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Pandemics and Soft Power: HIV/AIDS and Uganda on the Global Stage[1]

ABSTRACT
The COVID-19 outbreak of 2020 threatened years of effort by the Chinese authorities to extend its influence around the world. This article seeks to enhance understanding of China's defensive engagement with global health agencies, and more broadly of the relationship between pandemics and soft power, through an analysis of Uganda's evolving response to HIV/AIDS. As with COVID-19, HIV/AIDS presented a fundamental threat not only to countries' internal social stability and population health, but also to governmental legitimacy and nation-states' international reputation. HIV though also provided Uganda with an opportunity to enhance its global standing, influence international policy, and achieve national reconstruction. This case study highlights the importance of viewing international affairs from the perspective of the global south. It argues that the very weakness of Uganda, and the structural marginality of HIV/AIDS, provided the leverage which would in the end deliver radical shifts within global health.

KEYWORDS: HIV/AIDS; COVID-19; Uganda; China; soft power

Introduction

In the six months that followed the reporting of the first cases of a new viral infection in Wuhan in eastern China COVID-19 spread rapidly, affecting almost every country in the world. Between late December 2019 and June 2020 ten million cases and half a million deaths were recorded worldwide. In the great majority of nations severe quarantine measures were imposed in an attempt to contain the virus, resulting in the sharpest economic downturn in modern history. The first phase of the response to this global disaster was marked by a number of rhetorical and practical examples of international solidarity, including promises that effective vaccines would be distributed equitably around the world. But the unevenness of the pandemic's impact has fostered a profoundly comparative understanding of international relations. Pre-existing tensions, including those between Japan and South Korea and between the EU's wealthier north and poorer south, have been exacerbated. But even relationships that had hitherto been considered amicable have been threatened by COVID's existential threat, with for example Sweden's rejection of lockdown seeing it isolated within Scandinavia.

Statistically, China has suffered less from COVID-19 than most other countries. In late June 2020, the global average number of cases and deaths per million recorded since the pandemic began was 1,224 and 62; in China the equivalent numbers were 58 and 3, twenty-one times lower.[2] Reputationally, however, COVID-19 has been profoundly damaging for China on a number of levels. The role played by the capture, farming, and retail of live wild animals in enabling the coronavirus to jump species appears to have been crucial

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[2] https://www.worldometers.info/coronavirus/?, last accessed 25 June 2020. The accuracy of China's reporting has been questioned externally, though it should be noted that many other countries have revised estimates of incidence and mortality retrospectively. The US has, moreover, sought to limit criticism of its control programmes by querying the relationship between testing data and prevalence. 'They test and they test: Trump brushes off rise in COVID-19 cases', *New York Times*, 20 June 2020, https://www.nytimes.com/video/us/politics/100000007202285/trump-tulsa-rally-coronavirus.html?searchResultPosition=1, last accessed 30 June 2020.

epidemiologically, but the negative publicity associated with wet markets has also reinvigorated external perceptions of China as culturally other. Accusations that research laboratories near Wuhan deliberately developed and released a coronavirus appear groundless, but the possibility that Chinese science accidentally played a role in unleashing a highly infectious, deadly pathogen on the world has threatened China's academic and technological status internationally. More damning are the indications that the Chinese authorities sought to conceal evidence of the early outbreak and penalized whistleblowers, limiting the opportunity for other countries and international health organizations to prepare themselves for a potential pandemic. The implication that the repressiveness of the Communist Party of China (CPC) has proven profoundly dangerous to the Chinese population, and to societies around the world, undermines the regime's critique of the democratization movement, and further highlights the Chinese government's problematic human rights record.[3]

In response to this intense international criticism China's leadership has sought to reframe external perceptions of its handling of the pandemic. In doing so, the Chinese government can draw on the substantial lines of moral credit it has built up in recent decades. China has invested heavily in international academic engagement and cultural diplomacy, for example. In more concrete terms, China has argued consistently for the rights of national sovereignty, with this targeted defence of a philosophical principle winning the loyalty of several embattled regimes in the global south. Still more effectively, China has come to rival the USA as a source of material investment around the world. In Africa in particular, China's disregard for conditionality has made its loans and aid particularly attractive. The perception that China respects individual countries' right to govern themselves free from external interference is beneficial, despite being repeatedly questioned.[4] This willingness to turn external opinion to its advantage has borne some fruit during the COVID-19 crisis, though soft power is difficult to exert in a context of intense scrutiny and scepticism. China's greatest advantage was its rapid success in containing its own epidemic, highlighting the limitations of a number of liberal democracies. The decline in its own cases enabled China to provide medical assistance to countries more troubled than itself, including the provision of ventilators to the state of New York. This conscious emphasis on the inertia of America's federal government, and the implication that Americans' suffering resulted above all from the nature of the Trump presidency, may not have been particularly subtle.[5] Nonetheless, it

[3] 'Where did Covid-19 come from? What we know about its origins', *The Guardian*, https://www.theguardian.com/world/2020/may/01/could-covid-19-be-manmade-what-we-know-about-origins-trump-chinese-lab-coronavirus, last accessed 30 June 2020; 'As new coronavirus spread, China's old habits delayed fight', *New York Times*, https://www.nytimes.com/2020/02/01/world/asia/china-coronavirus.html, last accessed 30 June 2020.

[4] For an introduction to the concept of soft power see Joseph Nye, *Bound to Lead: The Changing Nature of American Power* (New York: Basic Books, 1990); for Chinese soft power see Kingsley Edney, Stanley Rosen, and Ying Zhu, eds., *Soft Power with Chinese Characteristics: China's Campaign for Hearts and Minds* (Abingdon: Routledge, 2020; Luca Bandier and Vasileios Tsiropoulos, 'A framework to assess debt sustainability and fiscal risks under the Belt and Road Initiative', World Bank Policy Research Working Paper No. 8891 (Washington DC: World Bank, 2019). China invested around $500 billion in Belt and Road projects within developing countries between 2013 and 2018. It has been accused of encouraging countries to put up key national assets as collateral, such as the militarily strategic port of Mombasa, which could be seized in the event of loan default.

[5] Cui Tiankai, 'China and the U.S. Must Cooperate Against Coronavirus', *New York Times*, 5 Apr. 2020, https://www.nytimes.com/2020/04/05/opinion/coronavirus-china-us.html?searchResultPosition=13, last accessed 30 June 2020. Cui Tiankai, China's ambassador to the United States, emphasized that 'This is not the time for finger-pointing. This is a time for solidarity, collaboration and mutual support . . . China is doing whatever it can to support the United States and other countries in need; New York, America's epicenter of the pandemic, is one of the biggest destinations of China's assistance.'

represented in a particularly symbolic way China's consistent efforts to move global discussion away from the origins of the virus, and towards its control. Crucial in this regard was the Chinese government's relationship with the World Health Organisation (WHO). China's achievement in avoiding public criticism from the WHO has not been without cost, particularly for the WHO whose perceived biases drew condemnation and the withdrawal of funding from the USA. Nonetheless, the WHO's consistent praise for the Chinese response to the pandemic is noteworthy, given that its internal documents reveal intense concern at CPC obstructionism during the first weeks of the outbreak. For the WHO, securing partial access to Chinese sources of epidemiological information required the exercising of discretion, a pact that the CPC exploited with some skill.[6]

This article seeks to enhance understanding of the relationship between pandemics and soft power through an examination of Uganda's response to HIV/AIDS. As with COVID-19, HIV/AIDS presented a fundamental threat not only to countries' internal social stability and population health, but also to governmental legitimacy and nation-states' international reputation. Uganda, though, was not an economic and military superpower in the mid-1980s. When Yoweri Museveni came to power in 1986, he took over one of the poorest countries in the world and a state that had been hollowed out by years of civil war and mismanagement. Unlike China, Uganda's response to an emerging pandemic was not primarily defensive, seeking to protect a position of established international influence.[7] Museveni's was a new regime, and his predecessors had done little to sustain the sources of influence in the global north and regional leadership in education and science that Uganda had enjoyed in the mid-twentieth century.[8] Indeed, Uganda was essentially bankrupt and had limited material resources to draw on in its attempt to exert influence globally. The Ugandan story then provides compelling evidence of how powerful soft power projects in the medical field can be.

