

Scourge of a Continent: The Devastation of AIDS, HIV Prevention Policies, and the Relief Effort in Sub-Saharan Africa

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Overview

As people and consumer goods travel with increasing rapidity across the globe and to remote areas, it has become much easier for viruses to spread. In 2003, all eyes were on China, where more than 800 died at the hands of a virulent strain of pneumonia, which came to be known as severe acute respiratory syndrome (SARS). More recently, Asia (and at the back door of Europe, Turkey) was again the epicenter of a global scare as researchers isolated cases of the deadly avian influenza. In each of these cases, fears of a pandemic were sufficient to warrant global media attention and international action. But while SARS and the avian flu are prime examples of modern viruses that pose a global threat, nothing in recent history has approached the devastation of HIV and AIDS.

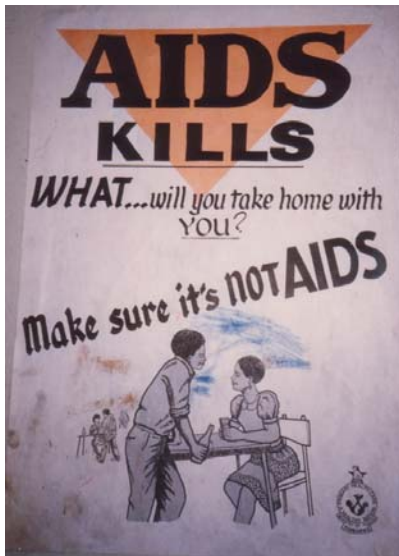
Oft-cited statistics tell a harrowing story. By the end of 2004, the number of people worldwide living with HIV was estimated to be 39.4 million and rising. That year saw 4.9 million new cases of HIV, and 3.1 million dying of AIDS.¹ AIDS is now the leading cause of death worldwide for people aged 15 to 49. More people are estimated to have died from AIDS in the past 20 years than died in the great influenza epidemic of 1918-1920, and the spread of HIV is hardly waning.

Why are so many dying of AIDS? HIV is not as readily contracted as some other viruses. Both standard influenza and SARS are spread from person to person through airborne droplets from the nose or throat of an infected person. HIV does not spread through casual contact, like a cold or the flu. It is passed in sexual fluids and blood, through intercourse or blood exchange. Undoubtedly, the difficulty in telling, without a lab test, whether an individual has contracted HIV is an important factor in its spread. While influenza flourishes in individual locations for less than a year, HIV can devastate a community for decades. Much of the virus' "success" is because, while the latency period for influenza is only a matter of days, for HIV the onset of symptoms can take many years. It is therefore common for people who are HIV positive but asymptomatic to unknowingly pass on the virus to their partners.

But the spread of the disease can, nonetheless, be halted, and this has been understood since the mid-1980s. AIDS awareness campaigns routinely emphasize that careful individual behavior can almost completely alleviate the concern for contracting HIV, if safe sex is practiced and clean needles are provided to drug users. And while the developed world has not by any measure conquered the disease, campaigns have been relatively successful in minimizing the spread of HIV, and palliative care has dramatically extended

¹ United Nations Economic and Social Council. *Joint United Nations Programme on Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome (UNAIDS)- Note by the Secretary-General-background information*, p. 5. The UNAIDS 2005 report puts the number of people worldwide who are HIV-positive at over 40 million.

the lives of people with HIV, thanks largely to advances in medicine. But these measures have not been enough, as HIV/AIDS continues to spread.



Zimbabwe Ministry of Health poster
Photo: Matthew Ruben, 1989

While HIV/AIDS can be considered a global pandemic, it is by any account overwhelmingly an African one. Sub-Saharan Africa is home to 24 of the 25 countries with the world's highest HIV levels. About two-thirds of all people living with HIV—some 25 million—live in sub-Saharan Africa. Women 15-24 years of age have been particularly vulnerable; 6.9% across the whole of sub-Saharan Africa were living with HIV at the end of 2003. More than 15% of young women in South Africa and Zimbabwe are HIV-positive. Infection rates are stabilizing in parts of the continent, but they are on the rise in most of the south.²

