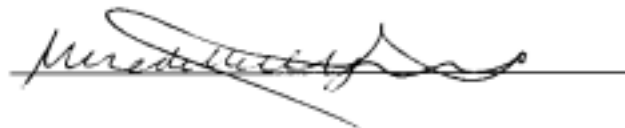


Massacre of the Millenium?
A Study of the AIDS Crisis in Sub-Saharan Africa

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Why Should We Care About AIDS in Africa?

A woman stands outside of her shanty in Uganda. She looks over her half hectare plot of matooke (green bananas), the staple food of Buganda, and her other plots in which she cultivates beans, sweet potatoes, cassava, tomatoes, chili peppers, and potatoes. Thirty-nine year old Edith provides for herself and her five children and trades some of her produce for salt, sugar, cooking oil, rice, and fish. By local standards, she seems well off, but appearances are deceiving.

Edith's husband died due to AIDS-related tuberculosis two months ago. His relatives plan to take her to court in the coming months to try to gain control of the land they insist is rightfully theirs. In addition, her three youngest children are infected with the virus and she must spend a good portion of each day caring for them. Edith also fears that she may be infected with the virus and is trying to teach her two older children how to care for the land before she becomes too sick. She often feels exhausted and overworked and because of the stigma attached to "slim disease," her relatives and the members of her township refuse to assist her. They believe she infected her husband and constantly harass her to leave.¹

This kind of case is commonplace in many parts of Sub-Saharan Africa. It paints a much different picture than the one of immune deficiency among middle-class American gay males more frequently encountered in AIDS literature. The disease received a great deal of attention in the United States in the late 1980s and early 1990s when its early victims became very sick and died. Extensive public health campaigns and the development of rapid HIV testing and life-

¹This is a fictional case adapted from a number of true cases found in the UNDP's Study Paper No. 2, "The Socio-Economic Impact of HIV and AIDS on Rural Families in Uganda: An Emphasis on Youth."

lengthening drug cocktails in the past ten years, however, have reduced the spread of the disease and decreased its prominence as an issue in developed countries.

The same cannot be said for developing countries, especially those in Africa. The struggle for everyday survival overshadows attention and concern for a virus that does not demonstrate any immediate harm. HIV finds a wealth of opportunities to thrive among tragic human conditions fueled by impoverishment, abuse, violence, prejudice, and ignorance. The unstable social and economic circumstances of many of these countries contribute to vulnerability to infection and amplify its impact. In turn, HIV/AIDS contributes to the very conditions that enable the epidemic to thrive and grow. Just as the virus strips people of their natural defenses, it can also deplete families and communities of assets and social structures necessary for successful prevention, care, and treatment of people living with the disease. With 95% of HIV-infected people living in developing countries, AIDS has become a "disease of Third World poverty rather than First World affluence."²

No one knows what AIDS will do to the economy and people's quality of life in poor countries, for nowhere has the epidemic run its course. We do know, however, the causes behind AIDS' prevalence in Sub-Saharan Africa; the devastating effects it has on families, communities, and governments; the response these entities have had to it; and what further steps should be taken to counteract its spread and destruction. Some countries, such as South Africa, have taken very few steps and rates of infection are steadily increasing. Uganda, however, serves as an elucidative model for what can occur when families, community organizations, non-

²Michael Bloor, The Sociology of HIV Transmission (London: Sage Publications, 1995), 102.

governmental organizations (NGOs), and the government make an effort to decrease the prevalence of this disease. Uganda testifies to the fact that although it is more difficult for developing countries to combat such a formidable foe with fewer resources than developed countries, it is possible, and it is definitely imperative.

The Capability Definition of Poverty

In Sub-Saharan Africa, "poverty is at its most stark and marginalization from the global economy most pronounced."³ The GDP per capita is a mere \$1,160 in Uganda and \$7,380 in South Africa, compared to \$29,010 in the United States. These are empty numbers, however, because they leave us with little idea of the quality of life experienced by the citizens of each country. For this reason, the wealth and poverty of Ugandans and South Africans ought to be determined by something more than just income.

Amartya Sen first suggested measuring poverty using capabilities and functionings rather than with a strictly monetary ruler. He believes "the basic failure that poverty implies is one of having minimally adequate capabilities, even though poverty is also *inter alia* a matter of inadequacy of the person's economic means (the means to prevent capability failure)."⁴ According to Sen, poverty ought to be defined as the incapability to achieve elementary functionings rather than deprivation of income. This argument takes into account other forms of deprivation and recognizes that a lack of income or even goods is not the only thing that could subject someone to impoverishment. The major fault with this definition, however, is that it is

³Dorothy E. Logie and Solomon E. Benatar, "Africa in the 21st Century: Can Despair Be Turned to Hope?" British Medical Journal 315 (November 1997): 1444.

⁴ Amartya Sen. *Inequality Reexamined* (New York: Russell Sage Foundation, 1992), 110.

difficult to quantify.

If we use income deprivation as the definition of poverty, we are able to measure it easily using a poverty line. To measure poverty accurately, we need to find a way to incorporate deprivations of health, nutrition, literacy, etc. into the equation. While it is not possible to quantify complex social achievements, like self-respect and active participation in the community⁵, the Human Poverty Index (HPI) serves as a valuable tool for use in developing some sort of "capability level index" for the countries being discussed.⁶ It takes into account the percentage of people not expected to survive to age forty, the illiteracy rate, the percentage of the population without access to health services, safe water and sanitation, and the percentage of underweight children under five. These measures will shed light on the socio-economic status of Sub-Saharan Africa, specifically Uganda and South Africa, and possibly give us some insight into how their poverty is related to the high prevalence of AIDS found within them.