The significance of health within international relations has attracted increasing attention in recent years. In particular studies such as Sanjoy Bhattacharya's analysis of the smallpox eradication campaign has challenged assumptions that global affairs are best understood through a focus on the interplay of the great powers. As Bhattacharya illustrates, viewing smallpox eradication, one of the greatest medical achievements in world history, solely through the prism of the cold war or as an example of WHO directionism, obscures the role played by multiple initiatives across the global south. Other studies have acknowledged the fundamental inequities of global health and politics, but have shown how unequal relationships have nonetheless empowered the weaker partner. Nicole Pacino's study of American public health investment in Bolivia in the 1950s reveals that while America secured an important regional ally, the local regime used foreign aid to extend the state's influence over rural communities. Elise Burton's analysis of geneticists' international networks of collaboration complicated assumptions of neo-colonial intellectual hegemony,

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[6] 'China withheld data on coronavirus from WHO, recordings reveal', *The Guardian*, 2 June 2020; 'China investing millions in WHO to make up for Trump cuts and boost its influence, officials say', *The Independent*, 24 Apr. 2020; 'U.S.-China Feud Over Coronavirus Erupts at World Health Assembly', *New York Times*, 18 May 2020. Other countries, with varying degrees of assertiveness, have also questioned the nature of the WHO's relationship with China. China responded directly to the US's defunding of the WHO by pledging $2 billion to global pandemic control efforts and stating it would 'always support the WHO in playing an important role in international public health and global anti-epidemic response'.

[7] For China's soft power defensiveness, see N. Eliküçük Yıldırım and M. Aslan, 'China's charm defensive: image protection by acquiring mass entertainment', *Pacific Focus* 35, no.1 (2020): 141-71, https://doi.org/10.1111/pafo.12153.

[8] As Africa's leading Christian country, Uganda had powerful advocates within the global Anglican and Roman Catholic churches. Before the 1960s it was home to East Africa's only university, while its medical school had tied Ugandan researchers into networks of funding and intellectual collaboration.

examining how local researchers in Iran and Israel sought to 'wrest narrative control of the nation's biology from Western scientists'.[9] The Ugandan case-study builds on these efforts to decentre global health history. It emphasizes Uganda's prominence within international HIV debates over more than three decades, highlighting above all the long and evolving history of this pandemic. While Uganda gained enormously from its international relationships in terms of external funding and state reconstruction, it also played a key role in shaping the development of HIV policy within international agencies and other African countries. AIDS caused immense suffering and societal damage, but it also gave Uganda a place on the world stage.

Comparing COVID-19 and HIV/AIDS

COVID-19 and HIV/AIDS are both devastating global viral pandemics, the worst the world has experienced since the influenza pandemic of 1918-20. Epidemiologically, however, they are extremely different diseases.[10] COVID-19 primarily affects and is transmitted through the respiratory system, has a short incubation period, is extremely infectious, and has an estimated case-fatality rate of 3.4%.[11] By contrast, HIV is predominantly transmitted through sexual intercourse, may remain asymptomatic for more than ten years, is relatively unlikely to be passed on in any individual sexual act, and is almost always fatal in the absence of treatment. HIV's characteristics have influenced societal responses to the pandemic in distinctive ways. Discourse around HIV has often been shaped by moralistic condemnation, with infections being attributed to sexual promiscuity, unsafe practices associated with drug addiction, or medical negligence. The long-term risk posed by healthy carriers encouraged compulsory, intrusive medical interventions, with testing being required in some countries for purposes such as border control, church marriage, or life insurance. Awareness that HIV's transmissibility was greatly enhanced by factors such as pre-existing sexually-transmitted infections, multiple partner exchange, or receptive anal sex prompted a focus on what have been defined in different periods as risk groups, risky practices, or particularly vulnerable key populations. Recognition of higher risk has, in different contexts, been associated with self-protection, uplift, or vilification, often generating new modes of civil society mobilization. The unavailability of a vaccine, despite trials continuing since 1987, and inequitable access to the combination therapies which prevent progression to AIDS, mean that heavily-affected societies must still adapt to high levels of mortality within the working-age population, and associated problems such as endemic orphanhood. While UNAIDS aimed in 2015 to 'end AIDS as a public health threat' by 2030, by 2018 there were still 470,000 HIV-related deaths in sub-Saharan Africa. Few countries had made significant progress towards the goal of eradication before the outbreak

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[9] Sanjoy Bhattacharya, *Expunging Variola: The Control and Eradication of Smallpox in India, 1947–1977* (Hyderabad: Orient Longman, 2006); Nicole Pacino, 'Stimulating a cooperative spirit? Public health and US-Bolivia relations in the 1950s', *Diplomatic History* 41, no. 2 (2017): 305-35; Elise Burton, '"Essential collaborators": locating middle eastern geneticists in the global scientific infrastructure, 1950s–1970s', *Comparative Studies in Society and History* 60, no. 1 (2018): 119-49. For a recent overview of health in international affairs see Erez Manela, 'A pox on your narrative: writing disease control into Cold War history', *Diplomatic History* 34, no. 2 (2010): 299-323.

[10] This basic fact indicates that further devastating pandemics, potentially with different modes of transmission, are likely to develop in the future.

[11] 'WHO Director-General's opening remarks at the media briefing on COVID-19, 3 March 2020', https://www.who.int/dg/speeches/detail/who-director-general-s-opening-remarks-at-the-media-briefing-on-covid-19---3-march-2020, last accessed 25 June 2020. Case-fatality rates for COVID-19 vary hugely from country to country, reflecting variation in the ubiquity and accuracy of testing, underlying health conditions and age profiles, intensity of exposure, and medical capacity. In June 2020 rates varied from 0.1% in Singapore to 16% in Belgium. https://coronavirus.jhu.edu/data/mortality, last accessed 26 June 2020.

of COVID, which gravely disrupted prevention and treatment programmes. In July 2020 a UNAIDS/WHO modelling study warned that COVID might cause AIDS mortality in Africa to double within the year.[12]

