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THE FACE OF AIDS:
CONNECTIONS BETWEEN POLITICAL LEADERSHIP AND EFFECTIVE
APPROACHES TO THE AIDS EPIDEMIC IN UGANDA AND SOUTH AFRICA

by

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Presented in partial fulfillment of the requirements
for the degree of

Master of Arts

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The Face of AIDS: Connections Between Political Leadership and Effective Approaches to the AIDS Epidemic in Uganda and South Africa

Director: Peter Koehn

The HIV/AIDS epidemic has devastated sub-Saharan Africa. It affects every aspect of society. Two of the most stricken countries are Uganda and South Africa. How their national governments have responded to, and approached, the AIDS epidemic varies. This thesis asks: does presidential leadership make a difference in HIV/AIDS prevalence? The correlation between presidential leadership and HIV/AIDS is analyzed against the historical background from which each administration rose using Rosberg and Jackson’s typology of personal-rule coupled with Gordon’s characteristics of an effective and creative leader and the World Health Organization’s 1986 recommendation for a plan of action in the African region.

Uganda is the most successful HIV/AIDS prevention case in Africa. It is the only country in sub-Saharan Africa where the incidence of HIV/AIDS has decreased. Under President Yoweri Museveni, Uganda became the first African country to acknowledge the seriousness and severity of the AIDS epidemic. Uganda’s government vowed to focus its efforts on fighting the disease, and responded actively. Through an autocratic style of leadership, Museveni has embodied Gordon’s characteristics and has enabled Uganda to fulfill WHO’s recommendations. In addition to a decrease in HIV/AIDS, condom use has increased substantially among young people. There has also been a subsequent rise in the age of first sexual intercourse and in monogamy.

South Africa is home to the largest population of HIV/AIDS victims on earth. Five million people lived with the disease at the end of 2001. Denial, ministerial wrangling, and the misallocation of resources characterize South Africa’s governmental response to the AIDS epidemic under President Mbeki. The result is that the HIV/AIDS epidemic in South Africa is escalating and the population is feeling its demographic and social impact. Utilizing an autocratic leadership style, Mbeki failed to realize Gordon’s characteristics or lead South Africa to meet WHO’s recommendations. Attitudes about HIV, sex, and condoms have been slow to change in South Africa. There, sexual behavior has remained dangerous and condom use low. HIV prevalence in antenatal clinics continues to rise. Where people have not modified their behavior, rates increase. Lack of strong presidential leadership has meant little change in attitudes about HIV/AIDS among South Africans.
To my dreams come true
Derek, Ella, and Liliana;
my breath, my light, my life.
Never before has man had such a capacity to control his own destiny, to end thirst and hunger, to conquer poverty and disease, to banish illiteracy and massive human misery. We have the power to make this the best generation of mankind in the history of the world—or make it the last.

John F. Kennedy, 1963
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INTRODUCTION

Sub-Saharan Africa has more than two times the number of people living with HIV/AIDS than the rest of the world combined. According to the *AIDS Epidemic Update*, published in December 2002 by the United Nations Programme on HIV/AIDS (UNAIDS), and the World Health Organization (WHO), 29 4 million of the 42 million people currently living with HIV/AIDS are in sub-Saharan Africa. There, the adult-prevalence rate, the proportion of adults 15 to 49 years of age infected with HIV/AIDS, is currently a staggering 8.8 percent, more than 80 times higher than Australia and New Zealand’s adult-prevalence rate of 0.1 percent, and more than 7.33 times the average global adult-prevalence rate of 1.2 percent. In more insular terms, three percent of the world’s population, located in what is referred to as the “AIDS Belt,” has close to 55 percent of the world’s HIV/AIDS cases.¹

The AIDS Belt extends from the Republic of Congo, through the Central African Republic and Southern Sudan, through Uganda, Kenya, and Tanzania to Malawi, Zambia, Zimbabwe, Botswana, South Africa, and Namibia. In the Belt, monitoring agencies classify HIV infection as generalized, which means that the HIV prevalence rate is at least five percent.² The HIV/AIDS epidemic has devastated Sub-Saharan Africa, and affects every aspect of society. Two of the most affected countries are Uganda and South Africa. How their national governments have responded to the AIDS epidemic varies.
This thesis asks: does presidential leadership make a difference in HIV/AIDS prevalence?

*History of HIV/AIDS in Sub-Saharan Africa*

The story of the disease known as Acquired Immunodeficiency Syndrome (AIDS) begins in 1979 and 1980, when doctors in the United States observed clusters of extremely rare diseases that occurred because of immunosuppression. Groups of unusual diseases that had previously been extremely rare in young adults in the West characterized the initial syndrome. Doctors first recognized AIDS in Los Angeles after five young homosexual men were hospitalized with *pneumocystis carinii* (PCP), a type of pneumonia carried by birds. PCP is often fatal and known to occur only in people with weakened immune systems. The Centers for Disease Control (CDC) published the first official announcement on June 5, 1981, in its weekly bulletin, *the Morbidity and Morality Weekly Report (MMWR)*. One month later it reported a clustering of twenty-six cases of Kaposi’s sarcoma (KS) in New York, adding that doctors identified an additional ten cases of PCP in California, bringing the total since September 1979 to fifteen. Kaposi’s sarcoma is a disfiguring cancer that shows up in purplish or brown blotches that usually appear on the arms and legs, but can appear on the face and other parts of the body. It can become extremely invasive, attacking the internal organs and had been seen only in elderly men. Subsequently, the number of cases of both diseases – which mainly centered on New York and San Francisco – rose rapidly. Scientists realized that they were dealing with something new.

On August 28, 1981, the CDC announced that it had registered 108 patients, most of whom were young men, of which 94 percent were homosexual. In the course of 1982,
the CDC, the United States National Institutes of Health (NIH), the Pasteur Institute, and
the World Health Organization (WHO) had defined the clinical characteristics of the new
disease. Officials identified more and more patients with similar symptoms outside of
the gay community, including injection drug users (IDUs), prostitutes, and hemophiliacs.
The medical community noted that the disease was not restricted to the United States, but
that doctors had observed it throughout the world. The CDC gave the new disease an
acronym: A.I.D.S. In the beginning, this set of initials signified Acquired Immune
Deficiency Syndrome, now it is generally interpreted as the abbreviation of Acquired
Immunodeficiency Syndrome. By the end of 1982, more than five hundred people had
died of AIDS in the United States.

By 1983, the first report in the medical literature indicated that AIDS had been found
in wealthy Africans seeking medical treatment in Europe. The medical community
quickly learned that AIDS had been spreading rapidly through parts of central Africa.
Reports of AIDS were coming from Zaire, Rwanda, Uganda, and Zambia. Officials
also issued reports of the disease in Europe, Latin America, Asia, and the Middle East.
The world health community began to see AIDS as an international epidemic.

The acronym AIDS is short for Acquired Immunodeficiency Syndrome. The “A”
stands for Acquired, which means that the virus does not spread through casual or
inadvertent contact, rather a person has to do something, or have something done to them,
which exposes him or her to the virus. The “I” and “D” stand for Immunodeficiency
The virus attacks the human immune system and renders it less capable of fighting
infections. The immune system becomes deficient. The “S” is for Syndrome. AIDS is
not one disease. It presents itself as a number of diseases that come about as the immune
system fails, and is, therefore, regarded as a syndrome.\textsuperscript{15}

\textit{Magnitude of HIV/AIDS}

AIDS has gained worldwide recognition because of its rampant spread and enormous
death toll. AIDS has developed into a global pandemic. According to the most recent
publication of the United Nations Programme on HIV/AIDS (UNAIDS)/World Health
Organization (WHO) \textit{AIDS Epidemic Update}, published in December 2002,
approximately forty-two million people around the world are living with AIDS. The
global summary of the HIV/AIDS epidemic estimates that there were five million people
newly infected with HIV in 2002.\textsuperscript{16} Nearly three quarters, or seventy percent, of those
infected live in sub-Saharan Africa, where the average adult-prevalence rate is the highest
on earth. The epidemic has already claimed more than 13.7 million Africans.\textsuperscript{17} More
than seventy percent of the total AIDS cases, 29.4 million, are in sub-Saharan Africa.
That region is where more than 88 percent of children with AIDS live today, and where
more than 78 percent of AIDS deaths occurred in 2001.\textsuperscript{18} HIV/AIDS is the first global
epidemic in sixty years. There is no known cure, and treatment is extremely expensive.

In 1984, scientists identified Human Immunodeficiency Virus (HIV) as both the
antecedent and cause of AIDS.\textsuperscript{19} HIV belongs to a family of viruses called \textit{Retroviridae}
Viruses are essentially “a piece of nucleic acid surrounded by bad news.”\textsuperscript{20} According to
Barnett and Whiteside, the virus works by entering the body and attaching itself to host
cells. HIV attacks cells known as CD4 cells, of which there are two types: positive T
cells and macrophages. HIV enters these cells and copies the human DNA, making itself
unidentifiable and impossible to destroy by the body’s defense mechanisms. Once the
virus replicates, it destroys the host cell, and moves on to infect more cells. Over time, the infection destroys the immune cells triggered to fight the virus at a more rapid pace than they are generated. Slowly, the number of CD4 cells falls from the average of approximately 1200 CD4 cells per microlitre of blood to below 200. At this point, opportunistic infections, which are infections by organisms not normally causing illness because the body’s immune system usually excludes them, occur, and the person is said to have AIDS.21

At a subregional program meeting held in Brazzaville, South Africa, in March 1986, the World Health Organization’s Regional Office for Africa (WHOAFRO) acknowledged that AIDS was becoming a major public-health concern in many areas of the world, including Africa.22 At the meeting, officials developed recommendations for a plan of action for AIDS control in the African region of WHO because all countries were threatened by the virus, and neither therapeutic agents nor vaccines were available for the treatment or prevention of AIDS. The committee recommended that actions including, education and information, assurance of safe blood and blood products, and avoidance of non-sterile needles, syringes, or other skin-piercing instruments be undertaken in order to avoid the further spread of AIDS.23

The WHOAFRO recommendation states that a comprehensive strategy on AIDS must start at the operational level with creation of a National AIDS Committee, a Task Force, or the like. This Committee, with representatives from health, social services, education, and other relevant sectors, should have coordinating and operational functions. The National Committee must develop details of a national strategy, which include three major components: 1) initial assessment of the AIDS situation in the country, along with
evaluation of existing resources, 2) strengthening of the health infrastructure in order to support epidemiological, laboratory, clinical, and preventative activities, and 3) education and information programs regarding AIDS and its prevention, directed to the general public, risk groups in the population, and health care workers at all levels.

The recommendation asserts that the initial assessment should determine the prevalence of AIDS infection through epidemiological surveillance and serosurveys of selected populations. The WHOAFRO recommendation further suggests the evaluation of the ability of the existing health infrastructure to support epidemiological surveillance and studies, laboratory testing, clinical case identification and management, and that health infrastructure be strengthened. The recommendation insists upon the establishment of laboratory capability and resources to support epidemiological and clinical diagnosis. Personnel training and the provision of equipment and reference materials are required to assist in establishing and maintaining surveillance activities. In addition, resources are necessary for epidemiological research to determine risk factors, modes of transmission, and other locally relevant epidemiological factors.

In its recommendation, the WHOAFRO regards education and information for the public, and to risk groups within the population, as essential. It is viewed as vital that at the operational level, general guidelines and available knowledge regarding risk factors and modes of HIV transmission be converted into specific, useful educational materials suitable to the local or national audience. The members of the World Health Organization's Regional Office for Africa determined it essential to make the public fully aware of the nature of AIDS and HIV, the modes of transmission, and its importance as a health concern. The members found it imperative to place emphasis on the feasibility of
preventing HIV infection and on teaching how AIDS transmission does not occur through casual contact with infected persons. The recommendation suggests that health care personnel should be encouraged to educate patients and members of the general public about AIDS, and ways of avoiding HIV infection. Generally, the recommendations for a plan of action in the African region of WHO, drawn up in March 1986, consisted of initial assessment at the national level, the strengthening of health infrastructure in order to support epidemiological, laboratory, clinical and prevention activities, educational and informational programs to the general public, risk groups, and health care workers, and the exchange of information, including reporting of AIDS cases.

By the end of 1989, with the exception of Libya, Madagascar, Mauritania, and Seychelles, every national government in Africa reported at least one case of AIDS. In their book, *The Geography of AIDS*, Shannon, Pyle, and Bashur wrote that at the end of February 1990, seven countries comprised the AIDS “belt”: Burundi, Kenya, Rwanda, Tanzania, Uganda, Zaire, and Zambia. The seven countries accounted for 30,512 reported cases of AIDS—approximately 74 percent of the total 45,516 cases reported for all countries in Africa. In addition to those “core” countries, officials reported high levels of confirmed cases of AIDS from countries in an extension of the “belt” westward through the Congo, Ghana, and the Ivory Coast, as well as through Zimbabwe and Malawi. When those five countries are included, the “epidemic belt” countries of central and eastern sub-Saharan Africa accounted for 38,067 reported AIDS cases, or 92 percent of the total number of cases reported for all of Africa. Five of those countries—Burundi, Malawi, Rwanda, Tanzania, and Uganda, were among the 42 poorest nations in the world. By February 1990, 48 countries had reported more than one case of AIDS.
Effects of HIV/AIDS in Sub-Saharan Africa

Many national governments refused to acknowledge that their country had an HIV/AIDS problem. The reasons are numerous. The AIDS pandemic in sub-Saharan Africa has led to significant negative effects for her people. AIDS has severely affected development in most sub-Saharan nations. The consequences of the epidemic are apparent across the social, political, and economic spectrum in health, education, industry, agriculture, human resources, and daily life. The demographic impact of the AIDS epidemic has led to the destabilization of Africa south of the Sahara. In places where HIV prevalence is the highest, all demographic indicators have been affected -- population growth has slowed, crude death rates are higher, life expectancies have fallen, improvements in infant and child mortality rates have been reversed, orphan populations have increased, fertility has declined, population structure has been transformed, and the dependency ratio has risen.

All mortality indexes are higher in sub-Saharan African countries because of the impact of HIV/AIDS. For the 1998 round of population estimates and projections prepared by the U.S. Census Bureau, AIDS mortality was incorporated into the 28 countries most severely affected by the AIDS pandemic, of which 21 were African. According to the UNAIDS AIDS Epidemic Update, released in December 2001, about one-in-nine South Africans, or 4.7 million people are living with HIV/AIDS. In 1970, South Africa’s midyear population was 22,740,000 people, and in 1980, it was 29,252,000 people. In 1990, the population escalated to 38,176,000 people and in 2000, the country’s population numbered 43,421,000 people. In the 10 years between 1970 and 1980, the growth rate was 2.5 percent. The period between 1980 and 1990 had a growth
rate of 2.7 percent. The following decade saw a substantial drop in population growth, falling 14 percent from the previous ten years to a rate of only 1.3 percent. The Census Bureau estimates that the population growth rate in South Africa will decrease by half of one percent between the years 2000 and 2010, and continue to decrease by up to 1.1 percent a decade until 2040, which translates to a growth rate reduction of more than 75 percent by the year 2010. Not only are populations projected to grow more slowly or not at all, but crude death rates are escalating rapidly as well.

Crude death rates are the number of people per 1000 who die. The 1998 World Population Profile shows the dramatic difference between expectations without AIDS and the expectations because of AIDS. The study estimates that for Botswana, South Africa, and Nigeria, crude death rates in 1998 would have been 8.6, 7.8, and 10.9 persons per 1,000 respectively. However, AIDS has significantly driven the numbers up to 20.9, 12.3, and 13 persons. For Botswana, the difference is more than 240 percent. By the year 2010, considering AIDS and its toll, Botswana is expected to have a crude death rate of 23.8 persons compared to 6.4 persons per 1,000 if AIDS were not a factor. South Africa can compare 17.8 persons to 7.1 persons. Nigeria can expect a crude death rate of 16.1 persons as opposed to 7.1 persons without AIDS. Crude death rates in nearly every part of sub-Saharan Africa are on the rise.

Statistically, however the most apparent demographic impact of AIDS is on life expectancy. Life expectancy is a basic measure of human welfare and the impact of AIDS. In 1950, life expectancy in sub-Saharan Africa was only 40 years. Forty years later, due to substantial progress in the fight against infectious disease, life expectancy increased 23 years to an average of 63 years. Four countries in sub-Saharan Africa now
have life expectancies of less than forty years: Botswana, Malawi, Mozambique, and Swaziland. If AIDS were not a factor in determining life expectancy, the average for sub-Saharan Africa would be almost 15 years higher, about 62 years instead of the current average of approximately 47 years. In 1997, the World Bank projected that for sub-Saharan Africa as a whole, life expectancy by 2020 will be 43 years. If AIDS did not exist, life expectancy would be a much higher 62 years. The AIDS epidemic has reduced life expectancies by 4 to 25 years in those countries most severely affected. The UNDP’s Human Development Report from 1992, 1994, and 1997 illustrate the marked change in life expectancy for several countries in Southern Africa. Two of the most notable examples, Botswana and Zimbabwe, show how the AIDS epidemic stopped the upward trend in the mid to early 1990s. In Botswana, the life expectancy in 1960 was 46 years. By 1975, the life expectancy had increased by seven years to 52 years and continued to increase, reaching 60 years by 1990. In 1992, life expectancy reached a record high of 65 years. The pendulum began to swing the other way as AIDS began to claim so many lives. By 1994, the thirty-year rise was over. In two years, life expectancy fell to the levels of 1975, decreasing a dramatic 13 years, from 65 years to 52 years.