Economic Growth and Poverty

At one time Sub-Saharan Africa was the international hope for the future. Filled with an abundance of natural resources and human labor, investors' hopes were high for this continent. In a few short years, however, everything changed. Mozambique and Angola became mired in civil war, iron-fisted autocrats took over Zambia and Malawi, Uganda's leadership changed continuously, and South Africa became "a white-run pariah state waging 'total onslaught' against

⁵While these achievements should define a capable individual, it is not possible or practical to try to measure them for an entire country. My justification for this is that although we would be leaving out certain capabilities, a "capability level index" of some sort would still be a more accurate measurement than the current income-based poverty line alone.

⁶The Human Development Report, 1999, ed. Bruce Ross-Larson (New York and Oxford: Oxford University Press, 1999), 146-147.

its foes."⁷ Africa became a continent engulfed in a pandemonium that destroyed societies and economies. Many countries, including Uganda and South Africa, have not yet recovered from these turbulent times.

On the basis of GNP per head and the fact that 55% of the population falls below the national poverty line, Uganda is among the fourteen poorest countries in the world.⁸ After taking the HPI into account, its rank improves slightly.⁹ There are many reasons for this poor international standing. From 1960-1970, Uganda had an expanding economy with a booming GDP growth rate and a comparable population growth rate. However, in the subsequent twenty-five years, the country suffered a period of military and civil unrest that resulted in the destruction of its social infrastructure and the disruption of the economy. Not until 1993, when the National Resistance Movement government initiated a recovery program, did the economy begin to pick up.¹⁰ Since then, the Universal Primary Education plan¹¹ has been initiated and economic growth has been relatively consistent.

Uganda's economy now ranks among the fastest growing in Africa at 7%¹², but before it truly can begin to benefit from its natural advantages – a favorable climate, fertile soils, and an

⁷Charles W. Henderson, "Southern Africa Hit by AIDS Explosion," *AIDS Weekly Plus*, 15 December 1997, 1.

⁸*Africa South of the Sahara*, 28th ed., s.v. "Uganda," by B.W. Langlands, Allen Rake, and Linda VanBuren.

⁹In the 1999 HDR, Uganda's HPI rank is 17th from the end.

¹⁰*Encyclopedia of Africa South of the Sahara*, 1997 ed., s.v. "Uganda."

¹¹This plan allows for free primary education for up to four children in every Ugandan family, yet 36% of adults are illiterate. Perhaps this will change as the younger generations will be better educated than their predecessors.

¹²*Encyclopedia of Africa South of the Sahara*, 1997 ed., s.v. "Uganda." Since 1993, the economy was estimated to be growing at this rate per annum.

abundance of natural resources – it must overcome some daunting obstacles. According to the Human Development Report, 54% of the population does not have access to clean water and 43% does not have access to sanitation. Twenty-six percent of children under five are underweight and 47% of the population is not expected to live to the age of forty.¹³ The latter figure is astounding and undoubtedly partially attributable to the AIDS epidemic that has been ravaging Uganda for more than fifteen years.

South Africa ranks far better than Uganda in the HPI, but its bloated status is misleading. While it is true that South Africa enjoys the most “productive, broadly based and modern economy on the African continent,” income disparities in this nation are among the largest in the world.¹⁴ In fact, about 8% of the population controls 90% of the wealth. GDP has grown considerably in the past five years, but “an estimated 40% or more of the burgeoning black majority cannot find work in the formal economy” and the average per capita income of blacks is just one-tenth the average for whites.¹⁵ While the HDR claims that only 13% of the population does not have access to sanitation and the illiteracy rate in South Africa is only 16%, other sources claim that 70% of the population live in homes lacking electricity and illiteracy among blacks is estimated at nearly 50%.^{16,17}

While South Africa in general may be improving economically, the quality of life for

¹³The Human Development Report, 1999, 148.

¹⁴The Political Risk Yearbook: Sub-Saharan Africa, vol. 4, eds. William D. Coplin and Michael K. O’Leary (East Syracuse: The PRS Group, 2000), 18.

¹⁵Ibid, 17.

¹⁶Ibid, 17-18 and The Human Development Report, 1999, 147.

¹⁷Since a majority of the population is black, if half of them were illiterate, the percentage of the total illiterate population would still be much greater than 13% (it would be at least 25%).

blacks is far poorer than that for whites, even though the Apartheid era has ended. Some experts claim that "black militancy and the general sense of frustration among the black majority will decline gradually," but others are afraid that black economic protests in the next few years will cripple the economy and lead to the emergence of an unstable regime and the disappearance of foreign aid and investment.¹⁸ Only time will tell how South Africa will deal with its post-Apartheid problems and the onslaught of HIV infections that are already beginning to have an impact on this fragile nation.

Sub-Saharan Africa definitely has a number of development issues with which to contend now and in the future if poverty in this region is to be eradicated. However, there is one issue in particular that uses the poverty of these nations to further exacerbate their already rampant deficiencies. It decreases people's access to food and medical care. It forces children to drop out of school and kills the most productive members of society. It hinders people from accomplishing complex social achievements. This overreaching issue is AIDS.

The Prevalence of HIV/AIDS

Thousands of people with AIDS die each day in Africa, and epidemiologists expect the daily death toll to reach almost 13,000 by 2005. By that time, health experts say, "more people in sub-Saharan Africa will have died from AIDS than in both world wars."¹⁹ This scourge is much more frightening than war, however. It preys on women and children, and the most impoverished. It destroys entire families and communities and instigates prolonged grief and

¹⁸The Political Risk Yearbook: Sub-Saharan Africa, 53.

