

THE 'INDIGENISATION' OF AIDS: GOVERNANCE AND THE POLITICAL RESPONSE IN UGANDA

GOVERNMENT RESPONSE

By 1988 HIV prevalence was beginning to rocket upwards. At the Kampala ANC surveillance sites, HIV infections had increased by approximately 150% between 1985 when figures were first recorded. This turned out to be the period of the steepest rise in HIV prevalence. The government response, still located primarily in the Ministry of Health (MoH) through the AIDS Control Programme (ACP), was supported by a significant response on the part of civil society. For instance, the Ugandan Women's Effort to Support Orphans (UWESO) was founded and chaired by First Lady Janet Museveni, with funding from international donors.¹ According to focus group discussion (FGD) respondents in July, 2003, President Yoweri Museveni had also begun to tour the country making speeches about HIV/AIDS and urging people in schools, and churches, and at funerals for AIDS victims, to be aware of the dangers of promiscuity, and to limit the number of sexual partners. Dr. Dorothy Balaba, currently head of THETA, the organisation of traditional healers (or 'traditional medical practitioners'), recalls this.

I think it is the late 1980s.... Including my own experience? When I was in high school we had a youth conference where the president addressed all the school going children in 1988. We went to a conference centre in the urban setting and talked about HIV. The president himself in person came and addressed us. [There was seating for] 2000... One of the big places where most of the urban schools had a talk by the president. Our school was invited. We were at Gayaza high. He was talking about abstinence, ... condoms ... well, really 'ABC'. Mostly on abstinence.²

During 1987-1988, a national sero-prevalence survey showed an overall prevalence of 6-9%.³ USAID began to import subsidised condoms and to oversee their distribution.

The government of Uganda began to recognise at this time, too, that AIDS was no longer simply a 'health matter' and began consultation and discussion on an approach that would bring all levels of government, government-supported institutions such as schools and clinics, and organs of civil society including NGOs, Faith based organisations (FBOs) and community-based organisations (CBOs) into a nationally integrated response to AIDS. This eventually resulted in the 'Multi-sectoral Approach' to AIDS control in the early nineties, but discussions in the late 1980s represented a significant departure from the position that AIDS was primarily a medical matter. President Museveni, together with the leaders of the health care system, began to make it clear that AIDS affected all parts and all levels of Ugandan society.⁴ According to Dr. Sekatawa, a leader in the development of the National Strategic Framework for HIV/AIDS,

¹ Kagimu, Marum et al. 1996. USAID provided \$4.2m to projects concerned with orphans from 1989-1999.

² Interview: Dr. Dorothy Balaba, THETA ['Traditional and modern health practitioners together against HIV/AIDS and other diseases']; 3 July 2003.

³ Uganda AIDS Commission 2002.

⁴ Uganda AIDS Commission 2002.

‘There was recognition that there are many problems with AIDS that are not medical and that go beyond the health sector. For example, all the orphans have implications for inheritance. Thus, AIDS goes beyond the sexual.’

In response to this recognition, he says that

‘We brought people together to decide how to build a world without AIDS. Then we went to the nation. [We] arrived at consensus about vision, mission, and objectives. ... This helped each individual sector see their role in the fight against AIDS. They could clearly see their role. Even churches could see what they could contribute; people believe in them. It allowed us to articulate various dimensions of AIDS, the biomedical, etc.’⁵

Although not recognised at the time—or even now—Dr. Sekatawa was explaining the process that led away from mere ‘medicalisation’ of AIDS, and the narrow focus on ‘behaviour’ to an indigenous understanding rooted in local cultural forms and knowledge. Issues such as the effect of orphan-hood on inheritance of property, and the role of churches, could be integrated with ‘the biomedical’ without succumbing to the hegemony of the biomedical worldview and technicism driven by USAID, WHO, and other large agencies.

The AIDS Control Programme was established in the Ministry of Defence⁶ in 1987-1988 in response to a warning from Cuba’s Fidel Castro that large numbers of the Ugandan National Resistance Army (later the Ugandan National Defence Force) personnel who had been sent to Cuba for training were HIV positive. Cuba refused to admit them, since Cuba had instituted a strict policy of quarantine of all HIV infected people. The AIDS Support Organisation, TASO, was started in a small shed on the grounds of Mulago Hospital by HIV+ people who wished to become involved in and to promote care of people living with AIDS. This small initiative grew rapidly from its origins at Mulago. USAID began to support training for peer educators and counsellors involved in rapidly growing IEC efforts, and funded care and support initiatives (such as TASO), STD management, and made grants to NGOs, and to National Resistance Army. TASO was first given USAID funding in 1988 with funding continuing to the present (2006). Ten years later, TASO had cared for at least 50,000 clients and their families and trained hundreds of AIDS counsellors in Uganda and elsewhere in Africa. Their programmes greatly helped to reduce the stigma associated with AIDS, and thus lowered levels of resistance to IEC programmes, and discrimination against those who suffered from AIDS. USAID also continued to provide food relief, and support for children who had been orphaned by the death of one or both parents from AIDS. WHO began to provide large funding to support the AIDS Control Programme in the MoH for IEC, epidemiology, surveillance, patient care, and STD control.⁷ By 1988, business became involved with the Federation of Uganda Employers initiation of the ‘AIDS in the Workplace’ project.

This was one of the most important shifts in policy, and one that eventually resulted in the nearly total involvement of all government, business, labour, religious, educational and other civil society institutions and organisations. This was significant, but could not have happened without the fact that Uganda had developed its own indigenous understanding of the disease.