The AIDS epidemic affects everyone in sub-Saharan Africa, but the children are those hardest hit. UNAIDS estimated that by the end of 2002 nearly 90 percent, or 2.8 of the 3.2 million children, those under the age of 15, living with HIV/AIDS were living in Sub-Saharan Africa. Between 1981 and 1986, Africa as a whole experienced a decrease in under-5 child mortality. In 1987, an upward trend in morality attributed to AIDS occurred, and child mortality rates continue to rise as more and more infants are born
HIV-positive in badly affected countries. More than 30 percent of all children born to HIV-infected mothers in sub-Saharan Africa become infected with the fatal virus. In 2001, the Joint United Nations Programme on HIV/AIDS and WHO estimated that in Zimbabwe, approximately 70 percent of deaths among children under five are due to AIDS. The US Census Bureau estimated that in 1996, Zimbabwean infant-and child-mortality rates were 25 and 43 percent higher, respectively, than they would have been without AIDS. In Zimbabwe, the Bureau estimated the infant mortality rate to be 72 percent higher in 1998 than it would have been without AIDS. However, many children who infected with HIV-AIDS at birth survive beyond their first birthday.

According to the U.S. Census Bureau, two-thirds of AIDS deaths among children will occur after age one, causing child mortality rates to escalate. In Nigeria, the projected child mortality rate is 65 percent higher than it would be if AIDS were not a factor. Those countries in East and Southern Africa that had seen a decrease in child mortality before the AIDS crisis will see an even more elevated percentage. By the year 2010, Kenya's estimated child mortality rate is 130 percent higher than without AIDS. In Zimbabwe, child mortality will be three times as high as it would have been in the year 2010 without AIDS.

Many children will die, but for those spared from such a premature death, many will be left parentless. UNAIDS estimates that by the year 2010 there could be as may as 42 million orphans in sub-Saharan Africa. Currently, 95 percent of all orphans live in Africa. Before the AIDS epidemic, orphans in developing countries comprised only about two percent of child population. By 1997, the proportion of orphans climbed to seven and in some places even eleven percent. In a report published by UNICEF and the
UNAIDS Secretariat in 1999, AIDS orphans are at a greater risk of malnutrition, illness, abuse, and sexual exploitation than children orphaned by other causes. AIDS orphans must grapple with the stigma and discrimination so often associated with AIDS, which can deprive them of basic social services and education. The director of Health Economics and HIV/AIDS Research Division at the University of Natal, Alan Whiteside stated:

The most obvious way children are affected is through orphaning. But, they're really orphaned before the death of their parents. Orphaning is a series of events, with the death of the parent the culminating one. We are ending up with millions of children who are unloved, unsocialized, and uneducated.

In some areas, more than half the children under 15 have lost a parent. Most adults dying of AIDS perish before they are forty years old, when they are likely to have young dependent children. The epidemic has doubled the rate of orphanhood.

Behavioral and biological changes arising from the HIV epidemic can have consequences for fertility trends. Women who know that they are HIV positive may avoid pregnancies. Women most often become infected during their reproductive years. Increased mortality rates correlate into decreased fertility rates. Studies also indicate that HIV infection lowers fertility through biological mechanisms. In their article “HIV and fertility changes in rural Zimbabwe,” Grieser et al. found that in Zimbabwe the difference in fertility between seropositive and seronegative women was as much as 25 percent. In that study, the conclusion was that such a significant decline is not explainable by behavioral change or condom use alone. There is evidence that HIV-positive women are less able to conceive than their HIV-negative counterparts are. In many places, despite the high prevalence of HIV/AIDS, there is still a stigma attached to the disease. Society, family, and friends often shun people who either admit to being positive, or in some
cases, are simply suspected to be carrying the virus. Therefore, many people who are infected do not know it because they are never tested and do not take any precautionary steps to prevent others from contracting the virus. Pregnancy often hastens the onset of AIDS in HIV-positive women; i.e., women who are HIV-positive and become pregnant one or more times will die sooner than those who do not become pregnant. Either way, fertility falls.

In a study entitled “Fertility and Child Death in Zimbabwe,” conducted from August 1998 through May 1999, researchers conducted in-depth interviews of 35 focus groups at six different sites 46 times. The study found that in Zimbabwe, like many parts of Africa, childbearing is critical. Children are required to maintain a relationship. Children also provide security for parents who know that as they age their children will care for them, especially in countries without governmental social security systems. Most respondents acknowledged that AIDS greatly affects mortality. Most also said that they would have fewer children because of the perceived child mortality, among other factors.

As more and more adults die due to AIDS, surviving family members take on responsibility for the children left behind, diminishing the desire for more children because it is not economically practical. The Zimbabwe Demographic and Health Survey (ZDHS) reports that in 1994 the total fertility rate, or the expected total number of children born to a woman in a lifetime, decreased by 16 percent from 1992 to 4.3 children per woman. In 1999, the ZDHS indicated that that the total fertility rate had declined further to four births per woman. The ZDHS expects that by the year 2025, the total fertility rate in Zimbabwe will be to be down to 2.0 children. The U.S. Census Bureau published total fertility rates by region and country from 1985 to 2025. As a whole, sub-
Saharan Africa has experienced a decline in the expected number of children born to each woman. In 1985, 6.5 children were born per woman. By 1998, the average had decreased to 5.8 children and the Bureau expects that by the year 2025, it will have fallen to 3.8 children. Each of the six demographic indicators have led to a large-scale transformation of population structure in the most affected regions of sub-Saharan Africa.

The U.S. Census Bureau illustrates population structure in the form of an age pyramid. One side of the pyramid represents the number of males in a specific age range and the other side represents the females in the same age category. The base, beginning with the age group 0-4 years, is the widest in an average population scenario. As the age categories escalate, the pyramid structure begins to form because each age category begins to decrease in total number of people due to deaths. By the time the pyramid reaches the 80 plus range, it has tapered off to a peak. In places most severely affected, the AIDS epidemic has altered the age pyramid to such a point that it no longer looks like a pyramid at all. People most likely to reproduce are falling victim to AIDS. The change skews the pyramid shape. The base of the structure is wide, but because of significant mortality and lower fertility, it quickly narrows and looks like the stem of a glass. The structure gradually widens as mortality rates decrease in the older age cohorts. The expansion resembles the bowl of the glass.

Two significant age ranges are being altered—the child and infant range and the range of 25-40 year-olds. Those ranges comprise seven of the 17 age categories, which begin at 0-4 year-olds and increase successively by four-year intervals until age 80. In Botswana, the age pyramid appeared normal in 2000, but the U.S. Census Bureau
projects that by the year 2025, the widest age category will be the 20-24 year-olds rather than the 0-4-age range.

A change in population structure is significant because it correlates to an increase in the dependency ratio. The epidemic has reduced the proportion of economically active adults in the 20-40 year-old age range and increased the number of orphans, thereby increasing the “dependency ratio” of the population. The “age pyramid” has narrowed significantly in the middle, placing greater burdens on the elderly and the young. The increase in the dependency ratio is even more prominent when HIV/AIDS-associated illnesses move infected adults from the economically productive segment of society to the dependent section of the population. Consequently, aging has been radically changed in sub-Saharan Africa. AIDS has wiped out age cohorts that children and the elderly are typically dependent upon, thereby creating a situation where the elderly are responsible for taking care of their own ill children as well as their grandchildren.

AIDS has affected countries in sub-Saharan Africa at different rates for different reasons. Implementing and maintaining a national response to the deadly disease has proven to be critical in preventing its further spread, managing AIDS in those already infected, and dealing with the effects on those people that are associated with an AIDS infected patient. AIDS is not a disease that only cripples the infected person; it can also destroy families, communities, and the economies where it thrives. Strong, effective, and creative leadership at the highest level of government is necessary for every successful national AIDS prevention campaign.
African Leadership

In Africa, political leadership has been the critical factor that ensures order or disorder within the state. In their book, *Personal-rule In Black Africa, Prince, Autocrat, Prophet, Tyrant*, authors Robert H. Jackson and Carl G. Rosberg assert that, in the provision or the destruction of such “political goods” as peace, order, stability, and non-material security, the personal actions of Africa’s rulers and other leaders have been more important than anything else. Jackson and Rosberg propose a typology of personal-rule in Africa, which emphasizes the socio-political aspects of rule. Rosberg and Jackson’s typology for analyzing individual rulers and regimes in Africa raises the question of why different types of personal-rule emerge where and when they do. It makes explicit the common features of personal-rule regimes in Africa, without losing sight of the fact that there are different types of personal-rulers in contemporary Africa.

The central feature of personal-rule is that politics is a dynamic world of political will and action that is ordered less by institutions than by personal authorities and power, a world of stratagem and countermeasure, of action and reaction, but without the assured mediation and regulation of effective political institutions. The study of personal-rule is an approach that highlights important features of African politics such as clientelism and patronage, factionalism, coups, purges, plots, succession crisis, and similar characteristics and dynamics of institutionless government. Jackson and Rosberg place such phenomena into a framework of theoretical explanation by drawing upon classical political theory and comparative government theory, and Weber’s sociology of authority and the sociology of clientelism.
Comparative government’s analytic tradition, which focuses on political institutions, their nature, the historical conditions that give rise to them, and their importance for political life, has directly influenced Rosberg and Jackson’s thinking about personal-rule. They also place emphasis on institutions, their characteristics, the historical circumstances from which they rise, and their significance in political life. Another major influence is Weber’s sociology of authority. For Weber there are two basic subtypes of personal-rule—traditional-personal domination and charismatic domination, which bear a resemblance to Jackson and Rosberg’s concepts of “princely rule” and “autocratic rule” on the one hand, and “prophetic rule” on the other. Jackson and Rosberg depart from Weber’s definition by not confining their subtypes to legitimate domination. Rather, they identify a type of personal-rule outside of Weber’s theoretical framework: that is, tyranny.

For Rosberg and Jackson, the four types of rulers include: the prince, the autocrat, the prophet, and the tyrant. The forms of personal-rule are ideal types. The specific characteristics of particular rulers will not conform exactly to the modalities of the category to which the leader is assigned. The prince is the type of ruler that is an astute observer and manipulator of lieutenants and clients. The prince tends to rule jointly with other oligarchs and to cultivate their loyalty, cooperation, and support. To rule as a prince is to preside over the struggle for preferments, to encourage it, to recognize that it is a source of the ruler’s and the regime’s legitimacy, but not to allow it to get out of hand.

The autocrat is the type of ruler who tends to dominate the oligarchy, the government, and the state without having to share power with other leaders. Where the prince resides
and rules, the autocrat commands and manages; the country is his estate. For the
autocrat, the ruling apparatus is ultimately his to deploy and direct, and the party and
governmental officials are his servants and agents. This type of personal-rule is
reminiscent of absolute monarchy. The African autocrat faces limitations of his rule, but
they are limitations on resources and organizational capability—not of discretionary
power. The relative “underdevelopment” of the ruling apparatus available to him limits
the autocrat’s power. Other limitations include inadequate finances, personnel,
equipment, technology, material, as well as the underdeveloped skills and abilities of his
officials. Nevertheless, his discretionary power to direct his apparatus, in principle, is
unlimited. Autocracy depends on the fortuitous confluence of circumstance and ability.
It depends on the strength of will and ability of the ruler to dominate, as well as the
ruler’s ability to confine and largely limit the process of politics to issues completely
within his immediate competence and control. The autocrat is successful in eliminating
the autonomous political power and influence of others.  

Prophetic rulers are visionaries, wanting to reshape society in ways consistent with
their ideology, which, in Africa, is usually socialist. Prophets tend to be impatient with
the social, economic, and political conditions about them, which they see as obstacles to
socialist progress. They seek to eliminate these obstacles, but usually do not possess
adequate political and economic resources to do so. Ideology is not separate from
prophetic rule but essential to it, and contained by it, although in practice it is often the
“charisma” of the leader—his charm, mystique, and personality—that counts most in a
prophetic regime. In other words, what really counts is not the ideology the ruler
enunciates, but the fact that the ruler enunciates it. Since ideology and rhetoric can
inspire but cannot guide, prophets must be concerned with plans and programs for guiding government.\textsuperscript{63}

Tyranny is a residual type of personal regime into which any or all of the other types may deteriorate. In a tyranny not only legal but also all moral constraints on the exercise of power are absent, with the consequence that power is exercised in a completely arbitrary fashion according to the impulses of the ruler and his agents. Tyranny is marked by particularly impulsive, oppressive, and brutal rule that has lacked elementary respect—and has sometime shown complete disdain—not only for the rights of persons and property but also for the very sanctity of human life. Tyrants rule through fear and reward agents and collaborators and make mercenaries of them.\textsuperscript{64}

Rosberg and Jackson’s typology shows that, in systematic terms, it is not primarily the ruler as a person that determines the relative stability of a polity. Rule is more about the leaders’ political skills and acumen, or the leader’s personal experience and understanding of the opportunities and constraints that govern personal actions and those of other leaders, and of the best methods for influencing and controlling other leaders and the countries. Africa’s most successful and enduring rulers have learned from experience about the resources and limitations of their own political systems.\textsuperscript{66}

Jacob Gordon updated Jackson and Rosberg’s typology in his book \textit{African Leadership in the Twentieth Century: An Enduring Experiment in Democracy}, published in July 2002. Gordon argues that the key to understanding the idea of African leadership is to examine the subject as a universal human experience and as African civilization. Both contexts, the universal and the African, are critical to understanding and appreciation for the contributions of African leaders to the development of African
society and world politics. Based on his literature review, Gordon compiled a set of twelve characteristics that a creative and effective African leader must embody and achieve. These characteristics go beyond Rosberg and Jackson by expanding on typology. Three of Gordon’s characteristics of creative and effective leadership that I will employ to compare Mbeki and Museveni’s leadership approaches are:

1) He knows and understands that bureaucratic hierarchies are dead and advocates community of responsibility.

2) He promotes and initiates change, viewing it as an opportunity for all stakeholders.

3) He inspires, motivates, and stimulates leading through personal persuasion and valuing emotions as well as ideas.

Gordon asserts that the future of African leadership is inextricably linked with the challenges with which Africa must grapple in the 21st century, including health. The AIDS epidemic has generated national crises across sub-Saharan Africa. Two countries that stand out are Uganda and South Africa. Connections between political leadership and effective approaches to the AIDS epidemic in Uganda and South Africa offer many compelling comparisons. Taking Gordon’s recommendation to examine African leadership within the context of leadership literature as a universal human experience into account, James David Barber’s categorization of American presidents also can be applied in the African context. Barber divides personality types of contemporary presidents into four categories: 1) active-positive presidents, 2) active-negative presidents, 3) passive-positive presidents, and 4) passive negative presidents. Both Museveni and Mbeki are active-positive presidents, which means that they want results, and push for change in institutions, policies, and procedures. They invest a good deal of personal energy into the office, and their personal needs and skills translate well into
political leadership. Active-positive presidents gain personal satisfaction from serving as chief of state. However, while both men are similar in this sense, they differ in their approaches.\textsuperscript{70}

This thesis will utilize Rosberg and Jackson's typology and Gordon's extension of it in exploring whether the leadership approaches of Mbeki and Museveni are likely to have helped shape the different HIV/AIDS outcomes experienced in Uganda and South Africa. To assess whether each man's political leadership effectively battled the HIV/AIDS epidemic in his country, successfully lowering HIV/AIDS prevalence rates, and changed public attitudes about the disease, I will employ WHOAFRO's 1986 recommendation as the standard for comparative evaluation.


Feldman and Miller, AIDS Crisis, 12.


Ibid., 32.

Feldman and Miller, AIDS Crisis, 14.

Ibid., 27, 28.


Barnett and Whiteside, AIDS in the Twenty-First Century, 9.

UNAIDS. AIDS Epidemic Update, 36.


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Ibid.

Ibid, 2-3.

Ibid.


Jan Isaksen, Nils G. Songstad, and Arlid Spissoy, Socio-Economic Effects of HIV/AIDS in African Countries (Bergen: Chr Michelsen Institute, 2002).


Ibid.


McDevitt, World Population Profile, 58.

Ibid.

Ibid.


McDevitt, World Population Profile, 58.

Ibid.


Ibid., 75.

Ibid., 4.

Ibid., 12.

Ibid., 6, 8.