¹⁹John Jeter, "AIDS Sickening African Economies, Farms Are Idle, Jobs Unfilled As Disease Devours Work Force," The Washington Post, 12 December 1999, A01.

suffering. HIV prevalence in Africa is so terrifying because it spreads rapidly in impoverished communities that depend on human labor for survival. The levels of national poverty are already so great that the resources for dealing with the care of the sick and dying and the orphans are extremely scarce to nonexistent.

The relatively long incubation period between infection and symptoms of the disease has made accurate estimates of its prevalence rather difficult. Looking at the bigger picture, researchers have focused on analyzing what kinds of people contract the disease in different regions. The World Health Organization characterizes three patterns²⁰ of HIV transmission. Pattern I is found primarily in the United States and Europe, and qualifies as "AIDS occurring among homosexual and bisexual males and intravenous drug users. Heterosexual transmission is responsible for only a small but increasing proportion of the total."²¹

Most African countries and several Latin American countries appear to follow Pattern II. This pattern is characterized by most cases of AIDS occurring among heterosexuals. "The male-to-female ratio is approximately one and perinatal transmission is common."²² The reasons for the discrepancies between Patterns I and II will be explained later, but it is important to realize that this pattern of transmission found in sub-Saharan countries, including Uganda and South Africa,²³ gives HIV the potential to reach almost all members of a community.

²⁰Pattern III transmission does not apply to this discussion. For reference purposes, a strong heterosexual or homosexual pattern does not yet characterize this pattern. It arose relatively recently and is found primarily in Asia, Northern Africa, and Oceania.

²¹Norman Miller and Richard C. Rockwell, eds., *AIDS in Africa: The Social and Policy Impact* (Lewiston: The Edwin Mellen Press, 1988), 33.

²²Ibid.

²³Pattern I is also found in South Africa, but primarily among the white, middle-class, homosexual male population, like in the United States.

African AIDS was first discovered in Uganda in the mid-1980s and now 9.5% of the adults in this country of about twenty million are estimated to be infected. Its prevalence is nearly equal between urban and rural regions.²⁴ While it is impossible to obtain exact figures of AIDS cases, a basic but significant indicator is the incidence of AIDS in every family. Some families, like Edith's, have multiple members suffering from the disease. "Every home is affected by AIDS in Kwapa village," says Helen Onyango, a TASO (The AIDS Support Organization) AIDS counselor in Tororo. "Either a relative is suffering, a family member is dying, or someone suspects he has AIDS." "We are burying almost every day; not a day goes by without burials."²⁵ On a more positive note, the incidence of disease has decreased markedly in the past few years due to the institution of prevention and intervention programs throughout Uganda.

Unfortunately, the infection appears to have moved southward from the "central African AIDS belt" (Uganda, Kenya, Rwanda, Burundi, and Tanzania) toward and through southern Africa. South Africa had an extremely low seroprevalence until 1992 when the rate of infection increased tremendously.²⁶ Time appears to be catching up to this fated nation. Currently, South Africa is host to an estimated 10 percent of the world's new infections – more than any other country. The national health ministry estimates 1,600 South Africans are infected daily and it

²⁴Mark Schoofs, "Use What You Have," *The Village Voice*, 4 January 2000, 53.

²⁵"The Socio-Economic Impact of HIV and AIDS on Rural Families in Uganda: An Emphasis on Youth," by the United Nations Development Programme (<http://www.undp.org/hiv/publications>)

²⁶Douglas Webb, *HIV and AIDS in Africa* (London: Pluto Press, 1997), 13.

projects the national infection rate to reach 25% by 2010.²⁷ This figure is mind-boggling because a 25% infection rate would be equivalent to 65 million previously healthy people in the United States being told they have less than ten years to live. It is therefore apparent that without the concerted efforts of communities, organizations, and the government to hinder the spread of this disease, South Africa will undoubtedly suffer egregious social and economic costs.

The Implications of HIV and AIDS for Families, Communities, and Economies

The long latency period of an HIV infection is responsible for bringing about both short-term and long-term effects. Many people, like Edith's husband, unknowingly spread the virus for months or years and then eventually die of opportunistic infections they acquire after HIV has decimated their immune systems. In addition to the adamant deaths of victims of the virus, this disease also lays claim to a great deal of corollary consequences. Evidence shows that the high prevalence of AIDS throughout many regions of sub-Saharan Africa affected families, communities and economies catastrophically and will continue to do so as the virus spreads further.

On a familial level, the AIDS virus affects people of all nations in generally the same way. Individuals can be categorized as members of three types of households.

First, there are afflicted households that have one or more members suffering from the disease, or who have already lost someone. Next there are affected households that do not have a member ill or dead from AIDS, but have received orphans from other members of the family or from neighbors. Then there are the households that are not directly touched by the disease.²⁸

²⁷Lynne Duke, "Ignorance Feeds Deadly South African AIDS Epidemic," The Washington Post, 16 February 1999, A01.

²⁸Tony Barnett and Piers Blaikie, AIDS in Africa: Its Present and Future Impact (New York: The Guilford Press, 1992), 58.

The afflicted households are generally those that suffer the most, and the blow dealt to members of a family is often sudden and catastrophic.

Unlike famines and epidemics that tend to affect the young and very old, AIDS tends to have the greatest impact on young adults who are both the parents of the young and the support systems of the old. When a breadwinner develops AIDS, his or her family may become impoverished twice over: "his income vanishes, and his relations must devote time and money to nursing him."²⁹ The story can get much worse than this, however. In Edith's story, her husband and three children are infected and she believes that she is also carrying the virus.