Furthermore, the high prevalence of HIV only begins to tell the story of the crisis that HIV/AIDS has wrought in Africa. At a macro level, the economic toll is significant, as a number of countries have lost as

much as 10 percent of the labor force, a figure that can be much higher in urban areas. Migrant workers often acquire the disease more readily than the general population. Armed forces in countries across the region also test positive for HIV at a much higher rate than the general population, because they are highly mobile and more often engage in high-risk behavior.³

Because sub-Saharan Africa contains some of the world's poorest and most politically unstable regions, halting these trends has proved to be an enormous challenge. Since AIDS predominantly strikes young adults, the social and economic consequences are considerable. In the early 1980s, barely 2% of African children were orphaned, but more recent estimates figure the proportion to be as high as 17% in some countries.⁴ But while a variety of statistics paint a confounding picture, the AIDS toll in many countries is not easily quantified. One researcher puts it this way:

Receiving scant attention are the local and gendered effects of labour productivity decline, losses of income, and caring for the sick at home. The evidence suggests girls being pulled from school, severely limiting their life chances and placing them at risk in the future; the movement of wid-

² UNAIDS, *2004 Report on the Global AIDS Epidemic: 4th Global Report*.

³ Heineken, Lindy. "Facing a Merciless Enemy: HIV/AIDS and the South African Armed Forces," *Armed Forces & Society*, Apr 2003, 29(2), 281-300, p. 285.

⁴ Deininger, Klaus, Marito Garcia & K. Subbarao. "AIDS-Induced Orphanhood as a Systemic Shock: Magnitude, Impact and Program Interventions in Africa." *World Development*, 2003, 31(7), 1201-1220, p. 1201.

ows and orphans to urban areas in search of income where many resort to 'high risk behaviour' out of economic necessity, and the physical and psychological exhaustion of women living in critical poverty left behind to care for orphans and sick.⁵

It has been more than twenty years since HIV/AIDS began to spread across Africa and medical researchers first identified the behavioral prescriptions to avoid HIV. Since then, AIDS prevention in Africa is more of a failure than a success. Why does the spread of HIV continue in ever-greater numbers? Are there policies that can work for Africa? Can the international community put together an effective response? The remainder of this essay will attempt to shed light on these questions.

HIV Prevention in Sub-Saharan Africa: Micro-Level Policy

Heterosexual transmission of the virus is by far the most common mode of HIV transmission in Africa. Therefore, to begin to understand the spread of HIV/AIDS, one has to examine sexual behavior, first and foremost. As emphasized above, the practice of safe sex does, at the level of the individual, dramatically reduce the chances of contracting the virus. Have AIDS education efforts met with any success? Can education about safe sex turn the situation around?

AIDS Education

By the mid-1980s, once it was determined that HIV carriers could appear healthy, and that the fatal disease is commonly transmitted through unprotected sex, AIDS education responded in kind. For the past 20 years, the standard prescription across the globe has been to preach "ABC"—*Abstinence, Be faithful, use a Condom*. For political, moral, and practical reasons, some AIDS awareness programs have chosen to emphasize abstinence and monogamy alone, while others have preached the need for readily accessible condoms. But nearly all agree that AIDS prevention programs begin with the "ABC" campaign, in one form or another. Information is critically important in showing people how HIV is accurately transmitted and how it can be prevented.

Although these safe sex education campaigns have been waged for up to 20 years, reports of their success are mixed. UNAIDS reports from the past few years have consistently shown that while Africans' understanding of HIV prevention methods tend to be more informed than their counterparts in other parts of the globe, only a minority of people can both identify the commonly prescribed ways of preventing HIV and understand that healthy-looking people can suffer from HIV. But other studies that allow perhaps a lower threshold of understanding AIDS suggest that Africans are not so ignorant about HIV prevention methods after all. One study suggests that even in rural parts of Africa, there is a fair understanding of the epidemic, and even, generally, dialogue between husbands

⁵ O'Manique, Colleen. "Global Neoliberalism and AIDS Policy: International Responses to Sub-Saharan Africa's Pandemic." *Studies in Political Economy*, spring-summer 2004, 73, 47-68, p. 64.

