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The political environment of HIV: lessons from a comparison of Uganda and South Africa

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Abstract

Considerable interest has arisen in the role of governance or political commitment in determining the success or failure of HIV/AIDS policies in sub-Saharan Africa. During the 1990s, Uganda and South Africa both faced dramatic HIV/AIDS epidemics and also saw transformations to new political systems. However, their responses to the disease differed in many ways. This paper compares and contrasts the ways in which policy environments, particularly government structures, can impede or expedite implementation of effective HIV prevention. Four elements of these environments are discussed—the role of political leadership, the existing bureaucratic system, the health care infrastructure, and the roles assigned to non-state actors. Two common international strategies for HIV prevention, syndromic management of sexually transmitted infections and sexual behaviour change interventions, are examined in relation to these elements in Uganda and South Africa during the mid-to-late 1990s. During this period, Uganda's political system succeeded in promoting behaviour change interventions, while South Africa was more successful in syndromic management efforts. Interactions between the four elements of the policy environment were found to be conducive to such results. These elements are relatively static features of the socio-political environments, so lessons can be drawn for current HIV/AIDS policy, both in these two countries and for a wider audience addressing the epidemic.

Introduction

The explosive rate of spread of HIV/AIDS across Africa has created one of the greatest crises of modern times. Yet other regions of the world are now seeing evidence of the beginnings of new large-scale epidemics. One of the most pressing questions facing governments and international aid organisations is how to mobilise sufficient financial, technical and political resources to fight the pandemic. For nearly two decades, international organisations have promoted technical guidelines for national HIV/AIDS control programmes, and those experienced with dealing with the disease now acknowledge that national prevention efforts need to address HIV through multiple sectors, involving initiatives that cut across social life. Two common components at the core of many internationally recommended HIV prevention programmes are the treatment of sexually transmitted infections (STIs) to reduce risk of HIV transmission, and interventions to change sexual behaviour to reduce risky activities (see Table 1). While often generalised in their prescription for HIV prevention internationally, the technical nature of these two interventions for HIV prevention requires different approaches to implementation.

Table 1. Details on two common interventions for HIV/AIDS prevention

Policy/ intervention	Description	Rise on the international agenda	Implementation	Impact
Syndromic management	Staff at local health centres are trained and provided with drugs to treat STIs according to algorithms which address specific sets of symptoms, rather than relying on clinical diagnosis.	Syndromic management emerged in the late 1970s from researchers and public health physicians working in sub-Saharan Africa who had to treat large numbers of STIs with limited resources (Lush, Walt, & Ogden, 2003). In the late 1980s, the WHO adopted syndromic management as policy and began to promote the strategy globally in the form of simplified guidelines.	Implementation was more complex than anticipated (Mayhew, 1999). In general, syndromic management has proved relatively popular among public sector health workers in sub-Saharan Africa. However among physicians in both public and private sectors, uptake has been much lower and syndromic management is perceived to be inferior to clinical diagnosis and management (Dehne & Snow, 1999)	A trial of using syndromic management to treat common STIs in primary health care settings in Mwanza Tanzania showed a 40% reduction in HIV transmission compared to control areas (Grosskurth et al.1995). Nevertheless, this impact has not been replicated on a national scale due partly to difficulties with implementation and differences in the specific nature of the epidemic in Mwanza.
Behaviour change interventions	Interventions may promote delayed sexual debut, reduced number of partners, reduced coital frequency, increased condom use, or some combination thereof.	Promotion of behaviour change has been a central component of HIV/ AIDS prevention strategies since the WHO's Global Programme on AIDS, formed in 1987. One of its first strategies was to call for health education to promote behaviour change (World Health Organization, 1989)	Altering behaviour is a difficult task, relying on influencing individuals' beliefs and personal practices. (Berkley, 1994; Cleland, 1995). People change behaviour for different reasons and a diverse population will require a range of messages and approaches.	Many different approaches have been shown to achieve some limited positive results, but none stands out as particularly effective (UNAIDS, 1999). Individually oriented messages may have an effect on some, others may be more influenced by social norms or environmental

				constraints and the presence of multiple messages from number of approaches (designed for specific communities) will have the greatest chance of producing desired health promoting changes.
	There is no set procedure or algorithm advocated for behaviour change. UNAIDS has categorised interventions emerging from various theories as focussing on individuals (such as the health belief model), social factors, or those which are structural and environmental in orientation (UNAIDS, 1999)		This need for diversity is often understated when HIV/AIDS prevention activities are being designed at national and international levels.	

