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Roles and approaches for an effective HIV/AIDS response

AIDS:

AFRICA'S GREATEST LEADERSHIP CHALLENGE

ROLES AND APPROACHES FOR AN EFFECTIVE RESPONSE

Overview

This paper is concerned with the demands made by the HIV/AIDS pandemic on leadership in Africa. The crisis of HIV/AIDS is quite simply the largest challenge facing the African continent today. It has been said, quite rightly, that combating HIV/AIDS requires the same level of commitment, vision and leadership as fighting a war of independence. This paper examines what sort of commitment, vision and leadership will be required. It concludes: even more is required.

Very often, analyses of the challenges of combating HIV/AIDS concern themselves in substantial detail with the bio-medical, public health, educational and care requirements of effective response, and then conclude with an appeal for 'political will' or 'leadership' to make these policy requirements a reality. This paper starts where these analyses stop. This requires a wide-ranging, comparative analysis that looks at actual and possible responses to HIV/AIDS, in the context of other examples of leadership and social mobilisation from around the world.

The paper considers leadership in its broadest sense. It identifies both the elements of agency required and the structures within which leadership can operate. It looks at the wider political and social systems that constrain possible responses to HIV/AIDS. It analyses opportunities for social mobilisation and public policy formulation and implementation.

The challenges of responding to HIV/AIDS are perhaps even greater than recent public debates would lead one to believe. The leadership challenges posed by HIV/AIDS have been compared to fighting a war of liberation. The comparison might however mislead: the leadership characteristics required for containing HIV/AIDS are very different from those demanded of a political leader seeking national liberation. And the task itself is rather more difficult: the cultural and political resources that can be brought to bear on the issue are more limited, and the demands for wide-ranging social, attitudinal, and political change is more considerable.

However, some remarkable progress has already been made. The speed with which the issue of HIV/AIDS has become a priority for continental and international public policy in Africa is unprecedented. The challenge is to build on this emerging political commitment, and ensure that the energies of leadership, public policy and social movements are channeled in effective and sustainable ways.

HIV/AIDS is manageable. Some countries in Africa have succeeded in containing it, though not eliminating it. If our target is to reduce transmission and provide treatment for people living with HIV/AIDS, so that they have longer and better lives, then combating HIV is achievable. This is one of the most important messages for leadership, public policy and social mobilisation: success is possible.

Leadership Challenges of the HIV/AIDS Pandemic in Africa

The HIV/AIDS pandemic in Africa poses extraordinary leadership challenges. The level of death and dislocation threatened by the pandemic is worse than any natural disaster or war that Africa has faced for a century if not longer. Some have said that the level of mobilisation required is equivalent to that needed to fight a war of national liberation. This comparison highlights the parallel with Africa's greatest and most inspiring leaders, who achieved independence from the European empires. It recalls Africa's most epic struggles, which mobilised entire nations within a single political, social, cultural and moral movement, and

which also generated an unprecedented level of unity of purpose and vision across the entire continent. The fight against HIV/AIDS cries out for the best that Africa can offer: a struggle and commitment comparable to continental liberation from tyranny.

HIV/AIDS, however, is an 'invisible enemy'. Unlike colonialism and Apartheid, there are no moral certainties in tackling HIV/AIDS. On the contrary, one of the characteristics of the pandemic is that it forces us to question moral certitudes, including deep-seated assumptions about the core values of African societies. It requires exceptional leadership skills to confront these complex and intimate issues.

The challenge of HIV/AIDS is particularly wide-ranging. Its unique pathological characteristics make it mysterious to laypeople. The period between infection and the development of full-blown AIDS is so long that HIV/AIDS can be spread unwittingly and become well-established in a population before there is any awareness that it is a threat at all. Moreover, the long latency period encourages silence as it works against people making the causal link between sexual relations years ago and the onset of symptoms. Its mode of transmission—predominantly sexually-transmitted—is intimate and makes it the subject of many taboos and culturally-imposed silences. Also, unlike previous pandemics, where the death of those infected was a matter of days, and thus the medical cost per individual was small, HIV/AIDS requires years of expensive drug cocktails to keep it at bay. There are serious hurdles facing any government or organisation that tries to make the pharmaceutical multinationals provide drugs at an affordable price to Africa. And the origins of the disease itself are so obscure and controversial that it is the subject of myth-making, and an arena for extraneous agendas and debates, in which a wide range of prejudices can be manifested. Critics have gone so far as to argue that even talking about HIV/AIDS stigmatises Africa, echoing some of the early, frankly racist, theories about how and why the disease appears to have originated in Africa. One of the first challenges for Africa is to face the reality of the pandemic in the continent.

The HIV pandemic in Africa also has unique characteristics. The strain of HIV prevalent in the continent, especially in eastern, central and southern Africa, is particularly virulent. However, 'becoming infected with HIV is not a random medical event. More perhaps than any other major health threat, it demonstrates the extent to which disease is in fact embedded in the social, political, economic, cultural, behavioural and medical experience of individuals' (Van Der Vliet, 1996: 118). Moreover, vulnerability to HIV/AIDS 'stems from lacking the power to control one's circumstances... the power to affect the outcome of the epidemic is intimately tied into the social, political, economic and cultural purposes of those in control' (op cit, p. 132). Africa is the continent worst-affected by AIDS, containing more than two thirds of the world's people living with AIDS. 'In the West, the fact that the epidemic has affected most directly marginalized populations (drug users, homosexuals, the poor) helps to explain the lack of a timely response. Globally, Africa is analogously marginalized' (Fredland, 1995: 9).

Africa is the continent least well-placed to respond to the crisis of HIV/AIDS. It is the poorest continent with the worst health and educational infrastructure. It has the weakest civil society, and the political leadership in many countries is marked by patrimonialism, corruption, authoritarianism and even militarisation and criminalisation. Africa is subject to a high degree of disruption, with mass displacement due to war and disaster, and mass migration in search of employment and opportunity. This raises a central tension in formulating how to tackle HIV/AIDS in Africa—the relationship between necessary short-term action and the need for more profound change. No problem can be seen in isolation. Yet with HIV/AIDS, the connection to broader questions of poverty and power is particularly stark (Collins and Rau, n.d., Baylies, 1999: 389). The absence of any medical 'magic bullets' or immediate technical fixes demands that responses involve a wide range of moral social and

economic challenges. As Fredland underlines, 'broad scale medical problems have politico-economic roots and ... any solution must be related to attacking these larger problems and not just medical occurrences' (1995: 5). This has led some to stress the importance of dealing with the broader issues of poverty, under-development, and gender inequality, at the expense of addressing the issue of HIV itself. The issue of armed conflict in relation to HIV/AIDS is equally important. However, as Van Der Vliet (op cit, p. 6) points out:

> The problem with seeing AIDS as essentially a product of poverty and socio-economic conditions is that prevention and cure must then be postponed till Utopia—or something approaching it... Long term, socio-economic, upliftment may well curb the epidemic, but AIDS is happening in the short term. Leaders are needed who can enable people and communities to devise appropriate strategies for coping with AIDS, rather than using it as a political football.

The leadership challenge is thus to make inroads into tackling underlying causes such as poverty, conflict and gender inequality while *simultaneously* taking specific steps to target HIV/AIDS.

Moreover, the challenges of combating HIV/AIDS arises at a time when Africa is crying out for leadership on a range of other issues including impoverishment and armed conflict. Unlike an earlier generation of struggles in Africa, when the enemy was clear and the moral purpose evident, today's social, political and military struggles are conducted in a context of moral uncertainty. Right and wrong is much less an issue of principle, much more a question of who you are and where you stand. Two of Africa's most respected figures of moral authority, Mwalimu Julius Nyerere and Madiba Nelson Mandela, have so far not succeeded in bringing peace to Burundi. This is discouraging: if the citizens of just one small country cannot succeed in practising the basic principle of living together in peace, what prospects are there for addressing the challenges of the entire continent?

This paper counsels against despair. The challenges are huge, and, we will argue, even more complex and difficult than most policymakers and planners have appreciated. However, there are important successes, and a rigorous analysis of the dimensions of the crisis can enable us to chart a course of action.

Major Moral Challenges

The 'safe sex' message, if universally adhered to, would stem the rampant spread of HIV/AIDS. The primary building block where change must occur remains with the individual. Individual behaviour, however, is contingent on social and cultural factors as well as 'biomedical factors such as condom availability and health services which facilitate or retard behavioural change' (Van Der Vliet, 1996: 121). Moreover, there is often a huge gap between what people know to be the best course of action, and what they actually do, and this gap is sustained by the social and economic pressures to which people find themselves subjected. This subsection will briefly review some of the main challenges facing those wanting to develop a comprehensive campaign to combat HIV/AIDS.

1. Gender relations.

HIV in Africa is predominantly transmitted by heterosexual activity. One of the groups at greatest risk is young women. They are infected at significant younger age than men (WHO

1994). In Africa, over 20% more women than men are living with HIV. The dangers that women face from the AIDS pandemic have been described as a 'triple jeopardy' (Panos Institute, 1990). HIV and AIDS potentially threatens women as individuals, mothers and carriers. A Ugandan study has showed that deaths from HIV/AIDS, especially of the mother, leads to reduced farm inputs and family labour, lower agricultural production, reduced schooling for children, and higher malnutrition (UNDP, 1995).

The challenge of gender interacts with the problem of poverty. Women are generally poorer than men, especially if they are heads of households. They are poor and sometimes are so desperate they cannot plan ahead more than a few days. They are relatively powerless when confronting husbands, boyfriends, employers and other men. The combination of poverty and inequality compounds the fundamental problem of gender relations.

A number of elements in gender relations in Africa need urgent attention if there is to be a realistic chance of containing the pandemic.

(i) *Sexual violence*. The level of rape in many parts of Africa is appallingly high. Rape is often a crime committed with complete impunity. Women and girls are coerced into sex by criminals, by policemen and soldiers, by teachers, by employers, by government officials—in fact by men in almost any position of authority. Rape is particularly common in wartime, and is identifiably used as a weapon of war. However, sexual violence is disturbingly common in 'normal' circumstances too. In many schools female students are pressured into having sexual relations with their teachers in return for good grades. Male students may believe that their female counterparts are 'fair game' and engage in mass rape. Members of the uniformed services, particularly when armed or in positions of arbitrary power, often commit rape and sexual violence.

(ii) *Economic pressures* on women contributing to a high rate of commercial sexual activity including survival sex. The economic crisis that afflicts Africa compels a wide range of young women to become commercial sex workers or engage in survival sex. These include the wives and partners of migrant workers, students, unemployed young women, single mothers who have been forced to drop out of school or leave employment (often their status as single mothers arising from reluctant sexual activity or rape). Another factor driving women into poverty is unequal property and inheritance rights: widows (some of whose partners have died of AIDS) may inherit little or nothing from their deceased husbands, and descend into poverty. Also, refugees and workers in insecure occupations such as waitresses, food sellers, barmaids and domestic work. Economic disadvantage puts women at special risk: it pressures them to enter unequal relationships with older men, it diminishes their negotiating power within relationships, it reduces their power to object to partners' infidelities, and it forces many into commercial sex work itself.

(iii) *Stigmatisation and double standards surrounding commercial sex work*. There is a general tendency in society to despise, stigmatise and discriminate against commercial sex workers, with the result that they are harassed by the authorities and driven to work in dangerous locations where they may be exposed to other risks such as rape, robbery, infection by other diseases, and the exploitation of under-age girls, etc. Every commercial sexual encounter takes two. Commercial sex workers are supplying a real demand. Experience around the world shows that trying to restrict the supply of a service without addressing the demand is a futile exercise. Taking policing measures simply means that the activity is driven

underground, becoming more dangerous and less easy to investigate and regulate. It may be a better approach to legalise and regulate commercial sex work.

(iv) *'Sugar daddies' and survival sex.* Short of commercial sex work, many women and girls enter into multiple sexual relationships in order to obtain some financial security from boyfriends and 'sugar daddies' (Manjante et al., 2000). The same factors as outlined above push women into these relationships, which are unequal and carry some stigma.

(v) *Powerlessness of women with respect to use of condoms.* Women who are aware of the dangers of HIV infection are frequently unable to insist that their partners use condoms. Men—particularly those who have dangerous occupations such as soldiers, construction workers and miners—may believe that their self-worth and masculinity is bound up with a disregard for risk, and they may insist on 'skin to skin' contact. The poorest commercial sex workers—for whom sex is a means for day-to-day survival—are those least able to insist on protection. Men may regard a partner's request for using protection as an accusation of infidelity. In addition, many women want to become pregnant and bear children, so they do not want to use any form of contraception. The Total Fertility Rate (number of live births that a woman can expect in her lifetime) in Africa in 1998 was 5.4. Cultural attitudes to fertility make it imperative for a woman to prove she is fertile by having a child. Men must also prove their virility by having children. This is all additional to the proscription on contraception by among others the Roman Catholic church (very recently slightly modified with the admission that condom use can be justified in some circumstances) and the problems of simple lack of availability of condoms, unreliability of condoms, and their expense which can be prohibitive for the poor. Lastly, there is a lack of female-controlled methods of barrier contraception, such as the female condom, available in Africa.

(vi) *Lack of privacy.* In many communities, women have no privacy and no confidentiality. They are treated as the possessions of their male guardians. This can seriously impede their ability to avoid risk. For example, for a woman to ask her partner to use a condom may be seen as tantamount to challenging his authority. Or if a woman should go for HIV testing, the health worker may feel obliged to inform her guardian—undermining the essentially confidential nature of the test.

(vii) *Domestic violence.* Women who are victims of domestic violence - far too common in Africa- are least able to influence their partners' behaviour. Female victims of domestic violence have reduced status and bargaining power within their relationships, which can be crucial when it comes to their partner's extra-marital sexual activities, or the use of condoms.

(viii) *Polygamy, early marriage and sexual activity of girls.* In many African societies, whether Christian, Moslem or following traditional religions, polygamy is deeply entrenched. In many societies men prefer to take very young women as their wives, including second and subsequent wives. Any girl old enough to be potentially fertile, and many who are not even that old, are considered eligible for marriage. There are strong social and financial incentives towards early marriage. Men have also acquired a preference for younger sexual partners because they believe them less likely to be HIV positive. In some countries there is even a belief that sex with a young virgin can be a cure for the infection. The level of defilement of underage girls is high in many countries. Child sexual abuse is rarely faced, and is almost always a taboo subject.

(ix) *Illiteracy and powerlessness*. Literacy rates for women are much lower than for men, which is a factor that stands in the way of them being reached by health education campaigns, and understanding and responding to those campaigns. Many women are virtually invisible: uneducated, absent from public life.

However, across all cultures, women tend to be more aware of their bodies than men, especially regarding reproductive health, and women also tend to be more risk-averse than men. Research indicates that women and girls are more likely to understand and appreciate HIV/AIDS education messages than men and boys of comparable education. However, this understanding is of limited use to women if men insist on risky sexual behaviours. Hence, reaching women is only part of the story: men must be reached too, and women's power vis-à-vis their menfolk must be increased.

This is a depressing catalogue of the powerlessness of women. It forces us to question the implicit assumption in conventional approaches to sex education and encouragement of condom use, namely that most sexual acts are consensual. If the contrary is true, that the norm in parts of Africa is non-consensual sex, or at least sex in the context of very unequal power relations between men and women ('partners' would be a euphemism in this context), then standard education about sex and HIV transmission becomes of limited relevance.

Note the disturbing long term implications of the high prevalence of multiple sexual relationships. Much research indicates that children who grow up in a domestic context marked by economic insecurity, lack of education, absence of a father at home, and multiple relationships by the mother, are likely to engage in early and multiple sexual relationships themselves.

Africa's political leadership is overwhelmingly male. There is a marked lack of women in senior positions in government, business and (to a lesser extent) civil society. Equally problematically, there is dominant masculinity in African forms of government. Many leaders are military men, for whom 'masculine' modes of behaviour—giving commands, taking decisive action, using violence—are indicators or their power, authority and legitimacy. Many civilian leaders are also obliged to incline towards these militaristic modes of authority, not least in order to keep their generals in check. The political sphere in Africa is a domain of 'hegemonic masculinity', in many cases tending towards the cult of machismo. 'Hegemonic masculinity' means much more than men wielding power over women: it is the way in which characteristically masculine and macho manifestations of power are embedded in society, and accepted by both men and women.

In these circumstances it is not difficult to understand why political leaders do not consider the systematic restructuring of gender relations and the empowerment of women to be a priority. In some cases they may espouse these values in some speeches and even in some actions, but they lack the motivation and structures to turn these commitments into reality.

