

Aid for AIDS: The Policies and Performance of PEPFAR in Uganda

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Abstract

Today, despite the vast resources given to stop the spread of HIV/AIDS in Uganda, the national prevalence continues to grow.

The U.S. developed the President's Emergency Plan for HIV/AIDS Relief (PEPFAR) as a response to the insufficient global effort to halt the spread of HIV/AIDS internationally.

PEPFAR has tied foreign aid to an HIV/AIDS agenda that is based on politics and religion, not on evidence. By promoting an abstinence-only approach to HIV/AIDS education and limiting international funding to only organizations that agree to restrict sexual health access for many people, including sex workers.

This thesis is about understanding the complex relationship between aid donors and recipients when evidence, politics and religion clash.

I conclude this thesis by finding that HIV/AIDS campaigns in Uganda are compromised by a complicated political and religious landscape.

April, 2014

Table of Contents

Abstract.....	ii
<i>Acknowledgments</i>	v
List of Acronyms and Abbreviations	vi
Chapter 1: Introduction and Research Methodology	1
Introduction	1
Background on Foreign Aid.....	4
Global Health and Foreign Aid	7
PEPFAR	10
U.S.' Struggle with Prevention	11
Prevention.....	12
Uganda	14
Rational for the study	17
Research Statement.....	18
Main argument	19
Methodology.....	21
Critical Theory	22
Justification for the study	24
Limitations of this study.....	27
Required information.....	28
Data Collection Techniques	29
Documents.....	33
Chapter 2: Literature Review	34
Foreign Aid and Development- Who gets to decide.....	35
U.S. and Foreign Aid.....	42
Foreign Aid and Health	46
Foreign Aid and HIV/AIDS: Where is the money going?	52
Foreign Aid and Uganda.....	57

	iv
Chapter 3: Findings	60
Uganda's HIV/AIDS prevention programme: Before PEPFAR	60
The start of the HIV/AIDS Epidemic in the U.S.	62
The Rise of HIV/AIDS in Uganda and the U.S.	64
PEPFAR Changes the Global Response to HIV/AIDS	68
A Local Fight goes Global	68
The Need for Evidence	71
Spreading the 'Good' Word	73
How PEPFAR is changing the HIV/AIDS policies of Uganda	76
Uganda Adopts AB	82
The Condom Shortage	85
How PEPFAR might have affected Uganda's HIV/AIDS prevalence	88
The need for a culturally appropriate HIV/AIDS response	92
 Chapter 4: Conclusions and Recommendations	 94
 Appendix A1:	 98
Appendix A2: Chart of international HIV/AIDS funding and HIV/AIDS prevalence in Uganda	99
Appendix A3: Collection of data technique: Scoping	100
 References	 103

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Lastly, this thesis is dedicated to the memory of Mary, Laura, and Jan who I miss greatly every day, I wish you were here to finally celebrate this graduation.

Any mistakes made in this thesis are solely the responsibility of the author.

List of Acronyms and Abbreviations

AB: Abstinence and Be faithful

Abuja Declaration: The 2001 Abuja Declaration on HIV/AIDS, Tuberculosis, and Other Infectious Diseases

ABC: Abstinence, Be faithful, use a Condom (or ‘Condomise’)

A-only: Abstinence-only

AIDS: Acute Immune Deficiency Syndrome

APP: Anti-prostitution pledge

ART: Antiretroviral therapy

ARV: Antiretroviral

CDC: Centre for Disease Control

COP: Country Operational Plan

FAO: Food and Agriculture Organization of the United Nations

Global Fund: The Global Fund for AIDS, Tuberculosis, and Malaria

HAART: Highly Active Antiretroviral Therapy

HIV: Human Immunodeficiency Virus

MOH: Ministry of Health

MSF: Médecins Sans Frontières

NGO: Non-Governmental Organization

OGAC: Office of the United States Global AIDS Coordinator

PEPFAR: The US President’s Emergency Plan for AIDS Relief

SAPs: Structural Adjustment Programs

STI: Sexually Transmitted Infection

TASO: The AIDS Support Organization

UAC: Uganda AIDS Commission

UN: United Nations

UNAIDS: The Joint United Nations Programme on HIV/AIDS

UNGASS: United Nations General Assembly Special Session

U.S.: United States

USAID: United States Agency for International Development

USD: United States Dollars

WHO: World Health Organization

Chapter 1: Introduction and Research Methodology

Introduction

The Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS) have been the cause of a global pandemic since the early 1980s. It is estimated that over 25 million people have died as a result of contracting HIV (UNAIDS Global Report, 2008). Seventy-five percent of those deaths occurred in Sub-Saharan Africa (UNAIDS Global Report, 2008).

HIV/AIDS is one of the greatest obstacles to development. Sub-Saharan Africa has 10 per cent of the world's population but 60 per cent of the world's population living with HIV/AIDS (University of Glasgow, n.d.). HIV/AIDS has changed the population structures of several Sub-Saharan African countries. Despite increasing access to health institutions and clean water, life expectancy in many Sub-Saharan African countries are shorter today than they were in the 1980s as a result of HIV/AIDS (University of Glasgow, n.d.).