Policy transfer between international and national levels is a complex process in which rational, linear views fail to represent adequately the multiple channels of learning and communication with their inherent power and interest relationships (Walt, Lush, & Ogden, in press). Each country's political environment has its own HIV/AIDS policy trajectory, into which international guidelines must be translated (Lush et al., submitted; Parkhurst, 2003). In trying to understand this process, some international actors have attempted to evaluate governments' efforts to introduce HIV interventions according to criteria such as political commitment, sometimes going as far as to develop rigid definitions of, or even quantify, government commitment to HIV/ AIDS prevention (Stover, 1999). Recent global interest in governance and development has furthered the debate around what constitutes 'good HIV/AIDS governance'—in particular, highlighting the importance of political leadership and identifying reasons why some leaders feel able to contribute political capital to HIV/ AIDS where others do not (Putzel, 2003). This literature, while useful, does not yet incorporate the role of other more institutionalised elements of the political environment—such as the health system and non-state actors (Moore & Putzel, 2000; Patterson, 2001). In addition, the analysis has been somewhat general—looking at overall AIDS efforts rather than specific policies.

The objective of this paper is to analyse the political circumstances which facilitated or constrained the implementation of particular HIV prevention programmes with the central thesis that different system structures may be particularly conducive to certain types of policy. We compare two policies

—syndromic management of STIs and sexual behaviour change interventions (see Table 1)—in two countries—South Africa and Uganda at points in their recent history. Specifically, our focus is on how the political, bureaucratic, and health systems contexts within each country influenced these prevention initiatives. More comprehensive reviews of HIV prevention history, policy and epidemiology in these countries have been undertaken elsewhere (readers can look to Bond & Vincent, 1997; Kalibala, Rubaramira, & Kaleeba, 1997; Epstein, 2001; Okware, Opio, Musinguzi, & Waibale, 2001; Parkhurst, 2002 for discussion on Uganda, and Abdool Karim, Matthews, Guttmacher, Wilkinson, & Abdool Karim, 1997; The Economist, 1998; Schneider, 1998a,b, 1999; Schneider & Stein, 1997 for South Africa). Here we compare experiences of two technical HIV prevention initiatives in light of four specific elements of political contexts: political leadership, the bureaucratic system, the existing health infrastructure, and the state's engagement with non-government actors.

Research methods

This paper draws on research undertaken for two independent investigations of HIV-related policy making in Uganda and South Africa. In both cases, research methods included a comprehensive review of national and international policy documents for HIV/AIDS using on-line databases, physical searches of institutional libraries and personal recommendations. Policy-oriented publications included a large number of technical reports and unpublished (grey) literature.

Semi-structured interviews were conducted with key decision makers in policy making bodies in Ministries of Health, provincial and district health offices, donor agencies, NGOs, and academic institutes. Triangulation of interview data with that obtained from document review was a principal method by which the reality of HIV prevention programmes was disentangled from the many versions of events obtained from such a wide variety of sources.

Fieldwork took place in Uganda during 1999 and 2000 and in South Africa in 1998. The time periods under investigation have to some extent been overtaken by events in both countries and international HIV/AIDS policy has developed rapidly, especially in the area of HIV treatment and care. Nevertheless, prevention remains a public health priority and lessons from previous eras are important for current policy decisions. We therefore focus our analysis on the period for which empirical data were collected (mid 1990s), combining this with on-going reviews of the literature, to draw historically informed lessons about political context for future policy development.

Choice of countries and historical background

Uganda and South Africa provide useful comparison in a number of ways. Uganda faced a period of civil war from the 1970s until 1986, when President Yoweri Museveni and the National Resistance Movement established a reasonably stable and democratic government (Ruffert, 1997). South Africa similarly saw a radical change to democracy in 1994 with the ascendance of the African National Congress under Nelson Mandela and the end of the Apartheid regime (Spence, 1999). Around the time of these transition periods, both countries also saw explosive HIV epidemics, with advanced spread of the disease into the general population. Uganda has in the past been considered one of the countries worst hit by HIV/AIDS (Boahene, 1996), although today it is southern African nations that hold that dubious distinction (UNAIDS, 2001). Finally, both Uganda and South Africa established national AIDS control initiatives, originally developed and implemented in the year of the change of government (Department of Health, 1997; Uganda AIDS Control Programme, 1987).

