ASSOCIATION OF CONCERNED AFRICA SCHOLARS

Bulletin

Summer 2006 No. 74

HIV/AIDS in Sub-Saharan Africa: Two Decades and Counting

ISSN 1051-08442

ACAS Executive Committee*

Co-Chairs

Meredeth Turshen
School of Planning & Public Policy
Rutgers University
New Brunswick, NJ 08903 USA
E-mail: turshen@rci.rutgers.edu

Michael O. West
Department of Sociology
Binghamton University
Binghamton, NY 13902 USA
E-mail: mwest@mail.binghamton.edu

Political Action Committee

Al Kagan
Africana Unit, Room 328
University of Illinois Library
1408 West Gregory Drive
Urbana, IL 61801 USA
E-mail: akagan@uiuc.edu

Research Committee

Imani Countess
1921 Featherwood Street
Silver Spring, MD 20904 USA
E-mail: icountess@adf.gov

Carol Thompson
Political Science Department
Box 15036
Northern Arizona University
Flagstaff, AZ 86011-5306 USA
E-mail: carol.thompson@nau.edu

ACAS Bulletin Editor

Jesse Benjamin
Department of Sociology
Kennesaw State University
1000 Chastain Road
Kennesaw, GA 30144
Email: jbenjamin@kennesaw.edu

Treasurer

Kristin Peterson
Department of Anthropology
Michigan State University
344 Baker Hall
East Lansing, MI 48824
Email : krisap@umich.edu

Webmaster

Noah Zerbe
Department of Government and Politics
Humboldt State University
Arcata, CA 95521
E-mail: noah.zerbe@humboldt.edu

Website: http://acas.prairienet.org

ACAS Board of Directors*

*Affiliation for identification purposes only

Introduction: HIV/AIDS in Sub-Saharan Africa [SSA] – Two Decades and Counting

Marda Mustapha [Guest Editor]

HIV/AIDS is one of the most devastating epidemics in recent history. The number of people living with HIV rose from around eight million in 1980 to thirty-eight million by the end of 2005 and is still growing. Around sixty-three percent of people living with HIV are in Sub-Saharan Africa (UNAIDS 2006). The adult prevalence rate in SSA is six times that of the global rate. The global HIV/AIDS death rate is about three million with two million of that taking place in Sub-Saharan Africa (SSA). In addition, by the end of 2005, HIV/AIDS had orphaned an estimated twelve million children (UNAIDS 2006). The figures are a clear indication that SSA is the epicenter of the disease with twenty-six of the twenty-eight worst affected countries.

Given these gloomy statistics, sober minds would expect that more should have been done in terms of prevention and treatment. On the contrary, of the estimated twenty-four million or more people living with HIV/AIDS in SSA, less than four percent, about eight hundred and ten people are receiving treatment. The World Health Organization (2006) estimates that about 1.3 million of HIV infected people are receiving anti-retroviral therapy (ART) globally.

The stark numbers notwithstanding, the fight against the spread of the disease in Africa has taken a turn that has put profit making over life saving, politics over viable policies and the lives of HIV/AIDS victims have been largely "commodified" in the global capitalist economy. In short, HIV/AIDS prevention in SSA has assumed a complex discourse that leaves Sub-Saharan Africans at the losing end. The dominant discourse in HIV/AIDS prevention is predicated with "saving lives" while the outcomes are usually "profit making" for the powerful states and pharmaceutical companies that stand to gain from the politics that now permeate HIV/AIDS prevention in SSA.

There has been a series of shift in the dominant discourse in HIV/AIDS prevention in SSA. Initially, the discourse was dominated by the indictment of the cultures in SSA as the culprit contributing to the spread of HIV/AIDS on the continent. Included among the indicted cultural practices were "wife inheritance" in Uganda, "polygamist" practices in Northern Nigeria and some scholars and practitioners even identified promiscuity as part of the African culture and one of the most important factors enhancing the spread of the disease. The discourse later became occupied with issues of policy and governance. In this shift, governments in SSA were indicted as either not doing enough or in denial of the existence of the disease. It is therefore not surprising that shortly after identifying SSA governments as part of the problem the World Bank moved in to control prevention programs in most of SSA. Presently, the discourse on AIDS prevention is taking a posture stemming from the reproductive

ideological battle between the "pro-lifers" and "pro-choice" in the United States. The reproductive ideological discourse is now dominated by seemingly conservative values that frown upon condom use while focusing on abstinence. No matter the direction of the shift over the decades, there seems to be a theme of blaming the victim for the spread of HIV/AIDS in SSA. It is difficult to see through some of these problems confronting AIDS prevention in SSA. As a result, this special edition of the bulletin on HIV/AIDS seeks to address some of these complex issues which include international migration, capital flow and dispassion, and agenda control to name a few.

Scarcity of adequately trained and qualified health professionals has presented difficulties in preventing HIV/AIDS in Sub-Saharan Africa. While the issue of adequate supply health workers is not new in SSA, the advent of HIV/AIDS and the economic and fiscal conditionalities from the International Monetary Fund (IMF), the World Bank (WB) and recently the migration of health personnel to the global north has renewed the urgency in dealing with the issue. Many SSA countries have suffered serious scarcities among almost all cadres of health personnel, making implementing HIV/AIDS policy difficult. In the 1980s the doctor to population ratio was about 1:10,800, compared to 1,400 in all developing countries and 300 in industrialized countries. During the same period, the estimated ratio of nurses to population was about 1:2,100 in SSA compared to 1,700 persons in other developing countries and 170 in industrialized countries (World Bank 1994). Thirty one countries fall below the WHO "Health for All" threshold of 1 doctor to 5,000 population. For those meeting the threshold they have severe geographic maldistribution (WHO 2003). International migration of health professionals to countries like the USA and Britain is making an already bad situation worse with far reaching implications for not only HIV/AIDS prevention but for the entire health care system of Sub-Saharan Africa. Jennifer Tanner's article, *International Migration of Health Professionals: Brain Drain and Sub-Saharan Africa*, throws light on international migration as one of the contributors to health personnel scarcity in SSA. The article further identifies the countries in the global North that benefits from such migration. Tanner also discusses the implications of such migration on among other things HIV/AIDS prevention in SSA. She concludes with sensible and feasible policy suggestions to either stem the outward flow of health personnel or remunerate SSA countries for losing their trained health professionals.

Tanner's article illustrates the predatory nature of the Global North's health system on SSA health systems as far as personnel are concerned while the African Action article, *Betraying Africa's priority: A Short Analysis of US policies on HIV/AIDS in Africa* does not necessary allude to the predatory activities of the global North, it focuses on the various ways external policies, specifically those of the USA and how they have hinder progress in HIV/AIDS prevention in SSA. Such hindrance Africa Action believes comes from the flaws entailed in the President's Emergency Plan for AIDS Relief (PEPFAR). PEPFAR focuses on prevention issues that satisfy the policy goals of the US instead of real priorities and efforts of SSA countries. The article concludes with a suggestion that defeating HIV/AIDS will require policies to refocus attention on supporting efforts and priorities of stake holders who are on the frontlines of the battle against HIV/AIDS.

In *Was the ABC approach (abstinence, being faithful, using condoms) responsible for Uganda's decline in HIV?* Murphy et al critiqued PEPFAR's focus on abstinence only approach in Uganda and question whether Abstinence, Be faithful and Condom use (ABC) was actually responsible for the successes in the reduction of HIV prevalence rate Uganda. While the authors acknowledge the successes in Uganda, they made a distinction between outcomes and prevention strategies. "ABC" has been constantly been referred to as the "strategy" that is most responsible for the reduction in the HIV prevalence rate in Uganda. Accordingly, Murphy et al argues that "ABC" related behaviors are more of an outcome of strategies rather than strategies in and of themselves. The authors argue that extensive social mobilization, addressing gender inequities

and strong political leadership are the strategies that influenced the ABC related behavior outcome. The article concludes with recommendations, one of which specifically calls for the inclusion of condom use as an integral aspect of PEPFAR.

Notwithstanding the betrayals of African priorities and the abstinence only approach forced on SSA countries in the fight against HIV/AIDS, Zimbabwe has also registered some success in the fight against the epidemic by reducing the HIV/AIDS prevalence rate between 2002 and 2004. Michael Fleshman's article ties into the Africa Action's idea of focusing attention on stake holders on the frontlines of the fight against HIV/AIDS. Zimbabweans working on prevention programs argued that Zimbabwe preferred to own the HIV/AIDS problem and its solution rather than depend on targets and programs from outside. Zimbabwe is yet another example that SSA countries are capable of making significant strides in the fight against HIV/AIDS if given the opportunity.

Kristen Peterson discusses a more complex issue that may end up impeding HIV/AIDS prevention in Africa as a whole and Nigeria in particular. Peterson argues that AIDS policies in SSA facilitate capital flows in and out of SSA and thereby mirroring neo-liberal economic policies toward the continent. Furthermore, Peterson argues that specific capital flows are generated by "*implicit agreements*" on AIDS policies by virtue of organizations being brought together. These organizations include international financial institutions that were previously at odds with each other. Peterson contends that policies of these institutions focus more on prevention and less on treatment. In conclusion, Peterson posits that the collaboration among multi-lateral organizations uses sustained dispossession as a strategy that facilitate capital flows specifically within the realm of intellectual property rights.

The last article focuses on the blame game that has informed HIV/AIDS prevention discourse especially when it comes to the role of SSA leadership. The article questions the claim that SSA governments were either in denial or acted a little too late to the disease. In addition, the article argues that the accusation may have paved the way for institutions like the World Bank and International Monetary to take over the policy agenda for HIV/AIDS prevention in SSA. It concludes by admonishing scholars to be critical and thoroughly scrutinize some of the accusations leveled at SSA government so as to prevent recurrence of such agenda take over and control.

While this special edition does not begin to address the multitude of issues confronting HIV/AIDS prevention in SSA, it gives a good over view of the issues that continue to dominate the HIV/AIDS prevention discourse. The bulletin also introduces other questions such as HIV/AIDS policies as a conduit for capital flow and also the mechanism for agenda control. In addition, the bulletin brings to the reader success stories in a way that highlights the good efforts of Sub-Saharan Africans in the fight against the spread of HIV/AIDS.

Marda Mustapha, PhD., is Assistant Professor of Political Science, College of Saint Rose, Albany, NY.

References

Joint United Nations Program on HIV/AIDS (UNAIDS).2006. *Report on the Global AIDS Epidemic*. UNAIDS, Geneva, Switzerland.

World Bank. 1994. *Better Health in Africa*. World Bank, Washington DC

World Health Organization. 2003. Health Personnel Estimates. http://www3.who.int/whosis/health_personnel/health_personnel.cfm. Retrieved January 2004.

_____. 2006. "Progress on Global Access to HIV Anti-Retroviral Therapy", *A Report on 3 by 5 and Beyond*. WHO/UNAIDS, http://www.who.int/hiv/mediacentre/news57/en/index.html. Retrieved October 29.

International Migration of Health Professionals: Brain Drain & Sub-Saharan Africa

Jennifer Tanner

The migration of medical professionals from developing nations in the South to wealthy nations in the North stresses already struggling health services systems in the developing world. "Brain drain" depletes the stock of skilled medical professionals in poor countries, in many cases to a critical point. In Sub-Saharan Africa, levels of health personnel are much lower than other parts of the world (Padarath et al 2003, 5). Many nations in sub-Saharan Africa are especially vulnerable to lose their health professionals to the UK, United States, Australia and Canada because of their common language. Migration of health professionals constrains the ability of developing nations to provide health care and impedes efforts to improve quality of life and combat HIV/AIDS. Brain drain exacerbates disparities in health care between urban and rural areas within low-income countries. A cycle of migration occurs as rural health professionals move to urban districts to fill vacancies created by personnel who have migrated to the North (PHR 2004, 1).

Health service delivery depends upon human resources to facilitate the transfer of medical technologies to individual patients according to their need and diagnosis. Health service systems in the developing world suffer from a desperate lack of resources that results in large part from structural adjustment policies that reduce or cap public spending. These policies are detrimental to health care systems and also disadvantage education systems that prepare the next generation of health professionals (PHR 2004, vii, Eastwood et al 2005, 1895). Brain drain additionally reduces the faculty at medical schools and teaching hospitals which constrains the production of new doctors and nurses. The contribution of brain drain to growing international health disparities is receiving increasing attention. In both 2002 and 2004 the World Health Assembly passed resolutions with regard to international migration of health professionals. The African Union named 2004 the "Year for Development of Human Resources with Special Focus on Health Workers" (PHR 2004, 14).

Developed nations benefit from the migration of health professionals. Financial benefits include the saved costs of education and training. In the U.S., many urban and rural hospitals depend on international health care workers to fill positions that are undesirable to domestic doctors (Hagopian et al 2004, 2, Martineau, et al 2004, 3). Flexible immigration policies and residency opportunities facilitate the brain drain. The brain drain is a regressive transfer of resources from poor to rich nations.

Scarcity of Health Personnel

The World Health Organization reports that 38 of 47 sub-Saharan nations have less than the minimum 20 physicians per 100,000 and 13 countries have five or less per 100,000 people (PHR 20041, 2). More than 4 million sub-Saharan African children die every year from treatable diseases (Johnson 2005, 3). Insufficient numbers of health professionals limit the capacity of developing nations to address Millennium Development Goals, such as a reduction in under 5 mortality, as well as targets for the treatment of HIV/AIDS. In one estimate, sub-Saharan Africa will require an additional 1 million health care workers to deliver the level of service necessary to meet MDGs by 2015 (Eastwood et al 2005, 1895). The President of Botswana named the shortage of health professionals as a foremost barrier to implementation of that country's universal AIDS treatment initiative (PHR 2004, 14). The World Health Organization (2003) reported that staffing problems prevented 17 of the 22 countries which account for 80% of the world's TB cases to work toward the 2005 targets for TB reduction set by WHO. The table below illustrates the shortage of physicians and corresponding burden of health problems in selected sub-Saharan African nations, compared

with the four largest recipient nations of the brain drain.