Globally 17.3 million children have lost one or both parents to HIV/AIDS. Orphaned children are twice as likely as children with living parents to drop out of school and they are at a greater risk of homelessness and poverty (UNICEF, 2013). Although international aid flows for HIV/AIDS have been generous, the high costs of ARVs outstrip the resources available and leave many people without access to treatment (Joint United Nations Program on HIV/AIDS, 2005, cited by: Canning, 2006).

HIV/AIDS has added enormous pressure to the capacity of national health care systems, it has caused high occupancy rates in hospitals, and it has brought about more patients for health care workers with already full workloads (AVERT, n.d.b).

The HIV/AIDS epidemic in developing countries places financial strain on households. HIV/AIDS has caused the loss of income earners because people are too sick to work, they die, or they had to leave work to care for a sick family member (AVERT, n.d.b). HIV/AIDS has added more dependents to households when children are orphaned by AIDS (AVERT, n.d.b). The cost of HIV/AIDS treatment is expensive and funeral costs are high (AVERT, n.d. b).

HIV/AIDS has caused food shortages in some countries due to the impact on labour. Malawi reported a food shortage in part due to HIV/AIDS in 2005 (BBC, 2005). Agriculture is heavily labour dependent. Sick individuals are often unable to participate. The Food and Agriculture Organization of the United Nations (FAO) estimates that approximately 23 million agricultural workers will die by 2020 (2003). The FAO also notes that because many African countries are still heavily dependent on agriculture for export, the loss of agricultural workers will have a significant impact on countries' economies (2003). HIV/AIDS has been declared a development crisis by the World Bank (The World Bank: Africa Region, 2000).

The global north managed to keep the rate of HIV transmission at less than one per cent (AVERT, 2011). Yet countries in the global south are still struggling with high transmission rates despite billions of dollars in foreign aid, the work of thousands of grassroots organizations, non-governmental organizations (NGOs), international forums, United Nations agencies, and the promises of governments around the world to halt the spread of this virus.

Uganda is one of the few countries in the Global South that experienced a dramatic and rapid decline in the spread of HIV/AIDS. Between the years 1990 to 2002, HIV/AIDS decreased by 7.1 per cent. By 2007, HIV/AIDS rates were increasing again. The

stagnation of the HIV/AIDS rates and the subsequent increase coincided with a radical shift in HIV/AIDS prevention programming.

Before 2002, Uganda's government promoted a comprehensive sexual health programme which focused on "zero grazing" (only having sex with committed partners), "just chill" (abstinence), and both education on correct and consistent condom use and the distribution of condoms. The prevention programmes were aimed at everyone in the country including sex workers. This approach has been praised as a major contributor to the initial decline in Uganda's HIV/AIDS rates.

In 2002 and 2004, First Lady Janet Museveni and President Yoweri Museveni (respectively) stopped promoting condoms and instead suggested that Ugandans did not require condoms to decrease HIV/AIDS rates (Epstein, 2005 and Tumushabe, 2006 respectively).

In 2003, the U.S. government announced a new international HIV/AIDS program (PEPFAR) which gave an unprecedented amount- \$15 billion in 5 years- of funds to Uganda for the purposes of HIV/AIDS prevention and treatment. PEPFAR's funding far surpassed any other bilateral and even multilateral funding source, but required Uganda to focus at least 33per cent of its prevention efforts on abstinence-only programming and required recipients to sign an anti-prostitution pledge (APP) promising to not work with sex workers (Office of the U.S. Global AIDS Coordinator, 2006). As a result, this change in narrative created a politics of contention in Uganda, and created a divisive and contradictory public health information as a result.

Background on Foreign Aid

Since the 1940s¹, foreign aid has been given to countries for a diversity of reasons. During times of humanitarian need, such as war or natural disasters, foreign aid is often available from other countries, international NGOs, and individual donors. A recent example is the 2004 Indian Ocean earthquake and tsunami that received an estimated \$16 billion USD from global pledges (Jayasuriya and McCawley, 2010).

Sometimes aid is given to gain power and influence (Browne, 2006). Browne uses the example that aid was given during the Cold war rather than during the 1990s when countries needed it more (2006). Browne suggests that this is because donors had more to gain in terms of power and influence during the Cold War when they were trying to convince the Global South to resist communism (2006).

Hayter suggests imperialism is at the heart of foreign aid (Hayter, 1971). Hayter argues that for donor countries aid is simply an opportunity to promote their own agenda and force recipients to adopt that agenda. It spreads the global north's political agenda globally (Hayter, 1971).

Taylor and De Campos describe the ability of aid to ensure the safety of expats and overseas military personnel (1979; 1998 respectively). With regards to hygiene and health, Taylor and De Campos describe aid being used to build hospitals and create infrastructure to clean and drain water (1979; 1998). This keeps military troops and expats safe from cholera and malaria. Health and hygiene infrastructure often has the additional impact on people living nearby expat and military compounds where they may

1 This paper looks at development aid post-1944. Many works cite the Bretton Woods conference as the beginning of modern international aid and our current international economic system (Moyo, 2009, 10; Hellinger et al., 1988, 14; Throp, 1971, 46).

also benefit from the additional infrastructure (Taylor, 1979; De Campos, 1998).