However, the two countries also possess significant differences. South Africa is the richest country in sub-Saharan Africa and the region's only truly industrial economy—gross domestic product (GDP) per head in 2000 was US$2941, although inequalities in access to this wealth remain stark (McIntyre, Bloom, Doherty, & Brijlal, 1995). Similar inequalities exist in access to services, with large variations in provincial expenditure on health by province (Central Statistics Service, 1997). Uganda, meanwhile, remains a rural, agriculturally based country, among the world's poorest with an estimated per person GDP of US$249 in 2001 (according to World Bank estimates of total GDP and total population). Furthermore, their two histories of political transition to democracy led to important differences in policy implementation structures, such as their bureaucratic systems and the development of health infrastructure.

The two countries' HIV/AIDS trajectories were also markedly different. While Uganda is often described as an HIV 'success story', HIV prevalence peaked at nearly 31% among women at urban antenatal surveillance sites in 1990—although rural sites saw considerably lower rates. Today, Ugandan figures have substantially declined, while South Africa has urban antenatal prevalence of 24% (Fig. 1), albeit with indications that rates may be beginning to decline (UNAIDS, 2002a). Uganda's HIV response has commonly been described as 'open' in many ways, with numerous groups such as NGOs, church-based organisations, donors and self-help groups operating alongside government interventions in the county (Parkhurst, 2001). By contrast, despite being much wealthier and in a stronger position to address health challenges, the South African government faced a number of years of acute controversy and difficulty implementing effective HIV/AIDS control programmes (Campbell & Williams, 1999; Kaiser Weekly HIV/AIDS Reports, 2001; Schneider & Stein, 2001; Volmink, Matchaba, & Zwarenstein, 2001).

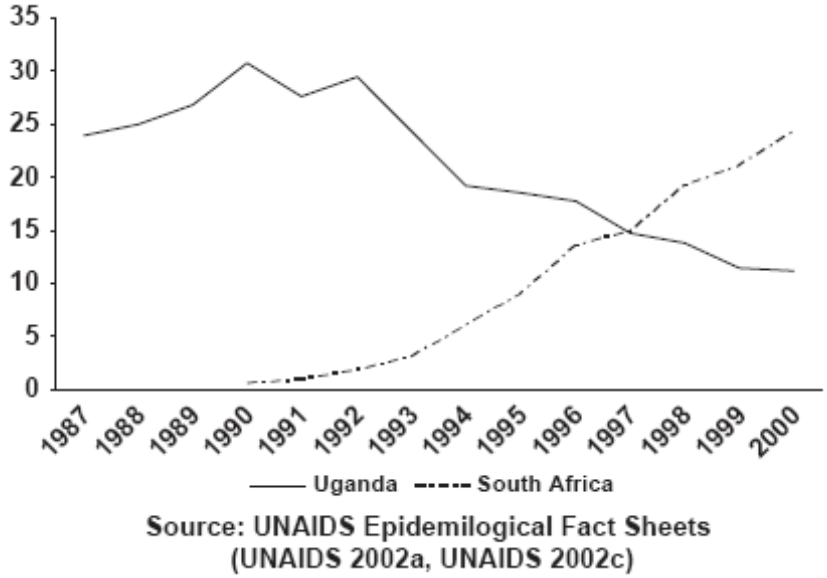

Fig. 1. Urban antenatal HIV prevalence in South Africa and Uganda. Source: UNAIDS Epidemiological Fact Sheets (UNAIDS, 2002a,c).

It is difficult to link changes in HIV prevalence to specific policies or individual interventions, and any broad epidemiological and policy evaluation statements would clearly be simplifications. Uganda

faced many HIV challenges but there is a general acceptance that early active governmental response was pivotal. While, there is continuing debate about the explanations for the decline in HIV seen in Uganda (be it delayed sexual onset, increased condom use, or some combination), there is a common view that Uganda managed to reverse the disease spread. The national response in South Africa was radically different, with a history of contestation and even at times denial of the link between HIV and AIDS. However, although the government faces national HIV prevalence rates higher than what would have been seen in Uganda at its peak (UNAIDS has estimated a prevalence between 10% and 20% in 1991 (UNAIDS, 2002b)), South African HIV policy was also successful in some areas. This paper, therefore, does not attempt to answer the question of what specific interventions led to the declining HIV prevalence in Uganda or the current high rates in South Africa, but instead discusses how the particulars of the political environment in the two countries in the mid-1990s may have accounted for the different histories of implementation of common HIV prevention policies.