and wives on the issue.⁶ Another researcher writes, “The unrestricted continuation of the epidemic is not a failure of the AIDS educational effort. ... Almost all Africans know that there is a sinister new disease, AIDS, that it is sexually transmitted, that it is more likely to be caught if one has multiple partners or participates in commercial sex, and that the disease kills most people it infects.”⁷

Whatever disagreements exist with regard to how much Africans understand about the transmission of HIV, few would argue with two points. First, education efforts must remain central to any HIV prevention efforts. And second, HIV prevalence continues to rise in sub-Saharan Africa, with only a few countries showing significant evidence of decreasing prevalence. Most researchers agree that even where education has largely been successful, condom use is less than one would hope for, and marital infidelity is commonplace.

“African” Culture and Sexual Norms

Does sub-Saharan Africa resist the “ABC” prescription? And are African beliefs about sexual behavior distinctive? Obviously one must be careful about generalizations, because African cultures vary widely. But numerous studies in a variety of African countries highlight aspects of African views of sexual activity and how dramatically they may differ from Western views.

If there are cultural reasons for Africans to resist the “ABC” prescription, they are not alone. In the West, conservative Christian movements and many Catholics criticize the promotion of condoms, despite their effectiveness in the prevention of the spread of HIV and other sexually transmitted diseases. And some major countries, such as China and Russia, have historically been slow to institute serious policy discussion about the disease.

But Africans may hold yet greater cultural and religious reasons to resist the prescribed HIV prevention methods. Distinctively sub-Saharan African traditions don’t emphasize fidelity and monogamy, as is done in the West and with Asia’s major religions. Even where Western religions are heavily practiced, these more traditional cultural norms persist.⁸

One researcher, investigating behavior in Malawi, emphasizes this point, saying that social conceptions of desirable living—based on women’s views as well as men’s—run counter to abstinence and fidelity as well as condom use. She writes, “Men say that multiple partners are desirable because each woman is different: just as ‘You can’t eat only

⁶ Watkins, Susan Cotts. “Navigating the AIDS Epidemic in Rural Malawi.” *Population and Development Review*, Dec 2004, 30(4), 673-705, p. 692.

⁷ Caldwell, John C. “Rethinking the African AIDS Epidemic.” *Population and Development Review*, Mar 2000, 26 (1), 117-135, p. 122.

⁸ Ibid.

nsima every day' (*nsima*, made from cornmeal, is the staple food.)"⁹ These attitudes also reflect the fact that polygamy was routinely practiced in a variety of southern African cultures as recently as a century ago.

Furthermore, fidelity is not the only cultural norm working against HIV containment. Some research reports a deep-seated unwillingness to discuss sex in the family, either between husband and wife or between father and child. A researcher studied sexual behavior in Tanzania, and found that in addition to widespread infidelities on the part of men, "Confessing to your partner about an 'illicit' relationship is beyond consideration: it is not only too cruel, but disrespectful."¹⁰ And few reports of sub-Saharan African policies suggest a widespread acceptance of condoms. A study of preferences of both men and women in Ghana referred to condoms as being a "double agony" in that they cost money (not a trivial concern in countries as poor as Ghana) and then take away from the pleasure of sex. While these concerns do not imply that condom promotion is entirely ineffective, they suggest such programs' limitations.¹¹

Beyond these tendencies, a different sort of cultural norm is also contributing to the spread of HIV. In sub-Saharan Africa, 75% of young people infected are female.¹² Girls who are not equipped with proper education and are not on an equal footing with men are often coerced into sex or marriage, and may be forced to become sexually active at a very young age, with disastrous results. Furthermore, women are physically more susceptible to HIV infection from sex than men because the female genital tract has a greater exposed surface area than the male genital tract. Rape is not uncommon, especially in areas with significant gender inequality. Studies suggest that infected males are significantly more likely to infect females than the reverse.¹³ And violent rape, which is abrasive and damages tissues, leaves a woman even more susceptible. Even faithful women must concern themselves with their husband's fidelity. Compounding these issues is the fact that, particularly in rural areas, poverty encourages women into sexual liaisons as a survival strategy.

