

NOTE/COMMENT

NOT AS EASY AS “ABC”: UGANDA’S APPROACH TO HIV/AIDS AND IMPLICATIONS FOR THE PRESIDENT’S EMERGENCY PLAN FOR AIDS RELIEF

Kate Fogelberg

Kate Fogelberg is a Master's candidate in International Development and Global Health Affairs at the University of Denver's Graduate School of International Studies. She holds a Bachelor's Degree from Tufts University in International Relations and African Studies.

I. BACKGROUND

Since its documented discovery twenty years ago, HIV/AIDS has created a global health pandemic, exacerbated poverty and inequality, and reversed gains in economic development. The disease now kills more people each year than have died in combat during the twentieth century (Hunter 2003). Ninety-five percent of people infected with HIV/AIDS live in the southern hemisphere, with Sub-Saharan Africa home to 70% of the infected population (Brown 2004, Craddock 2004). Resources have been mobilized from the grassroots to the supranational level to prevent, manage and treat the disease, but more commitment is necessary to turn the tide of the pandemic.

Many applauded President Bush’s pledge in his 2003 State of the Union address to increase U.S. involvement in the global “War on AIDS” with the \$15 billion President’s Emergency Plan for AIDS Relief (PEPFAR). One third (\$5 billion) of the funds will support ongoing bilateral HIV/AIDS programs, \$1 billion will go toward the Global Fund for AIDS, Tuberculosis, and Malaria (GFATM) over the next five years, and the remaining \$9 billion is “new” money pledged to support prevention, care, and treatment in 15 different countries.¹ PEPFAR specifically aims to provide treatment to 2 million HIV-infected people, prevent 7 million new HIV infections, and provide care to 10 million people infected and affected by HIV/AIDS (State Department 2004).

II. PROBLEM

¹ The 15 countries supported by PEPFAR are Botswana, Cote d’Ivoire, Ethiopia, Kenya, Mozambique, Namibia, Nigeria, Rwanda, South Africa, Tanzania, Uganda, Zambia, Guyana, Haiti, and Vietnam. State Department. 2004. *The President’s Emergency Plan for AIDS Relief: Strategic five year plan*.

Despite an increased financial commitment from the Bush administration, initial critiques of the proposal were abundant. Critics focused on the stringent requirements that restrict funding solely to FDA-approved drugs, the creation of new bureaucracies when the GFATM already exists, and the addition of the Pitts Amendment which earmarks one-third of the funds for abstinence only programs (EPN 2004, Health GAP 2004, Nation 2004, Economist 2004, Sternberg 2004). What is more problematic, however, is that the initiative’s prevention component is based on an incomplete and inaccurate assumption about the Ugandan experience with HIV/AIDS. Uganda is often cited as a success story for AIDS management strategies because of the substantial declines in its national HIV infection rate during the 1990s. PEPFAR extrapolated just one of many components of the Ugandan HIV/AIDS program named the “ABC” strategy (Abstain, Be faithful, or use a Condom), ignoring other Ugandan strategies integral to the decline in infection rates.

A broadly focused proposal, such as PEPFAR, assumes that an increased awareness of fidelity and abstinence will create results similar to the Ugandan experience and ignores many other important factors in Uganda’s success. The PEPFAR initiative lumps the fourteen recipient countries together as poor countries needing resources to fight HIV/AIDS. This generalization, while true to a certain degree, does not take into account other historical, economic, social and political differences which have the potential to affect health care programs. The Ugandan programs were, in part, successful because of the political and socioeconomic climate at the time of implementation and because Uganda addressed the problem with a blend of “top-down” and “bottom-up” strategies. It is imperative to evaluate health policies within both place and time contexts. What worked in Uganda in the 1980s was partially due to conditions that existed there at the time, and may not work globally in the 21st century.

III. UGANDA AND HIV/AIDS: POLITICAL WILL, ECONOMIC INITIATIVES, AND SOCIAL SOLUTIONS

As a result of years of repressive political regimes, the Ugandan climate of the mid 1980s was one of political and economic instability and social insecurity. Thus, the AIDS epidemic was thrust onto a nation already weakened by decades of civil strife. The political will, economic initiatives, and social solutions all combined to produce effective HIV/AIDS prevention strategies in a time of economic instability and social insecurity.