Dr. Dorothy Balaba discounted the earlier contributions of the Ministry of Health, however.

⁵ Interview: Dr. E Sekatawa, ISAE, Makerere University, 4 July 2003.

⁶ Uganda AIDS Commission 2002.

⁷ Kagimu, Marum et al. 1996.

They were not doing much. They were responsible for the adverts, and the TV, but it was not until they created the Uganda AIDS Commission [that things started to happen]. Then all the ministries had to become involved. It was created in the office of the president, but every ministry was represented. Every ministry became active. Before that it was seen as a health problem only under the Ministry of Health.⁸

Medical interventions, research and public health initiatives were not neglected. In 1988, several large-scale research projects that were designed to study the epidemiology of HIV and the natural progress of AIDS in communities were begun. The Rakai Project, a joint effort of Makerere University, the Uganda Virus Research Institute, MoH, Columbia University, and Johns Hopkins University, began its study in Rakai District along the western shores of Lake Victoria where the virus had first been identified, and where deaths from AIDS were rapidly increasing. The German international aid organisation, GtZ, together with the Ugandan MoH, initiated the Basic Health Services Project in Kabarole and Bundibugyo Districts (in the far western region of Uganda) and by 1991 had added a comprehensive AIDS control project including IEC/behaviour change, care and counselling, STD treatment, condom education, procurement and distribution, and programmes that sought to reduce the personal and social impact of HIV/AIDS through training and capacity building.⁹ Research to study maternal and paediatric HIV infection was developed through a co-operative programme with Makerere University, Mulago Hospital, the MoH and Case Western Reserve University (USA). USAID, in conjunction with the Government of Uganda and WHO, began to supply larger numbers of condoms to Maternal and Child Health Division of the MoH and provided \$1.5 million in funding to the AIDS control program overall.¹⁰

By the end of 1988, there were 7249 cases officially reported to the Ministry of Health,¹¹ but this figure probably grossly underestimated the true death rate from AIDS. A review of the ACP recommended considerable increase in activities, especially at district and community levels, and the preparation of district level plans that would include all governmental and political structures in the fight against AIDS.

THE SECOND DECADE OF AIDS IN UGANDA

Recognising the scope of the problem, and the efforts that were being made to respond to it, the Centre for Disease Control in Atlanta Georgia, sent Dr. Elizabeth Marum to lead the combined USAID/CDC response to AIDS. Research programmes were discovering by 1989 that there was already an extremely high level of awareness of AIDS and HIV across the entire spectrum of the Ugandan population. SIDA (Sweden) began at this time to support further IEC programmes together with an emphasis on care and support of HIV+ people and those suffering from AIDS.

USAID expanded its Family Health Services (family planning services) programmes and extended greater support for assistance to orphans and funding for two private-sector AIDS projects. It also funded 'Save the Children', an NGO based in the UK, to work with Dept of Child Care and Protection in the Ministry of Gender, Labour and Social Development. By 1991, it was estimated that 1.2 m children had lost at least one parent, while 250,000 to 300,000 had lost both parents. The principle focus of USAID then was family planning, AIDS

⁸ Interview: Dr. D Balaba, THETA, Kampala; 3 July 2003.

⁹ Kagimu, Marum et al. 1996.

¹⁰ Kagimu, Marum et al. 1996.

¹¹ Kagimu, Marum et al. 1996

prevention and orphans.¹² USAID funding reached its highest level since funding had been stopped in 1979 after the fall of Amin's regime and the beginning of Milton Obote's second period of presidency, known as 'Obote II'. The government of Uganda developed a policy on care and support of orphans, with support from USAID that emphasised community and home-based care for orphans, rather than seeking to institutionalise them.

All of these efforts by donor agencies, public health services of the government, and civil society organisations continued to lead to the development of better integration of a nationally co-ordinated response. In February 1990, the AIDS Information Centres began to be set up around the country, but especially in the south, to provide voluntary counselling and testing for HIV.¹³ By the end of 1998, around half a million clients had visited VCT centres and the numbers continued to grow rapidly.

1992 was a pivotal year in Uganda's AIDS epidemic in a number of ways. Although it could not have been known at the time, this was the year in which HIV prevalence peaked at nearly 30% in Kampala (based on ANC data for Kampala sentinel sites at Rubaga and Nsambya Hospitals). At that time, it was still far from clear what the future trend of HIV prevalence would be in Uganda, and there was little agreement on the actual situation. The foundation document the new Multisectoral AIDS Control Approach (February 1993) said, for instance, that 'there is evidence that possibly about 10% [not 30%!] of the adult population could be already infected by HIV'. The document noted that the 'current estimate for doubling rates of the disease is about eight to twelve months.'¹⁴ The prevalence peak was experienced at different times in different parts of the country, with Jinja peaking in 1989, Lacor Hospital (near Gulu in the north) in 1993, and Matany (in the north east) in 1994.¹⁵ There were also wide disparities in regional prevalence. Sero-prevalence in Rakai District varied from 1% in some rural villages to 33% in trading centres.¹⁶ The national sero-survey of 1988 also indicated considerable variability from 'as high as 50% and as low as 6%.'¹⁷ This variability was the result of the 'lumpiness' of the sexual network that was transmitting HIV across the country. This clustering of HIV infection in specific parts of the sexual network introduced instability into the network dynamic that led to the beginning of the collapse of HIV prevalence.