In a study based on fieldwork in the Rakai district of Uganda, researchers created an idealized longitudinal model of interrelated and incremental impact of the virus, accounting for coping mechanisms. In 1980, the model illustrates a household consisting of a husband, wife and seven children as healthy, prosperous and able to hire laborers for their farm. The husband then brings AIDS into the family and spreads it to his wife. After a ten-year period, the mother and father have died (leaving behind large funeral expenses), the children have dropped out of school to help run the neglected and only semi-functional farm, some of them have been sent to live with relatives, and clothing and food have become a problem for survival.³⁰

This model does not account for all of the possible detrimental impacts of AIDS on a family, however. In addition to surviving members losing the capabilities for adequate functionings, they may be stigmatized or ostracized by extended family members or the

²⁹Charles W. Henderson, "Lower Drug Prices Seen Helping Africa Fight AIDS," *AIDS Weekly Plus*, 25 May 1998, 1.

³⁰Barnett and Blaikie, 88-90.

community, they may develop crippling anxieties about the status of their own health, and surviving wives may be forced to live with their husband's brother(s) due to inheritance customs.³¹ Finally, HIV-positive mothers can pass the virus onto their children in utero. One 19-year-old mother in the Tororo District of Uganda infected her son perinatally. Now he is only one year old and they are both immensely ill. "They have aggressive herpes zoster on their bodies and the child has severe diarrhea and dry coughing. During an interview [with an NGO], her baby was too weak to breast-feed and flies were swarming its eyes, mouth and open sores."³² Seeing infants and children suffer horrible illness is probably one of the worst possible effects on families, and moreover in communities that look to the children as hope for future of their villages and districts.

Washington and Lee University

In addition to this loss, communities suffer many other consequences as a result of AIDS. These effects are currently more apparent in Uganda than in South Africa because more communities in Uganda have been affected, often to a greater extent. Although South Africa has not yet experienced the same purgatory that many Ugandans endure, it is likely that this troubled country will soon face similar obstacles or worse due to a lack of local and national methods of prevention and intervention.

AIDS orphans are another major concern of communities stricken by the epidemic. In fact, Uganda claims the highest number of AIDS orphans in the world – more than a million in

³¹"The Socio-Economic Impact of HIV and AIDS in Rural Families in Uganda: An Emphasis on Youth," 7-9. It should also be noted here that wife inheritance greatly facilitates the spread of HIV and has the potential of infecting several families very rapidly. A man who sees his late brother's wife looking healthy may ignore the possibility that she may be HIV-positive.

³²Ibid, 6.

all.³³ When parents die, relatives or neighbors generally take in the orphaned children.

Unfortunately, this attempt to help can have deleterious effects. Orphans that are uprooted from towns and sent back to villages may have a difficult time making the transition, which can lead them to increased risk behavior. They also may be taken out of school and sent to work in order to help support themselves and younger children. Finally, they may run away from their new homes to escape the stigma and poverty that surrounds them.³⁴ These lost children often end up lacking education and tend to lead delinquent lifestyles that put them at an even greater risk for contracting HIV and passing it onto others.

In addition to dealing with the deaths of loved ones, orphans and other survivors of families afflicted with AIDS are often harassed for being associated with "slim disease." Stigmatization of the sick and dying and their families is one of the harshest effects of AIDS on communities. The disease affects so many Ugandans that harassment by neighbors and relatives has become less frequent there. Infected South Africans, however, face "rejection, discrimination, and even deadly violence" when they admit they have the disease to friends and relatives.³⁵ In addition, facilities earmarked for AIDS patients often stand virtually empty even though the help they offer is needed desperately.³⁶ Sadly, people would rather die silent and suffering great pain than be known as someone with "slim disease."

³³Jeffrey Barholet, "The Anatomy of an Epidemic - And Its Rising Human Toll," PR Newswire, 9 January 2000.

³⁴Ibid, 12.

³⁵Kai Wright, "A Disease Spread by Silence," The San Francisco Chronicle, 5 March 2000, 1/Z1.

³⁶Suzanne Daley, "AIDS Patients Shunned in Africa," The San Diego Union-Tribune, 6 December 1998, A38.

resources, Uganda cannot afford to spend much of its budget on health and welfare. In effect, increased life and medical insurance costs also increase employers' costs. This too has a negative impact on the economy because many companies' profits go to cover the health costs of their employees. These effects in Uganda are an illustration of how economic and capability deprivations reinforce one another. If an employee is too sick to work, his company and eventually his country's economy will suffer. As the economy weakens, adequate healthcare will become more difficult to obtain. Since no one with AIDS ever gets cured, this vicious cycle accelerates, eventually causing massive capability deprivation *and* economic deprivation.

AIDS is beginning to evince a similar cycle in South Africa. The epidemic there is so young, however, that a damaging effect on the economy has yet to be statistically observed. In fact, GDP growth actually picked up in 1999.⁴¹ However, if the disease continues to spread in this country, its impact ought to be similar to what has been observed in Uganda.⁴² One possible difference in impact stems from the fact that AIDS affects both urban and rural populations equally in Uganda, but hones in on primarily urban populations in South Africa. Since urban areas are centers of economic development and generally contain better educated people, the epidemic in South Africa may have a greater impact on damaging the skilled labor force there than in Uganda.⁴³

⁴¹The Political Risk Yearbook, 20.

⁴²One author believes there will be a harsh economic impact, increased hospitalization costs, personal hardship, loss of productive members of society, and an increase in AIDS orphans. She believes these effects will undermine the apartheid transition process and lead to exacerbated racial tensions and a subsequent fall in foreign and domestic investment, trade and tourism. {"Apartheid and the Politics of AIDS," ed. Douglas A. Feldman, Global AIDS Policy, (Westport: Bergin and Garvey, 1994), 108-109.}

⁴³Miller and Rockwell, 44.