Political contexts

In South Africa and Uganda, systemic factors within the government played important roles in both hindering and facilitating the implementation of wide-reaching HIV/AIDS initiatives. Below, we compare the two countries in terms of the role of political leadership, the bureaucratic system, the health care infrastructure, and relations with external donors and NGOs (Table 2). In the next section, we examine how these factors influenced development of two HIV/AIDS policies.

Role of leadership—contestation for power vs. need for coalition building

The importance of senior political leadership in promoting, supporting and sustaining HIV/AIDS interventions cannot be ignored. Many authors have already discussed the roles of President Museveni in Uganda and President Mbeki in South Africa—with the two leaders often portrayed as opposites in their approach to the problem (Schneider & Stein, 2001). According to Schneider, South African discourse over HIV/AIDS was part of a larger struggle for authority and control of information by the state (Schneider, 2002). As a middle-income country, South Africa is in many ways self-sufficient, and is under pressure to act as a leader of the continent, setting an example in the move away from Western dependency. In the field of HIV/AIDS, Mbeki has similarly attempted to oppose the dictates of the West and listen to dissenting opinions.

Table 2. Comparison of political and administrative structures in South Africa and Uganda

Feature of political/ administrative structure	South Africa	Uganda
Role of political leadership	Highly centralised leadership relying on political consensus and alliance Disinterested in HIV/AIDS Plagued by scandal in relation to AIDS Major transformation to occupy them	Central government seeing non-isolation of political groups and non-sectarianism as key priorities Decentralised to an extent but still important central government Central government widely open and interested in HIV/AIDS, with calls for all government representatives to take up the issue in their communities
Bureaucratic system	Federal system since 1994 with relative provincial independence	Restructured bureaucracy from 1986 Representation structure

	Strong central policy making and formulation capacity Weak provincial implementation capacity Sunset clauses	from grassroots level upwards to national parliament Variable District capacity Overall weak bureaucracy, many alternative service providers
Health care infrastructure	Equity and financing are major issues AIDS programme weakly supported nationally and isolated Provincial focus on integration not vertical programmes Transformation of health system complex	Weak health infrastructure, lack of trained service providers Slow rehabilitation since end of civil war period in 1986
Roles of external donors and NGOs	Not a strong role for donors in general In AIDS, more donor money at national level: STI technical assistance; condom promotion; education materials Harder for donors to fund implementation NGOs legacy of political activism Association of AIDS with previous racist population control programme Recent advent of TAC Great variation by province	NGOs and donors play a large and active role in service provision for health. Many independent community-focused HIV prevention messages Funding can be tapped from a wide network of sources as well as from state and local governments

Despite recent high-profile statements on HIV/AIDS, Mbeki's predecessor, Nelson Mandela (who was in power during this research) placed HIV relatively low on the political agenda. At a time of radical political transformation in the country, some argue that in many ways the window of opportunity for preventing the epidemic's rapid rise was missed (Campbell & Williams, 1999). The new democracy relied on politics of consensus and inclusion, and issues seen to threaten the delicate balances of power were sidelined (Spence, 1999). What political attention to AIDS there was became tainted with scandal and mismanagement, with a number of intense debates and conflicts between 1994 and 1998, including bickering around the apparent discovery of a new drug, Virodene (a highly publicised treatment embraced by government but found to be ineffective), and accusations of corruption in the development of an educational play, Sarafina II. Despite support for HIV initiatives from the then Minister of Health, Dr. Zuma, this political context overshadowed the programme. Political tensions around HIV have continued under Mbeki's rule in relation to prevention of mother-to-child transmission of HIV and access to antiretroviral drugs.