Selected Health Indicators, Source and Recipient Countries

HDI rank	Country	Physicians per 100,000 1990-2004	Nurses per 100,000 2004*	Life expectancy at birth 2003	Under 5 mortality rate per 1,000 2003	TB cases per 100,000 2003
Source Countries						
120	South Africa	69	388	48.4	66	341
125	Namibia	30	168	48.3	65	477
131	Botswana	29	241	36.3	112	342
138	Ghana	9	64	56.8	95	369
144	Uganda	5	5	47.3	140	621
145	Zimbabwe	6	54	36.9	126	500
149	Lesotho	5	60	36.3	84	390
154	Kenya	13	90	47.2	123	821
158	Nigeria	27	66	43.4	198	518
164	Tanzania	2	37	46.0	165	476
165	Malawi	1	26	39.7	178	469
166	Zambia	7	113	37.5	182	508
167	Dem. Rep. of Conga	7	44	43.1	205	537
170	Ethiopia	3	19	47.6	169	507
Recipient Countries						
3	Australia	249	775	80.3	6	6
5	Canada	209	773	80.0	6	4
10	United States	549	497	77.4	8	3
15	United Kingdom	166	1010	78.4	6	12

Source: UNDP, 2005Human Development Report, *WHO 2005 Global Health Atlas

Vacancy rates in sub-Saharan African countries also reveal the scarcity of health personnel. Only 28% of posts were filled in Malawi in 2003. That same year, South Africa had 4,000 unfilled posts for physicians and 32,000 for nurses (PHR 2004, 18). The proportion of wealthy nations' health workforce that originates from abroad is another measure of the international migration of health professionals. According to Padarath et al (2003, 9), about 20% of the health care labor force in Canada, the United States and Australia is made up of international medical professionals. One-quarter of the physicians in Canadian hospitals are foreign born. In the UK, foreigners make up a full third of the medical workforce.

Measures of Brain Drain

Data on the scope of migration is difficult to obtain. Health and labor force information collected by developing nations is insufficient to make accurate measures. Often there is little data on private sector employment (Hagopian, et al 2004, 2). This lack of information makes policy planning difficult. Two studies used data from recipient countries to quantify the extent of medical migration into those nations. A measure of physician migration to the United States revealed that approximately 5,334 doctors practicing in the US in 2002 were trained in sub-Saharan African medical schools. 86% of those doctors came from three nations: Nigeria

(2,158), South Africa (1,943) and Ghana (478). Two hundred fifty-seven physicians originated from Ethiopia, 133 from Uganda, 93 from Kenya, 75 from Zimbabwe and 67 from Zambia. Ten medical schools produced 79% of the total (Hagopian et al 2004, 5). The total number of physicians trained in sub-Saharan Africa practicing in the US, UK and Canada is equal to 12% of all African doctors (Hagopian et al 2004, 5).

Mullan (2005, 1815) constructed measures of the percentage of medical graduates working in any of four wealthy nations: the US, UK, Canada and Australia. Sub-Saharan Africa had the highest regional emigration factor at 13.9%. In the region, some of the highest national emigration factors were recorded, with Ghana seeing 30% of its medical graduates leave, South Africa 18.5%, Ethiopia 15.4% and Uganda 14.2%. These factors understate the total loss of physicians because only those registered in the four recipient nations are included. Physicians who may have migrated and not registered in the recipient nation, such as those who conduct research rather than practice medicine are also excluded.

Mullan's (2005) study focused on four recipient nations where international medical graduates constitute are a significant proportion of the physician workforce: the United States, UK, Canada and Australia. In those four nations, doctors trained outside the country make up between 23 and 28% of the physician workforce. Graduates from lower income countries constitute 75% of international medical graduates in the UK, 60% in the US, 43% in Canada and 40% in Australia. Mullan (2005, 1816) points out that heavy reliance on doctors trained abroad is not typical of developed nations. Excluding the four countries on which the study was based, there are only three of the remaining 26 OECD nations in which internationally trained physicians account for greater than 10% on the workforce: New Zealand (34%), Switzerland (18%) and Norway (13%). In the latter two nations, a large proportion of international medical graduates are from Germany.

The Ministry of Health in Ethiopia estimated that 1/3 of doctors trained over the 12 year span 1988-2001 have emigrated. Zambia trained 600 physicians between 1978 and 1999; only 50 continue to practice in Zambia (PHR 2004, 19). In Ghana, 40 of its 43 medical graduates in 1999 planned to seek work abroad right away (Padarath et al 2003, 15). More than 2,000 nurses from six sub-Saharan nations (South Africa, Zimbabwe, Nigeria, Ghana Zambia and Kenya) registered in the UK in 2001, 3,500 in 2002 and 3,000 in 2003. At the same time, 2,000 nursing posts were vacant in Zimbabwe. In the United States, the percentage of nurses trained abroad increased from 6% to 14% from 1998-2002 (PHR 2004, 20). Ghana lost 328 nurses in 1999, exactly equal to the number of new nursing graduates (Padarath et al 2003, 16).

Consequences of Brain Drain

The impact of a shortage in health care workers has many far-reaching consequences. In the worst case, shortages are so severe that health facilities are forced to close. A spinal injury center in South Africa was temporarily closed in 2000 when both of its anesthetists were recruited by a Canadian hospital (Matineau, et al 2004, 4). Deficient staffing levels overburden staff that remains, which may cause burnout or life-threatening mistakes. High staff turnover depletes institutional memory which makes patient care longer as treatment strategies are reinvented and reassessed. This is particularly cumbersome in the treatment of HIV/AIDS, which involves complex treatment regimes, and diagnosis of opportunistic infections. Health facilities with inadequate levels of personnel often have long lines, which is a disincentive for patients to access care (PHR 2004, 21).

Programs to increase the treatment of HIV/AIDS worldwide depend on trained pharmacists to dispense antiretroviral and other medications. South Africa requires a 25% increase in licensed pharmacists by 2008 to implement the national AIDS treatment strategy. In 2001, 600 pharmacists emigrated from South Africa, according to its Pharmacy Council. Wal-mart recruits pharmacists from sub-Saharan Africa and India for its Canadian stores (PHR 2004, 20-21).

Brain drain also lessens the number of health professionals available for the training of new doctors in the developing world. Rural health services in the South suffer disproportionately from medical migration, as these posts are hardest to fill. Migration of an urban doctor will leave a vacancy that is filled by a rural physician, leaving the rural area as the loser (Martineau, et al 2004, 4). Rural regions are home to the poorest and most vulnerable citizens, who bear the greatest burden of the brain drain. In recipient countries, the reliance on foreign medical professionals prevents development of domestic supply (Martineau, et al 2004, 3)

The negative impacts of brain drain include financial losses to the countries which invest in the training of health professionals who then migrate and serve another population. The UN Commission for Trade and Development estimates that Africa loses approximately $184,000 per migrating professional (Hagopian et al 2004, 5). Another estimate states that developing countries spend $500 million each year to train health workers who leave for the developed world (PHR 2004, 22, Padarath et al 2003, 10). The financial losses associated with migration also include the sickness and loss of life that results from inadequate health services, diminishing human capital and growth (Padarath et al 2003, 24).

Financial gains to developing countries have been cited in the form of earnings sent home by professionals working abroad. Remittances from nationals working abroad are Ghana's fourth largest source of foreign exchange (PHR 2004, 23). However, the total amount of remittances is often far less than the financial loss associated with the loss of a health professional. Remittances do not go back into the national health system, and cannot make up for economic losses associated with a workforce that is burdened by illness because of insufficient health care.

Behind the Cycle of Migration

The root causes behind the brain drain can be delineated in terms of push and pull and stick and stay factors. Push factors are those within a source country that encourage professionals to leave, while pull factors originate from recipient countries and facilitate migration. Stick factors, such as family ties and reticence to learn a new language, keep skilled workers in their home countries despite push and pull. Stay factors are the reasons that professionals who have left their country of origin tend not to return, and include reluctance to disrupt new social bonds, children's education or current lifestyle (Padarath et al 2003, 12).

Push factors begin with the quality of work opportunities for health personnel in their country of origin. The foremost is compensation. Salary and benefits are often the most important reason that health professionals move, either from rural to urban areas, from the public to the private sector, or from their home country to the North (Padarath et al 2003, 5, PHR 2004, 3-5). Average monthly salary in US$ for junior doctors in Ghana was $199 in 1999, $200 in Zambia, $1058 in Lesotho and $1161 in Namibia (Martineau et al 2004, 2). Poor working conditions within the health system at home also encourages migration. Lack of appropriate supplies and medicines to treat patients, long hours and poor facilities and management decrease job satisfaction and may cause health care workers to explore other options. In addition, the personal risks associated with health care work in sub-Saharan Africa are great. With a high burden of HIV, TB and malaria, and sometimes insufficient equipment and supplies, the safety of the workforce is precarious. HIV prevalence in health care workers in Botswana was 17-32% in 1999, with the potential to increase to 28-41% in 2005 (PHR 2004, 15). This level of illness also contributes to the shortage of medical personnel. Push factors reveal that an important underlying cause of brain drain is underinvestment in health services in the developing world, which in part results from international economic policies that restrict public spending, and massive external debt that usurps resources for public goods.

Unstable political environments, high crime, poverty, lack of housing and poor education for children are non-health sector related factors that push health professionals to work abroad

(Padarath et al 2003, 19). Constraints on public spending and overwhelming debt similarly contribute to these conditions. Armed conflicts and war also play a part in diminished security and poverty while militaries appropriate resources that could support education, housing and other services.

Pull factors that draw medical professionals from the South to the North are push factors in reverse and include better pay and benefits, more resources for care and a safer working environment. Active recruitment practices of recipient countries are another, very important pull factor. Facing a dearth of trained medical personnel at home, wealthy nations such as the United States, the UK, Canada and Australia recruit trained professionals from abroad and offer incentives such as emigration support, job placement, housing and child care (Padarath et al 2003, 12, Hagopian, et al 2004, 2-4).

The United States in particular has more residency positions than medical school graduates, thus requiring recruitment of international health professionals as well as immigration policies that encourage the influx of highly skilled labor from abroad. The US also waives visa requirements that international residents return to their home country after the residency period for a commitment to practice in an underserved area (Hagopian, et al 2004, 2-4). The population of recipient countries in the North is ageing, and require more health services. The health care workforce is also ageing. According to Martineau et al (2004, 4) to avoid a shortage, the United States will need an additional 1 million nurses over the next 10 years.

Policies to Address Brain Drain

Evidence suggests that medical migration will increase in the near future. Recipient countries such as the US and UK face shortages of health professionals. Opportunities for foreign professionals have subsequently been expanded. Source countries prospects for economic growth that would expand domestic opportunities for health professionals are poor. (Martineau, et al 2004, 5, Mullan 2005, 1816). Given the likelihood that brain drain will persist, policy strategies to address it include: improvements in the condition of the health care infrastructure in developing nations, bi-lateral health trade agreements to help medical professionals find international employment that are time limited and facilitate an easy transition back to the country of origin (Martineau, et al 2004, 7), expansion of incentives in rich nations for new medical graduates to fill urban and rural posts, and systems whereby rich nations reimburse source countries for the training costs of migrant doctors (Hagopian et al 2004, 9). Additionally, the current level of data on the movement of medical graduates in poor countries prevents the development of sound policy to address migration. These data systems must be developed (Mullan 2005, 1811, Martineau 2004, 3). Strategies to reduce brain drain effects can also address domestic inequities in rural and urban health care. Care must be taken to ensure that new resources for health services are not funneled into urban health systems while rural systems continue to waste away. Recruitment efforts for medical schools can focus on rural students. Governments can offer salary or housing incentives for personnel who choose to work in rural settings.

Any attempt to address brain drain requires recognition that health care is requisite for economic growth. The WHO Commission on Macroeconomics and Health draws important parallels between health care and economic growth. The Commission maintains quite reasonably that only those who are alive can contribute to growth, and healthier people make greater contributions than those who are ill. It calculated the financial benefit to low-income countries of increased public health spending according to its recommendations at $186 billion dollars per year, or $360 billion per year from 2015-2020 in combined lives saved and corresponding economic growth (PHR 2004, 30). Lowell and Findlay (2001, 6) report on a study that quantified a negative relationship between highly skilled emigration and economic growth. The study found that a one-year increase in the average education of a national labor force increases per capita output by 5 to 15%. Thus a decrease in the overall education of the workforce resulting from the migration of

the most educated is a damper on economic growth.

Addressing Push Factors: The Role of International Economic Policy

The front line of response to brain drain must be to improve African health systems so that push factors are overcome. Strengthened public health systems and increased compensation and benefits for health professionals will not only address brain drain but also improve the health of citizens and boost economic growth. In order to improve the health infrastructure so that health professionals can appropriately care for patients and are encouraged to remain in their country of origin, macroeconomic policies that prevent public spending must be addressed. Policies attached to development assistance, whether loans or debt relief, limit national spending, place caps on public payrolls and impede the autonomy of developing nations to assess need and allocate resources within their own borders (Eastwood et al 2005, 1895). Physicians for Human Rights recommends that the IMF, World Bank and international donors lift monetary penalties to developing nations that exceed spending limitations on health and education. In Kenya, 4,000 nurses were unemployed in 2003 because of limitations on wages within the health sector (PHR 2004, 15). The Director of the WHO Stop TB Department cited removal of, "the administrative barriers causing the delays in appointing new staff, especially when major new funds come in" as one solution to the human resources crisis that hampers TB treatment (WHO 2003).

The provision of government owned housing has been used successfully to retain health workers and to urge them to practice in underserved areas. However, in some countries, the provision of aid from international financial institutions is tied to promises to sell many state owned enterprises. Public housing for health personnel has fallen victim to such policies with impacts for retention of health workers and accommodation for those in service (Eastwood et al 2005, 1898).

External debt also limits appropriate public health expenditures in sub-Saharan Africa. Health and education are often the sectors that are trimmed to free funds for debt service. Sub-Saharan nations paid $12.3 billion in debt service to international financial institutions and wealthy nations in 2000 and $14.5 billion in 2001. Tanzania spent 2.5 times the amount on debt service than it spent on health services in 2000. In 1999, Zambia spent 4 times as much on debt as on health (PHR 2004, 30). Without greater levels of debt relief African health systems will continue to deteriorate and medical professionals will leave for countries with greater resources and fewer risks. Debt relief can directly support improvements in health care by including commitments to spend savings on health care and lifting prohibitions tied to other aid against doing so.

Increasing African Physician Supply and Retention

African nations must devise policies to increase their production of medical professionals, and, more importantly, to retain them. This requires support to health training institutions in Africa, as well as greater investment in secondary education and math and science curricula, to prepare students for additional health services training (PHR 2004,7). Malawi has invested more resources in secondary math and science education to prepare students for medical school (Padarath, et al 2003, 28). Physicians for Human Rights recommends that Medical schools in the North forge partnerships with the South for exchange of resources, distance learning and internship opportunities (PHR 2004, 5). Namibia has initiated a system that includes end-of-service payments and subsidized home and car ownership (Matineau, et al 2004, 7). Although such systems may contribute to the retention of health professionals, they are not always plausible given budget constraints.