This situation places special and onerous demands on Africa's relatively small number of women leaders, especially political leaders. Many expectations ride with them. They have to be role models for women, as well as effective politicians: not an easy combination of tasks.

Changing gender relations in Africa is a demanding task. But we can also identify important social and cultural resources that can be brought to bear on the challenge. Africa's customary laws and traditional social structures commonly give more authority and freedom to women than has been recognised: these traditions need to be recognised and revived. Women's organisations are strong and growing across the continent, and there are powerful local, national and international coalitions for the promotion of women's rights. Lastly, we

must also recognise that the reality of HIV/AIDS is itself giving a new momentum to mobilisation around gender issues.

There is no avoiding the obvious: that HIV/AIDS is a gender-based disease, and nothing can be done to reduce its incidence without recognition of that fact.

2. Transparency.

> 'It's not a matter of heroism. It's a matter of honesty. It's an idea that may seem laughable, but the only way of fighting the plague is honesty.'
>
> Dr Rieux, in Albert Camus' *La Peste*

Facing up to a problem is a pre-condition of it being tackled. HIV/AIDS can only be effectively combated where it is not considered secret, but it is openly discussed. This is stressed by Van Der Vliet: 'Until individuals have a clear, complete, unvarnished picture of the disease, and how it can be avoided, appropriate behaviour modification is impossible' (1996: 124). Free and open public discussion is an essential prerequisite for any effective anti-AIDS programme. However, there are many reasons why the necessary public debate and transparency is rare in the African continent.

(i) *Governments refusing to admit the extent of the HIV pandemic.* This is now generally a thing of the past, as most governments are ready to admit that they are confronted with the disease. But the problem persists in certain countries. In addition, some governments prefer to obfuscate the issue by disputing the level of HIV infection, or the link between HIV and AIDS. Very often, the question of the level of HIV infection in a particular society is considered unimportant, because the government cannot see any effective way of responding to the problem (Fredland, 1998: 592). This stands in the way of undertaking good epidemiological studies of HIV, which in turn is a major impediment to effective public health measures. Epidemiology is not only a tool in the hands of public health planners, it is an instrument for public education: if people know the risks of HIV transmission, they are far better placed to respond individually and collectively. Early attempts by some western analysts to blame HIV on supposed African deviant practices were very unhelpful in this regard.

(ii) *Armies and police forces* generally have among the highest levels of HIV among any groups. But the armed forces are reluctant to admit the level of HIV positivity among their members. This is for several reasons.

- (a) It is seen as a national security threat: if a very high level of HIV is known to exist among the armed forces, the enemies of the state may take solace.
- (b) Easy sex is one of the unstated perks of military service, and this would become more problematic if the true level of HIV among soldiers were known.
- (c) Governments in Africa rely very heavily on their armed forces for survival, and to admit the extent of HIV would cause demoralisation and a crisis of confidence.
- (d) Many African armies are serving outside their frontiers, either involved in neighbours' wars or in peacekeeping missions. Admitting levels of HIV among these soldiers would have international repercussions. Lastly, armies are obliged to provide health care for their members and

the financial implications of providing HIV and AIDS treatment for so many soldiers could be crippling to defense or national budgets.

There is good evidence that, particularly in eastern and central Africa, the armed forces constitute one of the major elements in transmitting HIV. In the absence of good information and open discussion about this fact, there is little chance of instituting effective measures of control. Again, if the facts were known, soldiers and their partners would be more likely to change their behaviour.

There is a real fear, both within Africa and internationally, that the HIV pandemic may cause chaos and disorder in the continent. By attacking the most important age groups and occupational categories, the pandemic has the potential to become a major security threat within Africa, and also more widely, affecting the national security even of the USA. Is this a real threat? Is it just scaremongering, in the tradition of much western fear-fascination with Africa that has long predicted the doom of western civilisation based on supposed African 'barbarity'? Exaggerated prejudices about Africa and inflated fears about the impact of the pandemic can only be addressed by full openness.

(iii) *Discomfort in talking about sex*, gender relations, commercial sex and homosexuality. Effective measures to promote public education about HIV involve dealing with these issues in a practical way, without traditional conservative moralising that condemns these activities as immoral in themselves. Experience with HIV containment indicates that there is nothing to be gained by regarding sexual activity, commercial sex, homosexuality etc. as inherently wrong and seeking to control HIV by promoting restrictive sexual morality. Currently there is a wide gap between sex as it is talked about, and sex as it is practised: this gap needs to be closed.

(iv) *Fear*. Everyone is frightened of disease, especially new, fatal and mysterious diseases. The dominant messages concerning HIV/AIDS have centered on fear. Public education aimed at frightening people into protecting themselves as individuals is not the most helpful, on several counts.

(a) These messages are not relevant to those who are already HIV positive or fear that it is inevitable that they will become so. For such people, the message should be one of communal responsibility, not to spread the virus any further.

(b) For people who are already living under many different threats (destitution, hunger, violence, displacement), the fear of succumbing to AIDS at some point in the future is likely to be much less salient than for people (as in many western countries) who do not live with such fears.

(c) Within African tradition, protection of the community rather than the individual may be a more culturally appropriate message. Community-based approach may be also more practical and effective response in societies where certain groups (e.g. young women) have very little scope for individual action to protect themselves.

(v) *Admitting failures*. There is a strong tendency among bureaucracies and institutions never to admit failure. Development agencies are not immune from this. In Africa there is a long history of failed development projects, but it is rare for an international development agency to admit failure. Instead, new consultants are hired, new analyses made, new project documents produced, apparently oblivious to what has been occurred before. A new generation of development practitioners, schooled in a more critical social science literature on the failures of

its predecessors, has taken some of this critique to heart. But there is still a powerful institutional tendency to over-report success, to fail to analyse failure (or even to acknowledge it), and to argue that 'more needs to be done.' If the national and international institutions mandated to combat HIV/AIDS continue with the developmental bureaucracies' tradition in this regard, they too are destined to fail. More honesty is required, along with greater ruthlessness in acknowledging failure and learning the lessons.

The public education agenda for HIV/AIDS containment is in significant part an agenda for free expression and open debate about sensitive and highly charged issues. Breaking the taboos and demonstrating that these issues must be talked about openly is one of the most important tasks for political leadership.

Perhaps the most important factor in opening up public awareness on HIV/AIDS is simply the extremely high prevalence of the disease. The numbers of people falling sick and dying from AIDS and AIDS-related diseases is simply so high that no-one can in a high-prevalence country can avoid the fact.

The last year has seen significant breakthroughs in public debate on HIV/AIDS in Africa. A series of international conferences has highlighted the issue. This does not automatically translate into widespread transparency about the issue, but it is an important start, and creates an environment in which governments are better able to acknowledge the realities they face.

Diplomatic niceties, including the protocol of international conferences concerning Africa, militate against exposing the shortcomings of specific governments and institutions. It is considered unseemly to name names. This is, to say the least, unfortunate. Many millions of lives could have been saved if leaders both within Africa and in the international community had been willing to say openly that specific named leaders were failing to act, or were denying reality or showing no interest in facing it.

3. Stigmatisation of, and discrimination against, those with HIV/AIDS.

'How the disease is constructed in the public mind will profoundly influence the relative powerlessness of the infected.' Van Der Vliet, 1996: 6

People living with HIV/AIDS are among the most important actors in any programme to contain the pandemic. If HIV/AIDS is portrayed as something to fear then it becomes something to run away from. Denial is the worst response. Similarly, if people living with HIV/AIDS feel compelled to keep their status a secret, or are terrified of that status or become bitter and angry, then they are unlikely to take actions to prevent them passing the infection to others, and may even deliberately try to spread the virus. On the other hand, if people living with HIV/AIDS are confident that they will be respected, cared for and treated, they are more likely to act in a responsible way. People with HIV/AIDS are also the best people to carry the message about HIV prevention: they speak with an authority and immediacy that no others can match.

However, in many African countries, HIV positive status and AIDS carry with them a heavy stigma and fear. This is a powerful disincentive to action. Aspects of the necessary response include the following:

(i) *Care agenda.* Those with AIDS must be treated with respect and kindness, accepted in the community, counselled and given solace. This is a classic task for

religious hospices and the extended family. This task is hindered by religious attitudes that blame the victim and ignorance about how the disease is transmitted. The very high prevalence of the disease, and the fact that it affects many educated and elite people, has meant that a number of leaders have publicly acknowledged close family members who have HIV or AIDS. (Very few have admitted to being HIV positive themselves.) This has helped begin to change social attitudes and promote greater sympathy in some countries.

The care agenda also extends to the dependents of those who die from AIDS, especially orphaned children. These victims of the disease also require support, respect and kindness.

(ii) *Treatment agenda.* In industrialised countries there are now treatment regimes that mean that people with HIV/AIDS can live a near-normal life for extended periods. Unfortunately (because of the practices of pharmaceutical companies) it costs $4,000-6,000 to provide a year's course of antiretrovirals and the associated tests and consultations. This treatment is extremely expensive and it is far beyond the means of Africa's overstretched health services to provide AIDS treatment to even a small minority of those affected by the virus. As Caroline Bylies points out, this presents a 'danger that the global solidarity based on a common affliction which characterised the position towards AIDS in the early nineties, could diminish' (1999: 390). Until there is at least a minimal level of treatment available that can improve the quality of life of people living with HIV/AIDS, there is little chance that the stigma of AIDS and the behaviour of those with HIV/AIDS can be improved. The task of obtaining cheaper and more accessible treatment is a challenge that African leaders cannot address alone. This requires a partnership with aid donors and international pharmaceutical companies examining viable alternatives for Africa. But it may also require confronting the pharmaceutical companies as part of an international campaign aimed at shaming them into acting with wider social objectives in mind.

An additional element to the treatment agenda is how it interacts with the prevention messages in public education campaigns. Prevention campaigns that focus on generating fear, by saying that contracting HIV makes death inevitable, only serve to stigmatise those living with HIV/AIDS. This in turn militates against people going for testing. Improving the status of those with HIV/AIDS, and lessening the fear of the disease, will in fact assist with prevention.

(iii) *Protection agenda.* The very minimal requirement for a state is to respect and protect the rights of those with HIV/AIDS who choose to courageously declare their status, in some cases as a prelude to social activism on the issue. People with HIV or AIDS are human beings, citizens, and members of their community, who are fully entitled to their rights. But there are unfortunate instances of conspicuous failure of leadership on this issue, for example cases in which individuals have publicly admitted their HIV+ status, only to be victimised by vigilantes, who have escaped punishment. A basic civil rights agenda for people with HIV/AIDS is the very first step for political leadership on the issue of the pandemic.

A component of protection is privacy. Those who go for an HIV test should be guaranteed confidentiality. This can be difficult to achieve in small communities where everyone knows everyone else, and in which health workers may be under strong social pressure to divulge information to powerful members of the community. Breaking the rules on confidentiality should be treated as a serious offence.

People living with HIV/AIDS must not be written off, as though they are dead already. Treatment should not be seen as a waste of resources. Protecting the rights of those with HIV/AIDS, providing them with treatment and care, is intrinsically related to removing stigmatisation and discrimination, which in turn promotes prevention.

A number of factors are forcing change in social attitudes towards people living with HIV/AIDS. Perhaps the most significant is the sheer number of infected individuals: In most central and southern African countries, everyone has family members and friends who are living with HIV/AIDS or who have fallen victim to it. When a disease touches the lives of all, stigmatisation of the affected becomes more and more difficult. In addition, public education, the efforts of health workers and NGOs, and the public statements of national leaders, are all gradually changing attitudes. Those whom it is most important to influence: teenagers and young adults, are the most amenable to attitude change. (But by the same token, it is even more important to understand youth cultures in Africa, a much under-studied area.)

4. Religious attitudes and practices.

It is very unfortunate that HIV/AIDS is so intrinsically wrapped up in questions of personal morality as interpreted by religious authorities. It is very easy for those with a particular religious bent to see HIV as some sort of curse or vengeance from the creator. HIV can be an encouragement to the worst forms of hypocrisy and misguided piety. 'Leadership' on the issue by religious authorities, and secular authorities who have devout religious beliefs or who try and gain legitimacy from association with religion, can often be exactly the worst form of leadership, impeding effective action instead of promoting it.

We can identify several major challenges.

(i) *The Roman Catholic Church and teachings on contraception.* HIV/AIDS is a challenge not only to Roman Catholic church leaders across Africa but also to political authorities that have to cooperate with them, without provoking unnecessary antagonisms. Van Der Vliet describes how 'at a landmark conference on "The role of religion and moral behaviour in the Prevention and Control of AIDS and STDs," held in Cairo in September 1991, leading Muslim and Coptic Christian theologians "rejected safer sex education and condoms and affirmed that early marriage and marital faithfulness are more appropriate weapons against HIV infection"'(quoted in Van Der Vliet, 1996: 43). Only very recently, in September 2000, has the Vatican appeared to adjust its position on the use of condoms. In a potentially highly significant change in applied doctrine—if indeed it is formally endorsed—the Roman Catholic Church has consented to the view that the use of condoms in some circumstances should be permitted, specifically referring to the prevention of HIV transmission as such a circumstance. If this dramatic change in policy occurs, it would reverse the position taken by the church at the International Conference on Population in Cairo, 1994.

(ii) *Christian and Moslem teachings on personal morality.* As mentioned above, it is very tempting for many religious leaders to see HIV as some form of divine retribution, and use the pandemic as a weapon to bolster their campaigns for certain forms of personal morality. These teachings may have some value in themselves and may in certain places be able to prevent high levels of HIV from occurring in certain communities (for example small and relatively closed

communities following particular religions). But they cannot change the social and sexual behaviour of entire countries.

A related difficulty is the religious policing of pharmacies in the name of public morality. People may be deterred from buying condoms if the pharmacist interrogates them, 'are you married?' In some communities which make no distinction between ethics and law, this can be a particular problem.

(iii) *Unwillingness of religious authorities and religiously-inclined political leaders to talk about sex.* 'There is in much of Sub-Saharan Africa some gap between sex as it is practiced and sex as it is discussed. Islam and Christianity have compounded that problem and deepened the silence' (Caldwell, 1992: 1179). In some Moslem countries for example it is virtually impossible to talk about sex in public, except in very traditional moral terms. Hearing about European or north American cases of homosexuality or child abuse or the abuse of schoolchildren by teachers, there is a tendency among many to exclaim, 'that doesn't happen in our country!' The reality is that these activities are not confined to the 'decadent' west.

Additional difficulties arise in countries with actual or potential religious divides. If the leaders of one religious community are less willing than others to discuss HIV/AIDS, then raising the issue at a national level has political implications. Unwillingness to confront the religious sensibilities of a certain group may retard national openness about HIV/AIDS.

(iv) *Traditional religious beliefs and practices.* In many countries, traditional beliefs coexist with Islam and Christianity; often believers in Islam and Christianity also follow traditional beliefs in other aspects of their lives. Some practices may hinder the containment of HIV/AIDS, such as polygamy, early marriage, widow-inheritance, some scarification or circumcision practices that may mingle the blood of different individuals or use unsterilised instruments, and female genital mutilation.

For obvious reasons it is very difficult for religious believers and leaders, and political leaders in countries marked by high levels of religious beliefs, to be independent and objective about the health implications of religious beliefs and practices. The challenge before leaders is to ensure that the practical changes in attitude and behaviour can be accomplished without stretching existing belief systems to breaking point. Some debate and controversy will be inevitable, but too much bitter controversy can be counterproductive. Leadership can play the essential role in providing legitimacy to new forms of discourse and dialogue.

Africa's cultures and traditional religions can play a positive and helpful role. Africa has strong traditions of tolerance and inclusion, of the duty to care for both relatives and strangers. African chiefs traditionally do not inherit their position: they need to be approved by acclaim or consensus, and they maintain their status by their generosity to their communities. Such qualities are essential for the containment of the AIDS epidemic, and are as important as any medical and public policy advances. Stressing these positive cultural resources that Africa brings to the containment of HIV/AIDS will be a very important contribution to the continental struggle against the disease. To emphasise grassroots resources should not be seen, however, as an alternative to action from governments, pharmaceutical companies and the international community for whom it is an attractive option to make the affected groups bear the costs themselves (Baylies, 1999: 387).

5. Addressing Youth.

Youth are the group most at risk of contracting HIV. The highest incidence of new HIV infection among women is among late teenagers; among men it is in the twenties. There can be no effective response to HIV/AIDS in Africa that does not tackle the challenge of responding to the needs of youth. This is an agenda that is remarkably under-developed. To a large extent, even the most basic questions about youth in Africa are not understood by those who make public policy, lead their countries, or mobilise social movements.

