Addressing HIV/AIDS in South Africa and Uganda: Successes, Failures, and Recommendations for Other Sub-Saharan African Countries

by

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A NOTE ON TERMINOLOGY

Throughout this thesis, references will be made to HIV prevalence and incidence rates. Epidemiologists use prevalence rates to refer to the number of infected people in a certain population, while incidence rates refer to the rate at which people become infected. Incidence rates best indicate the future trends of the HIV/AIDS pandemic because they represent the number of new infections occurring each year. Unfortunately, incidence rates are difficult to record because a segment of the population has to be tracked over time, so prevalence rates are more commonly used to track the epidemic. Prevalence rates signify the number of current cases of HIV/AIDS per population at risk; but since antiretroviral drugs were introduced, these rates have declined at a slower rate because the therapy prolongs life (Epstein 2001).

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<tr>
<td>AIDS</td>
<td>Acquired Immunodeficiency Syndrome</td>
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<td>ANC</td>
<td>African National Congress</td>
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<td>ARV</td>
<td>Antiretroviral Drug Therapy</td>
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<td>CDC</td>
<td>Centers for Disease Control and Prevention</td>
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<td>DOH</td>
<td>Department of Health</td>
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<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
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<td>IMF</td>
<td>International Monetary Fund</td>
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<tr>
<td>MTCT</td>
<td>Mother-To-Child-Transmission</td>
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<tr>
<td>NGO</td>
<td>Non-Governmental Organization</td>
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<tr>
<td>NRM</td>
<td>National Resistance Movement</td>
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<td>PEPFAR</td>
<td>President’s Emergency Plan For AIDS Relief</td>
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<td>SIV</td>
<td>Simian Immunodeficiency Virus</td>
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<td>STI</td>
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<td>TAC</td>
<td>Treatment Action Campaign</td>
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<td>TASO</td>
<td>The AIDS Support Organization</td>
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<td>UNAIDS</td>
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<td>WHO</td>
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I dedicate this thesis to my mom.
INTRODUCTION

Since its discovery, HIV/AIDS has killed more than twenty-five million people worldwide. UNAIDS, the Joint United Nations Programme on HIV/AIDS, estimates that thirty-three million more are currently living with HIV/AIDS and two-thirds of them are located in sub-Saharan Africa. Over the past two decades, the life expectancy in the sub-Saharan African region as a whole has dropped to below 50 years of age primarily as a result of AIDS (UNAIDS 2008a). Human immunodeficiency virus (HIV) impairs and destroys cells that protect the body from foreign invaders, eventually destroying the human immune system's ability to fight infections, cancers, and other symptoms, at which point it is referred to as acquired immunodeficiency syndrome, or AIDS. The virus is slowing economic growth, damaging human capital, devastating families, and ruining infrastructure and health care systems.

HIV/AIDS crosses all social borders – gender, racial, cultural, and religious. It also crosses national borders and spreads primarily through personal interactions. Although HIV/AIDS has devastated Africa far more than any other continent, it has also ravaged wealthier, developed countries. For example, at the end of 2007, the Centers for Disease Control and Prevention estimated that approximately 1.1 million Americans were living with HIV/AIDS and one in every five HIV-positive Americans was unaware of his or her diagnosis (CDC 2007).

This thesis compares and contrasts the responses by South Africa and Uganda to their national HIV/AIDS crises and derives lessons from their actions and reactions. Several conclusions are drawn from these lessons to advise other sub-
Saharan African governments how to respond to their national HIV/AIDS crises. The Southern African region has struggled more than any other area of the world with HIV/AIDS and suffers from thousands of new infections daily. Senegal, in West Africa, and Uganda, in East Africa, are often referred to as the sub-Saharan African success stories in the fight against HIV. Senegal has managed to keep its rate of infection below one percent since 1997, while Uganda has done a tremendous job of lowering its infection rate from approximately 15 percent in 1991 to 5.4 percent in 2007 (Zaccagnini 2009). In contrast, at the end of 2007 South Africa was home to 5.7 million HIV-positive citizens and had an adult HIV prevalence rate of 18.1 percent (CIA 2009). Two major forces have impeded South Africa’s ability to combat HIV/AIDS: racism and the government’s preoccupation with the transition from apartheid to democracy. Uganda, on the other hand, has managed to combat HIV successfully through strong government leadership, public involvement, and international support.

This thesis is structured into six chapters for the purposes of analyzing South Africa’s and Uganda’s responses to the HIV/AIDS epidemic and offering lessons and prescriptions for other sub-Saharan African countries. Chapter One provides a basic scientific background of the human immunodeficiency virus and its development into acquired immunodeficiency syndrome. It also examines the theories of HIV origination, its spread throughout sub-Saharan Africa and the rest of the world, and several controversial theories about sub-Saharan Africa’s high HIV prevalence rates.

Chapters Two and Three take a close look at the situations in South Africa and Uganda, respectively. Chapter Two focuses on the impacts of apartheid, poor
government leadership, and discrimination on South Africa’s ability to counter HIV/AIDS. The virus infiltrated South Africa at a most inopportune time as the citizens were suffering from violence, racism, and segregation while the country transitioned from apartheid to democracy. During this hectic time, HIV was able to slowly permeate the country, infecting rich and poor, white and black, urban and rural (Noble 2009b). Chapter Three analyzes the positive impact of Uganda’s rapid reaction to HIV/AIDS and the importance of strong leadership and a unified population. Unlike South Africa, Uganda responded quickly to the virus by encouraging open communication and implementing extensive prevention and treatment programs.

Chapter Four compares and contrasts the responses to the epidemic by South Africa and Uganda. The chapter is divided into four main categories: the political and economic environments at the time of the spread, the government’s involvement, the reactions of Ugandan and South African citizens, and the role of international organizations. It concludes that South Africa has struggled to control the spread of HIV because of the country’s preoccupation with a smooth political transition, poor leadership, and disjointed society. Uganda, on the other hand, has decreased its adult HIV prevalence rate through strong government leadership, open communication, and international assistance.

The final two chapters provide roadmaps with a series of conditions to be followed by the relevant actors in order to successfully combat HIV/AIDS. The roadmap in Chapter Five has seven recommendations for sub-Saharan African governments and societies to reduce their prevalence rates. They are 1) respond
quickly, 2) have strong leadership, 3) encourage open communication among unified and dedicated citizens, 4) reduce poverty and income inequalities, 5) end domestic violence and promote gender equality, 6) implement effective prevention and treatment programs, and 7) treat other sexually transmitted infections that increase the rate of HIV transmission. Chapter Six provides a roadmap that includes ten recommendations for all forms of international assistance that flow into sub-Saharan Africa to fight HIV/AIDS. These recommendations are 1) involve recipient governments and civilians, 2) evaluate projects, 3) tailor prevention programs accordingly, 4) coordinate donor efforts, 5) do not impose Western values, 6) balance funding between prevention and treatment programs, 7) provide incentives, 8) monitor and follow up on projects, 9) keep the international spotlight on sub-Saharan Africa, and 10) increase transparency, avoid ineffective forms of aid, and improve infrastructure.
CHAPTER ONE

Biology and Epidemiology of HIV and AIDS

HIV stands for human immunodeficiency virus, a term coined in a 1986 compromise between France and the United States. The virus was first discovered in 1983 by a research team led by Luc Montagnier at the Pasteur Institute in Paris and named lymphadenopathy-associated virus (LAV). Within a year, an American research team headed by Robert Gallo confirmed the discovery of the virus, but referred to it as human T-lymphotropic virus type III (HTLV-III). Intense arguments between the French and American research groups over the discovery of the virus ensued for the next couple of years, but eventually President Mitterrand of France and President Reagan of the United States agreed on the name human immunodeficiency virus (Altman 2008).

HIV is a lentivirus, a type of retrovirus that infects cells in the human immune system and either destroys the cells or severely impairs their function. HIV mainly targets CD4 positive T cells and macrophages, both of which are crucial for preventing and stopping infections. Immunodeficiency viruses lead to a breakdown of the immune system and result in increased susceptibility to infections and diseases. When the human body loses CD4+ cells, it can no longer fight off infections and is vulnerable to a variety of foreign invaders. Infections that are associated with severe immunodeficiency are called opportunistic infections because they can easily destroy a weakened immune system. HIV is transmitted primarily through unprotected

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1 The terms HIV and AIDS cannot be used interchangeably. HIV is the virus that attacks the human immune system and causes AIDS. AIDS is the set of symptoms, infections, and cancers that arise at the most advanced stage of HIV infection (Fan et al. 2004).
sexual intercourse, shared needles, contaminated breast milk, pregnancy, and childbirth, from an infected mother to her baby (UNAIDS 2008c).

HIV infections are difficult to diagnose without blood tests because people exhibit different symptoms. Most people do not feel ill immediately but instead discover their infections after developing acute retroviral syndrome, a glandular illness that causes fever, rash, and enlarged lymph nodes (UNAIDS 2008b). To diagnose the virus officially, a blood test is conducted to measure the level of one's antibodies to HIV seroconversion. Antibodies are produced by white blood cells to identify and take action against foreign invaders. Within thirty days of infection, most immune systems produce measurable antibodies to HIV seroconversion, but occasionally it takes up to six months for detectable antibodies to develop. Antibody tests occasionally give false negatives during the window period, the interval time between infection and development of antibodies to HIV seroconversion, but overall are 99 percent accurate (Burke et al. 1988). HIV antibody tests are the most common method of testing for HIV because of their low cost and high accuracy.

Doctors use two main indicators, CD4+ T cell count and CD4+ T-lymphocyte percentage of total lymphocytes, to measure the progression of HIV into AIDS. On average, a healthy human has between 600 and 1,200 CD4+ T cells per cubic millimeter of blood to protect the body from foreign objects such as bacteria and viruses. The CD4+ T-lymphocyte percentage of total lymphocytes measures the number of CD4+ T cells in comparison to the number of total T-lymphocyte cells. Lymphocytes are a type of white blood cell that assists the human body in fighting infection. The two main types of lymphocytes are B-lymphocytes and T-
lymphocytes, the latter of which are further subdivided into two groups, CD4+ T cells and CD8 cells. A healthy human usually has a CD4+ T-lymphocyte percentage of approximately 40 (Cichocki 2007). According to the United States Centers for Disease Control and Prevention (CDC), the primary indicator that HIV has developed into AIDS is when an HIV-infected person has fewer than 200 CD4+ T cells or a CD4+ T-lymphocyte percentage of total lymphocytes that is less than fourteen percent (Castro et al. 1992). The CD4+ T cell count and CD4+ T-lymphocyte percentage provide a snapshot of the immune system and allow patients to be aware of their level of vulnerability to opportunistic infections.

AIDS, acquired immunodeficiency syndrome, can be detected based on signs, symptoms, infections, and cancers due to the deficiency of one's immune system stemming from HIV infection (UNAIDS 2008b). AIDS itself is not a disease; it is the set of symptoms and infections resulting from the human immunodeficiency virus. The conditions that develop because of AIDS are often caused by bacteria, fungi, viruses, and parasites that rarely occur in healthy individuals. Those infected with HIV face an increased risk of opportunistic infections, cancers, pneumonias, gastrointestinal infections, tumors, and neurological impairments. Kaposi’s sarcoma, a rare form of skin cancer, was especially common in early African infections and in homosexual males at the start of the American epidemic. Pneumocystis pneumonia is also common among infected individuals and is an immediate cause of death without prophylaxis treatment. Gastrointestinal infections, such as candidias, herpes simplex-1, and cytomegalovirus, often result in esophagitis, an inflammation of the lining of the esophagus. Neurological impairments, such as toxoplasmosis, progressive
multifocal leukoencephalopathy (PML), and AIDS dementia complex (ADC), tend to be the most difficult symptoms for a patient’s family and friends to experience. Caused by a parasite, toxoplasmosis can lead to infection in the brain, eyes, and lungs, and often causes brain damage and rapid death. Along with increased rates of Kaposi’s sarcoma, HIV-positive patients also have higher rates of cervical cancer, lymphomas, and Epstein-Barr virus (Watstein 1998).

Over the past decade, the number of tuberculosis infections in both the developed and developing worlds has drastically increased, largely due to the rise in HIV infections because the virus weakens the immune system and increases susceptibility to opportunistic infections. Tuberculosis differs from many other opportunistic infections because it is transmitted easily via the respiratory route. Without proper treatment, tuberculosis can be fatal. Unfortunately, many parts of the developing world do not have access to the drugs and medical personnel necessary to treat the disease effectively. Failure of patients to take tuberculosis drugs properly has caused a rise in the number of multi-drug resistant (MDR) cases of tuberculosis (Phillips 2004).

HIV/AIDS differs from past pandemics in several ways. First, it is spread primarily through sexual intercourse, a personal interaction between two people. It is, therefore, not contagious in the same way as the bubonic plague and the Spanish influenza. Second, HIV has the ability to remain dormant for a long period, so that those infected do not necessarily realize it and may inadvertently spread the virus before learning their diagnosis. In contrast, those infected with the bubonic plague and Spanish influenza were aware of their status within a couple of days of infection.
In the first half of the fourteenth century, the bubonic plague killed approximately 75 million people worldwide. Four of five people infected with the bubonic plague died within eight days (Totaro 2005). In 1918, the Spanish influenza killed 50-100 million people, approximately 2.5-5 percent of the total human population at the time. The influenza’s most frightening feature was its lack of differentiation between old and young or weak and strong when selecting victims (Moren and Taubenberger 2005). Although these epidemics were both extremely deadly, they differ greatly from HIV/AIDS in their manner of transmission. The bubonic plague was most likely transmitted to humans via bacteria that live in fleas and the Spanish flu was an especially potent strain of influenza that spread easily from person to person.

**Antiretroviral Drug Therapy**

Since HIV is relatively difficult to spread, victims can be unaware that they have the virus until years later. Most people develop HIV-related symptoms within 5-10 years, but it sometimes takes 10-15 years for the virus to develop into AIDS. Highly active antiretroviral therapy (HAART) was introduced in 1996 to slow the progression of HIV into AIDS. Antiretrovirals, commonly referred to as ARVs, are recommended for anyone infected with a CD4+ T cell count below 200, but they are not always available to those in need. ARVs do not cure HIV/AIDS, but they have “dramatically reduced mortality and morbidity, prolonged lives, and improved the quality of life of many people living with HIV/AIDS” (WHO 2003, 8). When HIV infects cells in the immune system, it destroys or impairs their function, leading to immune deficiency. Antiretrovirals prevent the virus from multiplying inside a
person and therefore stop the destruction of CD4+ T cells. However, HIV mutates quickly and can often adapt to antiretrovirals and render them ineffective. If this occurs, doctors prescribe a second line of antiretroviral treatment to stop the HIV virus from multiplying. Having to resort to a second or third line of treatment usually takes time, but if the antiretroviral drugs are not taken regularly and properly, it becomes a necessity. Antiretrovirals are also recommended for pregnant women in order to prevent passing HIV to their unborn babies. Mother-to-child-transmission (MTCT) of HIV can occur during the pregnancy, delivery, or after the birth through the mother's breast milk. The majority of MTCT occurs in sub-Saharan Africa and other developing regions that do not always have access to ARVs and proper medical care (UNAIDS 2008b).

One of the major goals of the Western world and international development organizations is to increase global accessibility to ARVs. However, accessibility to antiretroviral drug therapy currently faces three major challenges: they are expensive; they need to be taken religiously and in conjunction with a healthy diet; and they require extensive regulation and laboratory testing. The World Health Organization estimates that as of December 2007, approximately 6.7 million HIV-infected people living in low- and middle-income countries are in need of ARVs (WHO 2008).

Despite spending millions of dollars and dedicating thousands of hours to research, no one has been able to develop a successful HIV vaccine during the past twenty-five years. Developing a vaccine for HIV is extremely challenging because of the virus’s rapid integration into the DNA of the host cell and its ability as a retrovirus to constantly evolve (Fauci and Johnston 2008). In 2004, approximately
682 million dollars were spent by public, philanthropic, and commercial sectors in an attempt to create an HIV vaccine. According to the Coordinating Committee of the Global HIV/AIDS Vaccine Enterprise, this expenditure fell short of the suggested 1.2 billion dollars needed to speed up the process of creating a safe and effective vaccine (Lamourelle et al. 2005). Due to the lack of success in generating a vaccine, several AIDS experts have recently encouraged HIV vaccine research funding to be redirected towards prevention campaigns, routine testing, and improved access to treatment (Horton 2004).

Theories of HIV Origination

Although there is still some disagreement over the origin of the human immunodeficiency virus, most researchers and scholars believe that HIV developed from the simian immunodeficiency virus (SIV) in Central Africa. HIV is a type of retrovirus known for its slow maturation in the body. Lentiviruses have been identified in many animals, including cats, sheep, horses, cattle, and monkeys. Extensive scientific research has found that HIV-1 and HIV-2 bear close resemblance to two forms of SIV; thus, it is likely that both strains of HIV developed from simian immunodeficiency viruses. Further research has shown that HIV-2 corresponds with SIVsm, a strain of the virus that is found in sooty mangabey monkeys in western Africa. In 1999, a team of researchers from the University of Alabama discovered that HIV-1, the more potent strain of the virus, corresponds closely with SIVcpz found in chimpanzees. This discovery used a frozen sample from a sub-group of chimpanzees, *Pan troglodytes troglodytes*, to discover the link between SIVcpz and
HIV-1. The ten-year study was published in *Nature* and found “that wild chimps had been infected simultaneously with two different simian immunodeficiency viruses which had ‘viral sex’ to form a third virus that could be passed on to other chimps and, more significantly, was capable of infecting humans and causing AIDS” (Gao et al. 1999).

Both HIV-1 and HIV-2 are broken into subtypes. HIV-2 infections are divided into eight groups, but only two of the groups have become human epidemics. This suggests that many unsuccessful transmissions of SIV into HIV have occurred in the past. HIV-1 is divided into three groups lettered M, N, and O. Group M is primarily responsible for the global epidemic, Group O is as deadly as Group M, but has largely remained concentrated in Cameroon and only accounts for about ten percent of HIV cases worldwide, and Group N is extremely rare and has only been identified a handful of times in Cameroon (Allen and Kanabus 2009).

When a viral transfer takes place between animals and humans, it is known as zoonosis. Well-known examples of zoonoses include avian flu, ebola, cholera, and malaria. Scientists have proposed several theories to explain how zoonosis occurred and allowed SIV to become HIV. The most common theory, the hunter theory, is supported by most AIDS experts. According to the hunter theory, blood from killed monkeys and chimpanzees was transferred to the hunters via wounds, cuts, and consumption of the meat. Most of the time the human body fought off the simian virus, but occasionally the virus would adapt and develop into a human strain. This theory gained more credibility after a 2004 study published in *The Lancet* found that retroviral transfers from primates to hunters are still occurring today. The study
sampled 1,099 individuals in Cameroon and found that one percent were infected with Simian Foamy Virus, an illness that was previously thought only to infect primates. These infections were probably acquired via the hunting and consumption of chimpanzee meat and indicate that simian immunodeficiency virus could have developed into human immunodeficiency virus in the same manner (Allen and Kanabus 2009).

Preston Marx, a virologist at Tulane University, proposed the contaminated needle theory in 1997 as an extension of the original hunter theory. His theory is based on the idea that medical personnel in Africa reused syringes to inject multiple patients without sterilizing the needles between patients. Disposable plastic syringes became popular in the 1950s as cheap, sterile methods of administering medicines, and between 1952 and 1960 the number of syringes produced worldwide increased from eight million to approximately one billion (Marx 2001). In Africa, syringes were too expensive to be used once and then disposed of, so each syringe was used repeatedly. According to Marx’s theory, repeated syringe use transferred viral particles from person to person, allowing the virus to mutate and replicate in each patient. Despite failing to gain momentum and support from AIDS experts, it is possible that the contaminated needle theory contributed to the mutation and spread of HIV (Allen and Kanabus 2009).

In 1999, Edward Hooper’s book The River claimed that the HIV epidemic could be traced back to a polio immunization campaign that took place in the Belgian Congo, Rwanda, and Burundi in the late 1950s. Referred to as the oral polio vaccine (OPV) theory, it received a great deal of press at its release. The vaccine tested in
Africa was called Chat and had to be cultivated in living tissue to reproduce. Hooper believed that Chat was grown in kidney cells from local chimpanzees that were infected with SIVcpz and transmitted to dozens of Africans when the vaccine was tested. Since its introduction, Hooper’s controversial theory has been questioned by epidemiologists, biologists, and dozens of other researchers. Although it is nearly impossible to completely disprove the OPV theory, there is strong evidence that invalidates it. First, it is unlikely that an oral vaccine could reach the bloodstream and infect people. Second, tests run on an old vial of Chat found no traces of HIV or SIV. Third, many independent studies suggest that the introduction of HIV to humans took place in the first half of the twentieth century, well before the immunization campaign began (Illiffe 2006).