To retain more health professionals, countries have tried incentive schemes such as subsidies for training costs that require the professional to serve in the country, or in a specific underserved region, for a period of time after graduation. South Africa initiated a one-year period of community service for doctors which it then extended to dentists and other health professionals (Matineau, et al 2004, 7, Padarath

et al 2003, 30). Lesotho and Ghana have also introduced similar schemes. Success of these types of arrangements is limited in a number of ways. First, professionals may serve out their service term and migrate immediately afterward. Thus only the national stock of junior physicians is increased. Physicians who are able to migrate abroad and earn high salaries are also able to buy their way out of the service requirement (Padarath et al 2003, 30).

The Responsibility of Wealthy Nations

High income countries should develop strategies to address their domestic shortages of health personnel through means other than international recruitment and eliminate recruitment from nations that are deemed to have severe health personnel shortages. This requires better human resource planning, expansion of medical training, and incentive programs for domestic professionals to address urban and rural disparities in access to health care. Eastwood et al (2005, 1897) call on the UK Medical Workforce Standing Advisory Committee to publish a measure of the increase in domestic health professionals needed to eliminate the country's dependence on sub-Saharan African workers within 10 years. Absent such a measure, the country cannot strive to meet its needs for health workers and comply with its own prohibitions against recruitment from poor nations. The United States projects that it will expand the health care workforce by 1 million professionals over the next 15 years, precisely the number sub-Saharan Africa needs to meet Millennium Development Goals (Johnson 2005, 4).

Ethical Recruitment

Brain drain will continue as long as wealthy nations in the North recruit and provide assistance to health professionals from developing nations. High-income countries must recognize the impact of their actions on the health of those in the South and adhere to ethical principles of recruitment, to lessen the harm of brain drain. This could be as simple as ending recruitment from nations that have health personnel shortages of their own, or recruiting only under the auspices of memorandums of agreement that outline terms and conditions. The World Rural Health Conference in 2002 drafted a manifesto in support of memorandums of agreement governing recruitment of health professionals. In 2001, the UK drafted a code of practice for its National Health Service that banned recruitment from 154 developing countries unless the country's government consented (PHR 2004, 33). However, the policy is not generally enforced and does not apply to the private sector. UK work permits were issued for 5,880 health personnel from South Africa in 2003, 2,825 from Zimbabwe, 1,510 from Nigeria and 850 from Ghana. All four are on the list of prohibited nations for recruitment (Eastwood 2005, 1893).

The use of bi-lateral trade agreements for the export of human resources has also been proposed. If the continued migration of health professionals is assumed, a system that facilitates the transfer with some benefit to the source country is a viable policy option. Policies can encourage temporary overseas stays and simplify the return process. For example, source nations can help their professionals find overseas work that is time limited, allowing them to return and enter the civil service with credit for their overseas work. In this way, a greater rate of return may be achieved, and health professionals would bring the experience of their time overseas back home (Matineau, et al 2004, 7). Cuba and China have used such policies effectively. It is important to note that source countries must have the capacity to enforce these agreements. Eastwood, et al (2005, 1898) recommend that source government set up their own recruitment agencies that would arrange 2-3 year contracts for professionals to work overseas, and charge fees similar to private agencies.

The World Trade Organization's General Agreement on Trade in Services (GATS) Mode 4 speaks to the international mobility of health professionals. GATS aims to liberalize trade in services through an established framework for skilled migration (Lowell and Findlay 2001, 23). Physicians for Human Rights (2004, 7) urges developing nations to avoid commitment to GATS for health services and calls on the WTO

to educate developing countries about possible negative outcomes for their health care workforce. Restrictions in GATS are foremost where developing countries have an advantage, specifically where the agreement addresses trade in labor. Lowell and Findlay (2001, 23) argue that GATS could be effective if it clarified occupational definitions and specified time frames, making a distinction between temporary and permanent migration.

Brain Drain Tax

To balance the needs of source and recipient countries in the allocation of health personnel, wealthy nations could reimburse developing nations for the health professionals that they recruit. A sort of "brain drain tax" would compensate poor countries for training costs and allow them to reinvest in their domestic health systems. A tax would also make recruitment of foreign professionals more expensive and decrease demand (Padarath, et al 2003, 33). Monetary compensation, whether through remittances or a tax scheme, cannot replace the value of lost medical personnel in a region that is starved for experienced health professionals. As Eastman et al (2005, 1894) point out, "Transfer of funds might temporarily assuage the guilty conscience of the receiving country, but does little to replace a doctor who has taken 5 years to train and is a teacher and role model to students and junior doctors."

Contribution Networks

Organized networks of health professionals working in developed nations can contribute to the health services in their countries of origin. *Migration for Development in Africa* (MIDA), a program of the International Organization for Migration aims to help African nationals working abroad to directly contribute to the development of their countries of origin (Padarath et al 2003, 20, IOM 2004). MIDA provides needs assessments within source nations and matches professionals living abroad who are willing to donate time, money or expertise to meet those needs. MIDA will also facilitate the transfer of resources and ensure that the freedom of movement of the professional is protected (IOM 2004). The *South African Network of Skills Abroad* works to make connections between highly skilled South Africans living abroad and those in the country to exchange knowledge and collaborate on projects to boost South Africa's development (Padarath et al 2003, 31).

Conclusion

In June 2001, health ministers of Southern African nations released a statement that the active recruitment of health professionals by rich countries in the North, "could be seen as looting from these countries and is similar to that experienced during periods of colonization when all resources, including minerals, were looted to industrialized countries" (Padarath et al 2003, 31). The international migration of health professionals has important consequences for developing nations whose health systems struggle to meet minimum standards of care. Developing nations invest resources in the training of health care workers who then practice overseas, resulting in a financial loss to the source country while wealthy recipient nations reap savings. At the same time, the rights of individual workers to migrate if they are able, to seek a better life for themselves and their families must be preserved.

Policy responses to brain drain have therefore focused on redressing failing health systems in the South so that doctors and nurses are inclined to stay and health care is improved. This includes devising incentives to retain the health professionals that are trained, and expanding secondary education, particularly math and science education, to prepare more and varied students for health care training. None of these policies can be implemented without money. Donor funds and aid in the form of loans must exempt health and education from public spending caps that are often requisite. Debt relief can free up funds for these purposes. In addition, strategies that are built on the assumption that international migration will continue into the future include ethical recruitment and trade agreements which ensure source countries are compensated in some way for their lost training investment, that migrating professionals can return, or that recruitment to nations that suffer severe shortages of workers is

ceased. More radical policy options such as a brain drain tax have been suggested but are less likely to be well received by recipient nations. In order to meet future benchmarks for health, including Millennium Development Goals, the shortage of health care workers in developing nations must be addressed. Migration is a complex factor that contributes to the shortage. More and better information as to patters of migration and underlying causes will help policy makers in all parts of the world devise smart strategies to address the brain drain while protecting the rights of workers and developing nations who lose valuable health professionals.

References

Eastwood, J.B., R.E. Conroy, P.A. West, R.C. Tutt and J. Plange-Rhule. 2005. Loss of Health Professionals from sub-Saharan Africa: The Pivotal Role of the UK. *Lancet*. 365: 1893-1900.

Hagopian, Amy, Matthew J. Thompson, Meredith Fordyce, Karin E. Johnson and L. Gary Hart 2004. The Migration of Physicians from Sub-Saharan Africa to the United States of America: Measures of the African Brain Drain. *Human Resources for Health* 2:17.

International Organization for Migration. 2004. "Welcome to MIDA" Available at: http://www.iom.int/mida/

Johnson, James. 2005. Stopping Africa's Medical Brain Drain. *BMJ*. 331: 3-4.

Lowell, Lindsay and Allan Findley. 2001. Migration of Highly Skilled Persons from Developing Countries: Impacts and Policy Responses. International Labor Office. International Migration Papers 44.

Martineau, Tim, Karola Decker and Peter Bundred. "Brain Drain" of Health Professionals: From Rhetoric to Responsible Action. *Health Policy*. 70: 1-10.

Mullan, Fitzhugh. 2005. The Metrics of Physician Brain Drain. *The New England Journal ofMedicine* 2005:353:1810-8.

Padarath, Ashnie, Charlotte Chamberlain, David McCoy, Antoinette Ntuli, Mike Rowson and Rene Lowenson. 2003. Health Personnel in Southern African: Confronting Maldistribution and Brain Drain. EQUINET Discussion Paper Number 3. Available at: http://www.equinetafrica.org/bibl/docs/healthpersonnel.pdf.

Physicians for Human Rights. 2004. An Action Plan to Prevent Brain Drain: Building Equitable Health Systems in Africa.

United Nations Development Programme. 2005. "International cooperation at a crossroads: Aid, trade and security in an unequal world" New York: Human Development Report 2005

World Health Organization. 2003. "TB workforce crisis a major obstacle to treatment success," October 10, 2003 Available at: http://www.who.int/mediacentre/news/releases/2003/pr74/en/

World Health Organization. 2005. Global Health Atlas. Available at: http://www.who.int/globalatlas/dataQuery/reportData.asp?rptType=1

Betraying Africa's Priority: A Short Analysis of US policies on HIV/AIDS in Africa

Africa Action

Twenty-five years into the HIV/AIDS pandemic, Africa is "ground zero" of this devastating crisis – home to more than 25 million of the 40 million people living with HIV/AIDS worldwide. U.S. and international policies have fundamentally failed to address the roots and the impact of this pandemic, particularly in Africa. Across the continent, inadequate resources and other challenges continue to fuel HIV/AIDS and undermine African efforts to respond.

International support is critical to turning the tide of this pandemic in Africa and globally, but current U.S. policies on HIV/AIDS hinder the African response to this crisis in several ways. In the realm of HIV prevention, the U.S. continues to allow an ideological bias toward abstinence-only programs to bar the way of best practices and evidence-based approaches. When it comes to treatment, the U.S. preference for expensive, brand name medications rather than generic antiretroviral drugs hinders the pursuit of universal access to treatment in Africa and beyond. U.S. funding levels for HIV/AIDS programs have also fallen far short of the response a crisis of this magnitude demands. At the same time, the U.S. failure to provide strong and consistent support for the Global Fund to fight AIDS, Tuberculosis & Malaria has left this important multilateral initiative without the resources it needs to scale up its HIV/AIDS programs.

More than 80 representatives of African civil society met in Abuja, Nigeria in April 2006 to craft a position paper laying out their main concerns and recommendations for action against HIV/AIDS. In May 2006, African Union member states also convened for the five-year review of the "Abuja Declaration on HIV/AIDS, Tuberculosis and Other Related Infectious Diseases." Through such fora, civil society organizations and governments in Africa have made their priorities clear. An effective response to HIV/AIDS requires a more urgent and comprehensive approach from the U.S. and the international community. It requires greater funding, a scale-up of effective prevention, treatment, care and support programs, support for the rights and needs of women and girls, and new investments in Africa's human resources and health care infrastructure.

But despite these clear priorities, the U.S. continues to pursue policies that betray Africa's most urgent needs in the fight against HIV/AIDS.

PEPFAR – the U.S. Framework for Fighting HIV/AIDS in Africa

In his 2003 State of the Union Address, President Bush announced a new program to act as a framework for U.S. contributions to the fight against HIV/AIDS: the President's Emergency Plan for AIDS Relief (PEPFAR). Rather than engaging in multilateral initiatives and supporting pre-existing programs for prevention, treatment and care, the U.S. chose instead to launch its own parallel and unilateral initiative, creating a new and duplicative bureaucracy for HIV/AIDS work.

Twelve African countries are among the fifteen targeted by PEPFAR, a proportion that represents less than a quarter of the continent. This selective approach flies in the face of efforts to promote a comprehensive and coherent response to the continent-wide crisis.

The PEPFAR plan authorized spending of up to $15 billion over the course of five years, with $1 billion slated for the Global Fund to Fight AIDS, Tuberculosis and Malaria. Of the total, only $9 billion was new money, to be added to $5 billion in old bilateral assistance programs. In addition, only a portion of that money was to be dedicated to fighting HIV/AIDS in Africa, despite the President's original promise that the initiative would focus on the HIV/AIDS crisis in Africa and the Caribbean.

The funds devoted to PEPFAR programs were allocated by Congress with specific parameters: 55% for treatment of individuals with HIV/AIDS; 15% for palliative care of individuals with HIV/AIDS; 20% for HIV/AIDS prevention; and 10% for the support of orphans and vulnerable children. In spreading out the U.S. contribution over five years, President Bush promised to make gradual increases in funding, but a real U.S. investment in the fight against HIV/AIDS in Africa would involve a significant increase to scale up essential programs and to build Africa's health care infrastructure. This kind of financial commitment has not been a U.S. policy priority, as recent funding levels show. Meanwhile, an August 2005 UNAIDS report projects the level of resources needed to fully address the pandemic will be more than $18 billion for 2007.

In addition to criticism of the U.S. failure to input its fair share to funding of HIV/AIDS programs, policies included within PEPFAR programs and examined below have actually detracted from African countries' capacities to adequately and comprehensively address this crisis.

Prevention

Comprehensive prevention programs are designed to confront the variety of factors that increase vulnerability in populations. Lessening a person's susceptibility to HIV infection incorporates measures such as increasing their access to quality sexual education. It means addressing basic gender inequalities and other dynamics that underpin the disproportionate vulnerability levels that communities experience.

In an ideal analysis, abstinence education would figure as one segment of the "ABC" approach to the prevention of sexual transmission of HIV, educating people to "Abstain, Be faithful, and use Condoms." Instead, PEPFAR funding has prioritized "abstinence-only" programs, advocating limited condom use only for high-risk populations, and undermining comprehensive prevention policies that had been successful in combating HIV/AIDS. In Uganda, for example, education campaigns based on the "ABC" approach had been credited with dramatically lowering the national HIV prevalence rate to 6% by 2002. However, the recent shift away from education on condom use, influenced by PEPFAR funding guidelines, threatens to reverse this progress.

As recently demonstrated by a Government Accountability Office (GAO) report, policies that over-emphasize abstinence have led to cutbacks in the funding of other approaches. Nine of PEPFAR's fifteen focus countries decreased the amount in their 2006 budgets for prevention of mother-to-child transmission in order to meet the U.S. requirements for spending on abstinence promotion.

The narrow view of prevention promoted in current U.S. HIV/AIDS policies also leaves women in particular at risk. HIV prevalence rates are elevated and increasing rapidly among married and monogamous women in Africa, who are not addressed in the PEPFAR strategy.