Rather than outlining issues and potential actions, this subsection can do no more than identify several of the key questions that need to be investigated. Any investigation of these issues should be participatory, involving youth themselves in all aspects of research and recommendation. By these means, it should be possible to chart an agenda.

Some of the key issues involve:

(i) *What do we mean by youth?* In much of Africa, the term 'youth' has come into popular use because of the absence of educational and employment opportunities for young people, so that 'youth' are people living in economic uncertainty. By the same token, they are a category waiting to be mobilised. 'Youth' can refer, in different contexts, either to those who are fighting for a cause (exemplifying courage and righteousness), or those who are involved in crime and anarchy (gangsters, people to be feared) (Seekings, 1993). In either case, there is a strong link between 'youth' and violence, and attempts to organise youth will tend to follow one or other stereotype. If we can overcome these stereotypes and understand the real complexities of young people, we can begin to design and implement programmes that can reduce their risk of contracting and spreading HIV.

(ii) *What is the changing socio-economic context for youth?* In traditional African societies, 'youth' was a transitional age category, which was ended by initiation into full adulthood (for men) and marriage (for women). In 'modernised' African societies, young people went through the successive stages of home, education and employment. Now, with changing demography meaning that young people are the majority, and declining formal employment, 'youth' are a new category: numerous, insecure, with uncertain loyalties to families, hierarchies and institutions, often seeking livelihoods in the informal sector. Their activities are not valued by wider society; often they are despised and belittled. Their self-respect may be founded on the approval of their peers, with little value attached to the blessings of their elders.

(iii) *What is the changing political context for youth?* In the context of independence struggles, the category 'youth' was a political label, capturing a positive orientation towards the future. Many independence generation leaders saw themselves as 'youth'; organisations such as the Somali Youth League were at the forefront of the struggle, while the ANC in South Africa mobilised the youth as its vanguard against Apartheid. However, for certain political and military leaderships, 'youth' provide the raw material for militias, party youth wings, mobs, and other instruments of conflict and repression. For those who use youth in this way, they exploit the energy, risk-taking, physical prowess and frustration of young people. But, for such leaders, youths are also expendable; their lives are worth little. Such attitudes are not conducive to the youth themselves gaining self-confidence and self-respect, and seeking to protect themselves against HIV.

(iv) *What cults and organisations exist among young people themselves?* In much of Africa, there are strong organisations, some traditional, others new but informal or even clandestine, based on mobilisation of people in age groups. These include the traditional age grades of many societies, youth cults, students' societies, football clubs and others. Most are exclusively male: much less is known about young women's organisations. Some, such as some student societies, street gangs and sports clubs, have a collective agenda that includes seeking ready sex. This is an area that has only recently become the focus for social science research, and the agenda for how to influence these groups has yet to be developed. Mobilising the youth leaders themselves will undoubtedly be a crucial component in ensuring that such organisations become allies in the struggle against HIV/AIDS.

(v) *What do we know about risk-taking?* Among young men (in particular) there is often a sub-culture of engaging in risky activities, simply because they are fun and because those who excel can gain great esteem among their peers. Dangerous sports would not exist if it were not for the thrill of risk-taking. Research on driving cars shows that as cars are made safer, people drive them faster—seeking a certain level of excitement or danger. Some occupations are also inherently risky (e.g. soldiers, miners, construction workers on high buildings), and those who practice them gain a sense of self-worth and masculine identity from these jobs. For such people, engaging in 'unsafe' sex may be seen as either irrelevant (because there are other greater risks in their lives) or as part of their entire high-risk lifestyle. (It is interesting to compare military commanders' attitudes to cigarettes. These are known to be an important risk factor in fatal disease in later life, but cigarettes are routinely distributed to soldiers as part of their rations.)

(vi) *What do we know about orientation towards the future?* For many young people, especially in poor and insecure parts of Africa, the future is bleak and uncertain. It seems unlikely that they will enjoy the same life chances as their parents or grandparents. The central message of HIV prevention is based on self-control today in order to enjoy a brighter future. If the future is universally dark, what salience does such a message have? They ask, 'Why should I change my behaviour when I see little hope for improvement in life's opportunities?' (Collins/Rau: 29). Many young people, faced with a high likelihood that they will become infected with HIV, may merely revise their life expectations downwards, anticipating ten years of adult life instead of 20 or 30.

(vii) *What roles are there for schools?* Only a minority of African youth are in education, but this is the most influential group. Clearly there is a role for including teaching about HIV/AIDS in school and college curricula. But there are also other opportunities and challenges. Among these are the following:

(a) Sexual relations between students and peer-group education. Peer-to-peer teaching is likely to be the most effective at changing attitudes and behaviour. Can this be achieved between pupils and students?

(b) Sexual relations between teachers and students. Many teachers abuse their position of authority and respect, and exploit girl students, demanding sexual favours in return for grades. This is a rights violation, a high risk practice, and a bad example to set.

(c) Changing wider social attitudes and behaviours in the school context. Key social attitudes such as gender relations and attitudes to authority

can be cemented or changed in the school environment. Schools that practise gender equality and have a culture of transparency and consultation will help promote the social values that will help stop the spread of HIV.

(viii) *What do we know about youth cultures of resistance?* There is always the danger, when authority is addressing youth, that any messages will be subverted and precisely the wrong lessons will be learned. If their parents are acting in a certain way and encouraging the youth to conform, we can predict that many of the youth will choose to do precisely the opposite. Advertisers have learned much about how to reach youth consumers; how much of this expertise can be transferred to the issue of HIV/AIDS?

This broad analysis of youth is dispiriting. However, the fact that so much of Africa's male youth is organised, to a greater or lesser degree, in societies, cults and clubs, provides opportunities for positively influencing behaviour that may be lacking in more atomised or individualistic societies. In addition, the fluidity of youth culture means that it may be easier to change behaviour among younger people, if they are approached in the right way. (And there is some compelling evidence from Uganda and Zambia that sexual behaviour has indeed changed.) Moreover, what little research has been done into youth aspirations suggests that, even under the most adverse circumstances (e.g. Sierra Leone), African youth tend to hope for a very conventional future of education and employment (Richards, 1996). Similarly, even where structures have been systematically dismantled for decades, as in South Africa, there is still strong attachment to family, church and community (Hoelson et al, 1991). However, any conclusions are very tentative: there is an extraordinary absence of research into youth. Clearly, one of the most urgent priorities for any strategy for combating HIV/AIDS is further research into the values, expectations and behaviours of Africa's youth.

Poverty

The challenge of HIV/AIDS cannot be addressed outside the context of the poverty that prevails across Africa. This is a challenge both to Africa, and to the international community. As the discussion in this paper develops it will be evident that it is impossible to overcome the AIDS pandemic without far-reaching social and economic change across the continent.

The HIV/AIDS pandemic not only causes poverty: it is also fuelled by it (Collins/Rau: 7). Many cultural characteristics that prevail in African societies can be traced back to poverty and the need for material support, and many of them include a sexual component that allows for the transmission and spread of HIV/AIDS. In the following discussion only a few can be mentioned.

(i) *Poverty often means ignorance*. Access to information is often limited for those who do not have the means to travel to urban settings or trade centres. If there is an HIV campaign at all then it may not reach people in remote regions and places. Or they may simply not understand the education messages that are conveyed. A lack of electricity and a very bad or non-existent infrastructure prevent information from traveling. In many cases, infection with HIV can occur out of sheer ignorance about HIV and how it is transmitted.

(ii) *Protection can be costly*: the poorest simply do not have the option to make the right choice. Under conditions where a glass of clean water is luxury,

spending resources on condoms or on breast milk substitutes in order to prevent mother to child transmission is not even an issue. If a decision has to be made whether to walk ten miles to the next trading centre to buy a condom or whether to buy a fish from the neighbour to feed the family, the outcome is obvious. Poor people often do not have the choice to protect themselves.

(iii) *Poverty entails being unable to manage risk.* Even where people know exactly how HIV is transmitted and the risks that they are running, many have no real option but to run the risk. The parallel with environmental degradation stands out: poor people across Africa engage in environmentally destructive practices, not from ignorance, but from lack of alternative sources of income. Poverty forces them into short-term behaviours that undermine their long-term prospects. So it is for many poor youth in Africa, especially young women: their entire lives consist of uncertainty and risk, playing off one set of immediate pressing concerns against another, less visible and less immediate risk.

(iv) *Poverty drives women to unprotected sex.* As mentioned above, female poverty is a major factor that drives women, young and old, into risky behaviour, including commercial sex work, survival sex and dependence on multiple partners or 'sugar-daddies'. There is research that indicates that the poorer the sex worker, the less likely she is to ask for or insist on using a condom. Competition among commercial sex workers means that those who demand safe sex may be forced out of the market. (It should be stressed: the problem here is not commercial sex work as such, because this can be 'safe', but *unprotected* commercial sex work. The key factor in the latter is poverty.)

(v) *Poverty contributes to migration,* which is a major risk factor for HIV. A different association between poverty and the spread of HIV occurs when men have to leave their families for far away places where they have better job opportunities. These migrant workers, being deprived of their wives, have the tendency to engage in casual sex in the locations where they find work. Not only is the transmission rate amongst people working and living around these workplaces (e.g. mines) particularly high, there is also a very high risk of husbands returning home to their families and infecting them. There are many aspects to life among migrant workers' communities that predispose towards risk of contracting HIV. Among them are overcrowded all-male dormitories, forcing men to seek casual sex outside; boredom, predisposing men to drink alcohol and engage in casual sex; large numbers of men patronising relatively few commercial sex workers, who are likely to become HIV positive and transmit the infection; and macho risk-taking culture that is averse to 'safe sex.' In many ways, soldiers serving in armies are similar to migrant workers. Many conscripts chose a military career because of poverty. Far away from home, and under very harsh circumstances, casual sex is tempting.

(vi) *Poverty contributes to work in the informal sector,* which can also be a risk factor for HIV. Lack of employment opportunities in the formal sector have contributed to a flourishing informal sector in many African countries. Informal economies are based on trade, including smuggling and providing services to traders. One of the few African economic sectors that is booming is based on long-distance trading. Informal economy activities tend to be insecure, and to congregate together.

(vii) *Poverty is closely associated with factors such as malnutrition,* susceptibility to other diseases (including STDs) and risk of harmful traditional practices

such as female circumcision. These are all in themselves risk factors for HIV transmission, especially for women. This is what has been called 'a synergism of plagues'.

Inequalities: The Structure of Impoverishment

Clearly, poverty predisposes to vulnerability to HIV. However, equally important is the structure of poverty, or—to use different language—the inequalities built into impoverishment in Africa. Poverty and inequality are the membranes over which the AIDS pandemic has spread throughout Africa

Individual poverty does not always correlate closely with risk. For example, the category of men most at risk from HIV includes many who are relatively well-educated and well-off. They are not the poorest. What renders them at high risk of HIV is their readiness to engage in multiple sexual liaisons. Their ability to do this arises from the pronounced inequality that is a feature of African societies and economies; they can easily exploit vulnerable women. In a sense, they too are indirect victims of poverty.

Impoverishment has also forced many Africans, poor or less poor, into new forms of economic activity and social interaction. These in turn have become the continental arteries for the HIV pandemic.

There is much evidence that links migrant labour, armies' garrisoning, and truck routes with the spread of HIV. There are parallels here with how the development schemes of earlier decades contributed to the spread of certain diseases. For example, the Gezira scheme in Sudan created a problem of schistosomiasis, and the Volta River dam in Ghana accentuated the problem of river blindness. Similarly, the economics of labour mobility in contemporary Africa has been a major social vector of HIV transmission. We may blame individual behaviour, but changing social and economic conditions have put that behaviour in a new and very different, dangerous context (Schoepf, 1991).

Structural Adjustment and HIV

The correlation in time between the AIDS pandemic and the austerity measures imposed on Africa by international financial institutions is striking. In the last twenty years, Africa has suffered severe cutbacks in basic services including education and health. In the meantime, economies have been restructured, with growing unemployment, migration in search of work and food, and informal economies and export-oriented trade have grown. Inequality has grown. All these factors have intensified the conditions under which Africa's youth are obliged to seek sustenance by migration to cities, abandonment of traditional social ties, petty trade, commercial sex work, etc. And at the same time, the capacity of public service provision to contain the pandemic has suffered.

Perhaps equally importantly, structural adjustment programmes have entailed a new, tougher language of economic development in Africa. International donors have placed the primary and overwhelming responsibility for economic failures on African governments themselves. International focus on basic survival and social security has been conspicuously weak: these tasks have been largely delegated to relief NGOs, rather than lying at the centre of international assistance policies.

Health Service Crisis

The crisis in Africa's health services has contributed to the transmission of HIV/AIDS in many different ways. Among them are the following:

(i) *Mother-to-child-transmission* (MTCT). There are relatively straightforward drugs that can dramatically cut the risk of transmission if administered during labour and delivery. But run-down and bankrupt health services may be unable to afford them or unable to deliver them to where they are needed. There is also the issue of transmission though breast-feeding. This is a complex subject presenting huge challenges in providing appropriate information and infant feeding options.

(ii) *Needle-stick injuries* and other infections through contact with patients' body fluids. Some of these incidents of transmission may occur because health services are inadequately resourced. In the case of possible transmission, immediate administration of drugs can reduce the risk of HIV infection—if the drugs are available.

(iii) *Contaminated blood supplies, and unsterilised needles and surgical instruments* are two features of badly-resourced health services. These are all sources of HIV transmission.

(iv) *Voluntary testing and counselling* is an essential component in any campaign to combat HIV/AIDS. To be carried out properly this requires resources, including availability of reliable testing kits, staff training, and time and privacy so that counselling can be properly carried out.

(v) *Lack of drugs and facilities to treat STDs* and other diseases that can be risk factors for HIV. Reducing the prevalence of sexually-transmitted diseases would dramatically reduce HIV transmission. But resources for STD treatment are scarce.

(vi) *Weakness of outreach and health education services*. Much HIV education occurs during other, routine health visits. Where such services have collapses, opportunities for education are fewer.

(vii) *Shortages of condoms*. Health services including private pharmacies have been unable to supply enough condoms to meet demand.

(viii) *Failure to provide treatment for opportunistic infections* leads to the early sickness and death of people who are HIV positive, helping to intensify fear and stigma.

One of the more successful components of the campaign against HIV/AIDS in Africa has been the attempt to cut down secondary transmission that occurs in the health service. However, there is still much to be done before these transmission routes can be eliminated entirely.

Armed Conflict and Militarisation

For the most part, armed conflict is a major contributor to the spread of HIV/AIDS and is a major obstacle to the development of effective programmes to contain it. Armies themselves help spread HIV. Armed conflict impoverishes and displaces people, creating the economic conditions of vulnerability, poverty, inequality and forced migration that all contribute to HIV. Militarisation is antithetical to all the measures that are needed to combat HIV/AIDS.

Militaristic values are hostile to the emancipation of women. Militarists tend to mobilise youth as militias and conscripts, encouraging them to risk their lives in the service of a cause they may not understand. Conflict and militarism compel individuals and groups to identify their primary loyalties with their clan, tribe, religion, region, political party or nationality, while making dissent tantamount to treason. Military authorities are secretive and authoritarian. Almost every social and political characteristic that can be associated with conflict and militarism is profoundly hostile to the kinds of social and political change that is necessary to overcome HIV/AIDS.

On the other hand, in a few cases, conflict seems to have retarded the transmission of HIV (Mozambique is possibly a case of this: the civil war may have isolated large parts the country's population from the HIV transmission networks). Secondly, the centralised command and control of armies, and the insistence on discipline, can be an opportunity for armies to take a lead role in the necessary behavioural changes. If soldiers insist on safe sex, then the message to society—especially youth—will be strongly transmitted. Finally, post-conflict transitions tend to be a time when basic values in society are examined and discussed. This may be an opportunity for public debate on HIV/AIDS.

Options: Is Comprehensive Change Necessary?

This limited account indicates that poverty and inequality increase the likelihood of some sections of the populace engaging in frequent unsafe sexual intercourse. Comprehensive responses to the AIDS pandemic entail helping to stitch the African social fabric back together again, making it possible for millions of the poorest, especially women, to survive without engaging in regular unsafe sex, and making it possible for all Africa's young people to think positively about the future, and therefore believe that it is meaningful for them to protect themselves.

