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The Politics of HIV/AIDS in Africa: Ugandan HIV/AIDS Prevention Policy in Conflict with the Western Prevention Policies

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Uganda had the highest HIV/AIDS prevalence in the world. Between the late 1980s and 1990s, at a time when HIV/AIDS was well on its way toward ravaging Sub-Saharan Africa, Uganda achieved an extraordinary feat by lowering the rate of HIV prevalence in Uganda by 70%. It stopped the spread of HIV/AIDS and the nation's rate of infection was plummeted. Thus Uganda became a model of successful HIV/AIDS prevention for Africa and the world in general. As words of the "Uganda miracle" spread, journalists, researchers, policymakers and advocates all descended to ascertain how Uganda's dramatic decline in HIV prevalence was accomplished, since Policymakers around the world look up to Uganda as a role model in the fight against HIV/AIDS. The question is what happened in Uganda?

Uganda has two moments of HIV/AIDS response: the pre-1991 and the post 1991 responses. The first was based on abstinence and faithfulness through face-to-face Information, Education and Communication (IEC) to Ugandans at all levels in order to fight the disease called "Slim" (as HIV/AIDS was called). Uganda launched this prevention strategy in 1986 in a rather crude message of "zero grazing"[1]. The priority order was: Abstain, Be faithful, or use Condoms if A and B is impossible (ABC prevention model). President Museveni developed this model suitable to the economic and sociocultural realities of Uganda, which differed quite considerably from the model being urged by foreign experts.

The post 1991 moment on the other hand, is based on the medical/technical (condom) model introduced by foreign AIDS experts in the early '90s in many countries of Africa and world over. In this second instance too, Uganda shares policies with other countries; but the Ugandan pre-1991 policy is indigenous to the country.

As early as 1993 however, evidence of abstinence and fidelity known as "Primary Behaviour Change" (PBC) not anticipated by global AIDS experts emerged in Uganda. It lowered its HIV infection rate from 21 to 6 percent between 1991 and 2001[2]. Uganda's response was a rapid approach to HIV/AIDS seen primarily as a behavioral issue requiring behavioral solutions, rather than merely a medical problem requiring only medical solutions. With this success USAID and President Bush administration adopted the Ugandan PBC strategy as a model of HIV prevention. Until then, PBC model was the emphasis of some faith communities while condom is the major component of many Western governments and donor organizations. For over twenty years Condom-only strategy has been the officially mentioned HIV/AIDS prevention. Abstinence and fidelity were absent in the official projects or they were there simply in name to deflect criticisms. No reasonable portion of resources was put into such program that has a proven public health intervention. With the adoption of PBC, there engendered interests on both sides of the social-political spectrum, giving rise to the liberal-conservative controversy of the "condoms-only" people as against the "abstinence-only", known as the "ABC Controversy". This present work however, primarily surveys the contribution of the

PBC in the struggle against HIV/AIDS, especially in Uganda (Africa). How far has PBC fared in prevention of HIV/AIDS? This and some other issues alike constitute the politics of HIV/AIDS in Africa.

The precise size and timing of the HIV declines in Uganda are difficult to pinpoint because of limited data in the late 1980s and early 1990s. Determining the extent to which PBC and other prevention programs influenced the overall decline in Uganda's HIV rates is a highly charged political issue[3]. But, critical survey of the PBC strategy throws some light on how it strolled down HIV/AIDS prevalence in Uganda. We now know that the rate of new HIV infections in Uganda started to decline in the late 1980's, and that foreign experts began showing up in force in Uganda only in the 1990's. Still more, about the 1980s, when the epidemic began to slow down, there were very few condoms in Uganda. Condoms became widely available only after the experts appeared[4]. In the 2004 World AIDS Conference in Thailand, President Museveni testified that his country was able to achieve their success through abstinence[5]. Data shows that between 1989 and 2000, Uganda witnessed in abstinence "a two year" delay in the onset of sexual debut among youth ages 15-24[6], and among the unmarried 94.8%[7]. Cohen too, testified that AIDS workers even as they pay homage to the ABC mantra in Uganda, the kind of sex education Ugandans receive is: «A for unmarried people, bolstered by advocacy of B, but for most people, "anything but C"»[8]. Prior to 1992, "Abstinence and Faithfulness" were the message delivered by everyone to everyone from President Museveni on down. Thus the proportion of Ugandans reporting multipartner fell drastically, monogamy rose to 94.4% between 1989 and 1995. Ever-use of condoms was 40% in 2000, but nearly the entire decline in HIV incidence and prevalence had already occurred by 1995. Hence, it is unlikely that any other program (condom use) contributed much to the initial stabilization or declines in HIV in Uganda, whatever its later contribution.