Treatment

While there is still no cure for HIV, there are measures available to extend and improve the lives of people living with HIV/AIDS. Medications can combat the effects of a disease that often strikes people during their most productive years, and HIV no longer has to be a death sentence for millions of people. But according to a March 2006 World Health Organization (WHO) report, only a fraction of people in sub-Saharan Africa who currently need antiretroviral treatment are receiving such medication.

When President Bush first revealed his PEPFAR plan in 2003, he quoted the price of treatment for one individual living with HIV/AIDS as under $300 per year. But this figure refers to the cost of generic treatment, whereas PEPFAR-funded programs have relied almost exclusively on brand-name formulations that can cost two to three times as much, thereby reaching only a third as many people. The U.S. government has argued that generic medications must first be evaluated and approved by the Food and Drug Administration (FDA), whose guidelines are said to be safer and more rigorous than those of the WHO. Meanwhile, the Global Fund consistently and effectively makes use of WHO-certified generic drugs that also exist in amore convenient single-pill regimen.

Despite U.S. support for the international goal of achieving universal access to HIV/AIDS treatment by 2010, PEPFAR places unnecessary barriers in the way of the provision of cheaper essential medicines. It reduces the number of potential recipients of treatment in Africa, and undermines the achievement of the goal of universal access to life-saving HIV/AIDS treatment.

The Global Fund to Fight AIDS, Tuberculosis and Malaria

The Global Fund emerged from a worldwide recognition that the scope of the HIV/AIDS

pandemic created the need for a multilateral body to coordinate international funding.

The Global Fund, which was established in 2002, defines itself as a financing operation, providing a supply of internationally donated funding for nationally owned projects to combat these three target diseases. By relying on local experts to identify their own priorities and implement their own programs, the Global Fund promotes multilateral cooperation and partnership. So far, the Global Fund has disbursed almost $5 billion in grants to more than 130 countries and is now embarking on its sixth round of grants.

While President Bush promised only $200 million per year for the Global Fund when he launched PEPFAR in 2003, Congress has appropriated more than this each successive year. However, even this achieves only a fraction of the necessary U.S. contribution to this global effort. As a result, the Global Fund experiences chronic shortfalls in funding and has been unable to scale up its programs to meet established prevention and treatment targets in Africa.

Focus on Africa's HIV/AIDS Priorities

African civil society organizations have pointed out that achieving the many targets established by the international community in the fight against HIV/AIDS requires immediate action to drastically expand access to adequate prevention services, health care and affordable treatment. The resources are available, and effective programs exist. What is needed is more financial support, and more effective U.S. policies that support African priorities.

Africa Action joins the voices of civil society across the continent in calling for U.S. policies that secure sustainable financing for effective HIV/AIDS prevention and treatment programs funded by the Global Fund and other bodies. Africa Action calls for a greater U.S. investment in developing Africa's health care infrastructure, a new focus on addressing the rights and needs of women and girls, and a new commitment to achieving the goal of universal treatment access by 2010.

A successful approach to defeating HIV/AIDS globally will require a greater focus on supporting African efforts to turn the tide of this pandemic, and a new appreciation for the priorities of African governments and civil society who are on the front-lines of this crisis.

AFRICA ACTION 1634 Eye Street, NW #810 Washington, DC 20006. www.africaaction.org

Progress in Zimbabwe's HIV/AIDS Battle: Prevention Campaigns Show Results

Michael Fleshman

Despite serious economic and political challenges, Zimbabwe has become only the second country in sub-Saharan Africa to significantly slow the spread of HIV, the human immunodeficiency virus that causes AIDS. In a brief press statement on 10 October, the Joint UN Programme on HIV/AIDS (UNAIDS) announced that infection rates among a particularly vulnerable group — pregnant women — declined from 24.6 per cent in 2002 to 21.3 per cent in 2004.

The findings are good news in a country with one of the highest HIV infection rates in the world. It is an indication, UNAIDS Advocacy, Communication and Leadership Director Achmat Dangor said, that education and prevention programmes launched during the 1990s are beginning to show results. "For us," he noted, "that is very significant."

During an exclusive interview with *Africa Renewal* in New York in late October, Mr. Dangor, a noted South African novelist and former head of the Nelson Mandela Foundation,

also reported that infection rates among young people, another group at high risk, have dropped even further, from about 25 to 20 per cent.

Despite the impressive progress, he cautioned, "this is no reason for complacency. Zimbabwe still has one of the highest HIV prevalence rates in the world." The challenge now, he said, is to build on those gains.

Pinpointing the Causes

Zimbabwe is only the second African country, after Uganda, to reduce very high HIV rates through education and prevention. Continued reductions in Zimbabwe, which is at the geographic and epidemiological centre of the AIDS pandemic in Africa, could mark a turning point in the struggle against the disease and offer valuable lessons to other countries in the region.

Given the difficult circumstances in Zimbabwe, Mr. Dangor said, when evidence of a decline in new infections began to arrive, "we were skeptical at first." UNAIDS commissioned the Imperial College in London to review data from a wide variety of sources — including government reports and research by the US Centres for Disease Control — to confirm that there had been a real fall in infections, rather than an increase in mortality rates or some other statistical quirk.

"All reviews tell us that mortality does play a role [in prevalence rates], but that level of decline cannot be accounted for by outward migration or mortality," he asserted. "The death rate would have had to quadruple, in fact," to be the sole cause of the decline. The challenge now is to find out what aspects of Zimbabwe's anti-AIDS programme are responsible for the improvements. "At this stage we cannot pinpoint what the scientists call the 'specific programme interventions'" behind the decline, he explained. "We are now looking at the major programmes, governmental and non-governmental, urban and rural, to see if we can identify them."

Ideology Out, Ownership In

Early analysis suggests that behavioural changes, including young people waiting longer before becoming sexually active, fewer casual sex partners and increased use of condoms, are parts of the explanation. But Mr. Dangor also pointed out that Zimbabwe's strong education system, its emphasis on district and community management of AIDS programmes and improvements in the status of women since independence in 1980 could also be factors.

"We have ABC," he said, referring to Uganda's successful Abstain, Be faithful or use a Condom campaign. "If I could add another letter it would be 'W' for women, because we will never defeat AIDS in Africa until we empower the women. These things must become embedded in every activity of government at every level."

The country's progress cannot be explained by an abundance of external resources. Neighbouring Zambia received $187 in aid for every HIV-positive citizen in 2004, whereas Zimbabwe's strained relations with some donors meant that it received just $4 per person, according to the World Bank. But even that, Mr. Dangor said, offers an important lesson. "You do not have to wait for a massive amount of external funding to contain the spread of HIV." As vital as resources for prevention, care and treatment are, he continued, "what is even more important is that countries own both the problem and the solution, instead of the targets and the programmes coming from outside."

The country's struggling AIDS treatment programmes, however, have been particularly affected by the lack of funds. Only 15,000 of an estimated 300,000 Zimbabweans in urgent need of the anti-retroviral drugs (ARVs) that attack the AIDS virus currently have access to them. With little external financing available and foreign currency shortages hampering imports, patient costs have soared, despite government subsidies, from US$7.60 to $50 per month — beyond the means of most.

"AIDS will be with us for many years — maybe forever," Mr. Dangor concluded. "If governments of affected countries, donors and civil society can just remove AIDS from the party political arena, the ideological arena, I

think we have a chance of containing this disease much quicker."

Was the "ABC" (Abstinence, Being Faithful and Using Condom) Approach Responsible for Uganda's Decline in HIV?

Elaine M. Murphy, Margaret E. Greene, Alexandra Mihailovic and Peter Olupot-Olupot

Background to the debate

Uganda is one of the few African countries where rates of HIV infection have fallen, from about 15 percent in the early 1990s to about five percent in 2001. At the end of 2005, UNAIDS estimated that 6.7 percent of adults were infected with the virus. The reasons behind Uganda's success have been intensely studied in the hope that other countries can emulate the strategies that worked. Some researchers credit the success to the Ugandan government's promotion of "ABC behaviors"— particularly abstinence and fidelity. Uganda receives funds from the United States President's Emergency Plan for AIDS Relief, which promotes the ABC approach with a focus on abstinence-driven public health campaigns. Other researchers question whether the ABC approach was really responsible for the decline in HIV infection. Critics of the ABC approach also argue that by emphasizing abstinence over condom use, the approach leaves women at risk of infection, because in many parts of the world women are not empowered to insist on abstinence or fidelity.

A debate continues to simmer over the much-publicized "ABC" approach to HIV/AIDS prevention, most narrowly defined as: Abstain, Be faithful or reduce the number of your sex partners, and/or use a Condom. The discussion has become polarized in part because for some, the ABCs are synonymous with the promotion of abstinence-only sex education programs for youth, an area of considerable controversy [1] that seems to pit political and religious conservatives against their liberal counterparts.

In addition, although ABC behaviors have been credited with Uganda's dramatic decline in HIV rates [2–5], questions remain as to whether the ABC-related behavior changes are attainable in other developing countries, given many women's relatively limited control over their sexual relationships. Influential AIDS policy makers have expressed doubt that ABC-related behavior changes can take place in settings where women seem to have little control over their sex lives. On the eve of the 2004 International AIDS Conference in Bangkok, for example, the deputy executive director of UNAIDS observed that, "Most of the women and girls, as much in Asia as in Africa, don't have the option to abstain when they want to. Women who are victims of violence are in no position to negotiate anything, never mind faithfulness and condom use" [6]. An influential woman's advocate reinforces this view: "Most prevention messages...focus on the 'ABC' approach to fighting HIV-AIDS....While important messages, these things are often not within women's power to control" [7].

Gender Inequity and the Spread of HIV

These concerns are valid. Gender inequity is an indirect but powerful factor in the sexual spread of HIV. Gender norms create inequality between the sexes in power, autonomy, and well-being, typically to the disadvantage of females [8]. An extensive literature on women's subordinate status in most societies—but particularly in poor countries—points to widespread patterns of male privilege, visible in social discrimination such as lower levels of investment in the health, nutrition, and education of girls and women [9–12]. Institutionalized economic inequalities keep land, money, and other resources out of

women's hands, making women financially dependent on men, less likely to be able to negotiate sex with a partner, more likely to practice survival or transactional sex, and more subject to violence [13,14]. Violence against women varies by country but is a global problem and a well-documented risk factor for HIV [15,16]. In many countries, women's sexual subordination exposes them to elevated reproductive health risks: coerced sex and rape, maternal mortality, unsafe abortion, and sexually transmitted infections (STIs), including HIV [17].

However, ABC behaviors were attainable in Uganda, a society where many women had little power at the outset of the AIDS epidemic. Fortunately, a "this could not work here" attitude did not deter Uganda from moving forward to implement its wide-ranging HIV prevention program and adding gender-related elements when it became clear that this strategy was necessary. Other countries show signs of desirable change as well. In Zambia and Kenya, ABC-related behavioral changes are emerging among youth and adults, accompanied by reduced rates of incidence [2,18, 19]. Thailand, likewise, was not only successful in promoting—and requiring—condom use in brothels, but also in bringing about changes in fidelity and partner reduction among the general population—particularly young men—through community mobilization [20]. Research in Malawi provides additional evidence that poor women's protective strategies in response to the threat of AIDS have been overlooked by many AIDS prevention programs [21].

ABCs in Uganda: Outcomes, Not Strategies

ABC-related behavior changes have taken place in Uganda and a small number of other countries not only because fear of AIDS has led to protective action by men and women but because many interventions have also directly addressed gender inequities. Greater openness about the dangers of unprotected sex and challenges to women's subordinate role in sexual decision-making have helped to create an environment in which many more women have found it easier to abstain, reduce their number of partners, and/or negotiate condom use [22].

One important point is that abstaining from sex, being faithful, and using condoms—ABC-related behaviors— are outcomes of prevention strategies, not strategies in themselves. The reasons the ABC messages were exceptionally successful in Uganda extend beyond the content of the messages themselves. Abstinence, being faithful, or reducing one's number of partners were indeed promoted among the general public, and condoms were emphasized for high-risk groups. But Uganda's success in bringing about behavior change relied primarily on extensive social mobilization at every level and strong political leadership from its president, Yoweri Museveni, who particularly emphasized fidelity [23].

Challenging Gender Norms Supported ABC Behaviors in Uganda

The ABC behavior changes that cut Uganda's HIV prevalence by about two-thirds were the outcome of a massive, nationwide social mobilization against AIDS [2,4, 23]. The messages were not merely moral exhortations by religious leaders, although religious bodies along with schools and many other civil society groups were actively involved. Many feel that President Museveni's leadership was instrumental in bringing about widespread changes in sexual attitudes and practices.

In 1986, Museveni, a hero of Uganda's civil war, declared that the nation was still at war and the enemy was AIDS. He undertook public education on HIV, and his ongoing series of radio AIDS messages urged men in particular to change their behavior—to be sexually responsible—and encouraged "mutual respect" between spouses, widely interpreted as mutual fidelity. Women's groups also played a key role by mobilizing and publicizing women's difficulty in controlling the circumstances under which they had sex. Museveni responded by highlighting the importance of promoting sexual behavior change and equity between men and women (F. Kitabire, personal communication). In a 2001 keynote address to the organization that sponsors the Africa Prize for Leadership, a prize the country of Uganda and President

Museveni had won in 1998, Museveni spoke out on these issues:

> Permit me to tell you the obvious. In the fight against HIV/AIDS, women must be brought on board. In sub-Saharan Africa, most women have not yet been empowered and men dominate sexual relations. To fight this epidemic, the women must be empowered to take decisions about their sexual lives, and women in Uganda have been empowered and participate today at all levels of governance. This has made them more assertive of their rights than ever before. To fight AIDS effectively, we must empower women [24].

President Museveni ensured that affirmative action policies that enabled women to participate in local and national politics were written into Uganda's national constitution. Museveni also created a Ministry of Women's Affairs, charged with vigorous enforcement of laws against sex with minors. Both public and private school systems designed and implemented sexuality education, which included gender equity messages. The Museveni government developed both macro- and micro-credit schemes for women and fostered government and nongovernmental programs that promoted gender equity among women, men, and youth. President Museveni went so far as to propose a law—unfortunately, unsuccessful—against mate rape to the Parliament [25]. Though divorce laws favor men and it is still difficult for women to divorce or renounce abusive husbands, organizations such as the Uganda Association of Women Lawyers have opened the door for abused women to do so [26,27]. These actions are likely to have contributed to changing gender dynamics.