Aid has also been used as a tool for nation-building. Easterly (2011) argues that the US defence department has co-opted aid and is now using it to try and win the hearts and minds of recipient countries (2011). He argues that foreign aid is being misdirected and sent to warring countries where it is not accepted as a tool for development, but instead it is seen as a way to help aid agencies become rich (2011). He sees this use of foreign aid as a failed attempt to nation-build and argues that money should be spent on targeted and historically successful programmes such as building infrastructure, education and health care improvements (2011).

For citizens of the global north, foreign aid during the time of an HIV/AIDS pandemic has been used to keep them “safe” (Usdin, 2003). In the aftermath of September 11th, questions and concerns were being raised by US security committees on the desperation of People Living with HIV/AIDS (PLWHAs) were experiencing in developing countries (Sheehan, 2011). Children orphaned by HIV/AIDS and those with few economic options were deemed a security risk (Sheehan, 2011). The use of foreign aid to grow the economies of the global south and relieve some of that desperation was one way to secure the safety of the global north (Sheehan, 2011). Usdin (2003) quotes Stephen Lewis, former head of the UN Special Envoy for HIV/AIDS in Africa, as saying “no-one diminishes the question of security...but it does say something about the way we respond to the human condition” (2003, 27).

Outside of the HIV/AIDS epidemic, U.S. foreign aid has often been used to provide safety to the global north by strengthening fragile states, and “mitigating global and transnational ills” (Birn et al., 2009, 181). The U.S. Government claims that they prioritize development as one of the main components to national security (2009).

Moyo claims that foreign aid is used by donor countries to make recipient countries better trading partners (Moyo, 2009). Aid is often tied to procurement policies that guarantee the donor countries' products are purchased and their citizens are hired (Moyo, 2009).

Foreign aid may also be used to promote donor countries' diplomatic, commercial and cultural interests (Hudson and Goulet, 1971; Hopkins, 2000). Hopkins argues that countries which already share similar political philosophies may be more likely to enter into an aid relationship (2000).

But, as Riddell states, the primary reason to give aid should be for the acceleration of development (Riddell, 1987). If HIV/AIDS is a development issue, then reducing the spread of HIV/AIDS would accelerate development. In the 1980s, Uganda's rate of HIV/AIDS incidence was falling. From 1979-1985, Uganda was receiving \$2,440,189.11 USD² in foreign aid (Holmgren et al, 1999; CoinNews Media Group). Today, Uganda's HIV/AIDS rate of contraction is ceasing to decline at rates previously experienced and yet foreign aid to Uganda in 2011 was at \$1.6 billion USD (Global Humanitarian Assistance, n.d.). If Riddell is correct, this infusion of foreign aid decreases the rate at which HIV/AIDS is spreading in a community. But that is not happening. HIV/AIDS has been shown to accelerate in Uganda since mass infusions of foreign aid have come into the country. So consistent with Riddell's writing, aid may not be "necessary or a sufficient condition for development to begin or continue". However, contrary to Riddell's writing, it does not appear that aid is "accelerating" the development process (1987, 102).

² Uganda received \$1,126,552 USD between the years 1979-1985 (Holmgren et al., 1999) from international aid. Using the US inflation calculator, I have adjusted this amount for inflation and \$1,126,552 USD would be \$2,440,189.11 USD in 2013 (CoinNews Media Group).

Global Health and Foreign Aid

This thesis will not offer a fulsome account of the history of global health. However, relying on text from Lieberman (2009), Kickbusch (2000), and others, I will briefly explore the topic to offer readers a brief introduction to the role of the international community in global health.

The international community's first global health action may have begun in Dubrovnik in 1377 (Lieberman, 2009). The Rector Ragusa of Dubrovnik's quarantined ships traveling from countries infected with the plague (Lieberman, 2009).

In 1851 to address sanitation in response to cholera, plague, and yellow fever the first international conference on health care was held (Lieberman, 2009). This was followed in 1899 and 1902 with conferences on syphilis and venereal diseases (Lieberman).

In 1910, the Rockefeller Foundation began a national (U.S.) anti-hookworm campaign (Rockefeller, n.d.). In 1914, the International Health Division of the Rockefeller Foundation was created and it expanded the hookworm campaign expanded globally (Rockefeller, n.d.). According to Kavadi the Rockefeller's hookworm campaign created a "culture of public health" (Kavadi, 2007).

By 1978 and the Alma Ata Conference, several international conferences and organizations have been established to create global responses to epidemics and contagious health concerns (Lieberman, 2009). Yet Kickbusch considers the Alma Ata Conference (1978) to be the beginning of an international response to global health care (Kickbusch, 2000 cited Koivusal & Ollila, 1997).

The Alma Ata declaration "strongly reaffirms that health...is a fundamental human right and that the attainment of the highest possible level of health is a most important

world-wide social goal...” (Alma Ata, 1978, Declaration I). Alma Ata made it clear that all governments that committed to the declaration were responsible for the health of their people and to assist other countries in need (Kickbusch, 2000).