This silence, combined with ignorance, helps to spread the disease. Accordingly, one of the most detrimental impacts of AIDS has been the loss of the best and the brightest workers in many communities. The epidemic has taken the lives of “farmers, schoolteachers, bricklayers, and businessmen” and has shrunken the labor pool considerably in many areas. “Ten percent of the work force in southern Africa has been infected, and economists estimate that a shrinking labor pool...will [help] slow the continent’s rate of economic growth by up to 1.4 percentage points each year for the next twenty years.”³⁷ The effects of this decrease in economic growth are becoming apparent in Uganda, though South Africa has yet to experience much of a loss.

Companies in Uganda documented large losses due to absenteeism, a depleted pool of skilled labor, and growing health costs in recent years. According to a United Nations study, “Uganda Railways loses about \$300 annually per employee because of AIDS-related costs. A transportation company...reports that 20% of its profits are lost to AIDS.”³⁸ The loss of skilled workers is especially daunting. “As more workers are affected, the skills and experience they represent become progressively more difficult to replace.”³⁹ Consequently, the loss of businessmen and better educated males, who are at the greatest risk for infection⁴⁰, will definitely take its toll on the Ugandan economy.

While a loss of laborers is dangerous to the economy, sick laborers are an even greater threat because they drive up health and welfare costs. As a country already deficient in public

³⁷Jon Jeter, “AIDS Ravages Africa – Developing countries are losing their critically needed best and brightest,” The Seattle Times, 17 December 1999, final.

³⁸Dean E. Murphy, “Business Joins South Africa AIDS Fight,” Los Angeles Times, 19 February 2000, A5.

³⁹Yole G. Sills, The AIDS Pandemic (Westport: Greenwood Press, 1994), 45.

⁴⁰Ibid, 44.

All of the effects touched on here derive from the fact that individuals who get infected and die are economic actors, both producers and consumers. The effect of an infection is first felt by the person who falls ill. It then spreads like a ripple through the household, community, and finally through the country as a whole. However, if these nations of limited means can begin to understand how the AIDS virus spreads, perhaps they will be able to find ways to respond to it.

The Causes Behind the Spread of HIV

In the early years of the African epidemic, contaminated blood transfusions and injection with unsterile needles played some role in transmission of the virus, but these risks have been largely eliminated.⁴⁴ Presently, the characteristics of Pattern II transmission are the norm for the majority of AIDS infections in sub-Saharan Africa: the disease affects a basically equal percentage of men and women and is most often the result of heterosexual contact and less often from a mother infecting her child perinatally.^{45,46} Many experts would acknowledge that the enumerable instances of sexual activity that help spread the disease are the result of many factors including cultural practices, the role of women in society, ignorance among the population, and economic and political conditions.

Cultural practices often mirror women's reduced status in sub-Saharan societies.

Anthropologist Christine Obbo believes that "the accepted religious and social practices that

⁴⁴Bloor, 102.

⁴⁵Bloor, 11.

⁴⁶As was stated earlier, this differs greatly from the Pattern I transmission found in North America and Europe, in which the virus is transmitted primarily through homosexual contact and the use of intravenous drugs.

allow men to enjoy multiple partners as wives or 'wives' (i.e. consensual relations), while strongly condemning women's expression of their sexuality have been key factors in the spread of HIV.⁴⁷ These practices stem partially from the fact that sub-Saharan societies tend to be patrilineal. This means that property is inherited through the male line of descent and a wife joins a husband's family at marriage. Divorce is almost unheard of in these societies because women lack alternative means of economic support and a husband's kin will often refuse to return a woman's bride price.⁴⁸ Adultery, visiting prostitutes, and polygyny are accepted customs, while chastity and abstinence have no value.⁴⁹ Even if a woman knows her husband is cheating on her and possibly spreading HIV to the members of their family, she will not leave him because she will be left impoverished, lacking any sustainable livelihood, and because social expectations dictate that she procreate.

Motherhood is extremely important to women of this continent and fatherhood is vital to obtaining an heir. In many areas, "fertility overrides sexual control and exclusivity, opening the way for birth and marriage to be effectively dissociated in much contemporary practice...[This]

⁴⁷Christine Obbo, "Gender, Age and Class: Discourses on HIV Transmission and Control in Uganda," in *Culture and Sexual Risk: Anthropological Perspectives on AIDS*, ed. Han ten Brummelhuis and Gilbert Herdt (Amsterdam: Gordon and Breach Publishers, 1996), 86.

⁴⁸Bloor, 73.

⁴⁹Sills, 27-31.

means, in turn, that the pressure to prevent pregnancy (i.e. use contraceptives⁵⁰) is not strong."⁵¹ Moreover, even mothers who know they are HIV positive often opt for maternity, despite the danger this poses to their families. They do this because patriarchal assumptions define women's sexuality as a mere extension of procreativity.⁵² According to these assumptions, women who lack the capability to have children also lack the functioning to live a life without shame as result. This rationale, which may seem foreign to many Western women, is perpetuated both by women's traditional total dependence upon men and the sexual ignorance of much of the population.