If AIDS is the *only* disaster that threatens, it is likely that individuals and communities will take action against it. But when AIDS is only one disaster among many, it is not the highest priority. Across Africa, research indicates that people integrate the HIV/AIDS crisis into a wider pattern of hardship and calamity; they see it within a longer narrative of adversity and risk. In terms of the terminology used below to identify issues for social action, it is not easy to make AIDS a 'separable' issue.

Africa cannot wait for sustainable and equitable socio-economic development before it begins to combat the HIV/AIDS pandemic. There must be individual behavioural change; individuals and communities must protect themselves. But those who seek to change individual behaviour in Africa must also be aware that the challenge of HIV/AIDS can only be met in the broader context of combating poverty. Equally importantly, those who try to change individual behaviour must refrain from placing blame for the pandemic on supposedly 'irresponsible' behaviour: these actions take place in a context which leaves many of the afflicted with little choice but to gamble with their lives.

Need for Dialogue

'Leadership in the fight against AIDS must be indigenized' (Fredland, 1995: 14). The question of traditional religions leads on to the equally important issue of localism. In any issue as sensitive and intimate as HIV transmission, very local belief structures and practices are extremely important. Language is a key issue. Public education messages are most effective when transmitted in local languages. This demands a level of local connectedness

and awareness that is very difficult for an outsider, even from another part of the same country, to achieve.

No single formula can fit all cases perfectly. While the general shape of public education about HIV/AIDS is clear, the particularities must be tailored to very specific requirements. As Zaffiro underlines, 'any successful AIDS policy design must incorporate relevant cultural difference in local concepts of disease, contagion, treatment, and cure' (quoted in Fredland, 1995: 14). Each community needs to find its own mechanisms and idioms for responding. 'Thus the "safe sex" message is not, *ipso facto*, adequate. AIDS education runs counter to many traditional notions which lack scientific bases and therefore must be completely integrated into a group's consciousness if it is to be effective' (Fredland, 1998: 564). How is one to impart the message, to teenage girls, that it is essential to insist on using a condom during first sexual intercourse? An intrusion into one of the most intimate moments of a girl's life requires extraordinary sensitivity that no public policy formula can hope to achieve.

HIV/AIDS is also a major challenge because societies do not appear well equipped with the cultural resources for response. The cultural archive of African societies contains responses to many historical epidemics and famines. Strategies include moving away, isolating those who are infected, conserving resources, waiting, responding to the loss of life by increasing fertility. But none of these responses works for HIV/AIDS: Africa needs to develop a new cultural repertoire to deal with this challenge. This cannot be imposed, it cannot be formulated as part of a public policy initiative, it must emerge from national debate.

As mentioned above, when HIV/AIDS is seen less as a conventional epidemic, and more as a multi-dimensional social and political challenge, Africa's appropriate cultural resources become much more formidable. Traditions of care, obligation, hospitality, inclusion, socially-responsible leadership, solidarity of youth, etc., can all be mobilised in support of a wide agenda for combating HIV/AIDS.

Effective response to the challenge of HIV/AIDS therefore depends upon an open dialogue with all able to contribute. Leadership at national and international political levels, effectiveness in developing and implementing public policy, must be combined with ability to allow and promote free expression and debate, and sensitivity to very local and particular concerns.

What is Leadership?

This paper attempts to keep terminology to the minimum: the aim is not to test sociological hypotheses but to explore possibilities for social change. But we need to identify several major concepts:

Leadership: What can it do?

Leadership is a position of power and authority, with corresponding responsibility, over an organised institution, collectivity or community. For leadership to be more than simply presiding over an inert group or organisation, it must also have the component of agency: the ability to affect change (or, to resist change).

'Responsibility' derives from the Latin word *respondere*, or the English 'responding'. Leadership is thus not a matter of isolated action and existence but leadership always, by

definition, requires a group of people it responds to. There is never leadership without the led. To cater to and maintain the led is what constitutes leadership.

Leadership is also a form of guidance towards a particular goal, leaders have an impact on the way their constituency sees and responds to the world. Thus they help to define public opinion. In this process, they shape what is possible amongst the led, and what is impossible. This feature, unfortunately, is often misused for example when constituencies are manipulated into ethnic antagonism, discrimination and potential violence. We are all aware of the power of leaders to instigate unrest. In the struggle against HIV/AIDS leaders are challenged to use this capacity to influence their people in a positive way – to create a national, social environment that hinders the spread of the pandemic and cares for PLWA.

High-level leadership, especially political leadership, has several forms of agency:

(i) *Formal power within a system*. State power, namely the authority to direct government machinery to carry out instructions, is the prime example, but power within parties and the legislature in general is also important. (The special constraints of public policy will be examined below). In addition, power can be exercised through the legal system of the state.

(ii) *Power over discourse*. Leaders have the capacity, through their statements and actions, including symbolic actions, to shape debate and dialogue. Even when their formal power is limited, they can use their access to the media and stature in society to influence what people talk about.

(iii) *Moral authority*. Arising from leaders' power over discourse is their ability to shape morality, to determine what is acceptable and what is not. This can sometimes be more important than formal power, especially so in countries in which traditional hierarchies are important, and there is respect for authority.

These forms of agency are at the same time responsibilities. Leadership can be exercised in positive or negative ways, to promote change, to block it, or to promote obstructive measures. Role models can play a key role in transforming attitudes. But leaders can also serve as negative role models, promoting fear, fatalism and stigmatisation.

In defining leadership, we also need to distinguish the time frame and scope of the leader's ambitions:

(i) *Strategic leadership* for building a movement. This is the long-term leadership that is required to set high goals and work purposefully towards them.

(ii) *Tactical leadership*: what we do today. This is the leadership that facilitates an immediate response to a pressing problem.

If leadership is crucial, 'leaderism' must be resisted. As Horace Campbell argues, many prevailing European styles of leadership and communication stifle imagination and creativity (Campbell, 1996: 222). This emphasis on the 'great leader' that has become common across Africa can often be a handicap to effective mobilisation. A principal weakness of 'leaderism' has been the stress that is put on 'the importance of the speaker and organiser and the passive participation of the listener' (Campbell, op cit.). In short, there is a mechanical model of leadership, in which authority and knowledge is vested exclusively in the leader, and the followers are merely expected to follow the leader's instructions and parrot his words.

'Leaderism' can be a function of the failure of structures. Africa's institutions and bureaucracies are notoriously weak. Many political leaders have taken power with an agenda of social transformation, and then found themselves unable to deliver on their promises.

Partly this is on account of the external constraints (international debt etc), partly because problems are always more intractable than aspiring politicians believe, but partly it is because of the ineffectiveness of bureaucratic instruments. President Nyerere famously said, 'once I led the Tanzanian people, now I head their bureaucracy.' Bureaucracies are by their nature resistant to change and decisive action, a fact that frustrates many who head them. One result is that many leaders come to rely on military-style mobilisation, seeking intensive campaigns to undertake activities such as literacy programmes or environmental protection. Another is the profusion of new institutions aimed at bypassing existing, ineffective ones: but these soon generate the same internal problems. More and more frustrated, leaders are tempted to resort to 'leaderism', relying on moral authority (if any), threats and dictates alone.

In the context of HIV/AIDS, 'leaderism' can be disastrous. The impatient, commanding style of the 'leaderist' is counterproductive. There is a need for people to internalise the reasoning behind the measures proposed. Changing sexual behaviour is rather different to fulfilling quotas. Directives issued from on high will fall on barren ground and not take root. Effective leadership does not arise from an all-important individual who attempts to know and do everything himself, but from the ability of a person with authority and responsibility to engender in others confidence in their own leadership abilities. This is most effective when it is accompanied by an enabling environment in which the leadership qualities of others are supported and can have concrete expression.

Leadership in Africa

Leadership in Africa has regularly been decried by social scientists especially 'Afro-pessimists'. One thesis is the 'criminalisation of the state', which argues that many African leaders are uninterested in any form of legitimacy, and are simply plundering the resources of their countries and exploiting whatever illicit opportunities arise to enrich themselves (Bayart, Ellis and Hibou, 1998). A second thesis argues that legitimacy in African political systems derives from patronage, so that African states are marked by dispensing patrimony, the 'recycling' of elites, and the use of state resources for the consolidation of power through unproductive investment in social and political networks (Chabal and Daloz, 1998).

It would be futile to deny that these depictions do not contain some truth. Leadership in Africa has not been marked by major successes. Africa has struggled to maintain the same level of economic and social development as it had at independence four decades ago, while political institutions have often been in states of decay. At independence, many African leaders enjoyed high stature and respect, but few succeeded in maintaining those qualities over succeeding years. Subsequently, first in the 1980s and again in the 1990s, a 'new leadership' was hailed in Africa, but again hopes were disappointed. Africa's 'democratisation wave' toppled many authoritarian and military regimes, but democracy remains fragile.

However, we must also point to the resilience and legitimacy of the state in Africa. There has not been wholesale collapse of states or redrawing of national boundaries. There is a remarkable ability of national political leaders to acquire legitimacy from their positions despite the apparently artificial nature of the state.

The weakness of the state in Africa, and the limits of governmental power, mean that leadership in the continent is a complex affair. Later in this paper we attempt a typology of African states, identifying the extent to which social mobilisation is possible in different contexts.

Leadership operates at many levels. In the African context, there are leaders at all levels of social and political organisation; community activists, local chiefs and

administrators, religious leaders, party leaders, national leaders, and international leaders. All need to be involved and allowed to make their own particular contribution in the fight against HIV/AIDS. To caution against 'leaderism' is not to deny that at times it can take individuals of exceptional vision and calibre to provide a spark and harvest the potential for change. Different contexts require different kinds of leadership. First we will look at national level political leadership, then at other forms of leadership.

National Political Leadership

National political leadership has the prime responsibility for initiating and promoting change. In Africa, many political leaders have national power that exceeds that of their counterparts in western countries. National political leaders' power exists in several respects:

1. *Government and state leaders have moral authority*; they have often managed to obtain a high level of legitimacy, acquiring the status of paramount chiefs. The head of state merely has to make a public statement and it will be reproduced on national television and radio, and make the front pages of all the newspapers.

   Unfortunately, many men in political leadership positions in Africa do not have the personal moral authority to speak out against risky sexual behaviours. Public utterances are important, but setting personal standards is also important.

2. *States can operate in a highly hierarchical manner*, enacting top-down directives and campaigns. Examples include directives for combating illiteracy, or increasing agricultural production, in many countries. National institutions can achieve high levels of mobilisation, for example party mobilisation for elections. In these cases, cadres fan out across the countryside reaching every village, ensuring that all possible voters are mobilised. These can achieve impressive short-term results, but it is doubtful if citizens are committed to the campaigns in a long-term, sustainable manner.

   It is questionable whether this 'campaign' style of mobilisation is most effective in the case of HIV/AIDS, which does not require a short-term mass action, but rather a longer-term change in social attitudes and individual behaviour. In fact, it is possible that the militaristic campaign-style of public action may actually impede the necessary changes, because it may reinforce the belief that change can only come from the top, and that citizens only have to follow the directives of the national leadership. Change to combat HIV/AIDS requires rather more. However, some simple aspects of public action, for example the rehabilitation of some physical health infrastructure or the distribution of condoms, may be appropriately carried out through mass campaigns.

3. *States have bureaucracies and legislative and executive processes*. In the case of HIV/AIDS, these can help or hinder action.

   HIV/AIDS is a huge social, economic and political problem as well as a health problem. It requires the concerted attention of all sectors of the government, including all ministries. It is not merely the preserve of the ministry of health. However, bureaucracies guard their territories and privileges, and many health ministries will be alarmed at the prospect of losing control over HIV/AIDS policy to a higher-level initiative. Ministries of health are likely to argue that no separate policy is needed, only guidelines, and that only those qualified to speak on health issues should publicly pronounce on HIV/AIDS.

   Combating HIV/AIDS undoubtedly requires a leadership role from ministries of health. But it also requires far more, including integrating and coordinating policymaking

and policy implementation across ministries, mainstreaming HIV/AIDS into all policymaking, and monitoring the effectiveness of programme implementation. This in turn requires a policy initiative at the highest level, preferably at the head of state or head of government level.

There is a demand for bureaucratic leadership at various levels. Salaried civil servants, national and local, can make a huge difference. (Many of these considerations apply also to international civil servants.) Often, one of the biggest challenges for leaders is not transmitting their message, or inspiring their followers, but making large and complex bureaucracies, prone to inertia and infighting, actually deliver a policy. Far too often, policy initiatives get lost in the bureaucratic maze, so well satirised by the British TV programme 'Yes, Minister', in which a senior civil servant routinely reverses every initiative that comes from his ministerial boss. Governmental machinery tends to consume its energies in routine matters with little opportunity for strategic thinking and strategic action. Bureaucracies are especially averse to innovation and risk-taking: there is a strong tendency for each bureaucrat to do the minimum required to keep his or her job, not upset his or her superior, and not offend those outside the bureaucracy whom he or she may have to work with. Changing the orientation of a bureaucracy usually requires strong leadership from the top. If salaried civil servants decide to make the system work, they have great power in their hands to effect change.

4. *Military leadership*: armies are the most hierarchical and obedience-oriented institutions, and 'leadership' in its most formal sense is found among the officer class. However, military leaders are usually not selected for their ability or readiness to address issues such as the sexual behaviour of their troops. Given the importance of responding to the crisis of HIV in the military, this will call on military leaders to acquire new leadership skills. Military commanders have one important asset: their commands must be obeyed. If they command their troops to practise safe sex, with disciplinary measures enacted against those who fail to do so, this is a powerful means of changing behaviour, and also sending a clear message to the wider community.

   Demobilised soldiers can also be a force for change. Along with surrendering weapons and (hopefully) acquiring new skills that can enable them to earn a civilian livelihood, demobilised former combatants can be given education in HIV/AIDS and can themselves become agents of public education. Demobilised soldiers from victorious armies will have a high status in their communities on their return home, and can influence the behaviour of their peers and local youth.

5. *Governments have leadership roles with civil society*, religious organisations, international organisations, NGOs, the academic community, etc. It is clear that the struggle against HIV/AIDS requires more than policymaking and governmental action: it entails a mass mobilisation of many sectors of society.

   What roles should government play in helping to facilitate and mobilise action by other, non-governmental sectors? Should government seek to coordinate and regulate, or should it simply let civil society and international organisations operate independently?

   Clearly, there are options for different responses to different circumstances. National policies are required as a framework within which non-governmental actors can operate. But there should also be scope for allowing independent and innovative action by NGOs, and independent monitoring of programmes by civil society and academics.

All of the above can translate into effective action against HIV/AIDS. In several countries in Africa (e.g. Uganda and Senegal) there are positive examples of this.

Leadership, however, is constrained by structures, including the wider economic, political and cultural environment in which the leader operates. Leadership is also influenced by the constituency being served, the political and organisational arrangements in place and the nature of the tasks needing to be tackled. This suggests that leadership is a complex relationship rather than the property of an individual. Instead of reeling off a list of supposedly universal traits that the 'good leader' must possess, attention must be paid to the context in which acts of leadership must be performed. An understanding of both leader's agency and structure is necessary: each determines the other.

Other Levels of Leadership

African states are often weak, and effective leadership must exist outside government structures. Where states are strong, they are usually matched by strong civil society institutions. In each case, there are responsibilities on non-governmental leadership to take a leading role in combating HIV/AIDS.

1. *Religious leadership*: religious leaders combine access to and influence with huge constituencies, with the ability to take a stand on important social issues that will change people's behaviour. Religious leaders can have the power to encourage social responses to HIV/AIDS such as caring for sick people and orphans, renegotiating gender roles, social inclusion of PLWAs, fighting against stigma and human rights abuses. In countries with religious divides, it will be important for the religious leaders of both the Moslem and Christian communities to act together on this issue.

2. *Community leadership*: community leaders, including local political leaders, local chiefs, administrators etc. have a responsibility towards the people with whom they live on a daily basis. Their relationships, as well as their influence, can be personal and intimate, as well as exercising authority. Their scope of intervention and guidance can thus concentrate on the day-to-day struggle of households where they can encourage equality, care and respect, but also on local decision-making and politics.

3. *Trade union leadership*: based on notions of solidarity and equality, trade unions have the capacity, especially through peer education, to educate workers about protection and to act as a safety net for those who have been infected with HIV. The international connectedness of trade unions may be an important asset in helping to provide leadership on the basis of occupational or professional solidarity.