Ugandan President Museveni chose a contrasting role. From early in his administration Museveni talked openly about AIDS as a problem all Ugandans must face, making sure to mention it in his public speeches around the country, and publishing articles on the subject (Museveni, 1993; Museveni, 1998). As in South Africa, the new democracy relied on consensus and inclusion, but while South Africa seems to have deliberately kept the controversial issue of AIDS off the agenda, Uganda took the opposite approach. AIDS was placed high on the national agenda, with the government

calling for all groups to act to prevent it. Similarly, one early government document explicitly called upon public leaders to 'use every opportunity when they address the public to warn them against AIDS and to give them guidance' (Uganda AIDS Control Programme, 1989).

There is clearly an important role to be played by national leaders. Nonetheless, emphasising the importance of leadership is not sufficient to explain sustained outcomes. The context in which these leaders worked both shaped their views and affected the extent to which they could influence their constituencies by creating incentives, or disincentives, for action. The power and capacity of the bureaucracy, the state of the health infrastructure, and the role of outsiders were all key elements of this context.

The bureaucratic system

Walt (1994) has discussed how bureaucratic systems, and civil servants within such systems, have significant power over policy formulation and implementation, 'especially when civil servants have careers and stay in place while politicians change' (95). One of the most important differences in the bureaucratic structure between Uganda and South Africa was their flexibility, including the extent to which civil servants maintained their positions over the transition period. Schneider and Stein (2001) explain how, in South Africa, the bureaucratic legacy of the apartheid regime acted to hinder the implementation of the HIV/ AIDS plan as envisaged before the change of government in 1994. With the new government, a quasi-federal system was established under which provincial political institutions secured substantial independence, including, in 1998, the right to allocate centrally determined budgets as they saw fit. A system known as the 'sunset clauses' guaranteed job security to civil servants to maintain bureaucratic structures in the early transformation period (Welsh, 1999). These structures developed under a system of repression and as a result were typi.ed by inflexibility and difficulty in cooperating with the new government (Schneider & Stein, 2001).

At the change of government in 1986 in Uganda, however, no such accommodation was made for the existing political system—indeed, while South Africa had a well-established and dominant civil service, the post-civil war situation in Uganda was quite the opposite. As a result, Uganda established a completely new political structure through the Resistance Council system. This was a decentralised system of representation built from the grassroots level upwards—rather than top down (Nsibambi, 1991). A further national decentralisation policy was established in 1993 which attempted to give districts more autonomy in service provision and budget allocation, although today the national government still wields considerable power and budget control.

A second key feature of the bureaucratic system in South Africa was the difference in technical and managerial capacity between national and provincial authorities. Central-level capacity to develop technically sound, internationally informed policy was extremely high. The new federal system, however, made implementation the responsibility of provincial administrations which varied in their capacity to deliver public services effectively (Human & Strachan, 1996). Thus while provinces such as Western Cape and Gauteng enjoyed efficient management of public services, in the Northern Province and Eastern Cape, managers were overwhelmed by new responsibilities, administrative restructuring and negotiating new relationships with previous political enemies. This gap between policy formulation and implementation capacity was further played out in local district and municipal administrations which enjoyed considerable independence while varying in their capacity for service delivery (Welsh, 1999). The result was that despite reasonably generous national

HIV/AIDS budget allocations and international donor support, there were problems with expenditure and programme implementation in the provinces.

In Uganda, there were also great differences in capacity between larger well-established districts and newly created, small or remote districts. However, the Ugandan bureaucracy was much less important for HIV prevention than that in South Africa. The government lacked capacity to implement and control a wide range of activities while non-state actors played a large and relatively autonomous role in undertaking AIDS-related activities. Bureaucratic logjams thereby affected on the ground prevention activities less than was the case in South Africa.

Health care infrastructure

One of the most notable differences between Uganda and South Africa after their political transitions was in the level of development of their health infrastructures. The new South African government inherited a well-established and technically functioning health system, with a network of hospitals and around 56 doctors per 100,000 people (according to 1996 WHO health indicators). Although this figure hides large inequities in access to care, even the poor in South Africa benefited from better health services than many in sub-Saharan Africa.

In Uganda, on the other hand, the new government acceded to a health infrastructure typical of many developing countries, challenged by shortages of funds, human resources and drugs, and poor access to services for much of the population (Ablo, 1998). This situation was exacerbated by the breakdown of health services during the civil war period (Dodge, 1987; Macrae, Zwi, & Birungi, 1993).