The Uganda AIDS Commission was founded by an act of Parliament in 1992. Its primary goals and guiding principles had been under discussion during the previous four years. The critical document, 'AIDS Control in Uganda: The multi-sectoral Approach',¹⁸ was published in February 1993, but its objectives were already being implemented in 1992. It called for the 'Multi-sectoral AIDS Control Approach' (MACA) to be implemented in all parts of central government, district government, community level structures (CBOs), and NGOs among others. The UAC would co-ordinate these activities. MACA was immediately adopted with the goals of (1) reducing the spread of HIV; (2) mitigation of health and socio-economic effects; (3) strengthening national capacity to respond to the epidemic; (4) establishment of national information database on HIV/AIDS; and (5) strengthening the national capacity to undertake

¹² Kagimu, Marum et al. 1996.

¹³ Uganda AIDS Commission 2002; Kagimu, Marum et al (1996) give the date of founding of the AICs as 1991.

¹⁴ Uganda AIDS Commission 1993: 7

¹⁵ Ministry of Health, Uganda 2002a: 6-7.

¹⁶ Konde-Lule, Musagara and Musgrave 1993: 679; citing Wawer, Serwadda, Musgrave et al 1991.

¹⁷ Uganda AIDS Commission 1993: 8.

¹⁸ Uganda AIDS Commission 1993

research.¹⁹ This was strongly supported by international donor agencies, who had also been involved in the drafting of the plan. The UNDP funded community level IEC, care and support project, and poverty alleviation.²⁰ USAID increased its funding of AIDS community education activities, and supported IEC programmes in churches and mosques.

In July of that year, Uganda presented its plan to the Summit of African leaders at the OAU meetings in Dakar. It emphasised the commitment to an agenda for action including political commitment, multi-sectoral action to prevent transmission; care for PLWAs; support for AIDS research; support for multi-sectoral planning and action; and prioritising AIDS as a target for external funding. Unfortunately, Uganda seems to have been among the very few that took this to heart.

THE 'MULTI-SECTORAL APPROACH' TO AIDS

The founding of the Uganda AIDS Commission (UAC) was a major step in the co-ordination of the government's response to AIDS, but was fraught with intricate political manoeuvring in its early stages. The controversy revolved primarily around the question of whether the AIDS problem, and hence the nature of the response, was primarily medical—and therefore whether it should be controlled by medical doctors based in the Ministry of Health—or whether it was a more generalised social, political and economic problem—and therefore required broadly based social, political and economic responses developed and controlled by social scientists and political structures. By contrast, South Africans never resolved these kinds of disputes, and never managed to create an effective centre in government to manage the epidemic. Eventually, in Uganda, an effective compromise was reached which permitted inputs from both medical and social science. A similar compromise has so far eluded South Africa. The Ugandan MACA document noted that

because the coordination was being done by the Health Sector, the epidemic continued to be addressed almost exclusively as a health problem. Consequently, there was generally inadequate response and participation by other organisations in the public and private sectors, who felt that AIDS prevention and control was not their responsibility. It was later realised that the impact of the epidemic went beyond the domain of health and cut across all aspects of individual, family, community, and national life. Government therefore decided on an alternative approach towards AIDS control. A multi-sectoral AIDS control strategy was opted for.²¹

This proved to have been the right choice since it has become apparent that the Ugandan 'multi-sectoral approach' has been highly effective in shaping communication strategies, in the development of condom distribution plans, in creating organisational structures, and, ultimately, in changing behaviours in ways that led to lower incidence and the decline in prevalence. The idea for the UAC began to be discussed in the period from 1988 to 1991, with the MACA framework being developed from July 1991.²² It involved a broad grouping of social scientists, medical scientists and doctors, together with specialists in agriculture, statistics, development and other fields and the managers of ACP programmes in government and the private sector. According to a number of people interviewed, the first plan developed by Uganda was presented to WHO and the World Bank for funding. WHO, in particular, was

¹⁹ Uganda AIDS Commission 1993: x-ix.

²⁰ Kagimu, Marum et al. 1996.

²¹ Uganda AIDS Commission 1993: vi-vii, (para. 7 & 8).

²² Uganda AIDS Commission 2002; Uganda AIDS Commission 1993: vii (para. 13).

said to have rejected the first plan, claiming that the HIV problem was largely medical, and therefore should be managed by medical specialists. Several consultants were brought in by World Bank and WHO to advise on the plan that called for a 'multi-sectoral approach', that is, an approach that would seek to coordinate responses and interventions from government, NGOs, FBOs, CBOs and other community-based, or even informal organisations that were beginning to be acutely aware that AIDS now affected virtually every aspect of life. Finally, with assistance from the Center for Disease Control in Atlanta, Georgia, USA, a comprehensive and successful plan was put together that would ultimately fund the UAC. The UAC secretariat was set up and began immediately to develop plans for the 'multi-sectoral approach' that would eventually lead to the establishment of formally appointed AIDS-response contact personnel, called 'Focal Persons', in all 'line' ministries, and co-ordinate the activities of the now large and growing number of organisations in civil society, including Christian and Muslim FBOs, trade Unions, the Uganda Federation of Employers, schools, NGOs and CBOs across the country. In practice, however, most of the activity in the 1990s and up to the present is still located in the southern part of Uganda due to the security situation in the north. Only the lower tier of towns north of the Nile-Mt. Elgon line that roughly bisects Uganda, such as Gulu, Apac, and Lira have received adequate attention. The UAC immediately ran into more political difficulties because of its location in the Office of the President. The AIDS Control Programme (ACP) had already been established in the Ministry of Health in 1986. As the first government-initiated and funded formal response to AIDS, the ACP believed that it should continue to take the lead in shaping the response from government. The UAC was criticised as being too political, too policy orientated, and too diffuse in its direction since it included many people who were from fields other than medicine. The ACP, by contrast, was controlled by medical specialists and led by Dr. Kihumuro Apuuli, a medical doctor. Eventually, Dr. Apuuli was appointed by President Museveni to the Directorship of the UAC. From this position, Dr. Apuuli was able to coordinate the AIDS Control Programme within the Uganda AIDS Commission. This resolved, within this new overall framework the political problems concerning which organisational unit or which type of educational specialisations would control the government response. It was an astute move, and had significant benefits. By contrast, as late as the end of 2006, the national AIDS policy in South Africa was still directed from the President's office, with the Deputy President in charge. This has critically exacerbated the political conflict over AIDS in South Africa.