Condom use was not higher in Uganda than in other countries. Rather it is differences in "Be faithful" behaviours that Uganda stands out. There was far less multi-partnerism in Uganda than in other countries[9]. Most people choose the behavior change for themselves, whether or not promoted. PBC was the prevention intervention in the period 1987-1991, when sexual behaviour changed sufficiently to alter the course of an explosive epidemic in Uganda. «While the post-1991 elements are found in most countries, those countries have not been successful in HIV prevention. Therefore, the interventions of the pre-1991 period should be considered carefully since they hold the clue for changing behaviour and reducing HIV incidence in the absence of those interventions that have today become the standard package around the world»[10].

Uganda launched the prevention strategy in order to fight HIV/AIDS based on abstinence and faithfulness

In Africa, abstinence is baggage free[11]. Africans and their government say that PBC is the natural response to AIDS. Opinions of African scholars are strong on this issue. Nantulya of Uganda refers to PBC interventions as endogenous responses to AIDS in Africa. He maintained that prevention programs developed before foreign donor-driven projects exerted much influence in Uganda and Senegal[12]. For Leclerc-Madlala: «Africa should be looking not to Beverly Hills for answers to AIDS, but to Uganda, where people change their behaviour»[13]. She reiterated that Uganda's experiences suggest that promotion of abstinence before marriage and mutual faithfulness in relationships may be the keys to halting the spread of AIDS in Africa[14].

Also Tangwa of the University of Yaoundé recently reflected on the overall response to

AIDS in Africa, and observed that the response to the HIV/AIDS in Africa has so far ignored important traditional African values and attitudes toward disease. To deal with this epidemic, «the world should consider respect for, and possibly even adoption of those African values»[15]. Similarly, Ssemwogerere (Ugandan leader of youth group concerned with AIDS) reflects as follows: «I am convinced that the longer one takes before getting into sexual intercourse the more careful they get before getting into it at a later stage as they become adults or mature. If we convince our children and youth to abstain for now, they will certainly make better choices when they finally decide to get into sex (marriage). The same applies to adults. Those who have told themselves that condom is not the solution are not easily taken for a sexual ride. Abstinence is a better approach than throwing condoms around and expecting people to use them at all time. Once, twice, thrice with a condom and then one time without, what next?»[16]. African leaders would prefer to promote the behaviours that Africans say in surveys they are turning to. That is: «To stop having multiple sexual partners, unless they do, "they will continue to be infected and pass HIV to their wives and girlfriends, and through them, to their children. This is not some kind of a moralistic or socially conservative, pro-abstinence and monogamy message. This is Sociology 101»[17].

In 2004 the World AIDS Day, about 150 global AIDS professionals, including representatives of UN, WHO, World Bank, as well as President Museveni of Uganda and some religious leaders who gathered to examine the ABC controversy recommended that in both generalized and concentrated epidemics the priority should be for young people abstinence or delay of sexual onset as the best way to prevent HIV and other STIs and unwanted pregnancy; for sexually active adults mutual fidelity with an uninfected partner[18]. As a general rule, even if the risk reduction be necessary to high-risk groups, at the same time, PBC should be promoted among them. Each organization can focus on the part(s) they are most comfortable supporting. However, all people should have accurate and complete information about different prevention options of the ABC approach[19]. This stand endorses PBC. It also represents a fairly marked departure from many previous policies which tended to promote condom as the first and only line of defense for all sexually transmitted STIs.

The strength of these points is that the risk reduction approach should not be imposed on people. Insisting that Africans rely on Western technological fixes that do not even directly address risky sexual behaviour would be illogical. This however, does not mean that harmful indigenous norms would not be modified or changed.

Far from discrediting other strategies as having no place in the AIDS fight, this study shows that something else is working in HIV prevention other than the business as usual concept. «The take-home message is that the PBC cannot be written off as cultural-historical-geographical anomalies of Uganda. When PBC is actively promoted, we are building upon and enhancing what people are already inclined to do, and indeed already doing. PBC is what happened in Uganda. It has happened elsewhere in Africa and in the world as well, compared to the condoms which have not been effective anywhere»[20]. It makes public health sense to build upon what people already do rather than put all or most of AIDS prevention resources in promoting an alien technology, something that involves monetary costs to the people and that needs to be constantly re-supplied in vast quantities[21]: «It makes sense if promotion of PBC can be shown to reduce HIV transmission significantly…It should be "Anthropology 101" to approach behaviour change interventions in ways that are culturally acceptable, even apart from effectiveness considerations»[22].