In 2000, Jim Moore proposed the colonialism or “Heart of Darkness” theory to explain how the original HIV infection developed into an epidemic. Throughout the nineteenth and twentieth centuries much of Africa was colonized by European countries. Colonial rule was characterized by inequality, weak governance, and harsh living conditions. In some territories, Africans were forced into labor camps with poor sanitation, limited food, and minimal medical care. Coupled with the camps’ rigorous physical demands, the impoverished living conditions provided the ideal setting for the transfer of SIV in monkeys and chimpanzees to HIV in humans. Since the death rate in labor camps was high, the virus could have spread without anyone’s realizing that a new disease had developed. Unfortunately, it is impossible to verify Moore’s theory because all medical records from the camps were destroyed to cover up the huge number of deaths that occurred (Allen and Kanabus 2009).
In addition to scientific explanations of the evolution of HIV, over the past three decades several conspiracy theories have been proposed. When the human immunodeficiency virus initially popped up in certain populations, people grew suspicious of its origins. One theory claimed that HIV was created by the United States Special Cancer Virus Program in the 1960s to wipe out large numbers of blacks and homosexuals. Although most people in the developed world find this theory ludicrous, it still holds significant clout in certain regions and populations. Another conspiracy theory suggests HIV was spread either deliberately or inadvertently to thousands of people throughout the world via smallpox inoculations. Although it is nearly impossible to disprove these theories, the strong link between SIV and HIV makes the various conspiracy theories unlikely (Allen and Kanabus 2009).

Over the last couple of decades, research has been conducted to determine when and where the HIV-1 virus originated in humans. Although some argue that it is unnecessary to find the exact location of origination because of the negative repercussions the region will encounter, most researchers believe it is important to learn as much as possible about the virus in order to understand and fight it. Blood and plasma samples from the four earliest known HIV patients date back to 1959, 1960, 1969, and 1976. Over the past decade, three independent studies have hypothesized different time periods for the origination of HIV-1. The first study, conducted in 1998, found that HIV-1 was introduced to humans in the 1940s or early 1950s (Zhu et al. 1998). A second study was conducted in 2000 using a computer model of HIV’s evolution and determined that HIV-1 infection first occurred in 1931.
in West Africa (Korber et al. 2000). A 2008 study found significant differences between the 1959 and 1960 HIV-positive plasma samples and, therefore, hypothesized that the virus must have originated between 1884 and 1924 because of its diversification (Worobey et al. 2008).

Regardless of when simian immunodeficiency virus transfer to human immunodeficiency virus occurred, there is strong evidence suggesting that it first took place in western equatorial Africa. A 2006 study analyzed 599 chimps in Southern Cameroon and found that 34 of the chimps had droppings that reacted to a standard HIV DNA test (Keele et al. 2006). From their results, the researchers concluded that HIV-1 Group M and Group N most likely originated in the chimpanzees of Southern Cameroon and that Group O probably also originated in West Africa. Since the likely viral ancestor of HIV-1 has been found only in western equatorial Africa, it is probable that the virus originated there (Illiffe 2006).

Using a variety of specimens from Africa, North America, and Europe, researchers divided HIV-1 Group M into nine subtypes, lettered A, B, C, D, F, G, H, J, and K to differentiate between the various strains. Western equatorial Africa is the only region to which all subtypes of HIV-1 Group M can be traced, further indicating the virus’s origination in this area. Occasionally, an infected person can harbor two different human immunodeficiency viruses that mix genetic material and create a new hybrid virus. Most of these hybrid strains do not survive; but if they do survive and infect a second person they are referred to as circulating recombinant forms or CRFs. Although subtypes A and C are most widespread, each region of the world tends to have different dominant HIV-1 subtypes and CRFs. In West and Central Africa,
subtype A, subtype G, and CRF A/G are most common. Russia’s recent HIV epidemic is primarily driven by subtype A. Southern and eastern Africa, India, and Nepal are infected primarily with the deadliest of the strains, subtype C, which is responsible for about half of the world’s infections. In Europe, the Americas, Japan, and Australia, subtype B is the most prevalent strain of the virus, but recently other strains have become more common. Subtype D is generally found in East and Central Africa. The circulating recombinant form A/E is found in South-East Asia, but its roots can be traced to Central Africa. Subtype H has only been identified in Central Africa, subtype J only in Central America, and subtype K only in Cameroon and the Democratic Republic of Congo (Noble 2009a).

It is likely that new subtypes and CRFs will be identified in the future as recombination and mutation continue to occur. HIV’s ability to evolve quickly has proven to be one of the great challenges for those trying to develop a vaccine to the virus. Various studies have been conducted to determine the differences between the HIV subtypes in their transmission methods and rates. Research suggests that subtype B is primarily spread through blood via homosexual contact and intravenous drug use, while subtypes C and CRF A/E are mostly spread through mucous and, therefore, most prevalent in heterosexual epidemics. Despite speculation that Africa has a more potent strain of the virus, no studies have accurately proven this theory (Illiffe 2006).

Along with the discovery of SIV and the maximum diversity of all subtypes in western equatorial Africa, the final piece of evidence pointing to the origination of HIV in Africa is the high number of opportunistic infections present in the 1970s. At
the time, doctors and medical personnel did not know what was causing the surge in opportunistic infections but, in retrospect, realized that the human immunodeficiency virus was likely making its way through the region and leaving hundreds of people especially susceptible to infections (Illiffe 2006).

**Spread of HIV in Sub-Saharan Africa**

Although most research points to Southern Cameroon as the exact location of HIV’s origination, the “conversion of this low-level infection into an expansive epidemic probably took place in the urban environment of Kinshasa during the 1970s” (Illiffe 2006, 10). Kinshasa is located in the Democratic Republic of the Congo and has been referred to as the “epicentre of the HIV/AIDS pandemic” because of the virus’s rapid spread throughout the city (Worobey et al. 2008, 663). HIV probably made its way from Cameroon to Kinshasa in about 1960 via the Sangha River in Southern Cameroon to the River Congo that runs through Kinshasa. After gaining independence from Belgium in 1960, the Democratic Republic of Congo suffered unstable and corrupt leadership. During the adjustment to its freedom from colonialism, Kinshasa’s population grew dramatically from 402,500 in 1959 to 1,323,039 in 1970 to 2,664,309 in 1984 (Lahmeyer 2003). Rapid population growth, urbanization, high infectivity levels, and an extensive network of sexual relationships played important roles in the transmission of HIV in Kinshasa (Illiffe 2006).

After originating in Southern Cameroon and exploding in Kinshasa, HIV started to make its way around the rest of sub-Saharan Africa. The virus spread slowly through West Africa but quickly made its way through East Africa in
Bujumbura in Burundi, Kigali in Rwanda, the south-western region of Uganda, the north-western region of Tanzania, and Nairobi in Kenya. An extensive transportation system and high levels of mobility among young urban immigrants and truck drivers provided the ideal conditions for the rapid spread of HIV in eastern Africa. The populations infected by the virus tended to vary by city, country, and region. In Kinshasa, the virus was primarily prevalent among old, wealthy men and young women. East Africa’s HIV epidemic was primarily driven by sex workers who spread the virus to husbands seeking extra-marital relations. The husbands would then unknowingly transmit the virus to their wives. Although Kinshasa was the first major city to record high HIV prevalence rates, it was not the city hit worst by the virus. Unlike East Africa’s large cities, Kinshasa had relatively low rates of sexually transmitted infections and a high percentage of circumcised men, which both played a role in limiting the spread of HIV (Illiffe 2006).

When HIV arrived in East Africa, it entered a region divided “into two contrasting natural and social environments: the well-watered, densely peopled kingdoms around Lake Victoria and on the Ethiopian plateau, and the less centralised societies in the drier savanna country where populations clustered only on highland outcrops, in colonial cities along transport routes, and on the Indian Ocean coast” (Illiffe 2006, 19). These unique environments provided a distinct framework for the HIV/AIDS spread in East Africa. The virus diffused quickly around Lake Victoria and in the capital cities, while slowly penetrating the rest of the region. Easy mobility between city and countryside, widespread labor migration, heavily male-populated urban centers, low status of women, low rates of circumcision, and high prevalence of
sexually transmitted infections resulted in higher HIV rates in East Africa than in western equatorial Africa. The virus first spread through Rwanda, Burundi, and the Lake Victoria basin countries in the late 1970s and early 1980s. Although Rwanda’s Kigali and Burundi’s Bujumbura were composed primarily of strict Christians, HIV spread through commercial sex in these cities. Sex workers, already called Africa’s “urban witches” and constantly blamed for social ills and problems, were immediately held responsible and suffered discriminatory treatment within their communities. Initially the virus reached high prevalence rates in the capital cities of Kigali and Bujumbura but did not deeply penetrate the surrounding rural areas. However, by the mid-1990s, HIV had spread more evenly throughout the urban and rural populations of Rwanda and Burundi (Illiffe 2006).

Around the same time that HIV entered Rwanda and Burundi, the virus also made its way into the Lake Victoria regions of Uganda and Tanzania. The Rakai and Masaka districts of south-western Uganda and the Kagera region of north-western Tanzania were heavily hit by the epidemic. Again, sex workers played an important role in spreading the virus, but civil unrest and rapid partner exchange also furthered the spread. The virus continued to spread from the Lake Victoria region and cities of Uganda and Tanzania to the remaining rural portions of the countries. Most of the HIV transmissions in East Africa stemmed from sex workers, but the infected populations of Uganda were similar to those in Kinshasa, mostly old men and young women. The virus took Nairobi, the capital of Kenya, by storm and ravaged the commercial sex industry before spreading to the rest of the country via infected men.
Cities that were heavily populated with males often had large commercial sex industries and high rates of HIV (Illiffe 2006),

After striking Rwanda, Burundi, and the Lake Victoria countries, the virus made its way to the remainder of East Africa and into Southern Africa. At this point, HIV had originated in western equatorial Africa, slowly worked its way through West and Central Africa, and devastated East Africa. Despite being infected with HIV slightly later than the rest of sub-Saharan Africa, Southern Africa soon took on the highest prevalence rates worldwide. In 2007, Southern Africa, consisting of Angola, Botswana, Lesotho, Madagascar, Malawi, Mauritius, Mozambique, Namibia, South Africa, Swaziland, Zambia, and Zimbabwe, “accounted for almost a third (32%) of all new HIV infections and AIDS-related deaths globally” (WHO 2008). After spreading to Malawi in the late 1980s, the virus entered Zambia and was briefly contained in those two countries. However, by 1990, Zimbabwe’s national antenatal HIV prevalence rate had surpassed Zambia’s rate. After sweeping through Zimbabwe, the virus invaded Botswana, and the international world shifted its focus to these four countries (Illiffe 2006). In 1996, Malawi’s adult prevalence rate was 23 percent in urban areas, 18 percent in semi-urban areas, and 12 percent in rural areas. In 1995, Zambia’s adult infection rate peaked around 17 percent. Zimbabwe’s adult HIV prevalence rates were less reliable because of internal chaos but were recorded by UNAIDS as approximately 17.35 percent in 1994 (Adetunji 2000). Zimbabwe’s most frightening statistics did not come from the main cities but from the regions surrounding the cities, the borders of South Africa, and from the transportation routes. Of the four countries, Botswana’s HIV prevalence rates were the most astonishing.
In 1990, Botswana’s adult prevalence rate was recorded as 2-3 percent, in 1995 it was 23 percent, and in 2000 it was recorded as 28 percent by the government and 36 percent by UNAIDS. In 2007, Botswana’s HIV prevalence rate among adults was 23.9 percent according to UNAIDS (2008a).

While devastating Malawi, Zambia, Zimbabwe, and Botswana, the virus silently entered South Africa, Lesotho, and Swaziland. The warfare in Mozambique and Namibia in the 1980s slightly delayed their HIV epidemics and may have even limited the virus’s spread. South Africa, on the other hand, had the ideal social and political environment for rapid spread of HIV in the 1980s. The demise of apartheid, poor living conditions, weak government leadership, and high levels of rape and violence provided the perfect opening for the virus. South Africa’s initial epidemic was concentrated among mineworkers, a huge number of whom were migrant laborers. Miners from Malawi, Swaziland, Lesotho, and South Africa were forced to live in compounds for months at a time without seeing their families. During these periods, miners frequented sex workers and contracted many sexually transmitted infections, including HIV. After contracting the virus, the miners would return to their homes and unknowingly transmit the virus to their wives before returning to work. In the southernmost African countries, the virus was evenly distributed between urban and rural areas because of high levels of mobility. As migrant laborers returned to their countries, Lesotho and Swaziland recorded some of the highest HIV prevalence rates in the world (Illiffe 2006). In 2007, Mozambique’s adult HIV national prevalence rate was 12.5 percent, Namibia’s was 15.3 percent,
South Africa’s was 18.1 percent, Lesotho’s was 23.2 percent, and Swaziland’s was 26.1 percent (UNAIDS 2008d).

Aside from Cote d’Ivoire, HIV has not affected West Africa at the same rate as the rest of sub-Saharan Africa. Researchers point to cultural practices, transportation obstacles, high levels of male circumcision, Islamic influence, and low levels of the potent HIV-1 strain as the main reasons that West Africa’s epidemic has not reached the same deadly level as the rest of sub-Saharan Africa (Illiffe 2006). Cote d’Ivoire was the exception because its 1960 independence from France led to rapid urbanization and economic growth. In turn, this led to an influx of migrant workers and a flourishing commercial sex network at the start of the silent spread of HIV. Cote d’Ivoire’s southern port, Abidjan, exploded in size between 1955 and 1984 as thousands of men migrated to work. Because of the migrant labor system, Abidjan was heavily populated with men and, therefore, had a large commercialized sex network. High levels of casual sex and low levels of condom usage resulted in ideal conditions for the spread of HIV (Illiffe 2006). After two decades of high levels of HIV/AIDS, Cote d’Ivoire is finally recording a lower HIV prevalence rate of 3.9 percent (UNAIDS 2008c).

The spread of HIV in Africa in five-year intervals from 1990-2007 (UNAIDS 2008d)
Spread of HIV beyond Sub-Saharan Africa

While making its way through Africa, the human immunodeficiency virus was also spreading throughout the rest of the world. Although it is unclear exactly how HIV spread to the United States, research suggests that the virus arrived via the Caribbean island of Haiti in the late 1960s. When the AIDS epidemic struck the U.S. in the early 1980s, it primarily hit four subpopulations nicknamed the “Four H-Club,” Haitians, homosexuals, hemophiliacs, and heroin users. When American doctors recognized the high numbers of HIV-infected Haitians, the public immediately blamed them for the outbreak. Soon, however, the other groups of the Four H-Club were identified and heavily discriminated against, making it difficult for members of the Four-H Club to acquire and maintain jobs or homes. By the late 1980s, the Four H-Club discrimination finally subsided because the virus had made its way into the rest of the American population. In March 2007 a group of international scientists announced their findings that HIV did, indeed, probably enter the United States in the 1960s when Haitians were returning from working in the Democratic Republic of the Congo (Bowdler 2007). The study suggests that a single Haitian who immigrated to America had the capability of spreading the virus to other segments of the population. The origination of HIV in the United States remains a highly sensitive subject.

Although AIDS was first identified in Western Europe in the early 1980s, the region has maintained relatively low infection rates because of its aggressive education and prevention campaigns, emphasis on condom usage, and the screening of blood. As of 2007, all Western European countries recorded national adult HIV prevalence rates under one percent, signifying a relatively minor epidemic. As
HIV/AIDS spread outside of Africa in the 1980s, Asia remained largely unaffected by the virus. However, by the early 1990s, small AIDS epidemics surfaced in several Asian countries; and by the end of the decade, the virus had spread to nearly every region of the continent. Although the percentage of HIV-positive people in Asia is much lower than percentages found in other parts of the world, some Asian countries have such large populations that these low percentages correlate with large numbers of infected people. At the end of 2007, UNAIDS estimated that five million people living in Asia are HIV-positive (2008a).

Adult HIV prevalence rates worldwide (WHO 2007)
Theories to Explain Sub-Saharan Africa’s High HIV Prevalence Rates

HIV-1 is responsible for the global AIDS pandemic, but HIV-2 has also had devastating impacts. HIV-2 is less infectious and virulent than HIV-1 and, therefore, has primarily been confined to the coast of West Africa between Senegal and Cote d’Ivoire. According to Jaap Goudsmit, HIV-2 is “about three times more difficult than HIV-1 to transmit through sexual intercourse and at least ten times more difficult to pass from mother to child” (Iliffe 2006, 49). In 2003, a research team led by Anne-Mieke Vandamme hypothesized that HIV-2 originated in Guinea-Bissau in the 1940s. Similar to the transfer of SIVcpz to HIV-1, SIVsm probably transferred to HIV-2 via the butchering and consumption of monkey meat by humans (Lemey et al. 2003).

By the 1990s it was evident that HIV/AIDS had become a global pandemic. The virus crossed borders and ignored social, cultural, religious, and economic boundaries as it infected millions of people worldwide. By the end of 2007, more than twenty-five million people had died of AIDS, and thirty-three million more currently live with the disease. Approximately fifteen million children have lost one or both parents to AIDS-related causes (UNAIDS 2008a). Although HIV/AIDS affects people all over the world, approximately two-thirds of the thirty-three million people currently living with HIV/AIDS are located in sub-Saharan Africa. Over seventy-five percent of the fifteen million children orphaned because of AIDS live in sub-Saharan Africa. Since the discovery of HIV, dozens of researchers and scholars have attempted to explain sub-Saharan Africa’s exorbitantly high prevalence rates but have failed to agree comprehensively on a single explanation. Initially, the focus on
HIV in some African countries angered the leaders so much that they discouraged local newspapers from reporting on the growing crisis (Epstein 2007). However, most African countries are now much more open to international attention and research because the HIV epidemic has reached new heights. Although there is not one comprehensive explanation of sub-Saharan Africa’s high HIV prevalence rates, much progress has been made in determining some of the factors impacting the virus’s rapid spread in the region.

In 1989, a team of demographic researchers led by John Caldwell argued that HIV was spreading rapidly among Africans because of their "distinct and internally coherent African system embracing sexuality, marriage, and much else" (Caldwell et al. 1989, 187). Caldwell believed that high rates of casual and premarital sex, coupled with large amounts of sexually transmitted infections, allowed HIV to spread easily throughout Africa. Caldwell's argument sparked controversy because it reintroduced old stereotypes about African sexuality. However, reports at the time found that Africans were not more promiscuous than populations in other regions of the world. In fact, many studies found that African men and women tend to have "roughly similar, if not fewer, numbers of lifetime partners than do heterosexuals in many Western countries" (Epstein 2007, 51).

Along with promoting his theory about Africans’ sexual practices, Caldwell also pointed to transactional sex as playing an important role in the spread of HIV. Transactional sex is an interaction in which a man provides a woman with a present in exchange for sexual intercourse. Transactional sex is prevalent in many African countries but has been studied most thoroughly in Southern Africa. It is hard to know
exactly how great an impact transactional sex has had on the spread of HIV/AIDS in Africa, but it is likely that it has increased the spread of the virus (Caldwell et al. 1989).

Many of the theories in the 1980s and 1990s focused on the differences in sexual relations between Africans and Westerners. Some theories suggested that the spread of HIV was not necessarily affected by the number of sexual partners one had, but by the unique nature of sexual relations in Africa (Epstein 2007). These theories pointed to dry sex, widow cleansing, and the virgin cure as common modes of HIV transmission. Dry sex, a practice that reveals the gender imbalance between men and women in certain regions, involves a woman minimizing her vaginal secretions through the use of herbal aphrodisiacs, plants, and other substances to make sex more pleasurable for men. This process enhances the likelihood of HIV infection because it increases vaginal lacerations and suppresses natural vaginal bacteria. Even though it is uncomfortable or painful for women, dry sex is common because men enjoy it. Another custom, widow cleansing, is practiced in many African cultures but has been in decline since receiving international attention. The practice requires a recent widow to have sex with “one of her husband’s relatives, to break the bond with his spirit and, it is said, save her and the rest of the village from insanity or disease” (LaFraniere 2005). A third practice that may contribute to the spread of HIV/AIDS involves HIV-positive men having sex with virgins. The virgin myth unfolded throughout South Africa during the start of the twenty-first century and stated that having sex with a virgin would rid an infected man of AIDS. The myth was primarily supported by witchdoctors and traditional healers and quickly circulated through the
country before international attention shot it down. After a series of highly publicized “baby rapes” occurred in South Africa, the international community took immediate action, so the virgin myth probably did not have much of an impact on the spread of HIV in Africa. However, the myth demonstrates the power and influence of witchdoctors and traditional healers in some regions of Africa (Epstein 2007).

In 1996, more theories about sexual behavior in Africa surfaced. Roy Anderson of Oxford University suggested that Africans were vulnerable to AIDS because there were high levels of sexual mixing between high-risk populations and the rest of the country. In Africa, AIDS crossed social boundaries more often than in Western countries where HIV tended to remain most prevalent among homosexuals, intravenous drug users, and their partners. Africa’s epidemic crossed social, cultural, religious, and economic boundaries. Anderson suggested the colonial legacy impacted the virus’s inhibitions because it forced millions of Africans into migrant labor. Since HIV tended to follow the same routes as the migrants who shuffled back and forth from urban and rural areas, Anderson’s theory was immediately embraced and programs began targeting high-risk prostitutes and male clients. However, by the mid-1990s, when it became clear that HIV was tearing through the general populations of eastern and Southern Africa, people grew skeptical of Anderson’s high-risk sexual mixing theory (Epstein 2007).