Ibid., 9.

Ibid., 73.

Ibid., 74.

Ibid., 81.

Ibid., 77-78.

Ibid., 78.

Ibid., 79.

Ibid., 80.

Ibid., 4.

Ibid.


Ibid., 172.

Ibid., 171.

CHAPTER 2

THE CASE OF UGANDA

The African AIDS epidemic is a contemporary health crisis of staggering proportions and one with which African society and governments have signally failed to cope.¹ A country that lies within the AIDS Belt that has a unique story is Uganda. Uganda has been lauded as one of the most successful HIV/AIDS prevention cases in Africa. There has in fact been no change recorded at the national level in Africa except in Uganda, where HIV infection rates have fallen.² In Kampala, Uganda’s major urban area, HIV prevalence among antenatal clinic attendees tested increased from 11 percent in 1985 to 25 percent in 1990 and then 29.4 percent in 1992. Beginning in 1993 however, HIV prevalence among antenatal clinic attendees began to decline in Kampala, reaching 13.8 percent in 1998 and 11.25 percent in 2000. Median HIV prevalence among antenatal clinic attendees outside of the major urban areas has declined from 13 percent in 1992 to 5.9 percent in 2000. Median prevalence from 12 sites outside Kampala ranged from 1.9 percent to 10 percent.³ While seroprevalence has decreased dramatically, UNAIDS still classifies Uganda as having a high national adult-prevalence rate.⁴ The reason a decline in seroprevalence has taken place and national attitudes about HIV have changed is believed to be the strong leadership of President Yoweri Museveni since 1986 and his insistence that AIDS should be discussed and identified as a national crisis needing action.⁵
Using Jackson and Rosberg’s typology of personal-rule to identify and explain Museveni and his administration in conjunction with Gordon’s characteristics of an effective and creative African leader will help illustrate why his leadership skills translated into successful approaches to battle the HIV/AIDS epidemic in Uganda. Their leadership typology of personal-rule asserts that political institutions are extremely dependent upon the historical conditions from which they rise. The reason AIDS established such a stronghold in Uganda can be understood in the context of historical circumstance and events coupled with political leadership.

Overview of Uganda’s Recent History

Development of a risk environment and increased susceptibility in Uganda has much to do with the growth of ethnic, regional, and class differences as Ugandan society came into existence from the late nineteenth century to the middle of the twentieth century. In Uganda, these divisions became lines of conflict that tore a recently established polity to pieces. The development of the epidemic in Uganda since the late 1970s and the reconstruction of the society in the period since 1986 have gone together.

Late in the nineteenth century, Europeans artificially created Uganda without respect to boundaries that divided various ethnic groups. The creation of the state arbitrarily pulled more than forty ethnic groups together into the same political unit. Uganda was under British control, and the British were eager to stamp as much of their social-political culture as they could on Ugandan territory. One ethnic group within the territory, the Buganda, possessed a highly developed monarchical system. Such a centralized monarchy facilitated the British objective of control over this region of Africa.
Buganda became the favored tribe, and for years had the most political and economic power in Uganda.\footnote{7}

The epicenter of the AIDS epidemic was the region of Buganda. Its colonial history revolves around the cultivation of cotton and coffee. In 1902, the Uganda railway opened and linked Mombasa on the Indian Ocean to Kampala and reduced cost of transporting commodities produced in the African interior. Cotton production ensured that Great Britain's newly acquired territory was self-financing and guaranteed cheap raw materials for the declining Lancashire cotton industry. The British aimed to keep Africans in the rural areas producing cotton. The British put trade into the hands of Asians imported as laborers and settlers. By 1938, the Asians that the British imported controlled cotton ginning, wholesale trade, and commerce. Africans remained in the agricultural sector, but in an agricultural sector that was undergoing rapid change.\footnote{8}

Land tenure reform facilitated a wealthy Ganda peasant class. The social and economic circumstances of colonialism divided society into the traditional aristocracy, an economic class of independent small holders and rural entrepreneurs, or laborers, and the Asian ginnery owners, traders and merchants. National movements in the late 1940s organized political opposition to the status quo. The 1950s saw a succession of violent incidents and boycotts aimed at Asians, and by the 1960s, the language of political protest had become a racial one – Africans against Asians, which had very dramatic results in the next decade.\footnote{9}

In 1962, officials called the London Conference for the purposes of laying groundwork for an independent Ugandan state. Independence ushered the transfer of political power to the King of Buganda and his allies in a political party called the UPC. 26
Milton Obote, the leader of that party, was named Prime Minister. The transition of power from colonial to independent rule was not easy. The government inherited an extensive bureaucracy that the British created, but had a great deal of difficulty managing it effectively. The economy suffered through skyrocketing inflation.

Corruption in government and the private sector threatened to overwhelm the economy. As a result, internal dissension and resistance to the government increased, and political instability amplified. Obote tried to maintain power by becoming increasingly autocratic. The strategy only alienated him more, and in 1966, as political struggles mounted, the alliance between the monarchy and his party fell apart. Obote abrogated the 1962 constitution that recognized the monarchy and forced the King into exile in London. Under increasing pressure, and with the economy sliding, Obote increased his strongman tactics to maintain power. His action ultimately led to a coup in 1971 when Idi Amin led a successful overthrow of Obote and his government. His new military government was initially welcomed by disaffected opponents of the Obote regime, as well as by foreign investors and Western countries who saw it as putting an end to Obote's experiments with socialism, which had been threatening to foreign investors who had sizable holdings in Uganda.

The 1970s were years of destabilization with loss of security for life and property. Between 1971 and 1979, Amin and his regime subjected Uganda to one of the most capricious, terror-ridden, and inhumane governments yet to emerge in sub-Saharan Africa. Tyranny in Uganda arose in an historical context of government coercion and political violence, on the one hand, and inequity among groups, especially in their access to government controlled privileges and opportunities, on the other. The invasion of the
country in 1972 by Ugandan forces based in Tanzania set off widespread tribal killing as Amin sought to eliminate all opposition inside the country. Economic mismanagement and terror characterized the Amin period. Where Obote had imprisoned opponents, Amin had them physically eliminated; instead of harassing ethnic groups he distrusted, Amin simply massacred them. This is important for understanding the creation of a risk environment.

The key was *magendo*, a LuGanda word meaning “pilgrimage of greed.” *Magendo* developed as a system of illicit, semi-legal, and illegal distribution after Amin finally expelled all the Asians in August 1972, and destroyed existing systems of distribution. Amin’s economic policies froze agriculture prices and drew large quantities of cash crops into the black market. The essence of the *magendo* economy was smuggling coffee, paraffin, sugar, and gold out of the country, of vehicle spares and other necessities into the country, and food within the country. Illicit markets, secretive transport, and the human interactions that tied such a system together were a risk environment par excellence and fertile ground for the development of an epidemic of HIV/AIDS.

Conditions here created an environment that raised the potential for effective transmission of sexually transmitted infection. The conditions were all associated with illicit trade and survival in times of extreme disruption. The conditions included high mean rates of sexual partner change, high mixing of partners across geographical areas, large numbers of concurrent partnerships, and geographical mobility. Gender relations rooted in local tradition and disrupted by disorder increased the levels of individual and social susceptibility to HIV.
Survival strategies in times of hardship created demand for the provision of food, lodging, and sex at truck-stop townships, border towns, and the smuggling villages on Lake Victoria. The *magendo* economy inflated men’s cash incomes compared to those of women. This increased women’s insecurity and dependence. Such circumstances threw already unequal gender relations further imbalance, an imbalance that inevitably took on a sexual complexion.²¹ Buganda, and within it Rakai District, the focal point of Uganda’s HIV/AIDS epidemic, is adjacent to the lorry route from Mombasa in Kenya to Bujumbura in Burundi. It fronts Lake Victoria and has many casting off points for journeys to Kenya and Tanzania. When the Tanzanian army overthrew Amin in 1979, it is where the invading army passed and spent several months in 1979-1980.²²

The omnipresence of military interfered with nearly everyone and increased existing insecurity. The health care delivery system collapsed, and peasant farmers bore the brunt of the impact. Social welfare services disappeared as qualified people by the hundreds left the country, and the government filled the vacancies with mediocre, incompetent political appointees, thus ensuring total institutional collapse in the country.²³ Instead of national reconciliation in the months immediately after Amin, Uganda suffered persistent and widespread criminal lawlessness, which seriously undermined personal security and delayed reconstruction. In addition, factional conflicts and rivalries grounded not only in personal differences among leaders, but also in underlying ideological and ethnic divisions, exacerbated attempts to reestablish effective and orderly government.²⁴ Once again, Uganda came under the rule of Milton Obote, installed by the Tanzanians, and decay of the state structure continued.²⁵
Obote's regime did not allow normality to reappear in people's lives. The illicit economy continued to thrive as a vital part of people's survival strategies. In 1986, Yoweri Museveni defeated and expelled Obote and took office as president of Uganda. Museveni took office determined to reintegrate his collapsed state and set in on a course to political stability and economic development. Museveni's government rapidly established a higher level of civil and political order in most of the country. To restore government, he chose a "movement system." Instead of parties, the country would have one all-inclusive movement, thus eliminating opposition. It was a concept of direct rather than representative democracy that could easily play into the hands of the only organized forces, the movement and the government.

However, Uganda remained a troubled society for the next decade, and armed opposition groups remain active in parts of the country. In addition, Uganda's army is prominently involved in the Great African War in the Congo between forces from Uganda, Zimbabwe, Angola, Namibia, and Rwanda, as well as various Congolese factions and warlords. All of this, including the migration patterns and lifestyles of soldiers and others involved in or affected by the war, contributes to even greater population movement across this huge region spanning millions of square kilometers, creating a risk environment and facilitating the further spread and transmission of HIV.

History of HIV/AIDS in Uganda

Doctors documented the first cases of AIDS in the Rakai District of southwest Uganda in 1982. Between 1982 and 1986, the health sector largely handled the epidemic with spontaneous community initiatives to care for the infected and affected. The above historical survey of Uganda illustrates how change and fluidity in social, economic, and
political relationships create circumstances where HIV could lodge and spread rapidly. Susceptibility takes many forms. In this case, it is rooted in changes in structures of power, between ethnic groups, classes, genders, and political actors.⁴⁰

In 1986, not long after his guerrilla force seized power in Uganda, Yoweri Museveni sent 60 officers from the bush army to Cuba for training. Several months later Fidel Castro, Cuba’s president, approached Museveni at a conference in Zimbabwe with a staggering bit of news: medical exams in Cuba had revealed that 18 of the 60 officers were HIV-positive. Years of war, displacement, pillage, and rape had entrenched HIV in Uganda as early as the late 1970s. Museveni took Castro’s warning that he “had a problem” to heart, realizing that AIDS is potentially destabilizing and increases the likelihood of a military coup.⁴¹ The new president quickly made HIV/AIDS a top priority. Within one year, he was leading a nationwide mobilization against AIDS that drew in bishops, imams, and public health experts, as well as thousands of small community groups nationwide. The program would become known as ABC, for “Abstain, Be Faithful, or wear a condom”—in order of emphasis.⁴²

**Magnitude of HIV/AIDS in Uganda**

Doctors documented clinically defined cases of AIDS throughout Uganda in 1988.⁴³ Sentinel survey results in 1987 revealed that an estimated 33 percent of long-distance truck-drivers in Uganda were HIV positive. The number of reported AIDS cases in Uganda increased from 17 in 1983 to more than 7,500 in early 1990.⁴⁴ In 1988, scientists sampled the blood of 11,000 people and found that one in 16 was HIV positive.⁴⁵ In January 1990, Ugandan health officials reported cumulative totals to the World Health Organization, which determined that Uganda’s national HIV adult-prevalence rate stood...
at 11.4 percent. By June 1991, they estimated that 1.5 million Ugandans were infected with HIV. In urban hospitals, patients with AIDS-related infections occupied up to forty percent of the beds. In 1994, scientists estimated that one in six Ugandans was HIV positive.

In its annual *Report on the Global HIV/AIDS Epidemic*, published in June 2000, UNAIDS estimated that Uganda had brought its estimated prevalence rate down to around 8 percent from a peak close to 14 percent in the early 1990s. The report credits the decline to strong prevention campaigns, which resulted from Uganda's government, under President Museveni, recognizing the danger of HIV and taking steps to fight its spread through action by the government and other groups in society. By 2000, HIV prevalence rates in pregnant women in urban areas fell to 11.25 percent from a high of 29.5 percent in 1992. Uganda continues to present proof that the epidemic does yield to human intervention. Recent HIV infections appear to be on the decline in several parts of the country, as shown by the steady drop in HIV prevalence among 15-19 year-old pregnant women.

*Political Leadership in Uganda*

President Yoweri Museveni has gained international acclaim for having elevated HIV/AIDS to a national priority. Infection rates are decreasing. Uganda has successfully brought down HIV/AIDS prevalence from more than 30 percent in the 1980s and the early 1990s to the current rate of about 6 percent. Through autocratic rule, Museveni developed a creative leadership strategy that fulfills Gordon's guidelines for effective and creative leadership and follows the 1986 WHOAFRO recommendation.
Type of Personal-Rule

Jackson and Rosberg hold that it is crucial to consider the crucial role played by political leaders and their actions on the public life of states in contemporary Africa. Personal-rule has been evident in Uganda since it gained independence in 1962. Jackson and Rosberg categorized Idi Amin as a tyrant and effectively illustrated how his actions played a tremendous role in the development of Uganda following independence. The system of personal-rule has continued under President Museveni, who came to power in 1986 and restored political stability.

Museveni is an autocratic leader as defined by Rosberg and Jackson. He is a ruler that tends to control the oligarchy, the government, and the state without having to share power with other leaders. Museveni effectively guaranteed that the ruling apparatus is ultimately his to deploy and direct, and the party and governmental officials are his servants and agents. He ensured the absence of strong opposition by utilizing a movement system instead of parties and implementing a decentralized system of local government. Museveni only allowed the direct election of village councils. Members of lower bodies elect four other layers of councils indirectly. The layers culminate with district councils, which emerged as the most important unit of local government, and are far removed from voters’ control. The drafting of a new constitution also became an exercise in limited participation.

A constitutional commission held hundreds of meetings throughout the country, soliciting oral and written comments. As in elections, individuals could not participate as members of organizations. It was a concept of direct rather than representative democracy that could easily play into the hands of the only organized forces, the
movement and the government, both of which Museveni was in charge. What restrictions Museveni has on his rule are the limitations of resources and organizational capability—not of limited control.

Creative and Effective Leadership

Uganda became the first African country to acknowledge the seriousness of the AIDS epidemic due to Museveni’s leadership. In his approach to battle the HIV/AIDS epidemic in Uganda, Museveni embodies each of the three characteristics, drawn from Gordon’s set, which a creative and effective African leader must embody and achieve. The first characteristic is acknowledging and understanding that bureaucratic hierarchies are dead and advocating a community of responsibility. The second characteristic of creative and effective leadership, promoting and initiating change and viewing it as an opportunity for all stakeholders, is inextricably interrelated with the first.

Just after taking power, President Museveni vowed to focus his efforts on fighting the disease and promptly made it a national priority. Early in his administration, Museveni mobilized a wide spectrum of groups. The government engaged religious and traditional leaders in an intensive coordinated campaign to educate the population. Officials brought active prevention programs focused on delaying sexual relations and negotiating safe behavior into schools. Uganda has invested heavily in training health workers, creating counseling networks, treating sexually transmitted diseases, and expanding HIV testing. President Museveni’s administration established The Ugandan National Task Force on AIDS in 1990. One year later, a multi-sectored program began, which involved condom distribution and promotion through popular songs, drama groups, counseling, and support services.
In 1995, a nationwide promotion campaign initiated more approaches to promote safe
sex, abstinence, fewer sex partners, and condom use among young people. The Sexuality
Information and Education Council of the United States (SIECUS) reported in its Policy
Update for March 2002, that President Museveni stated, "We encouraged community
based initiatives and our campaign has produced a lot of mass networks. We encouraged
condom use, and in ten years have seen it go up from seven percent to forty-two
percent." In addition to a decrease in HIV/AIDS, there has been a subsequent rise in
the age of first sexual intercourse, and in monogamy The percentage of pregnant women
with HIV has dropped since 1991 The use of condoms has increased substantially
among young people.