But Magawa points out the flaws with Alma Ata (2012). Health care delivery systems in the global south were modeled from the systems of the global north (Magawa, 2012). As Taylor and De Campos pointed out that hygienic and health infrastructure were introduced to some countries by colonial governments to look after their own militaries and expats (1979; 1998 respectively). Now those global north health care delivery models have left a preference for high-tech, urban-centric, and curative health care that is dependent on hospitals and specialists (Magawa, 2012). This model of health care is inappropriate for many countries in the global south as is it expensive and allows for 70 per cent of health care services to be spent on only 30 per cent of the population (Magawa, 2012).

In the 1980s, governments around the world began to take notice of the HIV/AIDS epidemic (Usdin, 2003). Many governments, like Uganda and the U.S., worked to slow the spread of HIV/AIDS in their own countries; they also looked beyond their borders and recognized the need to work internationally. In 1985, over 2,000 HIV/AIDS scientists from around the world came together to share research and compare notes on AIDS (Bliss, 2012). In 1988, the International AIDS society held their first annual conference on HIV/AIDS, a conference which continues to be annually held to this day (Bliss, 2012).

The 1990s brought increased attention and bilateral funds for HIV/AIDS programming and education. By the mid-1990s, \$400 million USD in official development assistance for the purposes of HIV/AIDS had already been sent to the global south (Nunnenkamp and Hannes, 2010). Prior to the Global Fund, donor and recipient countries were trying to

scale-up HIV/AIDS programming in the global south. These programmes were becoming very political and there were concerns that the influence of donors was preventing a quick scaling-up from occurring (Schocken, n.d.; Justice, 1989; Kickbusch, 2000; Farmer, 2005; Walt et al., 2009).

At the 2001, meeting in Abuja, Nigeria, African leaders agreed to the Group of Eight's³ idea to create a Global Fund for AIDS, Tuberculosis and Malaria. The Global Fund was created to manage the HIV/AIDS pandemic, ensure effective use of funding, and to assist nascent national AIDS programmes (the Global Fund, n.d.; d'Askey, 2004).

African leaders stated that they wanted to “take the lead in strengthening current successful interventions and developing new and more appropriate policies, practical strategies, effective implementation mechanisms and concrete monitoring structures at national, regional and continental levels with a view to ensuring adequate and effective control of HIV/AIDS” (UN, 2001).

In 2001, Kofi Annan, United Nations Secretary- General, created a strategy to fight HIV/AIDS (IMF, 2008). That strategy included a comprehensive education campaign: “we must give young people the knowledge and power to protect themselves. We need to inform, inspire and mobilize them, through an awareness campaign such as the world has never seen... once they (young people) know what they need to do, young people must have the means to do it. That means they must have support from their families and communities, as well as access to voluntary counselling and testing and -- when appropriate -- to condom” (Kofi Annan, 2001). After the creation of the Global Fund

³ The Group of Eight (G8) is a forum for the heads of state or government of the major industrial democracies. The G8 meets at least annually to discuss international economic and political issues. For more on the G8, please refer to: http://www.g8.utoronto.ca/what_is_g8.html

and until 2008, HIV/AIDS funding had increased six-fold (Avert, 2009).

PEPFAR

In 2003, The President's Emergency Plan for AIDS Relief (PEPFAR) was launched. Two billion U.S. dollars were allocated from the American Government's budget for HIV/AIDS treatment and prevention programmes between the years 2003 to 2008. By 2007, the U.S. Government accounted for more than forty percent of the global funding to HIV/AIDS by governments (Avert, 2009).

Controversy struck in 2003, when the American Government announced that of the \$2 billion allocated to fight HIV/AIDS, thirty-three percent had to be allocated to abstinence-before-marriage programming. This mandatory condition greatly limited the messaging and education campaign of governments and NGOs. Critics of this programme have argued that the funding has ignored the need for culturally relevant HIV/AIDS prevention programming and consequently has put lives at risk (Cohen and Tate, 2006).

Despite the cautionary feedback from NGO workers and HIV/AIDS activists on the need for broader campaign options and concerns over the lack of epidemiological support for abstinence-only prevention policies, on July 30th 2008, an additional \$48 billion (USD) was promised for the international fight against HIV/AIDS for years 2009-2013 through PEPFAR. This second round of funding was attached to the condition that a report to Congress must be made if “less than half of prevention funds go to abstinence, delay of sexual debut, monogamy, fidelity, and partner reduction” (Avert, 2009).

The condition of abstinence and be faithful (A B) and abstinence-only policies attached to funding and the increased donor-driven policy agendas are causing much controversy and concern because they have not proven effective at altering sexual

behaviour which may lead to an increased risk of contracting HIV. Through the PEPFAR programme and the Global Fund (of which the U.S. is the largest donor) the U.S. Government is the largest financial contributor to global HIV/AIDS programme funding. This has given the Americans control of the prevention agenda. The effects of their influence on these programmes through both multilateral and bilateral foreign aid are continuing to be debated.

U.S.' Struggle with Prevention

Since the early 2000s, the U.S. has been making aggressive changes to its sexual health education in schools across the country. The George W. Bush administration advocated for abstinence-only (A-only) education to be taught in schools to the exclusion of other sexual health prevention.

The Bush administration promoted abstinence-only education as a means to delay sexual debut⁴ (SIECUS) despite there being no evidence that abstinence-only sexual health education lead to delayed sexual debut (McKay, 2001; Silva, 2001; Kirby et al., 2006; Kirby, 2007). All evidence-based studies have shown comprehensive sexual education to be the only program that could achieve a delayed sexual debut (Silva, 2001; Kirby et al., 2006; Kirby, 2007).