These health systems set the stage for the development of HIV/AIDS policy. South Africa framed its HIV prevention activities in light of a strong, centrally controlled and developed health infrastructure, while Uganda did so in the opposite setting. The South Africa situation was conducive to health interventions requiring standardised protocols and adequate supplies, while the Ugandan situation could not easily support such interventions, instead being susceptible to independent service provision and variability in approaches on the ground.

Relations with donors and NGOs

Relationships with non-state actors also varied hugely between the two countries during and after their transition periods. Until 1994, the Apartheid government had rendered South Africa an international pariah, with few links to international organisations and limited donor funding (Schneider & Gilson, 1998). The country's mineral wealth also helped it avoid the debt that burdens much of Africa and, after the change of government, South Africa was not heavily dependent on foreign aid. Nevertheless, USAID, DFID, the EC and the Belgian government all supported technical assistance in the National AIDS Programme, including condom procurement and distribution and the development of educational materials. Their support was, however, concentrated at national level, providing technical input into policy formulation and programme start-up, rather than supporting implementation at provincial level.

Similarly, in the context of a strong health system, NGOs did not play major roles in HIV/AIDS prevention programmes in the post-Apartheid period. Local NGOs (including civil society and advocacy groups) burgeoned in South Africa during the Apartheid era out of a context of civil mobilisation and resistance to the state (Schneider, 2002). In the period running up to the 1994

elections, many of these local groups provided vocal contributions to the development of HIV/AIDS policy. The 1994 National AIDS Plan was developed through a highly consultative process run by the National AIDS Coordinating Committee of South Africa and was accorded the status of Presidential Lead Project in recognition of the seriousness of the epidemic (Schneider & Stein, 1997). However, in 1994, the shift of many senior staff into positions in the new government administration weakened the NGO community.

Since then, relations between NGOs and government have become increasingly tense with the government often responding defensively to criticism from such groups. Furthermore, despite the change of government, popular perceptions of public health messages targeting sexual behaviour were tainted by association with the former regime's racist population control programme (Chimere-Dan, 1993; Kaufman, 1997) thus hindering the involvement by local groups in such campaigns. During the late 1990s, relations between the state and NGOs soured further with explicit contestation between the South African state and key advocacy groups over access to treatment (Schneider, 2002).

These experiences contrast with those of Uganda where the state engaged much more with the international aid community and encouraged NGO service provision. In Uganda in 1986, the breakdown of the health sector led the international community rapidly to establish projects and services. Macrae et al. (1993) describe how there was no coherent national health policy at this time, and so rehabilitation of the health sector was totally dependent on external support. By 2000, around half of the health budget was provided from external sources through a sector-wide approach (Ministry of Health, 2001).

HIV prevention initiatives resulting from this took the form of diverse and unintegrated programmes supported by a wide number of international groups. Donors or NGOs selected specific districts to work in with great variability in activities, services, funding and capacity. District-level activities were complemented by long-term partnerships between sectors at national level—nonstate groups participated in national policy bodies, such as the National Committee for the Prevention of AIDS, and its successor, the Uganda AIDS Commission.

Since it lacked the ability to undertake country-wide prevention activities, enabling outsider support was a logical coping mechanism for the Ugandan state which acknowledged a major HIV/AIDS problem. The resulting system created opportunities for variation and experimentation in HIV/AIDS efforts. In contrast, the weaker relationship between the South African government and the international community meant that the central government imposed a stronger imprint on the development of HIV prevention policy.

Results for programme implementation

These differences in bureaucratic structures, health systems, and relations with non-state actors in the two countries played important roles in shaping their implementation of particular HIV prevention activities.

Uganda

Uganda saw continual decline in HIV prevalence from the 1990s. Debate continues attempting to link these changes to particular sets of interventions, but most likely it was a combination of numerous interventions by government and non-government actors that led to sustained

population-wide behaviour change. The Ministry of Health developed widespread education and awareness raising campaigns, using a variety of media including print and radio messages in multiple languages to raise awareness. Screening and testing facilities were also established early on, with support from international donors. A vast network of organisations worked on AIDS-related activities, including community-based organisations, church-based groups, and international NGOs—many of which developed their own prevention messages tailored to individual communities. Funding to these organisations came from an equally complex network, supported by international bilateral and multilateral donors and .owing both directly and through government structures.