The organisational location of the UAC in the Office of the President, rather than in a ministry, gave it the power it needed to implement and coordinate policy. That 'national policy on AIDS that this document articulated stressed that

All Ugandans have individual and collective responsibility to be actively involved in AIDS control activities in a coordinated way at the various administrative and political levels down to the grassroots level. The fight against AIDS is not only directed at the prevention of the spread of HIV but also addresses the active response to, and management of, all perceived consequences of the epidemic.²³

The inclusiveness of this policy is extraordinary, and powerfully enabling. It directs attention to both individual responsibility and to collective efforts, and pointed out that effective AIDS control should not limit itself to prevention alone, but address the both real and 'perceived' consequences, while managing the response both administratively and politically. Moreover, the document envisioned a fully coordinated and total response:

²³ Uganda AIDS Commission 1993: vii.

The process of preventing HIV infection, and controlling its consequences by various organisations and individuals in the country should be comprehensive, and sensitive to all aspects of the epidemic and emphasise capacity building for sustainable activities among sectors and individual organisations.²⁴

This policy was predicated on the belief that ‘the current trend of the disease will not change much’²⁵ and conceptualised the response as a process rather than as mere administrative structures. It focused on a number of key political principles that had already been articulated by the Museveni government:

- ‘strengthening the role of women in development’;
- ‘decentralisation of planning and service administration’;
- ‘promotion of self-reliance and community empowerment’;
- ‘development of close partnerships between Government and NGOs and CBOs’;
- ‘continued strategic political will and support for AIDS control’;
- a demand for ‘positive public response to AIDS that will include rapid and substantial behaviour change’;
- ‘allocation of resources at all levels of Government ... increasingly ... in favour of HIV prevention and response to the effects of the epidemic’; and
- mobilisation and sensitisation of the public on the impact of AIDS’.

These were the keystones of Uganda’s multisectoral AIDS approach, but they also constituted major moves in the direction of national reconstruction more generally. The AIDS control programmes became part and parcel of the process of political reform that was being led by the new government. In practice, this policy had already been in effect for some time, while MACA represented the formulation and articulation of what was actually happening on the ground. It was a uniquely Ugandan initiative, and it noted that while ‘international support and assistance’ were welcome, it ‘will not unduly influence national priority interventions.’²⁶ It was built on a number of the principles of Museveni’s ‘Ten Point Programme of the National Resistance Movement’ that called for, among other things, the restoration of democracy, the restoration of security of person and property, the consolidation of national unity and elimination of all forms of sectarianism, and building an independent, integrated and self-sustaining national economy, and restoration and improvement of social services.²⁷ Significantly, MACA was not just a government initiative or ‘plan’. It called for ‘behaviour change’ on the part of individuals and families, and tied the struggle against AIDS to an overall development strategy and to strengthening of democracy, personal security, and human rights. It broadened the base of AIDS prevention strategies to include all parts and all levels of society. It explicitly sought to empower women, and to build institutions of civil society. Moreover, it articulated a belief and a means for all of these to work together.

While MACA was exceptionally comprehensive, it does not mention what has come to be called the ‘ABC’ approach. Instead, it calls for ‘behaviour change’ across the spectrum of

²⁴ Uganda AIDS Commission 1993: vii.

²⁵ Uganda AIDS Commission 1993: x (para. 21.g).

²⁶ Uganda AIDS Commission 1993: x (para. 21. f).

²⁷ Museveni 1997: 217.

sexual practices. It notes that several ‘demographic and social factors’ require attention, including

- early initiation of sexual activity (noting that 75% of both male and female children have had sex by age 17²⁸);
- migration and mobility (noting that there is rapid urbanisation in what has been a overwhelmingly rural population with ‘breakdown of traditional moral instruction’);
- a ‘knowledge versus moral and behavioural change gap’ (noting that Ugandans are already overwhelmingly aware of HIV and AIDS but that, despite this, ‘change of sexual partners is often rapid and sexual intercourse outside of regular relationships is frequent’ with ‘dispersed and interlinking networks of sexual contacts’);
- economic survival strategies linked to sexual risk (noting the effects of war, rape, disruption of family structures, poverty, illiteracy, and ‘increased use of sexual activity by women as an economic survival strategy’);
- biological factors including STDs and blood-borne risks;

and

- cultural practices, including language and communication issues, gender relations and alcohol use.