While the debate over abstinence-only sexual health education was happening in domestic American policy, international policy was being changed to reflect the preference for A-only sexual health education. With the U.S. being the largest donor for HIV/AIDS prevention programmes ethical concerns were raised by researchers and

4 The literature coming out of the United States uses the term “delayed sexual debut” or “delaying sexual initiation” to mean that adolescents have chosen to delay sexual intercourse. This does not mean that these adolescents have chosen to abstain until marriage.

scientists over this new direction (Kirby, 2007; Shambley-Ebron, 2009).

If there are no reliable studies showing that A-only education lowers sexual debut, thereby decreasing the HIV/AIDS rate, the U.S. should not be able to tie the majority of the international HIV/AIDS prevention money to A-only sexual health.⁵ Evidence does not always form policy and in the case of A-only education, the politics and theology of the U.S. and Uganda are being promoted through policy over evidence-based policy making.

Prevention

Prevention, rather than treatment, of HIV/AIDS is the focus of this study. While treatment is recognized to be an important part of combating HIV/AIDS, a thorough and comprehensive study of the issues of foreign aid and treatment is too large to be contained within this thesis.

HIV/AIDS can be transmitted through needles or other exchanges of blood; however, it is most often contracted from one person to another through sexual intercourse. Sex is a sensitive topic and subject to much taboo. Different cultures view sex and sexual relationships differently. Cultural practices, customs, and norms play a role in sexual exchanges and therefore they play a role in the transmission of HIV. Because of the relationship between culture and sex, a one-size-fits-all HIV prevention policy may not prove to be the most effective approach.

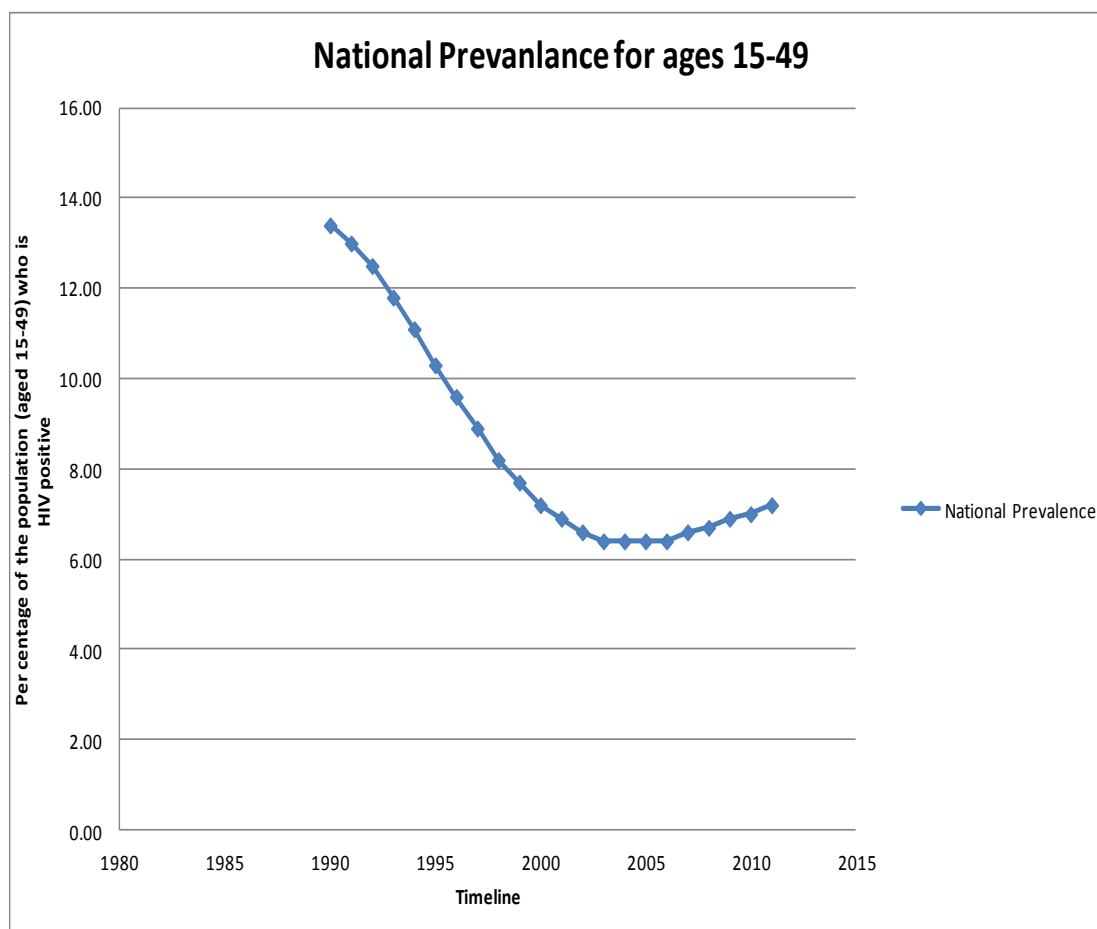
Yet the U.S. is not only emphasising an A-only approach to sexual health education through their bilateral aid programs, they are reducing their participation in programmes