Uganda pioneered the best balanced and successful implementation of the ABC approach[23], through simple PBC model, which exactly provides the needed change in the AIDS crisis. The President Museveni himself

spearheaded the awareness campaigns. In 1986, Museveni swiftly embarked on a nationwide tour, and in face-to-face interactions with Ugandans at all levels. Fighting the epidemic was a patriotic duty requiring openness, communication, and strong leadership from the village level to the State House[24]. The presidential commitment served as a springboard[25]. Ugandans saw that the PBC is in their common and personal interest. They did the right thing once they were provided adequate information. They understood that the control of HIV/AIDS lies with themselves and not with other third parties. Thus they embraced PBC, all sectors, including people living with HIV/AIDS (PLWHAs) in a unique manner promoted the same message (PBC) in different ways through a multiplicity of approaches and programs. Here, in fact lies the miracle of Uganda in rolling down HIV/AIDS. Since no other country can match Uganda's 66% decline in HIV prevalence, it became the first African country and the first in the world to experience HIV prevalence decline[26]. «Abstinence and partner reduction are the factors of greatest importance in the interruption of sexual networks and HIV dynamics in Uganda. In fact, in Uganda, partner faithfulness became part of cultural movement that changed the way Ugandan society viewed sexual experience, especially among young people»[27].

In Uganda the abstinence and faithfulness determined the decline in rate of HIV prevalence

The remarkable aspect of the Ugandan PBC is its replicability prospects. Already, other African governments are adopting the PBC approach. It has been implemented in Senegal by Abdou Diouf and in Zambia by Kenneth Kaunda. Zambia witnessed significant declines in HIV infection rates among youth in the 1990. Also Kenya, Jamaica, and Thailand's general population may provide the most recent examples of successful implementation of PBC. In Kenya for instance, the major response to AIDS before 1999 was condom, and there was little or no impact on the pandemic. Finally, the Kenyan government implemented ABC with emphasis on PBC. Evidence from Kenya DHS data from 1998 and 2003, shows a little change in condom use, but significant increase in proportion of unmarried people reporting no sex in the past year, and about 50 percent decline in the proportion reporting more than two partners in the past year both men and women[28].

Obviously, PBC is evidence-based. It is an indigenous, naturalistic and African idea to AIDS prevention: «It is a behaviour reflecting the natural law that the mind and heart of all men and women of goodwill can recognize if un-ambiguously guided». Of course, sexual abstinence for fertility regulation is a tradition in Africa and beyond. This is evidence of cultural affinity and religious compatibility of the PBC model. PBC has ethico-anthropological values. It is low-cost effective[29]. All these natural evidences find an easy understanding in the deep natural religiosity of our African culture. They are confirmed, re-affirmed, deepened and completed and not contradicted by the revelation of Christ[30]. Therefore the Ugandan model of behaviour change is exactly what our society needs now. Based on the scientific, anthropological, ethico-cultural and Christian validation of policies and best practices of some African countries and beyond with successful HIV/AIDS prevention programs: «Abstinence and fidelity are the only 100% preventive measures against HIV/AIDS. They are rooted in the human survival instinct and therefore universal. They are common human virtues and more effective means of controlling the HIV epidemic than any vaccine that will be developed in the future. They are evidence-based, and promote the core African values of virginity and fidelity in marriage. Obviously therefore, chastity before marriage and dur-

ing marriage is our greatest protection».

Given that only less than 1% of the world's population is infected with HIV, we have 99% to take care of. It is therefore ethical that abstinence and fidelity remain the cornerstone to HIV prevention. This absolute emphasis on prevention – quite obvious at the time when no treatment was known – must not be put aside, especially now when a treatment – not a cure – has become available[31]. «"Eternal vigilance is the price of freedom" and "prevention is better than cure". It is far more economically beneficial to prevent HIV infections than to treat people with AIDS or deal with the consequences of widespread illness and mortality»[32].

