakar organised by the NGO SIDA-Service in 1996 (though SIDA-Service itself was involved long before this).

While religious organisations thus played an important role in campaigns to control the epidemic, in both countries, 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. Some secular activists felt uncomfortable that government was putting its name to publications, which while constructive in mobilising members of religious communities, at the same time in citing the Qu'ran still spoke of God's instruction, 'don't go anywhere near sex outside of marriage. In reality this is a depraved act and a detestable road' adding 'If men transgress this divine warning, depravity will develop on land and sea as a result of their own sins'.¹⁴ Others suggested that it was not enough to get traditional and religious leaders not to oppose the HIV/AIDS campaign and government promotion of condom use, but felt that secular government and non-government leaders needed to put pressure on the religious sector to discard old taboos and prejudices.

The donors' enthusiasm about enlisting religious organisations as co-equal partners in stand alone commissions and coordinating bodies, ignores the extent to which addressing the long-term causes and impact of the epidemic will require a

¹³ In Uganda the Church joined the multisectoral organisations only in 1985. As late as 1994, Charles Becker (1994), a social historian long based in Senegal and working on HIV, berated the silence of the Church.

¹⁴ Comité National (n.d.), p.14. 'Dieu a dit dans le Saint Coran <<n'approchez point la fornication. En vérité c'est turpitude et quell detestable chemin>> (Verset 32-Sourate 17). Si les homes passent outre cet avertissement divin, la turpitude se développera sur terre et sur mer du fait de leurs propres pêchés'.

transformation of social norms – some of which are explicitly religious or influenced by reigning religious ideas – towards women, towards children and towards sex. In Senegal, the state preserved the colonial government's legalisation and regulation of the commercial sex industry, which clearly has played a major role in reducing the prevalence of sexually transmitted infections and of HIV, particularly in Dakar. Strong secular authority was able to achieve this despite the qualms of religious authorities. In Botswana and Malawi, independent churches preach faith healing as an alternative to modern medicine, and governments need to engage constructively with their messages but from a position of authority rather than deference, as Museveni did in Uganda.

The role of NGOs and the associational sector

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

In Uganda, despite the hegemony of the National Resistance Movement on the political scene, President Museveni and his cadres saw the importance of NGOs to their general reconstruction efforts after coming to power in 1986 and created a favourable environment for them to grow. The international donor community was instrumental in providing funding for the NGO sector from the earliest days of the Museveni regime. In 1987, The AIDS Support Organisation (TASO) was founded by people living with HIV/AIDS and members of their families and was a pioneer in promoting voluntary counselling and testing as well as the piloting the use of antiretroviral therapies in the country (TASO, 1999). Right from the start the Uganda AIDS Control Programme of the Ministry of Health worked closely with newly established NGOs. However, it is not surprising that the NGOs welcomed the early establishment of the UAC in 1992 and played an important part in its revival in 1999, given the major role allocated to the sector by the organisational template.

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

There is a particular dimension of NGOs' role in HIV/AIDS work, which is likely to ensure continued mobilisation and activity within civil society, unlike in many other dimensions of NGO work – that is, the organisations of People Living with HIV/AIDS (PLWH). Sustained bottom-up activity is now being promoted by these organisations and their role has been recognised by the World Bank, UNAIDS and the Global Fund. The promotion, involvement and financing of organisations of PLWH will be pivotal to all dimensions of action, from prevention through care and treatment, including the many difficult issues related to rights and ethics. However, for NGOs to play the roles they play best, they need an institutional framework only the state can provide. The organisational template suggests that NGOs can replace government as service providers and promotes the distribution of funds directly to the NGOs. The confusion this has sewn is clearly recognised in the on-going evaluations of Global Fund projects (Global Fund, 2004b).

Decentralisation and Privatisation of health services

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

In Uganda, President Museveni has been adamant about pushing resources out to the districts even if it means some funds will be lost. Early efforts by the World Bank to transfer funds directly to the district level floundered and project funding reverted to the Ministry of Health. However with the MAP, new efforts have been made to set up District HIV/AIDS Committees, mirroring the UAC at the national level. Capacity at the district level remains woefully inadequate especially as decentralisation proceeded very rapidly. The same problems experienced at the national level commission have characterised these local initiatives: the duplication of efforts and the utilisation of people without the necessary skills. Despite aspirations to develop a multisectoral approach here, this usually exists in name only.