4. *Intellectual leadership*: professors, researchers and public intellectuals have a responsibility and an opportunity for shaping thinking and action. Far too many policymakers and civil servants are locked into tactical thinking. Their concerns are short term, due to the unavoidable constraints of their jobs. Academics have the privilege to be able to think strategically, and the corresponding obligation to make their thinking relevant to the practical challenges of the day. There are mechanisms that academics may use, for example open seminars and opinion pieces in newspapers and journals, that can help policymakers plan more strategically, and can bring together different actors.

   Academics also have the opportunity to be innovative and iconoclastic. They can challenge accepted wisdom and break taboos. This paper identifies lack of transparency as a major obstacle to the effective combating of HIV/AIDS. Academics can play a key role in shining a light into these areas of neglect and secrecy.

A variant of this is education sector leadership: teachers have major influence on their pupils, not only while they are studying but throughout their lifetimes. Throughout Africa, teachers are revered and respected, and thus have enormous responsibilities with regard to their students. Bearing in mind that youth are the age group with the highest levels of HIV infection, teachers find themselves in a pivotal position.

5. *Cultural and social figures*: in all countries, cultural figures and celebrities (singers, artists, poets, sportspeople, newscasters, royalty) have important influence far beyond any formal powers they may enjoy. They can be role models and opinion formers, and can serve as the most effective messengers to spread attitude and behavioural change. In particular they have the possibility of reaching certain groups that are otherwise resistant to messages about changing sexual behaviour.

6. *Media leadership*. Journalists, broadcasters, editors, chat-show hosts, actors, script-writers for soap operas: all these individuals and their respective institutions can play important roles in educating the public, raising issues, breaking taboos, exposing the shortcomings and hypocrisies of governments and public figures, etc. The media can serve as a key link and intermediary between the public and various forms of public leadership. The very choice of what is 'newsworthy' or what is a 'legitimate' plot in a television comedy can be an important exercise in setting a public agenda.

7. *Voluntary and grassroots leadership*: the leadership of social movements and voluntary organisations is the most difficult to define and reach, but can be the most influential. Community-based organisations and NGOs can be flexible, rapid, innovative and effective; they can find unexpected solutions to problems. In Africa today, where so much responsibility for coping with adversity falls upon communities themselves, this level of leadership is among the most important. Being voluntary in nature, NGOs have the possibility to select themselves what aspect of the HIV/AIDS crises to focus on, and what strategy to deploy. Driven by nothing but concern, their impact can be tremendous and vital.

<u>International leadership</u>

At the international level, all of the above forms of leadership are also reflected, in differing ways. International influence can be exercised on many levels: on national political leaders, improvement of development, empowering of marginalised groups and encouraging of gender equality. There are international political-bureaucratic leaders (such as the senior figures in intergovernmental organisations), political leaders with international moral stature, and international religious, cultural and civil society leaders.

One of the challenges for Africa is to mobilise its relatively small number of political leaders with truly international moral stature. Their small number means that those that do exist are called upon to dedicate themselves to many important causes, and they may not necessarily see HIV/AIDS as a priority. It follows that HIV/AIDS should be incorporated, in some way, into all international initiatives on Africa, ranging from cultural support to conflict resolution.

Public policy formulation and implementation

Political leadership in a modern society, especially when it includes issues such as public health, requires public policy. We can identify four main aspects to this:

(i) *Policy formulation*: the process of identifying a policy. There may be specific problems on this score with HIV/AIDS. For example, a government may argue that it already has a national health *policy*: all that is needed for a specific disease such as HIV/AIDS is a set of *guidelines*. This technicality may prevent the issue being taken up at a very senior level in government: AIDS may simply be dealt with at a sub-ministerial level in the Ministry of Health.

(ii) *Obtaining policy consensus*: building a constituency in support of the policy and announcing the policy initiative to the public. In the case of HIV/AIDS, this may require cross-ministerial consensus

(iii) *Policy implementation*: ensuring that the public service and ancilliary organisations can actually carry out the stated policy, and not see it subverted, neglected or undermined.

(iv) *Consistency and commitment*: ensuring that the policy is implemented for long enough and with sufficient energy to actually work. This implies mechanisms for monitoring and accountability.

Policy also operates at different levels. Some of the most effective policies have originated as initiatives at a community or NGO level, and have then been replicated, adapted or scaled up, to become national programmes. Less often, an international policy initiative has been the initiator of major public policy change which has been implemented at national and local level according to a blueprint.

At a general level, we can identify some of the preconditions for effective public policy measures against a major social ill. In each case, Africa has particular challenges when facing HIV/AIDS.

(i) *A set of technical and/or policy measures* that a state can utilise to effectively tackle the specific social ill. There has to be a package that works in the most basic technical manner.

In the case of HIV/AIDS, there is a core package that is known to work, but there is no single simple remedy, and the different components of successful policy vary according to place and time. Leadership is required to help identify and reproduce successful responses to the crisis: this requires strategic, flexible and creative thinking. A particular problem with HIV/AIDS is that it is often labelled as a health policy issue. Those who are not health professionals may be reluctant to speak on the issue. It is important that HIV/AIDS is not confined to being solely a 'health' issue owned by that particular ministry. It is an opportunity for ministries of health to take the lead, but shortcomings in that ministry should not be allowed to impede national policy. Transcending the 'health ghetto' is a challenge for effective national policy-making.

As mentioned above, bureaucracies in general are ill-suited to identifying the kinds of strategic, flexible and creative policy frameworks that are required. There are some encouraging signs that some international organisations have recognised their shortcomings in this area, but much needs to be done to build a workable strategy that can be implemented by the existing wide range of international agencies. In terms of national

bureaucracies in Africa, the picture is varied. In some countries, capacities have virtually collapsed. In others, institutional capacity remains but is almost entirely limited to carrying out routine activities that require no initiative or risk-taking by bureaucratic officers.

(ii) *Mechanisms to ensure that the technologies and/or policies are adequately utilised*, backed by legislation, administrative commitment or other specific forms of sanctioning. There have to be mechanisms for ensuring that institutions function, and political processes for accountability. Action at the highest leadership level is required.

In the case of a simple remedy (e.g. releasing food stocks in the case of impending food scarcity) this is a relatively easy requirement. In the case of HIV/AIDS it is far more complex, with many different components required. Some of the challenges of integration, mainstreaming and scaling-up HIV/AIDS responses are outlined below.

Many bureaucracies in Africa, national and international, function with the ostensible aim of providing services or delivering economic development. Most repeatedly fail to do this in anything that resembles a consistent manner. However, they continue to frame their analyses and proposals in terms of 'more needs to be done', rather than asking, 'is there something fundamentally awry with the whole approach?' In a classic study of a developmental bureaucracy at work, Ferguson (1990) concludes that inappropriate and flawed 'development' programmes in Lesotho 'succeeded' in delivering major benefits to those who controlled them: the World Bank could justify itself and its programmes, while the national government could extend its bureaucratic control over rural areas. Successes for the development industry and the administrative state did not translate into benefits for the citizens themselves. Meanwhile, the intangible nature of 'development' means that new definitions can be introduced, and the activity can suffer many setbacks but never admit defeat.

HIV/AIDS is a less generous adversary than lack of development. Programmes may 'succeed' in distributing condoms or holding educational seminars, but any failures to contain the pandemic will be evident before long. HIV/AIDS will require more honesty in appraising the successes and failures of programmatic interventions. It may even require dramatic changes in the entire culture of bureaucracy in Africa, not excluding international organisations. Action at presidential level will be required in most African governments, to ensure that national policies can be formulated and implemented, ensuring that bureaucratic obstacles at the level of ministries are overcome.

(iii) *An ethical consensus* which rules that this specific social ill is unacceptable. The policy must be acceptable to the target group and the general public. This is especially important when the policy involves trying to change attitudes and behaviour.

This is particularly the case for a challenge such as HIV/AIDS, in which widespread social mobilisation is an essential prerequisite for successful action.

In the last year, Africa has witnessed unprecedented recognition, at all levels, of the importance of HIV/AIDS. This is encouraging. One of the challenges is to ensure that this is more than a passing fashion, and that this concern is sustainable.

Making a policy work

We can identify several challenges to ensuring that a sound public policy idea becomes workable within the context of national or international policy-making (Collins/Rau: 43ff). These challenges go some way to addressing the concern of a need for a change in bureaucratic culture.

(i) The need to *integrate* HIV/AIDS prevention and care programmes with existing sectoral activities, including businesses, NGOs and government programmes. HIV/AIDS is a health issue that affects all sectors. This can facilitate the most effective use of resources, it can routinise HIV/AIDS activities within existing programmes, it can be efficient for clients (especially marginalised target groups), and it can help to overcome stigma and discrimination against PLWA. Integrating HIV/AIDS programmes across both social mobilisation and public service systems is perhaps the greatest challenge (see below).

(ii) The need to *mainstream* HIV/AIDS prevention and care into normal bureaucratic activities such as planning, budgeting and evaluation. This is a particular challenge to national leadership, at a political and bureaucratic level, and also to the leadership of aid institutions. Bureaucracies are institutions that are often jealous of their operational independence and are resistant to taking on board cross-cutting initiatives. However there are some encouraging signs of change, often in the middle ranks of institutions.

(iii) Promoting *informal alliances*. This is far more than making different institutions work together on cross-sectoral initiatives. It also means encouraging official bureaucracies to work with unofficial ones. Governmental and intergovernmental staff have much to learn from the NGO sector and from scholars, while those who are outside official bureaucracies have much to learn about the constraints under which bureaucrats work. Given the reality that official bureaucracies will be slow to reform themselves and change their institutional cultures, there are possibilities for cross-cutting coalitions, forged in informal settings, whereby tasks can be divided and activities coordinated between like-minded individuals in government, international agencies, NGOs, and the community.

(iv) The challenge of *scaling-up* effective initiatives to cover a wider area or wider population. This requires leadership skills to identify what should be scaled up and promote it, which in turn requires flexibility in policy implementation. (Aid bureaucracies are among those needing to attend to this lesson.) Experts naturally prefer to work from professional blueprints rather than from grass-roots experience of what works: changing this mindset is one challenge needing to be faced. Scaling-up also requires a general capacity for implementation among state institutions, which entails reversing years of neglect and austerity.

(v) *Monitoring and accountability*. Honest evaluation is key to the prospects for success. HIV/AIDS programmes need clear and effective mechanisms for assessing success and failure. Failed programmes must be ruthlessly weeded out. Those that succeed must be acknowledged and the staff involved must be rewarded. Innovation and risk-taking in decision-making and programme

> implementation should be encouraged. The performance criteria for staff should be transparent and fair. Honest evaluation is only meaningful in the context of realistic expectation. If bureaucracies are asked to do the impossible, they will be forced to deceive to protect themselves.

Ensuring that these challenges are met normally will require an initiative from the highest level of national leadership.

Building trust

There are major problems with the implementation of public policy in Africa, based on Africa's unique historical experience. Since colonial days, lack of voluntariness and insensitivity to local realities have routinely undermined trust in public policy. This has left a deep legacy of distrust in governmental interventions. Ordinary African citizens routinely suspect that any initiative from a government department or international agency may have a hidden agenda, or may be a passing fad that will soon be superseded. For many ordinary people and low-level bureaucrats alike, the established modus operandi is to try and survive despite public policy initiatives, paying lip service to them and going through the motions of implementing them, but in fact either ignoring them or subverting them. Africa is littered with development or environmental programmes that failed because local people quietly undermined them from within.

This problem exists for some public health programmes as well. During the 20th century, many draconian policies were enforced in Africa in the name of public health, including the forcible bulldozing of shantytowns and relocation of their inhabitants, and the movement of villages to contain tsetse flies. The ethics of some colonial medical practices have also been questioned. Leaving aside the current debate about whether the origin of HIV can be traced to the use of infected chimpanzee livers as a culture for developing polio vaccines, it is evident that some European medical scientists relaxed their ethical standards when operating in Africa. In Apartheid South Africa there is a disturbing and sometimes bizarre history of medical experimentation conducted with the aim of finding pathogens that will selectively attack Africans. Our point here is not whether these allegations are true, but that many Africans have deep suspicions of national health policies. For example, some may fear that advocating condom use is the West's means of limiting Africa's population.

Again, this discussion brings us back to the challenge of leadership. For some leaders, implementing public policy is seen as a mechanical affair of consulting experts, drawing up blueprints, issuing directives, and calling on civil servants to implement what is required. The reality of HIV/AIDS in Africa is that leadership has also to establish a substantial level of mutual trust between the leader and the target group. The trust has to be mutual, so that (a) the target group trusts the messages from the leadership, and does not ignore or subvert them, and (b) the leadership trusts the target group to develop and implement their own responses to the crisis.

Health policy needs a positive environment

Public policy against HIV/AIDS has its limits. Whether HIV/AIDS programmes can make a significant difference in the absence of more general and elementary changes in Africa's predicament can itself be questioned. The success of campaigns based on condom promotion, sex education and the provision of information is hugely dependent on the existence of basic factors such as adequate infrastructure, gender equality and literacy. Actual resources are also

key. The run-down in health services has contributed to many easily-avoidable infections. Reducing mother-to-child-transmission can be done, given greater finances and organisational capacity. There is no point in knowing that condoms prevent HIV transmission if condoms are not readily available. Sometimes, African heads of government are encouraged to commit the political will to change the factors conducive to the spread of HIV/AIDS, but with little indication of 'how countries would achieve the wealth and independence to develop in these areas' (Klouda, 1995: 482). Poverty is not only the background to the AIDS pandemic in Africa, it intrudes into every aspect of the spread of the disease and efforts to combat it.

To ignore primary factors such as poverty and lack of governmental capacity in drawing up HIV/AIDS programmes is, argues Klouda, like attempting 'to put windows in a house before the walls are built... The vast majority of programmes stay fiddling with the windows, benefiting a few individuals who already have the walls, but leaving the vast majority of the poorest and marginalized unprotected' (1995: 470). Yet if this is accepted, the question then becomes, where will the 'walls' come from and when? In the absence of a profound and instant shift in the global economic order, we may be in for a long wait. In the meantime, HIV/AIDS continues to ravage Africa. The magnitude of the changes that need to occur to contain HIV/AIDS does not mean that they should not be undertaken. The opposite is the case. Yet if it must be stressed that HIV/AIDS is symptomatic of more general problems, this can be a double-edged sword. Those who argue that to take HIV/AIDS specific measures is to whistle in the wind, can merely provide a recipe for inertia. Tackling HIV/AIDS cannot wait for the end of poverty, inequality and exploitation.

Organisation or movement for social progress or emancipation.

This concept encompasses NGOs, grassroots organisations, civil society organisations, trade unions, political parties, and other forms of social organisation that involve the voluntary association of individuals. This is, self-evidently, a movement to remedy a perceived social ill and bring about social change for the better. It is the practical manifestation of the impulse for social change or emancipation, the popular counterpart of leadership.

We can try to identify several different kinds of movement, including:

(i) Power-seeking political mobilisation (by a party or faction seeking political power).
(ii) Ideological political mobilisation (in pursuit of an ideological agenda).
(iii) Social engineering (the use of state power to influence behaviour or enforce change). (Voluntariness in this case may be limited.)
(iv) 'Primary' social mobilisation (mobilisation of constituents in pursuit of their interests).
(v) 'Secondary' rights activism (professionalised activism by human rights specialists).

Once again, we find that the circumstances in Africa are unpropitious for the emergence of truly effective movements for social change and emancipation. One of Africa's tragedies has been that the emergent mass movements of the 1940s and '50s, which succeeded in obtaining independence for most African countries, did not subsequently translate into wide social movements for civil rights, democracy and development. There are many reasons for this. Among them we may note the way in which in rural areas, most 'primary' mobilisation was in the form of resistance against external intrusion, rather than for

obtaining social progress in specific areas. We can also note the importance of ethnic mobilisation, which in some cases has been hitched to emancipatory political programmes but in many others has simply become a vehicle for seeking power. Of particular significance also is the prevalence of armed struggle and the widespread use of violence as a means of achieving political goals. While this continues, mass non-violent social mobilisation is extremely difficult.

Among civil leadership, we can identify two contrasting modes of operation with regard to governments.

(i) *Advocacy*. This has various forms. Best-known is 'adversarial advocacy', which is the type of activity most commonly associated with human rights organisations and protest movements. They document the failures of government, criticise them with the aim of embarrassing those in power ('mobilising shame'), and thereby effecting change. There are other forms of advocacy that try to influence public policy by public education and raising awareness. This advocacy may either be aimed at the 'primary audience' of key decision-makers, or may target the 'secondary audience' of a wider group who will, it is hoped, influence the decision-makers.