ABCs in Uganda—Measuring the Impact

HIV prevalence in Uganda peaked in 1991 at about 15 percent of the adult population and declined to about five percent in 2001 [28]. Trend data reveal epidemiologically significant behavior changes in Uganda, especially in reduced numbers of sexual partners and later sexual debut. Concurrent partner reduction among both men and women was a key factor in the reduction of HIV infection in Uganda [4, 29]. Significantly, much of the most substantial behavior change occurred among men [30].

According to Demographic and Health Surveys (DHS) and other research, median age at first sex rose by 1.2 years for girls and 1.7 years for boys between 1989 and 2000 [31]. The percent of 15–19-year-old women ever having sex dropped from 74 percent to 51 percent; among men of the same age, the figure dropped from 68 percent to 42 percent. The percentage of Ugandan women aged 15–24 reporting premarital sex also declined from 53 percent to 16 percent; among young men, the decline in premarital sex was from 60 percent to 23 percent [28]. Data from Uganda's 2000–2001 DHS show a remarkably high 78 percent of unmarried 15–19year-old men and women reporting zero sexual partners in the past year [31].

Between 1989 and 1995, the WHO Global Programme on AIDS and UNAIDS reported that the percent of Ugandan women with one or more casual partners dropped from 16 percent to six percent, while the same figures for men went from 35 percent to 15 percent [28]. Perhaps even more remarkably, the number of men reporting three or more partners declined from 15 percent in 1989 to three percent in 1995 [18]. Reported extramarital sex among women in Uganda is now very rare at one to three percent [18]. Anecdotal evidence from field researchers suggests that among younger men, having an STI, once considered a badge of manhood, is now in the era of AIDS considered a matter of shame or stupidity (S. Watkins, D. Halperin, personal communications). The "B" message may also have been relevant for some women, especially younger unmarried women who were sexually active and had multiple partners [2].

Uganda was relatively slow in promoting condoms. For the first few years after ABC messages were promulgated, the focus was on abstinence and partner reduction, A and B. Between 1988 and 1995, the percent of married

Ugandan women who were currently using condoms rose from 0 percent to 0.8 percent and from 0 percent to 15.4 percent for sexually active unmarried women [31,32]. This trend continued between 1995 and 2000: the percent of married Ugandan women who were using condoms rose from 0.8 percent to 1.9 percent and for sexually active unmarried women it rose from 15.4 percent to 29 percent. Between 1995 and 2000 condom use among married men rose slightly from three percent to five percent. However, among unmarried men aged 15–24, reported condom use at last sex increased sharply—from 39 percent to 57 percent [32]. Thus marital use of condoms increased only slightly while non-marital increases were dramatic. However, a large proportion of sexually active unmarried youth, particularly young women, do not use condoms at all, and among those who do, there is no data on how correct and consistent their condom use is. More work is needed in this area to normalize condom-carrying by women.

Survey data also show a large proportion of women reporting that they can refuse unwanted sex under specific circumstances. Remarkably, in the 2000–2001 Uganda DHS, 91 percent of women said they could refuse sex with their husbands if they knew their husbands had STIs [31], a somewhat higher percentage than in several other African countries (73 percent in Malawi, 87 percent in Rwanda, 82 percent in Tanzania, and 71 percent in Zimbabwe) [33–36]. Even discounting some percentage points for social desirability factors, the levels in these countries are unexpectedly high. There is also evidence that some sex workers are taking effective steps to protect themselves [37]. While there are also large numbers of women who are sexually victimized, women in poor countries are not homogeneous in terms of their vulnerability or ability to protect themselves—and programs should be tailored accordingly.

Where Do We Go from Here?

The importance of including gender-related interventions is a lesson to be learned from Uganda, where policies to advance women's status were part of the ABC strategy. In the context of Uganda's political leadership, nationwide social mobilization, and gender empowerment policies, both women and men benefited and HIV prevalence declined.

However, in most developing countries, HIV prevention programs fail to address the pervasive challenges of gender inequity. Uganda provides one model, albeit far from perfect, and there are other successful or promising efforts around the world that challenge gender norms. In many of these programs, male involvement plays a central role [38]. While there are many examples of separate programs for women and men, we must not forget the importance of working with partners together. Research shows that dealing with couples is often more effective than working with men or women individually in terms of family planning and HIV counseling [39]. There are, however, few organized programs for couples.

To be effective in the long term, programs must work to transform the gender norms that make women subordinate to men and encourage men to take risks in the name of masculinity. To achieve this goal, special efforts must be directed to men and women, separately and together, and to policy makers. There are encouraging signs that increasingly women have acted to protect themselves from HIV, and that men are questioning the dimensions of masculinity that harm their health, and we need to learn more about their stories. We must listen to women and men in order to address their needs; this in itself constitutes a worthwhile AIDS prevention research agenda. It makes no sense either to dismiss or to promote "the ABCs" as if this were a strategy or program rather than behavioral responses to social mobilization, leadership, and empowerment. We must work to create an environment that makes these behavioral responses logical and possible for both women and men. The evidence suggests that these efforts will reap rewards in declining HIV rates.

With nearly 16,000 new infections daily, mostly occurring in sub-Saharan Africa, HIV/AIDS is the world's most urgent health problem. Public health efforts to reduce new infections and treat infected people are increasingly complex due to

politicization of the epidemic and to public health interventions that reflect specific groups' religious values. The largest source of international funding for HIV/AIDS, the US President's Emergency Plan for AIDS Relief (PEPFAR), has increased its funding by 55 percent over the past two years with a focus on abstinence-driven public health campaigns [40]. One-third of the funds are to promote abstinence, with future funding conditional upon demonstrated activities [41].

Uganda is one of the 15 focus countries currently receiving PEPFAR funding. Recent political and religious influences on Uganda's response to the epidemic, including guidance from PEPFAR, have led to the country promoting the "ABC" campaign. But the success of abstinence-focused campaigns is bitterly disputed [42]. PEPFAR has referred to its focus on abstinence as an "evidence-based" risk-reduction strategy, citing failure rates for condoms [43]. Sadly, PEPFAR fails to address the failure rates with abstinence. In our view, there are several important shortcomings of the ABC campaign.

Is Uganda Really an "ABC" Success Story?

Uganda's successes over the course of the HIV/AIDS epidemic must not be overlooked. It was the first sub-Saharan country to take an active role in acknowledging HIV/AIDS in the community and implementing interventions in the 1980s that successfully reduced prevalence rates in the 1990s. The Ugandan AIDS Commission developed a clear policy by 1986, focusing on mass education and awareness campaigns, blood system safety, voluntary counseling and testing, prevention of mother-to-child transmission, women's empowerment, and treatment [44]. However, abstinence was not a primary focus of the public health campaigns during the 1990s [45].

Political Motivations

Uganda has a complex mix of citizens divided north to south by a 20-year civil conflict. The increased humanitarian aid for HIV/AIDS and strong statements of response in the south has taken the international eye away from the fragile political situation which has left 1.6 million people living in internally displaced person (IDP) camps [46]. The HIV/AIDS prevalence rates in IDPs are thought to be similar to rates in people living in urban areas, and may be attributed to insufficient condom provision and inadequate sexual education in an area where control over sexual exposure to HIV is limited [47, 48]. The success that has been achieved in delivering increased sexual education to those in the southern areas of the country should not allow us to ignore the complexity of the HIV/AIDS epidemic and the neglected humanitarian crisis still present in Uganda.

Politicians have criticized condom promotion as "pushing young people into sex" and have described pre-marital sex as "deviant and immoral." Suggestions of a national "virgin census" on World AIDS Day in 2004 raised fears that children could be forced to submit to intrusive medical tests or breach of confidentiality [42]. Such extreme views about condoms and premarital sex have no place in rationally confronting a disease as complex and far-reaching as the HIV/AIDS epidemic in Africa. Political inclinations towards supporting one particular approach, without due consideration of local social, cultural, and biological factors, ignore the diverse political and demographic settings of the epidemic.

The Problems with A and B without C

By focusing on individual behaviors, the ABC approach does not acknowledge the underlying factors that make people vulnerable to HIV/AIDS. The ABC strategies dismiss the real social, political, and economic causes of the epidemic, and end up blaming infected people, because it is implied that they failed to adopt and practice the ABCs. The ABC approach ignores vulnerable populations, such as sex workers and those who lack the ability to negotiate safe sex. It further fails to address non-heterosexual risk groups such as men who have sex with men and intravenous drug users.

PEPFAR's ABC guidance contains rules for country teams to follow in developing and implementing their sexual prevention strategies, including parameters on the prevention messages that may be delivered to youths.

Specifically, although funds may be used to deliver age-appropriate AB information to in-school youths, ages 10–14 years, the funds may not be used to provide information on condoms to these youths or distribute condoms in any school setting, let alone youth out of school. And yet as many as 16 percent of all women in Uganda have sex before the age of 15 years [49].

The ABC campaign assumes abstinence will allow young women to focus on going to school, controlling their relationships, and becoming socially empowered, and yet it fails to acknowledge the social circumstances driving sex in the first place. Many sexual relationships include transactional or commercial sex, in order to pay for postsecondary schooling, to gain financial independence from family obligations, or to provide adequate resources for those contained in IDP camps [50]. Encouraging abstinence, while at the same time excluding sexual education and protection against HIV, puts these girls at great danger of exploitation and ignorance, depriving them of the opportunity to learn the needed tools to approach sexuality in a healthy and informed manner.

Ironically, by promoting marriage (Be faithful) as a prevention measure, this campaign negates one of the highest risk groups in Africa: monogamous, married women [50]. Surveys suggest a high incidence of extramarital sexual activity and STIs among some married men [50]. It is still widely believed in Uganda that women have no right to deny their husbands sex [51]. The assumption of the campaign that sex is a rational act and that women have the autonomy to choose abstinence ignores the forces behind the initiation of sex. The presumption that marriage is somehow protective is misleading and potentially dangerous for young women already deprived of proper sexual education.

The enormous disservice done by the recent campaign to discourage condom use (due to the assumed link to promiscuity) cannot be overemphasized. The effectiveness of condom use for prevention of HIV/AIDS is the most likely explanation for Uganda's early successes [45]. De-emphasizing the importance of condom use has the serious potential to hurt local prevention efforts. A 2005 study by researchers at Makerere University and the AIDS Information Centre showed that Ugandans aged 19–25 years were more concerned about getting pregnant than becoming infected with HIV; when condoms were used, they were primarily considered contraceptive tools rather than protection against infections [52]. The confusion in young women and men who initially doubted the efficacy of condoms has only been amplified by these new efforts by the Ugandan government [49].

Recommendations

We still don't know the most effective strategy for decreasing the number of new cases of HIV in Africa. Given the lack of evidence underpinning the abstinence strategy in the first place, it is crucial that condom use and education be emphasized if PEPFAR is to reach its target of preventing 7 million new infections by 2010 [53].

We need to ensure that the messages that we are sending to youth are not contradictory and that schoolteachers are adequately informed to provide objective counseling to sexually active pupils. We need to ensure that the special needs of vulnerable and oppressed populations are addressed. Urgent steps are required to provide factual and empowering information about each of the ABC components in order to counter misinformation, fear, and stigma. Finally, we need to increase and ensure free and widespread testing so that individuals can be empowered to protect themselves as well as their loved ones by being informed of their own and their partner's infection status. The sooner we confront HIV/AIDS as the multifaceted and complex issue it is, the sooner we can make important steps towards progress in HIV prevention.

Acknowledgments

Alexandra Mihailovic and Peter Olupot-Olupot thank Susan Walker of McMaster University and Edward Mills of the Centre for International Health and Human Rights Studies.

Citation: Murphy EM, Greene ME, Mihailovic A, Olupot-Olupot P (2006). Was the "ABC"

approach (abstinence, being faithful, using condoms) responsible for Uganda's decline in HIV? PLoS Med 3(9): e379. DOI: 10.1371/journal.pmed.0030379.

Abbreviations: DHS, Demographic and Health Surveys; IDP, internally displaced person; PEPFAR, President's Emergency Plan for AIDS Relief; STI, sexually transmitted infection.

Elaine M. Murphy is a scholar-in-residence at the Population Reference Bureau and Margaret E. Greene is a senior research scientist at the International Center for Research on Women, both in Washington, D. C., United States of America. E-mail: emurphy530@aol.com. Alexandra Mihailovic is in the Department of Surgery and the Department of Health Policy, Management, and Evaluation at the University of Toronto, Toronto, Canada. E-mail: alex.mihailovic@utoronto.ca. Peter Olupot-Olupot is at the Mbale Regional Referral Hospital, Mbale, Uganda, and the Department of Public Health, University of the Western Cape, Cape Town, South Africa. E-mail: polupotolupot@yahoo.com.

References

1. Halperin D, Steiner M, Cassell M, Green E, Kirby D, et al. (2004) The time has come for common ground on preventing sexual transmission of HIV. Lancet 364: 1913–1915.
2. Green E (2003) Rethinking AIDS prevention: Learning from successes in developing countries. Westport (Connecticut): Praeger Publishers. 374 p.
3. Stoneburner R, Low-Beer D (2004) Population-level HIV declines and behavioral risk avoidance in Uganda. Science 302: 714–718.
4. Shelton J, Halperin D, Nantulya V, Potts M, Gayle H (2004) Partner reduction is crucial for balanced "ABC" approach to HIV prevention. BMJ 328: 891–893.
5. Hearst N, Chen S (2004) Condom promotion for AIDS prevention in the developing world: Is it working? Stud Fam Plann 35: 39–47.
6. Cravero K (2004 July 7) Record numbers infected with HIV. Washington Post: A14.
7. Fleischman J (2004 June 29) Beyond "ABC": Helping women fight AIDS. Washington Post. Available: http://www.washingtonpost.com/wp-dyn/articles/A13501-2004Jun28.html. Accessed 2 August 2006.
8. Mason K (1995) Gender and demographic change: What do we know? Liege (Belgium): International Union for the Scientific Study of Population. 31 p.
9. Miller BD (1997) Social class, gender and intrahousehold food allocations to children in South Asia. Soc Sci Med 44: 1685–1695.
10. Das Gupta M (1987) Selective discrimination against female children in rural Punjab, India. Popul Dev Rev 13: 77–100.
11. Leslie J, Ciemins E, Essama S (1997) Female nutritional status across the life-span in sub-Saharan Africa: Prevalence patterns. Food Nutr Bull 18: 20–43.
12. Leach F (1998) Gender, education and training: An international perspective. Gend Dev 6: 9–18.
13. Agarwal B (1994) Gender and command over property: A critical gap in economic analysis and policy in South Asia. World Dev 22: 1455–1478.
14. Summerfield G (1998) Allocation of labor and income in the family. In: Stromquist NP, editor. Women in the third world: An encyclopedia of contemporary issues. New York: Garland Publishing. pp. 218–226.
15. Kishor S, Johnson K (2004) Profiling domestic violence: A multi-country study. Measure DHS+, ORC Macro. Available: http://www.synergyaids.com/documents/ProfilingDomesticViolence.pdf. Accessed 2 August, 2006.
16. Heise L, Ellsberg M, Gottemoeller M (1999) Ending violence against women. Johns Hopkins University School of Public Health. Available: http://www.vawnet.org/DomesticViolence/Research/OtherPubs/PopulationReports.pdf. Accessed 2 August 2006.
17. Murphy E (2003) Being born female is dangerous to your health. Am Psychol 58: 205–210.
18. Bessinger R, Akwara P, Halperin D (2003) Sexual behavior, HIV and fertility trends: A comparative analysis of six countries. Phase I of the ABC study. Measure Evaluation, USAID. Available: http://www.cpc.unc.edu/measure/publications/pdf/sr-03-21b.pdf. Accessed 2 August 2006.