A Micro-Level Prescription

"Africa" is not a single culture and AIDS is not a single epidemic. But to the extent that each of the aforementioned norms exists, there is a measure of resistance to HIV/AIDS education. These revelations about African society don't suggest that AIDS education efforts are futile. But they do suggest inherent difficulties in changing the behavior of Africans. And while it may be difficult to convince men in parts of Africa to wear a con-

⁹ Watkins, Susan Cotts. "Navigating the AIDS Epidemic in Rural Malawi." *Population and Development Review*, Dec 2004, 30(4), 673-705, p. 681-2.

¹⁰ Haram, Liv. "'Eyes Have No Curtains': The Moral Economy of Secrecy in Managing Love Affairs among Adolescents in Northern Tanzania in the Time of AIDS." *Africa Today*, summer 2005, 51(4), 57-73, p 125.

¹¹ Aheto, D.W. & K.P. Gbesemete. "Rural Perspectives on HIV/AIDS Prevention: A Comparative Study of Thailand and Ghana," *Health Policy*, 2005, 72, 25-40, p. 36.

¹² UNAIDS, *2004 Report on the Global AIDS Epidemic: 4th Global Report*, p. 22.

¹³ Ibid.

dom, or even avoid sexual liaisons outside marriage, or transform the status of women and girls, in some measure these behaviors must be changed in order to stabilize HIV trends in the region.



Rally in South Africa
Benny Gool / AP
<http://msnbc.msn.com/id/3606235/>
(Newsweek Health, 251 W. 57th Street, New York, NY 10019)

Researchers and practitioners understand that cultural norms in Africa often work counter to HIV prevention education. And the running theme is that where the norms run counter to good practice, erosion or modification of local belief systems is possible. The following examples illustrate the difficulties and successes of AIDS education.

One researcher, writing about men's views on HIV in a rural industrial area of South Africa, found that group sessions among men led to reflection about the "problematic nature of certain practices and beliefs," in particular with regard to the rights of women and the practical rationale behind safe sex measures. When confronted with epidemiological rationales for altering their perceptions about sexual practices, these men were open to dialog.¹⁴

A different study, which looked at the successes of a national HIV/AIDS campaign in Uganda in the late 1980s, found that men and women were open to changing their behavior when they were confronted with both a clear media message as

well as evidence in their communities (e.g., family and friends becoming sick or dying) that AIDS was taking a toll. The study contrasts this case with Botswana, where the incidence of AIDS was much lower at the time, so local people found little reason to change their behavior.¹⁵

A third study, which also took place in South Africa, found that targeting particular areas characterized by risky sexual behavior, particularly specific social networks, met with some success.¹⁶

¹⁴ Naidoo, Kammila, Zethu Matebeni & Mariana Pietersen-Snymani. "Complexities and Challenges: Men's Responses to HIV and AIDS in Winterveld, South Africa," *Commonwealth Youth and Development*, 2004, 2(2) 45-63, p. 58.

¹⁵ Allen, Tim & Suzette Heald. "HIV/AIDS Policy in Africa: What Has Worked in Uganda and What Has Failed in Botswana?" *Journal of International Development*, Nov 2004, 16(8) 1141-1154, p. 1148.

¹⁶ UNAIDS, *2004 Report on the Global AIDS Epidemic: 4th Global Report*, p. 75.

A researcher in Tanzania found that while few men were willing to subscribe to the “ABC” philosophy as a whole, individuals practiced a modified version of the strategy. The study explains that,

Some delay their sexual debut, others reduce the number of their sexual partners, and still others may even use a condom in casual sexual encounters. However, many deny that they are at risk of HIV infection and insist that ‘life itself is a chance’ (*maisha ni bahati*), meaning you can never fully protect yourself against the dangers of life, including the spread of HIV.¹⁷

A different researcher in Malawi found exactly the same sort of behavior there. Condom use was more common with risky partners, but seen as unnecessary with others. Rather than practicing fidelity or abstinence, men would use a “compromise” strategy, even “selecting less attractive women” as partners:

Because sex is perceived as central to the good life, because a variety of sexual partners is considered to add spice to life, and because resisting temptation is understood to be so difficult, modifications of fidelity are the main strategies of prevention being discussed in local networks. The primary modifications are a reduction in the number of partners, a more careful selection of partners, and the use of condoms with partners considered to be risky. All are advocated and all are criticized.¹⁸