In 1993, American sociologist Martina Morris created a computer program that predicted “how HIV would spread through a population, based on such factors as the number of sexual partners people had and the length of each relationship” (Epstein 2007, 54). Morris went to Uganda to test her software with the intention of
collecting thousands of sexual histories and inputting them into her computer program to see if she could accurately predict the future spread of HIV in other countries. However, while Morris was giving her first lecture in Uganda, she learned that her computer program was flawed because it could not track "concurrent" relationships among African men and women. Many African men and women had several serious ongoing relationships that overlapped weeks, months, or even years. These relationships are common in many parts of Africa and do not necessarily indicate promiscuity or prostitution but, instead, differ from the Western norm of monogamy. Morris quickly realized that concurrent relationships are more dangerous for the spread of HIV than monogamous relationships because they lead to an interconnected web between dozens of people. At the time, most Ugandans in concurrent relationships were comfortable with each other, did not use condoms with any of their partners, and were thus especially susceptible to HIV. After realizing her initial theories were inaccurate, Morris conducted extensive interviews and collected detailed sexual histories from dozens of Ugandans to calculate the average number of partners Ugandans had in their lifetimes and how many of the relationships were overlapping. Despite entering Uganda with a flawed computer program, Morris was able to adapt to the circumstance and collect valuable information that had been overlooked previously (Epstein 2007).

As Morris collected extensive sexual histories from Ugandans, similar research was collected in Thailand and the United States. In comparing the research, Morris found that "the average Ugandan had fewer sexual partners over a lifetime than the average American" (Epstein 2007, 60). Morris found a key difference
among relationships between Ugandans and Americans in that heterosexual Americans usually have a couple of long-term relationships throughout their lives, but unlike Ugandans, they usually have them sequentially, not concurrently. If HIV is transmitted between partners during a monogamous relationship in America, it is unlikely that either partner will pass it on to anyone else until the pair break up and find new partners. Even if one partner has a one-night stand, it is unlikely he or she will be infected with HIV because on average the virus spreads only once for every one hundred acts of sexual intercourse. This number is even lower among those who use condoms. In Thailand, most men have only one long-term sexual relationship in their lifetimes, and that is with their wives. However, research at the time indicated that half of Thai men had sex with prostitutes on average five times a year. Since many Thai prostitutes are HIV-positive, one could assume that Thai men are at high risk of contracting the virus; but, instead, only about two percent of Thai men were HIV-positive at the time of the research and the rate has declined since. Thailand’s low level of HIV/AIDS can be attributed to infrequent prostitution visits and high levels of condom use (Epstein 2007).

Unlike most Americans and Thai, many Ugandans have multiple concurrent relationships overlapping for several weeks, months, or years. Concurrent relationships are dangerous for the spread of HIV because even men and women who are faithful to a single partner are at risk because of their partner’s behavior. Even monogamous couples could be at risk if either partner had a previous relationship with someone in the concurrency web (Epstein 2007). After comparing data from Thailand, Uganda, and the United States, Martina Morris teamed up with Mirjam
Kretzschmar, a mathematician in Holland, “to develop a new computer program that could compare the spread of HIV through two populations: one in which concurrent partnerships were common and one in which serial monogamy was the norm” (Epstein 2007, 60). The computer program analyzed the effects of a hypothetical virus on the two populations over a five-year period. The two populations were the same size and had the same number of sexual relationships over the five years, but the virus spread ten times faster in the concurrency model than in the serial monogamy model. After observing this hypothetical virus, the program was run with actual data collected from Uganda, Thailand, and the United States, and "the simulations reproduced the same prevalence of HIV observed in those countries in the early 1990s, when the data were collected" (Epstein 2007, 60).

The computer program accurately reproduced similar HIV prevalence rates for Uganda, Thailand, and the United States, but it failed to take into account the genetic variations that HIV had developed. HIV is most infectious in the first weeks after infection when the viral concentration in the blood is the highest. A couple of weeks after infection, the immune system begins to produce antibodies and cells that attack the virus and keep the HIV levels low until the immune system finally fails and AIDS develops. Therefore, networks where people have sexual intercourse with multiple partners within a couple of weeks after infection are even more dangerous than the computer program predicted. The varying HIV potency also explains why HIV spreads slowly in monogamous populations because by the time a serial monogamist finds a new partner, his or her viral load has probably dropped to a less-infectious level. This theory also explains why HIV rates in Thailand have remained
low despite high prostitution. Most Thai prostitutes have been HIV-positive for a period of time and are, therefore, no longer as infectious as they were during the first couple of weeks after contracting the virus (Chakraborty 2001).

Morris's concurrency theory also explains the differences in HIV rates in various regions of Africa. North and West Africa's low HIV prevalence is heavily influenced by the Islamic religion and culture in two ways. First, almost all Muslim men are circumcised, decreasing their chances of contracting and spreading HIV. Secondly, Morris's concurrency theory is only applicable in societies where a significant portion of women and men are in concurrent relationships; but in North and West Africa, women's sexual behavior is strictly observed and, as a result, very few women are in concurrent relationships (Epstein 2007).

Along with theories focused on African’s sexual relations, other theories have also developed, but most of them have been disproved or rejected based on insignificant data. One of these theories suggested that Africa is home to an especially deadly strain of HIV and that Africans are especially vulnerable to HIV because of their weak immune systems. However, the idea that there is a super-strain of HIV in Africa has little evidence to support it, and the second theory is invalidated by the fact that the most impoverished and parasite-infested countries are not the ones with the highest HIV rates. South Africa and Botswana have two of the highest HIV prevalence rates in the world, and both countries are relatively stable and have lower levels of parasite infections. Since Morris’s concurrency theory was introduced, further research has also found similar results. Coupled with high levels of sexually transmitted infections, low levels of circumcision, and drastic gender imbalances,
concurrency relationships play an important role in sub-Saharan Africa’s high rate of HIV/AIDS (Epstein 2007).
CHAPTER TWO

History of South Africa and its HIV/AIDS Epidemic

“South Africa is the unkindest cut of all. It is the only country in Africa . . . whose government is still obtuse, dilatory and negligent about rolling out treatment. It is the only country in Africa whose government continues to propound theories more worthy of a lunatic fringe than of a concerned and compassionate state. Between six and eight hundred people a day die of AIDS in South Africa. The government has a lot to atone for. I’m of the opinion that they can never achieve redemption.”

(Lewis 2006)

South Africa currently has a population of more than 48.5 million, including approximately 5.7 million infected with HIV/AIDS. This statistic means that about 11 percent of the population will die from this deadly disease within 5-10 years. Among South Africa’s adult population, aged 15-49, the HIV prevalence rate is 18.1 percent. UNAIDS reports 1.4 million South African children are orphans as a result of parental deaths linked to AIDS (2008a). After two decades of devastation, the deadly HIV/AIDS epidemic appears to be leveling out in South Africa. However, the high infection rates will continue to pose serious economic, political, and social risks to the country (Epstein 2007).

Despite boasting strong economic growth and high literacy rates, South Africa has struggled with HIV/AIDS more than many other countries in the region.

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2 This chapter has been adapted from a final paper I wrote for Michael Nelson’s Africa in World Politics class in Fall 2008 at Wesleyan University.
Compounded by its apartheid history and weak government leadership, South Africa’s religious, cultural, and social practices have led to devastatingly high HIV/AIDS prevalence rates. Although the government has recently improved its stance on HIV/AIDS, South Africa’s slow initial response will cost the country millions of lives. This chapter is divided into several sections to identify the past and lingering impacts of apartheid on the spread of HIV, to understand the role of the government in the epidemic, and to acknowledge the recent changes that have been implemented to prevent and treat HIV/AIDS. This chapter will also discuss the current impact of HIV/AIDS in South Africa and the future direction it is heading.

Arrival of Europeans and Colonization

In 1487, Portuguese explorer Bartholomeu Dias rounded the Cape peninsula of South Africa, becoming the first European to sail around Africa. During the sixteenth century, the Portuguese government regularly sent fleets around the Cape of Good Hope, and in 1649 the Dutch East India Company annexed the Cape peninsula. Three years later, Jan van Riebeeck of the Dutch East India Company arrived with eighty company employees and created a racially complex colony. From 1673-77, the Europeans and indigenous Khoikhoi intermittently fought wars over land ownership and livestock; however, the fighting eventually ended because the Europeans had superior weapons. Then, in 1713, a Dutch ship brought smallpox and wiped out a huge portion of the Khoikhoi society because they lacked immunity to the disease. After the epidemic, the Khoikhoi society never fully recovered and mainly avoided Europeans (Thompson 2001).
South Africa has a long and complex history of indigenous, European, and Southeast Asian populations. South Africa is currently composed of four main racial groups – blacks, whites, Coloureds, and Asians. Blacks comprise 79 percent of the total population and are divided into several ethnic groups, including Zulu, Xhosa, Ndebele, Pedi, and Sotho. The white population, 9.4 percent of the total, is mainly divided into two distinct groups: the descendants of seventeenth and eighteenth century Dutch settlers, referred to as Afrikaners, and the descendants of nineteenth century British immigrants, usually called English South Africans. South Africa's Coloureds, who live primarily in the Western Cape of South Africa, make up 9 percent of the total population and are mixed race descendants of Europe, Indonesia, India, Madagascar, Mozambique, and Mauritius (Thompson 2001). Finally, South Africa’s Asian population, primarily of Indian descent, makes up 2.6 percent of the total. The British brought Indians to the eastern coast of South Africa in the 1800s as indentured laborers to work on sugar plantations. South Africa’s diverse population has led to a plethora of languages and cultures, resulting in conflicting values and goals among the different races over the past four centuries (Statistics South Africa 2008).

When alluvial diamonds were discovered in the Vaal and Harts Rivers west of Bloemfontein in 1867, men immediately rushed to mine the region. As competition over the mines increased, a young Englishman named Cecil Rhodes managed to monopolize South Africa's mines by gaining control of Kimberley and De Beers, the two most productive mines. Kimberley mine was one of the first places to institute strict racial laws and offered a hint of the racial laws that would dominate South
Africa for decades. In 1872, an all-white committee designed a set of rules that prevented black diggers from controlling claims to the mines and also made blacks subject to search, even without a warrant. These rules laid the foundation for further segregation and discrimination against black miners. During the 1870s, blacks were forced to live in segregated parts of town without their families; in order to leave the compounds, blacks were required to show passes and were subject to full-body searches (Illiffe 2006).

Segregation quickly became the norm in South Africa. Starting in 1885, white miners were promoted to supervisor roles with the opportunity for advancement and high wages, while black miners remained stuck in underpaid positions. Whites justified segregation by claiming they were preventing black miners from stealing diamonds. When rich gold deposits were found outside Pretoria in 1886, segregation of the miners was again implemented; and white miners earned eight times as much as black miners for the same work (Illiffe 2006).

By the end of the nineteenth century, South Africa was contributing significantly to the world economy through its mining industries, which the white population completely owned and controlled. Increased levels of mining and the development of a white-dominated capitalist economy led to the accentuation of the differences between races in South Africa. Leonard Thompson, a leading scholar on South Africa, notes that the “division between races was enhanced by the racist ideology that was now pervasive among Europeans and North Americans, as well as white South Africans, and it was becoming more rigid than ever” (2001, 111). The Boer War between Dutch Afrikaners and British immigrants broke out in 1899 after
years of pent-up hostility and conflict. The war ended in 1902 with the British defeating the Dutch Afrikaners. The Peace of Vereeniging was signed soon after and included a clause requiring the use of the Dutch language in schools and law courts; it also included a clause preventing discussion of black enfranchisement until self-government was instated. Many black Africans had expected their lives to improve with British rule; instead, conditions grew even worse for the black population (Thompson 2001).

From the end of the Boer War in 1902 until 1948, racial tension grew in South Africa. This tension had a range of impacts on blacks, Coloureds, and Asians that eventually affected the spread of HIV because of the constraints placed on them. During this period, the British focused on improving the mining industry primarily at the expense of blacks and Coloureds. First, the British enforced harsh taxes and pay cuts on blacks and Coloureds to limit their power and control. Then, in 1913, the Natives’ Land Act was passed to prevent non-white South Africans from owning land. Finally, in 1923, the British government designed Pass Laws to regulate black mobility by requiring all blacks over the age of 18 to carry pass books at all times. These Pass Laws served as the precursors to apartheid laws (Thompson 2001).

**Rise of Apartheid and Initial Responses to HIV**

Apartheid, derived from the Afrikaans word meaning separateness, began in South Africa in 1948 when the Afrikaners regained political power with the election of the Afrikaner National Party. Although the ideas and theories behind apartheid were actually based on the British Pass Laws, the strict apartheid policies were not
enforced until the National Party gained control. Throughout the apartheid era, South Africa’s domestic policies were focused on “enforcing race separation in every conceivable sphere: interpersonal relations, social and economic organization, residential patterns, and the political organization of the state” (Price 1991, 13). In order to achieve complete separation, the South African government planned to create ten different states for the African population while using only 13 percent of the country's land. Robert Price, a scholar of South Africa’s apartheid period, attributes the rise of apartheid policies to “clear political and security concerns” and “a desire to reassert and sustain white minority, and especially Afrikaner, control over a situation characterized by dramatic and potentially volatile social transformation” (Price 1991, 16). Dozens of laws were passed under apartheid to limit the power of non-whites and further segregate the state. These laws prevented mixed marriages, enforced segregation, and designated certain living areas for different races. The National Party’s goal was to suppress black and Coloured political and economic power while trying to gain international legitimacy. Blacks and Coloureds were not the only groups discriminated against during apartheid. Asians were often categorized as Coloured but were not usually treated as poorly. In addition, homosexuals were forced to hide their sexuality because homosexuality was illegal in apartheid South Africa. Apartheid policy divided the population and discriminated against everyone who fell outside the “superior” National Party frame.

South Africa’s early AIDS epidemic was prevalent primarily among male homosexuals. When a white, homosexual airplane steward was diagnosed with HIV in 1982, several major hospitals quietly opened clinics to monitor the spread of the
Throughout the early 1980s, HIV in South Africa was mostly spread among homosexual males and through blood transfusions, especially among hemophiliacs. In the mid-to-late 1980s, HIV made its way into the heterosexual community via a different strain of the virus. Homosexuals were primarily infected with the HIV-1 Clade B strain, which was not common in the heterosexual transmission of HIV. Instead, the heterosexual population was mostly infected with the HIV-1 Clade C strain of the virus, suggesting that two separate epidemics were evolving in South Africa in the 1980s. HIV has spread at different rates in South Africa, with the east coast consistently recording higher HIV prevalence rates than the west coast. Blood screening throughout South Africa has repeatedly found that the eastern provinces of ZwaZulu-Natal and Mpumalanga have the highest HIV prevalence rates. The uneven spread of HIV in South Africa is attributable to several factors, including migrant labor and the homeland system (Epstein 2007).
In general, HIV in South Africa is most prevalent among the poor, black population, especially those who live in informal settlements. Informal settlements, also known as shanty towns and townships, are composed of shelters made from corrugated metal, scrap plywood, and plastic. They originally developed under the Group Areas Act of 1950 when racial groups were assigned certain living areas. This law resulted in the relocation of thousands of blacks and Coloureds to regions typically many miles outside of the urban centers. Informal settlements lack proper sanitation and electricity and are usually very dangerous. They boast high rates of sexually transmitted infections (STIs), premarital sex, domestic violence, and concurrent relationships. All of these factors have led to high levels of HIV/AIDS in informal settlements (Epstein 2007).

Women in informal settlements are especially susceptible to HIV because of the submissive role they play to men. Not only are women unequal to men in society and the workforce, but they are also subservient to their husbands in their own homes. Many women do not have the option of saying no to having sex with a man and are often forced into sex. High levels of domestic abuse and rape have plagued South Africa for years. In 2006, over 52,000 rapes were reported in South Africa, and this number represents only a fraction of the total number of rapes that occur because thousands of cases go unreported each year (Amnesty International 2008). In a BBC News article, journalist Carolyn Dempster wrote that “a woman born in South Africa has a greater chance of being raped, than learning how to read” (2002). Dempster cites several factors as contributing to the high incidence of rape, including a rise in child rapes, drastic gender inequalities, and apartheid legacy.
Transactional sex and concurrent relationships have also played significant roles in the spread of HIV throughout South Africa. Transactional sex occurs regularly in Southern Africa when men buy presents for women in exchange for sex. In these situations, women are rarely able to refuse sex or demand that their partners use condoms (Dunkle et al. 2004). Concurrent relationships that overlap for several weeks, months, or even years provide the perfect environment for the spread of HIV/AIDS. These relationships are common in many parts of South Africa and are far more dangerous for the spread of HIV than monogamous relationships because they lead to an interconnection between dozens of people. Most men and women in concurrent relationships are comfortable with each other, do not use condoms with any of their partners, and are therefore especially susceptible to HIV (Halperin and Epstein 2004).

Most medical authorities and hospitals focused on the HIV epidemic among white homosexuals until the testing of African mineworkers in 1986 caused serious alarm. While prevalence among South Africans was 0.02 percent, Malawians suffered a 3.76 percent prevalence rate. The South African government required screening of all migrant workers; however, resistance from trade unions and Malawian authorities caused South Africa to stop recruiting in Malawi altogether. These migrant worker blood tests suggest that laborers from Central Africa helped introduce the HIV-1 Clade C strain to South Africa (Illiffe 2006).

In 1986, Jack Metz, the director of South Africa's Medical Research Council (MRC) and chair of the expert advisory group on AIDS, expressed his opinion that South Africa's isolation would protect the country from high HIV infection rates.
Unfortunately, he based his views and opinions primarily on reports from an advisory group that was composed of economists, scientists, and clinicians. The lack of representation from the heavily-infected black or gay communities prevented the group from developing successful prevention and treatment programs. In 1987, the MRC created an AIDS research unit to collect data on HIV prevalence rates. The research unit immediately detected a rise in heterosexual transmission of HIV, predominantly in the black community. At an International AIDS Research Symposium hosted by the MRC, South Africa acknowledged that AIDS was spreading among African miners and into the communities surrounding the compounds. Despite these findings, South Africa's Department of Health (DOH) failed to implement further HIV/AIDS prevention campaigns because AIDS education dealt with "taboo subjects such as sex, blood and death" (DOH 1989, 17).

Although the DOH warned that awareness of HIV/AIDS was not enough to combat its spread, the agency did little to address the epidemic and, instead, asserted that the private sector and broader community would need to get involved to help stop the spread (Furlong and Ball 2005).

Although testing in 1986 and early 1987 failed to detect HIV among African women, sex workers, and black miners, the high prevalence among migrant laborers was a warning sign that the South African government failed to recognize. Within just a couple of years, HIV prevalence among African women, miners, and sex workers skyrocketed. Annual blood screening began in 1987 and soon showed that HIV prevalence was doubling among blacks every six months and was already eight times higher than HIV prevalence in the white population (Illiffe 2006).
mobility and migration throughout the African continent coincided with the emergence of HIV, allowing the disease to silently spread throughout Africa in a short period of time. South Africa's apartheid regime remained in power through the 1980s under the leadership of Pieter Willem Botha. Pieter Fourie, a professor at the University of Johannesburg, describes South African society in the 1980s as characterized “by an unequal distribution of resources, widespread poverty, the profligate duplication of civil services, international isolation and regional military insurgencies, the absence of democracy and effective/good governance, domestic political instability and gender inequality” (Fourie 2006, 51). South Africa’s lack of social cohesion and the resulting cultural and economic factors created the ideal environment for the rapid spread of HIV.

Along with failing to educate the population about HIV/AIDS, South Africa’s apartheid regime fostered the spread of HIV by instituting the homeland system, which prevented blacks from finding work in urban regions of the country and forced large numbers of black men to move to rural parts of South Africa to find work. Thousands of migrant workers from South Africa and other nearby African countries living in rural communities and compounds gave rise to an extensive commercial sex network. Since strict apartheid laws “prevented workers from bringing their families to their places of work, workers were separated from them for long periods at a time, and in this environment the commercial sex industry flourished” (Fourie 2006, 55). Furthermore, the government did not implement any HIV/AIDS awareness programs because commercial sex was illegal under apartheid. When the migrant laborers returned to their homes, they often unknowingly transmitted the virus to their wives.
Throughout the late 1980s and early 1990s the political chaos of South Africa overshadowed the looming AIDS crisis. South Africa’s government was so preoccupied with achieving a smooth transition into democracy that it failed to recognize and slow the spread of HIV (Fourie 2006). The general attitude surrounding the virus was a combination of denial, disapproval, and ignorance. Many conservative whites dismissed AIDS as a punishment for sin because it mainly affected homosexuals, commercial sex workers, blacks, and recreational drug users. The early characterization of HIV as a disease found only among the morally sinful led to strong denial and discrimination by all South Africans. To this day, HIV’s stigma remains one of the most challenging issues that hinders the combat of the virus (Epstein 2007).

Further complicating matters, HIV was initially prevalent in the segregated white, homosexual community but not apparent in the black community. Thus, the black community was briefly able to avoid discrimination stemming from the disease. Originally, blacks considered AIDS a "white disease" and did not think it would ever spread to their societies because it countered their traditional culture. In addition, early attempts to inform the traditional black communities about the dangers of HIV failed because of the general belief that AIDS stood for "Afrikaner Invention to Discourage Sex" (Fourie 2006, 63).

South Africa’s "puritanical and racist apartheid mentality" prevented the government from implementing effective programs. South Africa's first national anti-AIDS education campaign began in 1988 with two separate approaches for the black and white communities. The campaign "tried to scare blacks with images of a coffin
and a funeral, while showing whites vague images of graffiti that suggested promiscuous relationships, but did not mention specific risky behaviors” (Fourie 2006, 130). According to Fourie, the socio-political environment of South Africa in the 1980s created “a perversely ideal breeding ground for the rapid spread of HIV infection” (50).