The third characteristic of creative and effective leadership is inspiring, motivating,
and stimulating, leading through personal persuasion, valuing emotions as well as ideas.
Museveni approached the AIDS epidemic in Uganda through word and action. Museveni
recognized early on that the personal involvement of the head of state was key to
implementing AIDS prevention and education programs. Speaking to African leaders
at the African Development Forum in December 2000, in Addis Abba, Museveni stated:

When a lion comes to the village, you don’t make a small alarm. You make a very
loud one. When I knew of this problem I said we must shout and shout and shout and
shout. When we started, our Ministry of Health were putting out a small
advertisement after TV news. But in 1986 we only had 100,000 television sets.
How many people would hear about it? I told them, this alarm of yours is a silent
alarm. The best channel for making a loud alarm are the political leaders . . . When a
district health officer comes to address a meeting, twenty people turn up. But if
Museveni is coming to address a rally, nearly 20,000 people turn up. That is the time
to pass the message. Talk about your politics, but talk about AIDS also . . . You
cannot just leave it to the bureaucrats. They will just put AIDS messages when
people are going to work and say “we’ve put it there.” They don’t care. So the
leadership must supervise this war.
WHO's 1986 Recommendation for a Plan of Action in the African Region

The recommendation for a plan of action in the African region of WHO, drawn up in March 1986, consisted of 1) initial assessment at the national level, 2) the strengthening of health infrastructure in order to support epidemiological, laboratory, clinical and prevention activities, educational and informational programs to the general public, risk groups, and health care workers, and 3) the exchange of information, including reporting of AIDS cases. At the same time the WHOAFRO meeting was taking place, Uganda was ushering in a new president. Devastated by years of dictatorship and war, Uganda has been ravaged by one of the highest prevalence rates in Africa. Today, those recommendations have become a reality in Uganda. Museveni’s prompt acknowledgment of the severity of the problem through speech and action has led to the ascertainment of the characteristics of effective creative leadership and has led to the decrease of national HIV/AIDS prevalence in Uganda.

HIV seroprevalence is known at the national and regional level, and is published annually in the AIDS Epidemic Update by UNAIDS and WHO. Primary modes of transmission have been traced and documented. Uganda went from being one of the most infected countries in the world to the best prevention case in Africa through action.

In 1986, Uganda’s Health Minister of the new government announced the existence of HIV/AIDS in Uganda during the World Health Assembly in Geneva, marking the beginning of openness about the epidemic that created an environment conducive for mass campaigns spearheaded by President Museveni. In the same year, the first government-structured effort to address the epidemic occurred when the government established the first National AIDS Control Program (NACP) in the Ministry of Health.
Its priority was focusing on safe blood, prevention of HIV infection in health care settings, information, education, and communication. The government charged the NACP with coordination between and within other departments of government, meaning that HIV/AIDS was and continued to be seen as a medical problem. Other bodies, both within and outside government, felt that HIV/AIDS was not their concern or responsibility.

The next year, the government established an AIDS Control Program in the Ministry of Defense to respond to the special need in the armed forces. By 1988, the government conducted a national serosurvey to assess the magnitude of the epidemic among the adult population. The average prevalence rate was already nine percent. The government conducted consultations on the multisectoral approach to control. The consultations helped the government understand that the impact of the epidemic went beyond the health sector, which lead to the recognition of the need to plan and implement relevant activities. In 1987, the government established The AIDS Support Organization (TASO) to provide psychological support for the infected and affected.

The government, in conjunction with NGOs and other institutions in civil society, was determined to deal with the issues openly and directly, and to place Uganda at the forefront of the fight against HIV/AIDS. This ensured not only that Uganda has one of the most vigorous and wide-ranging programs to combat the epidemic, but also that it began to develop consistent systems of monitoring, as suggested in the 1986 WHOAFRO recommendation. The results are a clear example of what can be achieved even in a country with few resources and poor infrastructure.
In November 1990, a team of United States demographers showed the president a glossy video in which they used a mathematical model of the epidemic to project the potentially devastating impact of HIV/AIDS on the population of his country. Impressive graphics informed the president that if there were no HIV/AIDS, by the year 2015 there could be 32 million Ugandans. However, if the dramatic AIDS epidemic continued, the population would be only 20 million people plus the added burden of 5-6 million orphans resulting from the death of AIDS victims. Soon after seeing the film, the president announced that the AIDS epidemic was now “beyond the control of the medical experts” and that Uganda needed “a massive campaign to educate people to change their sexual behavior.”

The following June, Museveni set a precedent by opening the annual International Conference on AIDS in Florence, a clear indication of the importance accorded HIV/AIDS by the political leader. While there, Museveni said AIDS was “not only a health problem but is a social, economic, and political nightmare.”

In 1990, the government charged a task force on AIDS with developing a multisectoral response to AIDS control. Participants included all government ministries, local and international NGOs, and the major international agencies. The process had strong support from President Museveni. It resulted in the establishment of the 24-member Uganda AIDS Commission. The task force on AIDS required the Commission to oversee, plan, and coordinate AIDS control programs, and be a reference point for the formulation of plans, policies, and national guidelines for HIV/AIDS control programs and activities.

The innovative Ugandan response encouraged active participation of everyone in reducing transmission and spread of HIV/AIDS, provided strategies for prevention and
impact mitigation, and advocated for capacity building at the community, sub-national
and national levels. This definition turned away from exclusively medical models of
response, included epidemic consequences, and recognized that all sectors and levels of
Ugandan society had to be involved. Over several years, agencies and participating
organizations identified a portfolio of more than fifty interventions.67

In 1990, the government formed the AIDS Information (AIC) for voluntary testing
and counseling services, and formally adopted the Multisectoral Approach to the Control
of AIDS (MACA) adopted in 1992, as a policy and strategy for responding to the
epidemic. The peak of infections in hard-hit areas occurred that year, with some urban
sites registering a prevalence rate of more than 30 percent.68 In the same year, an Act of
Parliament established the Uganda AIDS Commission to coordinate the multisectoral
efforts to unify the response.69 This National Policy and Strategy is based on the fact that
HIV/AIDS affects all strata of the population, and poses a serious threat to the socio-
economic life and development of the country. The MACA created an atmosphere of
openness and effective political commitment to HIV/AIDS control, which has created
high levels of awareness in the population about the dangers of the epidemic, and
possible means of prevention. It served as a basis for the development of the first
National Program, the National Operational Plan for HIV/AIDS/STD Prevention, Care
and Support 1994-1998, ad the consequent national programs. The establishment of
AIDS Control Programs (ACPs) outside the health sector, in twelve line Ministries, in
1995 further strengthened the multisectoral response to the epidemic.70

The UAC led and coordinated the development of the first multisectoral National
Operational Plan (NOP) for HIV/AIDS/STD activities from 1994 to 1998. The NOP
reflected the primary needs, and represented the sectors that took the lead in addressing the epidemic. In 1994 and 1995, the government established more AIDS Control Program Units in the Ministries of Gender, Education, Agriculture, Internal Affairs (Police and Prisons), Justice, Finance, Public Service and Local Government. In 1994, the government borrowed US$75 million in a soft loan from the World Bank, executed by the Ministry of Health through the Sexually Transmitted Infections Project (STIP) 1995-2000, to fight the epidemic. In 1995, Uganda successfully hosted and organized the International Conference on AIDS and STDs in Africa (ICASA), and announced the observance of declining trends in HIV prevalence. In 1996, Uganda received the first UNAIDS Country Program Adviser (CPA), and began vaccine trials after thorough consultations with all key stakeholders.71

A comprehensive review of HIV/AIDS activities in Uganda was conducted by development partners, supported by UNAIDS, including the UNAIDS Secretariat and its cosponsors particularly UNDP, WHO, UNICEF, World Bank, UNFPA, USAID, European Union, DFID, DANIDA, SIDA, and the Italian, German, and French governments among others, to assess coordination and implementation of HIV/AIDS activities in 1997.72 In the same year, the 1998-2002 National Strategic Framework (NSF) for HIV/AIDS Activities with consensus from partners from various sectors at national and district levels was developed, and initial research on the District Response Initiative (DRI) in the Kabarole district occurred. The DRI concept and framework has since been developed and agreed on by partners, and implementation began in 2001.73

In the mid-1990s, the national per capita spending on health was a little over $5.50. With no cure available, the only available weapon was information and efforts. For many
Ugandans, life would be forever changed by the governmental efforts to help prevent AIDS transmission.\textsuperscript{74} In 1998, the government established the Drug Access Initiative to advocate for reduced prices for anti-retroviral drugs, and to support the establishment of proper infrastructure for administering these drugs.\textsuperscript{75}

*Connections Between Political Leadership and Effective Approaches to the AIDS Epidemic in Uganda*

Uganda's government has met the terms of the WHO recommendation, and adult HIV prevalence rates have continued to decrease. Jackson and Rosberg's typology of personal-rule in conjunction with Gordon's characteristics of creative and effective leadership demonstrate how Museveni's determination transformed into effective action, and explain why his leadership skills have led to successful approaches to battle the HIV/AIDS epidemic in his country.

HIV prevalence continues to fall in Uganda, and public attitudes about the disease have gradually changed. By acknowledging the problem and implementing important suggestions asserted in the 1986 WHOAFRO recommendation, Museveni has been able curb the spread of HIV/AIDS. The average national prevalence rates among the adult population have declined from approximately 18.5 percent in 1995, to 14.7 percent in 1997, 9.5 percent in 1998, to 8.3 percent at the end of 1999.\textsuperscript{76} With comprehensive HIV prevention efforts that reach down to village levels, Uganda's response to AIDS has boosted condom use across the country. Frank messages and discussions on hitherto repressed subjects, put sexuality, sexual practices, and STDs on the agenda in ways never before known to most of the population. A major focus of much AIDS education was the introduction and use of condoms.\textsuperscript{77} In 1990, the majority of Ugandans professed to shun
the condom, which they thought to be non-African or foreign. By 1997, the situation had
changed considerably. Survey after survey showed high levels of knowledge about
condoms, and moderate levels of usage. In October 1996, the STD/AIDS Control
Program published its report on declining trends in HIV infection rates in parts of the
country. In the Masindi and Pallisa districts for example, condom use with casual
partners rose from 42 percent and 31 percent, respectively, in 1997, to 51 percent and 53
percent in 2000. In the capital, almost 98 percent of sex workers surveyed in 2000 said
they had used a condom the last time they had sex. The impact of condom use on the
incidence of HIV infection in prostitutes has been well documented in Kenosha and
Nairobi, and condom promotion, where successful, has slowed the spread of HIV.

Recent studies from Uganda show a decline in HIV seroprevalence rates, particularly
among young adults. Among young adults in the Makasa district, overall HIV
seroprevalence declined by less than one percentage point between 1989 and 1994, from
8.2 percent to 7.6 percent. However, the decline was greater among the young — from
3.4 percent to 1 percent among males, and from 9.9 percent to 7.3 percent among females
ages 13 to 24. The greatest declines were seen between males ages 20-24 and females
ages 13-19, with a decline from 23.4 percent in 1990 to 20.9 percent in 1992, and a
decline from 17.3 percent to 12.6 percent respectively.

HIV prevalence also declined among pregnant women attending antenatal clinics in
Uganda. In the main referral hospital in Kampala, HIV seroprevalence among pregnant
women fell from 28 percent to 16 percent between 1989 and 1993. All age groups under
age 38 experienced a decline in prevalence. The decline was greatest for those under 19
Between 1991 and 1994, officials observed similar declines among pregnant women at
antenatal clinics in other urban areas of Uganda. Since 1993, prevalence rates have fallen to fifteen percent among antenatal women in Kampala.\(^{81}\)

According to nationwide surveys conducted in 1989 and 1995, there have been important changes in sexual behavior that could explain the apparent decline in incidence of HIV among young adults observed in antenatal clinics, particularly in urban areas. The percentage of young adults ages 15 to 19 who have ever had sexual intercourse declined from 69 percent to 44 percent among men, and from 74 percent to 54 percent among women. Condom use has risen substantially among all age groups, and the percentage with a casual partner has declined, particularly among the young.\(^{82}\)

The Uganda AIDS Commission (UAC) is planning a project worth about US$ 350,000 to educate leaders at all levels on how to mobilize people and plan activities against HIV/AIDS. The project will target political leaders including ministers, members of parliament, councilors, administrators and religious leaders. The Leadership Mobilization Strategy will begin mid-2003 if funding is secured. Political leadership at all levels within and outside government is crucial for success in the fight against HIV/AIDS.\(^{83}\) Uganda has been successful in preventing the spread of HIV in many ways. Other governments can learn meaningful lessons from the way that the Ugandan government and other institutions have tackled the disease.


4. Ibid.


9. Ibid., 132.


11. Ibid.


17. Ibid.

18. Ibid.

19. Ibid., 135

20. Ibid., 134-135.


27. Ibid., 115.

28. Ibid.


\[\text{Jackson and Rosberg, Personal-Rule in Black Africa, 252-265.}\]

\[\text{Marina Ottaway, "Africa's "New Leaders." Ibid., 200}\]

\[\text{Ibid.}\]

\[\text{Jackson and Rosberg, Personal-Rule in Black Africa, 78.}\]

\[\text{Sexuality Information and Education Council of the United States (SIECUS). Policy Update (March 2002).}\]


\[\text{SIECUS, Policy Update, March 2002.}\]

\[\text{Ibid.}\]

\[\text{Ibid.}\]


\[\text{Ibid.}\]

\[\text{Peter Piot, "Signs of Hope As Poor Nations Show New Will to Fight AIDS, Increased Funding is Vital," The Missoulian, 8 July 2002, B4.}\]


\[\text{Barnett and Whiteside, AIDS in the Twenty-First Century, 322.}\]


\[\text{Switzerland, 1998): 1.}\]

\[\text{Setel, Lewis, and Lyons, Histories, 111.}\]

\[\text{Ibid.}\]


\[\text{Barnett and Whiteside, AIDS in the Twenty-First Century, 323}\]

\[\text{Ibid.}\]

\[\text{Uganda AIDS Commission Secretariat. Twenty Years. 2.}\]

\[\text{Ibid. 4.}\]


\[\text{Uganda AIDS Commission Secretariat. Twenty Years. 5.}\]

\[\text{Ibid.}\]

\[\text{Ibid.}\]

\[\text{Ibid.}\]

\[\text{Setel, Lewis, and Lyons, Histories, 112.}\]

\[\text{Ibid.}\]

\[\text{Ibid.}\]


\[\text{Ibid.}\]

CHAPTER 3
THE CASE OF SOUTH AFRICA

South Africa has not united in what former president Nelson Mandela has called "the new struggle" against AIDS under President Thabo Mbeki. Using Jackson and Rosberg’s typology of personal-rule to identify and explain Mbeki and his administration in conjunction with Gordon’s characteristics of an effective and creative African leader will help illustrate why his leadership skills did not translate into successful approaches to battle the HIV/AIDS epidemic in his country. Jackson and Rosberg emphasize that political institutions are shaped by the circumstance from which arise. President Mbeki’s recent controversial stance on alternative AIDS theories and his plea for an "African solution" to the problem can be understood only by knowing the history of South Africa and background of AIDS in the country.

Brief History of South Africa

South Africa, together with the uplands of central and east Africa, provided a home for the earliest known forms of man and his pre-human relatives. All of South Africa’s people, including the three most populated groups, relied heavily on the land to ensure life. South Africa’s most ancient peoples are the San, who were originally foragers, organized in small communities made up of a few hundred members at most. The San resided primarily in the northwestern region of Southern Africa, near the Kalahari Desert. When the San established contact with other peoples they commonly entered into trading.
relationships with them and appear to have adopted new food-producing methods from other peoples with whom they met. Some San communities eventually adopted pastoralism.

The most prominent group is the Khoi-Khoi, who occupied much of Southern Africa south and east of the San populations to the Orange and Vaal Rivers. The Khoi were organized politically into chiefdoms, which were considerably larger than the San hunting bands, but generally consisted of no more than one or two thousand members. The Nguni lived along the coastal land between the Drakensberg and the Indian Ocean. The eastern coastlands on which the Nguni settled are the best-watered areas in South Africa and also have some of the most fertile soil, which encouraged their population to grow faster and spread further south than other groups.

The Cape of Good Hope, which lays on the Southern most tip of Africa, first became known to Europe as a result of the exploring voyages undertaken by the Portuguese in the search for a sea route to India when Bartholomew Dias rounded the Cape in 1487. English and Dutch vessels on the way to and from the Indies came to use the Cape as a regular watering place in the early seventeenth century. The directorate of the Dutch East India Company decided the Cape was a favorable refreshment station and on April 6, 1652, Jan van Riebeek arrived with three vessels to set up the new post. The Dutch East India Company intended the enterprise to be a limited one.

The original settlement was tiny and made up exclusively of the Company’s servants. However, because farming undertaken by the Company’s full-time employees proved inefficient and expensive, van Riebeek suggested that a number of settlers establish farms of their own where they would grow crops and supply the Company’s needs for their
profit. In April 1657, twelve free burghers (settlers) settled on small farms along the Liesbeek River. The number of free burghers steadily grew over the years and a community of permanent settlers expanded beyond the original fort and took hold in the tip of Southern Africa.  