These findings portray a region understandably vulnerable to HIV, but also open to the possibility of change. With proper education, young women may practice abstinence a little while longer. Men may be marginally more selective about their partners. And a few more individuals might decide to use condoms when engaging in risky behavior. For example, in Uganda, where HIV prevalence has declined, while there is evidence that abstinence is not particularly common even among people with an understanding about HIV transmission, condom use with casual sex partners is more commonplace than it was a decade ago.¹⁹ Efforts to encourage condom use must continue in order to see any progress in other countries. And AIDS education will undoubtedly have to be a part of AIDS policy in the future if attitudes in Africa are going to be changed. Even today, in 24 sub-Saharan countries, only one woman in three aged 15-24 can both identify condoms and being faithful as primary ways of preventing HIV and knows that a healthy looking person can transmit HIV.²⁰ So AIDS education will undoubtedly have to be a part of AIDS policy in the future if greater progress is to be made.

¹⁷ Haram, Liv. “‘Eyes Have No Curtains’: The Moral Economy of Secrecy in Managing Love Affairs among Adolescents in Northern Tanzania in the Time of AIDS.” *Africa Today*, summer 20005, 51(4), 57-73, p 69.

¹⁸ Watkins, Susan Cotts. “Navigating the AIDS Epidemic in Rural Malawi.” *Population and Development Review*, Dec 2004, 30(4), 673-705, p. 687-8.

¹⁹ UNAIDS, *2005 AIDS Epidemic Update*, p. 26.

²⁰ *Ibid*, p. 18.

AIDS and the State: Macro-Level Policy

So there are indications that success is possible in the trenches. But policies must be implemented at the state level.

There have been successes. In particular, while southern Africa has been front and center in the war against AIDS, parts of east and central Africa have seen legitimate declines in HIV prevalence. The most notable African country that turned the tide against HIV is Uganda, where education campaigns have been a part of policy since 1986. But Ethiopia has met with success, while parts of Kenya and Tanzania have seen modest declines in HIV prevalence.²¹ These trends are far from settled, and each of these countries still has a significant HIV/AIDS problem. But not all the numbers are rising.

Even the success in Uganda is relative; the country has a long way to go before it can be considered out of crisis. But it can boast the most significant turnaround on the continent. Overall rates of infection dropped, according to one estimate, from 18% in the 1980s to just 6% as recently as 2003.²² The success in Uganda has been analyzed many times over, and the one commonality is that all credit the leadership of President Yoweri Museveni. Museveni took power in 1986 and almost immediately put in place policies that emphasized open discussion of AIDS, created a public education campaign, encouraged non-governmental organizations (NGOs) to operate within Uganda's borders, and employed policies consistent with prevailing suggestions from the medical and scientific communities.²³

How much credit does Museveni deserve? One researcher highlights the importance of creating community discourse; the President convinced government employees and entertainers and religious leaders to join a public dialog.²⁴ Another study suggests that policy is a direct way to overcome cultural norms that might hinder HIV prevention: "In Uganda, like in most parts of the world, fostering open discussion about sexual behaviors touches on matters deeply personal and closely linked to specific moralities, values, and religious beliefs. Early on in the campaign political leaders saw the necessity of involving religious leaders and organizations."²⁵

Other accounts suggest that Uganda is much more the exception than the rule. Most African governments have been less anxious to confront the HIV/AIDS issue. Governments may fear that acknowledgement of the AIDS epidemic would hurt the economy or tour-

²¹ United Nations Economic and Social Council. *Joint United Nations Programme on Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome (UNAIDS)- Note by the Secretary-General- background information*, p. 6.

²² "The war against AIDS and condoms." *Economist*, 10 September 2005, 376 (8442), 46.