Demise of Apartheid and Peak Spread of HIV/AIDS

In 1989, Frederik Willem de Klerk replaced Pieter Willem Botha as the last State President of South Africa. De Klerk's presidency marked the end of the apartheid era and the beginning of a racially united South Africa. Growing increasingly concerned about the HIV/AIDS epidemic in South Africa, de Klerk's government met in March 1990 with the African National Congress (ANC), the main opposition party to the apartheid government, to discuss AIDS and to request joint funding from the World Health Organization. A month later, an International AIDS Conference was held in Maputo, Mozambique, to create a national AIDS task force in South Africa. The government had already created DOH-funded AIDS Training and Information Counselling Centres (ATICCs) in several major cities throughout South Africa, but they almost exclusively served whites. Nevertheless, an ATICC was not approved for Soweto, one of the most heavily-infected black townships bordering Johannesburg, until 1993 (Illiffe 2006).

During Health Minister Rina Venter's 1990 budget speech, Venter announced South Africa's plan to reorganize health services with less racial and ethnic fragmentation and easier accessibility for all. She recognized the inefficiency of the
segregated health programs and expressed her goal to reform health care to reach out to all South Africans. Despite her enthusiasm in bridging the health care gap, Venter also warned that the economic constraints would severely limit the changes that could be made. Although Venter recognized the growing impact of AIDS, her speech drew sharp criticism from several liberal organizations that did not think she was doing enough to slow the spread of HIV (Furlong and Ball 2005).

In January 1992, the DOH and ANC formed a committee composed of church, union, and business representatives to organize the National AIDS Convention of South Africa. The convention, which focused on education, politics, insurance, health, and AIDS services, created the National AIDS Council of South Africa (NACOSA), a non-governmental organization whose purpose was to develop and implement a National AIDS Plan. Nelson Mandela, President of the ANC at the time, addressed the convention, but no other minister attended it, demonstrating the questionable commitment of the government leaders. Furthermore, disagreements between civil society groups and the two main political parties, the National Party and the African National Congress, marred the convention. Between the 1991-92 and 1992-93 fiscal years, South Africa's AIDS budget quadrupled; but in fiscal year 1993-94, the AIDS budget dropped. During this time, the budget's focus shifted from direct education to research and surveillance through non-governmental organizations and ATICCs, which were considered more credible than state agencies (Illiffe 2006).

Along with the political disagreements over AIDS, the "prudishness among both white and black South Africans hindered frank discussion about how AIDS is transmitted" (Furlong and Ball 2005, 129). Until 1993, South Africa’s Publications
Control Board banned several safe-sex education videos. Because of the lack of effective sex education and communication about the virus, many blacks thought the safe-sex campaign was part of a genocidal effort to lower their birth rate. By the time HIV hit South Africa, several other African countries were already implementing sex education programs to inform their citizens about the transmission of HIV. Although sexual intercourse is a difficult topic for most politicians to discuss, many other African leaders had already recognized the importance of open communication in slowing the spread of HIV. For example, as soon as Uganda recognized the catastrophic impacts of HIV in 1987, President Yoweri Museveni encouraged his citizens to follow the ABCs – abstinence, being faithful, and condoms – to slow the spread of AIDS. On the other hand, politicians in South Africa were virtually silent about HIV, terrified of isolating a racial sect or delving into topics considered too personal (Illife 2006).

**Transition to Democracy: Nelson Mandela’s Presidency**

In April 1994, Nelson Mandela was elected president of the new, democratic South Africa. As the African National Congress candidate, Mandela ran a platform focused on the Reconstruction and Development Program (RDP). The RDP highlighted six basic principles "based on the people, that provide[s] peace and security for all and build[s] the nation, link[s] reconstruction and development and deepen[s] democracy." The RDP recognized the devastating impact of AIDS on the country and claimed it would create a program that would "combat the spread of sexually transmitted diseases (STDs) and AIDS." This program would include health
facilities to treat these diseases and "mass education programmes which involve[d] the mass media, schools and community organisations" to combat the further spread of HIV. The RDP also prioritized AIDS education in rural communities and among women, while not tolerating discrimination against those who tested HIV-positive. These RDP clauses were met with approval by non-governmental HIV organizations, hospitals, doctors, and everyone infected and affected by AIDS. Unfortunately, the RDP lacked the proper funding needed to promote and implement all of its desired programs (ANC 1994).

In July 1994, South Africa's Health Minister Nkosazana Zuma announced plans to double the AIDS budget by reallocating other Department of Health funds. The AIDS budget was doubled again in 1995, and a quarter of the money was given to non-governmental organizations focusing on HIV/AIDS. Despite disagreements surrounding condoms, 97 million free condoms were distributed throughout South Africa between 1995-1996. Health Minister Zuma defended the distribution of condoms by recognizing that "in the long-term perhaps we do need to change the values of this society, so that it can be more acceptable for young people not to be sexually active. But in the short term, let's face it, condoms are useful" (Furlong and Ball 2005, 135). By 2001, South Africa was distributing more than 250 million free condoms each year. Although the AIDS budget increase was helpful in funding programs in South Africa, it failed to target the most vulnerable populations and have a meaningful impact on slowing the spread of HIV/AIDS.

In 1997, the South African government formed an inter-ministerial committee to coordinate AIDS efforts, and in 1998 Partnership Against AIDS was organized to
reach out to civil society. Despite these attempts to control AIDS, it was evident that the government was not fully supportive of prevention and treatment programs. Despite the attempts to control AIDS, it was evident that the government was not fully supportive of prevention and treatment programs.

During his final speech as president, Nelson Mandela mentioned AIDS only once even though South Africa’s HIV adult prevalence rate was 19.94 percent at the time (CIA 2003).

While Nelson Mandela is remembered as a critical actor in South Africa’s peaceful transition to a free and equal democracy, his slow and weak response to the HIV/AIDS crisis has become more apparent in recent years as HIV prevalence and death rates have continued to climb. During his term, Mandela only categorized AIDS as a health issue and therefore prevented the virus from receiving proper attention. Unfortunately, the ANC government did not have the time or resources to focus on health issues during the post-apartheid period, and the RDP often set unrealistic goals and failed to follow through on many of them because of a lack of financial resources. In March 1996, the RDP was replaced with Growth, Employment and Redistribution Strategy (GEAR), a program approved by the International Monetary Fund and World Bank (Furlong and Ball 2005). This strategy signified South Africa’s shift toward neoliberalism because of its fiscal discipline and commitment to open markets and privatization. The strategy was designed to create new jobs, increase foreign direct investment, and achieve sustained real gross domestic product growth over the years of 1996-2000.

Patrick Furlong and Karen Ball, professors at Alma College, also attribute Nelson Mandela’s failure in addressing HIV/AIDS to the difficulties of merging the “ANC's liberal position on human rights with the societal prudishness about sexual
behavior that had constrained policy reform in the de Klerk era" (2005, 138). However, since his departure from the presidency, Mandela has spoken out about AIDS and publicly admitted that he did not do enough to curb AIDS during his presidency. Following his presidency, Mandela urged his successor, Thabo Mbeki, to address the AIDS issue and repeatedly criticized Mbeki’s weak handling of the crisis. Despite doing a poor job of combating AIDS during his own presidency, Nelson Mandela is now doing his best to compensate by speaking publicly to raise awareness and increase funding for the disease.

Prior to the end of apartheid in 1994, foreign donors did not give directly to the South African government because of its racist policies. When apartheid ended, foreign donors switched their support from non-governmental organizations to state organizations, expecting the state to properly distribute funds to address the HIV crisis. However, new fiscally cautious policies meant South Africa was less willing to fund HIV prevention and treatment programs, forcing several private HIV/AIDS initiatives to end because they were no longer receiving the necessary financial support. For example, despite a long political allegiance to the ANC, the National Progressive Primary Health Care Network's AIDS Program had to halt its services in April 1995 because of a lack of funding (Illiffe 2006).

In 1996, many countries began using a combination of ARV drugs to effectively slow the development of HIV into AIDS. At this time, South Africa was only able to provide these drugs to a small minority of people who had private health care. Then, in 1998, Zackie Achmat, an HIV/AIDS activist, founded the Treatment Action Campaign (TAC) in order to place more pressure on South Africa to provide
ARV treatment. Achmat argued that the cost of prevention and treatment of HIV/AIDS would ultimately be less expensive than the economic impact of an unchecked epidemic. In 2003, TAC blamed Health Minister Manto Tshabalala-Msimang and her Trade and Industry colleague for the deaths of 600 HIV-positive people each day because they did not have access to ARV drugs. At this point, the governments of many less developed and poorer African countries had already begun providing public treatment programs. In November 2003, South Africa finally agreed to provide public access to ARV drugs. Unfortunately, however, despite this all-inclusive agreement, the distribution of ARVs in South Africa has been inefficient and slow (Pembrey 2009).

The South African government has also been slow in preventing HIV transmission between mothers and their children. Mother-to-child-transmission (MTCT) can occur during pregnancy, labor, birth, or via breastfeeding if the proper drugs are not provided. In 2000, South Africa’s Department of Health announced its plans to have two MTCT prevention sites in each province. When these plans were not implemented the next year, TAC sued the government and sought an order to make nevirapine, the MTCT antiretroviral drug, available in all state hospitals and clinics. Although many hospitals and health care professionals had already grown angry and impatient with the South African government and begun providing nevirapine to HIV-positive mothers prior to this order, the government continued to question nevirapine’s effectiveness. In late 2001, the High Court ruled against the South African government and required nevirapine to be available for all HIV-positive pregnant women. The South African government stood behind its opposition
to nevirapine and continued to hinder the distribution of the drug for several more years (Pembrey 2009).

**AIDS Denialism: Thabo Mbeki’s Presidency**

Much of South Africa’s reluctance to provide antiretroviral drugs can be blamed on politicians, including former President Thabo Mbeki. Mbeki served as the President of South Africa from 1999 to September 2008, when he was asked to step down. Although Mbeki’s presidency was filled with economic growth and prosperity, it will forever be marred by his AIDS denialism, fear of dependence on the West, and slow response to the epidemic. Mbeki continually questioned the link between HIV and AIDS and even stated that “a virus cannot cause a syndrome. A virus can cause a disease, and Aids is not a disease, it is a syndrome” (*BBC News Online* 2000b). Mbeki drew further criticism for his comments that HIV was only one of the factors contributing to AIDS and that poor nutrition and poverty also caused AIDS. Although there is a link between high HIV rates and poverty, it is inaccurate to imply that poverty causes AIDS. Mbeki was also skeptical of Western pharmaceutical companies and constantly accused these companies of exaggerating the importance of ARV treatment in order to enhance their profits. Mbeki’s fear of dependence on foreign donors and his stubborn determination to find an African solution to the “uniquely African catastrophe” of AIDS have played significant roles in South Africa’s struggle with the disease (Karon 2001). In 2006, TAC leader Zackie Achmat stated, “the biggest problem we have in South Africa is that we have a President who doesn’t believe that HIV causes AIDS” (Nduru 2006). Along with
Mbeki’s denial of the link between HIV and AIDS, South Africa also has been adversely affected by former Health Minister Tshabalala-Msimang’s suggestions that antiretroviral drugs do not work and that nutrition is a more effective method of treating the disease. In 2006, Tshabalala-Msimang publicly questioned the effectiveness of ARVs and suggested eating garlic and beetroots as an alternative to ARVs. In late 2006, Robert Gallo, co-discoverer of HIV, and more than 80 other prominent scientists from around the world signed and sent a letter to the South African government calling for “the immediate removal of Dr. Tshabalala-Msimang as Minister of Health, and for an end to the disastrous, pseudo-scientific policies that have characterized the South African government’s response to HIV/AIDS” (Blandy 2006). Poor leadership and failure to trust Western medicine has greatly hindered South Africa’s struggle with HIV/AIDS.

South Africa’s adult HIV prevalence rates, 1990-2007 (UNAIDS/WHO 2008a)
South Africa’s Current HIV/AIDS Epidemic

In September 2008, Kgalema Motlanthe became interim president of South Africa after Mbeki was pressured to resign. Although Motlanthe has been president for less than a year, he has already made great strides in addressing South Africa’s HIV/AIDS crisis. He replaced Mbeki’s Health Minister Manto Tshabalala-Msimang with Barbara Hogan, a move viewed favorably by most internal and external AIDS organizations. Although it is unlikely Motlanthe will win South Africa’s 2009 presidential election, his quick action and strong response to the epidemic has earned him positive reports locally and internationally (Biles 2008).

Jacob Zuma, the current President of the African National Congress, will probably replace Motlanthe as the President of South Africa in April, 2009. Although Zuma has distanced himself from the unfavorable views of Mbeki and Tshabalala-Msimang, he lacks legitimacy among AIDS activists and organizations for comments he made while on trial for allegedly raping an HIV-positive woman. Zuma claimed he showered after having unprotected sex in order to “minimise the risk of contracting the disease” (BBC News Online 2006). This comment infuriated HIV activists and educators because it lacks legitimacy and sends an inaccurate message about preventing the spread of the virus.

During apartheid, the South African government was relatively uninterested in combating the spread of HIV because it was primarily affecting blacks, homosexuals, commercial sex workers, and recreational drug users. The virus started to spread to the rest of the South African population during the demise of apartheid when the majority of the government’s attention was focused on a peaceful transition to
democracy. When Nelson Mandela was elected as the President of South Africa in 1994, the country was preoccupied with promoting equality, improving the economy, and preventing violence during the transition into a democracy. When Thabo Mbeki was elected as Mandela’s successor, many AIDS activists and organizations thought the government would direct more attention towards the growing epidemic. However, Mbeki’s ignorance and disbelief in the seriousness of the issue impeded South Africa’s efforts to fight the deadly disease. Since Mbeki’s resignation in September 2008, Kgalema Motlanthe has demonstrated his commitment to combating the AIDS epidemic through his appointment of Barbara Hogan as the new Minister of Health.

On April 22, 2009, South Africa will hold presidential elections and Jacob Zuma, the current President of the African National Congress, is expected to win. Although Zuma’s commitment to AIDS is questionable, he has the ability to help South Africa in a serious time of need. South Africa has the financial capabilities and resources necessary to combat the epidemic but is desperately in need of a strong leader. If Zuma commits himself to the crisis, it is likely that South Africa can make huge strides in fighting HIV/AIDS; however, if Zuma reverts to Mbeki’s policies of denial and non-action, South Africa’s struggles with HIV will continue. Regardless of who is elected as South Africa’s next president, he or she will hopefully share Motlanthe’s enthusiasm and commitment to ending South Africa’s HIV/AIDS crisis.
CHAPTER THREE

History of Uganda and its HIV/AIDS Epidemic

Uganda’s population of 31.3 million includes about one million people infected with HIV/AIDS (UNAIDS 2008e). The majority live in urban rather than rural areas, and 59 percent of infected Ugandans are women (Zaccagnini 2009). Over 91,000 Ugandans have already died from HIV/AIDS, and more than 1.2 million children have lost at least one parent to AIDS. Among Uganda’s adult population, aged 15-49, the HIV prevalence rate is approximately 5.4 percent, a considerable rate but nowhere near as high as Uganda’s previous prevalence rates from the late 1980s and early 1990s (UNAIDS 2008a). In 1986, Uganda recorded an adult prevalence rate up to 29 percent in some urban areas; and by 1991 the epidemic peaked at 15 percent among all adults and rose over 30 percent among pregnant women in the cities (Zaccagnini 2009). After peaking in the early 1990s, Uganda’s HIV rates have stabilized at about 5-6 percent over the past couple of years. Uganda has been extensively studied because of its recent ability to reduce HIV/AIDS rates and is often used as a model for other sub-Saharan African countries. Uganda’s prevention and treatment methods, government openness, and communication are highlighted as the likely contributors to decreasing the spread of HIV. Unfortunately, however, during the past few years Uganda has come under scrutiny for changing its focus and techniques in battling HIV/AIDS.

This chapter is divided into several sections to identify the role of Uganda’s past and current government leaders and civilians in the spread of HIV/AIDS. The chapter will also discuss the current impact of HIV/AIDS in Uganda and the direction
it is heading. Several AIDS experts and organizations divide Uganda’s epidemic into phases to explain the country’s transformation over time. Avert, an international AIDS charity, divides Uganda’s epidemic into three phases. The first phase occurred during the country’s war-torn period of the late 1970s through the first six years of Museveni’s presidency to 1992, the second phase occurred from 1992-2000 when Uganda’s prevalence rate drastically fell, and the third phase represented the stabilization of the virus in Uganda from 2000-2005 (Zaccagnini 2009). Helen Epstein’s 2001 article “AIDS: The Lesson of Uganda” divides the epidemic into two phases: the first phase occurred from the war-torn 1970s to 1986 when Museveni took power, and the second phase occurred from the mid-1980s through the early twenty-first century. By adding a third phase dating from 2003 to the present, Epstein’s timeline provides clear distinctions between the stages of Uganda’s epidemic.

**Early Ugandan History and Colonization**

In the fourth century A.D., hunter-gatherers inhabited modern-day Uganda. Their lineage can be traced through the pygme population of western Uganda. When these Bantu-speaking populations from central and western Africa migrated to southern Uganda, they brought their agricultural and iron working skills with them. They also brought fresh ideas about social and political organization that shaped Uganda's centralized kingdoms of the fifteenth and sixteenth centuries. The Bantu-speaking populations of Uganda include Buganda, Bunyoro, Nkore, Toro, and Busoga. The Bantu-speakers developed a form of government using clan chiefs to help settle disputes, coordinate religious observances, and organize work projects.
This kinship system of government was effective for limited numbers of people; but as larger polities expanded, they developed into states (Rowe 1990).

Around the tenth century A.D., the Nilotic and Central Sudanic peoples began occupying northern Uganda. Nilotic-language speakers migrated from the Nile Valley region and worked primarily as cattle herders and subsistence farmers. Central Sudanic speakers migrated from the north and now compose only about six percent of Ugandans. Together, the Nilotic and Central Sudanic peoples are referred to as the non-Bantu speakers of Uganda. As the Bantu-speakers and non-Bantu speakers slowly moved toward each other, a system of patronage developed with the Nilotic peoples offering military protection in exchange for the Bantu peoples helping with agricultural soil fertility (Byrnes 1990).

From this patron-client system, three different types of states emerged in the region: the Hima, the Bito, and the Buganda. The Hima state used a caste system to maintain separation between the rulers, their pastoral relatives, and the agricultural workers, referred to as Hutu. The Hima, a sub-group of Tutsi, are still prevalent throughout Rwanda and Burundi, but in Uganda the Hima people have adopted the Bantu language and culture over time. The Bito state developed in Bunyoro, a region in south-western Uganda that dominated the area from the sixteenth century to the nineteenth century. Although the Bito society did not have a caste system, it ruled over the Hima pastoralists and Hutu agriculturalists. The Bito ideology’s greatest weakness was its susceptibility to coups d’état because it granted all Bito clan members the right to rule. Even during periods of political stability and expansionism, the Bunyoro region was plagued with civil wars and secessions.
Uganda’s third type of state, the Buganda, emerged in the swamps and hillsides of the northern shores of Lake Victoria. The Buganda kingdom of the Baganda people was composed of many clans, each with a king selected by clan elders. The Buganda developed largely as a refuge for those escaping Bito rule (Rowe 1990).

From the sixteenth century through the nineteenth century, the Bunyoro kingdom in south-western Uganda was the strongest in the region. The Bunyoro’s powerful economy and military dominated nearby kingdoms until internal divisions in the nineteenth century resulted in a shift in power. By the mid-nineteenth century, Buganda had gained considerable power through the acquisition of certain Bunyoro regions and eventually became the dominant kingdom in the region. When the British arrived in 1862, their focus on discovering the source of the Nile River caused them initially to ignore the local Ugandans and their kingdoms. However, the British soon recognized and exploited the deep rivalry between the Bunyoro and Buganda in order to obtain power. In 1984, the British created the Uganda Protectorate to control Buganda. The captured region was renamed Uganda because it was easier for Europeans to pronounce and understand than the term Buganda (Kanyeihamba 2002).

After gaining control of Buganda, the British and Baganda people fought together against the hostile Bunyoro. In exchange for their service, the Baganda were rewarded with captured Bunyoro territory, which became known as the Lost Counties. The favoring of the Baganda by the British caused major ethnic divisions that have continued to this day (Mutibwa 1992).

During the “Scramble for Africa,” many colonial powers entered African countries and created territories based on their own preferences, failing to recognize
the impact on the indigenous populations. When determining Uganda’s territorial boundaries, the British did not give much consideration to the ethnic or tribal groupings of people, which later caused problems for Uganda. The boundaries primarily fell along mountain ranges and riverbeds rather than tribal lines. After discovering the source of the Nile, the British were interested in Uganda because its climate and fertile soil provided the ideal conditions for growing cotton. Over the past two centuries, Uganda's economic system has changed from ivory trade to slave trade to agricultural trade and now to cash crop trade. In the early 1900s, when local British administrators encouraged Ugandan farmers to grow cotton on their own plots of land to sell to Indian traders, the Buganda kingdom became relatively prosperous in growing and selling cotton compared to the rest of Uganda. By the 1920s, the British also encouraged the Baganda to plant and grow coffee for the export market, creating a strong partnership between the British and Baganda that allowed Buganda's schools to grow and improve much more quickly than other schools in the region (Clark 1990). Unlike other colonial powers, the British tended to discourage white settlement in their colonies. Even at the peak of the colonial period, fewer than six hundred British people lived in all of the Ugandan Protectorate. The British also allowed most land to remain in the hands of Ugandans, and some tribes were able to maintain their traditional forms of government (Epstein 2007).