Three factors distinguish COVID-19, in its early phase at least, most clearly from HIV/AIDS. One is the age profile of COVID mortality, with the pandemic primarily afflicting the elderly.[13] The second is the seemingly short period between the first COVID infections and the disease being identified; HIV, remarkably, was able to spread gradually around the world over a period of perhaps sixty to eighty years before local outbreaks of AIDS occurred on a scale which brought the disease to medical attention.[14] The third is COVID's geographical distribution. In the six months since it emerged, COVID-19 cases have been almost equally distributed between Asia, Europe, and North and South America. Oceania and Africa have accounted for only 0.1 and 3.6% of recorded infections. In sharp contrast, AIDS has predominantly afflicted the African continent. Between 1981 and 2018, sub-Saharan Africa accounted for the great majority of the 75 million people around the world who were infected with HIV and of the 32 million people who died of AIDS-related illnesses. As the pandemic peaked in 2005, 77% of AIDS-related deaths occurred in sub-Saharan Africa. In 2018, this region still accounted for 68% of people living with HIV and 61% of AIDS-related mortality.[15] As levels of infection accelerated through the late 1990s, AIDS became the leading cause of death in many sub-Saharan African countries. The virus took a particularly devastating hold in southern Africa, with 36 per cent of adults infected in Botswana by 2000. Across the continent, the burden of AIDS took multiple forms, reducing food security and school attendance, pushing households into poverty, and crippling already overstretched health services. In Rwanda in the mid-1990s, two-thirds of public health expenditure was taken up by HIV.[16] The scale of the global response to COVID-19 relates directly to its exponential growth, and the danger that coronavirus infections might overwhelm healthcare systems. The rapidity with which the world reacted to the coronavirus reflects the fact that most of the countries worst affected are members of the G20. AIDS was only prioritized in terms of global funding and attention from 2002, more than two decades after the disease was identified. To some degree, this delay reflected HIV's structural marginality. In its first decades, AIDS, from the perspective of the global north, was a disease associated with moral failure, and an affliction largely confined to the poorest continent in the world. In 1986, Uganda's new government sought to confront these assumptions, endeavouring to turn the world's attention to the devastation it was experiencing, to embed a more positive narrative around HIV within international discourse, and to address the inbuilt inequities within global health.

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[12] John Cohen, 'A campaign to end AIDS by 2030 is faltering worldwide', *Science News*, 31 July 2018; 'WHO: access to HIV medicines severely impacted by COVID-19 as AIDS response stalls', 6 July 2020, https://www.who.int/news-room/detail/06-07-2020-who-access-to-hiv-medicines-severely-impacted-by-covid-19-as-aids-response-stalls, last accessed 10 July 2020.

[13] In England and Wales, 89% of deaths involving COVID have occurred among people aged 65 and over. https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/conditionsanddiseases/articles/coronaviruscovid19roundup/2020-03-26, last accessed 29 June 2020.

[14] For debates around HIV's long history see Shane Doyle, 'Chronology and causality in Africa's HIV pandemic: the production of history between the laboratory and the archive', *Past & Present* (forthcoming); John Iliffe, *The African AIDS Epidemic: A History* (Oxford: James Currey, 2006); Jacques Pepin, *The Origins of AIDS* (Cambridge: Cambridge University Press, 2011).

[15] UNAIDS, *Global AIDS Update 2019*, https://www.unaids.org/sites/default/files/media_asset/2019-global-AIDS-update_en.pdf, 188-91, 202-5, last accessed 29 June 2020; UNAIDS, AIDS Epidemic Update December 2005, https://data.unaids.org/publications/irc-pub06/epi_update2005_en.pdf, 2, last accessed 29 June 2020.

[16] Report on the Global HIV/AIDS epidemic, June 2000, 24-30, https://data.unaids.org/pub/report/2000/2000_gr_en.pdf, last accessed 24 June 2020.

Uganda, HIV, and World History

Uganda's intense engagement with HIV in the 1980s and 1990s was far from typical. For most African governments in this era, AIDS was not an issue to be put at the top of the political agenda. Open discussion of sex risked offending powerful religious and traditionalist lobbies; fully acknowledging HIV risked reinforcing external tropes of African hypersexuality; and a comprehensive effort to contain AIDS might derail all other developmental initiatives. On the African continent, only Senegal came close to matching the scale of Uganda's efforts. Senegal's government though confronted a HIV epidemic that was comparatively limited, with prevalence of around 1%. It could build, moreover, on an unusually effective tradition of public health intervention, with long-established programmes of blood screening, STI control, and sex worker registration. As John Iliffe notes, Senegal's achievement was in preventing the development of a generalized AIDS epidemic. Uganda's situation was very different. HIV prevalence in rural and urban communities was already shockingly high and rising rapidly when Museveni took over, reaching 24% in Kampala by 1987. Uganda's public health system had weakened progressively since the early 1970s, and both the structures and personnel of local government had been completely replaced in 1986. Its economy, meanwhile, which had been weakening since 1972, shrank by 13% in the three years before the change in government. Uganda was in an extremely weak position to confront an epidemic, which makes its achievements in the years that followed all the more significant.[17]

It is common to read in accounts of Uganda's conversion to an activist AIDS policy that it was Museveni's recognition of the threat posed by the epidemic to the stability of his regime that convinced him to place HIV control at the heart of his governing strategy. In particular, the finding that, months after it had brought Museveni to power, a large proportion of the National Resistance Army was HIV+ is held to be key in much of the scholarship. From this perspective, 'the imminent loss of much of his officer corps struck directly at Museveni's power base.'[18] There is no doubt that Uganda's AIDS strategy was in part shaped by the regime's sense of self-preservation. But, as internal documents from the early years of the epidemic reveal, the Ugandan government's motivations and goals were more complex than the standard formula would suggest.

Above all, records from the Ministry of Health in the late 1980s indicate that HIV was understood as posing a fundamental threat to Ugandan society as a whole, not merely the military. Seroprevalence figures from sentinel sites across Uganda were described by the director of Uganda's AIDS Control Programme, Samuel Okware, as 'bad and gloomy'. Museveni, from the beginning, related AIDS to his broader programme of national rejuvenation. In 1987 he informed the Ministry of Health that AIDS control should seek to reverse 'the erosion of cultural attitudes and practices to sex . . . Our society should be made aware that the liberal attitudes on sex are putting us into problems today. This is one of the lessons we must learn . . . [The president] recommended that people be told in no uncertain

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[17] Samwel Ong'wen Okuro, 'Daniel arap Moi and the politics of HIV and AIDS in Kenya, 1983–2002', *African Journal of AIDS Research* 8, no. 3 (2009): 275-283; Iliffe, *The African AIDS Epidemic*, 67, 71; UNAIDS, *Acting Early to Prevent AIDS: The Case of Senegal* (UNAIDS: Geneva, 1999), 7-14, https://www.unaids.org/sites/default/files/media_asset/una99-34_en_1.pdf, last accessed 30 June 2020; https://data.worldbank.org/indicator/NY.GDP.PCAP.KD?locations=UG, last accessed 29 June 2020.