19. Central Bureau of Statistics (Kenya), Ministry of Health (Kenya), ORC Macro (2004) Kenya Demographic and Health Survey 2003. Calverton (Maryland): Central Bureau of Statistics, Ministry of Health, ORC Macro.
20. UNAIDS (2004) UNAIDS 2004 Report on the Global AIDS Epidemic. Available: http://www.unaids.org/bangkok2004/GAR2004_html/GAR2004_00_en.htm. Accessed 3 August 2006.
21. Watkins S (2004) Navigating the AIDS Epidemic in Rural Malawi. Popul Dev Rev 4: 673–705.
22. Duong T (2003). The ABCs and gender in Uganda [thesis]. Available from the Department of Global Health, George Washington University School of Public Health and Health Services, Washington DC
23. Green E, Halperin D, Nantulya V, Hogle J (2006) Uganda's HIV prevention success: The role of sexual behavior change and the national response. Washington (D.C.): The Synergy Project.
24. Museveni Y (2001 October 13) Africa Prize for Leadership: Keynote address. Available: http://africaprize.org/01/ceremony/museveni.htm. Accessed 3 August 2006.
25. Diarrah C, Riley C (2002 July 10) A dose of democracy for Africa's AIDS crisis. The Boston Globe: A19. Quoted in Green E (2003) Rethinking AIDS prevention: Learning from successes in developing countries. Westport (Connecticut): Praeger Publishers.
26. Human Rights Watch (2003) Policy paralysis: A call for action on HIV/AIDS-related human rights abuses against women and girls in Africa. Washington (D. C): Human Rights Watch. Available: http://www.hrw.org/reports/2003/africa1203. Accessed 3 August 2006.
27. Human Rights Watch (2003) Just die quietly: Domestic violence and women's vulnerability to HIV in Uganda. Washington (D. C): Human Rights Watch. Available: http://www.hrw.org/reports/2003/uganda0803. Accessed 3 August 2006.
28. UNAIDS (2002) Epidemiological fact sheets on HIV and sexually transmitted infections, 2002 update. Geneva: UNAIDS. 29. Cohen S (2004) Promoting the "B" in ABC: Its value and limitations in fostering reproductive health. The Guttmacher Report on Public Policy. Available: http://www.guttmacher.org/pubs/tgr/07/4/gr070411.html. Accessed 3 August 2006.
30. Wilson D (2004) Partner reduction and the prevention of HIV/AIDS. BMJ 328: 848–849. Available: http://bmj.bmjjournals.com/cgi/content/full/328/7444/848. Accessed 3 August 2006.
31. Uganda Bureau of Statistics and ORC Macro (2001) Uganda: Demographic and health survey 2000–2001. Calverton (Maryland): ORC Macro.
32. Ministry of Finance and Economic Planning, Uganda and ORC Macro (1996) Uganda: Demographic and health survey 1995. Calverton (Maryland): ORC Macro.
33. Malawi National Statistical Office and ORC Macro (2000) Malawi demographic and health survey 2000. Zomba (Malawi): ORC Macro.
34. Ministere de la Sante, Republique du Rwanda (2001) Enquete demographique et de sante: Rwanda 2000. Kigali (Rwanda): Office National de la Population.
35. Tanzania Commission for AIDS, National Bureau of Statistics (Tanzania), and ORC Macro (2004) Tanzania HIV/AIDS indicator survey 2003–04. Dar es Salaam (Tanzania): Tanzania Commission for AIDS.
36. Central Statistical Office (Zimbabwe) and ORC Macro (1999) Zimbabwe demographic and health survey 1999. Calverton (Maryland): ORC Macro.
37. Horizons Project (1999) Peer education and HIV/AIDS: Past experience, future directions. Washington (D. C): Population Council. Available: http://www.popcouncil.org/pdfs/peer_ed.pdf. Accessed 3 August 2006.
38. White V, Greene M, Murphy E (2003). Men and reproductive health programs: Influencing gender norms. Washington (D. C): The Synergy Project. Available: http://pdf.dec.org/pdf_docs/PNACU969.pdf. Accessed 3 August 2006.
39. Becker S (1996) Couples and reproductive health: A review of couple studies. Stud Fam Plann 27: 291–306.
40. United States Government Accountability Office (2006) Global health: Spending requirement presents challenges for allocating prevention funding under the President's Emergency Plan for AIDS Relief. Available:

http://www.gao.gov/new.items/d06395.pdf. Accessed 3 August 2006.
41. Office of the United States Global AIDS Coordinator (2004) Appendix 2: The Emergency Plan for AIDS Relief: Fiscal year 2004 prevention expenditures and program classification criteria. Washington (D. C.): US Department of State.
42. Cohen J, Tate T (2005) The less they know, the better: Abstinence-only HIV/AIDS programs in Uganda. Human Rights Watch. Available: http://hrw.org/reports/2005/uganda0305. Accessed 3 August 2006.
43. Kennedy D (2005) Twilight for the Enlightenment? Science 308: 165.
44. Uganda AIDS Commission (2006) HIV/AIDS in Uganda. Available: http://www.aidsuganda.org/HIVug.htm. Accessed 3 August 2006.
45. Kirungi WL, Musinguzi J, Madraa E, Mulumba N, Callejja T, et al. (2006). Trends in antenatal HIV prevalence in urban Uganda associated with uptake of preventive sexual behaviour. Sex Transm Infect 82 (Suppl 1): i36–i41.
46. Lowicki-Zucca M, Spiegel P, Ciantia F (2005) AIDS, conflict and the media in Africa: Risks in reporting bad data badly. Emerg Themes Epidemiol 2: 12.
47. United Nations High Commissioner for Refugees (2006) Refugees, HIV and AIDS: Fighting HIV and AIDS together with refugees. Available: http://www.unhcr.org/cgibin/texis/vtx/protect/opendocpdf?tbl=PROTECTION&id=447c001b2. Accessed 3 August 2006.
48. Fabiani M, Nattabi B, Opio AA, Musinguzi J, Biryahwaho B, et al. (2006) A high prevalence of HIV-1 infection among pregnant women living in a rural district of north Uganda severely affected by civil strife. Trans R Soc Trop Med Hyg 100: 586–593.
49. Uganda AIDS Commission (2005) Uganda country report January 2003–December 2005. Available: http://data.unaids.org/pub/Report/2006/2006_country_progress_report_uganda_en.pdf. Accessed 3 August 2006.
50. Ntozi JP, Najjumba IM, Ahimbisibwe F, Ayiga N, Odwee J (2003) Has the HIV/AIDS epidemic changed sexual behaviour of high risk groups in Uganda? Afr Health Sci 3: 107–116.
51. Gage AJ, Ali D (2005) Factors associated with self-reported HIV testing among men in Uganda. AIDS Care 17: 153–165.
52. Wakabi W (2006) Condoms still contentious in Uganda's struggle over AIDS. Lancet 367: 1387–1388.
53. Gale Group (2006) HIV prevention policy needs an urgent cure. Lancet 367: 1213.

Rethinking Health and Political Economies: AIDS, Africa and the US

Kristen Peterson

AIDS policies in Africa are not often the subject of scholarly inquiry, yet they virtually shape political economies and indeed are important determinants to Africa's own engagement with globalization. Rather than examining these policies as forms of practice or governance, I prefer to think about them from the point of view of capital and political economy. Indeed the very conditions of global aid, which sets these policies in motion even if they are nationally driven, functions as a form of global capital. That is, AIDS policies actually facilitate the existing flows of capital in and out of Africa and indeed are paradigmatic of neo-liberal economic policy toward the continent.

Existing theories of globalization cannot actually account for these dynamics mostly because they are preoccupied with "accumulation," viewed as the locus of globalization (via global cities, flexible capital, speculative markets, etc.), as if accumulation exists as a singular phenomenon. Due to the emphasis on accumulation as fundamental to theories of globalization, it is perhaps no wonder that claims are consistently made about Africa's marginalization in the

global political economy. This is a remarkably profound mis-pronouncement and misdiagnosis of neo-liberal Africa (Ferguson, 2006; Mbembe, 2001) as the continent is being rigorously "re-inscribed" in the world economy via trade, development, and economic policies that suggest an importance greater than simple marginalization; and therefore, notions of wealth accumulation cannot solely account for Africa's place in the world. In following David Harvey (2004), accumulation is always tacked to other logics that are equally in play, especially in Africa, such as wealth extraction (via extractive industries) and dispossession.[1] Generated by the IMF's Structural Adjustment Programs most dramatically during the 1980s-90s, the dispossession of pharmacies, drug manufacturing firms, and health care systems is the very precondition for the neo-liberal nature of AIDS policies twenty years later.

***

HIV/AIDS brings together a number of institutions that just twenty years ago were at odds with one another. Here, I am referring to the financial interaction among, and capital movement facilitated by, policy organizations as well as financial institutions overseeing the implementation of policy. In being "brought together" by AIDS, policy organizations make *implicit agreements* with each other that generate very particular kinds of capital flows. Specifically, most AIDS development agencies have favored HIV prevention policies over widespread treatment. This means that in Nigeria, where I conduct most of my research, HIV education and prevention programs function as an AIDS humanitarian apparatus that provides protectionist measures for the oil extraction industry. That is, long-term and sustainable AIDS treatment polices would require, first and foremost, converting oil wealth,[2] into funding for treatment for the nearly five million who are HIV positive and many more that are infected with numerous other infectious diseases. Fundamentally, any attempt toward widespread treatment necessitates reconfiguring the relationship between African states and their corporate partners, between external debt and foreign aid, between African states and their creditors. Because Africa's creditors are also Africa's AIDS donors, it is perhaps no coincidence that a very particular "bio-political" regime manages both HIV bodies as well as relationships between the state, humanitarian, and international financial institutions.

Dispossession is the primary organizational strategy that generates such protectionist measures and alters health and medical practices, as well as drug production and consumption. The very drive of this dispossession is the implicit agreements made among institutions that enable capital to thickly accumulate in ways that contradict the interests of public health. It may be counterintuitive to imagine that state and other forms of dispossession negate capital accumulation and wealth. Indeed, dispossession ultimately curtails incentives for foreign direct investment when state services like electricity no longer function properly and constant social conflict carry on amidst scarce resources. But dispossession actually serves as a productive contradiction in a Marxist sense whereby the AIDS policy becomes a primary structuring device that enables the subsidizing of new drugs markets, and particularly for Nigeria, keeps the flow of oil wealth and debt economies sustained.

***

HIV prevention policies are exported directly to an individual's own management and responsibility. As such, these policies implement ontological approaches such as "empowerment" and "living positively," which does not usually include access to basic medicines for opportunistic infections or HIV.[3] While information on HIV and its transmission is important, prevention, education, "empowerment" and "living positively" are delinked from the health care system; in fact, very few AIDS policies even mention primary health care as part of local or national AIDS strategies in Africa. When individual management is put forth as a primary HIV prevention strategy and the need to rebuild (collapsed post-IMF) primary health care is erased, there is no urgency to redirect the flow of funds, debt, and capital needed for general health care, which is important for the daily

maintenance of HIV infection, not to mention the health of an entire population. Prevention and education strategies thus disconnect the imperative link between therapeutic, oil, and debt economies, while keeping the existing flows of capital, of all sorts, completely intact.

***

The demand for widespread treatment in Africa and elsewhere caught world wide attention at the 2000 International AIDS conference in Durban. Since then, new national and multilateral treatment programs have been put into place.[4] In Nigeria there are two competing antiretroviral treatment policies at work. One is the Nigerian government's, which uses only generic anti-HIV drugs produced in India by Ranbaxy for the 20,000 enrolled patients. As the primary Nigerian government supplier, Ranbaxy has cornered the generic market, whose drug prices actually exceed the cost of similar generics. While at the 2004 Nigerian National AIDS conference, I witnessed a confrontation between Ranbaxy and Nigerian AIDS activists over the fact that the company was selling ARVs at their booth without a prescription. There are numerous incidences that indicate that Ranbaxy does not want the more extreme problems of drug distribution in Nigeria to be widespread public knowledge, particularly around the issue of counterfeits, which were especially prolific during the period immediately following structural adjustment. The company must contend with a popular Nigerian opinion that the majority of counterfeits are made and exported from India (generics and fakes can be confused as the same, and fakes are often referred to as "India drugs" in Nigeria), a strategy that keeps Nigeria at the forefront of Ranbaxy's own global aspirations.

The second program is George Bush's US President's Emergency Plan for AIDS Relief (PEPFAR). PEPFAR is the largest international health initiative ever to target a single disease since colonialism. All antiretroviral (ARV) drugs being subsidized and distributed to 8,000 patients (soon to be scaled up to 350,000 by 2008) are required to be proprietary or FDA approved. Critics argue that four times as many people could be served, or the program could be extended in terms of treating additional diseases over longer periods of time if the drugs were less expensive generics. PEPFAR is literally absorbing the struggling government program, which is in contrast to the stated goals of development throughout Africa, where nation-state and individual empowerment are now no longer part of the agenda. Moreover, there is no long-term plan of sustainability for either PEPFAR or the Nigerian government's program. PEPFAR is only intended to last until 2009 at which point hundreds of thousands of patients will face the potential of being taken off their treatment. This could be a disastrous development move as much research has shown that resistant HIV strains are capable of developing shortly after treatment interruption (in fact numerous numbers of people living with HIV who were enrolled in the government program, developed resistant HIV strains which were directly linked to a government two month-long drug stock-out in 2002). The prospect of so many resistant strains entering into such a large population of nearly 140 million would not only generate enormous treatment costs, it would also make generic first line drugs completely moot; and Nigeria would be faced with purchasing second line drugs which are largely patented.