Uganda's development during the nineteenth and twentieth centuries was influenced by Islamic and Christian religious factions, numerous ethnic groups, centralized and non-centralized societies, and colonization. During and following World War I, Uganda's agricultural production drastically increased because of the
worldwide demand for cash crops. In the 1920s and 1930s, farmers avoided the world market fluctuations by decreasing cash crop production and resorting to subsistence agriculture (Epstein 2007).

During the colonial period, the Kagera region of north-western Tanzania, which cultivated coffee and cotton, also had an influence on Uganda. Haya, the main tribe in Kagera, was unlike many neighboring tribes because women did not inherit land from their fathers and were completely subservient to their husbands and male in-laws. Women fared poorly, performing most of the manual agricultural labor but receiving none of the profits. In addition, abuse and abandonment drove many women into prostitution, enabling them to make enough money to wear fashionable clothes and save some of their earnings in bank accounts. Then in the 1950s when women began to gain more rights, prostitution lost its allure, only to regain it in the 1970s when an all-time low price for coffee and baweevil devastation of banana trees made prostitution lucrative again. With failing socialist policies, rising oil prices, corruption, crime, and a strong black-market trading center that bordered Uganda, Tanzania attracted smugglers and prostitutes from both countries (Tibajuka 1997).
Independence from Britain

When Uganda gained independence from Britain in October 1962, the central government maintained control over northern Uganda; but the four southern kingdoms of Toro, Ankole, Bunyoro, and Buganda and the centralized society of Busoga were given substantial autonomy. The British legacy of using violence to maintain control set the stage for the political and ethnic violence that plague Uganda to this day (Epstein 2007).

Independence brought troubles of its own to the region after Sir Walter Coutts, the British Governor-General of Uganda, appointed Milton Obote as the Prime Minister of Uganda in 1962. The following year, Mutesa, the King of Buganda, replaced Coutts as the ceremonial President of Uganda, and Obote became the Executive Prime Minister. During Obote’s reign as Executive Prime Minister, he
was implicated in a gold smuggling controversy along with Idi Amin, the deputy
commander of the Ugandan Armed Forces at the time. In March 1966, when
Parliament demanded an investigation of Obote and the firing of Amin, Obote
suspended the Constitution, declared himself President, and had several rival cabinet
members arrested and detained without charge. In May, Obote led an armed attack
on Mutesa’s palace and forced Mutesa into exile, leaving Obote in sole power (Rowe
1990).

Obote’s position was fortified in 1967 when Parliament passed the Republican
Constitution and declared the President as the Head of State, Commander-in-Chief of
the Armed Forces, and the Head of Government. Under the Constitution, Uganda’s
government “was democratically elected in the sense that it consisted of the members
of the National Assembly, the majority of whom were directly elected by the people”
(Kanyeihamba 2002, 117-118). Uganda’s new Constitution gave Obote executive
power and the Parliament legislative power, while the Judiciary was independent in
judicial matters, and the people of Uganda were considered to be politically supreme
through the power to vote. The 1967 Constitution abolished the federal structure of
the independence constitution and created an executive Presidency. Despite its
attempt to distribute power to the executive, legislative, and judicial branches, the
Constitution basically gave Obote total power. In addition, the President’s regime
depended on the Armed Forces of Uganda to maintain control under Idi Amin as
Army commander. The frailty of the Constitution was demonstrated in 1969 when an
attempt was made on Obote’s life, and all opposition parties were subsequently
banned. At this point it was clear that Obote had become the absolute ruler of
Uganda. Despite his attempts to maintain control, however, tensions between Obote and Amin arose in 1969, and in 1971 Amin led a coup that overthrew the government when Obote was out of the country (Kanyeihamba 2002).

Idi Amin’s Dictatorship

The resulting change in leadership placed Idi Amin Dada in power for eight terrifying and destructive years, characterized by ethnic persecution, “economic decline, social disintegration, and massive human rights violations” (Rowe 1990). Amin amended the constitution several times in order to maintain absolute power and rewarded those who helped him reach the presidency. Amin forced dozens of intellectual entrepreneurs, most of whom were Asian, to leave the country because of their heritage. Staunchly anti-Israel, he rediscovered his Islamic roots in order to receive foreign aid from Saudi Arabia. During Amin’s reign, thousands of Ugandans were murdered, especially those in the Acholi and Langi ethnic groups because they had supported Obote. In addition to creating internal chaos, in October 1978, Idi Amin attempted to grab the Kagera Region of Tanzania after claiming it rightfully belonged to Uganda. In response, Tanzania’s government organized a volunteer army to defend the Kagera Region and, with Ugandan exiles, united to wage a war against Amin and the Libyan soldiers who were aiding him. In April 1979, the Tanzanian army and Uganda exiles captured the Kagera Region and forced Amin and his remaining troops to flee (Ofcansky 1990).

The 1978-79 border war provided the ideal environment for the spread of HIV/AIDS. At this point, the virus had not deeply penetrated the Western world but
was quietly making its way from western equatorial Africa to East Africa. Tanzanian and Ugandan “soldiers, smugglers, and prostitutes began returning from the military posts and trading centers at the border not only with syphilis, gonorrhea, and other STDs, but with strange symptoms that no one had ever seen before” (Epstein, 2007, 158). HIV spread rapidly through the border region’s complex sexual networks. By 1987, almost a quarter of the adult population in Bukoba, a north-western city of Tanzania, was HIV-positive. In the Ugandan districts of Masaka, Rakai, and Kampala across the border from Kagera, HIV prevalence rates were also soaring. Idi Amin's 1971-79 regime promoted an illegal black market centered on highway trade that ran from Kenya to Uganda. The highways also led to Sudan, Rwanda, and Burundi and were "lined with illicit or unregulated services, such as hotels, restaurants, and brothels that catered to truck drivers" (Ostergard and Barcelo 2005, 162). These transport routes played a dangerous role in the spread of HIV in East Africa because the virus was able to make its way through several countries before it was identified.

From the beginning of Amin’s rule in 1971 to the start of Museveni’s rule in 1986, Uganda’s lack of strong political and economic leadership led to high poverty rates and a sense of insecurity. The difficult living situation “created a group of risk takers who were placed in an environment that made them sexual risk takers” (Barnett and Whiteside 2002, 116). Women’s social, economic, and political disadvantages placed them at the top of the list and resulted in many women having little choice but to exchange sex for food, goods, and security. In addition, the deterioration of Uganda’s education and health care systems exacerbated the
environment for diseases to spread, and the lack of access to treatment for sexually transmitted infections or other diseases furthered the spread of HIV.

Interim Governments and Neglect of HIV/AIDS

After Amin's forced departure, the Ugandan National Liberation Front formed an interim government with Yusuf Lule as the new president of Uganda. Soon, however, Lule was replaced by Godfrey Binaisa, who was quickly replaced by Paulo Muwanga, an important leader in the governing body of the Uganda National Liberation Front. Muwanga briefly ruled through a Military Commission until the December 1980 election returned power to Milton Obote. Despite the controversial election results, Obote maintained power for several years (Ofcansky 1990).

Uganda's first officially recognized AIDS deaths occurred in 1982, when seventeen traders in the southern district of Rakai died of symptoms that came to be associated with the disease. HIV first spread in Uganda through the urban sexual networks in the Lake Victoria region. The doctors in this region were familiar with the disease, referring to it as "slim disease" because of the wasting away of those infected. Initially the virus was detected in the districts of Masaka, Rakai, and Kampala, but by 1989, it was detected in all eighty of Uganda’s districts. Spreading primarily along main transportation routes, men and women were equally infected, although men’s deaths were more likely to be reported to officials. The majority of AIDS cases occurred in people aged 16-40 years, but by the late 1980s, an increasing number of babies were born HIV-positive. The rise in innocent youth deaths shocked many Ugandans into changing their risky behavior. Fewer than ten AIDS cases were
reported among school-age children, who constituted nearly one-half of the population, prompting intensive efforts to prevent its spread into this age group (Epstein 2007).

Although most researchers point to Southern Cameroon as the starting place for HIV, the virus did not explode into the mainstream population until it reached Kinshasa of the Democratic Republic of Congo. After Kinshasa’s HIV prevalence rate peaked in the mid-1980s, the virus made its way to East Africa. First entering Rwanda and Burundi, HIV traveled to the Kagera Region of Tanzania, bordering Lake Victoria, Uganda, Burundi, and Rwanda. AIDS expert Helen Epstein points to Kagera’s legacy of prostitution, fertile land, and gender inequalities as playing important roles in the rampant spread of HIV (Epstein 2007).

Milton Obote remained in control of Uganda until an army brigade forced him out of office in 1985. During Obote’s second presidency, Uganda was plagued with human rights abuses and guerilla warfare led by Yoweri Museveni’s National Resistance Army (NRA). After Obote’s overthrow, two military commanders briefly ruled Uganda through a Military Council until Museveni seized control of the country in January 1986 (Ofcansky 1990).

**Yoweri Museveni and Uganda’s Initial Responses to HIV/AIDS**

Although most Ugandans were initially skeptical of Museveni, they were quickly reassured by his commitment to ushering Uganda into a peaceful and secure era. The political wing of Museveni’s NRA was the National Resistance Movement (NRM), commonly referred to as the Movement. Immediately upon gaining power,
the Movement created a Ten-Point Program to outline Museveni’s goals for Uganda. The program focused on a broad-based democracy with a series of resistance councils that would mediate between the national government and individual villages. The NRM embraced Western economic reforms including structural adjustment and export diversification programs in an attempt to improve Uganda’s faltering economy. In addition to incorporating Western economic institutions, Museveni cracked down on the behaviors of government officials (Kasfir 1990).

Although the NRM’s new political ideas were not immediately embraced and insurgencies continued in northern and eastern Uganda, the only significant rebel group currently in Uganda is the Lord's Resistance Army (LRA), led by Joseph Kony. The LRA operates mainly out of northern Uganda and regions of Sudan but has been tied recently to conflicts in the Democratic Republic of Congo. Over the past decade, thousands of Ugandans have been killed by the LRA and countless young boys have been forced to join the army. The LRA often uses threats and violence in order to recruit new members. For example, a common method of recruitment involves LRA members setting fire to an isolated school and abducting all of the males who exit the school alive. The boys are then offered a choice of joining the LRA or being shot to death. Those who join the LRA are forced to commit an atrocity in their home district, such as raping an older woman, in order to make it difficult for them to return to their homes (Collier 2007). Aside from the rebel movements in the north, most Ugandans believe that Museveni has successfully ushered Uganda into a relatively peaceful and prosperous period (Kasfir 1990).
Uganda’s war-torn period of the late 1970s and the ensuing political instability of the early-to-mid 1980s provided the ideal environment for the spread of HIV. High levels of corruption, violence, and poverty during this time corresponded with high levels of casual sexual relations, rape, and prostitution. At times, Ugandan women were so desperate for money, food, and shelter that they had no choice but to exchange sexual favors for basic needs. The lack of knowledge about HIV/AIDS at this point also played a role in furthering the spread of the disease. Since HIV has the ability to propagate silently without showing any major symptoms for weeks, months, or years, it was able to make its way through many regions and populations before being recognized. It is likely that HIV/AIDS moved rapidly through Uganda and the rest of East Africa during this chaotic period of the late 1970s and early-to-mid 1980s (Byrnes 1990).

The second phase of the HIV epidemic in Uganda began when Museveni assumed power and has lasted through the early twenty-first century. Government involvement, open communication, and extensive campaigns during this period are commonly cited as the reasons for Uganda’s relative success in combating AIDS. In addition, Uganda welcomed foreign aid to fight the disease. As South Africa and other sub-Saharan African countries continued to ignore their growing epidemics, Uganda faced HIV/AIDS and drastically decreased its spread through support groups, education programs, and treatment campaigns (Epstein 2001).

Museveni first truly learned of the destructive impact of AIDS in September 1986 at a Non-Aligned Heads of State meeting where Fidel Castro told Museveni that 18 of 60 Ugandan soldiers who had been sent to Cuba for high-level military training
were HIV-positive. After learning this, Museveni immediately created the National Committee for the Prevention of AIDS (NCPA) in October 1986. The NCPA, which included physicians, academics, educators, administrators, security forces, politicians, church leaders, and non-governmental agencies, was designed to coordinate technical and operational activities and institute an AIDS Control Program (ACP) to devise HIV/AIDS policy guidelines for Uganda’s fight against the disease. The ACP proposed a five-year plan to focus on health education, blood screening, improved sterilization practices, and terminal patient care (Garrett 2000).

Along with the formation of the ACP, Museveni assembled a team of Ugandan health experts to implement an HIV awareness and prevention program. The program focused on the ABCs of slowing the spread of AIDS by encouraging abstinence, being faithful, and condom usage. Along with the ABC model for eliminating HIV/AIDS, Ugandan leaders also recognized the importance of open communication to limit discrimination and stigma surrounding AIDS. Samuel Ikwaras Okware, a senior Health Ministry official and the architect of Uganda’s ABC model, wrote in 1987 that the best approach to handling HIV was “to sensitize everyone so that they become guardians of their lives because sexual behavior is an issue of individual responsibility” (Okware 1987, 726).

One component of Uganda’s AIDS Control Program was a comprehensive nationwide school education program initiated by government health officials in 1987 to prevent the spread of HIV among youth. The campaign “implemented nationwide blood screening and public education programs, including television, radio, and local press warnings in English and local languages” (Byrnes 1990). By the late 1980s and
early 1990s it was clear that Uganda’s health care system was not able to meet the needs of its growing sick population, so the government increased its efforts to attain international assistance to cope with the spread. Organizations such as the World Health Organization (WHO) and Global Programme on AIDS (GPA) provided Uganda with funding and direction for initiatives to combat AIDS.

In retrospect, it is difficult to pinpoint why Museveni was so much more aggressive in targeting HIV/AIDS than other African leaders at the time. One theory suggests that Museveni’s rapid response stemmed from his desire to protect the Ugandan army, his primary source of power. When Museveni saw firsthand the damage of HIV/AIDS in the military, he aggressively implemented programs to limit its spread. While some scholars note the impact of HIV/AIDS on Lyantonde, a town in southwest Uganda which was home to many of Museveni’s relatives and to several senior army officials, others point to Museveni’s willingness to adopt international economic reforms as indicative of his willingness to listen to outside opinions (Tumushabe 2006). Another theory credits Museveni with being ahead of his time in recognizing the potential impact of HIV/AIDS on his country. Regardless of the reasons for his aggressiveness, it is evident that Museveni’s strong response to fight AIDS saved thousands of lives.

Starting in 1987, Yoweri Museveni openly demonstrated his commitment to fighting HIV/AIDS through three public speeches that clearly outlined the government’s position on the disease. According to James Putzel in “The Politics of Action on AIDS: A Case Study of Uganda,” Museveni emphasized four themes in these public interventions. First, Museveni listened to and respected the information
and views of scientific and medical experts. He was quick to reprimand Ugandans who associated the disease with witchcraft and warned journalists of the potential damage that could result from inaccurate reporting about AIDS. Second, Museveni believed in public health care and the control of private providers, especially traditional healers. This approach limited outside influence and opinions on HIV treatment. Third, Museveni simultaneously “called for protection of the rights of women and children and advanced a socially conservative agenda, which while rejecting superstitions and abusive family practices, at the same time called for a revival of traditional values” (Putzel 2004, 25). Fourth, he implemented an extensive campaign to educate all Ugandans by using different strategies for rural and urban populations.

Also in 1987, Noerine Kaleeba and fifteen colleagues founded The AIDS Support Organization (TASO) of Uganda with the purpose of eliminating the stigma, ignorance, and discrimination surrounding HIV/AIDS. Initially, the founders met informally to provide physical, mental, and social support to each other, but the group quickly developed into an extensive volunteer organization. Researchers and journalists flocked to Uganda to learn more about TASO, the first indigenous HIV/AIDS self-help group in Africa. Early in its development, TASO members provided basic care and resources to AIDS patients, but now TASO offers counseling and antiretroviral drugs to those infected. TASO is the largest indigenous, non-governmental organization in Uganda and has supported over 200,000 people since its creation. Over the past two decades, TASO has expanded to include eleven
service centers and twenty-two “mini-TASOs” and community based organizations (CBOs) throughout Uganda (TASO 2008).

When Museveni came to power, Uganda’s economy was weak and unstable. Along with a dismal tourism sector and high levels of corruption, Uganda suffered from a lack of foreign and domestic investment. Uganda’s economic troubles date back to its colonial history but were exacerbated by Idi Amin’s reign of terror. Many neighboring African countries were unwilling to acknowledge their growing AIDS crises because they feared losses in their tourism sectors. In Kenya, for instance, President Daniel arap Moi discouraged the local media from reporting on HIV in fear of its effect on Kenya’s tourism industry. In Uganda, however, Museveni’s new government had little to lose by acting aggressively in adopting structural adjustment programs and extensive HIV/AIDS prevention and treatment campaigns. As a result, the World Health Organization and American experts helped expand the AIDS Control Program. Many international organizations and Western countries were so impressed by Uganda’s economic success and HIV/AIDS transparency that they funded more extensive HIV/AIDS education and treatment programs (Epstein 2007).

In addition to attacking health issues, Museveni restructured Uganda’s economy based on advice from international agencies, including the International Monetary Fund and World Bank. The subsequent structural adjustment reforms proved to be fairly effective in Uganda, with the country experiencing a real per capita GDP average growth of 4.2 percent from 1992-1997. Although part of Uganda’s rapid economic growth can be attributed to its stagnant economic policies of the prior decades, the World Bank and the IMF also deserve credit for stimulating
the economy. Coupled with trade liberalization, reduction of export taxation, and privatization of state-owned industries, Uganda’s economy in the mid-1980s was well-situated for quick growth. The relative success of Uganda’s structural adjustment reforms brought about immense praise from international agencies and donors (O’Manique 2004). Despite overall economic growth, Uganda’s health care and education sectors struggled to keep up with the structural adjustment reforms. Even though public spending on health care increased as government spending rose, it did not grow as a share of the new budget, and therefore ended up at a slightly lower level than before structural adjustment reforms. In order to lower Uganda’s debt, the IMF stressed the importance of fiscal restraint and high debt service payments. Unfortunately, these policies limited the government funds channeled into health care and public education (Naiman and Watkins 1999).

After experiencing relative economic success in the structural adjustment reforms, Uganda became the first country to experience debt relief under the Heavily Indebted Poor Countries (HIPC) Debt Initiative in April 1998. Unlike most other countries receiving debt relief, Uganda did not have to undergo the extensive six-year qualifying examination because the donor industry and government cited Uganda’s previous commitments to macroeconomic reform and to poverty reduction as proof of its dedication to eliminating its debt. Joseph Tumushabe, a development consultant in the United Nations Research Institute for Social Development, notes that Uganda’s “macroeconomic and political reforms, such as privatization and decentralization, had been largely implemented with success in Uganda,” but the country’s “commitment to poverty reduction was questionable, considering the fact that less investment has
gone to the production sectors, particularly agriculture, from which the majority of the poor derive their livelihood” (Tumushabe 2006, 5). The HIPC debt relief ended up increasing the socio-economic divide and failed to have long-term positive impacts on the poverty level. A year after forgiving 650 million dollars of Uganda’s debt through the HIPC Debt Initiative, Uganda’s economy already accumulated a debt that was once again unsustainable. This was mainly a result of the World Bank and IMF overestimating the revenues that Uganda would receive from coffee exports and trade (Naiman and Watkins 1999).

In about 1991, Uganda’s HIV/AIDS prevalence rate peaked, and soon after researchers realized that the HIV prevalence rates in the Lake Victoria region and the rest of Uganda were dropping. Bukoba, the northwest region of Tanzania, recorded an HIV prevalence rate in 1996 that was 50 percent lower than its rate in the mid-to-late 1980s, and by 2005, Bukoba's rate was down 80 percent from its peak years (Epstein 2007). Antenatal clinics in Kampala, the capital of Uganda, recorded HIV prevalence rates of 31 percent among pregnant women in 1993. In 1998, the rates dropped to 14 percent, indicating a drastic decline over a short period. According to the World Health Organization, “antenatal care coverage is an indicator of access and use of health care during pregnancy” (WHO 2009). In developing countries, antenatal clinics often double as HIV testing clinics because they capture a portion of the sexually active female population. Even though antenatal clinics usually have higher HIV prevalence rates than the entire adult population of a country, they are a good indicator of the prevalence trends throughout a country. Initially, most people believed that Uganda’s HIV prevalence rate decline was a result of the natural HIV
curve with the most susceptible people succumbing to the disease and fading away. However, by the late 1990s, it was clear that HIV prevalence rates were not declining elsewhere in Africa and researchers flocked to the Lake Victoria and Kagera regions to find out how they had decreased their HIV infection rates (Epstein 2007).

While most African countries were ignoring the AIDS crisis in the 1980s and early 1990s, "hundreds of tiny community-based AIDS groups sprang up throughout Uganda and Kagera to comfort the sick, care for orphans, warn people about the dangers of casual sex, and address the particular vulnerability of women and girls to infection" (Epstein 2007, 160). Museveni's government developed and implemented rigorous prevention campaigns funded by the World Health Organization and run by Ugandans. The compassion and determination of Ugandans to stop the disease led to a rise in discussions about prevention, treatment, and discrimination. Ugandans’ willingness to talk publicly about the virus separated the country from all other countries in the area and played an important role in reducing AIDS-related stigma and denial. Although it is nearly impossible to know why Ugandans were more willing than other African people to openly discuss sexual intercourse and the virus, Helen Epstein suggests that Ugandans recognized that HIV/AIDS “was not just a disease of prostitutes, truck drivers, and other high-risk groups” (Epstein 2007, 161). The Ugandan government was quick to highlight the devastating potential impacts of HIV on individuals, families, and communities.