(ii) *Programmatic engagement*. This is the activity more commonly undertaken by implementing NGOs, that work with government structures to deliver services, to discuss policies, and to effect internal reform and capacity building within existing systems. But there are also possibilities for alliances—usually informal—between individuals in government and those in advocacy organisations, to promote common goals.

Western human rights NGOs are often criticised in Africa for focussing on adversarial activities to the exclusion of programmatic engagement. In some cases this may be a fair criticism. However, in the case of the HIV/AIDS pandemic, it is clear that there is room for *both* types of activity, including *all* kinds of advocacy. Most NGOs and community-based organisations will focus on programmatic engagement, some will include policy advocacy and public education, but the selective use of adversarial methods—'naming and shaming'—is also necessary. There are many, among national and international leaders, who have signally failed their people, and there is nothing to be gained by refusing to confront them with their failures and its consequences.

The basic triangle of concepts—leadership, public policy, and social mobilisation—which will be elaborated later in this paper, provide the props for exploring the potential for effective leadership measures, public policy and social movement against HIV/AIDS in Africa.

HIV/AIDS in Comparative Perspective

There is no precise parallel for HIV/AIDS. There is no disease and no social ill that matches its combination of components. However, there is much that can be learned from a comparative summary of historical experiences in combating other diseases and overcoming other social or political ills. This allows us to learn lessons and see what may be applied to the case of HIV/AIDS.

Public Policy Measures against Disease

This section examines, comparatively, cases of public policy measures to combat epidemic diseases, famine and poverty. HIV/AIDS has no exact parallels in the history of medicine, and even the closest models (such as TB and syphilis) are inexact. Each case that follows is a model that has attractions and disadvantages for the case of HIV/AIDS.

1. *The eradication of smallpox*. The conquest of smallpox in the 1970s is one of the greatest public health achievements of all time—if not the greatest. One of the greatest scourges and causes of death in the world was eliminated completely. This was achieved by a coordinated worldwide international public health campaign. It was facilitated by a relatively simple technological package: a single-dose immunisation that could be 100% effective, made possible because of the nature of the disease. Smallpox was solely a human disease, so that elimination from human hosts meant total elimination. In addition, the disease could be progressively eradicated: the elimination from a single country or region, followed up by careful monitoring and quick response when new cases were detected, meant that the campaign could bring major progress even before reaching its ultimate goal. Because a one-off total eradication campaign was possible—and was achieved—it was not necessary to supplement the technical package (immunisation plus monitoring) with public education or attitude change.

   The eradication of smallpox was a monumental achievement of public policy. However it was one of the least complex political and social challenges for international public health. It is also a misleading model for the eradication of many other diseases, among them AIDS, because it implies that success can come through a technical, bio-medical package alone. The vaccine model of 'solution' for disease also ignores the 23 million Africans already infected with HIV, and the millions more who will become infected before any vaccine becomes available and universal vaccination is provided.

2. *The elimination of cholera* and other waterborne infectious diseases from industrialised cities in Europe in the 19th century. This is an interesting and instructive case highly relevant to the political history of HIV. Cholera was effectively eliminated from northern European cities well before any effective treatment was found. It was eradicated by public health measures. But this was not achieved without a struggle. One particular struggle was the valiant and ultimately successful attempt by the pioneer epidemiologist John Snow (1813-1858) to establish that cholera was waterborne, and carried by contaminated water supplies. Following an outbreak of cholera in an area of London in 1854, Snow demonstrated statistically that cholera was far more prevalent in streets served by one particular water company than in streets, otherwise similar, served by others. With the removal of a single water pump around which cases were concentrated, incidents of cholera declined immediately (Porter, 1997: 413). Water companies that failed to ensure strict separation between waste and clean water were marked by high levels of cholera transmission; those that effected good hygienic practices were marked by low cholera levels. Snow's efforts were vigorously opposed by the water companies, which took the extreme measure of suing him for libel in the courts. Snow fought and won. His findings contributed to the construction of new sanitary infrastructure. They succeeded in changing public policy. His efforts demonstrated an important link between moral courage, social activism, the rule of law, and the conquest of an epidemic disease.

   Rudolf Virchow also made such links when investigating a typhus epidemic among a suppressed polish minority in Prussia in 1847. As Porter explains, Virchow stressed how 'epidemics were symptoms of a general malaise; they mainly affected oppressed groups.

The answer was thus not medicine, but "political medicine": education, freedom and prosperity. "The improvement of medicine would eventually prolong human life," he proclaimed, "but improvement of social conditions could now achieve this result more rapidly and more successfully"'(Porter, 1997: 415).

It is arguable that the shortage of good epidemiology of HIV in Africa reflects the interests and biases of institutions that have little positive interest in promoting complete transparency. An epidemiologist with the courage of Snow, working in Africa in the 1980s, might have been able to slow significantly the spread of the disease by identifying key agents of transmission such as the military and exposing the dangers of impunity for crimes of rape.

3. *The campaign against polio.* The attempt to eradicate polio has become one of the more controversial international public health decisions of the later 20th century. Polio is a disease that has ravaged many across the world, and has been effectively eliminated in industrialised countries within living memory. A campaign to eliminate polio is a worthy goal. However, it is also a complex disease that is extremely difficult to eradicate entirely. Because it has non-human hosts, it requires constant re-vaccination of every new generation: unlike smallpox it cannot be eliminated once-for-all. In addition, the disease is more dangerous the older the infected person. Therefore, once vaccination has been started, it becomes *even more* important to maintain constant programmes of vaccination, for fear that an even worse outbreak of the disease should occur.

   It is interesting to contrast the attempt to eradicate polio with the failure to institute any comparable campaign against measles. Like smallpox, measles is a disease that has only a human host, and is therefore potentially eradicable. The vaccine against measles is also effective and simple. Measles takes many lives across the developing world, and in many respects is a greater public health menace than polio. However, it was not chosen as a priority for eradication, perhaps because measles does not have the same profile as polio in western countries, from where funds for the campaign have been sought. The case also demonstrates the shortcomings of a market-based global health system to develop the appropriate medical technologies for poor parts of the world.

   The comparison with the disparity of research resources focussed on strains of HIV prevalent in Europe and America compared with those prevalent in Africa is obvious if inexact. The lesson here is the importance of allowing the precise needs of African countries to take their proper proportion in relation to the demands of obtaining resources and public support elsewhere in the world. The limited market 'demand' of Africa for appropriate drugs must be bolstered by international public policy.

   Strong leadership has made it possible for effective mobilisation and public policy measures to reduce the incidence of polio across the world, eliminating it in many countries. The absence of any such leadership or public policy initiative concerning measles has been a notable absence.

4. *The containment of leprosy.* Leprosy is a mysterious disease: its mode of transmission remains unclear; it is slow-onset, highly-stigmatised and feared, and the reasons for its disappearance from large parts of the world are unknown. The control and containment of leprosy is a very complex task, including public education to remove or at least reduce the stigma, ensuring high rates of patient compliance in drug-taking (making sure that patients continue to take medication for months after symptoms have disappeared to ensure no relapses, and that drug resistance does not emerge), care for those disabled or scarred by the disease, and maintenance of monitoring and case-identification systems in health services. The medical challenges posed by leprosy are minor compared with the

challenges of changing attitudes and behaviour. Even after decades of patient public education, negative attitudes towards leprosy and widespread rejection and ostracisation of leprosy sufferers remains widespread. The fact that the disease is continuing to spread (very slowly, it is true) is discouraging to those who are optimistic about changing health-related behaviours. On the other hand (with a few notable exceptions such as the late Princess of Wales) there have been very few high profile figures ready to associate themselves with the campaign against leprosy. Leprosy sufferers have suffered from a lack of political leadership ready to try to change wider social attitudes.

5. *The conquest of famine in India* during the 20th century, in comparison with the failure to do so in Africa, is an interesting case that illustrates the potential for social mobilisation under effective leadership. Civil and political liberties are used to enforce, a state obligation to protect basic economic rights, founded on a national political consensus that famine is completely unacceptable. This case can only be understood in its specific historical context.

   In the last decades of the 19th century, a coalition of Indian farmers and labourers, nationalists, and foreign sympathisers with the nationalist cause, succeeded in shaming the British government over the extent of poverty and famine in India. Mass starvation in the subcontinent was, they said, an indictment of Britain's supposed mission to bring civilisation to the world. Fearful of the security threat posed by destitution and restlessness, and the loss of legitimacy arising from the nationalist critique, the British Raj first instituted the famous Famine Codes, and then reformed them to make them more effective. Intended as no more than an administrative obligation, famine prevention and relief quickly became adopted as basic rights by Indians themselves, so that when in 1943 the British allowed a devastating famine to strike Bengal, the loss of legitimacy for the imperial regime was devastating. The fact that famine prevention usually worked so effectively made this failure all the more striking. The hungry masses themselves would not have been a major threat, and neither would the nationalist leaders as a class—but the combination was profoundly threatening.

   One of the important achievements of the anti-famine coalition in India was to change the moral terms of the debate. For most of the 19th century, the British insisted that the Indian poor starved because of their own moral shortcomings: they were idle, failed to plan for the future, and had too many children. By changing the debate from one centred on the supposed moral inadequacies of the victim, to be one of combating a wider social ill, it became possible to develop effective public policy and political commitment. This has clear parallels with the challenge of HIV a century later.

   Post-independence governments in India have feared that famine would destroy their credibility and electability. They have proved responsive to press exposure of impending famine and inept or inadequate relief, and have been ready to support expensive but effective anti-famine programmes. As Sen has described, the Indian political system ensures that both the informational and the incentive factors are present for famine prevention. This is a classic 'political contract' against a social ill.

   In many parts of Africa, there has been a comparable political contract that ensures that states are obliged to provide food for townspeople. But that obligation has rarely been extended to rural areas, and in fact urban food security has often been maintained to the detriment of rural food security. For various reasons, comprehensive anti-famine political contracts in Africa have been elusive. These reasons include the less visible and less politically threatening nature of rural African famines, the traditional nature of political authority in rural areas, the failure to politicise famine in a consistent way, the internationalisation of responsibility for response to famine, and the lack of civil

and political liberties in many African countries. The rural food insecure do not tend to identify with one another and mobilise around the issue of food: instead they tend to seek individual security within local networks of patronage and local economic niches.

The difficulty of mobilising rural constituencies in Africa around generic issues (rather than around locality-based demands) is highly relevant to the challenge of HIV/AIDS. Mobilisation and protest require that people hold the state accountable for HIV/AIDS prevention and care. It is highly unlikely that rural people with HIV/AIDS in Africa will come together as a constituency to press for their common interests; it is more probable that they will continue to seek individual solace where they can, in the context of the extended family or local charitable efforts. The fact that the wealthiest can afford treatment also reduces the pressure on such people to identify themselves as HIV positive and to identify their common interests with poorer people living with HIV/AIDS.

6. *The struggle against poverty in India.* Let us contrast the success of the anti-famine political contract in India with the failure to develop a wider political contract against poverty. As Prof. Amartya Sen and others have pointed out, India's success in eliminating famine contrasts sadly with its failure to reduce the extent of chronic poverty that afflicts the subcontinent. Why is this? We can identify several possible reasons. Each of them has some relevance to the difficulties of mobilising a coalition in support of the issue of HIV/AIDS:

   (i) Lack of *visibility*. Famines in India are highly visible: there are mass movements of people to cities, mass destitution on the streets. But poverty is less visible. Urban poverty is likely to be a higher-profile issue than rural poverty, because (a) some of the urban poor can be seen sleeping on the streets, (b) there are negative public health implications of large-scale urban destitution and (c) urban poverty is usually ugly (and prosperous city dwellers like their cities to look clean and attractive). Making rural poverty visible is notoriously difficult.

   HIV/AIDS is an extraordinary epidemic, in that it can affect a huge proportion of the adult population of a country, and yet remain all-but 'invisible'. Because of the slow onset of the disease, the way in which it disguises itself (particularly as TB), and the stigma attached to it, there can be little visible sign that a country is being ravaged by the pandemic. It is not like an epidemic of cholera or a famine. It takes an effort of political will to make the issue visible. This can either follow from an act of bold leadership or from social mobilisation by affected people and their friends.

   The sheer level of HIV/AIDS infection in many countries will, tragically, make the disease visible. Fortunately, the level of national and international attention generated by recent national, regional and international conferences and media campaigns has undoubtedly broken through the visibility barrier in much of Africa.

   (ii) Lack of '*separability*'. It is easier to mount a campaign or develop a public policy focussed on a single, separable issue. But poverty is so complex, so multi-faceted, that it is difficult to identify what aspects to prioritise and tackle.

   Is the abolition of poverty, like the abolition of war, simply too vast to be practicable for a social movement or a political contract? There are good arguments for believing that this may be the case. Social mobilisation requires visible issues, simplification of issues, possibilities for tangible progress, etc. Poverty is probably too huge and complex an issue to allow for these measures.

In addition, in most societies, the concept of poverty is so heavily laden with religious and cultural baggage that it may prove a difficult concept to isolate as a focus for political mobilisation. On the other hand, it may be possible to target specific aspects of poverty. Some, for example, measures aimed at children or nursing mothers are likely to be far more popular than benefits for labour migrants or refugees.

The parallels with HIV/AIDS are immediately apparent. While HIV/AIDS is in some sense 'distinct' it is inextricably linked to a context of poverty, exploitation and injustice. HIV/AIDS is cause but primarily consequence of a raft of factors, some of them structural, which must be challenged for long-term progress to be made. As is the case with people, for whom prevention and cure (or rather care) must both be undertaken, HIV/AIDS strategies must tackle the root causes of the prevalence of HIV/AIDS alongside the symptoms of such causes (e.g. inadequate health services and education). It is to be hoped that the HIV/AIDS pandemic, because it is impossible to ignore and because multiple constituencies stand to benefit from its containment, can become a rallying point for related issues and a vehicle whereby women, victims of abuse and suffers of other diseases (e.g. TB) can press their cases into public debate.

(iii) Lack of *political and moral salience*. There are problems of building a coalition of different interest groups, including a 'primary movement' and 'secondary activists.' Measures to favour classes of poor people always face considerable obstacles—solid political and economic interests stand in the way of land reform in any particular area, or financing new housing, or increasing a minimum wage, or increasing state benefits. In each case, those opposed to vigorous measures to help the poor can make moral arguments in their favour (e.g. arguing that land reform undermines principles of private ownership or economies of scale), impeding the development of a practical moral consensus on the issue of poverty. This is where political leadership becomes essential: identifying the less popular but more effective policy choices.

A component of salience is urgency: combating famine is always more urgent than struggling against chronic poverty.

There are no groups that have an obvious vested interest in the continuation of the HIV pandemic. But unfortunately there are many powerful groups that have vested interests in opposition to many of the specific measures required to tackle HIV. Some governments and institutions have fears about too much transparency about the epidemiology of the disease. Others have moral agendas that contradict effective measures against HIV. Others are simply too timid to take the steps required to initiate a campaign against HIV, or are too distracted by other pressing issues. HIV/AIDS must become politically salient.

Africa has taken remarkable steps in making HIV/AIDS a politically salient and urgent issue. There can be few cases in which a previously invisible, unknown issue has leapt to such prominence in such a short period of time, and acquired such a political momentum at many levels. This element of urgency is crucial in mobilising a coalition against HIV. However, unrealistic goals must not be set: nothing would be more discouraging than to expect rapid results, which may then fail to be achieved. Urgency must be combined with realism.

(iv) Lack of *clear threat*. One reason why both colonial and post-colonial governments have reacted to famine is that it is a clear and immediate threat to political stability. Large numbers of hungry people roving around the countryside and converging on towns presents a political threat. Marching, picketing and rioting

are strategies utilised by the famine-stricken in modern India. In addition, famines have historically sparked outbreaks of infectious diseases such as smallpox and cholera, which have threatened the rich as well as the poor. Poor people in India have no illusions about this: 'they would let us die if they thought we would not make a noise about it,' said one labourer (Dreze, 1990: 93).

But chronic poverty is not a threat to the powers that be. Or, to be more precise, it is not recognised as a short-term threat. In the long-term, widespread chronic poverty is likely to undermine the viability of any state in the modern world. But for most leaders, it is a problem that can be postponed.

HIV/AIDS is a serious threat—but it is not always recognised as a clear and immediate threat. President Museveni of Uganda first responded to the AIDS crisis in Uganda because a large proportion of his soldiers and officers were HIV positive, and he clearly saw this as a real threat to the stability of his government. Unfortunately, other leaders have been less clear-sighted about the problem, and have seen the *admission* of an HIV epidemic as more of a short-term threat than the epidemic itself. This is a rather short-sighted approach, because a high rate of HIV—even in an institution as tightly controlled as an army—cannot be kept secret indefinitely. And the longer the reality of HIV prevalence is denied, the larger the threat becomes.