The Cape acquired the first substantial batch of slaves in 1658 from the Dutch East Indies and eastern Africa. By 1660, slaves outnumbered the freemen. In 1717, the Cape’s Council of Policy adopted the free importation of slaves as official policy. The continued importation of slaves and the expansion of the non-white labor force, available to the white settlers prevented the development of a white laboring class, which led first to an increasing view that menial labor was beneath the dignity of a white man and to a pattern of class distinction which corresponded closely to differences of color. The white population often exploited and mistreated blacks and other non-whites, setting the way for future generations. Perceptions of white racial superiority were apparent from the earliest colonial encounters of the Dutch settlers with Khoi-Khoi pastoralists at the Cape. The growth of the labor force also made possible the expansion of farming enterprises; differences among the colonists increased accordingly, and towns expanded.

As areas nearer the Cape filled up with settlers, traders continued to open up the interior, and farmers followed. Most settlers moved eastward along the line of greatest rainfall and took up cattle and sheep raising in the veld, which required large areas of land because of the relatively dry conditions of the land. With each ranching family occupying at least one farm of 2500 hecta acres (ha), and with a high rate of natural increase among the white population, the frontiers of settlement expanded very rapidly,
absorbing part of the indigenous population as farm servants and driving the rest further into the hinterland. This process, which got underway in the late seventeenth century and in the eighteenth century, was to continue through most of the nineteenth century. The expansion of the frontier depended on the development of the economy of the settled areas, which in turn depended on the fortunes of the Company and of the economy of Europe in general.

The fact that Khoi and San occupied the immediate hinterland of the Cape made the rapid expansion of the colony easier. The relatively sparse population of these peoples could offer only limited resistance to white expansion in its early stages. The presence of the Khoi, moreover, meant the possibility of acquiring stock and labor relatively cheaply, without which such rapid expansion would have been impossible. Khoi groups generally adopted a friendly attitude to the first whites they met, seeing them as a source of valuable trade goods. As they began to realize what was happening, Khoi attitudes changed. However, due to limited population size and the division of their group into many different chiefdoms, Khoi resistance proved largely ineffective.

In 1814, Britain took permanent control of the Cape as a result of the Napoleonic wars. At the Cape, by the late eighteenth century, race and class had overlapped for so long that to many Europeans this social structure appeared to be natural or God given. There, more hesitant colonial expansion marked the first half of the nineteenth century than before.

The British administration focused on attempting to make the colony pay its own way rather than expanding its boundaries. Britain abolished slavery in South Africa in 1834. At the same time, the focus of the economy shifted away from the arable western areas.
This transformed the Cape from the 1830s, leading to the emergence of a capitalizing farmer gentry, the increasing value of land, and the extrusion of labor tenants. These developments led to the migration out of the colony of about 15,000 eastern Cape pastoralists in the 1830s. The “Great Trek” is the seminal event in South African history that provided the symbolic images crucial to the ethos of Afrikaner nationalism that many white South Africans still celebrate.

In the 1850s, after much turmoil between the British administration and the Dutch settlers, the British appeared to withdrawal from direct political control over the South African interior. The discovery of diamonds and gold in South Africa changed that. The development of the diamond fields at Kimberly and the gold mines of the Witwatersrand transformed South African society. From the 1870s, the British adopted an aggressive thrust into the whole sub-continent. In the course of two decades, Basutoland, Griqualand West, the South African Republic in the Transvaal, the Transkei, and Bechuanaland were conquered or annexed, the Zulu and Pedi were defeated, and their lands brought under imperial control.

By the end of the 1880s, the British had effectively exerted control, either directly or through their colonies, over a large number of African societies. However, the British were unable to accomplish their goal of a South African Confederation. The reason was primarily due to resistance by the Boer trekkers in the Transvaal whose farm and ranch land were being overtaken by miners and mining companies. The British agreed to withdrawal from the Transvaal in 1881, which marked a significant growth of Afrikaner nationalism and resentment at continued British influence in the region.
The Boers, or Dutch farmers, were in constant turmoil with the indigenous populations as well as the British authority. The process of conquest of African politics in the last three decades of the nineteenth century was the direct result of a more aggressive British imperial intervention. The process largely destroyed indigenous independence and cemented Boer segregationists ideals. However, it was not until the early twentieth century that a concerted ideology and overarching plan of segregation was developed.25

In the early 1890s, South Africa was still divided into settler colonies and Boer republics. It took a major war between them before the Union of South Africa was formed in 1910.26 The South African War of 1899-1902 and its aftermath marked the end of the protracted process of the conquest of South Africa by settler and imperial powers. The Union dashed African hopes of regaining access to land encouraged by British rhetoric before and during the war. The new government entrenched white supremacy into the constitution.27

Economic and political stability required incorporation of Afrikaner politicians into the central organs of government rather than self-governing Boer provinces. Therefore, the new constitution of 1910 did not follow the Australian pattern of federalism. The constitution established a union, with major central government power. In an ominous sign of what lay ahead, the constitution upheld white unity at the expense of black political and land rights.28 In 1914, with the passage of the Natives Land Act of 1913, the government allowed blacks to settle on only 7 percent of South Africa's land (which was increased to 14 percent in 1936) in “Native Reserves.” These areas became the basis of the “homelands” of the apartheid era.29 The passage of more segregationist and racially
discriminatory acts followed until the government officially adopted Apartheid in 1948 under D.F Malan and the National Party. For the next half-century, until Nelson Mandela was inaugurated as South Africa's first black president in 1994, black South Africans struggled under the oppression of the apartheid government.

Mandela retired in 1999. He left the presidency to Thabo Mbeki who sought to define South Africa's role at the turn of the millennium in terms of his notion of an "African Renaissance," by which the country would lead the continent out of its poverty and alienation. Jackson and Rosberg assert that it is necessary to consider the crucial role played by leaders and their actions on the public life of new states in contemporary Africa. Personal-rule continued under President Mbeki in South Africa.

Mbeki's administration began two years after the new government implemented the post-apartheid constitution. His administration started during a period of transition. Rosberg and Jackson consider this origin—when one institutionalized order had broken down and another had not yet fully replaced it, typical for the development of personal regimes. Another effect of an unstable period transition is the creation of a risk environment that facilitates the transmission of HIV. South Africa's peculiar history has made it fertile ground for the spread of AIDS.

**History of HIV/AIDS in South Africa**

AIDS began under the old order, and burgeoned under the new, which complicated attempts to respond to it. The initial epidemic, virtually confined to the gay white male community, surfaced at the same time as it did elsewhere in the developed world. A newspaper headline announced "Gay Plague Hits South Africa" and intimated that homosexual men were polluting white society. Homosexuality was illegal in South
Africa, and in the 1980s, the gay community kept a low profile. By the time this first outbreak peaked in South Africa in 1989, it was clear that, like many countries in sub-Saharan Africa, South Africa faced a new, heterosexually transmitted epidemic, predominantly affecting black African communities.

The racially differentiated nature of the epidemic has made it more difficult to manage. The fact that it is sexually transmitted and that HIV is believed to have its origins in Africa have, on the one hand, fueled racist stereotypes, discrimination, and Afro-pessimism, and, on the other, prompted anger, denial, and genocidal conspiracy theories. Had the disease afflicted all South Africans equally, regardless of race, the politics of the epidemic would undoubtedly have looked different.

Apartheid Origins

The apartheid regime was ill prepared to handle the new challenge. It responded to the first phase of the epidemic by ensuring the safety of the blood and blood-product supply as soon as an HIV test was available, and by providing some funding for education campaigns, training, counseling, and research. An AIDS budget of R 1 million in 1987 grew to almost R 22 million by 1992-1993, but fell marginally the following year. This was far short of the World Health Organization's recommendations of R 143 million a year for South Africa at the time. From the beginning of the AIDS epidemic in South Africa, the government failed to take the 1986 WHOAFRO recommendation seriously. Shrinking funds in the face of a growing epidemic stirred suspicions that the government was not taking the matter seriously, because it was now clear AIDS was going to affect blacks more than whites. Some also seemed to believe South Africa was "different" from the rest of Africa, and would not suffer the devastation seen to the north,
or that the country could insulate itself from the epidemic by keeping out infected foreigners. An attempt to legislate the exclusion of people who tested positive for HIV, aimed particularly at Malawian migrant mineworkers who had high infection rates, met with outrage from the National Union of Mineworkers, who blamed the disease on the migrant labor system itself, which provided "fertile ground for an AIDS epidemic, and the state and industry should bear the responsibility." 39

The political circumstances in which the epidemic arrived made the efforts of the South African government to deal with it more problematic. The mid-1980s saw the country in a state of unprecedented political turmoil and violence, with blacks bent on overthrowing the government by making the country "ungovernable." A major feature of black resistance was the school boycott, which kept children in some areas out of school for years at a stretch. In other areas, the schools themselves turned into "sites of struggle" for political education. "Liberation before Education" was the call. In 1986, the same year the World Health Organization's Regional Office for Africa convened in South Africa and published its recommendation, pamphlets appeared proclaiming "The Year of No School." 40 AIDS, which had not yet found its way to South Africa, did not seem to be on the minds of South Africans who were in the midst of revolution. The UNDP and UNAIDS estimates that, between 1984 and 1986, three hundred children were killed, one thousand wounded, eleven thousand detained, and eighteen thousand arrested on protest charges. 41 As Saths Cooper, a clinical psychologist and activist, has remarked, there was "little normality in the lives of politicized children. No good familial relationships, no normal schooling, no integrated existence. Norm restraints were non-existent." 42
The children of those turbulent years, now in their twenties and thirties, bear the brunt of today's HIV/AIDS epidemic. The 1999 antenatal survey show that over 25 percent of twenty to twenty-nine year olds, and 22 percent of thirty to thirty-four year olds, are infected. There probably could not have been more effective prevention campaigns by the previous government to forestall this. While AIDS is inevitably politicized, the superheated political climate between 1984 and 1994 ensured that people of all ideological persuasions interpreted, manipulated, or ignored it to suit their own political agenda.

AIDS proved a powerful image for social disorder in the 1980s, metaphorically evoking white fears about escalating black political protests and the disintegration of apartheid. Through the 1970s and 1980s, as the country slipped into recession, the currency devalued, and the union movement consolidated its strength, the country’s economic vulnerability was of prime public concern. AIDS heightened the country’s sense of economic crisis and anxieties about dependence on a volatile African labor force. Images associated with AIDS embraced current political tension. The government banned the African National Congress and the South African Communist Party in the 1980s, but their insignia, symbols, and songs were part of the popular uprising led from within the country during the mid-1980s. The government acted directly against the 1986 WHOAFRO recommendation to make the public fully aware of the nature of AIDS and HIV, the modes of transmission, and its importance as a health concern while placing emphasis on the feasibility of preventing HIV infection and on teaching how AIDS transmission does not occur through casual contact with infected persons. The government attempted to discredit the ANC by characterizing HIV as the new swart
gevaar (black peril) sweeping down from the north in the form of ANC guerrillas. The apartheid government launched a smear campaign and distributed pamphlets in Johannesburg in 1988, which warned "socialize with the ANC freedom fighters and cry and die from AIDS," in a further attempt to damage the reputation of the ANC and scare potential supporters.45

The association between AIDS and the ANC implied that the organization and political protests were a disease spreading across the country, which unless rooted out and destroyed, could lead to an ugly and violent death. In 1990, when the ANC was unbanned, the government distributed another smear pamphlet warning parents of ANC exiles that returnees would be quarantined and tested for AIDS. Other pamphlets, claimed that all blacks would be infected with AIDS by 1992 and that the disease was spread by informal contact, such as sneezing and coughing, or by mosquitoes.46 The Conservative Party insisted that AIDS could be spread by informal contact in its effort to reinforce the fears among its supporters about social integration.47

Any attempt to put conventional AIDS education into black schools—assuming they had been functioning—would undoubtedly have been met with suspicion and hostility. Given the conservatism of South Africa's black and white parents, sex education in schools has long been problematic. What safer-sex campaigns there were provoked criticism and anger.48 In 1988, AIDS posters targeted separately at white and black audiences were dismissed by antiapartheid groups as "typical of government racist propaganda." Non-collaboration and pressures to keep the state isolated internationally were integral parts of the opposition's strategy—a strategy that created its own dilemmas,
went ahead with plans to desegregate hospitals, schools, swimming pools, blood banks, and other amenities. Anonymous pamphlets defended the rights of whites to "survive in an AIDS sea," and demanded compulsory testing for returning ANC exiles or legislation to make AIDS a notifiable disease.

In the antiapartheid camp, there were many grassroots community groups, churches, student organizations, and nongovernmental organizations involved in AIDS initiatives by the late 1980s and early 1990s, but their efforts were for the most part fragmented and sporadic. The major alliance partners that were to form the new government did little. The African National Congress had signaled its concern—but had offered little in the way of concrete interventions. In April 1990, 250 delegates, including representatives of the ANC, the United Democratic Front, the National Medical and Dental Association, and other antiapartheid organizations, met at a conference on health and welfare in Maputo, and discussed AIDS. The delegates passed a resolution calling for immediate action by "progressive" organizations in the face of the impending AIDS "crisis." The resolution urged delegates to play a leading role in AIDS campaigns "situated within the broader struggle for political change." It also urged senior political leadership to become involved to overcome the suspicion around AIDS that the apartheid government had aroused. A year later, AIDS analyst, Mary Crewe, remarked "one has yet to hear any of the [ANC] National Executive raise the issue of AIDS at a political rally or public meeting." 55

While the ANC and affiliated organizations were clearly aware of the AIDS threat, a coherent plan to address the disease as laid out in the WHOAFRO recommendation eluded them. In 1991, the ANC journal, Mayibuye, had to admit that the democratic
such as South Africa's exclusion from the World Health Organization's Global Program on AIDS.\textsuperscript{49}

In 1993, on the eve of the transition to democracy, the government had reported only a few hundred AIDS cases. In the black townships, the epidemic remained invisible.\textsuperscript{50} Many black militants dismissed the AIDS scare as a government fabrication, the acronym said to stand for "Afrikaner Invention to Deprive us of Sex." The emphasis on condom usage raised suspicions that the real objective was to reinforce the government's "genocidal" family-planning program. Talk of safer sex seemed at the time like "a plot devised by the government, supported by the employers, and pumped through a restricted press to convince black people to have less sex, and therefore fewer babies."\textsuperscript{51} In November 1988, an article by Mzala, in \textit{Sechaba}, an official publication of the ANC in exile, questioned the African origin of the virus. The \textit{Sechaba} essay suggested that the virus may have been developed "in the secrecy of the laboratories of many imperialist countries."\textsuperscript{52} Some said police sprayed the virus in tear gas; others argued that it had been deliberately spread to black prostitutes by infected ex-ANC guerrillas (\textit{askaris}) working for the police.\textsuperscript{53}

As AIDS activist and antiapartheid campaigner, Ivan Toms, said at the time: "there is no possibility that the present government could, even if it has the inclination, run an effective campaign to limit the spread of HIV infection. It has no credibility or legitimacy whatsoever among blacks."\textsuperscript{54} The response of the white right wing served further to politicize AIDS. In Parliament, AIDS figured prominently in political infighting. Right-wing newspapers insisted that "evidence" that HIV could be transmitted by casual contact meant that whites would be in danger if the government
movements' "deep commitment and sense of urgency . . [had not] translated into practice." The political priorities of the time saw issues such as housing, unemployment, poverty, and violence take center stage. AIDS, with its unpopular message of condoms and safer sex—a message necessarily overlapping with that of the government—was not taken well. Black youth were particularly unreceptive to warnings about AIDS. Brutalized by the turmoil of the 1980s, they had learned to live with the fear of death. Despite the guidelines in the WHOAFRO recommendation, AIDS education was poor, and public awareness was low. In a survey of seventeen- to twenty-three-year-olds in KwaZulu in 1990, Dr Darryl Hackland, KwaZulu secretary of health, found that a third of the respondents believed that AIDS was "a joke." Ninety percent said that they would never use a condom. For those caught up in political violence, AIDS was "almost a laughing matter. It's a case of eat, drink and be merry, for tomorrow we die!" Whether the safer sex message came from the white government, or from parents and elders, whose political timidity they had ridiculed, it was clear that the militant young were in no mood for messages of caution and moderation. Politicians hoping for the youth vote avoided the issue of AIDS altogether.

It was clear that interventions could not wait for a new political order. In compliance with the WHOAFRO recommendation that a comprehensive strategy on AIDS start at the operational level with creation of a National AIDS Committee, a Task Force, or the like, the health secretariat of the ANC indicated willingness to meet with the Department of National Health and Population Development (DNHPD) to formulate a strategy in November 1991. They convened a meeting on January 15, 1992, attended by people in the AIDS field. The participants resolved to convene a national forum on AIDS, and to
mandate the ANC and the DNHPD to set up a steering committee to plan a response to the AIDS crisis. In October 1992, the organizations held a national conference—"South Africa United Against AIDS." The 442 delegates recommended a national strategy that would address education, counseling, prevention, health care, welfare, research, human rights, law reform, and socioeconomic issues. The National AIDS Coordinating Committee of South Africa (NACOSA), which emerged from the conference, was to implement a national strategy on HIV/AIDS.