[18] See for example Robert Thornton, *Unimagined Community: Sex, Networks, and AIDS in Uganda and South Africa* (Berkeley: University of California Press, 2008), 132; Edward Green, *Rethinking AIDS Prevention: Learning from Successes in Developing Countries* (Westport, CT: Greenwood Press, 2003), 204; Alex De Waal, 'A disaster with no name: The HIV/AIDS pandemic and the limits of governance', in *Learning from HIV and AIDS*, eds. George Ellison, Melissa Parker, and Catherine Campbell (Cambridge: Cambridge University Press, 2003), 259.

terms to remain faithful to one sexual partner or abstain.' According to Okware, from the beginning Museveni had 'insisted that we should not feed people on lies but facts, and use facts to produce fear and instil change in behaviour.' This sense of moral urgency also influenced Museveni's attitude to external interactions relating to HIV. Museveni encouraged the Ministry of Health to foster international research collaborations so long as they were 'in good faith for humanity'.[19]

Uganda's reputation for openness in relation to HIV/AIDS was crucial in securing international aid and approval. That this reputation was sustained for decades is a testament to the diplomatic skill of Museveni and his health officials. Within months of taking power in 1986, Museveni's officials were already emphasizing the risks of transparency. As the first progress report on AIDS noted, 'the MoH [Ministry of Health] has adopted a free and frank policy on this disease. We believe this is the only way for primary prevention. Unfortunately the international media has overdramatised the situation most irrationally.'[20] Accordingly the Ugandan government quickly adopted a policy of quiet censorship. The early willingness to allow foreign reporters to film in Uganda's hospitals 'because we were convinced that AIDS must be handled with openness, and … education' was soon closed down. 'It is disappointing that those who came in first . . . were more interested in sensationalism and the desire to reinforce the stereotyped view that AIDS originated in Africa with Uganda as the cradle! This was unfair and we decided that the best way was to stop giving permission to outsiders where we are not in a position to monitor and control the end product.' Okware therefore 'made it very difficult for any journalist to come here.' When exceptions were made, journalists had to be accompanied by Ministry of Information staff, and only the director of the AIDS programme himself could give interviews relating to HIV.[21] A more sensitive issue was Uganda's relationship with the international AIDS research community. As Okware noted in 1989, 'we can't exclude foreigners because funding for Ugandans [is] almost non-existent unless [they] work in partnership.' Yet, uncontrolled access threatened the publicization of 'most damaging facts'. Uganda's sensitivity had been demonstrated with the deportation of a leading expatriate researcher in 1987 and the temporary suspension of the high-profile Rakai study soon afterwards. As Okware noted, Uganda trod a fine line. Official complaints about the Rakai study deliberately avoided direct criticism of the WHO since this would in effect have ended the country's AIDS programme. Rather, disapproval focused on American partner universities, and on a perceived external fixation with the virus's natural history. Uganda, seeking to deflect global attention from the question of who was to blame for this global pandemic, argued that HIV's origins 'was not of any significance now – what was important was how to control the spread of the disease.'[22]

Growing awareness within the AIDS Control Programme that HIV was 'so politically sensitive' resulted in an emphasis on information management. While policy continued to be

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[19] S. Okware, 'Brief Report and Policy Considerations on AIDS Control Programme for Minister of Health', 15 Apr. 1989: Centre of African Studies Library, Cambridge, Uganda Ministry of Health (hereafter UMoH), John Iliffe papers, section 13, memos and letters from the AIDS Control Programme; H.E. the President, 'Prevention of AIDS', National Committee for the Prevention of AIDS (extraordinary) meeting, 10 July 1987: UMoH, John Iliffe papers, VNNUMR.RGD, section 12.

[20] 'Progress Report. AIDS in Uganda, 1986', TS: UMoH, John Iliffe papers, GCR.16.

[21] A. Ogola to Ministry of Health, minute, 5 June 1989: UMoH, John Iliffe papers, GCD 2/1; S. Okware, 'Brief Report and Policy Considerations on AIDS Control Programme for Minister of Health', 15 Apr. 1989: UMoH, John Iliffe papers, section 13, memos and letters from the AIDS Control Programme; Okware to ACP Staff, 'Prevention of AIDS', 7 Dec. 1987: UMoH, John Iliffe papers, VNNUMR. RGD Section 12.

[22] S. Okware, 'Brief Report and Policy Considerations on AIDS Control Programme for Minister of Health', 15 Apr. 1989: UMoH, John Iliffe papers, section 13, memos and letters from the AIDS Control Programme; Deputy VC Makerere to Chief Research Coordinator, National Research Council, 24 Sept. 1986: UMoH, John Iliffe papers, PHC/D/2; Fortieth World Health Assembly, Geneva, 4-15 May 1987: summary records of committees, WHA40/1987/REC/3 https://apps.who.int/iris/handle/10665/163852, last accessed 24 June 2020.

'that dry facts are the best weapon to promote behaviour change', health officials sought to control which facts reached the Ugandan public and the outside world. Sensitive information, such as the finding that 86% of sex workers were HIV+, was to remain confidential until cleared for publication by the health minister or director of medical services. Data, it was noted, must be handled almost exclusively by Ugandans. What was perceived to be biased reporting caused leading officials to adopt a policy of 'guarded openness', with communications being channelled through one spokesperson, 'who would give approved innocuous information in a most pro-Uganda, pro-Africa profile'. HIV then was viewed by health officials as providing both internal and external threats to Uganda's national interests. Perceptions of racial bias and structural discrimination fostered a determination to control the representation of HIV's history, to exert sovereignty over AIDS research and policy within Uganda's borders, and to reshape global perceptions of both the virus and Uganda.[23] For these goals to be achieved, however, a reputation for transparency and engagement had to be sustained.

It is important to note that Uganda's initial emphasis on openness in relation to HIV was largely driven from within, rather than responding to international pressure. Uganda established a central AIDS Control Programme within ten months of Museveni's inauguration, and launched a campaign that sought to foster public discussion, dispel stigma, and use enhanced public health knowledge to drive behavioural change. A United States governmental review of global AIDS policy in 2002 reveals how much credibility Uganda built up through its early, comprehensive, enabling approach to the pandemic:

> Uganda's new head of state, President Yoweri Museveni, responded to evidence of a serious emerging epidemic with a proactive commitment to prevention that has continued to the present. In face-to-face interactions with Ugandans at all levels, he emphasized that fighting AIDS was a patriotic duty requiring openness, communication, and strong leadership from the village level to the State House. His charismatic directness in addressing the threat placed HIV/AIDS on the development agenda, and encouraged constant and candid national media coverage of all aspects of the epidemic. This early high-level support fostered a multi-sectoral response, prioritizing HIV/AIDS and enlisting a wide variety of national participants in the "war" against the decimating disease.

The externally-perceived authenticity of Uganda's approach was enhanced by Museveni's use of vernacular slogans such as 'zero grazing' (an agricultural term referring to stall-feeding of livestock to reduce exposure to disease), and the straightforwardness of messages such as 'love faithfully'. The Ugandan government's willingness to encourage civil society organisations to provide community-level interventions, and to harness schools and religious institutions' local influence proved crucial epidemiologically, and did much to encourage outside observers' sense of the pervasiveness and inclusivity of the Ugandan approach.[24]

Uganda's willingness to acknowledge the scale of its epidemic, and to place its control at the heart of government, bore immediate fruit. At a meeting of the World Health Assembly in May 1986 Uganda's minister of health emphasized that HIV was already well established in the southern half of the country, was now a governmental priority, and required

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[23] S. Okware, 'Brief Report and Policy Considerations on AIDS Control Programme for Minister of Health', 15 Apr. 1989: UMoH, John Iliffe papers, section 13, memos and letters from the AIDS Control Programme. This analysis of Okware's nationalism draws on John Iliffe, *East African Doctors: A History of the Modern Profession* (Cambridge: Cambridge University Press, 1998), 223, 244; H.E. the President, 'Prevention of AIDS', National Committee for the Prevention of AIDS (extraordinary) meeting, 10 July 1987: UMoH, John Iliffe papers, VNNUMR.RGD, section 12.