Political Will

One of the key factors of a successful HIV/AIDS policy is a leader committed to facing the problem with solutions appropriate to his country (Shisana et al 2003). The case of Uganda illustrates this importance of involvement of a national leader. Following the destructive Amin years, Ugandan President Yoweri Museveni's fight against the disease created a sense of nationalism. Museveni achieved support from the populace in breaking down stigmas about the disease and opening up channels of communication under the rhetoric of nationalism. Museveni created a multi-sector approach, using media, schools, churches, local governance and even the establishment of new government bodies to facilitate the transfer of information to the population. The Uganda AIDS Commission (UAC) was formed in 1992 to coordinate and monitor the national AIDS strategy across all sectors (Hogle 2002). In addition, departments were created in the Ministries of Defense, Education, Gender, and Social Affairs. The involvement of multiple ministries demonstrates Museveni's realization that HIV/AIDS was not solely a biomedical issue, but one that required a concerted effort across many aspects of society.

In addition to this top-down approach, non-governmental organizations (NGOs) and community-based organizations (CBOs), a particular type of NGO created by and composed of people with similar characteristics (such as HIV positive women), offered a local response to the epidemic. As in many developing countries, indigenous NGOs are responsible for a growing proportion of the health care provisions in Uganda, making them instrumental in HIV/AIDS services. The AIDS Support Organization (TASO) is one such homegrown Ugandan NGO that has garnered worldwide attention for its successes on the local level. NGOs and CBOs are often the only source of support for the people living with HIV/AIDS, thus neglecting their roles and impacts will only weaken their responses.

The Ugandan government also correctly recognized the importance of including women at national and local levels in their campaign, using women’s empowerment as a tool for slowing the epidemic. At the national level, the Ministry of Gender added an AIDS task force and President Museveni’s amended the constitution, mandating women must make up at least one-third of the members of Parliament (Hogle 2002). At the local level, social, economic, and political women’s organizations have a strong presence, and their influence has increased as a result of the dependency on local institutions to provide HIV/AIDS support in both rural and urban areas (Tripp 1998).

Economic Initiatives

HIV/AIDS hurts a country’s economy, as the majority of people dying of HIV/AIDS are in their most economically productive years and those people not infected must stay home to take care of the ill. In order to achieve a politically and socially stable state, the economic problems must be rectified alongside the HIV/AIDS programs. In Uganda, a combination of

macroeconomic and microeconomic adaptations implemented at both the national and community levels contributed to the country’s economic recovery. Like many other ailing economies, Uganda embarked on a strict Structural Adjustment Program in 1987, including privatization, deregulation, and liberalization. Although there were some improvements in physical infrastructures, these macroeconomic policies did not improve the lives of many of the poorest people, who were excluded from the benefits of privatization and liberalization. One of the people’s responses in the capitol, Kampala, was to turn to urban agriculture. Museveni emphasized a diversification of the economy to decrease the export sector’s dependence on coffee and to create more jobs.

Uganda did not invest all of its money in growing its economy, knowing that money would not trickle down to other sectors, such as health care. Another one of Museveni’s strengths was recognizing a healthy population is a potential means to economic development and a tool for social empowerment. The fact that public expenditures on health care in Uganda comprise approximately 3.5% of its GDP and private expenditures make up 2.5% of GDP - some of the highest numbers among African countries - attests to the country’s commitment to health issues, especially HIV/AIDS (UNDP 2004).

Social Solutions

The empowerment of younger women and girls was one component of the social adaptations in Uganda. Indeed, one aim of the ABC campaign was to empower women. The implementors of ABC in Uganda took the individualistic assumptions of the strategy further, however, to address structural determinants of the disease. This was partially achieved through increased political representation in Parliament and greater opportunities afforded to local

women’s groups, as discussed earlier. The creation of credit facilities for women has also provided them with a source of income and economic independence (Monico 2003). The fees for primary education were removed, allowing for more young girls to complete school (Monico 2003). Schools expose girls to curriculum on HIV/AIDS, keep them away from older men and transactional sex, and give them necessary skills for later education and employment (Monico 2003).

Another social emphasis of the ABC approach has been one of the more controversial topics outside of Uganda, and a favorite of PEPFAR: faith-based organizations (FBOs). These Muslim, Catholic, and Protestant groups have been historically strong institutions in Uganda. In fact, mission hospitals were among the first to develop AIDS care and support programs (Hogle 2002). However, FBOs were a *component* of the Ugandan strategy, not a focal point. FBOs contributed to creating an environment in which HIV/AIDS was openly discussed, alongside the efforts of popular figures, politicians, and community leaders (Hogle 2002).

IV. LIMITS OF PEPFAR

The Ugandan example should be seen as a success story for political will, not just a triumph of the ABC strategy. PEPFAR, however, incorporates only parts of the strategy and limits national governments’ participation.

The fact that one-third of the PEPFAR money is reserved for abstinence-only programs does little good for the growing percentage of women infected and affected by HIV. More than four-fifths of new infections in women result from sex with a husband or primary partner (IWHC 2004). Abstinence-only programs will be of little use to women who cannot insist on either abstaining from sex or ensuring that their husbands are being faithful (IWHC 2004). Many

women throughout Sub-Saharan Africa are at risk for contracting HIV only because they are in a so-called monogamous relationship in which men are not remaining faithful (WIIN 2003, Nyaga et al 2004, IWHC 2004).