High rates of illiteracy, limited spending on health and education, and the relative novelty of this disease all contribute to the information gap that exists in the Pattern II nations of sub-Saharan Africa. In fact, "the language constraints alone, force less precise, often simplistic coverage of AIDS. It is not uncommon, for example, to hear the same story covered by a given reporter in five languages on East African radio, with all but the English language version confined to very basic concepts of the disease."⁵³ Limited knowledge of the true nature, causes,

⁵⁰It should be noted that condoms are also a topic of much contention in the developing world. From the widespread belief that condoms are the white man's tool for keeping the black population down to the equally accepted conviction that a request to use condoms during sex implies a lack of trust, the misconceptions are countless. Fortunately in countries like Uganda, where the disease has begun to take its toll, people are starting to realize that condoms help to protect them and have begun to use them more often. Their high price and bad reputation, however, remain as barriers to ubiquitous use. (Webb, 148; Sills, 36.)

⁵¹E.M. Preston-Whyte, "Half-Way There: Anthropology and Intervention-Oriented AIDS Research in KwaZulu/Natal, South Africa," in Culture and Sexual Risk: Anthropological Perspectives on AIDS, ed. Han ten Brummelhuis and Gilbert Herdt (Amsterdam: Gordon and Breach Publishers, 1996), 322.

⁵²Obbo, 83.

⁵³Laurie Garrett, "AIDS Government and the Press," in AIDS Prevention and Education: A World View, ed. Jaime Sepulveda, Harvey Fineberg, and Jonathan Mann (New York: Oxford

and effects of the disease in some areas and almost no knowledge in others leads many people to be confused about warning messages or to selectively interpret advice, and to believe their personal vulnerability is low, when in reality, it may be very high.⁵⁴ In affected villages, this ignorance also causes the aforementioned withdrawal of social support and stigmatization, which both help to perpetuate the disease.⁵⁵ Low levels of educational capabilities definitely contribute to the spread of this pandemic.

Cultural particularities and widespread ignorance fail to explain why some countries have much greater incidences of the virus than others. For instance, the prevalence of AIDS in Uganda is much greater than that in South Africa. This phenomenon is partially attributable to the time it has taken HIV to spread from central to southern Africa, but is also a result of unique economic and political conditions in each country.

Uganda's politically tumultuous past helped to make it susceptible to the ravages of the AIDS epidemic. One scholar suggests,

As a result of civil war within Uganda, many men have died and there is a glut of women including widows, single ladies, and unmarried women who are single parents in the urban and rural areas. This situation has apparently predisposed to promiscuity and increased numbers of sexual partners favoring heterosexual transmission of STDs and HIV-1.⁵⁶

These conditions also pushed many women into prostitution as their only source of income in a

University Press, 1992), 277.

⁵⁴Sills, 193.

⁵⁵Brooke Grundfest Schoepf, "Culture, Sex Research and AIDS Prevention in Africa," in *Culture and Sexual Risk: Anthropological Perspectives on AIDS*, ed. Han ten Brummelhuis and Gilbert Herdt (Amsterdam: Gordon and Breach Publishers, 1996), 29.

⁵⁶A. Olufemi Williams, *AIDS: An African Perspective* (Boca Raton: CRC Press, 1992),

society where most of the power and money are controlled by men. This burgeoning occupation has been a major cause of the spread of HIV because it is socially acceptable for men to visit prostitutes who rarely use contraception. They are also more likely to have STDs, which facilitate the spread of AIDS by making it more easily transmittable through open sores and infections.⁵⁷⁵⁸ Prostitutes are not the only reason for the quick spread of this epidemic in Uganda, however. There are many more frequent carriers of the AIDS virus.

Anthropologist Michael Bloor calls these recurrent transmitters “core-groups” and defines them as “factions of efficient transmitters of HIV that are more likely than the general population to be infected with other STDs that increase the likelihood of transmitting HIV.”⁵⁹ The core-groups in Uganda are truck/lorry drivers, soldiers, itinerant traders, police, and prisoners.⁶⁰ The latter group has such a high incidence because of the prisoners’ close proximity to one another and their limited sexual choices. The four other groups are able to spread the virus so well due to both their power over others and their ease of movement over large areas.

Movement is key to the spread of AIDS throughout Uganda. Due to the demands of the economy, many occupations call for migration on the part of male workers while their wives remain in the villages. The long-distance lorry drivers act “as highly geographically mobile

⁵⁷One researcher also mentioned that some areas of this region have strange sexual practices that cause ulceration of the genitalia. These rituals supposedly increase the male’s sexual pleasure, but also help spread AIDS and other STDs by increasing the likelihood of major body fluid exchange.

⁵⁸Sills, 36.

⁵⁹Bloor, 17.

⁶⁰John C. Caldwell, John K. Anarfi and Pat Caldwell, “Mobility, Migration, Sex, STDs, and AIDS: An Essay on Sub-Saharan Africa with Other Parallels,” in Sexual Cultures and Migration in the Era of AIDS, ed. Gilbert Herdt (Oxford: Clarendon Press, 1997), 46-47.

clients spreading HIV along the highways among each of the local prostitution populations, as well as casual girlfriends."⁶¹ Also, a recent study found that approximately one-third of the Ugandan army, which frequently travels on extended missions around central Africa, tested positive for HIV-1.⁶² These quite frightening proportions most likely contribute their share to the problem of AIDS in Uganda.

Appearing only as recently as 1992, the epidemic has not yet reached cataclysmic proportions in South Africa. Factors unique to this recently desegregated nation, however, are helping to increase its incidence rapidly. South Africa shares with Uganda the problem of highly mobile core-groups. In addition, Apartheid has separated spouses for decades, "institutionalizing multi-sex partnerships in which migrants with wives in the country set up relations with women in town, and poor women in both rural and urban areas depend on sex to earn money for survival."⁶³ The recent political changes also may help to increase the spread of the epidemic because as many as 40,000 exiles may be returning in the next few years, many from neighboring countries that already have high levels of seroprevalence.⁶⁴ In general, the combination of a migrant workforce similar to that of Uganda and a high frequency of political and social disruption over the past few years does not bode well for South Africa's impending fight against the AIDS crisis.