[24] USAID, *What Happened in Uganda? Declining HIV Prevalence, Behavior Change, and the National Response* (Washington DC: USAID, 2002), 3-5.

international collaboration above all. This frankness, which contrasted with the silence or inertia of most African governments, initiated a re-evaluation of HIV at the heart of the WHO. Its director-general, Halfdan Mahler, had resisted calls to devote more resources to AIDS, fearing that this would undermine the WHO's achievements in establishing effective primary health care programmes around the world. But as Okware pointed out to the World Health Assembly in 1987, 'the health-for-all strategy was based on a need for adequate manpower, and yet it could be the young productive population which would be decimated by AIDS, and the disease could moreover neutralize or reduce the benefits of the Expanded Programme on Immunization.' Health-for-all, he continued, was threatened more fundamentally by HIV's pandemic potential. How, he asked, could the 'silent public consensus that AIDS victims were being punished by a process of natural justice for their deviant lifestyles' be allowed to continue, when HIV 'could strike any race and either sex', and threaten entire populations? Uganda was already acting, Okware emphasized, having adopted 'a policy of frankness about the disease. . . Health education campaigns had been initiated, urging people to limit their sexual activity', but crucially their efforts were limited due to 'inadequate financial resources . . . WHO should speedily provide more funds to assist them.[25]

Uganda's warning of impending disaster, early interventions, and willingness to collaborate with external partners helped convince the WHO to invest significant funds and energy into combating the emerging HIV pandemic. When the WHO's Global Programme for AIDS was established in 1986, Uganda was first to act on its request that countries should develop a medium-term national AIDS control plan. Accordingly, Uganda was the first country to host a WHO-organized donor's meeting, and the first to be allocated WHO seconded staff and funding (initially $1.4 million). In 1988 Uganda was again the first country in the world to launch a systematic review of its AIDS programme, leading to the rapid development of a revised medium-term plan, all with WHO assistance. Before 1990 Uganda was the only country with which the WHO worked where a single AIDS national plan and budget existed, which was used by all donors. Uganda had found a formula which maximised funding, while retaining a significant degree of control over policy. By 1989 the WHO and bilateral donors contributed $17.6 million to Uganda's AIDS programme, thirty-five times more than Museveni's government was able to provide, and at least four times more than was allocated to any other country in the global south. This external aid supported a national organization which, in terms of staffing, was more than three times larger than any other control programme in Africa. Crucially, the emphasis on capacity building and multisectoralism ensured that funding not only provided Uganda with a core of expertise that was unique in its scale, but also permitted a more generalized revitalization of the country's health infrastructure.[26]

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[25] Thirty-ninth World Health Assembly, Geneva, 5-16 May 1986: verbatim records of plenary meetings, reports of committees, WHA39/1986/REC/2, https://apps.who.int/iris/handle/10665/162253, last accessed 24 June 2020; Fortieth World Health Assembly, Geneva, 4-15 May 1987: summary records of committees, WHA40/1987/REC/3 https://apps.who.int/iris/handle/10665/163852, last accessed 24 June 2020. The World Health Assembly is the decision-making body of the WHO, attended annually by delegations from all member states.

[26] Jonathan Mann, 'Global AIDS: a status report', *The Geneva Papers on Risk and Insurance* 13, no. 49, (1988): 303-13; Gary Slutkin et al., 'How Uganda reversed its HIV epidemic', *AIDS and Behavior* 10, no. 4 (2006): 351-60; H.E. the President, 'Prevention of AIDS', National Committee for the Prevention of AIDS (extraordinary) meeting, 10 July 1987: UMoH, John Iliffe papers, VNNUMR.RGD, section 12. Uganda's broad alignment with WHO goals meant that its limited enthusiasm for condoms was tolerated. Uganda's approach would be branded in the 1990s as ABC (abstain, be faithful, or use condoms), though the relative weight given to each element varied over time. For an example of its continental influence see https://www.gov.za/documents/health-sector-strategic-framework-1999-2004, last accessed 10 July 2020.

In parallel to Uganda's internal reconstruction, HIV also provided opportunities for the country to reposition itself internationally. By 1989, the director of Uganda's AIDS Control Programme noted with satisfaction that it was 'the best' on the continent. It was 'used as a model programme for Africa, and has received very satisfactory comments from the international community'. Uganda had already trained AIDS personnel from six other countries, and would go on to educate staff from many other African nations. Her achievement in reducing her own epidemic, and well-evidenced claim to have embedded HIV control more solidly than any other country, enabled Uganda to take on a leadership role on the continent. Uganda's achievements were acknowledged by other African leaders. Even Senegal, Africa's other success story, expressed admiration. Its president informed the United Nations General Assembly in 2003 that Uganda was 'an interesting model from which we can learn', a success story that gave the global south 'cause for hope'. The following year a journalist for the Senegalese newspaper *Le Soleil* wrote admiringly of how Uganda's programme 'concerns everyone' and had become 'a matter of patriotism' and national pride.[27] The WHO and, from 1995, UNAIDS played a key role in advertising Uganda's achievements. As an internal review of UNAIDS' achievements noted, its staff across Africa presented 'leaders with evidence of change, of good practice, in countries such as Uganda . . . "We would explain … Senegal and Uganda have been very successful because they had [the] very clear commitment of their leaders, and they were not denying this is a real story."' Speaking at various Africa-wide conferences, UNAIDS' first director Peter Piot repeatedly emphasized that Uganda's success in reducing HIV prevalence was repeatable. Uganda was preventing new infections, but also helping individuals and families adapt to AIDS morbidity and mortality, 'creating a social vaccine or, better still, a social immune system' against HIV.[28]

Uganda's pre-eminence in AIDS control, and the very large numbers of individuals engaged within the country in high level policy development, brought Ugandans into positions of prominence at a global level. The first of many examples came as early as 1990. When donors instituted an external review of the WHO's Global AIDS Programme, a Ugandan diplomat, Bernadette Olowo-Freers, was appointed as its chair. In 1995, Noerine Kaleeba, founder of The Aids Support Organisation (TASO) in Uganda and a globally-recognized activist, was one of ten people charged with planning how the new multisectoral Joint United Nations Programme on HIV/AIDS (UNAIDS) should operate. She subsequently served as the Community Mobilization Adviser at UNAIDS headquarters for eleven years. Other Ugandans took up leadership positions, with, for example, George Tembo becoming UNAIDS' first Country Programme Adviser in Kenya. Perhaps the most significant appointment was UN Secretary-General Kofi Annan's selection in 2002 of Chrispus Kiyonga, Uganda's former health minister, as the first head of the Global Fund, an agency with an annual revenue of $4 billion focused on AIDS, malaria and tuberculosis. Such influence continued. Of eighteen civil society representatives from around the world called to shape UN HIV policy in 2008, two were from Uganda.[29] While Uganda's governmental and non-governmental agencies have not always enjoyed a positive relationship, both have

[27] United Nations A/58/PV.3 General Assembly Fifty-eighth session 3rd plenary meeting Monday, 22 September 2003, 7, https://documents-dds-ny.un.org/doc/UNDOC/GEN/N03/526/82/pdf/N0352682.pdf?OpenElement, last accessed 24 June 2020; *Le Soleil* quoted in Iliffe, *The African AIDS Epidemic*, 128.

[28] Lindsay Knight, *UNAIDS: The First 10 Years, 1996-2006* (Geneva: UNAIDS, 2008), 49, 64, 118.

[29] Michael Merson and Stephen Inrig, *The AIDS Pandemic: Searching for a Global Response* (Cham: Springer, 2017), 284; Knight, *UNAIDS*, 34-5, 53, 74; Organizations at the UN General Assembly's Sixty-second session, Agenda item 44, Implementation of the Declaration of Commitment on HIV/AIDS and the Political Declaration on HIV/AIDS, https://documents-dds-ny.un.org/doc/UNDOC/GEN/N08/411/99/pdf/N0841199.pdf?OpenElement, last accessed 21 June 2020.

benefited from external perceptions of extensive expertise in the official and non-official sectors.