5 For more information on the weak link between health plans, strategies and evidence, see: M. Foster, *Fiscal Space and Sustainability—Towards a Solution for the Health Sector*. 2005.

that do offer comprehensive programming. The U.S. withdrew much of their funding from the Global Fund which had been the primary donor for developing countries on HIV/AIDS prevention and treatment. The U.S. was the largest contributor to the Global Fund- which takes donations from member organizations. Ninety-five per cent of the Global Fund's operating budget comes from governments. Of that, the U.S. contributed 35 per cent in 2011⁶. Without the U.S' donation, the Global Fund is unsure of its financial sustainability (The Global Fund, 2012). Even with contributions from the Global Fund, in 2010/2011 bilateral funding from the U.S. made up 93 per cent of HIV/AIDS directed foreign aid to Uganda (Uganda AIDS Commission, 2012). The tying of American domestic political preferences, such as abstinence-only, to global health aid by the largest donor leaves Uganda with few options to create an HIV/AIDS prevention programme that is has been proven effective in Uganda, such as the comprehensive sexual health programming used in the 1980s and 1990s.

6 Author's own calculations using data from: The Global Fund to Fight AIDS, Tuberculosis and Malaria's Contributions to Date. More information can be found at: <http://www.theglobalfund.org/en/donors/statistics/>

Uganda



Data taken from UNAIDS Data Analysis for Uganda

Uganda was one of the first countries to experience a large HIV/AIDS epidemic. The country showed enormous capability in tackling HIV/AIDS early-on despite having little international funding for such a campaign (see appendix A1 and A2). Uganda's domestic campaign brought the epidemic from a general population rate of 13.2 per cent (ages 15-49) in 1990⁷ to 6.1% by 2002 (UNGASS Report, p.16).

⁷ According to the World Health Organization (2005) the epidemic in Uganda peaked at 18 per cent in 1992. The accuracy of both these numbers has been questioned (Green, 2003; Parkhurst, 2010, 2.1; Cohen and Tate, 2005,

<i>Year</i>	Rate of HIV/AIDS prevalence in Uganda (percent)	Rate of HIV/AIDS incidence in Uganda (number of people)
2000	7.2	N/A
2001	6.9	N/A
2002	6.6	N/A
2003	6.4	N/A
2004	6.4	N/A
2005	6.4	N/A
2006	6.4	N/A
2007	6.6	115,775
2008	6.7	119,258
2009	6.9	124,261
2010	7.0	128,980
2011	7.3	145,000

In 2001, the U.S. created PEPFAR. That same year the Ugandan HIV/AIDS epidemic had declined to 6.9 per cent. Two years later in 2003, PEPFAR made its first donation to Uganda for HIV (UNAIDS). Uganda's HIV/AIDS rate was 6.4 per cent. Since then Uganda's HIV/AIDS has stagnated or risen.

pg 13-14; Chin, 2007). 18% is the number that many international and United Nations' agencies are using when citing the peak of the HIV/AIDS epidemic in Uganda (World Health Organization, June 2005. pg 1.). For consistency sake this paper will rely on UNAIDS data as it is one of the only complete sets of data from the 1980s to 2010.

The large infusion of American aid into HIV prevention programmes did influence Ugandan prevention policies. However, it is unlikely that funding could have had immediate and widespread influence on the rate of the spread of HIV/AIDS.

While Uganda was initially a success story in the Sub-Saharan African HIV/AIDS epidemic, as of 2007 Uganda's HIV/AIDS prevalence rate has been slightly rising. Uganda is among the most severely affected countries in Sub-Saharan Africa today. It is estimated that there are close to 1.4 million People Living with HIV/AIDS (PLWHAs) in Uganda at the end of 2010 (UNAIDS, Data Analysis) and HIV/AIDS is still considered a major impediment to Uganda's development.

Uganda is used as an example in much of the literature on Sub-Saharan Africa and HIV/AIDS because it has been such a success story and has provided an adequate example for those arguing both for and against the American ABC (Abstinence, Be Faithful and consistent and correct Condom use⁸) approach to HIV/AIDS prevention.

In the literature it is disputed which policies and programmes led to the initial HIV rate of decline in Uganda (Cohen and Tate, 2006; Green, 2006; Parkhurst, 2010). It is often claimed, particularly by PEPFAR, that ABC is a successful “homegrown” African approach to HIV prevention because it is a model similar to the prevention campaigns run by the Ugandan Government in the early 1990s (Hearst, 2007). However, many NGO workers and those on the ground in Uganda working on HIV/AIDS prevention during the initial decline argue about what role ABC played and how those terms are defined (Green et al, 2006). Avert and Cohen and Tate argue that ABC is not a homegrown Ugandan approach and rather an approach implemented because of PEPFAR funding policies

8 Condom use is promoted by the American Government, and many in the international community, as only for those who engage in high-risk sexual activities. For the purposes of PEPFAR, high risk sexual activity means having more than one sexual partner.

(n.d.G and 2005, respectively).

Rational for the study

Even if it were possible to get enough money for our needs from external sources, is this what we really want?...Gifts which increase, or act as a catalyst to our own efforts are valuable. But gifts which could have the effect of weakening or distorting our own efforts should not be accepted until we have asked ourselves a number of questions.