Museveni’s early prevention campaign used slogans like "love carefully" and "zero grazing" to emphasize the importance of faithfulness in relationships. Uganda's ACP broadcast these slogans on the radio, posted them on public buildings, and used
prominent politicians to deliver their messages. The Ministry of Health educated dozens of volunteers on the prevention and impact of AIDS and dispersed them throughout the country to spread the word. The message was found in newspapers, theaters, and in songs (Epstein 2007). Marion Frank, in “AIDS Education through Theatre: Case Studies from Uganda,” notes that plays and performances always made “references to promiscuity as the cause for AIDS” and heavily stressed monogamy and traditional moral values (Frank 1995, 105). The plays were also educational and informed the public that HIV was spread through sexual intercourse and could be stopped by limiting promiscuity. By encouraging Ugandans to revert to traditional cultural and social values, the plays presented “the disease as a social rather than an individual threat” (106). The plays placed social responsibility on all Ugandan adults to protect the youth by stopping the spread of AIDS. HIV-positive and HIV-negative Ugandans were both encouraged to live responsibly with one sexual partner and to use condoms.

Since the start of the AIDS epidemic, the promotion and distribution of condoms has been controversial worldwide. On the one side, many organizations encourage the use of condoms to protect the sexually active from contracting HIV. On the other side, religious figures and conservative leaders believe no forms of contraceptives should be used and fear that “okaying” the use of condoms would be a step away from their abstinence programs. In an opinion column of The New York Times, Nicholas D. Kristof criticized the Vatican for weakening the war against AIDS by preventing Catholic organizations from distributing and promoting condoms and by arguing “that condoms don’t protect against H.I.V., thus discouraging their use”
(Kristof 2005). In Uganda, debates between the opposing sides are part of everyday life in newspapers, churches, and conversations. In 1993, Uganda's government-run newspaper, The New Vision, started distributing Straight Talk, a newsletter that discussed sensitive sexual topics. The newsletter allowed Ugandans to speak openly about puberty, sexually transmitted infections and AIDS, contraception, drugs, and sexual abuse (Epstein 2007).

As the virus gained publicity, more and more Ugandans changed their way of life. The number of Ugandans with multiple partners sharply declined, and the HIV infection rate followed a similar trend. The percent of Ugandan women of all ages in urban areas who reported having abstained from sexual intercourse over the year increased from 19 percent in 1989 to 31 percent in 1995 (Blum 2004). Bars and discos that had previously been packed with men and single women went out of business. These sexual behavior changes coincided with Uganda’s flourishing women’s rights movement. After the removal of Idi Amin from power, the women's rights movement gained momentum because of the politically active and accepting atmosphere. Prior to Museveni's presidency, rape was often considered an excusable crime in Uganda; but as the AIDS crisis escalated, women's rights activists began speaking out against sexual abuse and rape. The attitude surrounding rape changed completely in the early 1990s when Miria Matembe, a member of the Ugandan parliament, declared that "rapists, defilers and all those who in one way or another commit sexual offenses are in possession of potentially dangerous instruments which must be taken away from them if they can't use them properly" (Epstein 2007, 164).
Although Uganda’s rate of rape is still relatively high, it is nowhere near its past levels.

Museveni was also very proactive in encouraging women to participate in community organizing. In 1985, Maxine Ankrah helped to establish the Action for Women in Development, the largest women's rights organization in Uganda at the time. The organization constantly discussed women's rights in regards to AIDS and encouraged wives to divorce their husbands if they were unfaithful and sick with HIV/AIDS (Epstein 2007). Ankrah was ahead of her time in accurately understanding the HIV/AIDS crisis in Uganda. In her 1992 article “Aids in Uganda: Initial Social Work Responses,” Ankrah recognized that Africa’s AIDS epidemic spread in a different manner from the epidemic in the West. The Western epidemic was mainly contained in the male homosexuals and intravenous drug users populations, while Uganda’s epidemic was mostly driven by concurrent heterosexual relationships, gender inequalities, high levels of sexually transmitted infections, and decades of oppression. Ankrah was also one of the first people to recognize the impact of HIV on the “most socio-economically productive sectors – the 15-40 year-olds in whom much has been invested in terms of education” (Ankrah 1992, 55). In 1992 at the time of Ankrah’s article, AIDS was devastating the rich and poor communities alike and had not yet become associated with socio-economic status.

Maxine Ankrah’s article places great blame on Africa’s colonial history for creating the ideal environment for the spread of AIDS. Decades of colonial rule created export-oriented economies that resulted in “an increasingly marginalised peasant labour force, the social disorganisation of rural society, a growing migrant
labour force and the emergence of squalid slums surrounding major cities with contingent high rates of unemployment and prostitution.” Since many African countries lacked the means to prevent and treat malnutrition, malaria, measles, tuberculosis and sexually transmitted infections, these diseases were especially widespread. Ankrah cites Uganda’s civil war, widespread urban and rural poverty, and failure of the government and health care system as major factors in the spread of HIV throughout the country. Uganda, like dozens of other African countries, was not prepared to fight AIDS (Ankrah 1992).

Nevertheless, unlike many of its neighbors in sub-Saharan Africa, Uganda made several crucial moves to slow the spread of HIV. Uganda immediately sought help from non-governmental organizations to implement counseling and patient care programs. Uganda’s “government work[ed] through the central Ministry of Health with its efforts being supported by local non-governmental organisations (NGOs), and the World Health Organisation, UNICEF, USAID, UNDP, Save the Children and other international organisations” (Ankrah 1992, 56). Uganda also allowed international researchers and the media to document and monitor the spread of HIV inside its borders to increase transparency and garner attention. Uganda’s AIDS prevention programs were decentralized in 1988 to allow district medical personnel and local leaders to work together through resistance councils, non-governmental organizations focusing on education and services (Ankrah 1992).
In the early 1990s, ninety percent of Ugandans lived in rural areas. Unlike several other African HIV epidemics in which the urban population was first devastated with the virus, Uganda’s rural population was hit most heavily by AIDS initially. At first the disease was prevalent among smugglers, wealthy traders, and fishermen in the Rakai and Masaka districts of southern Uganda. At the time, many local Ugandans believed that those who were HIV-positive had been “bewitched because of their prosperity of unfair practices against Tanzanian traders who lived in Bukoba on the opposite side of Lake Victoria” (Ankrah 1992, 56). However, when the wives of infected patients also grew sick, it became clear that the virus was heterosexually transmitted.

In general, Museveni’s presidency, which has managed to guide the country away from the corruption and violence that plagued Amin and Obote’s reigns and into a fairly peaceful and prosperous period, has been viewed favorably by most Ugandans and most Western countries. From the start of his presidency, Museveni
eagerly adopted many of the World Bank and International Monetary Fund structural adjustment programs and adjusted his views to follow the neoliberal agenda. Nevertheless, although he has encouraged and supported some limited forms of democracy, his term in office has been interpreted as relatively anti-democratic because he has forbidden political parties other than his own National Resistance Movement. When a 2005 constitutional referendum removed the 19-year ban on political parties, Ugandans and the West received the news favorably (*BBC News Online* 2004).

Uganda’s first presidential elections under Museveni’s governance took place in 1996 and resulted in a landslide victory for Museveni. Museveni also won the second term election in 2001 when running against his former friend and physician, Dr. Kizza Besigye. During the campaign, Museveni accused Besigye of being HIV-positive, angering many AIDS organizations that thought these comments would further bolster the stigma and discrimination surrounding the disease. Despite charges that illegalities marred the election, Museveni remained in power. Then, in 2005, the Ugandan Parliament amended the constitution to allow Museveni to run for a third presidential term although he had promised that the 2001 election would be his last. In 2006 after the removal of the ban on political parties, Uganda held its first multiparty elections in 25 years with Museveni and Besigye as the two main candidates. Although Museveni did not capture as many votes as he did in previous elections, he still won by a strong majority with 59 percent of the vote. Besigye again challenged the results, but the Supreme Court of Uganda eventually upheld the results of the election despite finding that violence, intimidation, and other irregularities
were implemented during the elections. Some foreign countries, unhappy with Uganda’s progress towards democracy, are now using aid as leverage to convince Museveni to reform. Since 1987, Uganda has received more than 11 billion dollars in foreign assistance, accounting for more than half of Uganda’s budget. After the controversial presidential elections, instead of funneling aid into budgetary assistance, many donors are diverting aid to specific humanitarian programs. For example, Britain announced in 2005 that 26 million dollars in direct assistance to Uganda would be redirected to relief projects because of concerns over Uganda’s slow progress towards democracy (Crane 2006).

**Change in Policies: Museveni’s New Approach to the Epidemic**

Uganda’s current phase of the HIV/AIDS epidemic began with a heavy focus on abstinence and faithfulness. Unfortunately, the shift away from condom promotion is largely a result of Western influence and funding. In 2003, United States President George W. Bush announced the U.S. President’s Emergency Plan for AIDS Relief (PEPFAR) to combat global HIV/AIDS. PEPFAR committed fifteen billion dollars over the years 2003-2008 to a variety of causes and programs, including antiretroviral drug roll out, opportunistic infection prevention and treatment programs, training medical personnel, renovating health care facilities, updating laboratory equipment, providing HIV counseling, and working with leaders and organizations to eliminate stigma surrounding AIDS. Fifteen “focus countries,” including Uganda and South Africa, were prioritized because of their especially high HIV/AIDS prevalence rates. Although PEPFAR is the largest bill ever passed to fight
a single disease, it has several restricting qualities. First, PEPFAR sets aside a chunk of money for abstinence-only education programs. These programs have proven to be largely unsuccessful in the United States and are also unsuccessful in Africa. Many parts of Africa view sexual intercourse differently than it is viewed in the West, and it is unfair for the United States to impose its beliefs on other countries. Second, the First Annual Report of PEPFAR to Congress announced that no funding would support needle or syringe exchange. Although this clause has valid intentions of not wanting to condone drug use, a large number of drug users are HIV-positive and continue to pass the virus on to others. Instead, I believe PEPFAR should offer a dual service to drug users by providing them with sterile needles and counseling and therapy to reduce drug addiction. The other major funding restriction of PEPFAR is the “Leadership” act of 2003 that refuses giving funds to any organization that “does not have a policy explicitly opposing prostitution and sex trafficking” (United States Leadership Against HIV/AIDS, Tuberculosis, and Malaria Act of 2003). This condition forced Brazil to turn down 40 million dollars in PEPFAR funds because the country wanted to remain autonomous “on issues related to HIV/AIDS as well as ethical and human rights principles” (Boseley and Goldenberg 2005). The last major complaint about PEPFAR is that over half of its budget is spent on treatment of HIV-positive individuals through the distribution of antiretroviral therapy, treatment of opportunistic infections, and nutritional care. While all of these treatments are important, some scholars argue that a larger portion of the budget should be directed at preventing HIV transmission instead of treating HIV transmission (Khanlou and Weinstein 2008).
The shift away from condoms has received mixed reviews from scholars, epidemiologists, doctors, researchers, and local Ugandans. On the one hand, some programs have successfully increased the age at which Ugandans first have sex and decreased the average number of sexual partners Ugandans have in a lifetime. However, it is impossible to expect all Ugandans to wait until marriage to have sex and to have sex with only one person during their lives. Not only is this unrealistic, but it is unfair. In Uganda and many other countries around the world, sexual intercourse is not perceived in the same way as it is in the United States and other parts of the Western world. Unfortunately, however, many prominent Ugandans have not rejected the focus on abstinence in fear of losing funding.
CHAPTER FOUR

Similarities and Differences in Responses to the HIV/AIDS Epidemic

There are four main distinctions between South Africa and Uganda’s HIV/AIDS epidemics. First, the virus spread throughout the two countries in very different political and economic environments. Second, Uganda’s government took a proactive stance to fight the disease while South Africa’s leaders failed to recognize and address the threat of HIV. Third, upon learning of the dangers of HIV, Ugandans spoke openly amongst each other in order to increase awareness and decrease discrimination. South Africans, on the other hand, rarely conversed with each other about the virus and regularly discriminated against those who were HIV-positive. Finally, the Western world and international organizations have played a role in slowing the spread of the virus in both countries, but they have distributed the aid in different ways. Since Museveni assumed power in 1986, Uganda has undergone a series of economic reforms, and the government has received outside funding for extensive HIV/AIDS education and treatment programs. In South Africa before the end of apartheid in 1994, most international aid flowed through non-governmental organizations because the Western world did not support the government’s racist policies. Since transitioning to democracy, the South African government receives more international aid directly, but is strategic and selective in accepting the aid. Only a small percentage of the government budget is composed of foreign aid and the government is not afraid to reject donations, especially if they will not flow through the National Treasury. South Africa’s selective foreign aid policies and novice
government have caused the country to struggle with the allocation of much of its international HIV/AIDS funding.

**Political and Economic Environments**

When HIV reared its ugly head in South Africa in 1982, the National Party controlled the country, and apartheid was still in place. Three years later, the country entered a state of emergency because of the growing violence and resistance over apartheid. As the virus began to spread more rapidly in the late 1980s, the government was too preoccupied with the transition to democracy to realize the gravity of the growing epidemic. In a meager attempt to slow the virus, the government set up South Africa’s first AIDS Advisory Group, which, unfortunately, failed to take initiative and did not have much of an impact on the spread of HIV (Pembrey 2009).

South Africa’s complicated racial history has played an important role in failing to slow the progress of HIV/AIDS. In the 1980s, as the apartheid government began to crumble, some conservative white Afrikaners attempted to use fear of the virus to rekindle racial tensions and maintain segregation. Members of the Conservative Party warned fellow white Afrikaners that desegregating nursery schools and swimming pools could lead to the transfer of AIDS from the black community to the white community. Although these scare tactics were ineffective at preventing the end of apartheid, they effectively frightened many South Africans and increased the stigma surrounding HIV/AIDS. The negative portrayal of anyone associated with AIDS lingers to this day, posing numerous challenges for those trying
to slow the spread of HIV because denial and discrimination are so common (Richter 2002). While members of the apartheid regime used scare tactics to try to maintain segregation, many blacks grew suspicious and resisted government suggestions for reducing the spread of HIV. When white government officials recommended the use of condoms for sexual intercourse, many blacks viewed this as an attempt to limit their population growth and rebelled by not using condoms. The apartheid mentality and miscommunication surrounding HIV led to further stigmatization and limited South Africa’s initial success in combating its spread (Fourie 2006).

Not only did apartheid further racial tensions and discrimination, but it also undermined family structures and created a drastic income inequality gap throughout South Africa. In general, whites were privileged and relatively wealthy while blacks, Coloureds, and other non-whites were disadvantaged and poor. Migrant labor, pass laws, and forced relocation tore apart many non-white families, and the riots and violence of the 1980s left hundreds dead and further fragmented South African society. Oppressed South African children of the 1980s lived in disjointed societies where political activism and violence were the norms and education was placed on the back burner. As these children grew up, they became the most heavily infected sector of South Africa’s population (Campbell 2003).

While the apartheid government of South Africa was too racist and ignorant to address the epidemic and the post-apartheid government was too preoccupied to successfully combat HIV/AIDS, Uganda tackled the virus head on. Uganda also had a transition in government during the early spread of HIV/AIDS; however, in contrast to South Africa, the new leadership recognized the seriousness of the medical crisis.
Although AIDS was first identified in Uganda in 1982, Milton Obote ignored the disease, which then silently spread throughout the country. Four years later when Yoweri Museveni assumed the presidency and limited Uganda’s violence, corruption, and human rights abuses, the country was able to focus heavily on combating the spread of HIV/AIDS (Eboko 2005).

Before Uganda’s new leadership took control of the country, the economy was stagnant and the tourism sector was nonexistent. As a result, international financial organizations saw Uganda as the perfect landscape to implement their neoliberal reforms. Since Uganda was desperate for growth and change, Museveni was willing to experiment with Western economic reforms and extensive HIV/AIDS education, prevention, and treatment programs. Starting in 1986, the neoliberal agenda of the International Monetary Fund (IMF) and World Bank mandated three main reforms in Uganda: trade liberalization, progressive reduction of export taxation, and privatization of state-owned industries (Naiman and Watkins 1999). Overall, the reforms increased Uganda’s real per capita gross domestic product, but decreased government spending on education and health care. As a result, Uganda now relies on non-governmental organizations and inter-governmental organizations to fund these sectors (Patterson 2005). By praising Uganda’s success with the structural adjustment reforms, the IMF and World Bank increased confidence in Museveni’s leadership. As a result, international donors were willing and even excited to fund extensive HIV/AIDS treatment and prevention programs. Other sub-Saharan African countries did not receive as much international funding because of weaker leadership and closed attitudes on the crisis. Museveni trusted the West and was willing to give
international organizations the power to implement and maintain their own programs (Ostergard and Barcelo 2005).

**Government Responses**

Since the discovery of HIV, no South African president has prioritized AIDS. Although the disease was first recognized in South Africa in 1982 under the segregationist leadership of P.W. Botha, the government virtually ignored the virus because it primarily affected the homosexual and black populations. During the late 1980s and early 1990s when National Party leader F.W. de Klerk was president, he worked closely with Nelson Mandela and the African National Congress to end apartheid and South Africa’s segregation policies. By this time, HIV was spreading rapidly throughout the country. Unfortunately, civil unrest and political uncertainty marred these years and hampered the efforts to slow the virus (Patterson 2006).

Although de Klerk was vaguely aware of the dangers of the virus, he was constrained by the racial, cultural, and political implications of HIV. When trying to introduce AIDS initiatives, de Klerk met with resistance and suspicion from both the white and black communities. In the late 1980s and early 1990s, when the virus was still progressing slowly and had not yet developed into full-blown AIDS or killed thousands of South Africans, de Klerk and Mandela feared that AIDS education and prevention programs in schools would be viewed as racist. Since teachers had a variety of religious, cultural, and political beliefs, South Africa had very limited sexual education in the schools. Without a unified sexual education program already in place, it was hard for South Africa to introduce AIDS education. Finally, racial
and cultural implications were brought to the forefront in the AIDS crisis. During the mid and late 1980s, when HIV spread rampantly through the homosexual and black migrant communities, the apartheid government was mostly uninterested in funding education and treatment programs for a disease that was chiefly infecting the outlawed homosexual population and the “inferior” black population. Because South Africans had such a negative and discriminatory view of the disease, de Klerk avoided public discussion of HIV/AIDS and primarily maintained non-interventionist policies while he was president (Furlong and Ball 2005).

Nevertheless, in 1990, many prominent South African leaders attended an HIV/AIDS conference in Maputo, Mozambique. At the conference, leaders were encouraged to speak openly with their citizens about HIV/AIDS when they returned to their countries in order to eliminate suspicion and discrimination surrounding the disease. Unfortunately, the South African leaders mainly continued to ignore the disease (van der Vliet 2004). Chris Hani, an anti-apartheid activist and chief of the Umkhonto we Sizwe, the military wing of the African National Congress, was one of the few leaders who recognized the potential impact that HIV/AIDS could have on South Africa. At the conference in Maputo, Hani stated, “We cannot afford to allow the AIDS epidemic to ruin the realisation of our dreams. Existing statistics indicate that we are still at the beginning of the AIDS epidemic in our country. Unattended, however, this will result in untold damage and suffering by the end of the century” (Marais 2000). Hani was assassinated in 1993 before he was able to spread his message and warn South Africans of the real dangers of the disease. Meanwhile, the
peak spread of HIV in South Africa occurred from the start of de Klerk’s presidency in 1989 to the election of Nelson Mandela in 1994 (Furlong and Ball 2005).

Even with Nelson Mandela as president, South Africa continued to neglect HIV/AIDS. In fact, from 1994-1998 Mandela delivered only one major speech addressing AIDS, and it was in Switzerland in 1997. During Mandela’s five years in office, South Africa’s adult HIV prevalence rate jumped astronomically from 7.6 percent to 22.4 percent (Stannard 2001). In 1998, Mandela was scheduled to make a nationally televised address on HIV/AIDS, but at the last minute he backed out and asked Thabo Mbeki, his Deputy President, to deliver the speech for him (Marais 2000). By this time, with such ineffectual leadership in the fight against HIV/AIDS, the epidemic overwhelmed South Africa.

After his presidency ended, Mandela surprisingly became one of South Africa’s main spokesmen for the fight against HIV/AIDS. In 2000, he acknowledged his failure to address the epidemic during his term, and he has done his best since then to increase awareness (BBC News Online 2000a). In 2005, Mandela’s eldest son died from AIDS, and he used the tragic event to speak openly about the disease and his son’s fight for life. At a news conference following his son’s death, Mandela announced, “Let us give publicity to H.I.V./AIDS and not hide it, because the only way to make it appear like a normal illness like TB, like cancer, is always to come out and say somebody has died because of H.I.V./AIDS, and people will stop regarding it as something extraordinary” (Wines 2005). He continued by stating his hope that “as time goes on, we realize that it is important for us to talk openly about people who die of AIDS” (Wines 2005). Mandela now recognizes the importance of eliminating
HIV/AIDS discrimination in order to fight the disease effectively in South Africa. By speaking about his son’s death, Mandela has made the disease tangible and has shown it to be a problem that affects everyone: white, black, rich, poor, young, and old. Along with acknowledging his own failures in dealing with the virus, Mandela has publicly denounced Thabo Mbeki’s denialist approach to the disease (Furlong and Ball 2005).