Senegal has a long experience of highly centralised government. However, in 1991 the government created a district level health system, with a further transfer of authority to local governments in 1996. By the year 2000, roughly 44% of HIV/AIDS funding went to the centre, 15% to the regional level and an impressive 41% to the district level, which demonstrates a genuine effort to ensure money reaches the operational level (Mbengue and Kelly, 2001). The pattern of the distribution of funding, however, was determined by donor zoning requirements rather than relative needs between the districts. This is a problem that appears to be shared in Uganda, underlining the need for government to establish clear criteria so that funds reach districts on the basis of need and epidemiological evidence rather than due to particular political connections.

In Senegal the central state has had to play a key role in training local actors and ensuring they have the financial resources to carry out their work. As of 2000, no regions received funds for HIV/AIDS from local authorities outside of Dakar. However, since then USAID has been working with local government units to provide

a ‘full package’ of support for HIV/AIDS related work. Interestingly it requires local governments to raise tax revenues to finance, at least partially, campaigns against the virus as a condition for funding, something also being advanced by the MAP.

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

In Uganda, when Museveni came to power, what had once been an efficient and well run health service had long since virtually collapsed. The issue was not one of privatisation, as the narrow base of health service delivery after years of war, political instability and economic decline had wrecked the public sector. What health care existed was almost entirely private. NGOs and church related organisations were encouraged to deliver health care as efforts were made to reconstruct the public sector. Cost-sharing (patient fees), long practiced at least informally through the payment of bribes and the like, was tolerated by the Ugandan government but never endorsed as policy by Museveni. In 2001 it was abolished in what some claim was a blatantly political move by the President to gain support before elections. While the abolition of cost-sharing initially led to difficulties in supplying adequate drugs to meet demand, studies have reported a significant expansion in the use of government health services and access to health care more generally (Uganda MFPED, 2002, Uganda MOH, 2002).

Clearly, there are compelling reasons in the fight against HIV/AIDS to have an integrated health system, at least as a long-term policy goal. In Uganda, it was the fight against AIDS which provided the opportunity to develop a centralised system for monitoring disease.¹⁵ The requirements of surveillance of the epidemic, of providing experienced counselling and testing facilities, of ensuring safe blood supplies and parenteral practices, of treating opportunistic infections and developing antiretroviral therapy in the future, all militate towards greater integration in approaches to public health, rather than dispersal to systems of private providers.

¹⁵ Jim Holt of the WHO in 1987 said, ‘We are using AIDS in order to establish an effective surveillance system for Uganda, and one that will operate for measles, cholera and other such diseases as well’ (cited by Hooper, 1990, p.254).

Democracy, rights and the imperatives of public health

There is a tension between the principles of democracy and respect for individual rights on the one hand and the imperatives of securing public health on the other. 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 and Senegal, as elsewhere, calls for a more nuanced understanding of the role of democratic organisations and institutions.¹⁶

In both Uganda and Senegal, the absence of effective political competition in the late 1980s allowed leaders in both countries to spearhead a nationwide campaign on HIV/AIDS almost overnight without needing to be overly deferential to potential opponents of the strategy. In Uganda, in the face of a full-blown epidemic, the government's radio campaign, where people woke up each morning to hear the thunderous beating of drums warning of the dangers of the virus, was built on fear, but appears to have played a role in influencing sexual behaviour, at least in urban areas.

Programmes such as compulsory testing for new recruits to the armed forces in both countries received some criticism, but nevertheless have been important to ensuring against the further proliferation of the virus in this high risk group. Compulsory registration and regular testing of commercial sex workers in the urban areas of Senegal has played a pivotal role in containing HIV/AIDS, but some might object on rights grounds. While rights advocates oppose the extension of compulsory testing for HIV to other groups, or the population at large, in some countries such programmes have had marked success in containing the virus. Compulsory testing for HIV/AIDS in Cuba was seen as draconian, and the limitations placed on the movement of HIV positive people were indeed draconian, but Cuba has succeeded in heading off the epidemic where others have failed (CCM Cuba, 2002). The reigning organisational template ignores the fact that ensuring public health has always involved a degree of coercion, even in today's established democracies, with some measures deemed to be of vital importance to public health assuming precedence over individual rights.