One outcome of this ability to secure positions of influence was Uganda's success in reshaping the global understanding of HIV and Africa's place in the pandemic's history. As early as 1988, a global review of AIDS programmes made it clear that Uganda's was the most advanced in the world. The following year the director of Uganda's AIDS Control Programme reported that it 'has had a very large role in international AIDS policy', relating to, for example, the allocation of WHO dedicated funding. 'Such high-level participation by Uganda', he continued, 'has assisted in the development of positive global policies on AIDS for Africa'. In the early 1990s Uganda sought to broaden the scope of the global response to AIDS, by emphasizing that its impact extended far beyond the medical field. Uganda's multisectoral approach to its own epidemic provided it with evidence of HIV's relevance to a range of UN organisations. In 1991, for example, Uganda's representatives to UNESCO argued that AIDS should be recognized as a development disaster 'due to the decimation of human capital', restricted labour supply, the high cost of treatment, and orphanhood. The detrimental effects of HIV on education, economic production, food security, and poverty in Africa were already visible and poorly understood. The 'scant attention' devoted to HIV in the first draft of UNESCO's forthcoming *Report on the World Social Situation 1993* was a 'serious concern'. Uganda's emphasis on AIDS' 'grave socio-economic impact' and need for wide-ranging research bore immediate fruit, with the published version of the 1993 *Report* providing extensive discussion of HIV in Africa, and UNESCO becoming a cosponsor of UNAIDS in 1995.[30] In 1997, Ugandan Ministry of Health officials presented evidence of declining HIV prevalence drawn from its highly advanced surveillance sites at an international UNAIDS conference, resulting in 'a lot of excitement'. The Ugandan model would be replicated across Africa through the rolling out of a Second Generation Surveillance network in 2000.[31]

Uganda's close relationship with a range of agencies provided the country with repeated opportunities to place itself at the forefront of HIV innovation, with, for example, the country being selected to pilot vaccine development in 1992, demonstrating between 1997 and 2003 that antiretroviral therapy could be effective and affordable in Africa, and taking the lead in providing accessible testing with same-day results in 2001.[32] This sustained

[30] World Health Organization, *AIDS Prevention and Control: Invited Presentations and Papers from the World Summit of Ministers of Health on Programmes for AIDS Prevention, London, 26-28 January 1988* (Geneva: World Health Organization, 1988; S. Okware, 'Brief Report and Policy Considerations on AIDS Control Programme for Minister of Health', 15 Apr. 1989: UMoH, John Iliffe papers, section 13, memos and letters from the AIDS Control Programme; United Nations A/C.2/46/SR.16, General Assembly Forty-sixth session Second Committee, Summary Report of the Sixteenth Meeting, 16 October 1991, https://documents-dds-ny.un.org/doc/UNDOC/GEN/N91/565/76/img/N9156576.pdf?OpenElement, last accessed 24 June 2020; United Nations A/C.3/46/SR.24, General Assembly Forty-sixth Session Third Committee, Summary Report of the Twenty-Fourth Meeting, 28 October 1991, https://documents-dds-ny.un.org/doc/UNDOC/GEN/N91/568/34/img/N9156834.pdf?OpenElement, last accessed 24 June 2020; UNESCO, *Report on the World Social Situation 1993* (New York: United Nations, 1993), 39-41.

[31] Douglas Richards, '"There's always going to be that political filtering": The emergence of Second Generation Surveillance for HIV/AIDS, data from Uganda, and the relationship between evidence and global health policy' (PhD diss., University of Edinburgh, 2017), 102-4, 150-7. It is important to note that Ugandan officials could not control how their data and innovations were interpreted and applied by global policy-makers. In this case, a policy struggle within UNAIDS reportedly saw Ugandan surveillance data manipulated in Geneva so that condom usage was promoted ahead of delayed sexual debut and reduction in the number of sexual partners as a means of achieving prevalence decline.

[32] W. Heyward, S. Osmanov, and J. Esparza, 'Preparing for HIV vaccine efficacy trials in developing countries', in *AIDS in the World II: The Global AIDS Policy Coalition*, eds. Jonathan Mann and Daniel Tarantola (Oxford: Oxford University Press, 1996), 194; Knight, *UNAIDS*, 69, 76, 122, 165; United Nations,

evidence of successful engagement and leadership was recognized beyond Africa and international agencies. By the early 2000s, Uganda was being held up as an example of African capability and moral influence by countries across Europe, Australasia, and the Americas. As the United States finalized its plans for the President's Emergency Plan for AIDS Relief (PEPFAR), 'the largest commitment by any nation to address a single disease in history', Uganda's role in inspiring the escalation of HIV funding was emphasized by both president and Congress. As G.W. Bush put it, 'This is . . . not a hopeless disease. We know that AIDS can be prevented. In Uganda President Museveni began a comprehensive program in 1986 . . . The results are encouraging. Congress should make the Ugandan approach the model for our prevention efforts.' In response, the Senate Sub-Committee on African Affairs held a special session, titled 'Fighting AIDS in Uganda: what went right?', and reported that 'Uganda's success has played an important role in convincing people here in Washington and around the world that it is possible to fight AIDS and win.'[33] Many factors contributed to the shift in global attitudes which led to the institution of the Global Fund in 2002 and PEPFAR in 2003. Recognition of the enormous scale of suffering across southern Africa, examples of success in other countries such as Thailand, and recognition that antiretrovirals could become affordable for all, were clearly significant. But Uganda's achievements were perhaps the most compelling, as it had demonstrated that HIV was a humanitarian disaster that could be contained given sufficient commitment, coordination, and funding. By 2019 the Global Fund had committed to a total expenditure of $31 billion and PEPFAR to $90 billion.[34] The scale of this commitment was unprecedented, and provided a precedent for the enormous state commitments that have been made in response to the COVID-19 pandemic.

Uganda then played a key role in shifting global humanitarian and medical priorities. While its larger contribution should be recognized, so too should its sustained ability to secure a particularly large share of what HIV funding was available in different periods. A 1996 survey found that Uganda had received more donor aid related to HIV/AIDS than any other African country, in part because of its ability to secure funds from a wide range of organisations and countries. Between 1989 and 1998, Uganda received approximately $180 million from outside sources in support of its AIDS programme. When PEPFAR was launched to combat HIV/AIDS in the fifteen most afflicted countries in the world, Uganda was 'foremost among them' in terms of initial investment. Similarly with the Global Fund, Uganda's chairship, representation on key committees, and close relationship with the Fund's founding partners, ensured that it was better able than most countries to align its aid requests

Review of the problem of human immunodeficiency virus/acquired immunodeficiency syndrome in all its aspects, Special session of the General Assembly on HIV/AIDS, Report of the Secretary-General, Fifty-fifth session, Agenda item 179, 16 Feb. 2001, https://documents-dds-ny.un.org/doc/UNDOC/GEN/N01/246/85/pdf/N0124685.pdf?OpenElement, last accessed 25 June 2020.