This work therefore is a call to try something else than the business as usual condom-maxim since condom promotion has had a poor record of producing lower HIV infection rates, especially in generalized epidemics[33]. As a public health intervention, condom would be an invalid health option. It would be a misdeed to Africa, her culture and life. AIDS prevention programs should not bet all their money, or even most of it on the condom solution[34] - a program that quickly reaches a point of diminishing returns.

Unfortunately, there have been confusion and resistance, political and ideological debates, misunderstanding and misrepresentation by the international AIDS workers on the Ugandan ABC approach, thus the lack of consensus over what happened in Uganda. Many AIDS professionals still think that Uganda's success was due to condoms. Hence, only lips service is paid to PBC[35], while favoring condoms and other technological forms of risk reduction. They stress that the delayed debut and faithfulness sound judgemental and moralistic and may lead to stigmatization of those who do not or cannot follow the dictum[36]. Abstinence for them is honourable, but not a reality for AIDS death of millions of people every year[37]. They insist that condom use is the most effective means of preventing the sexual transmission of HIV provided they are of good quality and are correctly and consistently used. Their argument is that «if condoms have not produced the expected result, that means enough condoms have not been distributed in order to have the desired effect. Therefore, the solution would be to redouble efforts to test and counsel people, and then give them condoms». The pro-condom have further indicted the abstinence-only organizations for increasingly using Uganda as an example of the success of their methods, while the pragmatic sexual behaviours that took place in Uganda are certainly not a feature of the pro-abstinence-only agenda. Uganda's example cannot be allowed to be misused in this way. In fact, for the pro-condom people there is no evidence that abstinence-only educational programs were even a significant factor in Uganda between 1988 and 1995. They sustained that *Abstinence* and *Be faithful* components are no longer relevant in "mature epidemics," of Uganda, since the strict "abstinence fatigue" would also present danger as it has happened with the "condom fatigue" in United States[38]. For them the apparent condom failure is on account of the U.S. "abstinence-until-marriage" programs, which is only ploys of the U.S. political imperialism and religious conservative agenda. They have also accused the Catholic Church as directly responsible for the condom failures and the AIDS death of millions, since the Church could not adjust its "rigid" position on condom use so as to keep abreast with reality.

Investigations on some of the above allegations however, demonstrate that they are too simplistic and superficial. It is impossible to demonstrate that Catholic countries are more afflicted by AIDS than non-Catholic countries whose religions are "open" to the use of condoms. Rather, it is on the contrary[39]. Furthermore, it must be noted that the PBC approach was developed and successfully implemented by Africans, without significant involvement of the U.S. or other large donor organizations. The major organizations and agencies working in AIDS: USAID, UNAIDS, the World Bank, the

WHO, the EU, as well as implementers such as Family Health International and Population Services International, have several decades of experience in designing and implementing condom programs. They had no such experience with AB programs. And they have not put significant resources into abstinence or faithfulness interventions anywhere in the world. PBC was outside the prevention programs funded by donors until its recent adoption in 2002/3[40]. In fact: «Museveni refused to dance the way of donors (especially at the initial stage of the programs) and donors refused to give him money»[41]. African's response to HIV is to promote abstinence, faithfulness, until the advent of condoms.

One strong factor that favoured abstinence is the problem of condom morality. In Africa, condom is seen as a sordid sign of mistrust, promiscuity and a tacit approval of sexual license. Condoms prevent pregnancy. Pronatalism is so strong in Africa, even among unmarried girls. Condom strategies are incompatible with conceiving children. Often the desire to have babies may outweigh the desire to protect themselves against STIs (HIV)[42]. Also, uptake and use of condoms in Africa is affected by people's perceptions of how effective condoms are. Africans simply do not believe that condoms can protect against AIDS, despite all the Behaviour Change Communication (BCC) they have been exposed to[43]. Africans down to the villages remain to be convinced that condoms are good thing to promote to the general public. Africans abhor the use of condoms. Africans scholars and leaders decry the condom strategy as mismatch to African culture of life.

In Africa, condom is seen as a sordid sign of mistrust, promiscuity and a tacit approval of sexual license

Many government and religious leaders in Africa condemned condoms[44]. Christians and Muslims alike who believe in active promotion of abstinence discourage their governments from importing condoms since such would encourage young people to have premature sex. The Catholic Episcopal Conferences of Africa also stood firm against the deadly condom error as part of the Catholic Church's larger opposition against birth control[45]. They maintain that the Catholic Church in Africa would not accept condom or financial aid from secular NGOs to fight HIV/AIDS[46]. In a more brunt manner, the Secretary General of the Council of Imams and Preachers of Kenya, Sheik Mohammed Dor said Kenyan country would be «committing suicide» by importing 300 million condoms as planned by the government[47].