The biggest contribution of democratic institutions to the fight against the epidemic is related to ensuring the possibilities for free association and freedom of expression. We have already considered the important role the associational sector has played, with protection and facilitation from the central state, in the HIV/AIDS campaigns in Uganda and Senegal. No less important, particularly in influencing behavioural change, has been the role of the media in ensuring a plurality of messages about HIV/AIDS reaches 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 to and trust what they hear. In Uganda, when still in private practice, Dr. Elioda Tumwesigye, now head of the Parliament's standing committee on HIV/AIDS, teamed up with privately-owned Capitol Radio to offer a programme on health matters and HIV/AIDS. He said this

¹⁶ For a comprehensive review of literature on democracy and HIV/AIDS, which also makes a compelling argument in favour of the positive virtues of democracy in fighting the epidemic, see Manning (2002) and Boone and Batsell (2001).

was made possible with the liberalisation of the media in 1994 and now there are some forty programmes that discuss health issues over the airwaves. Even government buys time on private radio for its own HIV/AIDS advertisements.¹⁷

As democracy is deepened in Uganda, with the government's recent recognition of party politics and opening of greater space for competitive electoral processes, education of politicians about HIV/AIDS becomes even more important. USAID is pioneering work with the Standing Committee in Parliament to increase legislators' substantive knowledge about HIV/AIDS.

Even if more coercive measures of testing and control may be judged necessary to fighting the epidemic, the legitimacy of such measures would be much more readily established if they were arrived at through democratic processes of decision making. The character of the HIV/AIDS epidemic is such that both individual sexual behaviour change and the transformation of social norms of sexual behaviour lie at the core of prevention and it is difficult to secure these through coercion.¹⁸ It is this that makes the case for democracy compelling.

CONCLUSION

Subtlety has never been one of the virtues of the World Bank or the international donor community more generally and, indeed, there are strong arguments why campaigns for major changes – like scaling up the fight against HIV/AIDS – cannot be belaboured by presenting the complexities of processes or prevaricating over solutions. However, the organisational template proposed by the World Bank, UNAIDS and the Global Fund to respond to the most devastating epidemic of our times is deeply problematic. Most importantly, in their zeal to break from the inertia that characterised both the international community and national governments in Africa, the donors have misrepresented the experience of countries like Uganda and Senegal, where some success has been achieved.

It was not the establishment of supra-ministerial bodies in these countries that allowed progress to be made. In fact, when national commissions were established they resulted in inadequate attempts to *reinvent* government. Progress was achieved in Uganda and Senegal, not only because of the involvement and leadership provided by the heads of state in both countries, but because these leaders controlled political organisations that could ensure the campaign against AIDS was made a priority *within* and throughout government. The organisational template attempts to replace what is essentially a *political challenge* of prioritising HIV/AIDS in government and non-government sectors with an *organisational fix*.

Successful multisectoral action by governments in Uganda and Senegal was achieved with health ministries playing a central part, and, indeed, medical experts played a leading role in their national campaigns. In reaction to over-reliance on the

¹⁷ 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).

¹⁸ While coercion, however unsavoury, has worked effectively in some family planning programmes, like Indonesia's under Suharto, the extent of change necessary here is more complex and impossible for government to monitor.

health sector in the past, the organisational template promoted by the donors has tended to *secondarise* medical expertise, by treating ministries of health as just one among many co-equal (bureaucratic and incompetent) government ministries and the medical dimension of the fight against the epidemic as just one among many co-equal aspects of what must be a multi-dimensional effort. A review of the functional requirements of a campaign against HIV/AIDS demonstrates that medical expertise is essential to developing systems of surveillance of the epidemic, to providing experienced counselling and testing, to ensuring safe blood supplies and parenteral practices, to treating sexually transmitted infections that aid the spread of the virus, to treating opportunistic infections that follow its contraction, and to developing antiretroviral therapy in the future.

In many parts of the world there is a deep-seated distrust and cynicism towards the medical profession, no doubt owing to often well-founded perceptions of the aloofness of practitioners who wield their power over the body with arrogance and who often hail from privileged backgrounds and enjoy high standards of living. Indeed, the donor community's emphasis on private sector delivery of health care has accentuated, rather than reduced such perceptions and behaviour. However, in the fight against HIV/AIDS, doctors in Uganda and Senegal, as well as many other parts of the developing world, have played the role of modern heroes and have often been at the leading edge in developing multisectoral action. Where they have not been, much like with state bureaucrats and politicians, the solution is not to marginalize the profession, but to encourage its transformation. The AIDS crisis throws up the challenge of reviving an "ethos of public service" in the state and in the medical profession, something seldom given any attention within the reigning paradigms that govern thinking about development.