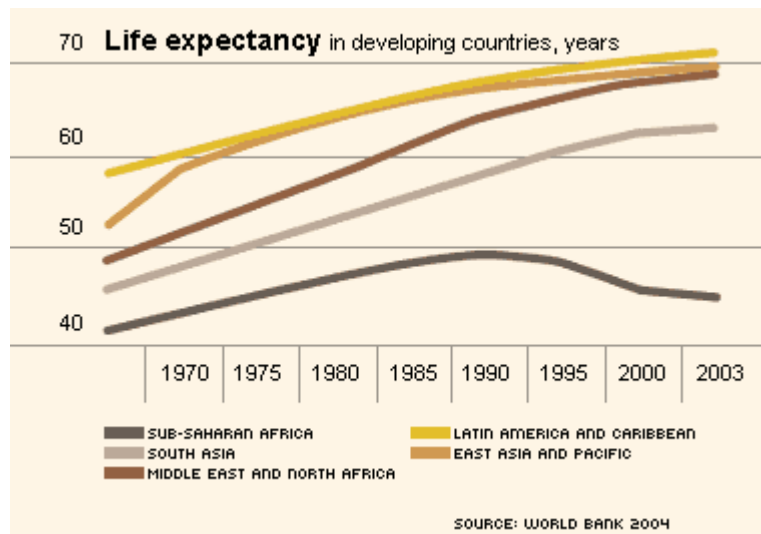
²³ Putzel, James. "The politics of action on AIDS: a case study of Uganda." *Public Administration and Development*, Feb 2004, 24 (1), 19-30.

²⁴ Allen, Tim & Suzette Heald. "HIV/AIDS Policy in Africa: What Has Worked in Uganda and What Has Failed in Botswana?" *Journal of International Development*, Nov 2004, 16(8) 1141-1154, p. 1149.

²⁵ *Ibid*, p. 27.

ism. Notably, as recently as 1999, no African leaders attended the Lusaka AIDS conference.²⁶

In contrast, South African President Thabo Mbeki has been criticized for his lack of action against HIV/AIDS, although the country has arguably made significant strides in the last couple of years. Mbeki denied the link between HIV and AIDS in 2000, and as recently as September 2003 he was quoted as saying, “Personally, I don’t know anyone who has died of AIDS. I honestly don’t.”²⁷ An estimated 370,000 South



Life expectancy in developing countries, years
<http://www.guardian.co.uk/hearfrica05/statistics/0,15844,1435604,00.html>
 (Guardian Unlimited, 164 Deansgate, Manchester M60 2RR, England)

Africans died of AIDS that year.²⁸ Not surprisingly, this lack of political commitment has undermined South African AIDS education.

While strong leadership can help bring about change, a stable political situation is equally necessary. Where the commercial sex industry is significant, policies to regulate or influence it, or provide outreach programs for sex workers, must be put in place. NGOs that wish to help need to be given that opportunity. AIDS testing must be made available. Condom promotion and distribution must be organized. Infrastructure is needed to confront rising numbers of orphans. Also, private employers seem largely unwilling to pay increased health care costs as a result of the crisis.²⁹ At a minimum, the state has to comply with the international community and provide allowances for it to operate. But strong leadership that attracts and coordinates help from abroad is even more beneficial.

A corollary to this thesis is that proper infrastructure requires funding, a topic that will be addressed in more depth in the next section. Uganda has received substantial support from the international community and NGOs to fund its HIV prevention programs. But

²⁶ Caldwell, John C. “Rethinking the African AIDS Epidemic.” *Population and Development Review*, Mar 2000, 26 (1), 117-135, p. 121.

²⁷ Willan, Samantha. “Briefing: Recent Changes in the South African Government’s HIV/AIDS Policy and Its Implementation,” *African Affairs*, Jan 2004, 103(410), 109-117, p. 114.

²⁸ UNAIDS, *2004 Report on the Global AIDS Epidemic: 4th Global Report*, p. 193.

²⁹ Rosen, Sydney & Jonathon L. Simon. “Shifting the burden: the private sector’s response to the AIDS epidemic in Africa,” *Bulletin of the World Health Organization*, 2003, 81(2), 131-137.

funding is required for almost all aspects of HIV prevention activities, from testing and media campaigns to health care and antiretroviral (ARV) therapy. Countries with strong leadership but little ability to care for their AIDS orphans and little money for public health education measures will not be effective either.