- *Tanzanian Leadership's Development Manifesto, 1967 (as quoted in Sogge, 2002).*

There has been ample debate on what really happened in Uganda that led to a dramatic decline in HIV/AIDS rates. Tumushabe has noted that deaths may account for some of the decline (2006). Green (2003), Cohen and Tate (2006), Chin (2007), and Parkhurst (2010) argue that the decline has been exaggerated. However, even those who argue that the numbers have been inflated still agree that a particularly aggressive decline did occur in Uganda and that success is now at risk as rates of HIV begin to climb.

Foreign aid should be used to promote and accelerate development (Riddell, 1987). However, the literature argues that aid is often tied to policies that are aligned with the politics of the donor country. These policies may not follow epidemiological trends and may not be relevant to the culture where they are being promoted or implemented (Pisani, 2010; Chin, 2007). It is unclear how the impact of these politically motivated policies is affecting HIV/AIDS prevention work on the ground. Although inconclusive, it has been suggested in the literature that policy agendas driven by donor politics could be one of the reasons that hinder comprehensive public health action and consequently leads to the rising HIV transmission rate in Uganda (Bass, 2005).

There is literature available on the grassroots campaign that happened in Uganda that may have lead to the initial decline in HIV/AIDS rates (Hogle, J.A., et al., 2002; USAID, 2002; Black and White, 2003; Parkhurst, J. O., 2010). There is also literature

available on the changes to the campaign that occurred as a result of PEPFAR (Epstein, 2007; Cohen and Tate, 2006; Aidsmap, 2006). However, there is little research available on the relationship between U.S. funding, U.S. domestic policy, and changes to the Ugandan HIV/AIDS prevention campaign since 2004 when the national prevalence stopped declining (Dietrich, 2007). As of 2010, PEPFAR contributed 70 per cent of all funding for HIV/AIDS activities in Uganda (Goosby, 2010) and U.S. funding made up 83 per cent of resources for HIV/AIDS by all external funders (Uganda AIDS Commission, 2012). At least 33-50 per cent of that funding was tied to the implementation of abstinence-only sexual health education programmes which have been proven ineffective at changing sexual behaviour. The financial power of the U.S. is influencing Ugandan policy makers and NGOs to adopt ineffective prevention programmes. These programmes could be affecting Uganda's rise in HIV/AIDS prevalence rates. Further exploration of policy changes and political decision-making that may have led to the fluctuation in the national HIV/AIDS prevalence rate is required.

Research Statement

With early success in decreasing the spread of HIV/AIDS, Uganda demonstrated capacity to slow the epidemic. Uganda was then given increased financial assistance and resources from the global community with the intent to further decrease the national HIV/AIDS prevalence. After receiving increased foreign aid targeted at HIV/AIDS, Uganda's HIV/AIDS levelled off and rates began to slightly climb. As increased donor funds entered the country, and consequently created multiple approaches to HIV prevention, and with it, overwhelming contradictions in health promotion advice, HIV/AIDS rate rose. This thesis asks the question:

Through the use of foreign aid tied to the adoption of U.S. prevention policies, has

PEPFAR contributed to the politicization of HIV/AIDS prevention programming of Uganda, and consequently to poorer incidence rates than that of the past?

Main argument

This thesis argues that funding from PEPFAR has contributed to policy changes in the HIV/AIDS prevention programmes of Uganda. Through use of aid tied to the adoption of U.S. policies for HIV/AIDS prevention, many of Uganda's prevention programs are now focused on an abstinence-only model to sexual health education. This is also backed by the President of Uganda and the First Lady. In order to receive foreign aid Uganda has foregone a unified, and comprehensive evidence-based prevention programme in favour of introducing abstinence-only campaigns into the health promotion landscape. Since receiving PEPFAR funding Uganda has been less effective at reducing their rate of HIV/AIDS. By diversifying the public health education of the country, and by consequently introducing conflicting and conflating public health awareness into the country, Uganda's capacity for reducing HIV/AIDS has been compromised.

Findings from the literature conclude that several factors, including comprehensive sexual health education campaigns and a reliable supply of condoms are essential to once again decrease the rate of HIV/AIDS prevalence.

The key findings are:

1. Uganda prevented much of the spread of HIV/AIDS in the late 1980s-early 2000s through comprehensive HIV/AIDS sexual health programming which focused on abstinence, being faithful and consistent and correct condom use. The language of the campaign

(“zero grazing” and “just chill”) was familiar to Ugandans and the phrases became popularized. The initial effort to curb the climbing of HIV/AIDS rates was inclusive of all Ugandans including sex workers⁹ and family planning clinics. The vast availability of free condoms was also attributed to the decrease in the rates of HIV/AIDS. “Zero grazing” was a homegrown prevention programme and reflected Ugandan culture.

The introduction of PEPFAR guidelines on prevention programming did restrict Uganda’s original HIV/AIDS campaign. The PEPFAR prevention programme excludes high risk groups such as sex workers and intravenous drug users. It limited campaigning on messages other than abstinence, and later on messages outside abstinence or faithfulness (meaning having sex only with those you are in a committed relationship with). PEPFAR’s policies did influence the design of Uganda’s original homegrown “no grazing” approach to HIV/AIDS.