NACOSA developed the strategy through an intensive program of consultation via a national and regional NACOSA network, with input from political parties, trade unions, the business sector, civic associations, churches, academics, government departments, AIDS service organizations, and others. The network developed a draft of a national AIDS strategy for discussion at a strategy workshop in September 1993. The strategy was comprehensive, presenting a detailed plan to achieve three overriding objectives: the prevention of HIV transmission, the reduction of the personal and social impact of HIV, and the mobilizations of local, provincial, national, and international resources to fight the epidemic.

After the 1994 elections, the government endorsed the NACOSA strategy as the National AIDS Plan. Located in the Department of Health under the directorate of HIV/AIDS and STDs, the program's budget doubled, and donor funds grew. With cabinet endorsement, it looked like the plan would have the multi-sectoral support and level of political commitment that had proved crucial in successful programs elsewhere. Despite the cabinet endorsement, and being designated a Presidential Lead Project in the Reconstruction and Development Program, AIDS came to be seen as simply a health
issue. The resources necessary for a plan of the size and complexity envisaged by NACOSA were not forthcoming because AIDS failed to be prioritized in the way in which NACOSA had envisaged, and because the new government faced the difficult task of trying to restructure the fragmented systems created by apartheid and weld together the sometimes reluctant, even obstructive, old and new bureaucrats. Tension between national, provincial, and local governments over budgetary allocations, program design, and policy decisions also impaired implementation.

A further dimension to the problem was the intrusion of the WHO's Global Program on AIDS (GPA). The GPA program not only emphasized priorities different from NACOSA and required even more money to implement, it also talked of an "African approach," as if the continent were a homogeneous whole. Rather than strengthening the government plan through collaboration with NACOSA, the GPA shook the confidence of local groups and blurred responsibility for implementation. By 1996, the AIDS Plan was in serious trouble. Two years into its implementation, not only had HIV prevalence climbed from 7.6 percent in 1994 to 14.2 percent in 1996, the ideal of "South Africa United Against AIDS" had not been realized. A major review of the AIDS strategy in 1997 also drew attention to the lack of political leadership on the issue. Effective and creative leadership characteristics were lacking severely when it came to HIV/AIDS prevention, awareness, and education. Both government and NACOSA leadership failed to achieve even the first characteristic, understanding that the bureaucratic hierarchies were ineffective and advocating a community of responsibility. Rose Smart, head of the Health Department's National HIV/AIDS and STD Directorate, wrote: "Despite the impression internationally that there is significant political commitment in South Africa
to addressing HIV/AIDS, in reality this was found to be limited (with few exceptions) to the Minister and the Department of Health.\textsuperscript{67}

The credibility of the government's AIDS strategy was also affected by a series of scandals and blunders, beginning with the Department of Health's commissioning, in 1995, of a musical. The government intended Sarafina II to take the AIDS message to the public in a popular form. It was a disaster on a number of levels. An inappropriate, all-star, big-budget production, it cost a whopping R 14.2 million. The government had not authorized the expenditure, there were irregularities in the tendering process, and the message the creators intended to convey was far from clear. The media and opposition parties had a field day reporting on the issue, but it also served to drive further wedges between government and AIDS organizations.\textsuperscript{68}

The organizations pointed out that, at a time when funds were scarce, the money could have been better spent on smaller local projects with a better understanding of AIDS issues. They resented the increasingly non-consultative way in which the Health Minister made decisions, and that the expected the organizations to refrain from criticism.\textsuperscript{69} A body representing more than two hundred organizations working in the AIDS field tried to take up its concerns about the play with the Health Department in a constructive way, but eventually went public and assisted the Public Protector in his investigation of the matter. The government's response to criticism was particularly disturbing. It raised questions about the relationship of NGOs and the government. Many AIDS service organizations (ASOs) relied on government funding and felt unable to challenge the Health Department. Despite the minister's stated commitment to transparency and accountability, the ASOs were feeling increasingly marginalized by her actions. Some
even felt that the funding cut to ASOs from R 19 million to R 2 million in 1998 was partly motivated by spite directed at a sector that had tried to hold her to account.  

While investigation of the Sarafina II matter was still in progress, the government found itself embroiled in yet another major controversy surrounding their support for a suspect AIDS drug, Virodene P058. The drug, an industrial solvent (dimethylformamide), had previously been tested in cancer therapy, but abandoned as ineffective and toxic. When a team of researchers at the University of Pretoria noticed Virodene had antiviral properties, they administered the drug to a number of AIDS patients, without clearing its use via the normal ethical and scientific protocols. On January 22, 1997, the researchers attended a cabinet meeting with patients who had purportedly seen their full-blown AIDS reversed by the drug. After receiving a standing ovation, the researchers asked for a grant of R 3.7 million for further research. They claimed it was necessary to take the unusual step of going directly to the cabinet, after the "AIDS research establishment" had blocked their work because they refused to share their patent rights.

Over the following year, allegations of government financial involvement, repeated rejections of Virodene's credentials by the Medicines Control Council (MCC, the country's drug regulatory authority), and pleas by people with HIV/AIDS to be allowed access to the drug vied for headlines. Like Sarafina II, Virodene succeeded in dividing those who should have been united in the fight against AIDS. This time not only the department of health, but also the whole cabinet, including the deputy president, Thabo Mbeki, was involved in a scientific matter on which they were ill equipped to pass judgment. The initial elation on the part of people with HIV/AIDS that a cheap cure
might have been found, their desperation to get access to the drug, and their anger and
despair when they realized how threadbare the claims were increased their skepticism
about government AIDS initiatives. The 1986 WHOAFRO recommendation seemed to
have fallen by the wayside.

The AIDS epidemic reflects the history of the region. Migration and mobility created
patterns of sexual behavior and mixing which are perfect for the spread of sexually
transmitted disease. In addition, high levels of inequality aided the creation of risk
environment by shifting previously unequal gender relations further imbalance, forcing
women to be more dependent. The breakdown of family structure in the rural areas and
townships, government policy toward its black population, and the violence that
accompanied the end of apartheid combined to create a widespread philosophy of
fatalism. This perception that “what will be, will be” in turn diminished individual
worth, responsibility and accountability. The feeling is still prevalent and makes people
live for today without valuing tomorrow. It can be summed up in a shrug of the
shoulders and the response: “if AIDS kills me in five years’ time, so what?”

Magnitude of HIV/AIDS in South Africa

HIV caught most South Africans by surprise. The virus battered much of Central and
East Africa in the 1980s. However, HIV is a relatively new arrival in South Africa, its
spread hastened by the opening up of the post-apartheid economy to greater trade and
migration flows from the north. As apartheid was ending in South Africa, an influx of
commercial trade and migrant workers from neighboring countries opened up a kind of
viral superhighway for the epidemic. Legislators, grappling with the momentous political
and social changes at hand, failed to foresee that these changes might also bring deadly
consequences, and failed to implement a proper prevention strategy. Forced
displacement of black people under apartheid, and the deploying of workers far from
their families, had also led to higher rates of extra marital sex and prostitution.\textsuperscript{75}

In South Africa, HIV rates soared during Nelson Mandela's administration, a fact that he later acknowledged. "It's the silence that is letting the disease sweep through the country," Mr. Mandela said on World AIDS day in December 1998. He concluded, "It is time to break the silence."\textsuperscript{76} In 1999, Dr. Peter Piot, Assistant Secretary General of the United Nations and head of its AIDS programs applauded Mr. Mandela and his successor Mr. Mbeki for calling national attention to AIDS, but said it took a long time and many deaths could have been prevented if they had spoken out earlier.\textsuperscript{77} The lack of dialogue and effective action to prevent HIV transmission has encouraged the drastic increase in HIV infection and related deaths.

The UNAIDS/WHO Working Group on Global HIV/AIDS and STI Surveillance estimates that five million adults and children were living with HIV/AIDS in South Africa at the end of 2001 and that 360,000 adults and children died of the disease that year.\textsuperscript{78} The same study estimated that 660,000 children under the age of 15 lost their mother or father or both parents by the end of 2001.\textsuperscript{79} Every year as many as 100,000 babies are born with HIV in South Africa, where one in four pregnant women are HIV positive.\textsuperscript{80} The average adult-prevalence rate stood at a staggering 20.1 percent by the end of 2001.\textsuperscript{81}

The Working Group has conducted national sentinel surveillance of antenatal clinic attendees in South Africa since 1990 and surveillance data is available by province and at a national level. Antenatal HIV prevalence in South Africa increased rapidly from 0.7
percent in 1990 to 10.5 percent in 1995 and then 22.8 percent in 1998. HIV prevalence among antenatal clinic attendees was 22.4 percent in 1999 and 2000 respectively. In some provinces, the rate of increase was even more drastic. For instance, in KwaZulu-Natal,Mpumulaga, and Guateng provinces, HIV prevalence rose swiftly from 7.1 percent in 1990 to 36.5 in 2000. HIV prevalence among sex workers tested in Natal increased from 50 percent in 1997 to 61 percent in 1998.

One study, conducted by the Medical Research Council (MRC) with partial government funding, and published in October 2001, suggests that as many as 7 million South Africans will have died of AIDS-related illnesses by 2010. According to UNAIDS, average life expectancy in South Africa is only 47 years, instead of 66, because of AIDS. Orphanages are bursting with children whose families have fallen victim to AIDS. The study expects two million by 2010. Some companies in KwaZulu-Natal have barred employees from going to more than two funerals a week.

The impact of the HIV/AIDS epidemic on production and the costs of fighting the disease might cause South Africa's economy to be 17-20 percent smaller by the year 2010 than it would have been without the syndrome, according to a study presented at a conference in Johannesburg in September 2000, by two US economists, Jeffrey Lewis of the World Bank and Channing Arndt of Purdue University.

**Political Leadership in South Africa**

South Africa has the largest absolute number of HIV-positive people in the world. Yet, from the president down, there is a failure to talk publicly about the scale of the problem. Alarming as the forecasts are, South Africa's government has barely awakened to the problem. Many had hoped that President Nelson Mandela would
spearhead the South African AIDS program. Mandela seldom addressed the issue in South Africa, even though he did make a major speech on AIDS at the World Economic Forum in Davos, Switzerland, in February 1997. "When the history of our time is written," said Mandela, "it will record the collective efforts of societies responding to a threat that has put in the balance the future of whole nations. Future generations will judge us on the adequacy of our response." He concluded his speech by saying South Africa's National AIDS Program, conscious of the need "to put the effort to combat AIDS on a higher plane," had "made the call for 'A New Struggle!'" It was a stirring message, but one he seldom repeated from South African platforms. In his speech, Mandela urged the world to help control AIDS in Africa, but at home never made it a priority.

AIDS workers hoped that a speech by Mandela to be aired on national radio and television stations on October 9, 1998--billed, "Ten Minutes to Save the Nation"--would help focus public attention on the issue. There was deep disappointment when Mandela delegated the job to Thabo Mbeki. The address, filmed at a Salvation Army Children's home, with Mbeki sitting stiffly in his crisp business suit and tie, surrounded by HIV-positive children, had obviously been designed for Mandela's more informal style. In the speech, Mbeki said nothing new, but did admit, "We have closed our eyes as a Nation, hoping the truth was not real." He added: "Nothing can prevent infection except our own behavior." The point of the speech was to draw people into a "Partnership Against AIDS." On one of the rare occasions in which Mandela publicly addressed the AIDS issue, at a World AIDS Day rally at Mtubatuba in KwaZulu Natal in 1998, Mandela commented "because it spreads mainly through sex, prevention requires of us that we
speak of it in a way our traditions, our cultures and our religions provide little guidance.93

In September 1998, the government held an "AIDS crisis summit" to launch a new "Partnership Against AIDS," meant to revitalize South Africa's flagging program. The minister of health was late, and Mbeki made a brief appearance on the way to open a World Athletics meeting. Further controversies have surrounded the provision of antiretroviral drugs to prevent mother-to-child transmission (MTCT) of HIV. With a predominantly heterosexually transmitted epidemic, women of childbearing age are commonly infected, and stand a 25-35 percent chance of passing the infection on to their babies. The use of AZT (zidovudine) administered from thirty-six weeks of pregnancy and for six weeks to the infant has been shown to lower transmission substantially, and recent research suggests that a new drug, nevirapine (Viramune), may achieve even better results with just a single dose during labor and one dose to the baby within seventy-two hours of birth.94 Given the humanitarian considerations and the fact that such prophylaxis can be demonstrated to be highly cost-effective by comparison with repeated hospital care for an infected infant, the case for anti-retrovirals seems clear.95

The main obstacle in curbing the spread of HIV is not technical, but cultural: the tyranny, familiar across Africa, of denial and taboo.96 In October 1998, Minister Zuma announced that she and her nine provincial health ministers had decided not to make the drug available and to discontinue planned pilot projects to test it. She pointed out that the government's priority was prevention and stated that "The AZT treatment will have a limited effect on the epidemic, as we are targeting individuals already infected."97 As critics were quick to point out, the prevention of MTCT was the object of using AZT, but
Zuma was adamant. Even after GlaxoWellcome, AZT's manufacturer, drastically reduced the price of the drug, Zuma insisted it was too expensive, given that the intervention would also require testing, counseling, formula feeding, and technical support. James McIntyre and Glenda Gray, directors of the Perinatal HIV Research Unit at Soweto's Chris Hani Baragwanath Hospital, wrote of their concern that attempts to discuss the issue constructively had been "overshadowed by inflexible public statements by the Minister's spokesperson, including questioning the political motives of those who advocate MTCT prevention strategies." They noted that while South Africa guaranteed free maternity treatment and free treatment for children less than six years, including expensive hospital procedures, it "specifically excludes the provision of a R 300-R 400 drug treatment which prevents half the cases of pediatric HIV."  

In the Western Cape, provincial health authorities decided not to follow national policy. In January of 1999, they went ahead with pilot projects to provide AZT and free formula at two clinics in Cape Town communities with substantial HIV infection levels. By 1999, Zuma's position had become untenable. The health minister had stonewalled on AZT, become immersed in bitter battles with the pharmaceutical industry, failed to consult or answer to the AIDS constituency, and presided over a series of minor and major public-relations disasters. After the 1999 election, President elect, Thabo Mbeki, named Zuma minister of foreign affairs. Her replacement, Dr Manto Tshabalala-Msimang, appeared more approachable. She arranged early on, to meet with NACOSA, with doctors involved in MTCT prevention, and with representatives of the pharmaceutical industry. Within weeks of Tshabalala-Msimang's appointment, she organized a trip to Uganda to review their nevirapine project and to investigate how the
country, much poorer than South Africa, had managed to bring their AIDS epidemic under control. There were hopes that confrontational stalemates would end and partnerships become possible. In June 1999, Tshabalala-Msimang had already said that the government was examining finding ways to ensure a sustainable AZT program for MTCT prevention.

Type of Personal-Rule

Personal-rule in South Africa began under Nelson Mandela, and continued with Thabo Mbeki, elected president on June 16, 1999. Mbeki has an autocratic style of leadership. He is a ruler that controls the government and the state without having to share power with other leaders. For South Africa, it is a striking shift in substance and style. Mandela delegated many responsibilities, serving as a charismatic caretaker president. Mbeki thrives on details, closely manages his cabinet, and often analyzes important matters way into the night. His critics say this means that the president sidelines his own ministers and experts. In practice, it means that all but his most capable ministers sometimes fade from view. Mbeki is no stranger to challenging the establishment. During the apartheid years, he was among the first members of the African National Congress to argue that negotiation with whites, not armed revolution, would lead to the demise of apartheid. However, Mbeki's autocratic style of leadership has impeded his ability to create effective approaches to deal with the HIV/AIDS epidemic in South Africa. For instance, it was clearly Mbeki, not the health minister, who drove the government's inquiry into the causes and treatments of AIDS.

Mbeki was the one who came across the research by U.S. biochemists Peter Duesberg, Charles Geshekter, and David Rasnick, who deny that HIV causes AIDS and argue that it
is the result of poverty and malnutrition. He was the one who began questioning the safety of the commonly prescribed drug AZT after reading criticism of the drug on the Internet. Mbeki contacted local and foreign researchers, surrounded himself with books and journals, and consulted with the minister of health when he came across medical terms he did not understand.

Creative and Effective Leadership

Mbeki has failed to realize each of Gordon’s characteristics of effective and creative leaders when it comes to HIV/AIDS. In his address to the National Council of Provinces, President Mbeki, ushered in a new phase in the AZT debate, saying that, as there was a large scientific literature on the toxicity of AZT, he felt it would be irresponsible not to heed these warnings. He asked the minister of health, as a matter of urgency, to establish "where the truth lies." He also urged council members to consult "the huge volume of literature on this matter available on the Internet so that all of us can approach this issue from the same base of information." Mbeki neither advocated a community of responsibility about AIDS and its effects nor promoted change. Some governmental officials worried that Mbeki’s ruminations on AIDS, and the media’s simplification of his views, may have undermined efforts to prevent the disease.