War and AIDS

It has been demonstrated that African leaders must help promote public policies in order for them to be effective. It further becomes clear that where leadership is absent, or lacks the means to promote health policy, HIV is difficult to contain. And a particularly unstable political situation can spell disaster. As Gabriel Madiye, head of the only HIV/AIDS hospice in Sierra Leone, points out, "If you recognize that we have a war and AIDS, which are you going to put a premium on?"³⁰

The use of rape as a weapon is the most horrifying example of how war can worsen the spread of HIV. Since the AIDS epidemic began, rape has been used in Liberia, Rwanda, Sierra Leone, the Democratic Republic of Congo, and Mozambique. Two-thirds of a sample of 1200 Rwandan widows tested positive for HIV,³¹ while soldiers also become much more prone to contracting the syndrome.

An even greater threat to public health might be the general destabilization that accompanies a wartime region. Rape is one aspect of a more general breakdown of behavioral norms. And with war can come economic despair. Women who aren't raped can nonetheless be forced into prostitution or exchanging sex for favors. With the state's collapse the public health system also collapses, as does public health education in all likelihood.³²

International Relief and Relief Organizations

Ultimately, fighting AIDS means fighting poverty, as this essay has alluded to in a number of areas. However, a greater emphasis on this problem is needed, especially because sub-Saharan Africa encompasses many of the very poorest communities in the world. In most of the hardest hit of sub-Saharan countries, health clinics are overwhelmed and under-funded, and the state cannot adequately meet the needs of its growing numbers of widows and orphans, nor take on basic public health campaign needs such as HIV testing and ARV drugs. An international response is the only hope to contain the epidemic.

Through the mid-1990s, the international community responded to the AIDS crisis in a very minimal way. To a large degree, that has changed in the past decade. In 1996, available AIDS funding in low- and middle-income countries amounted to no more than \$300 million. That year, the joint UN Programme on HIV/AIDS (UNAIDS) was launched.

³⁰ Elbe, Stefan. "HIV/AIDS and the Changing Landscape of War in Africa." *International Security*, fall 2004, 27 (2), 159-177, p. 174.

³¹ Elbe, Stefan. "HIV/AIDS and the Changing Landscape of War in Africa." *International Security*, fall 2004, 27 (2), 159-177, p. 167-9.

³² Altman, Dennis. "AIDS and Security," *International Relations*, Dec 2003, 17(4), 417-427, p. 421.

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Released February 2006

Combining the World Health Organization's program with those of five other agencies, UNAIDS quickly gained center stage in the global battle against AIDS,³³ and ushered in a new era of international engagement. By 2002, foreign aid had risen to \$1.7 billion, increasing to \$4.7 billion by 2003.³⁴

The effort is not simply a humanitarian one. Because of globalization, if an epidemic is not contained in one country, surrounding countries will be affected: "The concern of the US government is largely based on preserving stability and protecting its own citizens from contamination from abroad. A quite different perspective begins with the conditions in the poor world that are leading to the rapid spread of infectious diseases, and argues for a greater global response to eliminate these."³⁵

Spending is the top priority for HIV/AIDS health efforts. Spending per person living with HIV in the United States remains 1000 times higher than the comparable figure in Africa.³⁶ Much of this money goes directly to AIDS patient treatment and care, a topic outside the scope of this piece. However, even the dramatic recent increase in global funding of HIV prevention initiatives is probably not adequate to curtail the region's HIV/AIDS growth. The "3 by 5" initiative, launched by UNAIDS and the World Health Organization in 2003, was a goal to provide three million people living with HIV/AIDS in low- and middle-income countries with antiretroviral treatment by the end of 2005. But, while former President Bill Clinton has championed the initiative, and it has more than doubled the number receiving ARV therapy in these low- and middle-income countries from 400,000 to about 1 million by June 2005, this is well short of the need, despite the billions of dollars committed by governments and private donors. The number of adults and children living with HIV in sub-Saharan Africa exceeds 25 million, and there is little hope that most of these will receive ARV therapy. According to the World Health Organization, a dramatic reduction in the price of these drugs has been offered to sub-Saharan countries, which reduces costs from about \$10,000 per person per year to as low as \$300. But vast amounts of international aid and proper health infrastructure are still required to fund and administer the drugs, and because of the numbers of sick are so vast and the countries are mostly extremely poor, fully funding these drug programs and administering care to most HIV patients is far from a trivial matter.