Rather than opposing such a wide network of actors and activities, the government of Uganda acted strategically to support it. First, President Museveni spoke openly about the need for all Ugandan's to fight HIV/ AIDS, providing leadership for other government officials to follow. The government made explicit calls to include NGOs in service provision (Ministry of Health, 1993; Uganda AIDS Control Programme, 1999). In managing the diversity of actors, the state avoided strong policy lines, and did not dictate the 'right way' to prevent the spread of HIV. For example, church groups re-worded the country's early 'love carefully' message for their 'love faithfully' campaigns (Ministry of Health, 1987; Twaddle & Hansen, 1998). Only later did government documents openly discuss condoms, pursuing first a 'quiet promotion of condoms', inviting religious leaders to participate in discussions of condom policy (Condom Coordination Unit, 1999; Uganda AIDS Commission, 1994). This combination reduced conflicts between interest groups, and today religious organisations accept the government's role in promoting condoms, even if they personally disagree with it (Parkhurst, 2001). The provision of education and awareness raising messages also supported the activities of NGOs, as they could shape their interventions to specific local constraints, building on a previously established information base. Macintyre, Brown, and Sosler (2001) also found higher levels of disclosure of HIV status and lower levels of denial in Uganda than in other countries.

By contrast with the success in promoting behaviour change initiatives, a widespread use of syndromic management for STIs was not a strong feature of Uganda's HIV/AIDS response. The Ugandan government established an STD programme in the Ministry of Health, and international initiatives promoted syndromic management from the mid 1990s, including a US$66 million World Bank funded project starting in 1993 (Kagimu, Marum, & the AIDS Prevention and Control Activities Review Team, 1996; World Bank, 2003). Yet the infrastructure and capacity constraints within the health sector limited the implementation of these efforts. While the syndromic management approach was the current practice in Ugandan health centres, treatment protocols were not well known, with a variety of possible drugs given (Weissman et al., 1998). Constraints to the effective implementation of this policy included a limited number of personnel trained in syndromic management, poor delivery systems for drugs, and irregular supplies (Government of Uganda, Uganda AIDS Commission, & UNAIDS, 2000).

South Africa

Needless to say, the South African experience was fundamentally different. Microbiologists keen to develop appropriate STI treatment for primary health care settings initiated efforts to promote syndromic management in the early 1990s. Later, the Department of Health scaled up these efforts through a highly consultative process (Schneider, Lush, & Ogden, 2003). In the 1997/98 HIV/AIDS operational plan, STI management was specifically highlighted and the national AIDS programme allocated significant financial and technical resources to a concerted effort to mobilise support for the new guidelines at all levels of the health system. The effort was widely successful within public

sector health clinics across the country (Mayhew, Lush, Cleland, & Walt, 2000; Schneider et al., 2003). Unlike Uganda, South Africa possesses the domestic capacity and infrastructure to provide these services.

Behaviour change efforts were also developed by the national AIDS programme, including youth-oriented life skills programmes, mass and targeted communication strategies and condom promotion. Budgets were allocated specifically to encourage partnerships with NGOs and representatives of people living with HIV/ AIDS. Nevertheless, the clarity of these plans belies the confusion and mismanagement which characterised the implementation efforts during the post-transition period. For example, the budget allocated for HIV/AIDS in the fiscal year 1998/99 was inexplicably and suddenly halved from 100 million Rand to just over 50 million Rand (Lush, 2000). Simultaneously, a new office was established to coordinate HIV/AIDS programmes through an interministerial AIDS committee, under the then Deputy President, Thabo Mbeki, suggesting high-level political commitment. However, the position went unfilled for months and, when occupied, had weak authority over the line departments responsible for developing and implementing relevant activities (Lush, 2000). Development of a parallel implementation plan for this new office also undermined unity in government and heightened insecurity in the beleaguered Department of Health. As a result the ability of the new office to support specific policy activities was compromised and political capital gained by the raised attention to the issue was lost.

At a community level, awareness of AIDS in South Africa remained patchy and characterised by myths, conspiracy and denial for several years. While knowledge of HIV and means to prevent transmission was high, open discussion was highly stigmatised and this did not translate into changed behaviour. Unlike the deliberately inclusive approach seen in Uganda, Schneider explains how ‘‘the AIDS policy process in South Africa [was] marked by very public disagreement and almost complete non-accommodation between senior (ANC) politicians and a range of non-governmental actors in South Africa’’ (Schneider, 2002, p. 146). Similarly, government efforts to foster local-level initiatives faltered in a context of increasing insecurity among the ANC political elite and the steady erosion of alliances which functioned so effectively through the early years of the democratic state. Only later did NGOs cohere around a different campaign to gain access to anti-retroviral drugs.