There is in the organisational template promoted by the donors an implicit assessment of the inability of organisations *within* the state, or public authority, to implement HIV/AIDS programmes and an implicit, virtually ideological belief, that NGOs, religious organisations and private sector organisations will be able to do better. Donor agencies promoting the organisational template failed to recognise that in countries like Uganda and Senegal, it was initiative from the state and the political organisations that controlled it, that mobilised and negotiated the involvement of religious organisations and NGOs in the campaign against HIV/AIDS and not the other way around. The organisational template obscures important tensions and trade-offs necessary in the fight against AIDS and confronted by leaders in Uganda and Senegal: between respecting individual rights and ensuring the rights of all to public health; and between promoting the decentralisation of resources and authority and ensuring effective deployment of resources and central direction to control a health emergency.

The World Bank, UNAIDS and the Global Fund were, of course, justified in attempting to distil positive lessons from successful work on HIV/AIDS and to push governments slow to respond to the epidemic to adopt them. With the devastating impact of the epidemic, people living with HIV/AIDS and the families and communities related to them were desperate to see more effective action taken and often welcomed the initiatives introduced by donors as offering new hope. What was problematic in the elaboration of the organisational template was not the intentions of the agencies or their officials, but the relentless pursuit of a model that has shown so

little promise. The biases in favour of action outside of normal government structures, based on “contracting out”, decentralisation, public-private partnerships, and the participation of faith-based groups, NGOs and private businesses, all correspond with elements of the “post-Washington consensus”.

Despite the problems with the organisational template the Global Fund and the World Bank seem undeterred in promoting its conditionalities. In Uganda, the donors reacted to continued UAC weaknesses by setting up a new Partnership Committee, effectively donor led, in an attempt to coordinate programmes and eliminate duplication and waste. Despite its recognition of core problems related to the organisational template in the evaluation of the first phase of MAP, the World Bank (2002b) concluded that many problems could be resolved by intensifying the “contracting out” of activities by the national commissions. In its latest report on the global epidemic, UNAIDS recognises there have been problems in the national commissions. However, it puts these down to the venal actions by competing ministries within states and bemoans the fact that, “in far too many countries, civil society representatives still do not participate in high-level decision-making”. (UNAIDS, 2004, p164). In which of the developed democracies do self-declared representatives of civil society participate in the highest levels of decision making and would it be desirable for them to do so?

One of the problems faced by all developing countries attempting to mount effective campaigns to fight the epidemic has been the huge demands, in terms of reporting, programme design and organisational requirements imposed by having so many different donors involved in funding HIV/AIDS programmes. In the face of yet another initiative coming from the United States in the form of the Presidential Emergency Plan for AIDS Relief (PEPFAR) launched in January 2003 with its own set of requirements, many welcomed an agreement reached in Washington to harmonise donor intervention around the so-called “three ones”: “one agreed HIV/AIDS action framework that provides the basis for coordinating the work of all partners; one national AIDS coordinating authority, with a broad based multi-sector mandate; and one agreed country-level monitoring and evaluation system” (US State Department, 2004). From a strategic perspective, the multilateral action on AIDS endorsed by the World Bank, UNAIDS, the Global Fund and most European bilateral donors is preferable to the unilateralist initiatives of the United States. However, effective harmonisation should not mean the application of a uniform organisational template in the face of mounting evidence that it is faulty.