MACA insisted that ‘all of these issues have to be addressed in order to control the HIV/AIDS epidemic, and that ‘a multiplicity of behaviour options have to be encouraged’.²⁹

The MACA document is particularly explicit in calling for change in cultural practices, and details these in several sections. It notes, for instance, that

Certain socio-cultural practices have contributed to the rapid and sustained spread of HIV/AIDS. For example, inheritance of widows is quite common, scarification for treatment using a common instrument, uvulectomy³⁰, tooth extraction, circumcisions, tattooing. Overnight parties with open access to alcohol and sexual laxity are a regular occurrence at last funeral rites in some areas of the country.³¹

Under the heading of ‘cultural practices’, the MACA document also highlight the plight and role of women in Uganda as particularly burdened by care of AIDS patients, more likely to be infected, and often culturally dis-empowered.³²

While Uganda’s policy integrated AIDS control measures into the national reconstruction programme and political reform, it was also revolutionary in its straightforward discussion of cultural practices and the complex role that sexual practices played within systems of kinship, religious and ritual life, gender, language and communication practices, migration and mobility. It was, in effect, a manifesto for revolution.

²⁸ There is no attribution of source for this figure.

²⁹ Uganda AIDS Commission 1993: 26-27.

³⁰ ‘Uvulectomy is the removal of the uvula, or soft tissue at the back and top of the throat, something like an tonsillectomy.

³¹ Uganda AIDS Commission 1993: 27.

³² Uganda AIDS Commission 1993: 36.

AIDS AND 'CULTURAL PRACTICES'

Here, Uganda stands out among other African governments in *specifically naming and describing* African cultural practices that lead to risk. Uganda stands out, then, in integrating the struggle against AIDS into local cultural forms and practices. Focus Group discussions universally mentioned these practices, among others, as major contributors to HIV risk. Elsewhere in Africa, and even in the past in Uganda, cultural practices having to do with sexuality were rarely talked about, and certainly not openly criticised.

It was also exceptional in seeking to empower and promote positive traditional African cultural practices such as those of traditional healers (traditional medical practitioners), including traditional surgeons (who perform circumcisions, uvulectomies, and tooth extractions³³), traditional birth attendants, and 'syncretic practitioners' who use herbal treatments often in conjunction with bio-medical treatments. The document states that 'The Commission will collaborate with all these groups which are essentially concerned with *body healing* [emphasis in original], adding further that 'spiritual and physical diviners will also be educated and guided. This policy led to the foundation of a national organisation of traditional healers, also founded in 1992, named THETA (**T**raditional and Modern **H**ealth Practitioners **T**ogether against **A**IDS and other diseases). It was started by TASO and by Médecins sans Frontières, initially as a research initiative.³⁴ Dr Balaba explained,

The HIV epidemic was a mystery. People were dying, it must have looked like a god was unhappy somewhere. So people went to traditional healers. It started off as research. We wanted to know what they had to offer. So we started with research; this involved over 500 clients. We were looking at *Herpes zoster*. We provided clients with herbs, comparing [their use and effectiveness] to a control standard. What we found out is that these were effective against *herpes zoster*, chronic diarrhoea, and comparing against western treatment. That success is what prompted us to start a programme. We realised that traditional healers were respected. When they talked to people, people believed in them. We tried to see if they could communicate. We found out that they were natural counsellors. We found out that they were good counsellors.³⁵

³³ The removal of the foreskin of the penis (male circumcision) is practiced in some areas in Uganda, but not all (especially not in Buganda). Removal of teeth and the uvula are related to traditional medical beliefs. Female circumcision is not practiced traditionally in Uganda, but may exist in Muslim-majority parts of the north due to contact with Islam in the Sudan.

³⁴ Interview: D. Balaba, THETA, Kampala, 3 July 2003.

³⁵ Interview: D. Balaba, THETA, Kampala, 3 July 2003.

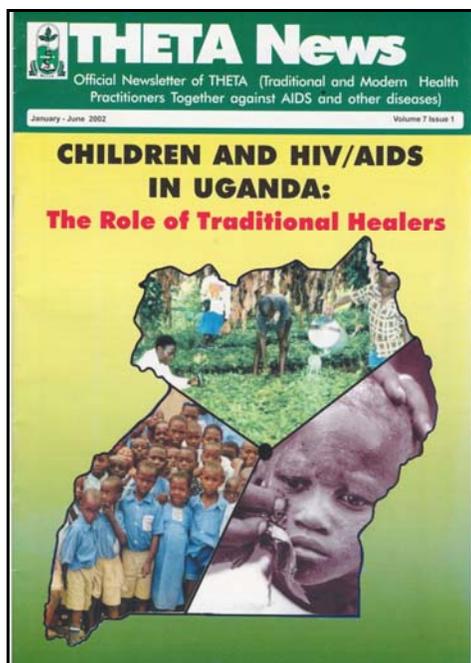


Figure 7.1. *Theta News*, Official newsletter of the ‘Traditional and Modern Health Practitioners Together against AIDS and Other Diseases’ (THETA).

Dr. John Rwomushana, current UAC Director for AIDS Research and Policy, told me that he, in particular had supported the inclusion of traditional healers in the MACA plan since this was a central institution of African culture. He acknowledged that there had been resistance from others, especially other medical doctors.³⁶ Dr. Rwomushana served as the first chairman of THETA. Today, THETA publishes a newsletter three times a year and is involved with intensive training of traditional health care practitioners throughout Uganda.³⁷

The MACA strategy for behaviour change was similarly comprehensive. It called for ‘sustainable behaviour change’ and ‘risk reduction’ through the following measures to be taken:

- Create and sustain peer and community behavioural support resources groups;
- Improve access to HIV testing and individual counselling;
- Improve access to STD diagnosis and treatment facilities, through training for health workers and healers, plus improved testing and treatment guidelines;
- Establish a better provision for condoms, through improved procurement, storage and distribution system;
- Ensure provision of IEC in various formats for presentation in community meetings;
- Facilitate provision of health care and condom dispensing sites near job locations; and
- Develop and promote guidelines on family housing at work locations, linked with adequate support and work opportunities for spouses to keep families together.³⁸

³⁶ Interview: Dr. John Rwomushana, Uganda AIDS Commission, 29 July 2003.