The lack of certain capabilities among the people of Uganda and South Africa have contributed greatly to the spread of AIDS in these countries. Lack of education and the unequal

⁶¹ Bloor, 17.

⁶² Williams, 54.

⁶³ Preston-Whyte, 321.

⁶⁴ Barnett and Blaikie, 169.

social status of women make it difficult to avoid unprotected sex. Christine Obbo asserts, "A worker who needs to keep a job or be promoted, or a poor woman with no alternative way to generate an income that constitutes a living wage are in no position to say no to AIDS."⁶⁵ In order to thwart the advance of this disease, steps toward prevention and education on local, national and international levels must be increased, and in some instances initiated, in the developing world.

The Response to Uganda's Crisis

The pattern of response to the AIDS crisis in Uganda has been similar to the pattern in more developed areas. In most of Africa, an initial period of denial was followed by a period of inaction, based on the rationale that the magnitude of the problem was exaggerated. As time passed, some noncontroversial interventions, like blood screening and limited education and communication campaigns, were initiated. Finally, by early 1987, when the problem reached grave proportions, the government and NGOs launched extensive AIDS public education and intervention campaigns.⁶⁶ This nation has had much more time than others to respond to the crisis. It is often touted as the sub-Saharan country that has contributed most to combating the epidemic. Uganda serves as a model for countries like South Africa, which are just beginning the battle against AIDS.

Uganda has been so effective in its fight due to extensive prevention and intervention efforts developed by community organizations, the national government, and international

⁶⁵Obbo, 81.

⁶⁶Peter Lamptey and Sharon Weir, "Targeted AIDS Intervention Programs in Africa," in *AIDS Prevention and Education: A World View*, ed. Jaime Sepulveda, Harvey Fineberg, and Jonathan Mann (New York: Oxford University Press, 1992), 153-154.

NGOs. Community programs tend to get the least media attention, but they are vital to the continuing success of this movement. These programs tend to be the most resource-starved, but also the most bravely experimental efforts of Ugandans to cope with the impact of the pandemic in their own way.

Sandra Thurman, Director of the Office of National AIDS Policy concurs, "From the young people doing street theater in Lusaka to educate their peers about HIV to the support groups in Soweto providing home and community-based care for people living with AIDS, communities are mobilizing and creating ripples of hope."⁶⁷ The key to these programs lies in the people using what they have, although it is limited. They build upon the strengths of kinship networks and adapt preventive education to existing customs.⁶⁸ Support organizations try to conquer stigma and make family and friends more aware of the disease while providing counseling and education to affected families. Material resources are limited, but Ugandans continue to use their vast human resource networks to combat this disease.

Uganda's government has been using both human resources and part of its health budget⁶⁹ in its response to the AIDS epidemic. "The initiative for the all-out-battle came from President Yoweri Museveni, who understood the extent of the disease from the day he came to power in 1986...he earmarked funds for a large-scale national prevention campaign," that

⁶⁷Congressional Testimony on AIDS in Africa, by Sandra Thurman, Director, Office of National AIDS Policy (Washington, D.C.: Federal Document Clearinghouse, 2000).

⁶⁸Barnett and Blaikie, 156.

⁶⁹Christine Obbo suggests that this budget could be better allocated because the AIDS Commission in Uganda is no different from the AIDS Control Programme and it wastes part of the budget in rent and inflated salaries. She claims, "AIDS control in Uganda is being sabotaged by complacency and indifference by those in a position to make a difference" (86).

included posting large roadside signs throughout Uganda urging the population to take protective measures.⁷⁰

Museveni's campaign is one of public education, condom distribution, voluntary testing, counseling, and support services, and it has produced remarkable results. The rate of infection in some towns has dropped from 30 to 15 percent of the population and young women attending antenatal clinics have had a one-third reduction in the incidence of HIV between 1990 and 1997.⁷¹ There has also been a 30 to 40 percent increase in condom use and a large reduction in casual sex.⁷² The Ugandan government is not solely responsible for this success; international organizations also contributed to these changes.

Due to Uganda's status as a country of limited means, international organizations have provided most of the material assistance needed to combat AIDS. For instance, the Joint United Nations Programme on HIV/AIDS (UNAIDS⁷³) and some pharmaceutical companies are running a pilot project in Uganda that sells HIV drugs at discounts up to 56 percent.⁷⁴ In addition, "a very intensive HIV counseling and testing program fiscally supported by the U.S. Agency for International Development (USAID) with CDC technical expertise, has reached upwards of one-

⁷⁰Damien Rwegera, "A slow march forward," *UNESCO Courier*, 1 October 1999, 22.

⁷¹*Ibid* and *Congressional Testimony on US Role in Combating HIV/AIDS*, by Timothy Dondero, M.D. Chief, International Activities Branch Division of HIV/AIDS Prevention, CDC (Washington, D.C.: Federal Document Clearinghouse, 1999).

⁷²*Ibid*.

⁷³Created in 1996, UNAIDS replaced the World Health Organization's AIDS program.

⁷⁴Mark Schoofs, "Use What You Have," *Village Voice*, 4 January 2000, 53. It should be noted that this article goes on to say that very few of Uganda's HIV-positive population can afford these drugs and many patients drive themselves and their families into debt trying to pay for them.

half million persons since 1990 through AIC (AIDS Information Center), a major NGO.”⁷⁵

International agencies have helped Uganda immensely by contributions of funding, research, and infrastructure.