Additionally, US defense contractors and other military institutions are being courted as PEPFAR contractors in Africa. Northrup Grumman (the maker of the B2 bomber and the owner of Vinnell Corporation which trained the infamous Saudi National Guard) is already in Nigeria designing software to "track" programs for PEPFAR. On reading some of the bidding documents, I found that questions were raised about whether a contractor can purchase generic drugs. The answer provided by the US government did not indicate yes or no. But if a contractor were allowed to purchase generic drugs, it would mean that far more drugs could be bought and distributed. This may appeal to a contractor who would have either four times as many drugs to distribute or simply room to extend a contract far longer than proprietary drugs would allow due to cost. What does it mean to advocate for the use of generic drugs that may be distributed by a subsidized defense industry? While it has been argued that the most

recent trend of the US administration has been to decrease foreign aid while increasing a US military presence in Sub Saharan Africa, foreign aid budgets for ARV supplies may be one of the options that finance security and anti-terrorist measures in West Africa. And moreover, as extensive West African military expansion (since Bill Clinton's initiation, expanding under the Bush administration) appears to be continually facilitated not only by anti-terrorist efforts and the search for steady oil supplies, it may also be expanding off the back of marketed pharmaceutical products. Indeed both US foreign health and military policy are fundamentally unilateral in scope.

***

There is an additional policy strategy that dovetails with the PEPFAR's drug circulation efforts. This is being facilitated by the US Department of Commerce, funded by United States Agency for International Development (USAID), which has been steadily rewriting Nigeria's intellectual property law that, by all evidence, aims at making generic drug imports illegal. Together, the demise of the Nigerian drug manufacturing industry via SAP, the mass introduction of proprietary ARV drugs, and the imposition of an anti-generic intellectual property law open the way for US subsidized proprietary drug markets that would otherwise be unsustainable due to high cost.

One of the early predecessors to the current Bush administration's PEPFAR initiative was a lesser known program that may mark the beginning of multilateral AIDS policy networks: the UN Accelerated Access Initiative (AAI), a joint 2000 UNAIDS/WHO/proprietary pharmaceutical industry initiative[5] that utilized public relations firms to bilaterally negotiate the reduction of high and out-of-reach drug prices in Africa. In exchange, stringent—intellectual property laws were conceptualized, proposed, and often implemented for African states in a manner that favor and protect multinational pharmaceutical companies' business practices in Africa. After a coalition of drug companies withdrew a well-known suit against South Africa in 2001, claiming that its 1997 Medicines Act violated World Trade Organization (WTO) regulations on compulsory licensing and parallel importation – an act that South Africa never even acted upon – companies taking part in the AAI began to heavily recruit many African countries to negotiate bilateral confidential agreements with the apparent aim of wiping out the global generic drug industry. While these negotiations were hailed as some of the best and only options to access treatment, even though only 0.1% more people were put on treatment (ACT UP Paris, 2002), other issues were crucially erased. At the end of this program, drug prices were not heavily slashed, but the AAI served as one of many now existing gateways for the proprietary pharmaceutical industry to out compete generics by making policy that eradicates the generic industry. Such policies and actions shape what kinds of drugs circulate on future markets, not simply in Africa, but throughout the world.

In addition to bilateral intellectual property negotiations, the Trade Related Intellectual Property (TRIPS) Agreement of the World Trade Organization, to which Nigeria is a signatory, gives proprietary pharmaceutical companies exclusive twenty-year manufacturing, pricing and distribution rights on their drug patents. US government's Agency for International Development (USAID) funds the Commercial Law Development Program (CLDP), an initiative of the US Department of Commerce to "assist" Nigeria in complying with TRIPS. The CLDP sponsored several meetings jointly with the Nigerian Intellectual Property Law Association between 2000 and 2004. At these meetings, there were many panels and instructions on how to comply with the TRIPS/WTO geared around how Nigeria can "be on the right side of globalization." Consistently, the discourse, without any explanation, was that the stronger a country's intellectual property law, the more economically viable and powerful it becomes in the global economy. Compared to the vast numbers of IP lawyers in the US and European patent offices who have access to world wide databases that can easily determine if an invention is new or discern an IP violation, the Nigerian patent

office awards a patent if the two page application form is filled out correctly. Such technological and expertise disparities can hardly be expected to compete internationally or instantly instantiate power in the global economy.

The US submitted its own drafts of a new Nigerian intellectual property law to the Nigerian government in 2002. I acquired these drafts, which clearly showed that the US desires a law that favors US businesses while it wipes out all legal provisions to import less expensive generic drugs. At the "final" drafting meeting, AIDS activists (with technical support from international actors like *Medicines Sans Frontiers* [Doctors without Borders], and Ralph Nader's Consumer Project on Technology) muscled their way into the meeting to demand the inclusion of "health care safeguards" which were incorporated into the draft. This was perceived as a great victory. However, less than a year later, the CLDP returned to Nigeria apparently (rumored at least) under the instructions of the US Trademark and Patent Office that viewed the new Nigeria IP draft as not meeting US desires. A new secret meeting took place without activists' or government health officials' knowledge. But the meeting became known when its "successful conclusion" was announced on national television. I acquired this latest IP draft, which may or may not be the official document because in the past, several drafts have been known to be in circulation among Nigerian and US officials who have generated confusion over the "real" document. However, lawyers at MSF in Europe analyzed it and found that "data exclusivity" measures were included that, in short, effectively reduces the generic drug industry's capacity to quickly manufacture generics coming off patent. Such provisions already carried out in other free trade agreements allow proprietary drug companies to keep data confidential. Such an act actually undermines the original intent of a patent that exchanged inventive data for short-term exclusive marketing. Moreover, it may be a strategy that slowly begins to whither away the public domain. That is, without the data in hand, a generic company is restricted from developing the technological design to engineer a generic product, a delay that can essentially extend the life of a drug patent.

USAID simultaneously funds a great deal of local AIDS NGOs to carry out prevention and education programs. To some AIDS activists, there is the appearance of a USAID policy contradiction, which supports AIDS activism yet also works to severely curtail drug access. But there may not in fact be a contradiction, as prevention and education campaigns are located in the realm of individual empowerment and responsibility, drawing attention away from the legal structures that generate obstacles to pharmaceutical flows. AIDS activists and NGOs have objected to the relationship between the Nigerian and US governments. But this relationship demonstrates a conflict that the state itself has with multilateral organizations. That is, the state opposes US and European stances on treatment access at global trading negotiations, but at the same time attempts to meet the pressure to comply quietly behind the doors of federal ministries. This represents an increasingly common strategy utilized by the US, whereby it capitalizes on the lack of communication between ministries, and between ministries and Nigeria's Geneva representatives; and bilateral and regional (trade or otherwise) agreements become the alternative avenue and means for compliance when global negotiations continually fail. Yet, what does it mean exactly for Nigeria to buy generic drugs for its own national antiretroviral program while at the same time it cooperates with the US government to legally wipe out generic drug access? Such an action will effectively make its own antiretroviral program illegal. Nigeria still has not complied with TRIPS, but is expected to do so in the next year; and the outcome of compliance will largely determine the future of drug access in the country.

***

The "implicit agreements" made among multilateral institutions fundamentally drive a political economy that relies upon an ongoing and sustained dispossession as its primary

organizational strategy, which marks contemporary capital flows into and out of Africa. Unlike the massive state and economic adjustments made under the IMF that literally teeter economies on the edge of collapse, a sustained dispossession is very particular and targeted; it takes place amidst already chaotic economic and social environments and therefore must operate in more delicate ways that do not threaten the existing thresholds of disintegration. As shown here, the most particular example is found in struggles over intellectual property designs, that do not necessarily destroy entire economies, but targets specific industries that are viewed as especially competitive; and the massive introduction of free ARV drugs that will not be sustained over time will also have a similar impact on this industry. In sum, the flourishing of US subsidized drugs is dependent on the dispossession of the local manufacturing industry, which will come to a competitive head eventually, as the industry is making a remarkable recovery under newly transformed IMF drug related policies. Rationales for public health and imperatives of capital, and humanitarianism efforts and military cultures combine and conflict, but ultimately show that the AIDS crisis itself is the greatest thorn in any country's national neo-liberal agenda, or perhaps its greatest opportunity.

This is a shorter and revised version of a forthcoming article: "AIDS Policies for Markets and Warriors: Dispossession, Capital, and Pharmaceuticals in Nigeria," in *Lively Capital: Biotechnologies, Ethics and Governance in Global Markets*. Ed. Kaushik Sunder Rajan. Duke University Press.

References

Act UP Paris. 2002. "'Accelerating Access' serves pharmaceutical companies while corrupting health organizations." http://www.globaltreatmentaccess.org/content/press_releases/02/051502_APP_PS_WHO_ACC_ACC.html.

Ferguson, James. 2006. Global Shadows: Africa in the Neo-Liberal World Order. Durham: Duke University Press.

Harvey, David. 2004. The New Imperialism. Cambridge: Oxford University Press.

Mbembe, Achille. 2001. On the Post-Colony. Berkeley: University of California Press.

Nguyen, Vinh-Kim. 2004. "Antiretroviral Globalism, Biopolitics, and Therapeutic Citizenship." In Aihwa Ong and Stephen Collier, editors, Global Assemblages Technology, Politics, and Ethics as Anthropological Problems. Oxford: Blackwell.

World Bank. 2004. World Bank Development Report.

1. I am specifically referring to David Harvey's notion of "accumulation by dispossession" (2004:137-182), where he rethinks the importance of primitive accumulation since 1973. In contrast to both Karl Marx and Rosa Luxemburg's constructs of primitive accumulation as an "original state," Harvey argues that the character and conditions of primitive accumulation (such as commercialization and privatization of land; imperial processes of appropriating assets; usury, national debt, and credit system, etc.) remain as powerful preconditions of capitalist expansion in the 21st century (2004: 144-145). In attempting to compensate for crises produced by over accumulation (defined as the lack of opportunities for profitable investment) within expanded reproduction, financialization and a stronger organization of the international financial system was introduced on a global scale. Accumulation by dispossession is a process that devalues and then releases an existing set of assets (such as large blocs of laid-off workers, privatization of land, etc.) to which over accumulated capital can seize hold and turn into profitable use by recycling them back into the system at very low cost (149-150). My use of his work is meant to show the ongoing logics of neoliberal reforms that produce very particular kinds of development projects linked directly to existing extraction patterns and capital flows throughout Africa.

2. The official statistic oil wealth makes up over 46% of Nigeria's GDP and accounts for 85% of the country's foreign exchange (World Bank Report, 2004).

3. Vinh-Kim Nguyen (2004) has wonderfully analyzed the impact of these typical AIDS development strategies in Cote d'Ivoire in terms of both access to treatment and donor/non-governmental organizations (NGO) relations.

4. The three main multilateral treatment programs are run by the UN's Global Fund, initiated by Kofi Annan; the World Health Organization's 3x 5 Plan which aims at treating 3 million people by the end of 2005; and the US government's PEPFAR plan. The Global Fund is highly multilateral, the WHO is purely administrative and PEPFAR is the largest ARV rollout thus far, which incorporates numerous international development agencies and NGOs. Nigeria intends on putting 250,000 people on ART by the end of 2006. Compliance with the World Trade Organization may largely determine the cost, delivery and promise of such a program.

5. The Joint United Nations Programme on HIV/AIDS, World Health Organization and the five companies included Boehringer Ingelheim, Bristol-Myers Squibb, Glaxo Wellcome, Merck, and Hoffmann-La Roche.

Unsubstantiated Blame and Agenda Control in AIDS Prevention in Sub-Saharan Africa

Marda Mustapha

The literature on AIDS prevention is replete with scholars, activists and policy analysts arguing that the spread of HIV/AIDS in Sub-Saharan Africa was exacerbated to a large extent due to the African leaders' denial, lack of action and responding a little too late to the pandemic. This paper will argue that the claims blaming African leaders and Africans for the spread of the disease are mostly unsubstantiated. As a matter of fact few if any scholar ever produced clear evidence that African leaders were guilty of the charges of denial, underreaction and lack of political will. Even progressive scholars may have been complicit in these charges due to the fact that little if any scrutiny was made of the charges. As such the complicity of progressive scholars may have actually aided the World Bank in taking control of the AIDS prevention agenda in Sub-Saharan Africa. The charge of denial gave ammunition to the World Bank to change the HIV/AIDS agenda to focus on prevention through "political will" instead of other more important factors such as improving health infrastructure and improving access to healthcare in the fight against HIV/AIDS in Sub-Saharan Africa. As a result, Sub-Saharan African governments have been faced with newer constraints such as lack of agenda and discourse control that are subtle but powerful. To ease some of these constraints, the paper calls on activists and scholars to revisit the denial and inaction theses. Revisiting the theses will give activists and scholars a chance to challenge the agenda and discourses that World Bank and PEPFAR are trying to entrench in the fight against the disease.

Constructing SSA Governments' Response to HIV/AIDS

Caldwell, Orobuloye and Caldwell (1992) indicted the African community by arguing that SSA governments and even the private sector under-reacted to the disease and that such an under-reaction was due to the fact that the community did nothing to hold the government responsibles. In short, African communities failed to blame their governments for the spread of the disease. They invariably used the absence of riots and demonstrations against government on the part of communities as basis for concluding underreaction. De Cock, Mbori-Ngacha and Marum (2002) in Lancet, concluded their paper by arguing that lack of commitment and reluctance to address HIV/AIDS in SSA are barriers to prevention. In the same light Martha Ainsworth and Teokul (2000) also attributed the lack of impact on the epidemic to the reluctance of governments to confront the disease. As a matter of fact, Ifeyinwa, Umerah-Udezulu & Bassey Williams (2000) argued that despite the "diligent" effort of international organizations, SSA countries have failed to respond to the disease. These negative construction and representations of SSA governments' and communities' response to AIDS gained traction in the late 1980s and by the mid 1990s, African governments became part of the problem of the spread of HIV/AIDS and as a result, the World Bank (WB) slowly but surely became the premier voice in AIDS prevention, effectively dislodging the World Health Organization. By the end of the 1990s, the WB was in complete control of the AIDS policy Agenda in most of

SSA, rewriting and recreating HIV/AIDS policies and institutions.