Conclusions

HIV continues to spread at alarming rates across many countries of the world. While international recommendations can provide some guidance on the various means to slow this spread, countries must implement these recommendations within specific political and health system contexts. This paper looks at two countries in sub-Saharan Africa during the 1990s to highlight their experiences implementing two common HIV prevention programmes—sexual behaviour change interventions and syndromic management of STIs. In examining their political contexts, we focused on four elements of the policy environment in each country— political leadership, bureaucratic system, the health infrastructure and relations with external actors. Each of these elements influenced the implementation of these policies uniquely, and furthermore, interacted in complex ways.

The Ugandan situation was particularly conducive to achieving a diversity of locally tailored behaviour change messages. Behaviour change advocacy requires consultation with wider groups in society in order to ensure that policies are in tune with popular attitudes and beliefs in the sensitive area of sexual behaviour. In a number of ways, the Ugandan government provided an enabling environment for a wide range of intervention messages, with no one policy line being pushed too

strongly, and an overall grassroots orientation to representation and democratic participation. In addition to the leadership of the presidency, which has been widely reported, the flexibility of the Ugandan bureaucracy and the continual engagement with donors and NGOs further enabled the country to see a diversity of messages which may have been a key factor behind any sexual behaviour change to reduce HIV transmission. Uganda's limited bureaucratic and health system capacity, however, limited its ability to implement a widespread STI management programme, despite this being a component of the national HIV policy and receiving substantial resources from international donors. Here, political leadership played a muted role—the technical nature of the intervention perhaps providing disincentives for greater engagement.

In South Africa, the existing strong state, with a rigid bureaucracy and significant domestic capacity was not dependant on NGOs for service provision or donors for finance. The approach of the Department of Health was particularly exclusionary during the period studied. Syndromic management is an example of a policy which lends itself to national government-led approaches, since it relies on standardised clinical algorithms based on international guidelines. South Africa introduced syndromic management successfully into the public health system through a careful process of consultation with professional cadres at all levels. In keeping with the weak links between state and non-state, however, private providers remained outside the system and antagonistic to the approach. Similarly, in order to stimulate sustained behaviour change, the government needed to facilitate the necessary diverse messages on the ground through contact with external actors at local levels. NGO strategies were dynamic and evolving, however, with many years of difficulty adjusting to their new role in the South African system. At the time of fieldwork, relations with the state in the area of HIV/ AIDS were worsening, as evidenced in the later conflicts over treatment.

The HIV policy situation in these two countries has unsurprisingly changed since the late 1990s, in particular with treatment issues rising in prominence. The South African epidemic has continued to grow to rates higher than were ever seen in Uganda with significant contestation between the President Mbeki and external actors over the cause of AIDS and how to treat it. In Uganda, the epidemic has been in decline, while treatment has slowly become available, if only to small groups.

The elements of the political system we have examined have, however, changed only incrementally, as they reflect underlying, embedded socio-political institutions. Comparison of the historical experiences of these two countries, therefore, illuminates the potential areas in which political context can affect the implementation of HIV strategies. Interactions between the four elements will continue to influence policy development. For instance, political leadership on HIV/AIDS in South Africa might channel resources to build health infrastructure capacity to deliver HIV treatment and care equitably. Similarly, as the health system grows in capacity in Uganda, with the assistance of international donors, it will acquire the ability to deliver antiretrovirals as well as syndromic management. NGOs and other actors can also help to reshape the agenda of political leaders, as seen in South Africa, where pressure from local and international groups forced the government to back down from its denial on the virus origins of AIDS.

The transfer of internationally recommended policies for HIV/AIDS control must be undertaken with care and blue prints are unlikely to be universally appropriate. In particular, while political leadership supporting HIV/AIDS programmes is important, equally critical are existing bureaucratic systems, the national health infrastructure and state relations to NGOs and donors. Other nations now facing current or potential HIV epidemics may look outside for lessons to learn, but to apply them they must equally look within.

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