The poor use of condoms however, was not only African. It seems a general malady. In America and Europe condom use was never very high nor consistent, even among the gays during the critical moment of the mid-1980s. Condom never worked. UNAID officials and donor organizations in the 2002 International AIDS Conference in Barcelona, made a large shift from condom prevention to treatment intervention[48]. Condom promotion is seen as a double standard in the HIV prevention. It does not even qualify as a form of behaviour change. It allows continuation of previous high-risk sexual behaviour patterns by conveying a feeling of protection from the consequences of those risky behaviour. Condoms are disentangled from the symbolic nexus in which they are fused with diseases, and malevolence[49]. «PBC on the other hand, is seem a "social vaccine", which could save about 3.2 million lives in a ten-year period. This would mean the defeat of HIV/AIDS if the Condom experts did not retool Uganda's prevention efforts away from abstinence and fidelity goals»[50]. We therefore recommend that, if governments want to offer their people something more than empty rhetoric they must enhance effective PBC policy, through serious indigenous government and multisectoral commitment

to a common focus in HIV/AIDS prevention.

Secondly, the AIDS crisis as a great opportunity of interfaith relationship brings out the common denominators of all beliefs in God – issues of human dignity, human equality, human rights, preferential care for the vulnerable, God's loving care and forgiveness, human solidarity, the challenge against self-righteousness and judging others rashly. All come to the fore in all world religions. These summarize the role of the Religious Organizations in this AIDS era.

Furthermore, community-based approaches involving women and men associations, age-grades, youth organizations, health workers, local media, traditional leadership can foster new norms of sexual behaviour, like it occurred with successful zero-grazing in Uganda[51]. Parents and families have the task of communicating those values and expectations about sexual behaviour. Relevant indigenous social and cultural approaches respectful of human rights must be endorsed. The identification and direct involvement of most-at-risk and marginalized populations and people living with HIV/AIDS (PLWHAs) is essential in order to achieve the behavioural objectives necessary to reduce HIV incidence at the population level. Prevention programmes need to address issues such as stigma, gender inequality, sexual coercion, cross-generational relationships and transactional sex[52]. The global community will need to greatly expand access to services for testing, effective counselling and treatment of HIV/AIDS and other STIs, prevention of mother-to-child transmission, and responsible parenthood[53].

Thirdly, AIDS experts and donors should be applauded for generous investment in the fight against AIDS. Most donors however, have not supported the cause enough. If Uganda with very few resources in the early years of its response to AIDS could design and implement a balanced and targeted PBC program, surely the major donors with their billions of dollars can do more than at present. In fact, the AIDS epidemic offers another powerful challenge of filling the gap of authentic human development by halting the spread of AIDS[54], and also by improving the living conditions of human persons. In all dealings however, AIDS experts must always remember where they are – in Africa where people are still tradition bound, very religious and conservative. It would be unnatural to make decisions or project assumptions from a culture more distant away from African cultures. More sincerity is needed on the part of AIDS experts to accept and support PBC interventions. In this way we would be marketing ideas instead of simply condoms. Design input from Africans themselves should be involved sincerely and not just on cosmetic level, whereby the donors call the tune with their earmarked funds. Africans are more concerned with staying alive in the AIDS era than with fighting homophobia, which only perpetuates confusion and allows Uganda's achievement to be lost in the polemics of "culture wars".

The time has come to leave behind divisive polarization and move forward together in designing and implementing evidence-based prevention programmes to reduce the millions of new HIV infections occurring each year. This work will undoubtedly provoke further inquiries towards national and international strategic collaborations, program emphasis and teamwork on the factors influencing behaviour changes and the subsequent decline of HIV rates as it happened in Uganda. It also lays out the possibility for adoption and replication of the indigenous Ugandan model in countries of the world combating the HIV/AIDS epidemic.

NOTE

[1] This refers to the practice of keeping cattle within their boundaries and out of neighbours fields applied in this case to encourage fidelity. Cf. P. BAKYENGA, *Key Note Address Integral Sexuality Message. The 15th Plenary Assembly of the Association of Member Episcopal Conferences of East and Central Africa* (AMECEA), June 7, 2005, 4.

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