[33] United Nations A/57/PV.45, General Assembly Fifty-seventh session, 45th plenary meeting, Friday, 8 Nov. 2002, 3 pm: Implementation of the Declaration of Commitment on HIV/AIDS, Report of the Secretary-General (A/57/227 and A/57/227/Corr.1), https://documents-dds-ny.un.org/doc/UNDOC/GEN/N02/681/11/pdf/N0268111.pdf?OpenElement, last accessed 21 June 2020; 2001 United Nations, A/S-26/PV.1, General Assembly Twenty-sixth special session, 1st meeting, Monday, 25 June 2001, https://documents-dds-ny.un.org/doc/UNDOC/GEN/N01/424/61/pdf/N0142461.pdf?OpenElement, last accessed 25 June 2020; U.S. Senate, Subcommittee on African Affairs, Committee on Foreign Relations, *Fighting Aids In Uganda: What Went Right?, Monday, May 19, 2003* (Washington, DC: U.S. Government Printing Office, 2003), 4-7.

[34] https://www.kff.org/global-health-policy/fact-sheet/the-u-s-the-global-fund-to-fight-aids-tuberculosis-and-malaria/, last accessed 1 July 2020; https://www.kff.org/global-health-policy/fact-sheet/the-u-s-presidents-emergency-plan-for-aids-relief-pepfar/#:~:text=PEPFAR%20is%20the%20largest%20commitment,government%20is%20the%20largest%20donor., last accessed 1 July 2020. HIV was the primary, though not the sole, focus of these funds.

with the Fund's expectations. Thus, in its first three years, the Global Fund allocated $370 million to Uganda.[35]

At the core of Uganda's funding success was of course its achievement in reducing HIV. This was a constant in Uganda's self-promotion from 1989, when the first indications of behaviour change emerged.[36] But Uganda also consistently sought to align itself with the shifting priorities of key funders. This was particularly effective where Uganda could refer donors to relevant pre-existing initiatives. Thus Uganda's close relationship with Jonathan Mann, the charismatic founder of the WHO's Global Programme for AIDS, partly drew on governmental efforts to combat stigma which fitted closely with Mann's understanding of AIDS as a human rights issue. When UNICEF recognized that HIV fitted within its remit, Uganda was selected as one of the first countries to be funded, being 'particularly commended for the energy and comprehensiveness of its [existing] child-focused interventions'. Uganda, meanwhile, could legitimately claim to have developed a multisectoral approach to HIV long before it became global orthodoxy. In some cases, Uganda followed trends, though still with some success. As the Jubilee 2000 movement came to a climax, Uganda began to link indebtedness to its inability to fully implement its expanding HIV programme (and secured $2 billion in debt relief). Rather more quickly, in 2002, Uganda's rhetoric relating to HIV responded to the post 9/11 securitization of health, which helped maintain the country's favoured status with the US.[37]

Uganda's global influence had peaked by 2003. The logic of PEPFAR and the Global Fund was to replicate what it had achieved, with local adaptation, in other countries, and attention necessarily focused on southern Africa, where the pandemic had reached devastating proportions. Uganda's reputation for efficiency and probity weakened as corruption scandals grew in frequency. Most damaging was an audit in 2005 which led to the suspension of aid from the Global Fund. President Museveni's increasingly high-profile opposition to the use of condoms from 2004 provoked concern among multiple HIV agencies and donors. Finally, the passing of a bill making 'aggravated homosexuality' a capital offence depleted Uganda's moral credit abroad, and drew condemnation from a number of funders.[38] The number of bilateral donors from which Uganda sourced HIV funding shrank between 2003 and 2020 from sixteen to two. But Uganda still received $555.9 million in HIV aid in 2020, accounting for 84% of all AIDS-related expenditure in the country. Crucially, one of Uganda's two remaining bilateral funders is the most generous of all, the USA. It may

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[35] Margaret Laws, 'International funding of the global AIDS strategy: official development assistance', in *AIDS in the World II: The Global AIDS Policy Coalition*, eds. Jonathan Mann and Daniel Tarantola (Oxford: Oxford University Press, 1996), 386; USAID, *What Happened in Uganda?*, 11; Esther Nakkazi, 'As Uganda Takes Control of the HIV Epidemic, U.S. Shifts Funding', 6 June 2020, https://undark.org/2020/06/10/uganda-takes-control-of-hiv-epidemic/, last accessed 1 July 2020; M. Donoghue et al., *Global Fund Tracking Study, Uganda Country Report* (London: LSHTM, 2005), 1-6.

[36] Samuel Okware, 'Giving AIDS a new face', *World Health* (Oct. 1989), 18-20.

[37] Samuel Okware, 'Planning AIDS education for the public in Uganda', in World Health Organisation, *AIDS: Prevention and Control* (Geneva: World Health Organization, 1988), 32-6; World Health Organisation & United Nations Children's Fund, *Report on WHO Global Programme on AIDS (GPA)* (Geneva: World Health Organization, 1989); United Nations, A/S-26/PV.1, General Assembly Twenty-sixth special session, 1st meeting, Monday, 25 June 2001, https://documents-dds-ny.un.org/doc/UNDOC/GEN/N01/424/61/pdf/N0142461.pdf?OpenElement, last accessed 25 June 2020; United Nations A/57/PV.45 General Assembly Fifty-seventh session 45th plenary meeting Friday, 8 Nov. 2002, 3 pm: Implementation of the Declaration of Commitment on HIV/AIDS, Report of the Secretary-General (A/57/227 and A/57/227/Corr.1), https://documents-dds-ny.un.org/doc/UNDOC/GEN/N02/681/11/pdf/N0268111.pdf?OpenElement, last accessed 21 June 2020.

[38] Lynn Eaton, 'Global Fund pulls grants to Myanmar and Uganda', *British Medical Journal* 331 (2005), 475; 'Uganda: Condoms not ultimate answer, says Museveni', *East African Standard*, 13 July 2004; 'Uganda president: homosexuals are "disgusting"', *CNN*, 25 Feb. 2014; K. Cheney, 'Locating neocolonialism, "tradition", and human rights in Uganda's "gay death penalty"', *African Studies Review* 55, No. 2 (2012): 77-95.

be more appropriate to think of Uganda's narrowing of global influence since the early 2000s as a recalibration rather than a fall from grace. While it is tempting to see Uganda's retreat from a rights-based approach to HIV primarily as an indication of the country's infiltration by American evangelical Christianity, it should be noted that President Museveni's desire for moral reform was long-held. So too was his scepticism regarding the appropriateness of condoms in the Ugandan context, which he had insisted on as early as 1987, and repeated at international meetings through the 1990s. The record of the United States government's discussions around the PEPFAR proposals in 2003 can be read as a reflection of the growing resonance of Ugandan moral conservatism within American global health thinking. The testimony of Uganda's first lady, and increasingly influential AIDS activist, Janet Museveni, that '"My experience has led me to conclude that when dealing with young people especially, it is vitally important to emphasize abstinence as the first line of defense"', resonated with the increasingly conservative USAID leadership, as well as many members of Congress and the Bush administration.[39] From the perspective of Ugandan international influence and sovereignty, the years after 2003 need not be understood as marking an absolute decline.