Mbeki’s caution following the Virodene debacle was understandable, but the evidence on the Internet would have reinforced the urgent need to make AZT available. It was endorsed by the U.S. Food and Drug Administration, the Centers for Disease Control in Atlanta, and the Medicines Control Council of South Africa, and was on the essential drugs list of the WHO. Despite this, Tshabalala-Msimang said AZT weakened the
immune system and posed the danger that "mutations" might lead to mothers producing children with disabilities. AIDS activists were irate.

A series of subsequent events leading up to the AIDS 2000 Conference in July dashed hopes that there would be some attempt at "damage control" over the president's statement. In the face of rapidly rising infection rates, and the disarray among the forces that should have been collaborating to turn the tide, AIDS organizations had repeatedly called for a multi-sectoral national AIDS commission, to address the problem. There were hopes that a new South African National AIDS Council (SANAC) might fulfill this role. When Deputy President Jacob Zuma launched SANAC on January 14, 2000, public reactions ranged from indifference to despair. Instead of the envisaged council of experts, SANAC appeared to duplicate the existing Interministerial Committee and the "sector" representatives of the partnership initiative. Of the fifteen cabinet ministers and government representatives, many lacked any real interest in the AIDS issue, as their performance on the Interministerial Committee, established in 1997, had demonstrated.

The sixteen sector representatives were an odd assortment. The six-hundred-plus NGOs and ASOs that dealt with AIDS had one representative. High-profile organizations like the AIDS Law Project and the Treatment Action Campaign were not represented. There were three members representing sport, the hospitality industry, and "celebrities," and there were two traditional healers--but no scientists, no medical practitioners, and no representatives from either the Medical Research Council or the Medicines Control Council. The dust had barely settled when it became clear that Mbeki's skepticism about AZT extended to a wider mistrust of the whole "science of AIDS." While surfing the Internet he had come up with pages like virusmyth.com, where
a small network of AIDS dissidents publishes alternative—and discredited—theories of the epidemic. Among these theories is the belief that HIV—if it exists—is a harmless "passenger" virus, that AIDS is a "lifestyle" disease, where, recreational drugs, or even AZT, cause the breakdown of the immune system, and that the increased morbidity and mortality of the disease in Africa result from poverty, which aggravates old disease patterns.\(^{111}\)

Mbeki's inquiry into these alternative theories, and their protagonists led him to set up the "Presidential International Panel of Scientists on HIV/AIDS in Africa."\(^{112}\) In a pamphlet explaining its purpose, the Ministry of Health said that the panel would explore "all aspects of the challenge of developing prevention and treatment strategies that are appropriate to the African reality." The ministry noted that the inclusion of dissidents, who believed that AIDS was "due to lifestyle factors such as poverty and malnutrition" rather than HIV, had "caused uproar among the scientific and medical fraternity." Since orthodox treatments had met with little success against AIDS in Africa, "blind acceptance of conventional wisdom would be irresponsible."\(^{113}\)

The thirty-three-member panel consisted of both dissident and mainstream scientists, including some of the best known on each side. At their first meeting in May, just two months before the AIDS 2000 Conference in Durban, Mbeki appeared to hope that the scientists could reach some kind of compromise position. Science, unlike politics, is based on a method that tests hypotheses and ruthlessly discards what does not fit the facts; its aim is not consensus.\(^{114}\) On April 3, 2000, Mbeki took the unusual step of sending hand-addressed letters to UN Secretary General Kofi Annan, Britain's Prime
Minister Tony Blair, U.S. President Bill Clinton, and other world leaders, setting out his position on the epidemic.

The letter was an impassioned plea to revisit the African AIDS epidemic. Its tone so stunned the Clinton administration, that according to the Washington Post, which published a leaked copy of the letter, they checked to see if it was a hoax, and attempted to suppress it lest it spark international controversy. In the letter, Mbeki compared AIDS in the West—a declining epidemic, "largely homosexually transmitted," where relatively few people have died—with AIDS in "Africa," a rapidly growing heterosexually transmitted epidemic, which seemed destined to kill tens of millions of people—a "uniquely African catastrophe." Given the differences, "a simple superimposition of Western experience on African reality would be absurd and illogical." South Africa's task, argued Mbeki, was "to search for specific and targeted responses to the specifically African incidence of HIV/AIDS." To exclude dissident opinions from this search would be to "freeze scientific discourse on HIV/AIDS at the specific point this discourse had reached in 1984."

In reality, it was the dissidents who were frozen in the 1980s. Perhaps the most alarming aspect of Mbeki's letter was his intemperate defense of this embattled minority, portrayed as fighting to have their voices heard against a world guilty of terrorizing and intimidating them, much as the "racist apartheid tyranny" once did in South Africa. Mbeki's letter provoked strong reactions locally and internationally, ranging from shock and outrage to derision. When the president visited the United States in May of 2000, some feared that the AIDS issue could swamp the wider agenda. The New York Times wrote that critics were in something of a quandary and that "Most seem to have decided
that the best offense is to give no offense, an approach they say is being counseled by the
Clinton administration." There were fears that Mbeki would become stubborn if he were
pressured.\textsuperscript{117}

Mbeki had still failed to meet any of Gordon's characteristics of creative and effective
leadership. He almost did the opposite of inspiring, motivating, and stimulating, leading
through personal persuasion, and valuing emotions as well as ideas. During the visit,
Mbeki avoided controversy He set out the government's conventional AIDS strategies
and pointed to the real problems, financial and infrastructure-related that providing
antiretroviral therapy would create. He flatly denied that he had ever said AZT was
ineffective--"pure invention" -- or that HIV did not cause AIDS, but did say that the
African epidemic presented particular and unique problems.\textsuperscript{118} Clinton appeared to have
sympathy for Mbeki's problem, especially regarding the high price of drugs. Jane Silver
of the American Foundation for AIDS Research in Washington commented: "Finally the
world is focusing on AIDS in Africa. Part of the challenge is making sure it is not
sidetracked."\textsuperscript{119}

The AIDS 2000 Conference, the thirteenth in the international conference series, was
to be held for the first time on African soil—the epicenter of the pandemic—with Durban
itself in a province where 33 percent of women in the 1999 antenatal survey had tested
HIV-positive. However, the controversy kicked up by Mbeki had turned AIDS in Africa
into a front-page story Back home, scientists, embarrassed and concerned by Mbeki's
stance in light of the upcoming conference, had tried to cool things down. There were
calls for Mbeki to leave science to the scientists.
The scientific panel met for the last time on July 3 and 4, 2000, having supposedly thrashed out their differences in closed Internet debates and discussions since May. Based on the panelists' deliberations at the final meeting, the international community expected decisions and suggestions. Finding common ground was difficult. Just how difficult is suggested by Mark Schoofs, one of the few journalists invited as an observer. He reported that David Rasnick, a dissident with whom Mbeki had been in close contact, proposed that all HIV testing be banned. Stunned South African scientists asked whether that should include testing the blood supply. Rasnick responded: "If I had the power to outlaw the HIV antibody test, I would do it across the board." Rasnick also denied seeing "any evidence" of an AIDS catastrophe, despite testimony of African physicians to the contrary. While the Ministry of Health publicly applauded the "robust" debate, in private, Schoofs says, health department officials "veered between amazement and ridicule" at the outlandish positions taken by dissidents. In the end, the panel was a face-saving exercise; its main substantive outcome was a decision to reassess the accuracy of the ELISA test, used internationally to check blood for HIV antibodies. AIDS workers were predictably furious, not only at the waste of money and resources, but at the message it sent. What point was there in urging people to go for counseling and testing if the panel was suggesting the tests were not accurate? Those who had tested positive might now believe their results were false.

The publication in *Nature* of the Durban Declaration overshadowed the controversy around the panel. The journal noted that the declaration was a response to the "massive consternation among all scientists, doctors and many others in the international community" who work in the AIDS field. In an effort to set the record straight on the
causal link between HIV and AIDS, five thousand scientists, including local members of
the president's panel, Nobel Prize winners, and directors of leading research institutions
and medical societies, signed the document: "Curbing the spread of this virus must
remain the first step towards eliminating this devastating disease." Tshabalala-
Msimang said the declaration was "an elitist document" signed exclusively by health
scientists--"You can't have a certain exclusive group of people saying this is what we
believe about HIV and AIDS."

With the world's media now focused on Durban, President Mbeki delivered the
opening address to the AIDS 2000 Conference. Instead of clarifying his position, he
sidestepped the issue by concentrating on the role of poverty in ill health and the
HIV/AIDS epidemic in Africa. He also gave a brief outline of the government's AIDS
strategy: awareness, prevention, targeting poverty and opportunistic diseases, a "humane"
response to those affected--including orphans--and further research on antiretrovirals. He
did not mention the government's support of vaccine initiatives. A substantial portion
of his speech repeated findings of a 1995 WHO report, which argued that the world's
biggest killer was "extreme poverty." Mbeki referred in passing to criticism leveled
against him for asking questions--"akin to grave criminal and genocidal misconduct"--but
did not directly address the controversy, except to say that the ELISA test was to be
reassessed. After listing the enormous health problems of Africa, he said, "One of the
consequences of this crisis is the deeply disturbing phenomenon of the collapse of the
immune systems among millions of our people, such that their bodies have no natural
defense against attack by many viruses and bacteria... [I]t seemed to me that we could
not blame everything on a single virus."
If Mbeki is saying that poverty, ill health, and malnutrition make people vulnerable to HIV/AIDS, his position is unexceptionable. Some experts hear Mbeki as echoing the dissident position. It is true that people are dying of "old diseases," but that is the nature of the epidemic, which destroys the immune system and makes the infected vulnerable to whatever diseases exist in their environment. While the dissidents may refuse to see a "new" epidemic, the people in affected countries often noticed the new pattern even before Western epidemiologists did.

Mbeki's speech deeply disappointed those gathered in Durban. In his closing address, former president Nelson Mandela urged people to make every effort to bridge that gap when he said, "in the face of the grave threat posed by HIV/AIDS, we have to rise above our differences and combine our efforts to save our people. History will judge us harshly if we fail to do so, and right now " While he talked of Mbeki as a man who took scientific thinking seriously, and of a government committed to the principles of science and reason, he deplored the way peripheral debates had distracted attention from the real life-and-death issues with which AIDS confronts the world. Experience in countries like Senegal, Uganda, and Thailand proved that HIV/AIDS could be prevented by providing young people with information about abstinence, safe sex, the use of condoms, and the early treatment of sexually transmitted infections. It was a plainspoken statement of the facts. Apart from calling for large-scale actions to prevent MTCT, his strategy was not much different from that outlined by Mbeki. His plea to move from rhetoric to "action at an unprecedented intensity and scale," and his call to mobilize "all of our resources and alliances, and to sustain the effort until this war is won," touched a chord. The audience stood to applaud his address.
In the face of mounting criticism, Mbeki’s own constituency finally stepped in. The Congress of South African Trade Unions (COSATU), South Africa’s largest trade-union body, the SACP, and even some elements in the ANC have publicly asserted that HIV does indeed cause AIDS. In the words of COSATU president Willie Madisha: "The link between HIV and AIDS is irrefutable, and any other approach is unscientific and, unfortunately, likely to confuse people."\(^{128}\)

As it became clearer that Mbeki’s position was not only widening divisions between the ANC and its alliance partners but also damaging him personally, both at home and abroad, he, at last, backed down. In October of 2000, he informed the ANC’s national executive committee that he was withdrawing from "the public debate" on the science of HIV and AIDS.\(^{129}\) At the same time, the High Court in Pretoria ordered the government to draw up, by April, a comprehensive plan to stop mothers infecting their children. Failure, the judge said, would be unreasonable and unconstitutional. The government is appealing, but some members of the cabinet quietly agree with the court. The next campaign may concentrate on treating the country’s tragically large number of rape victims.\(^{130}\)

Mr Mbeki still appears to deny that AIDS is a big problem. His spokesman are reluctant to list the disease as a top priority for the country, preferring to talk about the economy, race, housing, poverty, crime, and general health problems.\(^{131}\) Mbeki’s failure to acknowledge the severity of the problem through speech and action indicates failure to satisfy the characteristics of effective and creative leadership and has allowed the national HIV/AIDS prevalence in South Africa to increase.
WHO’s 1986 Recommendation for a Plan of Action in the African Region

The recommendation for a plan of action in the African region of WHO, drawn up in March 1986, consisted of 1) initial assessment at the national level, 2) the strengthening of health infrastructure in order to support epidemiological, laboratory, clinical and prevention activities, educational and informational programs to the general public, risk groups and health care workers, and 3) the exchange of information, including reporting of AIDS cases. South Africa’s government has complied with the first and third recommendation, but did so before Mbeki became president. Under Mbeki’s administration, the government has failed to fulfill further the seventeen-year-old recommendation.

Assessment at the national level and the exchange of information established under the apartheid regime continues. However, analysis shows that Mbeki has done little to explicitly strengthen the health infrastructure in order to support epidemiological, laboratory, clinical and prevention activities, educational and informational programs to the general public, risk groups, and health care workers. His explicit lack of action has allowed for the expansion of a risk environment where HIV can thrive.

Connections Between Political Leadership and Effective Approaches to the AIDS Epidemic in South Africa

South Africa’s government has largely failed to comply with the WHO recommendation, and adult HIV prevalence rates have continued to increase. Jackson and Rosberg’s typology employed in conjunction with Gordon’s characteristics for creative and effective leadership illustrate why his leadership skills have not translated into effective approaches to battle the HIV/AIDS epidemic in his country.
HIV prevalence rates remain high in South Africa and public attitudes about the disease have been slow to change. By ignoring the problem and not implementing important suggestions asserted in the 1986 WHOAFRO recommendation, Mbeki has been unable to stop or even curb the spread of HIV/AIDS, which today affects almost every family in South Africa as more than a fifth of the adult population are HIV-positive.\textsuperscript{132}

2Ibid., 2-6.

3Ibid., 8.

4Ibid., 9.

5Ibid., 17.

6Ibid., 17-18.

7Ibid., 18.

8Ibid., 22.

9Ibid.


12Ibid., 24-25.

13Ibid., 25.

14Ibid.

15Ibid., 26.

16Tony Barnett and Alan Whiteside, *AIDS in the Twenty-First Century: Disease and Globalization* (Great Britain: Palgrave Macmillan, 2002), 147


18Ibid., 11-12.

19Ibid., 13.

20Ibid., 21.

21Ibid., 41.

22Ibid., 21.

23Ibid., 27.

24Ibid.

25Ibid., 82.

26Ibid., 28.

27Ibid., 35.

28Ibid., 36.

29Ibid., 56.

30Ibid., 50-105

31Ibid., 168.


34Ibid., 146.


42Johnson, “The Soldiers of Luthuli,” 120.


44Ibid.

45Ibid., 234

46Ibid., 234, 235.


Barnett and Whiteside, AIDS in the Twenty-First Century, 121.


Campaigning Against AIDS,” Mayibuye (Johannesburg) (April 1991): 37


Ibid., 2.


Marais, “To the Edge,” 17


Ibid.


Ibid., 9


Ibid., 30.

Ibid., 153.

Southern Africa’s Unmentionable Curse,” The Economist, 5 July 1997, 47


Ibid.

90. "Mary Crewe, "Reflections of the Partnership Against AIDS," *AIDS Bulletin* 7, no. 3 (December 1998): 5-6
91. "Southern Africa’s Unmentionable Curse," 49
96. "Southern Africa’s Unmentionable Curse," 49
98. "Health Minister Holds News Conference on Return," *Pulse track* 528, 6 August 1999
100. "Maria's, "To the Edge," 33.
102. "Interview with Dr. Manto Tshabalala-Msimang," *Pulse track* 496, 29 October 1999
104. Ibid.
105. Ibid.
112. Ibid.
116. Ibid.
121. Ibid.
126. Ibid.
127. Ibid.
“Stop Denying,” *The Economist*, 49.

Each day more than 10,000 people in Sub-Saharan Africa contract what is almost surely a death sentence, and all of them will likely be dead by 2010. The people are infected with HIV/AIDS. It is now clear that the deaths of so many adults in their most productive years will have a devastating impact not only on individual families, but also on their communities and their countries. When AIDS emerged from the shadows two decades ago, few people could predict how the epidemic would evolve, and fewer still could describe with any certainty the best ways of combating it. Already, more than twenty million people around the world have died of AIDS. Nearly twice that many are now living with HIV. Experience shows that AIDS can devastate whole regions, knock decades off national development, and push already-stigmatized groups closer to the margins of society. Just as clearly, experience shows that the right approaches, applied quickly enough with courage and resolve, can and do result in lower HIV infection rates and less suffering for those affected by the epidemic.