³⁷ Interview: D. Balaba, THETA, Kampala, 3 July 2003.

³⁸ Uganda AIDS Commission 1993: 33.

As thorough as the UAC's MACA document is, however, nowhere does it mention the 'ABC' programme that has been recently associated with Uganda's approach to controlling the spread of HIV. Instead, it seeks to embed activities aimed at the control of HIV in a broad social framework.

Of course, the 'multi-sectoral approach', as such, was not meant to address specific behavioural interventions. If anything, it emphasises condoms, changing cultural practices, and control programmes embedded in government ministries and other organisations. (One is tempted to call it the 'CCC' approach.) This approach has guided virtually everything that Uganda has done in combating AIDS through the 1990s up to the present. The emphasis on a total socio-political integration, and the attempt to change behaviour through programmes that are embedded in the larger social, cultural and political fabric of Ugandan life, gives the MACA an especially African character. It subordinates the emphasis on the individual—a characteristically Western approach—to the social and the cultural context. In particular, Uganda has been exceptional in the development of support programmes for PLWAs through TASO and in the roll out of voluntary counselling and testing (VCT).

The Uganda AIDS Commission, through MACA and the implementation of the 'National Operational Plan', has also sought to continuously monitor its progress. Developments through the middle of the decade reflect this.

Condom imports and distribution rose swiftly after 1992. An estimated 12 m condoms were sold and/or distributed in 1993³⁹ as USAID and other organisations expanded reproductive health services. There is little reliable data on total numbers of condoms distributed in Uganda, but a compilation of figures from multiple sources shows that the number available greatly increased only after 1992 (see Figure 7.2). Contrary to a wide-spread belief—propagated by the US President George W Bush, and the Heritage Foundation, a conservative research centre—that condoms played little or no role in Uganda's HIV-prevalence decline,⁴⁰ millions of condoms were in fact distributed in Uganda from the mid-1980s. USAID began to import condoms in 1985 even before the Museveni administration took control of the government and while fighting continued. The International Planned Parenthood Foundation began distribution in 1989, while the United Nations Population Fund and the World Health Organisation joined the effort a year or two later, pushing condom availability from these sources alone to over 10 million a year. USAID's shipments continued to increase into the mid-1990s before beginning to fall, but many organisations began to provide large numbers of condoms through the rest of the 1990s including The German Development Bank, Kreditanstalt für Wiederaufbau (KfW, 'Reconstruction Credit Institute'), the UK's Department of International Development (DFID), Population Services International (PSI), Marie Stopes International, Pathfinder International, and others.⁴¹

In addition, the Ugandan government itself sourced, manufactured and distributed condoms through the Ministry of Health, and later through brand names Protector, Lifeguard, and Engabu (meaning 'protector' or 'shield' in Luganda). Precise numbers have been difficult to ascertain, but estimates are given in Figure 7.2.

³⁹ Kagimu, Marum et al. 1996.

⁴⁰ The Heritage Foundation 'Briefing document', cited by the Bush administration in support of its negative policy on condoms said, 'Condoms do not play the primary role in reducing HIV/AIDS transmission' (Loconte 2003).

⁴¹ See Kirby 2004 for summary of condoms distributions and sources.

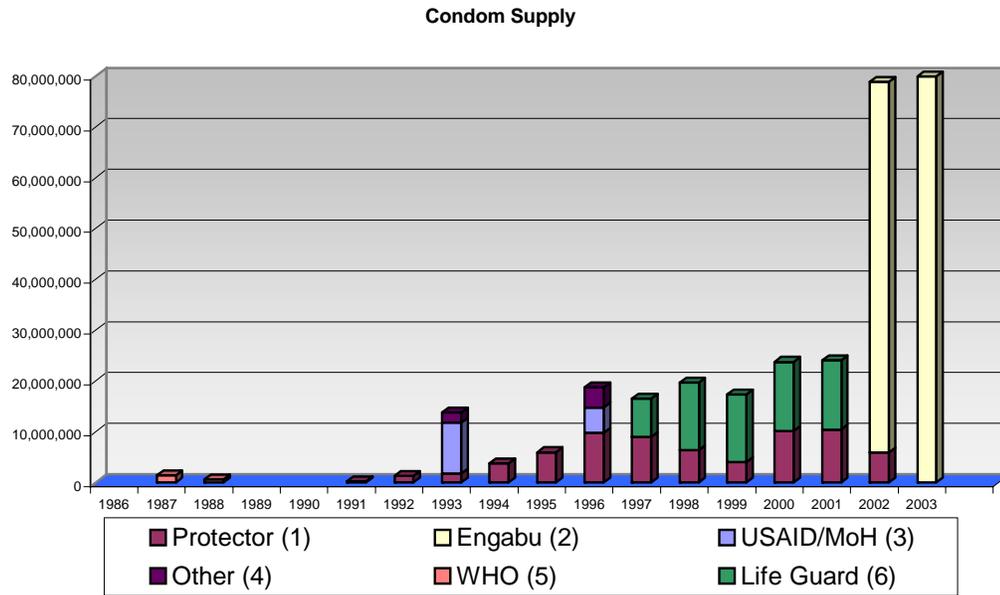


Figure 7.2. Partial compilation of total condom imports and local distribution in Uganda, 1987-2003.

Notes to Figure 7.2.