In 1999, Mbeki was elected to succeed Mandela as the president of South Africa, and he maintained this position until 2008 when he was pressured to resign. Mbeki’s presidency was filled with economic growth and generally strong foreign policy leadership, but will be remembered for his failure to address South Africa’s AIDS crisis (Alden and Soko 2005). Throughout his nine-year term, Mbeki’s views and position on AIDS changed several times, provoking strong negative reactions locally and internationally. At the International AIDS Conference in Durban in 2000, Mbeki’s opening address implied that poverty caused AIDS (Swarms and Altman 2000). Mbeki stirred up more controversy when he backed a small group of dissident scientists who believed the human immunodeficiency virus did not lead to AIDS (Bayer and Oppenheimer 2007). In addition, his Minister of Health, Dr. Tshabalala-Msimang, encouraged HIV-positive South Africans to eat garlic and beetroots instead of taking antiretroviral drugs, a recommendation that the international community strongly criticized. By the time Mbeki began to shift his stance to be more proactive in fighting AIDS, millions of South Africans were already infected (Furlong and Ball 2005). In December 2008, the *Journal of Acquired Immune Deficiency Syndrome* published the results of a study by Harvard researchers that revealed that that South
Africa’s poor leadership under Thabo Mbeki led to more than 365,000 premature deaths (Chigwedere et al. 2008). *The New York Times* published a front-page article addressing these results and criticizing Mbeki for not providing the necessary drugs to slow the progression of AIDS and to prevent transmission of HIV from pregnant women to their babies (Dugger 2008).

During these years, Uganda took an entirely different approach to combating HIV/AIDS. In contrast to de Klerk, Mandela, and Mbeki, Museveni immediately took proactive measures by speaking openly about the dangers of the disease. It is unclear exactly why Museveni took such an aggressive stance against HIV, but some theories suggest that he feared the potential damage of the disease on the military at a time when Uganda faced several security threats (Patterson 2005). Whatever the reason, Museveni responded quickly and assertively to the growing HIV/AIDS crisis and encouraged his citizens to abstain from sex until marriage, be faithful to one partner, practice safe sex, and talk openly about the disease. While South African leaders were too afraid of being accused of racism and discrimination to discuss AIDS, Museveni and his government had little to lose by openly addressing the disease (Furlong and Ball 2005).

Museveni realized early in the epidemic, that Uganda’s “fragmented population could only be reached through an intense, grassroots, face-to-face educational campaign” (Boone and Batsell 2001, 9). He rallied many political figures to publicly demonstrate their commitment to ending the spread of AIDS. While Mbeki’s Health Minister was promoting garlic and beetroots to treat AIDS, Uganda’s Minister of Health took to the streets to distribute condoms. By involving Ugandans
of all socio-economic backgrounds, Museveni was able to decrease the stigma surrounding HIV and unite all Ugandans to fight against the disease (Boone and Batsell 2001).

Museveni aggressively sought help from government agencies and non-governmental organizations to create and implement education and health services programs. Africa’s first anonymous AIDS testing and counseling center was established in Uganda, and nationwide testing was encouraged (Boone and Batsell 2001). Museveni also changed laws to permit local shops as well as licensed pharmacies to sell medications for the treatment of sexually transmitted infections (STIs). This provided wider distribution of necessary medications and resulted in “increased cure rates for STIs, such as urethritis, from 46 per cent to 87 per cent” (Kauffman 2004, 27). By changing the regulations and laws for the distribution of medications to treat sexually transmitted infections, Museveni demonstrated his power, confidence, and commitment to ending Uganda’s HIV/AIDS crisis.

South African and Ugandan Culture

Extensive discrimination and stigma have contributed to the AIDS epidemic since its discovery in South Africa. Because the virus was first prevalent among homosexuals and blacks, two sectors of the populations that the apartheid government considered inferior, South Africans ignored or hid the virus (Campbell 2003). Apartheid significantly affected the mentality and attitudes of all South Africans. Most white South Africans considered themselves superior to all other races, and most non-whites were suspicious of the white government. In the poor, crowded
townships, male-dominated relationships, with high rates of domestic and sexual abuse, were the norm. Compared with the violence, riots, and poor living conditions of the townships, AIDS seemed like a minor concern. In addition, in the mining communities, many miners focused solely on day-to-day survival, were unwilling to consider the long-term consequences of HIV and, therefore, rarely used condoms (Campbell 2003). Sex workers in and around the compounds did not, and still usually do not, have the authority to demand condom use. In townships and mining communities, sexual abuse remains common, and HIV rates continue to soar (Campbell 2004).

Fifteen years after the end of apartheid, little cohesion and solidarity exists in the entire South African nation. South Africa has the highest rate of rape in the world and is also plagued with high rates of crime and domestic abuse (Metcalfe 2000). Kyle D. Kauffman notes in his article “Why is South Africa the HIV Capital of the World?” that the extremely high rates of rape “are an indication of the way South African men view their relations with women” (Kauffman 2004, 23). Rape often involves rough sexual intercourse and can lead to vaginal tears and the transmission of HIV. South Africa’s rate of rape exemplifies the gender inequalities and sexual abuses that occur regularly in the country (Bonnin et al. 1998).

In addition to these problems, bias against HIV victims is a major issue in South Africa and inhibits people from revealing the fact that they have the virus. In 1998 Gugu Dlamini, an HIV-positive South African, publicly disclosed her status in an attempt to decrease the stigma surrounding the disease. Soon after her public announcement, Dlamini was beaten to death by her neighbors (Derryck 2008).
Overcoming discrimination has been a major obstacle for HIV education programs and non-governmental organizations because few South Africans admit their HIV-positive status even to their family and closest friends. One organization sought to decrease mother-to-child-transmission rates by providing bottled milk for HIV-positive mothers in place of breastfeeding. Despite this organization’s good intentions, most South African mothers, especially those living in townships and other poor communities, breastfed their newborns and were afraid of immediately being labeled HIV-positive if seen with a bottle. As a result, the organization found dozens of unused bottles in the dump, and HIV-positive mothers continued to put their newborns at risk of infection by breastfeeding (Taha et al. 2006).

Racism and domestic abuse are not as prevalent in Uganda as they are in South Africa. Despite being home to dozens of languages and three main different ethnic groups, Uganda has maintained a fairly peaceful environment since Museveni took control of the country. Although the northern region of Uganda is plagued by rebel warfare, the violence generally is contained and has not had a serious impact on the rest of the country. Gender imbalances are present throughout Africa, including in Uganda where women have lower rates of literacy than males, less ownership of land, and higher rates of HIV. However, since Museveni’s National Resistance Movement came into power, steps have been taken to reduce gender inequalities. From 1994-2003, the vice-president of Uganda was a woman, and the number of female cabinet ministers, state ministers, and members of parliamentary has been steadily increasing since 1986 (Saito 2002). Rates of rape and domestic violence have declined in the years since Idi Amin and Milton Obote’s reigns. Most of
Uganda’s reported sexual abuse occurs among married couples and in the war-torn north of the country. Uganda has worked hard since 1986 to decrease the gender gap and limit sexual violence, proving to be far less troubled with these issues than South Africa (Tuhairwe-Bataringaya 2004).

Research has shown that South Africans and Ugandans have different levels of community involvement, trust in neighbors and relatives, participation in government, and general openness. The Afrobarometer is an independent research project that conducts interviews throughout several countries in Africa to measure social, political, and economic differences. A standard set of questions is asked in each country, and the interviews are repeated regularly so the responses and trends of public attitudes can be tracked over time. Using the Afrobarometer country studies, the social and political attitudes of Ugandans and South Africans can be compared (Afrobarometer 2005).

The 2005 Afrobarometer studies found that South Africans are less involved in community activities, church functions, and neighborhood events than Ugandans. The studies also found that local government is more accessible in Uganda and that Ugandans are more likely to trust their neighbors. When asked “Do you know a close friend or relative who has died of AIDS?” thirty-one percent of South Africans said yes and eighty-nine percent of Ugandans said yes (Afrobarometer 2005; Afrobarometer 2006). At the time of this question, South Africa’s HIV adult prevalence rate was 16.2 percent and Uganda’s was 6.5 percent, clearly indicating either dishonesty or lack of knowledge by many South Africans (Noble 2009b; Zaccagnini 2009). In South Africa, families often lie about how their relatives die
because they are too ashamed and afraid to admit that AIDS was the cause of death (Campbell 2003).

**International Support**

Foreign aid to combat HIV/AIDS varies by country. Some countries tend to receive more aid than others because of their government structure, leadership, colonial history, and domestic spending capabilities. Philanthropic individuals and organizations often have personal connections with a cause or a country, while donor governments often allocate aid based on their political interests. Uganda and South Africa have both recently received huge amounts of aid through the United States’ PEPFAR initiative to fight their HIV/AIDS crises. In July 2008, George W. Bush signed the “Tom Lantos and Henry J Hyde United States Global Leadership Against HIV/AIDS, Tuberculosis and Malaria reauthorization Act of 2008” to extend PEPFAR funding through 2013. Currently, Uganda and South Africa are two of PEPFAR’s fifteen “focus countries” that receive the majority of the 15 billion dollars. As a result, PEPFAR gave South Africa 459 million dollars and Uganda 409 million dollars over the fiscal years from 2004-2006 (Kanabus and Noble 2009). Prior to the creation of PEPFAR, varying levels of development aid were disbursed throughout sub-Saharan Africa to fight HIV/AIDS. Since Museveni assumed the presidency, Uganda’s government has been one of the top recipients of foreign aid because of the country’s openness and willingness to embrace international support. On the other hand, the South African government has only recently been accepting higher levels of foreign aid. Historically, South Africa has tried to maintain independence from the
West by having only a small percentage of its government revenue composed of foreign aid. The South African government is also more selective and strategic than most other sub-Saharan African countries in accepting foreign aid (Johnson 2008).

Since privatizing its economy, allowing for transparency, and adopting the International Monetary Fund and World Bank reforms, Uganda has become the perfect country for international donors to pour aid into for HIV/AIDS programs. For many years, the influx of foreign aid has funded Uganda’s HIV prevention and treatment programs, the distribution of antiretroviral drugs, and the improvement of the country’s infrastructure. Recently, however, Uganda’s high levels of foreign aid have been scrutinized because it has drastically impacted the country’s economy, democracy, and domestic capabilities. The Ugandan government cannot precisely record the amount of foreign aid it receives because some donations are given directly to non-governmental organizations through commercial banks and, therefore, are not processed through the central bank of Uganda, making them difficult to track.

Estimates for the 2005-2006 fiscal year suggest that Uganda received about 989 million dollars in total foreign aid with about 100 million dollars directed specifically to HIV/AIDS programs. From the fiscal years 1997-1998 and 2000-2001, Uganda’s fiscal deficit nearly doubled to 12 percent of the country’s gross domestic product (Brownbridge and Tumusiime-Mutebile 2007). It has become more important for Uganda to monitor foreign aid because it has the ability to change the macroeconomic environment by appreciating the Ugandan shilling and increasing the risk of inflation. In order to counter its dependence on foreign aid, Uganda has started to decrease the portion of its government budget deficit that is financed by aid (Sheikh 2005).
There are dozens of negative stories about foreign aid furthering corruption, promoting undemocratic practices, and hurting weak economies. Andrew Mwenda is the most well known critic of foreign aid in Uganda. Mwenda has repeatedly criticized aid agencies, individual donors, and the West for fueling corruption and damaging Uganda’s economy through development aid. His 2006 article, “Foreign Aid and the Weakening of Democratic Accountability in Uganda,” recognizes the importance of aid for basic health care, education, and infrastructure in Uganda but also accuses the international community of making Uganda dependent on development aid (Mwenda 2006). Approximately one-half of Uganda’s budget is composed of foreign aid, and Mwenda argues this has three major negative impacts on Uganda. First, foreign aid has furthered political patronage through the lack of tax collection. The Uganda Revenue Authority (URA) aims to collect enough taxes to account for 24 percent of the GDP, but currently the taxes only amount to approximately 12 percent of the GDP. Since there is little regulation of the URA, the rich and politically well-connected are often unjustly exempt from paying taxes. Second, much foreign aid is secretly diverted and spent on the military. Approximately 20 percent of military spending in Uganda is paid to “ghost soldiers” and ends up being pocketed by military officials. Considering its failure to end the rebel movement in the north, the Ugandan military receives a disproportionate amount of money. The third negative impact of foreign aid in Uganda is its inability to produce long-term, sustainable economic growth. Despite debt cancellation under the Heavily Indebted Poor Countries Initiative in 1998, Uganda’s debt has again reached an unsustainable level. Instead of pouring aid into programs and
organizations stimulating economic growth, too much money has been directed
toward increasing the size of Uganda’s bureaucracy. Over the past decade, the
number of cabinet ministers, presidential advisers, and local government officials in
Uganda has drastically increased (Mwenda 2005).

Peter Mulira, a prominent Ugandan lawyer, has also publicly expressed his
concern over foreign aid. Mulira accuses the West of having a skewed perception of
good governance that includes holding elections regularly and having multiparty
politics. According to Mulira, these factors are not enough to indicate good
governance. In Uganda, most power is concentrated in Kampala and the rest of the
country does not have enough representation (Sheikh 2005). Fredrik Erixon, an
economist, also addresses the concern and potential consequences of foreign aid on
Uganda’s economy by stating, “growth that is dependent on aid is intrinsically fragile.
It threatens to unleash unsound political economy processes that surely will occur – if
they haven’t already – if Uganda continues with its present level of aid dependency
. . . If Uganda’s aid decreases in the near future, its GDP will fall significantly”
(Erixon 2005, 19). As of now, Uganda has continued to receive foreign aid for
HIV/AIDS programs in addition to general development aid.

Regardless of disagreements over development aid, it is hard to argue that
foreign assistance has not played a role in Uganda’s fight against HIV/AIDS.
Coupled with Museveni’s proactive and aggressive approach, the rapid response of
the West to assist Uganda was vital to the country’s success in fighting AIDS.
Although Uganda has recently taken a step in the opposite direction with the relaxing
of its AIDS campaign, the country has done a good job overall of properly using development aid to decrease its HIV rates.

South Africa, on the other hand, has been selective in accepting foreign aid and has often struggled with effectively distributing it. As noted before, South Africa primarily received foreign aid through non-governmental organizations prior to 1994 because the West did not want to be associated with the segregationist apartheid regime. Therefore, non-governmental organizations in South Africa were primarily “arenas of social and political protest acting in opposition to the white apartheid state” (Mindry 2008, 4). When apartheid ended in 1994, most foreign aid no longer flowed through non-governmental organizations, but instead was redirected to flow through the government. Unfortunately, this slowed progress in South Africa’s AIDS crisis because the civil society organizations were better developed, managed, and coordinated than the new government. As a result, the post-apartheid fight against HIV/AIDS was weak and unorganized (Mindry 2008). South Africa’s AIDS crisis was also negatively affected by the neoliberal reforms that accompanied the country’s transition to democracy. These reforms decreased the quantity of state resources available to spend on AIDS programs and slowed the pace of transformation in the health sector, “thus continuing apartheid-era institutional and economic legacies and prolonging bureaucratic incapacity to implement AIDS programs effectively” (Johnson 2004, 112).

The South African government’s tepid attitude with donors and selectiveness in accepting foreign aid also has affected the country’s fight against HIV/AIDS. Historically, the government has had an ambivalent relationship with foreign donors.
Krista Johnson, a professor and researcher, believes the tensions between the government and donors are “fuelled in part by the South African government’s determination to avoid the trap of dependence at all costs and develop a response to the pandemic that is affordable and sustainable using domestic resources” (2008, 496). Regardless of the reasons causing the tension, the ambivalence has become more apparent in the country’s handling of the HIV/AIDS crisis. Recently, the South African government has increased its domestic HIV/AIDS spending so that foreign aid does not become a significant portion of the country’s budget. Most of sub-Saharan African countries do not have the resources or power to be picky in accepting and rejecting foreign aid, but South Africa is financially secure enough to be selective and strategic in accepting foreign aid. The role of foreign organizations in conjunction with the government is especially important to South Africa. Since development aid only makes up a small percentage of South Africa’s HIV/AIDS spending, the government does not like to cede control to foreign agencies. Johnson hypothesizes that the United States’ decision to not give any PEPFAR funding directly to the South African government has led to the United States having “a more marginalized and tepid relationship with the [South African] government than other major donors” (2008, 508). The European Union and Global Fund to Fight AIDS, Tuberculosis, and Malaria both donate directly to the South African National Treasury, which allows the government to have more control and coordination over the distribution of its funds. There are advantages and disadvantages to giving development aid to non-governmental partners in South Africa and giving directly to the National Treasury, but it is clear that the South Africa government is more
concerned about directly receiving foreign aid than many of its sub-Saharan African counterparts.

In comparing South Africa and Uganda, Johnson recognizes that both countries face different bureaucratic restructuring and capacity-building challenges. Uganda has struggled with “bureaucratic incapacity” but benefited from “the presence of strong, centralized leadership beginning with President Museveni.” Museveni’s commitment to fighting AIDS united all sectors of society around a common goal, which was further supported and funded by non-governmental organizations and international donors. In South Africa, “the exclusion of a broad spectrum of civil society . . . spurred animosity and a sour working relationship between government and civil society actors—which remains an obstacle to policy implementation” (2004, 126).
CHAPTER FIVE

Roadmap for Sub-Saharan African Countries Fighting HIV/AIDS

This chapter draws on the positive and negative lessons learned from South Africa and Uganda’s responses to HIV/AIDS and provides a series of conditions for other sub-Saharan African countries to follow while fighting their epidemics. Seven guidelines are suggested in order for these countries to combat HIV/AIDS efficiently and effectively.

Respond Quickly

Although most countries were initially slow in recognizing the growing epidemic, those that were open to learning and responding to the spread of HIV were more likely to record lower prevalence rates. For example, the governments of Uganda, Brazil, and Senegal all responded within a couple of years of discovering the virus within their borders and subsequently were able to decrease their HIV prevalence rates. On the other hand, the governments of South Africa, Kenya, and Botswana virtually ignored the virus until it had thoroughly infiltrated their countries. By the 1990s, HIV prevalence rates in these countries impacted economic growth, human capital, and family structures (Noble 2009c).

Have Strong Government Leadership

In addition to responding quickly to HIV, it is also important for a country to respond aggressively, as exemplified by Yoweri Museveni in Uganda. Strong leadership is necessary to limit stigma, unify the country, and coordinate national and
international HIV prevention and treatment programs. Poor leadership and negligence, as exemplified by F.W. de Klerk, Nelson Mandela, and Thabo Mbeki in South Africa, can obstruct a country from delivering the proper education and treatment to its citizens.

**Encourage Communication among Unified and Dedicated Citizens**

Committed citizens and open communication are the keys to minimizing stigma and discrimination surrounding HIV. By portraying the disease as “everyone’s problem,” people feel more comfortable speaking openly about the impacts of being infected and affected by HIV/AIDS. The shame and embarrassment surrounding HIV/AIDS have hindered the effectiveness of many prevention and treatment campaigns because too many people are afraid to be tested and, therefore, inadvertently continue to spread the disease. If HIV discrimination were reduced, more people would opt for testing and take the necessary precautions to prevent further spread. Counties with limited ethnic and religious fragmentation, internal conflict, and political repression tend to have an easier time uniting their citizens around a common cause. In general, South Africa has had trouble unifying its citizens because apartheid was so polarizing, but Museveni has been fairly successful in encouraging Ugandans to fight together against HIV/AIDS.

**Reduce Poverty and Income Inequalities**

Currently, many countries in sub-Saharan Africa struggle with poverty and income inequalities. According to the Gini coefficient, a measure of inequality of
wealth distribution, both South Africa and Uganda have significant income equality gaps. South Africa’s income inequality gap, ranking in the ten highest in the world, is substantially worse than Uganda’s, according to the 2007/2008 Human Development Report (UNDP 2008). South Africa’s apartheid government promoted the income inequality gap through its discriminatory policies. Since the end of apartheid, considerable budgetary redistribution has attempted to decrease the disparities in income, but fifteen years after apartheid ended, the country is still suffering from high rates of income inequality (Triegaardt 2008).

HIV is commonly labeled a “disease of poverty,” but extensive research on the relationship between poverty and risk of HIV infection has yielded mixed results. A recent study by Peter Piot, Robert Greener, and Sarah Russell “indicates that AIDS is a disease of inequality, often associated with economic transition, rather than a disease of poverty in itself” (2007, 1571). The study shows that countries with higher levels of inequality, measured with the Gini coefficient, tend to have higher HIV prevalence rates. These findings are also applicable to inequality on a household basis where women who rely on their partners for economic and social security have less power in sexual safety.

Research conducted by Emily Oster, an economist at the University of Chicago, found that “behavioral response is larger for those who have higher non-HIV life expectancy and those who are richer” (2009). From these results, Oster deduces that sub-Saharan Africa’s AIDS epidemic would not be as high if the region’s income and life expectancy were equivalent to those in the United States.
End Domestic Violence and Promote Gender Equality

Women comprise 50 percent of the total HIV infections worldwide, but in sub-Saharan Africa women account for nearly 60 percent of infections (UNAIDS 2008a). Domestic violence, sexual abuse, and a wide gender gap are common problems contributing to the disproportionate number of female HIV infections in sub-Saharan Africa’s epidemic.