Furthermore, the separation of funds for abstinence only programs decreases money for more comprehensive efforts, which often include abstinence only information along with other services (IWHC 2004). The Smith Amendment to PEPFAR allows FBOs to not provide information about proven strategies of HIV/AIDS protection, such as condoms, or to abstain from providing referrals to clinics that provide preventive services, such as testing for sexually transmitted infections (IWHC 2004). Policymaking based on an ideology awards those with similar interests, not necessarily those with proven best practices. For example, a recent PEPFAR grant was awarded to an American group to promote abstinence in Africa, even though their application for funding was deemed “not suitable” by the panel of experts that evaluated all proposals (Brown 2005).

PEPFAR also does not adequately include the input of national governments. Although the mission statement of PEPFAR includes “working with leaders throughout the world,” the Zambian health minister has said that his government did not have a formal meeting on the program with the American ambassador until 15 months after Zambia’s role was announced (Sontag 2004). Furthermore, to its detriment, PEPFAR’s apolitical approach does not consider or attempt to strengthen political infrastructures in any given country, which raises the issue of sustainability. PEPFAR is scheduled to end in 2008, raising questions of sustainability for any of its interventions, especially if they continue to “promote US skills and capacities to the detriment of local expertise with greater understanding of the issues in their local contexts” (EPN 2004).

A growing body of experts cites the imperative role of CBOs in managing the epidemic (Altman 1994, Reid 1994, Collins and Rau 2000), yet PEPFAR excludes not only national governments but also indigenous grassroots organizations from its funding parameters. PEPFAR grant requests must be at least \$1 million dollars, making it near impossible for an indigenous organization to apply for funding since many smaller, frontline groups have neither the technological capacity nor the institutional means to implement such large programs. Funding preferences to date have included American universities, foundations, and organizations (Health GAP 2004, USAID 2004). The 2004 International AIDS Conference recognized the growing role of CBOs and NGOs as service providers, urging an inclusion of these groups in discussions on policy and implementation, not on the other hand excluding them from resources entirely.

V. POLICY RECOMMENDATIONS AND LESSONS LEARNED

Although PEPFAR is a step in the right direction, it could be much more effective. A closer examination of the Ugandan experience, upon which PEPFAR’s prevention policies is based, shows that “ABC” has been conflated with the *entire* Ugandan experience. Uganda’s multi-level, multisectoral approach can teach us much more about the structural causes of HIV/AIDS than the “ABCs” of prevention. A more accurate lesson learned from the Ugandan experience with HIV/AIDS is that health phenomena are rooted in particular places at particular times and require structural solutions.

Because of the Bush administration’s emphasis on bilateral foreign policy, it would be more constructive to make a few adaptations to PEPFAR as it is, than to suggest it be channeled through a multilateral institution, as some critics have urged (Nation 2004. Rubenstein et al. 2004). Furthermore, the actions of the administration, such as their enforcement of the “global

gag rule” which denies funding to international organizations providing comprehensive reproductive health care, speak much louder than their words on empowering women in PEPFAR. Therefore, it is unlikely that the Pitt’s Amendment will be revoked. However, there are a few recommendations that could strengthen the initiative in all fifteen countries, some of which draw from Uganda’s pro-active political, economic, and social efforts.

- A re-examination of its funding priorities to include both national governments and local, indigenous organizations supporting people living with HIV/AIDS
- Decrease the minimum grant size, which would allow smaller, frontline organizations to apply for funding
- Limit the number of grants awarded to American institutions, which would allow for more awards to organizations indigenous to the 15 PEPFAR countries
- Include an independent evaluation of all components of PEPFAR, but especially the abstinence-only area
- Develop an advisory board of politicians from all 15 countries to provide input at planning, implementation, management, and evaluation stages of PEPFAR
- Address structural macroeconomic issues, such as the high costs of debt repayment, and microeconomic issues, such as the creation of small, income generating activities
- Require that women-specific NGOs and CBOs in each country receive a portion of the award to strengthen the position of women in society.

In the case of HIV/AIDS, we can learn from the dynamic, multi-sectoral approach of Uganda, and encourage policymakers to support politically, economically, and socially appropriate policies that recognize the importance of time, place, and history. Unfortunately, HIV/AIDS is not as easy as ABC. Policymakers must learn from other failed projects that country-specific initiatives which blend top-down and bottom-up strategies are key ingredients for success. If they do not, PEPFAR will fail to meet its objectives and even worse, fail to reach those who are all too familiar with the realities of HIV/AIDS.

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