The developed world’s ability to pour money into medicines, research, and clean needles, does not exist in sub-Saharan Africa. Uganda has demonstrated, however, that HIV prevalence can be cut in half by combining international support with a strong political commitment and sustained nationwide programs. A lack of material resources does not necessarily condemn a whole population to death. Uganda’s well-managed use of limited resources to provide education programs, counseling and support services, and cheap condoms is proof of this.

The Lack of Response to South Africa’s Impending Crisis

While the epidemic may be plateauing in Uganda, it is still spreading at alarming rates in other parts of sub-Saharan Africa, including South Africa. Since it is relatively new in this country, there has been much less of a response to its devastating effects. With infection rates rising daily, however, communities, the government, and international organizations are beginning to respond to the impending crisis.

AIDS has not devastated nearly as many communities in South Africa as it has in Uganda. For this reason and because the general population is largely ignorant of the causes and effects of the virus, there is great stigmatization of the sick and denial of a problem in many areas. This leads to the lack of a response to combat its spread.

There have been some semblances of community responses, however. A small number

⁷⁵Dondero, 2.

of traditional healers have "adopted modern teaching and methods to deal with maladies like AIDS."⁷⁶ In addition, some individuals have begun to teach AIDS awareness courses, although their classrooms usually stand empty due to the stigma attached to the disease.⁷⁷ Sadly, the South African government has also been denying the existence of the disease through its actions. In fact, it just signed a \$3 billion contract to obtain fighter jets and submarines from Europe, which helped to shrink its health budget by 5 percent.⁷⁸ All hope for some kind of government intervention is not lost, however.

South Africa is beginning to realize that it too has limited resources to combat this devastating disease and can stand to learn quite a bit from Uganda. The health minister of South Africa recently led a delegation to Uganda to study the country's strategy for fighting AIDS.⁷⁹ Also, President Thabo Mbeki announced a new five year plan to combat the epidemic in January of this year.⁸⁰ While the South African government has taken some baby steps to combat this epidemic, its limited response unfortunately remains one commonly characterized by denial, ministerial wrangling, and the misallocation of resources.

International organizations and NGOs may be the only entities that realize the devastation that AIDS could cause in South Africa. As a result, UNAIDS programs send HIV sufferers to work in various companies to teach and counsel about AIDS.⁸¹ The National Association of

⁷⁶Tom Cohen, "Traditional medicine healers vital link in African health system," The Fort Worth Star, 30 November 1997, 15.

⁷⁷Paul Salopek, "Official and cultural denial hobbles fight against AIDS: Africa's Grim Prognosis," Seattle Times, 20 January 2000, A1.

⁷⁸Ibid.

⁷⁹Pat Reber, "South Africa to Study Ugandan AIDS Plan," AP Online, 24 July 1999.

⁸⁰"Newsweek: AIDS in Africa," PR Newswire, 9 January 2000.

⁸¹Daley, A38.

People Living with HIV/AIDS also employs people “to go around the country talking to people in a campaign to promote ‘disclosure and acceptance.’”⁸² AIDS awareness groups like Siyaphila (“We are alive) are popping up all over the country in an attempt to counteract the bruising South African culture of shame and denial. It is unknown if these groups are hindering the spread of the disease. What is well-known, however, is that in order for South Africa to be successful in ridding itself of this epidemic, its communities, organizations, and government must learn from Uganda how best to use their limited resources to accomplish change.

Looking Toward the Future...

The Center for International Research of the U.S. Bureau of the Census, made some predictions of the impact of AIDS in sub-Saharan Africa over the next twenty-five years. Assuming that there are no relevant medical breakthroughs and no behavioral changes made, HIV cases are expected to increase sevenfold.⁸³ In Uganda, life expectancy will have dropped from 59.5 to 47.6 and from 68.2 to 48.0 in South Africa by 2010. Already high infant and child mortality rates in both countries will also increase tremendously.⁸⁴ These projections are astonishing, but as has been demonstrated by Uganda, they need not become truths. With the combined efforts of individuals, communities, governments, and international support, the AIDS epidemic can be stopped.

Uganda, and to a much smaller extent South Africa, have achieved reductions in the prevalence of AIDS through aggressive prevention and intervention programs. Many researchers

⁸²Ibid.

⁸³Sills, 44.

⁸⁴U.S. Bureau of the Census, Report WP/98-2, “HIV/AIDS in the Developing World,” (Washington D.C.: U.S. Government Printing Office, 1999), 8-9.

believe that even more can be done to hinder the spread of AIDS. For risk reduction to occur, there has to be a favorable social structure and social policy network. This can include a greater push by NGOs and governments for gender equality, so women become less vulnerable to infection. Also, in countries like South Africa where there still exists a counterproductive stigma, a transformation in education is needed. Youth need to learn effective ways of practicing safe sex and what patterns can result in HIV infection. Leaders also must be forced to acknowledge the problem and the ways their nations can fight it effectively.

The developing nations of sub-Saharan Africa can least afford ineffective interventions, both because “budgets are extremely limited and because large numbers of AIDS cases will impose crippling economic burdens while simultaneously reducing economic production.”⁸⁵ In addition, only 6 percent of worldwide expenditures for AIDS prevention are spent in the developing world, which accounts for 80 percent of all HIV infections.⁸⁶ Since these countries lack economic means, they must use their most valuable asset, human capital, to effectively combat the disease by providing people with the capabilities to accomplish minimum functionings. Uganda has proven that the wise use of both human capital and very limited resources by communities and governments is the only thing we know of that can save families like Edith’s from losing their current capabilities and descending into poverty.

⁸⁵Bloor, 126.

⁸⁶Sills, 176.