The challenge is for leaders to recognise that the threat of HIV becomes greater the longer any responses are postponed. Meanwhile, as the reality of the HIV/AIDS pandemic in Africa becomes clearer and clearer, the 'threat' of admitting the problem decreases.

(v) Lack of *manageability*, or absence of an accessible solution. A solution to the problem of famine was at hand, in the form of effective early warning, labour based relief measures, and (later) intervention in the grain market. However, in India, as in most countries, the question of poverty is simply too large and complicated to be manageable. For this reason alone it may be preferable to identify specific elements of poverty that can be tackled and eradicated.

This is one of the greatest threats to effective action against HIV: fatalism.

> ...fatalism comes easily to societies beset by daunting and uncontrollable factors. When life expectancy is in the 40s or below, when the quality of life remains the same decade after decade despite the promises of independence and development when access to those modern devices that ameliorate the miseries of poverty, malnutrition, ignorance and dependence are unavailable, fatalism is logical. Thus when AIDS strikes there is not the frantic reaction so often observed in the affluent West to search for a cure, for medical treatment, or for amelioration from anguish, uncertainty and fear. Africans have had to accommodate to human circumstances beyond their control, not to mention natural disasters, for several centuries; AIDS is not much different. (Fredland, 1998: 561)

Many governments believe that they can do nothing against HIV/AIDS, and therefore do not even attempt to try. (Often when attempts have been made to 'do something' they have been superficial interventions that have involved harassment, and violations of privacy and confidentiality). In doing so, they miss opportunities and prevent others from taking initiatives that could help. Fredland cites a Nigerian official who disputes the value of channeling funds to a hopeless cause when so many still die from readily curable illness (Fredland, 1998: 561).

HIV/AIDS is manageable. Some countries in Africa (e.g. Uganda) have succeeded in containing, though not eliminating it. This is also a question of

definition. If manageability is seen as elimination, then HIV is not manageable. But if manageability is defined as reducing transmission and providing treatment for people living with HIV/AIDS, so that they have longer and better lives, then combating HIV is manageable. This is one of the most important messages for leadership, public policy and social mobilisation: success is possible.

The comparison of Indian mobilisation against famine and against poverty is instructive, in allowing us to identify some of the structural conditions that facilitate or impede effective action. These are lessons that will be relevant to the attempt to combat HIV/AIDS.

Mobilisation for Social Progress or Emancipation

The cases of cholera, leprosy, famine and poverty indicate the importance of social mobilisation as an adjunct to effective public policy. Let us therefore look more widely at the meaning of social mobilisation. This should also be seen as a means of examining the range of leadership skills and types required for social mobilisation: political, social, religious, local, national and international. All of these forms of leadership and mobilisation may be called upon in the struggle against HIV/AIDS, in coalition, or to tackle specific aspects of the pandemic and its social, political and cultural ramifications.

1. *Women's rights.* The history of the women's movement is too well-known to need repeating. But an important set of factors recurs: a coalition of the relatively privileged, including articulate intellectual leaders, a mass movement with the capacity to make a government feel distinctly uncomfortable should they do nothing, and a new moral consensus that the ruling values of a previous generation needed to be supplanted. The women's movement can be seen as building a new political contract, primarily in industrialised countries but also in a number of developing countries.

   But there are also important weaknesses indicated by the women's movement. Enacting emancipatory laws and mobilising a core constituency are important—indeed essential—components of progressive social change. But their impact can be limited. Changing the real power position of women in society historically depends upon a range of other, wider social and economic changes. The changing situation of women in the labour market, the increased education levels of women, smaller families, a shift in the demands of the labour market to service industries, are all factors that have been vital in contributing towards the social and economic emancipation of women.

   The implications of this are disturbing for the struggle against HIV/AIDS. It would appear that more is needed than action to protect women's basic rights, mobilise women's organisations and encourage changes in attitudes. It would seem probable that African women will only be structurally capable of protecting themselves against the threat of HIV/AIDS when there has been more far-reaching social and economic change in the position of women. However, it is also erroneous to suppose that African women's emancipation can only follow the model of their sisters in industrialised countries: there should be opportunities for women to gain more power and influence in their societies, workplaces and homes in a distinctively African context. There is a pressing demand for leadership to identify a moral and social discourse that can enable progress in this direction. Some technologies, such as female condoms, can also have an emancipatory impact.

2. The *American civil rights movement* is perhaps the pre-eminent case of a modern mass movement for basic rights. The civil rights struggle under the leadership of Martin Luther King was remarkable in that it was non-violent, using moral force and force of numbers alone. The civil rights movement aimed to effect real, material, change in the lives of its members, and it succeeded. But by casting its aims in moral terms, and by using irreproachably moral methods, it achieved more than simply a new political dispensation. It achieved a new moral consensus about the unacceptability of racism and the equality of all citizens. But the more militant approach of Malcolm X and the fear of violence were also instrumental in shaping the political process. The legislation that resulted represented a new political contract.

   The civil rights movement is the immediate ancestor of contemporary human rights activism in the U.S. Many of today's leading human rights activists graduated from its ranks. It is also the paradigmatic case of a mass 'human rights movement'—a key link in a chain that stretches from Mahatma Gandhi's resistance to the British to the Velvet Revolution in Prague. We see the characteristic elements of a struggle for a political contract at work. First, there is an essentially *political* struggle. Political parties are part of it: in fact they are an integral part of 'civil society'. Second, the aims are for concrete social gains. Third, the least tangible but perhaps most important outcome is a new moral consensus. We also see a characteristic coalition between the mass mobilisation of an affected constituency and activists with professional backgrounds, some of them drawn from the ranks of the movement, and others motivated by their consciences alone.

   Since the late 1970s, the human rights movement has adopted a universalistic human rights rhetoric. This has focussed more on universal ideals and abstract legal standards, and less on the immediate interests of marginalised and oppressed people. It has been less easy to organise the mass mobilisation of people in pursuit of their own (legitimate and moral) interests. Instead, there has been a growth in professionalised human rights institutions, in which human rights specialists can pursue their careers, using techniques including lobbying politicians, writing in the press and raising court cases, to achieve their ends.

   The analysis of the moral challenges of HIV/AIDS, above, has indicated the importance of a rights agenda. The basic protection of people living with HIV/AIDS is the foundation for enabling these people to mobilise in pursuit of their rights of care and treatment, and to enable the disease to lose its secrecy, stigma and fear. The lessons of the civil rights movement are therefore highly relevant.

   The HIV/AIDS pandemic has seen a resurgence of some primary mobilisation, notably in Europe and America. (AIDS in the World, pp. 775-781) It was people living with HIV/AIDS themselves who mobilised in support of their rights; initially in favour of care and recognition, and subsequently for their right to adequate treatment (when the drugs became available). In Africa, only South Africa has comparable primary movements on a significant scale. Elsewhere, HIV/AIDS is overwhelmingly the responsibility of 'secondary' organisations such as international NGOs. The difficulties of mobilising a wider constituency in support of the issue are very marked.

3. *Arms control or restriction*, notably the case of anti-personnel land mines. The land mines campaign is an important case study because its success has strongly influenced other international social movements and is widely held out as a model by international campaigners on social issues.

   The campaign against land mines has many elements of a classic single issue campaign. Land mines are a visible, arguably unique (or at least, somehow 'different') weapon of uncertain military utility. The injuries produced by landmines, many of them

to civilians, are conspicuously gruesome. Land mines are particularly ugly because they are so inherently indiscriminate, and continue to claim casualties years after the end of hostilities. Following the precedent of chemical weapons, the solution—a ban—is simple and attractive (perhaps misleadingly so—chemical weapons do not need to be dug out of the ground one by one).

The land mines campaign was broad and often unorthodox. The U.S. section (the most orthodox) focused on lobbying policymakers, especially in Washington DC, to support an international treaty banning land mines. Other parts of the campaign built a wide coalition of organisations across many different countries, focussing on mobilising a grass roots campaign that could initiate a new social consensus against the weapons. So far, the campaign has certainly worked in stigmatising western land mine producers and users. Most western countries have signed the Ottawa Convention banning the production, stockpiling, transfer and use of anti-personnel land mines. And, more importantly, any public exposure of the fact that they may not be fully complying with the treaty provisions sparks public outrage.

However, in the countries where most land mines are actually laid—mostly poor countries in Africa and Asia—the campaign has yet to reach the critical threshold of establishing a moral consensus that absolutely prohibits the laying of mines. For many front-line commanders in the wars of Africa, Asia and south-east Europe, anti-personnel mines are still seen as a useful weapon. In fact, more mines have been laid in the last two years than have been removed from the ground. (Though huge stockpiles have also been destroyed.) In addition there is the problem of the legacy of the past. At current rates of clearance it will take many decades to remove land mines from many countries. Casualties from land mines remain very high. The land mines campaign still has to do the hardest task of maintaining the momentum of international public policy to remove land mines. In doing this, the campaign is weakened by the relative weakness of the social mobilisation of affected people within its ranks, compared to the prominence of 'secondary' organisations, many of whom have begun to lose interest in the issue after the success at Ottawa.

The land mines campaign was one of the most rapidly successful international movements of modern times: it achieved a major triumph (Ottawa) less than six years after it was formally launched. Perhaps the most important lesson from the land mines campaign is that success at the level of international leadership has not yet translated into the effective prevention of land mine use in conflicts, especially in poor countries.

A comparison with HIV/AIDS indicates the greater challenge facing a campaign on this issue. Success in terms of international legislation has limited meaning in the context of HIV/AIDS. Perhaps, agreements with pharmaceutical companies can be achieved within a few years to ensure relatively cheap provision of drugs to Africa or generic production within the continent; or there can be a charter on the rights of people living with HIV/AIDS to be ratified by most countries around the world. But whether this would translate into a reduction in HIV transmission and AIDS mortality for some years would be open to question.

These cases illustrate the diversity of struggles for social change and emancipation. They indicate the different challenges of leadership. They allow us to ask success has been achievable in some cases, while not in others. They underline the reality that all objective facts need to be mediated by some form of social, moral and political representation. Effective public policy needs to be founded on leadership and social mobilisation. But perhaps the most important lesson is that success is nurtured over a period of time—usually decades.

Conditions that Facilitate or Impede Progress

This section examines the context within which political leadership and social movements operate. All social change must take place within an existing social and political system, be it liberal democracy, dictatorship or a weak state with little authority. First, the focus is on different kinds of governmental authority in Africa. Given these realities, what should be the priorities for change? Second, the focus is on the wider context for social action.

Nature of Government and Political System

We must turn to elements of the political system that are necessary for a political contract to be workable. The first element in this is the nature of government and the political system in the country in question. We will look at five different kinds of state, each one relevant to Africa (see Moore/Putzel, 1999). Within each kind, there are different options for leadership, for the formulation, implementation and stability of public policy, for the adoption of open discussion, and for social mobilisation.

1. *Collapsed states*, with absence of effective government or civil war.

   (i) Leaders, who have limited territorial or ethnic power bases, have very limited scope for taking leadership action on social issues.
   (ii) The scope for public policy interventions is virtually nil. There are only project interventions by NGOs that can achieve some limited impact. There is likely to be virtually no reliable information about prevalence.
   (iii) In the absence of free debate and a national media, it will be extremely difficult to promote attitudinal or behavioural changes among the population.
   (iv) The capacity for political mobilisation by affected people is virtually nil.

   The only sensible intervention is to try to establish central government, while pursuing ad hoc initiatives using local and international NGOs.

2. *Personal rule or arbitrary rule.* Policies are unstable; political activity is focused on taking or retaining power and enriching those in power.

   (i) National political leaders may appear to have great scope for taking leadership action on social issues, and in some cases they may actually do so. But this is inherently unpredictable, and the extent to which any such initiatives translate into public policy, and the extent to which they are stable and predictable, is very uncertain.
   (ii) Public policies are fragile and unpredictable, and tend to have little credibility among the target population, which may expect rapid and unpredictable policy shifts or policy neglect.
   (iii) Such governments are hostile to free expression and basic civil rights. The opportunities for attitudinal or behavioural changes among the population are very slight.
   (iv) The capacity for social mobilisation by affected people is virtually nil.

Effective policies on HIV/AIDS in these circumstances are improbable and if they do occur, they are unlikely to be effective or robust. Improved governance is a prerequisite for stable and effective policies. However, the possibilities for some ad hoc initiatives either by leaders with a personal interest in the issue, or by NGOs, should not be ruled out altogether.

3. *Minimally institutionalised states*: weak, sectarian or divided and unstable government. Some institutions and mechanisms for public policy and national debate are available, but they are weak and patchy.

   (i) Leadership opportunities in such states are in some ways considerable. National political leaders sit atop hierarchies and patronage systems, and their power and authority is bound up in symbolic authority. They may be able to act with relatively few constraints in terms of consulting constituencies. On occasions therefore they may have considerable scope for action, while their semi-traditional authority may mean that their words and actions carry great weight. However, it is very questionable the extent to which these kind of leadership initiatives really become institutionalised as public policy, or internalised in public debate and attitude change.
   (ii) Reflecting this, public policies are inherently fragile. The capacity for implementing policy decisions may be limited, and policies, once initiated, may wither through neglect. Some states may need to move into 'campaign' mode in order to actually effect social change. NGO project-type interventions, with their inevitably limited impact, will continue to be important.
   (iii) The opportunities for open public debate, the promotion of a basic rights agenda, and real public education are limited.
   (iv) There is some capacity for mobilisation by people living with HIV/AIDS, but very little, and it is very dependent on patronage or protection by political authorities.

   In such states it is tempting to focus on the opportunities for influencing the leadership at the top, in the hope of obtaining a personal commitment from a national leader. However this should not neglect other priorities, including improving the institutionalisation of politics and the coherence and predictability of public policy. A rights agenda is also important.

4. *Institutionalised government with limited political freedoms* and minimal political competition. A wide range of welfare services may be provided, sometimes to excellent effect. But citizens can have little influence over these policies, and the opportunities for political mobilisation are extremely limited. There may be opportunities for developing technical skills and expertise, and also pushing for greater civil and political liberties.

   (i) Many of the leadership considerations noted in category 3 above also apply here. Note especially that the political colour of the leadership is vitally important: conservative, religiously-oriented leadership will be far less inclined to take the necessary actions than more liberal or left-wing leadership.
   (ii) There is much greater scope in such states for the systematic development of effective public policy. National institutions such as ministries are likely to have strong cadres of professionals, and to have credible sustainable programmes. Like all such institutions, some may be innovative while others will be highly

conservative and risk averse. NGO project type interventions are likely to be more effective in this policy environment, as they can augment national plans.

(iii) Promoting real behavioural and attitudinal change among the population is likely to be rather more difficult. Changes initiated by top-down public policy initiatives may achieve marked success in the short term, but the behavioural and attitudinal changes may be superficial and easily reversed, in the absence of a true open debate in which people are genuinely convinced of the need for change. Vigilance must be maintained in the aftermath of early successes to ensure there is no relapse. In left-leaning authoritarian states, the suppression of some conservative moral voices may assist in promoting public education on HIV/AIDS.

(iv) There are real if limited opportunities for both primary mobilisation and secondary activism. But their scope for influencing public policy is limited.

The strategy in such cases should be to exploit the opportunities that exist within the system as it is constituted, while also pressing for greater transparency and more civil rights, so that the anti-HIV agenda can be truly internalised within society.

5. *Institutionalised government with political competition.* These are stable and mature democratic states with legitimate organisations and civil and political rights. They normally provide a wide range of welfare services, and there is much debate and scrutiny of service provision. A wide range of groups have the scope to organise, and groups that are otherwise invisible politically (e.g. the handicapped, very small ethnic minorities and people living with HIV/AIDS) may find a voice. There are myriad opportunities for promoting the interests and mobilisation of the poor.

(i) Exercising leadership in such countries may be more challenging than in more autocratic states. Political leaders have to reconcile the demands of a range of constituencies, and must be vigilant in the light of scrutiny by an independent press (which may reflect reactionary political and moral viewpoints). Clear statements of leadership may be more openly contested by other political or social forces. Hence, the dramatic leadership initiatives possible in less open societies may not exist. However, the long-term impact of effective leadership is greater in such environments.