Conclusion

Epidemics can change the course of world history. They do so not only through their weakening of an established status quo, but also by providing new opportunities to effect change. COVID-19 threatened years of effort by the Chinese authorities to extend its influence around the world. China's response, in the form of targeted briefings, strategic generosity, and carefully managed engagement with foreign and international health agencies, limited the initial damage to a degree. It is likely, though, that as the global costs of COVID mount, in terms of mortality, morbidity, and finance, that the Chinese government will be required to expand its soft power strategy. The Ugandan case shows how much can be done in the field of health to enhance (or restore) a state's global standing and influence, albeit over a period of decades rather than months.[40] Other than duration, there are of course other striking differences in the nature of the two pandemics, and in the position of the Chinese and Ugandan states. To a degree, the very weakness of Uganda, and the structural marginality of HIV/AIDS, provided the leverage which would in the end deliver such radical

[39] Esther Nakkazi, 'As Uganda takes control of the HIV epidemic, U.S. shifts funding', 6 June 2020, https://undark.org/2020/06/10/uganda-takes-control-of-hiv-epidemic/, last accessed 1 July 2020; 'AIDS Commission still underfunded', 18 Feb. 2020, https://www.parliament.go.ug/news/4027/%E2%80%98aids-commission-still-underfunded%E2%80%99, last accessed 1 July 2020; H.E. the President, 'Prevention of AIDS', National Committee for the Prevention of AIDS (extraordinary) meeting, 10 July 1987: UMoH, John Iliffe papers, VNNUMR.RGD, section 12; U.S. Senate, *Fighting Aids In Uganda*, 24-6. For a wider discussion of Uganda's culture wars and engagement with the American religious right, see Lydia Boyd, *Preaching Prevention: Born-Again Christianity and the Moral Politics of AIDS in Uganda* (Athens OH: Ohio University Press, 2015). It is important to recognize that Uganda fitted within a broader Republican strategy of promoting family values within foreign policy for domestic political gain.

[40] There is potential for China to replicate Uganda's multisectoralist approach to HIV, should it seek to use coronavirus as a means of advancing its longer-term future global leadership. China might, for example, move beyond its very public efforts to treat and prevent COVID infection, by addressing, in a replicable manner, contextual factors which heighten risk of serious illness, such as air pollution and underlying health conditions like diabetes, hypertension, and obesity. Again, as epidemiological attention increasingly focuses on workplace infections, China, given its ideological commitment to the interests of labour, may seek to redesign working environments to reduce emerging structural inequalities. Experience suggests that such fundamental change will likely only be considered should the search for effective vaccines and treatments in the near future prove fruitless.

shifts within global health. A sense of Ugandan overachievement and an accumulation of guilt within the global north provided a model and moral impetus for change.

AIDS should perhaps have changed the world more than it did. It showed that a virus that jumped species could spread around the world before it was identified, cause enormous mortality and social and economic disruption, and evade all attempts to develop a safe, effective vaccine.[41] Its consequences were catastrophic within Africa, and contributed to the external perception of Africa as a collection of failing states. Its impact was of course broader, restoring fear and caution to sex and reproduction around the world, and helping shift global narratives around health to one of patient rights. HIV also facilitated the strengthening of non-governmental organizations as bearers of power and influence in the global south.[42] The Ugandan story links AIDS to a series of reorientations which have transformed global health over recent decades. Ugandan pressure in 1986 helped shift health strategy from the horizontal model of health for all back towards an emphasis on vertical, disease-specific interventions. Most significantly, Uganda played a key role in convincing the global north to provide funding for AIDS, in the form of PEPFAR and the Global Fund, on a scale that matched its significance. Uganda has also contributed significantly to the securitization and moralization of health, and to ensuring that the language of aid, development, and research moved further towards one of equal partnership.

Uganda helps us understand China's logic of information management in response to COVID, of managing the risks of transparency and engagement in a hostile global environment. It also shows that other states and international agencies are willing to make allowances for expressions of national pride. The WHO evidently has decades of experience of working around nation-states' guarded sharing of data, or outright disinformation. The Ugandan experience also reveals that while soft power can strengthen through the accumulation of expertise and influence, equally it can narrow where a regime's interests align with an ever-reducing range of international nodes of influence. Since the early 2000s Uganda has been viewed as falling ever more deeply under the sway of the American religious right, and criticized for retreating from policies which had proven successful in earlier years.[43] This narrowing should not necessarily be equated with a weakening of power, externally and particularly internally. Soft power, after all, does imply an engagement with outside forces which has the potential to limit state sovereignty. Arguably, Uganda adopted an expansive approach to soft power as it sought to rebuild its state infrastructure, and developed more targeted alliances as the regime entered a period of consolidation.[44]

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[41] Of many warnings that further devastating pandemics were likely, the most readable is Laurie Garrett, *The Coming Plague: Newly Emerging Diseases in a World out of Balance* (New York: Farrar, Straus and Giroux, 1994).

[42] For discussion of the relationship between state sovereignty and NGOs see Gregory Mann, *From Empires to NGOs in the West African Sahel: The Road to Nongovernmentality* (Cambridge: Cambridge University Press, 2014). While this article has focused on the Ugandan state, NGOs were crucial in facilitating behavioural change at the local level, to some degree limiting the government's exposure to criticism from conservative opinion.

[43] Of many important studies of American influence on the prioritization of abstinence see Jo Sadgrove, '"Keeping up appearances": sex and religion among university students in Uganda', in *Aids and Religious Practice in Africa*, eds. Felicitas Becker and Wenzel Geissler (Leiden: Brill, 2009), 229.

[44] For a seminal analysis of the relationship between development aid and the strengthening of bureaucratic power, see James Ferguson, *The Anti-politics Machine: "Development," Depoliticization, and Bureaucratic Power in Lesotho* (Minneapolis: University of Minnesota Press, 1994). The internal politics of AIDS in Uganda are complex and merit further research. Museveni's regime has used AIDS as a means of enhancing state legitimacy, smearing opponents, and mobilizing sectional support. It has further been accused of diverting HIV-related donor funding to finance government political programmes. See Susan Reynolds Whyte, 'Introduction: the first generation', in *Second Chances: Surviving AIDS in Uganda* (Durham NC: Duke University Press, 2014), 11; Joseph Tumushabe, 'The politics of HIV/AIDS in Uganda', *United Nations Research Institute for*

It is also important to bear in mind that soft power is neither one-dimensional, nor exerted in isolation. Uganda's enthusiastic engagement with external donors and agencies in relation to AIDS was driven by a sincere commitment to alleviating suffering, but also by a broader goal of national rehabilitation. Uganda's HIV policy reflected a larger strategy of responsible engagement. It was for example perhaps Africa's most steadfast adherent to the rules of structural adjustment in the late 1980s and 1990s, and proved 'a strong ally in the war on terror'. This approach to international affairs secured influence and aid, greatly strengthening state capacity, and allowed Uganda to achieve many of its 'hard power' goals.[45] Just as China's growing pressure on Taiwan and weakening of Hong Kong's autonomy in 2020 must be understood in the context of COVID, so Uganda's skilful soft power interventions limited international criticism of its invasion of a neighbouring country, a destructive civil war, the suppression of opposition, and high-level corruption.

Finally, while this article has highlighted Uganda's skill at influencing global understanding and securing international aid, it must be remembered that major donors' soft power was also enhanced through this relationship. Uganda is nowhere to be seen in the indices of soft power, which are headed by countries such as France, the UK and the US. HIV has facilitated an equalization of scientific relationships, but not a larger realignment of global influence.

Social Development Social Policy and Development Programme Paper Number 28 (August 2006). It remains to be seen how effectively the Chinese government's efforts to minimize its reputational damage resonate among a domestic population already scarred by successive health-related scandals.

[45] A. Geske Dijkstra and Jan Kees Van Donge, 'What does the showcase show? Evidence of and lessons from adjustment in Uganda', *World Development* 29, no. 5 (2001): 841-63; Jonathan Fisher, '"Some more reliable than others": Image management, donor perceptions and the Global War on Terror in East African diplomacy', *The Journal of Modern African Studies* 51, no. 1 (2013): 1-31.