REFERENCES

- Beck, Ulrich. 2003. "The Analysis of Global Inequality: From National to Cosmopolitan Perspective", in *Global Civil Society Handbook 2003*, London: London School of Economics: 45-55.
- Becker, Charles. 1994. 'L'église et SIDA en Afrique', *Afrique & Parole*, 39:2-4 (February), also in *Perspective missionnaires*, 27: 66-76.
- Boone, Catherine and Jake Batsell. 2001. 'Politics and AIDS in Africa: Research Agendas in Political Science and International Relations', *Africa Today* Volume 48, Number 2 (Summer), pp.3-33.
- Byamugisha, Gideon. 1998a. *AIDS, the Condom & the Church: Are Science and Morality Exclusively Antagonistic?* (Ecumenical Association of Third World Theologians – Uganda Chapter.)
- Byamugisha, Gideon. 1998b. *Am I My Brother's Keeper: Reflections on Genesis 4:9* (Ecumenical Association of Third World Theologians – Uganda Chapter.)
- Byamugisha, Gideon. 2000. *Breaking the Silence on HIV/AIDS in Africa: How can religious institutions talk about sexual matters?* (Tricolour Designers & Printers.)
- CCM Cuba. 2002. National Coordinating Group for the Cooperation with the Global Fund, "Strengthening the Multi-sector National Response to Prevent and Address the HIV/AIDS Epidemic in the Republic of Cuba", proposal submitted to the Global Fund (Geneva, September).
- Comité National de Lutte contre le SIDA, Association Nationale des Imams et Oulémas du Sénégal, ONG Jamra, *Guide Islam et SIDA: Recueil de Sermons et Conférences* (n.d.).
- Commonwealth. 2002. Technical Report (draft) of the 36th Regional Health Ministers Conference of the Commonwealth Regional Health Community for East, Central and Southern Africa: Entebbe, Uganda (18 – 22 November).
- Copson, RW and T Salaam. 2002. The Global Fund to Fight AIDS, Tuberculosis, and Malaria: Background and Current Issues Foreign Affairs, Defense, and Trade Division, Congressional Research Service, RS21340 (October 21).
- Global Fund. 2002. The By-Laws of the Global Fund to Fight AIDS, Tuberculosis and Malaria. Global Fund: Geneva.
- Global Fund. 2003a. Guidelines on the Purpose, Structure and Composition of Country Coordinating Mechanisms. Geneva: Global Fund (June 4).
- Global Fund. 2003b. Report of the Fourth Board Meeting, 5-6 June, GF/B5/2. Global Fund: Geneva.
- Global Fund. 2004a. Guideline for Proposals: Fourth Call for Proposals. http://www.theglobalfund.org/pdf/2_pp_guidelines_4_en.pdf Global Fund: Geneva (10 January).
- Global Fund. 2004b. Country Coordinating Mechanisms: A Synthesis and Analysis of Findings from CCM Case Studies, Tracking Study, GNP+ and other Surveys. Governance and Partnership Committee: Working Document. Global Fund: Geneva (8 April).
- Hildyard, N. 1998. "The World Bank and the State: A Recipe for Change?", London: Bretton Woods Project. <http://www.eldis.org/static/DOC8490.htm>
- Hooper, Edward. 1990. *Slim: A Reporter's Own Story of AIDS in East Africa*. London: The Bodley Head.