HIV Prevalence among 15-24 years old, by sex, selected countries, 2005-2007 (UNAIDS 2008a)

Violence and sexual abuse lead to increased rates of HIV transmission because of the subordination and rough sexual intercourse that men often force upon women. Throughout most of Africa, women do not have much power or control in their relationships and, therefore, have a hard time saying no to sex and demanding
that a man use a condom. South Africa and Uganda both have high rates of reported domestic violence, a statistic that is difficult to record accurately because women seldom go to the hospital or police after being abused by their spouses (Annual Crime Report 2008). This suggests that in addition to the reported cases, thousands of unreported cases occur each year in these countries and in the rest of sub-Saharan Africa. South Africa has been referred to as the “rape capital” of the world because of its consistent placement at the top of the rapes per capita crime statistic (News24 2005). Several studies estimate that 4.5-7.2 percent of South African women aged fifteen to forty-nine have been raped in their lifetimes (Jewkes and Abrahams 2002; Jewkes et al. 1999). If sub-Saharan Africa can promote gender equality and reduce the number of acts of sexual violence, HIV prevalence rates will certainly decline.

**Implement Prevention and Treatment Programs**

Effective government reaction to HIV includes the development of comprehensive and extensive education programs and widespread affordable treatment for those with AIDS. Different African countries and leaders have had success with various prevention programs, but one of the most commonly replicated initiatives is Uganda’s ABC model that promotes abstinence, being faithful to one partner, and condom usage. Although controversial, this approach has been adapted by several large organizations, including PEPFAR (2005) and UNAIDS (2008a), to emphasize the importance of abstinence and being faithful while encouraging condom use only for those practicing high-risk behavior or those with an HIV-positive partner.
Both South Africa and Uganda have implemented extensive prevention programs to educate their citizens about HIV. South Africa was initially slower than Uganda in developing and employing the programs but has recently committed significant funds and resources to them. In addition to providing HIV/AIDS education, in 1998 the Ugandan government agreed to run a trial of antiretroviral therapy “to test the feasibility of rolling out effective anti-AIDS treatment to people in developing countries” (Zaccagnini 2009). Uganda has been limited by its financial resources but has provided free ARVs to those with AIDS since 2004. This treatment has obviously benefited many despite the fact that some scholars believe that the presence of antiretroviral drugs in Uganda has changed the perception of AIDS and has led to an increase in risky behavior. In contrast, despite having the economic capacity to implement a public treatment program, the South African government was hesitant to provide ARVs to its citizens because of Mbeki’s fears that drug companies exaggerated the importance of therapy to increase their profits. In 1998, Treatment Action Campaign (TAC) was formed to put pressure on the government to increase public access to ARVs. In 2001, along with the support of about 200 doctors, TAC sued the South African government, demanding wider use of nevirapine, the ARV to prevent mother-to-child-transmission (James 2001). While the quick response by the Ugandan government to accept international help for AIDS treatment programs has saved the lives of thousands, the South African government’s slow response and continual denial of the disease has led to the premature deaths of thousands. Prevention and treatment programs are important components of the fight against
HIV/AIDS. It is important for the programs to be country-specific in order to target the greatest number of people.

Treat Other Sexually Transmitted Infections

In 2005, Emily Oster published an article with her findings on the impact of sexually transmitted infections (STIs) on the viral transmission rates of HIV. She discovered that “for a given unprotected sexual relationship with an HIV-infected person, Africans are between four and five times more likely than Americans to become infected with HIV” (Oster 2006). Oster cites the high prevalence of STIs, especially those that cause genital sores, as the major cause of sub-Saharan Africa’s high HIV prevalence rate. Several other reports with similar findings have encouraged more HIV prevention programs to target the treatment of sexually transmitted infections (WHO 2006; Cichocki 2009).

Surveys have found that patients prefer to seek care for sexually transmitted infections in the private sector because of convenience, confidentiality, and the less-stigmatizing and judgmental environment. In response, programs have been developed to provide those in the private sector with the knowledge and equipment to give better STI treatment. A team in Uganda also came up with a method of decreasing their STI rates by creating the pre-packaged “Clear Seven” kit for men with urethral discharge. The kit contained the medicine to cure the STI, condoms, partner referral coupons, and an instruction pamphlet for easy at-home treatment. The kits were easily accessible at clinics, pharmacies, and retail drug stores and
proved to be successful in decreasing Uganda’s rate of sexually transmitted infections (Mayaud and Mabey 2002).
CHAPTER SIX

Roadmap for Development Aid Directed at Fighting Sub-Saharan Africa’s HIV/AIDS Epidemic

Since the discovery of HIV in 1981, billions of dollars have been dedicated to slowing the spread of the virus in developing countries. In 2007, more than ten billion U.S. dollars were given to low- and middle-income countries to fight HIV. Despite the generosity of developed countries, spending per person living with HIV is 1,000 times lower in Africa than in the United States. In low- and middle-income countries, AIDS-related funding “from the international community usually reaches the projects that spend it via one (or more) of four main funding streams: donations from national governments; multilateral funding organisations; the private sector; and domestic spending” (de Boer et al. 2009).

Donor governments provide a large portion of funding for the HIV/AIDS epidemic, mainly through bilateral donations directly from one government to another. Aid from the United States currently accounts for more than 40 percent of government donations for the HIV/AIDS epidemic, with the United States Agency for International Development (USAID) serving as the primary organization of distribution. Bilateral donations tend to be driven by the donor government’s political and economic interests and, therefore, are not necessarily the most beneficial forms of funding. Multilateral organizations receive funding from a number of national governments and then distribute the funding more objectively and independently. The two largest multilateral funding organizations are the World Bank and the Global Fund to Fight AIDS, Tuberculosis, and Malaria. Private sector
funding only accounts for four percent of spending on the AIDS crisis but includes corporate donors, individual philanthropists, religious groups, charities, and non-governmental organizations (NGOs). The Bill and Melinda Gates Foundation is the largest transparently operated private foundation in the world, currently donating millions of dollars each year to improving global health. The fourth main channel of assistance is domestic spending, which varies greatly by country. Wealthy countries tend to have more funding available for HIV/AIDS treatment, while many developing countries do not have the resources to properly care for their infected citizens (de Boer et al. 2009).

The amount of international funding a country receives differs greatly depending on the country’s HIV prevalence rates, geography, type of funding needed, governance, and personal ties to a donor country. Funding usually flows from a large donor to a primary transfer agent, such as a developing country’s government or an international NGO, to an intermediate transfer agent, such as a national NGO, and finally to implementing local partners. It is rare for large donors such as PEPFAR and the Global Fund to give money directly to grassroots organizations on the community level. Although this long chain of fund transfers can be effective, it also can be inefficient and costly. Every time a donation passes from donor to country to bank to organization, money is spent on administrative costs before it reaches its final destination (de Boer et al. 2009). Further complicating matters, foreign aid has the potential to impact a country negatively by inadvertently promoting corruption, dependency, and patronage.
In order to maximize the effectiveness of foreign aid, recipient countries and their citizens should be involved in the development and implementation of prevention and treatment programs. Currently, too much aid is given to projects that are not suitable for certain regions and populations. Therefore, it is important for organizations to work at a local grassroots level to determine which programs are most beneficial. Development economists Abhijit V. Banerjee and Ruimin He encourage donors “to get involved in the process of decision making and delivery at the ground level” to make sure both donors and recipients get what they want out of projects (2008, 49).

It can be difficult to develop and maintain an effective balance of power between donors and recipients, but without this balance donors inadvertently can...
undermine a country’s domestic capabilities or recipients can render the aid ineffective. Finding a compromise between the two is challenging because they often disagree over who should have oversight and control of the funding. They each have their own agendas and views on how and where the money should be spent, and these views do not always overlap.

The South African government is especially fearful of dependence on international assistance and has worked hard to ensure that only a small portion of its government budget is composed of foreign aid. The South African government also has been vocal about wanting foreign aid to flow directly into the National Treasury instead of to local programs. For instance, at the opening ceremony of the 2006 Annual PEPFAR Implementer’s meeting, Minister of Health Dr. Manto Tshabalala-Msimang expressed South Africa’s view that “external funding must be coordinated through government systems . . . to achieve better outcomes” and that previous PEPFAR funding had “posed a serious co-ordination and harmonisation challenge” for the country (Tshabalala-Msimang 2006). At a press conference following the opening address, Dr. Tshabalala-Msimang mentioned South Africa’s surprise when PEPFAR initially selected it as a focus country in 2003 because the government had not been consulted (Cullinan 2006). From the South African government’s perspective, the United States “has made little effort to consult or liaise with it regarding the implementation of PEPFAR” (Johnson 2008, 508). On the other side of the argument, Dr. Francois Venter, president of the Southern African HIV Clinicians Society, spoke out in opposition to Tshabalala-Msimang and complained that South Africa’s health system was weak “not because of PEPFAR, but because of the health
ministry" and that Tshabalala-Msimang did not have the right to argue “for donors to fit in with local agendas” because of her past negligence in dealing with HIV/AIDS (Independent Online 2009). The lack of communication and constant disagreements between foreign aid agencies and African governments has consistently caused problems throughout the HIV/AIDS crisis.

**Evaluate Projects**

Development economists generally agree that random independent evaluation of aid agencies, programs, and projects is necessary to increase the effectiveness of aid. William Easterly, a development economist at New York University, argues that “lack of feedback is one of the most critical flaws in existing aid” (2006, 15). Economists Esther Duflo of MIT and Michael Kremer of Harvard deem that “rigorous and systematic evaluations have the potential to leverage the impact of international organizations well beyond simply their ability to finance programs. Credible impact evaluations are international public goods: the benefits of knowing that a program works or does not work extend well beyond the organization or the country implementing the program” (2008, 117). Currently, most organizations use “self-evaluations” from within their aid agencies to assess the effectiveness of projects. Self-evaluations are largely a waste of money and time because they are more likely to be biased and inaccurate in favor of the agency. Independent evaluations are important in “making sure that the project is carried out as it should be, and for figuring out how much people are getting out of it and whether it continues to be what they need or want” (Banerjee and He 2008, 49).
The main goals of random independent evaluations are twofold: first, to determine which techniques and projects are most effective and cost-efficient, and second, to pressure aid agencies to constantly experiment and improve their interventions (Easterly 2006). It would be too time-consuming and expensive to evaluate every project, but independent organizations should conduct random evaluations to determine which projects are successful and which are not. The successful projects can then be replicated and adapted accordingly, and the unsuccessful projects can be abandoned. In addition, the possibility of being evaluated at random will put pressure on aid agencies to continually improve their programs. Monitoring and evaluating projects is also useful in helping other donors and recipients to improve their techniques.

Currently there is no method of enforcing random evaluations on aid projects, but William Easterly suggests that all aid agencies set aside a portion of their budgets “to contribute to an international independent evaluation group made up of staff trained in the scientific method from the rich and poor countries, who will evaluate random samples of each aid agency’s efforts.” The evaluations would focus primarily on surveying the poor to see if they are better off with the program. If the aid is not beneficial, pressure from the donors needs to be placed “on the agencies to make their money actually reach the poor, and to get angry when the aid does not reach the poor” (Easterly 2006, 370).
Tailor Prevention Programs Accordingly

Along with incorporating recipient governments and civilians and randomly evaluating projects, it is important to adapt programs according to the targeted population. To create the most effective prevention program, agencies need to understand the “epidemic dynamics and social context” of a country in order to reach the most vulnerable populations (Piot 2007, 1573). For example, when research found that Thailand’s epidemic was primarily spread via sex workers, the country sponsored a massive program to decrease visits to commercial sex workers, increase condom usage, and decrease the prevalence of sexually transmitted infections (Kanabus et al. 2009). In sub-Saharan Africa, regions experiencing an increase in trade have aimed prevention programs at mobile transport workers.

Coordinate Efforts among Donors

The aid effort currently suffers from too much fragmentation and not enough communication among donors. In contrast to successful government bureaucracies and private corporations that focus on specialization, aid agencies tend toward fragmentation by splitting “their assistance between too many donors, too many countries, and too many sectors for each donor” (Easterly et al. 2008, 10). Fragmentation causes coordination problems and leads to high overhead costs for both donors and recipients. The lack of communication among donors is also a major impediment to the success of HIV/AIDS projects. Ritva Reinikka of the World Bank charges that “donors often do not know (or do not care) what the other donors and the
recipient are doing, which results in duplication, waste, and gaps in services” (2008, 195).

**Do Not Impose Western Ideals and Morals on Other Nations**

The allocation of development aid for HIV/AIDS prevention and treatment projects to both abstinence and condom programs is highly controversial. Many research studies have been conducted to determine the effectiveness of each part of the ABC model, but in general, it seems that the most successful countries combating AIDS are those that incorporate all three aspects. PEPFAR probably has been the most controversial funding initiative because a portion of its budget was specifically earmarked for HIV prevention programs to promote abstinence and faithfulness (Epstein 2007). The decision to set aside money for these programs was primarily motivated by President George W. Bush’s commitment to appeasing the United States’ religious right and to maintaining its political support. However, it is impossible to create a fully effective African HIV program when American political ideals are at the forefront. Numerous studies of the impact of abstinence programs have been conducted in the United States and virtually all of them have found that encouraging abstinence has “no effect on sexual behavior of young people, except to discourage them from using condoms” (Easterly 2006, 254). Since these programs have not been effective in the United States, it is ludicrous to believe they will be effective in Africa. Many non-governmental organizations that aggressively market condoms have either lost their funding or been threatened by religious groups for supposedly promoting sexual promiscuity.
Recently, Pope Benedict XVI stirred up further controversy when he stated that HIV/AIDS was “a tragedy that cannot be overcome by money alone, that cannot be overcome through the distribution of condoms, which can even increase the problem” (Sofroniou 2009). The Vatican has long been discouraging the distribution of condoms in Africa, a moral determination that should not be decided for an entire continent by an outside entity.

**Balance Funding Between Prevention and Treatment**

Over the past couple of years, several scholars have suggested that more funding should be directed toward HIV prevention programs rather than spent on treatment for those already infected with HIV/AIDS (Easterly 2006; Filmer et al. 2002). Others believe that prevention and treatment programs are not mutually exclusive interventions and that it is important to continue funding both (Sachs 2003; Farmer 2005). Despite extensive research on this debate, no decisive answer has been reached.

William Easterly (2006) and Lant H. Pritchett, Deon Filmer, and Jeffrey S. Hammer (2002) are several of the development economists who believe it is more cost-effective to direct aid towards effective prevention programs than towards treatment programs. According to Easterly’s research, “if money spent on treatment went instead to effective prevention, between three and seventy-five new HIV infections could be averted for every extra year of life given to an AIDS patient” (2006, 255). One of Easterly’s main complaints is that nobody has asked impoverished Africans if they would prefer development aid to be spent on
prevention or treatment programs. Instead, Easterly states that AIDS treatment programs are more popular than prevention programs because “the rich-country politicians and aid agencies get more PR credit for saving the lives of sick patients, even if the interests of the poor would call for saving them from getting sick in the first place” (262).

On the other hand, Jeffrey Sachs and Paul Farmer argue that according to Article 25 of the Universal Declaration of Human Rights, “everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control” (General Assembly 1948). Sachs argues that “drug treatment for the poor would actually cost the donor world much less than appeared to be the case from drug prices in the rich countries” (2005, 206). Farmer takes this argument a step further and says that antiretroviral drugs are effective “because they’ll reduce suffering, because they’ll reduce mortality—but also because they may in fact be effective as prevention tools through various mechanisms and channels that are complex, interesting, and as-yet unstudied” (2005, 12).

**Provide Incentives**

At the United Nations Millennium Summit in 2000, eight Millennium Development Goals were developed to respond to the world’s greatest development challenges. Despite being well-intentioned, these goals are unrealistic. The goals,
which include eradicating extreme poverty and hunger and achieving universal primary education, are supposed to be achieved by 2015, but if they are not, it is likely that no one will be held accountable or reprimanded for the failure to meet them (UNDP 2005). Currently, most aid agencies do not have a method of holding people accountable for failed projects or for unmet goals, and without these accountability mechanisms it is unlikely that aid agencies are maximizing the efficiency of their funds. Easterly suggests that there should be “individual accountability for individual tasks” and that aid agencies should “specialize in the sectors and countries they are best at helping” (2006, 369). By holding both individuals and aid agencies accountable for specific tasks, there will be an increase in pressure to succeed.

Monitor and Follow Through on Projects

Aid agencies are often too quick in moving from one project to another without providing the necessary oversight and maintenance to sustain successful projects. Aid agencies want to fund projects that produce quick and tangible results so they can receive more donations. Easterly accuses aid agencies of being “rewarded for setting goals rather than reaching them, since goals are observable to the rich-country public while results are not” (2006, 185). For example, a donor funded the construction of roads in Tanzania to help with the country’s infrastructure, but failed to follow through on the maintenance of the roads. The roads fell apart after several years without upkeep and are now badly damaged and too expensive to
repair. Aid agencies and donors need to invest a portion of their budgets to the preservation and long-term management of their projects.

Keep Sub-Saharan Africa in the International Spotlight

Over the past decade, sub-Saharan Africa has received considerable attention for its high rates of disease, poverty, corruption, and hunger. The attention has led to increased awareness and concern for the region, and, subsequently, large sums of development aid have been given to sub-Saharan Africa over the past decade. It is important to keep the spotlight on sub-Saharan Africa to encourage more foreign intervention and aid.

Jeffrey Sachs is one of the most prominent development economists in the world and has devoted his life to researching economic development, poverty alleviation, debt cancellation, and globalization. Sachs has spent much of his career in the public spotlight arguing for increased aid and activism in underdeveloped countries. He also has worked with several celebrities, including Bono of U2, to bring worldwide attention and support to underdeveloped countries. In the past decade, celebrities, film documentaries, and popular newspapers all have started to shed light on the poverty and disease affecting sub-Saharan Africa. The international focus on the underprivileged has led to an increase in donations and the rise of a powerful and compassionate younger generation (Bono 2005).
Importance of Transparency and Strong Infrastructure

In addition to the nine recommendations already listed in this chapter for development aid to be distributed successfully, several other minor policies also deserve mentioning. Countries with high levels of transparency tend to have the most success in fighting HIV/AIDS because donor agencies appreciate the flexibility and openness of the recipient governments. In land-locked countries with so-called “bad neighbors,” aid should be directed toward improving infrastructure in and around the trapped country. For example, Paul Collier, the Director for the Centre for the Study of African Economies at The University of Oxford, points to Uganda’s landlocked position as the main reason that the country has had difficulties integrating into the global markets for manufactured products, which require complicated transport. A common concern about development aid is that the funding often makes it difficult for new exports to enter global markets. In order to counter this, aid agencies should set aside a portion of their budgets to help the export sector of a developing country. This aid can be spent on improving infrastructure, changing trade policies, or focusing on activities with a large import content (Collier 2007).
CONCLUSION

Despite being home to just over 10 percent of the world’s population, sub-Saharan Africa contains 67 percent of the world’s HIV-infected individuals. More than four thousand people in this region die every day due to HIV-related causes. However, after more than two decades of suffering, sub-Saharan Africa is beginning to see relief in HIV prevalence rates that are finally stabilizing and even dropping in some countries (UNAIDS 2008a).

An analysis of the responses to HIV/AIDS in Uganda and South Africa provides a framework from which other sub-Saharan African countries can learn. Uganda’s strong leadership, committed civilians, and effective use of foreign aid allowed the country to drastically reduce its HIV prevalence rates over a relatively short period of time. Despite its successes, Uganda needs to maintain its aggressive stance in order to continue to limit and reduce its HIV rates. South Africa, on the other hand, was slow initially in responding to the epidemic but appears finally to be heading in the right direction. Eliminating the stigma and discrimination surrounding HIV/AIDS, educating the public, and continuing to distribute antiretroviral drug therapy are the keys to decreasing South Africa’s HIV prevalence rates.

In order to fight HIV/AIDS properly, sub-Saharan Africa needs to learn from the accomplishments and mistakes of Uganda and South Africa. Throughout the past two decades, it has become evident that medical professionals and foreign donors will not be able to eliminate the disease without the support of strong governments, committed civilian populations, and assistance from the international community.
With cooperation among governments and teamwork within countries, sub-Saharan Africa will have greater success in tackling the scourge of HIV/AIDS.
REFERENCES


BBC News Online. 2006. SA’s Zuma ‘Showered to Avoid HIV.’ April 5.


Blandy, Fran. 2006. Scientists Call For Manto’s Removal. Independent Online,


Bonnin, Debby, Roger Deacon, Robert Morrell, and Jenny Robinson. 1998. Identity
and the Changing Politics of Gender in South Africa. In South Africa in
Transition, edited by David R. Howarth and Aletta J. Norval. Houndsmill:
Macmillan Press Ltd.

http://www.time.com/time/subscriber/2005/time100/scientists/100sachs.html#
(accessed April 13, 2009).

Boone, Catherine and Jake Batsell. 2001. Politics and AIDS in Africa: Rearch
Agendas in Political Science and International Relations. Africa Today 48 (2):
3-33.

04/brazil.aids (accessed January 12, 2009).


UNAIDS/WHO. 2008a. South Africa; Epidemiological Country Profile on HIV and AIDS.

______. 2008b. Uganda: Epidemiological Country Profile on HIV and AIDS.


national/africa/07mandela.html?scp1&sq=mandela%20aids%20n&stcse
(accessed March 29, 2009).