- (1) data from 'Protector Sales from Launch Date'; provided by Twebese Rukandema, Commercial Marketing Services (CMS), Kampala
- (2) data from 'Condom distribution plan (Draft) Sept 2002', The condom Coordination Unit, STD/ACP, Kampala. These are apparently projected figures. (Ministry of Health, Uganda 2002c)
- (3) Kagimu, Marum, et al. 1996 'Review of AIDS Prevention and Control Activities in Uganda. IMAU/Makerere. P.14
- (4) Kagimu, Marum, et al. 1996 'Review of AIDS Prevention and Control Activities in Uganda. IMAU/Makerere. P.14
- (5) New Vision' newspaper article. Feb 20, 1987 1.4 million available, 600,000 'on the way' (for 1988?)
- (6) Data interpolated from Hogle et al 2002, 'Number of social marketed condoms sold in Uganda' source: Deloitte Touche Tohmatsu, Commercial Marketing Services, Uganda Report 2001

International donors stepped in to help. The UNDP funded AIDS control programmes in at least 11 ministries, including Ministries of Gender, Education, Agriculture, Internal Affairs (Police and Prisons), Justice, Finance, Public Service, Local Government. DANIDA (Denmark) assisted with funds for TASO, also funded by USAID. The World Bank supported the blood screening for the National Blood Bank, and provided \$75 m in loans for the implementation of a Sexually Transmitted Infections Programme (STIP). In order to evaluate the effectiveness of this programme, the collaborative Rakai project began a five year study to examine the effect of modified mass treatment of STDs on the incidence and prevalence of STDs and HIV infection. Other donors included CARE, World Learning, CONCERN, AMREF, World Vision.⁴² The first UNAIDS Country Programme Advisor was posted to Uganda in 1996.⁴³

⁴² Kagimu, Marum et al. 1996

⁴³ Uganda AIDS Commission 2002

By the end of 1995 Uganda organised and hosted the International Conference on AIDS and STDs in Africa (ICASA). At this conference it announced for the first time what appeared to be an observed decline in HIV prevalence. By then 48,312 cases of AIDS had been officially reported⁴⁴, but the true number was estimated to be around 340,000.⁴⁵

Numbers of new statutes were passed by parliament in order to discourage discrimination based on HIV status, and to add additional support for AIDS and HIV interventions. The Children's Statute of 1996, for instance, encouraged community care with support to families who care for orphans. As a result of this, as little as 1% of all orphans are housed in public institutions.

SUCCESS ACKNOWLEDGED

During 1996-97, a comprehensive review of AIDS control programmes was conducted by the Uganda AIDS Commission, Ministry-based AIDS Control Programmes (ACPs), UNAIDS, and representatives of NGOs.⁴⁶ It found, for instance, that overall knowledge of HIV/AIDS in Uganda was extremely high, and that many strategies for risk reduction and behaviour change had been implemented. Cultural practices involving multiple sexual partners were effectively discouraged throughout the country. Approximately 300,000 were reported to have benefited from AIDS Information Centres (AICs) provided Voluntary Counselling and Testing (VCT),⁴⁷ in addition to other benefits provided by Uganda's strategy. The report noted that,

'Virtually every component of the WHO recommended Global Strategy for responding to the AIDS epidemic has been implemented in Uganda, including intensive education campaigns, condom education and distribution, voluntary HIV testing and counselling, STD treatment and control, and the provision of safe blood supply. Programs to provide long term supportive care and terminal care for persons living with AIDS have been implemented in many areas, and counselling has become available in many areas. Persons living with AIDS have formed associations both to provide mutual support and to educate communities about HIV prevention. Numerous efforts have been developed to reduce the social and economic impact of the epidemic on individuals, families, communities and the society at large. Uganda's efforts to control and respond to the AIDS epidemic have been greatly enhanced by strong political leadership and will at every level. There have also been commendable efforts to mobilise and unify the response to the epidemic at the external, national, district and community level including the establishment of the multi-sectoral Uganda AIDS Commission, line Ministry AIDS Control Programmes, and District AIDS Coordinating Committees'.⁴⁸

In addition to the huge success of these programmes based on the multi-sectoral approach, there were a number of significant developments in bio-medical treatment. For instance, SOMARC, the USAID funded social marketing project, developed drug kits for treatment of STIs, especially men with urethral discharge.⁴⁹ Uganda began to participate in a study designed to examine the effectiveness of Nevirapine, an anti-retroviral drug (ARV) on Mother-to-child transmission of HIV.⁵⁰ The Government of Uganda established a Drug Access Initiative that

⁴⁴ Ministry of Health, Uganda 1996.

⁴⁵ Uganda AIDS Commission 1993: 7.

⁴⁶ Kagimu, Marum et al. 1996.

⁴⁷ Kagimu, Marum et al. 1996.

⁴⁸ Kagimu, Marum et al. 1996.

⁴⁹ Kagimu, Marum et al. 1996.