The situation is misunderstood and the problems aggravated because of the silence and governmental inaction surrounding the AIDS epidemic. The silence goes far toward explaining the passivity of the people in the face of the ravages of the pandemic and the failure of governments to speak out and act to effectively eradicate the virus. Means already known and easily implemented can defeat AIDS in Africa. The central plank in
the victory over AIDS is first the recognition by African governments of social and sexual reality followed by prompt action, which can lower national HIV prevalence rates. Heads of state and their more powerful ministers must personally and vigorously respond to the crisis their nations face. United Nations Secretary-General Kofi Annan told African presidents and prime ministers, donor officials, and civil society members attending the 2001 African Development Forum in Addis Ababa that “The leadership we need in Africa cannot come from outside, but rather must flow from within,” as he called upon African heads of state to launch a total war on HIV/AIDS in Africa. Visible political leadership is critical.6

Presidential Leadership in Uganda and South Africa

Nearly a decade ago, Ugandan President Yoweri Museveni chipped a few bricks out of the wall of silence erected by political leaders around the fearful subject of AIDS in Africa. Faced with rising sickness and death in his country, Museveni reversed his long-standing opposition to condoms and began talking openly about AIDS.7 The subsequent national response helped bring about a significant fall in the prevalence of HIV infection in the country.8 In Uganda, powerful leadership at the presidential level has encouraged widespread changes in attitudes about HIV/AIDS and sexual behavior, which led to a decline in national HIV prevalence rates. Clearly, Museveni’s strong and creative leadership was key.9 In a speech at Makerere University in Kampala, U.S. Treasury Secretary Paul O’Neill said, “Thanks to President Museveni’s leadership, Uganda has become the first country in Africa to reduce its AIDS infection rate.”10

Uganda is where the largest number of reported AIDS cases in Africa—nearly two million in the late 1990’s, according to UN figures, resulted.11 President Museveni has
gained international acclaim for having elevated HIV/AIDS to a national priority.
Infection rates are decreasing.\(^2\) Uganda has successfully brought down HIV/AIDS prevalence from more than 30 percent in the 1980s and the early 1990s to the current rate of about 6 percent.\(^3\) Through autocratic rule, Museveni followed the 1986 WHOAFRO recommendation and developed a leadership strategy that fulfilled Gordon’s characteristics of effective and creative leadership.\(^4\)

By 1988, a national serosurvey occurred in Uganda, in compliance with the first aspect of the WHOAFRO recommendation for a Plan of Action: initial assessment at the national level.\(^5\) The survey gauged the magnitude of the epidemic among the adult population and determined that the average prevalence rate was nine percent.\(^6\) Museveni understands that the old centralized bureaucratic hierarchies are dead and advocates community responsibility. He also promotes and initiates change, viewing it as an opportunity for all stakeholders. Under Museveni, Uganda was the first African country to respond pro-actively to the AIDS epidemic and adopt a multi-sectoral approach.\(^7\) Museveni mobilized civil society, the schools, and the media to spread the message about AIDS.\(^8\) He took active steps to fight its spread through action by the government and other groups in society, including religious leaders and community development-organizations. Museveni and his administration encouraged each to tackle AIDS in ways that made best use of their particular skills.\(^9\) This broad-based approach to the epidemic contributed to a reduction in HIV infections.\(^10\)

At the same time, Museveni fulfilled the second aspect of WHOAFRO’s recommendation. The government strengthened the health infrastructure. The new agencies Museveni created are semi-autonomous. The first government structured effort
to address the epidemic occurred in 1986. The government established the first AIDS-Control Program in the Ministry of Health.\textsuperscript{21} The program focused on safe blood, prevention of HIV infection in health care settings, information, education, and communication. Soon, the government response expanded. Museveni recognized that the impact of the epidemic went beyond the health sector and planned and implemented relevant activities in other sectors. His government established The AIDS Support Organization (TASO) in 1987 to provide psychosocial support for people affected by AIDS, and in 1992 adopted the Multisectoral Approach to the Control of AIDS (MACA) as a policy and strategy for responding to the epidemic.\textsuperscript{22}

Museveni inspires, motivates, and stimulates community action and participation through personal persuasion, valuing emotions as well as ideas. Uganda showed that educational programs could change sexual behavior after AIDS had struck in vast numbers.\textsuperscript{23} Studies now demonstrate that Ugandan youth are learning safer sexual behavior—later initiation, fewer partners, and more condom use.\textsuperscript{24} Safer sexual behavior has led to lower national HIV prevalence rates in Uganda. Yearly updates of HIV seroprevalence at the regional and national level, which have shown a consistent decline in HIV prevalence rates since 1993, are published by UNAIDS.\textsuperscript{25} The publication of Uganda’s AIDS data fulfills WHOAFRO’s third recommendation, to exchange information, including reporting of AIDS cases.

In South Africa, the situation is much more bleak. After a relatively slow start, South Africa now has one of the fastest growing HIV infection rates in the world. In Kwazulu-Natal province, the region with the greatest incidence of AIDS, demographers have established that because of AIDS, deaths are now exceeding births. Government
response to the growing AIDS crisis has been lack-luster and controversial. South Africa’s President, Thabo Mbeki, has failed to fulfill any of Gordon’s characteristics of an effective and creative leader or help his administration complete the 1986 WHOAFRO recommendations.

Denial, ministerial wrangling, and the misallocation of resources characterize South Africa’s governmental response under President Mbeki to the AIDS epidemic. South Africa has complied with two of WHOAFRO’s three recommendations, but did so before Mbeki became president. Initial assessment at the national level occurred for the first time in 1990 under the apartheid regime. The UNAIDS/WHO Working Group on Global HIV/AIDS and STI Surveillance continues to conduct national sentinel surveillance. The Working Group assesses prevalence rates at the provincial and national levels, and UNAIDS publishes the results annually.

Despite realizing important aspects of WHOAFRO’s 1986 recommendation, Mbeki gives no leadership and denies the scale of the problem. The government has failed to fulfill WHOAFRO’s second recommendation, to strengthen the health infrastructure in order to support prevention activities and educational and information programs. In August 2001, Mbeki ordered a re-examination of health and social policy, spending, and research in the light of figures on deaths from AIDS. In a letter to his health minister that he wrote on August 6, 2001, Mbeki chose HIV/AIDS mortality figures from 1995, when deaths were considerably fewer than in 2001 and when figures did not include the many deaths from disease related to AIDS. He instructed the health minister to look at the 1995 figures, when AIDS was shown as accounting for only 2.2 percent of deaths in South Africa, and consider whether the current health polices dealt adequately with
preventing death, given the chief causes of death in the country. He then questioned whether priorities for health and social spending were appropriate. Finally, he asked whether state-funded medical research was appropriate.\(^{32}\)

The letter repeated a proposal from the presidential AIDS panel to question AIDS figures “that are regularly peddled as a true representation of what is happening in our country.” The letter continued, “Needless to say, these figures will provoke a howl of displeasure and a concerted propaganda campaign among those who have convinced themselves that HIV/AIDS is the single biggest cause of death in our country.”\(^{33}\)

Effective leadership does not cost money\(^ {34}\) However, implementation of creative and effective leadership policies does. The government’s inaction, despite strong global criticism bewilders many. Money may not be the only reason Mbeki has ignored the problem. Another reason may be cultural. His unwillingness to talk about condoms and encourage people to take HIV tests reflects his unease over how outsiders view Africa.\(^ {35}\)

Mbeki’s autocratic style of leadership has impeded the government’s ability to establish an effective strategy to deal with the HIV/AIDS epidemic there. Several members of the cabinet privately admit that the government’s approach is wrong. Leaked documents from the health ministry in September 2001 suggested that many there believe the government’s policy is politically dangerous. However, the president alone is able to freeze policy, and loyalty compels most ministers to follow his lead.\(^ {36}\) The result is that the HIV/AIDS epidemic in South Africa is rapidly escalating and the population is feeling its demographic and social impact.
Results of Presidential Leadership in Uganda and South Africa

Within one year of taking office, Museveni implemented and led a nationwide mobilization against AIDS in a program called "Abstain, Be Faithful, or wear a Condom,"—the "ABC’s." Trends in behavioral indicators such as delayed sexual initiation, a decrease in the number of sexual partners, and increased condom use among sexually active people are all positive in Uganda.\(^{37}\) In South Africa, behavior has been slow to change. "The ABC’s" have paid off in Uganda. The country’s pioneering efforts in combating AIDS changed social mores: teenagers are postponing sex, casual sex is declining, and unmarried adults are practicing abstinence.\(^{38}\) The most important behavioral change related to lower percentages of 15-19 year-olds having sex, a higher percentage of people delaying sex until after marriage, and fewer non-regular partners.\(^{39}\)

Between 1989 and 1995, the proportion of 15-19 year-olds who reported never having had sex increased from 26 percent to 46 percent for girls and from 31 percent to 56 percent for boys.\(^{40}\) Women aged 15-24 have also delayed sexual intercourse or abstained completely according to a UNAIDS report published in December 2002.\(^{41}\) For the youngest, the 15 year-olds, the proportion of boys or girls reporting that they had never had sex rose from around 20 percent to 50 percent between 1989 to 1995.\(^{42}\)

The most striking epidemiological feature of Uganda’s success is the drastic reduction in multiple partnering by Ugandan adults. Among women aged 15 and above, the number reporting multiple sexual partners fell from 18.4 percent in 1989 to 8.1 percent in 1995 to 2.5 percent in 2000.\(^{43}\) Between 1989 and 1995, the proportion of men who reported sex outside a regular partnership in the previous twelve months fell from 22.6 percent to 18.1 percent respectively. The number of additional sexual partners tended to
be fewer—the mean number falling from 2.3 in 1989 to 2.0 in 1995.\textsuperscript{44} In 2000, while the average Ugandan girl becomes sexually active at the age of 17—about one year older than was the case a decade ago—the rate of marriage among girls aged 15-19 is 76 percent.\textsuperscript{45} Condom use also increased.

The John’s Hopkins School for Public Health reports that promoting condoms is effective in lowering HIV/AIDS rates and spotlights Uganda as an example of a successful campaign.\textsuperscript{46} There, voluntary testing occurs, and condoms are distributed. More and more men and women of all ages are now using condoms. In 1997, some 14 million condoms were distributed in a country of 19 million people.\textsuperscript{47} The proportion of people reporting that they had used a condom at least once rose from 15 to 55 percent for men and from 6 to 39 percent for women.\textsuperscript{48} Condom use by single women aged 15-24 almost doubled between 1995 and 2000/2001.\textsuperscript{49} The percentage of teenage girls who had ever used a condom tripled between 1994 and 1997, and more teenage girls reported condom use than any other age group, indicating that acceptability of condoms is growing more rapidly among young people. Lifetime condom use among the men who have sex with these women also rose, more than doubling in all age groups between 1994 and 1997.\textsuperscript{50}

Museveni took a leadership role that has had a tremendous impact on the anti-AIDS campaign.\textsuperscript{51} His frank discussion about AIDS encouraged Ugandans to develop personal behavioral strategies, which dramatically reduced HIV prevalence. In a country where parents once would not discuss sex with their children, they now discuss sex and HIV/AIDS almost routinely all over Uganda.\textsuperscript{52} Personal communication networks through which people acquire knowledge about AIDS relate to and drive these changes.\textsuperscript{53}
The main communication channel is discussion with family and friends. While 90 percent of Ugandans have these discussions, less than 35 percent of South Africans do.\textsuperscript{54}

The political and social climate in South Africa has been slow to change. The government has been accused of stifling non-governmental actions with bureaucratic restrictions. Social stigmatization runs high.\textsuperscript{55} The lack of effective leadership in South Africa has led to a similar lack in personal dialogue about AIDS there. In South Africa, mothers bring their sexually active daughters to family planning clinics without having discussed with the daughters why they need to go, and without being able to tell the clinic staff why they have brought their daughters.\textsuperscript{56} In these circumstances, most parents do not wish the government to admit to the existence of adolescent sex, let alone facilitate it or reduce the risks by providing condoms. Many church leaders concur. This attitude has presented AIDS programs with great difficulties.\textsuperscript{57} Subsequently, sexual behavior in South Africa has remained dangerous, and condom use low.

A startling proportion of South African women's first sexual experiences involve violence, which not only means that contraception is out of the question, but greatly enhances the chance of HIV transmission.\textsuperscript{58} In one South African study, around 85 percent of both men and women said that use of condoms could prevent AIDS, and high proportions of respondents had multiple partners or believed that their regular partner was unfaithful, but over 60 percent of both men and women had never used a condom.\textsuperscript{59} While half of all the men said they intended to use a condom every time they had sex with a casual partner, only 16 percent of them actually did so.\textsuperscript{60} Attitudes about HIV, sex, and condoms have been slow to change in South Africa.
Condoms are associated with illicit sex and promiscuity. They are thus unlikely to be used in stable, ongoing relationships. These negative attitudes are major obstacles to the development of condom use as a means of protecting against the spread of HIV. In 2001, one urban South African male stated, “Condoms waste time and you don’t enjoy sex.” Another man said condoms indicate a lack of trust. It is manifestly practically impossible for most women to ask their partners to use a condom; men turn nearly always such requests against them. They accuse their partners of promiscuity. A rural man said, “If my girlfriend gave me a condom I cannot accept it. This means she is a prostitute.” Another one said, “If she talks about that with me, I will hit her because she has no right to talk to me about that. A man will always be a man.” Behavior change is indicative of national prevalence rates. Where people have not modified their behavior, rates increase.

Leadership and National HIV Prevalence rates in Uganda and South Africa

Uganda’s experience underlines the fact that even a rampant HIV/AIDS epidemic can be brought under control. The axis of any effective response is a prevention strategy that draws upon the explicit and strong commitment of leaders at all levels, is built on community mobilization, and extends into every area of the country. High political commitment, coupled with prompt action in Uganda shows that the AIDS epidemic is reversible. Between 1991 and 1996, the percentage of pregnant women testing positive for HIV in some urban areas dropped by half from about 30 percent to fifteen percent. By 1999, Uganda cut HIV/AIDS prevalence from double-digit figures to around nine percent, and in some age groups by half.
At one time Uganda had the highest AIDS infection rate in the world. While most other countries experienced an increase in HIV/AIDS, Uganda experienced a decrease 25 percent in the HIV infection rate compared with the rate in the 1980s. By 2001, the number of pregnant Ugandan women testing positive for HIV antibodies fell from 21.2 percent in 1991 to 6.2 percent. In the capital, Kampala, HIV prevalence rates fell nine consecutive years, from 29.5 percent in 1992 to 11.25 percent in 2001. On May 14, 2002, Museveni announced in Washington, D.C., that Uganda’s HIV/AIDS infection rate, which peaked in 1992 at more than 30 percent, decreased to 6.1 percent in 2002.

Uganda’s prevention model has the potential to reduce the AIDS rate in Africa’s worst stricken countries by 80 percent—the same level of efficacy one might expect from an HIV vaccine.

In South Africa, the situation is desperate. Lack of strong presidential leadership has meant little change in sexual behavior among South Africans or attitude changes about HIV/AIDS. The death rate is climbing, life expectancy falling, and the reality of more than a million AIDS orphans is clamoring for the attention of a nation. If the current HIV prevalence rate of about 20 percent continues, the lifetime risk of AIDS death for 15 year-old boys in South Africa is 65 percent. There, HIV prevalence in antenatal clinics continues to rise. The prevalence-rate among 20-24 year-olds increased from around two percent in 1991 to around 16 percent in 1995 to close to 30 percent in 2001. For 25-29 year-olds, HIV prevalence rates have followed a similar pattern, increasing from two percent in 1991 to 20 percent in 1995 to more than 30 percent in 2001. UNAIDS projects that overall HIV prevalence rates for adults age 15-59 year-olds, which increased
from 0.2 percent in 1990 to 4 percent in 1995 to 12 percent in 2000, will reach 18 percent in 2005 and 22 percent in 2010.\(^{80}\)

**Conclusion**

In the absence of massively expanded prevention, treatment, and care efforts, the AIDS death toll is expected to continue rising before peaking at the end of this decade.\(^{81}\) If the present level of government inaction continues, it is likely that 50 million Africans will die before there is an effective vaccine, and the numbers could go much higher still.\(^{82}\) This means that those societies will feel the worst of the epidemic's impact in the course of the next decade and beyond. It is not too late to introduce and augment measures that can reduce that impact. There are hopeful signs that the epidemic could eventually be brought under control.\(^{83}\) Thanks to the strong leadership of President Museveni, the number of affected individuals dropped significantly in Uganda, making it a model for other African countries in the fight against HIV/AIDS.\(^{84}\)
4Caldwell, “Rethinking,” 131.
8Ibid.
16Ibid.
20Ibid.
21Uganda AIDS Commission Secretariat. Twenty Years. 3.
22Ibid.
28“People Power; South Africa and AIDS,” The Economist, 2 February 2002, 45
29Ibid.
30Stop Denying the Killer Bug; South Africa and AIDS,” The Economist, 23 February 2002, 49.
32Ibid.
33Ibid.
34Stop Denying the Killer Bug,” The Economist, 23 February 2002, 50.
35Ibid.
36Ibid.
38Mwaura, “Pioneers,” 8.

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