- Kaldor, Mary, Helmut Anhier and Marlies Glasius. 2003. "Global Civil Society in an Era of Regressive Globalization", in *Global Civil Society Handbook 2003*, London: London School of Economics: 3-17.
- Manning, Ryann. 2002. 'AIDS and Democracy: What Do We Know? A Literature Review', paper prepared for 'AIDS and Democracy: Setting the Research Agenda' a workshop held in Cape Town, April 22-23, , organised by Health Economics and AIDS Research Division (HEARD), University of Natal Democracy in Africa Research Unit (DARU), University of Cape Town Institute for Democracy in South Africa (IDASA).
- Mbengue, Cheikh and Allison Gamble Kelly. 2001. 'Funding and Implementing HIV/AIDS Activities in the Context of Decentralization: Ethiopia and Senegal', Abt Associates for Partnerships for Health Reform and USAID (February).
- Munthali, A and A McDonnel. 2000. *The National Response to the HIV/AIDS Pandemic*. Centre for Social Research: Zomba.
- Parkhurst, J. 2002. *HIV Prevention Policy in Sub-Saharan Africa: The Ugandan Experience*, Ph.D. Thesis submitted to the Faculty of Sociology, University of Oxford.
- Putzel, J. 2003. *Institutionalising an Emergency Response: HIV/AIDS and Governance in Uganda and Senegal*. Submitted to the Department for International Development: London (May).
<http://www.crisisstates.com/download/HIV/Putzel.pdf>
- Putzel, J. 2004. The politics of action on AIDS: a case study of Uganda. *Public Administration and Development* 24(1): 19-30.
- Putzel, J. Forthcoming. Globalization, Liberalization and Prospects for the State, *International Political Science Review*.
- Senegal CNLC. 2003a. *Plan Stratégique 2002-2006 de Lutte contre le SIDA*. CNLC: Dakar (January).
- Senegal CNLC. 2003b. *Manuel de Mise en Oeuvre du Programme National de Lutte Contre le Sida*. CNLC: Dakar(January).
- Stiglitz, Joseph. 2002. *Globalization and its Discontents*. London: Allen Lane.
- Stoneburner, Rand Daniel Low-beer, Tony Barnett and Alan Whiteside. 2002. "Enhancing HIV prevalence in Africa: Investigating the role of social cohesion on knowledge diffusion and behaviour change in Uganda", powerpoint presentation from HEARD, Durban, ,
- TASO. 1999. The AIDS Support Organisation, 'Operational Strategy and Plan of Action, January 1999 to December 2002' (April).
- Uganda MFPED, 2002. Ministry of Finance, Planning and Economic Development, 'Uganda Participatory Poverty Assessment Process' National Report (final draft) December.
- Uganda MoH, 2002, 'The Effects of Abolition of Cost-sharing in Uganda: Report on the Findings for 2001', WHO and Ministry of Health Uganda (June).
- UNAIDS. 2001. *Lutte Contre le SIDA: Meilleures Pratiques, l'expérience sénégalaise* UNAIDS: Geneva (June).
- UNAIDS. 2002. Final Report: Uganda AIDS Commission Review – September 2001, m.s., n.d. UNAIDS: Geneva (circa April).
- UNAIDS. 2004. *2004 Report on the Global Epidemic*. UNAIDS: Geneva.
- United States State Department. 2004. Aid Donors Agree to Further Coordinate Efforts to Fight AIDS; Agreement coincided with World Bank/IMF meetings

- in Washington, press release. US State Department: Washington D.C. (26 April).
- WHO, World Bank and UNICEF. 1992. Evaluation Team, The Report of the Joint Evaluation of the Uganda AIDS Commission and Secretariat, final draft, rev.3. Kampala (16 October).
- Williamson, John. 1990. "What Washington Means by Policy Reform", Chapter 2 in John Williamson, ed., *Latin American Adjustment: How Much Has Happened?* Washington DC: Institute for International Economics.
- World Bank, 1979. (The Berg Report): *Accelerated Development in Sub-Saharan Africa*. World Bank: Washington, D.C.
- World Bank. 1997. *Confronting AIDS: Public Priorities in a Global Epidemic*. World Bank: Washington D.C.
- World Bank. 1999a. A wildfire is raging across Africa, Memo (signed Callisto & Jean-Louis) issued on June 2, to World Bank staff and supporters announcing the new AIDS in Africa initiative and the AIDS Campaign Team (ACT) for Africa. <http://www.worldbank.org/aids-econ/africa/fire.htm> World Bank: Washington, D.C.
- World Bank. 1999b. *Intensifying Action Against HIV/AIDS in Africa: Responding to a Development Crisis*, Africa Region. World Bank: Washington, D.C. (June).
- World Bank. 2000a. Africa Multi-Sector HIV/AIDS Program (APL), project identification document, PID 9365. World Bank: Washington D.C. (27 July).
- World Bank. 2000b. Multi-Country HIV/AIDS Program. Project Appraisal Document, Report No: 20727 AFR. World Bank: Washington, D.C. (August 14).
- World Bank. 2000c. *Lending Instruments: Resources for Development Impact*, Operations, Policy and Strategy series. World Bank: Washinton, D.C. <http://www.worldbank.org/poverty/wbactivities/lend.pdf>
- World Bank. 2001. Senegal-HIV/AIDS Prevention and Control Project, project ID SNPE74059, PID prepared 22 November and processed the following week. Report No. PID10681. World Bank: Washington, D.C.
- World Bank. 2002. AIDS Campaign Team for Africa, Second Multi-Country HIV/AIDS Program (MAP2) for Africa, summary of World Bank documents pertaining to the Second Multi-Country HIV/AIDS Program for Africa. World Bank: Washington, D.C. (January).
- World Bank. 2002b. The US\$500 Million Multi-Country HIV/AIDS Program (MAP) for Africa: Progress Review Mission – FY01. World Bank: Washington, D.C. (November).