Actual Response to HIV/AIDS in SSA

Notwithstanding the above assertions by scholars which in so many ways further the regime of truth, the following evidence of African governments' response to AIDS suggests otherwise. The evidence shows that some SSA countries actually had a response mechanism in place before the first HIV case was diagnosed in their respective countries. Many of them put in place some form of response mechanism within a year after the first HIV/AIDS case was diagnosed. The table below shows selected SSA countries response date to HIV/AIDS.

Table 1: Year of Response to HIV/AIDS by Select Sub-Saharan African Countries

Country	Year of Response	Year of Diagnosis	Structure
Ethiopia	1985	1986	National Task Force
Ghana	1985	1986	Ministry of Health
Sierra Leone*	1986	1987	National AIDS Committee
Tanzania	1985	1983	Ministry of Health
Kenya	1985	1984	National AIDS Committee
Malawi	1986	1985	Ministry of Health Technical Committee

Note: Information for year of response, diagnosis and structure retrieved from Stover and Johnston. 1999. "The Art of Policy Formulation: Experiences from Africa in Developing HIV/AIDS Policies." Policy Project: Futures Group International. Washington D.C.
*Kosia et al 1989 "HIV and TB in Sierra Leone" IV International Conference on AIDS and Associated Cancers in Africa, Marseille, France. Abstract 210.

Table 1 above contradicts the denial, lack of action and reluctance charge that has become one of the central themes for the spread of HIV/AIDS in SSA. It should be noted that the countries may not be representative of the whole of Africa but it shows that at least these African countries with location spanning from West to South would not create institutions to respond to HIV/AIDS if they were in denial, inactive or reluctant to deal with the disease. Countries like Sierra Leone, Ghana and Ethiopia responded to the AIDS threat before the first case was diagnosed in their respective countries. The next question that comes up now is why the charge of inaction?

Why the Charge of Inaction?

In the early 1980's the governments of SSA were seen as part of the problem of underdevelopment and economic decline therefore, they could possibly not be part of the solution. I argue that the charge of African governments being responsible for the spread of the disease seems to have come from the view that SSA governments were corrupt, insensitive to the needs of their people, despotic, undemocratic and most times incompetent. These assertions which were first expressed in the 1980's became the general assumption of a lot of scholars when giving reasons for under-development in SSA. These assertions also partly helped pave the way for the push by the

International Monetary Fund (IMF) and the WB to demand the withdrawal of SSA government from some economic activities and the provision of social services. In short, the governments of SSA were discredited as solvers of problems. Similar perspectives have been proffered about the problem of the spread of HIV/AIDS. The World Bank quickly jumped on the inaction, denial accusation bandwagon by commissioning working papers such as "The Cost of Inaction: The Spread of HIV in Sub-Saharan Africa, 1982-1997" (1999). Such papers became blue prints for WB interventions in HIV/AIDS prevention in SSA.

Outcome of the Charge

The outcome of the charge of inaction or under-reaction to the AIDS pandemic in SSA is similar to the outcome of the charge of economic incompetence that started in the early 1980's to the mid 1980's that some how legitimized Structural Adjustment Programs (SAP). SAP effectively took over the agenda of fiscal policy of most SSA countries and the rest is history. In the case of HIV/AIDS prevention, the charge of inaction, lack of interest etc. seem to have legitimized the WB in taking over policy agenda setting for AIDS prevention in SSA.

It should be noted that most if not all SSA countries' response to the pandemic was within the context of health. As a result, almost if not all of the AIDS institutions that were created by SSA countries were within the ministries of health. However, with the involvement of the WB in AIDS prevention policy, semi-autonomous institutions were created outside the ministries of health under the jurisdiction of the offices of the president. The rationale for such move is to give a semblance of political will and hopefully jolt the governments into political action and "acceptable" response. Such a move effectively changed the agenda for HIV/AIDS prevention policy from health to politics and outreach.

Changing the Agenda

The initial responses of SSA countries can by no means be described as inaction, under-reaction or denial. The responses may have been inadequate for want of funds. Now it should also be noted that most of SSA had signed on to SAP and therefore the health budgets of these countries were set at a ceiling which could not be breached. The amount of money that could then be spent on HIV/AIDS policy response was limited and within the existing health budget, thus, making it inadequate.

While the SAP proscribed over spending in the health sector, the WB recommended that some SSA countries take out more loans to deal with the HIV/AIDS scourge. Access to loans from the WB comes with substantial control of HIV/AIDS policy agenda. As a result, HIV/AIDS responses in SSA had to accept WB recommendations as to how HIV/AIDS policy should be charted. In the case of Sierra Leone and Uganda, the WB laid out specifics about the type of institution to be created, what bank should control the loan when paid out and even the auditors had to be approved by the WB (World Bank 2000 and 2002). In addition, the agenda in the two countries were changed from health approach to outreach and education. Such changes are evident in the HIV/AIDS response project documents which came with the loans to these countries. For instance, Sierra Leone, a country just coming out of a ten year civil war and having almost half of its health infrastructure destroyed, under loan terms was only allowed to refurbish four hospitals as part of the response to HIV/AIDS and not invest in anti-retroviral therapy (World Bank 2002). Similarly, Uganda was also not allowed to invest in anti-retroviral therapy (World Bank 2000). In essence, the initial HIV/AIDS policy response and agenda by SSA countries attempted to approach the issue as a comprehensive health issue, while the new agenda espoused by the WB fails to recognize health as the basis of prevention. The WB focuses basically on prevention and less on treatment if any. The result of this is that HIV/AIDS mortality has increased in countries like Uganda which has been praised for its success in reducing the HIV/AIDS prevalence rate.

The control of the HIV/AIDS agenda in SSA by the WB is not a new phenomenon in global health governance. It may have started with the Alma Ata declaration of 1978, where Third

World countries in concert with the WHO set an agenda for health for all by 2000 through primary health care. As it has happened with the AIDS policy literature, the debate in the dominant peer reviewed journals on health policy at that time argued that universal primary health care was not cost effective and that countries must move from universal primary health care to specific primary health care (SPHC) (Warren 1988). The tenets of SPHC were later repackaged and renamed Health Sector Reform by WB. By 1993, the WB, instead of the WHO became the primary agenda setter for global health policy.

The same path to the take over of the agenda of HIV/AIDS policy seems to have been followed. The WHO in concert with Third World countries faced with the AIDS pandemic created the Global Program on AIDS (GPA). The GPA program helped set up the AIDS response in various SSA countries in the early to the mid 1980s. However, the World Bank seems to have taken advantage of the uncontested reasons given by scholars and practitioners for the spread of the disease, and took over the HIV/AIDS agenda in SSA. In short, the WB now controls the international agenda on AIDS. It also dictates the national agenda on AIDS policies in SSA countries.

Conclusion

I have attempted to question the assertions made by scholars about the accusation that SSA governments and communities under reacted and/or were in denial about the disease. I have also presented selected evidence to show that the assertions do not reflect the reality of response. There is no doubt that funding was one of the greatest problems in the fight against the spread of the disease. However, inadequate funding in an atmosphere of SAP is far removed from inaction and denial. It is unfair on Africans and their leaders when scholars and activists accuse them of inaction and denial without taking into consideration one of the most important aspects of HIV/AIDS prevention-funds.

With the possible exception of South Africa, there is no evidence that African communities have rioted or demonstrated against their governments. Does that then mean that African communities are still under-reacting? Invoking riot as a sign of adequate action or reaction is both unfortunate and an exhibition of the common pattern of ignoring positive events done by Africans. It could have been very helpful in any case if some of the scholars who accused SSA communities and leadership of inaction and denial had defined what was adequate reaction or response.

It is not out of the ordinary to say a lot of scholars and activists dropped the ball on scrutinizing some of the claims made about denial and inaction by SSA governments. Such phenomena have allowed the WB to tighten its neo-liberal grip on AIDS policies on SSA. While the ball may have been dropped on this issue, progressive scholars must now more than ever be vigilant in scrutinizing assertions made about HIV/AIDS policies in SSA. This not withstanding, there is tremendous opportunities now for progressive scholars to assume more responsibility in lending voice to the voiceless victims of HIV/AIDS with the aim of prevent another victimization through accusation.

References

Ainsworth, M and Teokul. 2000. "Breaking the Silence: Setting Realistic Priorities for AIDS Control in Less-Developed Countries" *Lancet* Vol. 356, 55-60, July 1.

Caldwell, Orubuloye and Caldwell. 1992. "Underreaction to AIDS in Sub-Saharan Africa," *Social Science and Medicine* 34(11), 1169-1182.

De Cock, Kevin, Dorothy Mbori-Ngacha, and Elizabeth Marum. 2002. "Shadow on the Continent: Public Health and HIV/AIDS in Africa in the 21st Century." *Lancet* 360(9326): 67-72

Ifeyinwa, Umerah-Udezulu & Bassey Williams. 2000. "Combating the HIV/AIDS Crisis in Africa: Sustainable and Preventive Models," http://www.sahims.net/regional/Aids/ARC_Combating_the_HIV.pdf.

Warren, K. 1988. "The Evolution of Selective Primary Health Care," *Social Science and Medicine*. Vol 26: 891-898.

World Bank. 2000. "Project Appraisal Document on a Proposed Credit in the amount of SDR 37.7 million (US$ 45.7 million equivalent) to the Republic of Uganda for an HIV/AIDS Control Project." Report No: 2i350-UG. December 28. http://www-wds.worldbank.org/servlet/WDSContentServer/WDSP/IB/2001/01/26/000094946_01010505342442/Rendered/PDF/multi_page.pdf

_____. 2002. "Project Appraisal Document on a Proposed Grant in the amount of SDR $15.1 million (US$20 million Equivalent) to the Republic of Sierra Leone for a Health Sector Reconstruction and Development Project." *Report No. 23206-SL*. World Bank Document. February 21. http://www-wds.worldbank.org/servlet/WDSContentServer/WDSP/IB/2002/03/22/000094946_02031304003782/Rendered/PDF/multi0page.pdf. Retrieved January 2003.

The Second Annual Bud Day ACAS Activism Award, 2006
The Winner is: Bill Minter
With a posthumous award to Carole Collins

William (Bill) Minter has been a writer, researcher, and activist since the mid-1960s, focusing particularly on southern Africa and international issues. He holds a Ph.D. in sociology and a certificate in African studies from the University of Wisconsin at Madison. He studied at the University of Ibadan in Nigeria in 1961-62 and taught in Tanzania and Mozambique at the secondary school of the Mozambique Liberation Front (FRELIMO) in 1966-68 and 1974-76.

Minter worked as a writer, editor, and researcher at Africa News Service (now allafrica.com) in Durham, N.C. in 1973 and 1976-82. Based in Washington since 1982, he has combined personal research and writing with contract work for a number of organizations and has developed computer-mediated communication tools. He worked for Africa Action and its predecessor organization, the Africa Policy Information Center (APIC), from 1992 through fall 2003, and for the affiliated Washington Office on Africa (WOA), from 1992 to 1997.

Minter was editor and producer of the Africa Policy E-Journal, published by Africa Action, from the publication's beginning (under the auspices of the Africa Policy Information Center) in 1995, until mid-October 2003. In November 2003, Minter introduced the AfricaFocus website and AfricaFocus Bulletin, which he continues to edit and produce.

Carole Collins (1946-2006) was actively involved in Africa solidarity work for more than three decades--in Chicago, Washington, D.C., New York, Los Angeles, and Southern Africa. She worked as an independent consultant and free-lance writer on Africa policy issues, as well as working for a variety of NGOs promoting African emancipation and development. She did research and policy analysis about debt, trade and HIV/AIDS issues in Africa for various ecumenical advocacy coalitions. She worked as a journalist in Africa and at the United Nations. In recent years she wrote extensively on the Democratic Republic of the Congo (ex-Zaire).

In the 1970s, Carole was active in the Chicago Committee for African Liberation. In the early 1980s she was a visiting fellow at the Institute for Policy Studies in Washington, DC, and was the national coordinator of the campaign to oppose bank loans to South Africa. From 1986-1990, Carole was based in Zimbabwe as the American Friends Service Committee's international affairs representative for Southern Africa. She later served as senior research associate in an office funded by the US Foreign Disaster Assistance, and published a study on humanitarian intervention in Somalia.

Carole received a Masters in International Affairs from Columbia University School for International and Public Affairs in 1993. From 1998-1999, she served as national coordinator of the US Jubilee campaign for debt cancellation and co-authored "Jubilee 2000: Citizen Action Across the North-South Divide" in Michael Edwards and John Gaventa (eds.), Global Citizen Action (Boulder, CO: Lynne Rienner, 2001). Before moving from Washington, D.C. to California in the early 2000s, Carole was a senior policy analyst at Africa Faith and Justice Network.

Bill was presented with the award at the 2006 African Studies Association conference in San Francisco, and a memorial ceremony was held in honor of Carole as well. Thanks to all who participated.

ASSOCIATION OF CONCERNED AFRICA SCHOLARS
2006 Calendar Year Membership Form

Special Offer: As part of our continuing effort to enhance member benefits, we have arranged for a special offer that includes reduced membership costs for ACAS (and thus issues of the ACAS Bulletin) and a discounted one-year subscription to the Review of African Political Economy (normally $60/year). This offer is valid only for individual memberships and not institutional or overseas memberships/gifts. *Please be sure to include your e-mail address if possible for electronic action alerts.*

Name _____

Address _____

City/State/Zip _____

Affiliation _____

Phone: Office _____ Home _____ Fax: _____

E-mail (print carefully please) _____

Interests:

Region _____

Country/Area _____

Topic _____

I am willing to participate in ACAS in the following ways:

____ Political Action Committee
____ Bulletin articles
____ A specific campaign or issue: _

_____

Annual Membership/Subscription Dues

Please indicate if you are choosing:

_____ ACAS only membership/renewal.
_____ ACAS and ROAPE membership/renewal.(for individual members only)

	ACAS Only	SPECIAL: ACAS & ROAPE
___ Annual Income to $10,000	$10	$35
___ $10,000 to $25,000	$25	$50
___ $25,000 to $50,000	$35	$60
___ Over $50,000	$45	$70
___ Sustainer	$80	$105
___ Institutions (ROAPE offer does *not* apply)		$60
___ Contribution to "Bud Day Award"		

___

We will forward subscriptions to the Review of African Political Economy.
Please send this page and checks payable to "ACAS" in U.S. $ to:

Kristin Peterson
Anthropology
Michigan State University
344 Baker Hall
East Lansing MI 48824 USA
E-mail: krisp@msu.edu

Kristin Peterson
Anthropology
Michigan State University
East Lansing, MI 48824
Email: krisap@umich.edu

Forwarding and Address Correction Requested