In the United States, President Bush has substantially increased support, launching the President's Emergency Plan for AIDS Relief (PEPFAR) in 2003, a five-year, \$15 billion initiative. While the international community has praised this, the initiative has also been criticized for allocating funds to promote abstinence rather than condoms. The Baltimore Sun reported in December 2005 that international aid required two thirds of funds allocated for preventing sexual transmission to be spent on promoting abstinence and being

³³ O'Manique, Colleen. "Global Neoliberalism and AIDS Policy: International Responses to Sub-Saharan Africa's Pandemic." *Studies in Political Economy*, spring-summer 2004, 73, 47-68, p. 62.

³⁴ UNAIDS, *2004 Report on the Global AIDS Epidemic: 4th Global Report*, p. 131.

³⁵ Altman, Dennis. "AIDS and Security," *International Relations*, Dec 2003, 17(4), 417-427.

³⁶ UNAIDS, *2004 Report on the Global AIDS Epidemic: 4th Global Report*, p. 132.

faithful.³⁷ Critics of the policy claim that condom promotion is a requirement in the fight against AIDS, and if America dictates that funds should be spent in other capacities, campaigns will be unreasonably hindered. One report suggests that in Uganda, where President Museveni strongly attacked condoms in a 2004 speech, and where the government is storing 30 million condoms that it used to distribute for free, the de-emphasis on condoms has been a problem. A health survey in that country indicates that HIV prevalence in Uganda has worsened since the Museveni speech.³⁸



Bono and Bush meet about AIDS funding, Summer 2005
<http://www.southernvoice.com/2005/7-1/view/ontherecord/record.cfm>
 (Southern Voice, 1075 Zonolite Road Suite 1-D, Atlanta, GA 30306)

Whether or not African countries agree with the terms attached to the United States aid, it can hardly be argued that any funding should be refused. Most African countries are desperate for any form of help. Furthermore, even in instances where money is not earmarked for a particular policy, it has to be spent effectively. Disbursement of funds from multiple sources is not easily coordinated. NGOs and community-based organizations need the capacity to make these funds effective. The community sector is the lynchpin for providing these services directly.³⁹

Conclusion

This essay began with a puzzle. In an era where HIV prevention is comprehensively understood by the medical community, and public health publicity efforts show such promise, how has AIDS devastated much of Africa? Upon reflection, however, the question might be the reverse. In light of all the economic, political, and cultural challenges Africa faces, how might it be able to conquer the disease?

Effective AIDS policy in sub-Saharan Africa will require some combination of shrewd policies at the community level, political stability, good public policy from the state, a commitment from the international community, and a properly coordinated effort. To expect all of these ingredients at once is perhaps unreasonable. But as long as aspects of all of these measures improve, some communities will successfully pull themselves out of the grip of AIDS.

³⁷ Kohn, David. "More HIV funds to promote abstinence", *Baltimore Sun*, 10 December 2005.

³⁸ "The war against AIDS and condoms." *Economist*, 10 September 2005, 376 (8442), 46.

³⁹ Halmshaw, Caroline & Kate Hawkins. "Capitalising on Global HIV/AIDS Funding: The Challenge for Civil Society and Government," *Reproductive Health Matters*, Nov 2004, 12(24), 35-41.

In the meantime, other regions of the world must remain on alert. The steepest increases in infections in 2004 occurred not in Africa, but in East Asia, Eastern Europe, and Central Asia.⁴⁰ The most recent UNAIDS statistics report that AIDS killed almost twice as many people in Eastern Europe and Central Asia in 2005 as compared to just two years earlier.⁴¹ In order for Europe and Asia to contain HIV in these areas, resources must be directed toward prevention efforts sooner and more effectively than they have been in Africa. HIV/AIDS is not going to disappear quickly. It must be a foremost priority.

⁴⁰ United Nations Economic and Social Council. *Joint United Nations Programme on Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome (UNAIDS)- Note by the Secretary-General- background information*, p. 5.

⁴¹ UNAIDS, *2005 AIDS Epidemic Update*, p. 45.