⁵⁰ Uganda AIDS Commission 2002

sought to advocate for reduced prices on ARVs and to support infrastructure to administer them, while the National Institute of Health (NIH) began providing research grants to American scientists to study the HIV epidemic and to test and identify effective treatments.⁵¹

Following the glowing review it received for its programmes, Uganda began to develop a new National Strategic Framework for HIV/AIDS. In particular, it sought to further integrate AIDS control programmes into the context of national development goals. AIDS activities became part of the Poverty Eradication Action Plan (PEAP). At the same time, the Local Government Act of 1997 re-organised and decentralised government services, with financial and administrative devolution to District level of education, medical and health services, social development activities, and management of remedial welfare programmes, welfare of children and elderly. Since all of these services and agencies involved an AIDS component, this meant that control over AIDS programmes was also devolved to a level closer to the community. The effect of these interventions, and their overall effectiveness can be inferred from the average national prevalence among adults which fell from 18.5% in 1995, to 14.7% in 1997 9.5 in 1998, to 8.3% at end 1999. In 2001, Uganda received a further \$50m in loans from the World Bank to secure and to support all AIDS activities in all sectors at national, district and community levels.⁵²

Notwithstanding the effectiveness of Uganda's response, cumulative AIDS deaths had mounted to 947,552⁵³ by the end of 2001, and there were approximately 1, 050,055⁵⁴ people living with AIDS out of a total population of 24 million (4%), while even more HIV+ people had yet to manifest symptoms.⁵⁵

Clearly, even though the incidence and prevalence has dropped, Uganda was still left with a major challenge. Remarkably, it seemed ready to deal with this. The growth of agencies and institutions in civil society that had been enabled and empowered by the Ugandan approach was exponential. A sample of local organisations, NGOs, CBOs and FBOs that dealt specifically or in part with HIV or AIDS showed tremendous growth during the 1990s and up to the present. Figure 7.3 shows this remarkable development.⁵⁶

⁵¹ Uganda AIDS Commission 2002

⁵² Uganda AIDS Commission 2002

⁵³ 427,153 women, 425,644 men; 852,797 adults, 94,755 children

⁵⁴ 531,909 women; 413,591 men; Adults 945,500; 105,055 children < 15 years.

⁵⁵ Ministry of Health, Uganda 2002a: 22; UNDP 2002: 27

⁵⁶ Data from files in the administrative offices of the Uganda Network of AIDS Service Organisations (UNASO), Block 10, Plot 264, Nakulabye, Balintuma Rd., Kampala, Uganda.

Cumulative N of HIV/AIDS Organisations Registered with UNASO

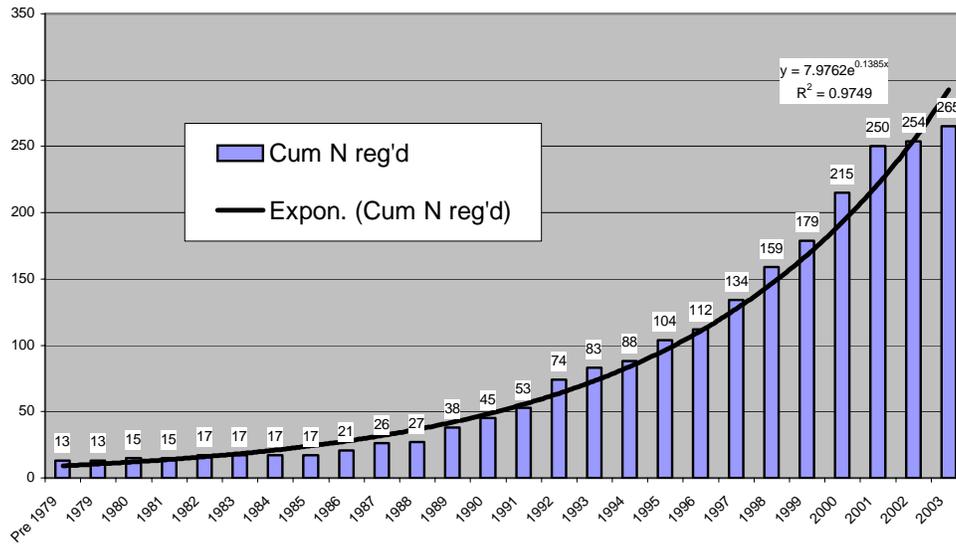


Figure 7.3. Cumulative growth of NGOs, CBOs and FBOs (by date of registration to provide HIV/AIDS services) dealing wholly or in part with HIV and AIDS. (Data from files in the offices of Uganda Network of AIDS Services Organisation, Nakulabye, Kampala.)

This fact that this curve is almost perfectly exponential ($R^2=0.9749$), rather than linear, suggests that each of these civil society organisations was responsible for the establishment of others. In effect, the creation of such organisations has been organic, with each one reproducing itself several times over. This in fact seems to be the case. The MACA policy, and the overall encouragement of the development of a civil society response by government, and by international donor funding, has led to the spawning of numerous ‘spin-off’ organisations, as the goals and tasks of each organisation grew and specialised. For instance, TASO and *Médicins sans Frontières* created THETA. This sort of organic process has been at work from the late 1980s with an exponential growth in HIV/AIDS related organisations the result. This has greatly enhanced the ability of government to cope with the HIV/AIDS problem in Uganda. Significantly many of these organisations are also involved in economic development projects of all kinds. They represent, too, a tremendous growth of democratic ideals and grassroots involvement.

Uganda, then, has not only been successful in decreasing HIV prevalence throughout the country, but has leveraged its response to HIV/AIDS into an effective and pervasive commitment to economic growth and social empowerment. The establishment of the Uganda AIDS Commission successfully managed political conflict by placing control of the AIDS programmes in the hands of independent administrators, most of whom were highly qualified professionals rather than politicians. While government response was probably not effective in lowering HIV levels, especially in clusters of high-density sexual networks, it probably did have the effect of helping to eliminate some of the contacts across these clusters, and thus bringing about the collapse of the network that did result in rapid HIV declines overall. While prevalence remained high in many areas and locations, the transmission of HIV across the country as a whole was disrupted through the integrated efforts of government and civil society. Neither similar efforts nor similar results have yet been seen in South Africa.