(ii) Public policy in such states is effective, comparable to or greater than in category 4 states. The making of public policy may be slower than in authoritarian states because of the demands for wide consultation and debate, but the results once achieved should be more sustainable.

(iii) Open public debate and a high degree of transparency on key issues is possible. However, highly open societies also provide opportunities for reactionary political and moral voices to be heard, which may make it more difficult to promote some of the necessary public education messages.

(iv) Given a context with the rule of law, free association and free expression, the capacities for both primary mobilisation and secondary activism on the issue of HIV/AIDS should be considerable.

In such countries, every tool for combating HIV/AIDS is available and should be utilised.

In addition, it is important to note the urban-rural divide: in many African countries, major urban centres count as a more well-established and formalised arena for government than

rural areas, which are generally more patrimonial, and less institutionalised. Some South African cities (e.g. Cape Town) undoubtedly fall in category 5. South Africa is a unique case requiring separate analysis: although one of the most democratic societies on the continent, the history of Apartheid and the associated discrediting of public institutions and public policy, have had serious negative repercussions for the ability of any government to influence public attitudes and behaviour.

This categorisation is helpful in showing the empirical link between greater political institutionalisation and respect for civil and political liberties, and opportunities for promoting effective public policy and social mobilisation. It underlines the basic fact that action against HIV/AIDS will be facilitated by the wider social, political and economic development of Africa. A campaign against HIV/AIDS cannot be a pretext for delaying or diluting the need for progress and change on these wider issues: instead social reform, respect for human rights, promotion of good governance are all intrinsic parts of the necessary mobilisation.

The Context for Social Action in Africa

The five categories of state indicates a difficult climate for effective leadership and social action in Africa. Clearly, conditions across Africa are highly variable, but some key points in common can be elaborated. In each case, a factor that seems to contribute to weakness in terms of conventional responses to the threat of HIV/AIDS, can also be an asset, when considered from another angle.

1. *Weakness of formal structures* including weakness of legitimacy of national political leaders. There is a huge confidence gap between national institutions, such as ministries of health and education, and the wider populace. This is based on a real history of unpredictable and ineffective public policy, and often on social policies that are coercive and even violent. Colonial, racist and mission-influenced educational policies have played their role in generating distrust. There is a huge amount of remedial work to be done to restore or establish the basic confidence among people that government institutions can operate for their benefit.

   But, by the same token, traditional beliefs and loyalties remain strong. The mobilisation of cultural traditions, customary leaders, and historical loyalties can play an important and positive role in organising African societies to combat HIV/AIDS.

   In addition, formal bureaucracies in Africa are 'soft' in the sense that bureaucrats can be influenced by factors other than institutional discipline. This is usually seen as a problem, seen in terms such as 'favoritism' and 'corruption'. However, can it not also be an advantage? If the extra-bureaucratic loyalties of civil servants push them towards implementing measures against HIV/AIDS that command widespread popular assent, but which may fall outside the strict requirements of their jobs, is that not to be welcomed? The challenge is to create a social and moral environment in which civil servants are encouraged in such a direction.

2. *Prevalence of personal or patrimonial rule*. Most forms of authority in Africa depend on the power of an individual, who has both political authority and the ability to dispense economic rewards, in the form of jobs, contracts, licences, or money. This operates at the level of nations, regions and villages. Much political activity becomes focused on court politics, including trying to get the ear of the chief, or setting up intrigues to remove rivals for favour. This makes any form of mobilisation around wider social issues more

difficult. However, by the same token, loyalties to place and family, and traditions of gift-giving, hospitality and care for the sick, are all positive traditions that can be the foundation for an effective agenda for care, treatment and the inclusion of people living with HIV/AIDS.

3. *Prevalence of armed conflict.* Armed conflict marginalises civil society and retards social mobilisation. It forces individuals and groups to identify with ethnic groups and political forces, narrowing the space for mobilisation around issues. Militarisation marginalises women and undermines their status. Where there is armed conflict, the opportunities for implementing all the measures for public education, service delivery, human rights and empowerment, are far fewer. As mentioned above, armed conflict tends to promote the transmission of HIV/AIDS.

   On the other hand, post-conflict reconciliation and reconstruction is a time for re-examining moral values and behaviours, and in this fluid context there may be greater opportunities for influencing attitudes towards HIV/AIDS and towards risky behaviour.

4. *Weakness of primary mobilisation.* Primary mobilisation does exist in Africa. Cases include pastoralist groups in Kenya and Tanzania over land rights, popular uprisings in Sudan in 1985 and Ivory Coast in 2000, and the pressure for democratisation and sovereign national conferences in the early 1990s. But it tends to be weak or transient. Outside South Africa there is virtually no primary political mobilisation of people living with HIV/AIDS. There are beginnings of social mobilisation around NGOs and local organisations, weak because of lack of resources and wider negative public attitudes. This lack of primary mobilisation is a weakness where it is essential to have an adversarial struggle to assert rights. But, primary mobilisation is less important if there is leadership, drawing upon social and cultural traditions, loyalties and obligations, that can develop an agenda for addressing the issue of HIV/AIDS within the community. The success of, for example, Uganda in containing HIV indicates how this can be achieved. This should not be an agenda for neglecting primary mobilisation, but for combining it with other forms.

5. *Weaknesses of secondary activism.* Initiatives by professional activists, chiefly local and international NGOs, play a key role in any actions to combat HIV/AIDS. They have filled a part of the gap left by the weakness of public policy and the absence of primary mobilisation. But there are a number of systemic weaknesses to this form of activism:

   (i) It tends to be project-based, with uneven coverage and uncertain predictability and sustainability.

   (ii) Projects may reflect the particular orientations and biases of the implementor or donor, leading to mixed messages. On the other hand, the multiplicity of approaches allows for experimentation and innovation.

   (iii) It often has weak linkages to primary mobilisation (if there is any). For example, while organisations of people living with HIV/AIDS are often concerned with care and treatment, major international donor projects tend to focus on prevention.

   (iv) For many reasons, secondary activism in Africa (local NGOs, both advocacy and programme oriented) tends to have a strong external orientation, reflecting the priorities, funding cycles and modes of activities of international donors, perhaps at the expense of sensitivity to local concerns. Local NGOs can be so eager to please their donors that they do not stress enough the demands of being sensitive to very local particularities. When dealing with an issue as complex and intimate as HIV/AIDS, this can be problematic.

(v) The links between adversarial, human rights-type activities and programmatic engagement are often weak. Many NGOs have been reluctant to criticise national and international leadership failures, even when these have been very evident.

Recognising these weaknesses, we must also see that secondary activism on the issue of HIV/AIDS has played an essential role in providing care, treatment, public education and activism. Without the level of concern by professionals in governments and NGOs, the HIV/AIDS agenda would not have reached the high level that it has. The commitment and mobilisation of professionals, civil servants (national and international) and NGO workers is one of the greatest resources in any struggle against HIV/AIDS.

6. *Strength of international linkages*. Public policy in Africa is highly internationalised. On one hand, it is dependent on aid donor assistance. On the other hand, there tends to be a regional coherence with neighbouring countries adopting broadly similar policies. There are also strong moves towards regional economic integration. This opens up options for initiatives to combat HIV/AIDS at a regional and subregional level, building on the coherence and regional identity that is strong in Africa. The high level of movement across borders that were artificially imposed under colonialism means that regional and pan-African co-operation is all the more necessary. Any inroads into containing the pandemic at a national level risks being undermined unless partnerships are forged with neighbouring countries. Moreover, successful efforts in one part of Africa will more easily replicated elsewhere in the continent, and progress towards, for example, generic drug production in one country can have an impact throughout Africa. But, at the same time, the need for sensitivity to local particularities is even greater.

   Africa is fortunate in that there have been a number of important regional initiatives, which have set standards for openness and leadership across the continent. The Durban conference was a landmark. The OAU took the unprecedented step, in its 2000 Summit in Lome, Togo, of discussing the HIV/AIDS pandemic. The attention given to the issue at the Africa Development Forum in 2000 is also important. The leadership provided by these continental institutions has challenged the continent: national leaders, local leaders, religious leaders, community leaders should all respond to the call for mobilisation against HIV/AIDS. The international connectedness of Africa is an asset in the mobilisation against HIV/AIDS, which is of course an international problem.

The particular context in Africa demands responses specifically attuned to the social, cultural and political realities of the continent. What appears as a weakness can, in the hands of creative and committed leadership, become a strength. Africa will need to develop its own unique combination of international best practice and African responses. This calls for the best leadership the continent can offer.

What has Succeeded?

The challenges are huge, but in some cases they have been met, at least in part. Many of the successes are 'below the radar' (as Collins and Rau put it): they are community level or NGO responses that are not properly acknowledged or documented. But others are clearly evident.

(i) *Uganda*, whose HIV rates peaked at a (then) staggering 14% in the early 1990s, was the first country in sub-Saharan Africa to reverse the AIDS epidemic. Today, Uganda has nearly halved its HIV prevalence to around 8%

by strong prevention measures. Even rural areas, which are frequently among the last to evidence signs of both the advent and the reversal of an HIV/AIDS epidemic, have shown a reduction in HIV rates. In some areas of rural Uganda, for example, HIV infection rates among teenage girls dropped to 1.4% in 1996-97, from 4.4% in 1989-90. This was matched by a fall in teen pregnancies. Among youth in general, HIV positivity rates have fallen dramatically.

President Yoweri Museveni was the first African head of state to take a strong public stand on the HIV/AIDS crisis. This was in response to the clearly-perceived threat posed by HIV in the Ugandan army. He instructed his ministers to mention AIDS on all possible occasions, and the Ugandan government initiated and cooperated with a wide range of initiatives.

However, enthusiasm should be tempered, because the measurement of success in combating epidemics is inexact. The stagnation, or even reduction, of cases in Uganda may well be due to President Museveni's exemplary HIV/AIDS policy, but we cannot be certain. For example, there is also a possibility that the reduction in numbers is consequent on the maturation of the HIV/AIDS pandemic. It is possible that HIV levels will 'naturally' stabilise at a lower level over time, irrespective of health policy interventions. Epidemiological research should thus be encouraged to allow for a clearer picture.

(ii) *Zambia*: In 1993, HIV rates among young women in Lusaka, Zambia, exceeded 25%, but they have been almost halved in just six years by effective HIV prevention. Premarital sex appears to be losing popularity: only 35% of young women in Lusaka reported premarital sex in 1996, a substantial reduction, and than half of young unmarried men reported no sex in the past year compared with just over a third two years earlier. Additionally, the frequency of casual sex is decreasing, as shown by a fall in the proportion of men reporting two or more casual partners in the past year.

(iii) *The Egyptian government* has helped set up an AIDS Hotline and Counselling Service. Staffed by counsellors and widely advertised, this anonymous hotline attracts thousands of calls and provides a vital link to HIV information and counselling services that would not otherwise be accessible. This is a significant step in a society where HIV vulnerability is heightened by cultural taboos that prohibit open discussion of topics such as sexuality, condom use, premarital sex and homosexuality.

(iv) *Zimbabwe* has established child-friendly courts in every province after finding that low rates of conviction in cases of sexual assault and rape, particularly of children, were usually due to lack of testimony. With the help of a friendly intermediary, abused children can testify in privacy without fear or embarrassment. They are also provided with male and female dolls to demonstrate the sexual acts to which they may have been subjected. More people are now bringing cases to trial, and the percentage of convictions is on the rise. The government also provides medical and psychological care to abused children through the Family Support Trust, a special service located within a major hospital in Harare. In 1998-99, over 5% of children aged 13-16 seen at the Family Support Trust were estimated to have become infected with HIV at the hands of their abuser.

(v) *Senegal* is at present the country with the lowest HIV infection rate in Africa. It is possible to identify three major factors directly determining exposure to

HIV infection and resulting in the low levels recorded in Senegal. First, sexual activity begins relatively late and extramarital sex is relatively limited. Secondly, condom use during extramarital sex, and especially during commercial sex, is high. Thirdly, STD control programmes are apparently effective.

The second and third of these factors are certainly linked to the country's AIDS prevention efforts. Late first sex and limited extramarital sex are probably determined more by social and religious values than by AIDS prevention messages. It is, however, plausible to imagine that these values are being reinforced and maintained by an AIDS prevention programme in which religious, community and political leaders are all actively engaged. Hence, it appears that Senegal's early and comprehensive prevention efforts have made a major contribution to keeping HIV infection rates low. But how was the country able to mount such a swift response, on such a massive scale, at a time when the country was struggling through particularly difficult economic times? The answer must lie in part in political leadership, and in part in the country's social organization. Political leadership laid the groundwork for a productive dialogue with religious and other community leaders. A long and active tradition of community participation in health and development was mobilized around AIDS prevention activities. Maximum use was made of existing structures to provide information and services to communities at high risk, especially sex workers. A pragmatic approach to public health—emphasizing prevention and the provision of essential services— provided the foundation for strengthened efforts at STD control and the widespread promotion of condoms.

Clearly, there was much in the social structure of Senegal as well as in the structure of its health services even before the advent of AIDS, that favoured a response once the threat of an HIV epidemic became clear. But it was the determined use of those existing advantages to generate a national response early on that can be credited with the fact that, at the end of the 1990s, Senegal had one of the lowest rates of HIV infection in sub-Saharan Africa. (UNAIDS, June 1999).

The above examples are all encouraging and invite action along similar lines. But an extremely cursory survey such as this cannot provide a foundation for analysis or recommendation: far more research is required to identify what really has caused HIV levels in these cases to stabilise or fall. What these cases indicate is that, with the right conditions and the right leadership, the HIV/AIDS pandemic can be tackled, contained and overcome. The challenge is to repeat these successes across Africa and continue until the pandemic is truly defeated.

Conclusion

HIV/AIDS is probably the most serious leadership challenge facing Africa since independence. It is easy to become fixed on what Van Der Vliet calls 'the grand solution': 'be it biomedical (a vaccine which prevents infection or a drug that cures it), social (the elimination of poverty, war, labour migration, exploitation, oppression, irrationality and greed, from the human condition), or behavioural (chastity before marriage and fidelity thereafter and the elimination of injectable drugs...)'(1996: 120). In fact, HIV/AIDS will be

contained by a broad coalition of groups, institutions and individuals, acting in a common cause.

An effective response to the pandemic requires an extraordinarily broad range of initiatives. HIV/AIDS is intrinsically difficult to manage, extremely so. It is one of the most inaccessible subjects for political mobilisation: organising for war or democratic reform is by contrast a much easier task. Mobilising public policy against HIV/AIDS is like trying to overcome illiteracy, end domestic violence, establish basic social rights, and provide universal primary health care all at the same time. It is asking too much of the response to HIV/AIDS that it achieves all the above. Nonetheless, such underlying causes must be tackled and there remain some very simple steps that, if properly implemented, would have a major impact: for example distributing free condoms, testing for pregnant women and providing drugs to reduce mother-to-infant transmission during birth, well-known people living with HIV coming out and admitting their status in public.

As this paper should have made clear, responding to HIV/AIDS can only be undertaken in the context of a wider leadership approach to a range of social, political and economic problems affecting Africa. A strategy to combat HIV/AIDS will require, first and foremost, an open debate across the continent, that provides an opportunity for all, including people living with HIV/AIDS, to have their voices heard. This in turn requires an agenda for basic civil rights; to provide legal protection for those living with HIV/AIDS when they decide to speak out publicly.

Many of the bio-medical, public education and wider public policy requirements for effective action to contain HIV/AIDS are becoming well established through research. The next step, of translating this into real public policy, that is consistent, effective and credible, is more challenging still. This can be done only by a combination of leadership (at a national and international political level), alongside social mobilisation at all levels within Africa. The leadership skills and approaches required are very different from those demanded for conventional political struggles: this leadership cannot mobilise on the basis of nationalistic certainties, but rather on the basis of promising openness, tolerance and a readiness to change. These are not qualities for which Africa's leaders are well known, but they are qualities they must acquire if they are to play a role in combating HIV/AIDS.

As this paper has attempted to show, remarkable progress has also been made in raising the issue of HIV/AIDS and developing strategies for response. Africa may suffer from great weaknesses in its struggle against HIV/AIDS, but African societies and cultures also have great resources and strengths that can—and must—be drawn upon. One of the challenges is to bring these resources to bear on the crisis, and to integrate the human, caring, rights-based, inclusion agenda for the 23 million Africans living with HIV/AIDS, with the ultimate agenda for preventing transmission. Africa's goals must include the treatment, care, and respect for those living with HIV and AIDS, as well as prevention. If Africa can set realistic but ambitious goals for the containment of HIV, then it will be possible to achieve success.

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