2. Foreign aid from the U.S. is earmarked for particular plans and programs. Many of these are in favour of abstinence-only education. Funding from PEPFAR far outweighs the international funding available from any other source. Most of the Uganda HIV/AIDS prevention programs depend on PEPFAR funding and wish to attract more funding. Therefore, they are required to adopt an abstinence-only campaign in order to receive international financing.
3. A campaign promoting abstinence and largely neglecting condoms has been waged by

⁹ Men who have sex with men (MSM) are not directly included in this thesis when focusing on Uganda because :

1. it is very difficult to access information on MSM in Uganda because of the severe discrimination they suffer.
2. Unlike the HIV/AIDS experience in North American, Uganda’s epidemic have been much more generalised.

political and religious leaders in Uganda since 2003. These campaigns are largely supported both politically and financially by leaders in the U.S.. In Uganda, new policies requiring additional quality testing on condoms has been put in place. This delays market entry of condoms and often causes a short supply problem. Without available condoms, progressive and comprehensive sexual health education is at risk. If condoms cannot be obtained by those wishing to use them because of their short supply, then safe sex cannot be practiced and people are either forced into abstinence or they risk contracting HIV.

Methodology

To find books, reports, and journal articles to conduct a literature review on foreign aid, HIV/AIDS, PEPFAR and Uganda the method of scoping was employed. Research on the political implications and policy agendas attached to foreign aid is widely available, as is information on behavioural change policies and their impact on participants. However, most of the peer-reviewed literature in journals that I have access to through the Saint Mary's University electronic database, Google scholar, and PubMed are written by those living in donor countries.

It was important to find a way to include the perspectives of Ugandans in how PEPFAR impacted their HIV/AIDS prevention policies. Because fieldwork was not included in this study due to time and financial constraints, the methodology of scoping had an advantage over methods like systemic review. Scoping allows for a broader inclusion of literature as quality is not the major criteria of assessment (Arskey and O'Malley, 2005).

Scoping also provides a mechanism for rapid mapping of key information such as main sources of information as well as summarising and disseminating research findings

(Arskey and O'Malley, 2005).

Books and peer-reviewed journal articles were reviewed on the topic of foreign aid, global health, and donor influence. Bibliographies and reference lists were searched to find additional sources. Abstracts were read to narrow search results and select studies which focused on the relationships between aid donors and aid recipients, and the politics of foreign aid.

Secondary materials from highly reputable NGOs such as Human Rights Watch and AVERT were used in this thesis. An attempt to gather a Ugandan perspective and voice on HIV/AIDS policies was accessed through Ugandan newspaper articles. Newspapers were also used to understand the influence of Evangelicalism on Uganda's HIV/AIDS policies as there is a gap in the academic literature in this area.

Critical Theory

To understand the relationship between U.S. foreign aid and the HIV/AIDS epidemic in Uganda, this thesis applied the meta-theory position of critical theory. Critical theory provides an ontological and epistemological perspective that generates knowledge while acknowledging power asymmetries and conflicting interests (Mikkelsen, 2005). The aim of critical theory is to generate knowledge of the political character of social phenomena and to counteract irrational social structures (Mikkelesen, 2005).

Critical theory applies to this thesis because of the unbalanced power relationship between PEPFAR (aid donor) and Uganda (aid recipient). I argue that Uganda's initial HIV/AIDS prevention policy followed epidemiological understandings of HIV/AIDS by offering comprehensive education (including information on condoms and their distribution) to all of Uganda society- including homosexuals, sex workers, and youth.

After 2003, the Government of Uganda changed their HIV/AIDS prevention strategy and adopted narrower prevention policies namely: abstinence-only and ‘faithfulness’ to the determinant of condom education and distribution. I argue that this change in policy was influenced by pressure from the U.S. and the Evangelical church, which have profound financial and political influence in Uganda. Although condoms are still promoted by many NGOs in Uganda, the contradictory messages create conflict and confusion in the public health landscape of the country.

Habermas, a German sociologist and philosopher in the tradition of critical theory, warned of the encroachment of political-administrative systems on the “lifeworld”. He used the term ‘lifeworld’ to mean the private sphere such as family institutions (Habermas, 1984, 1987). For the purposes of this thesis I am considering private (i.e. not sex work)¹⁰ sexual behaviour as a part of the lifeworld and examining the restriction of people’s sexual behaviour – i.e. not being able to access condoms or education on condoms - by political-administrative system through communicative action (mass communication institutions).

In some of Habermas’ later writings, namely *Political Communication in Media Society: Does Democracy Still Enjoy an Epistemic Dimension*, Habermas describes how the media and political figures have significant power to shape ‘public opinion’, but that some of that “power is constrained... by the reflexivity of a public sphere that allows *all* participants to reconsider what they perceive as public opinion” (2006, emphasis in italics is original). He argues that people can use the public sphere to participate in opinion shaping particularly through open and democratic media (Habermas, 2006). This thesis

¹⁰ I am not considering sex work as part of the lifeworld as it is as system rooted in economic transactions (fiscal or otherwise) and not entirely in the domain of Habermas’ lifeworld.

looks to the Ugandan media for that public participation and voice of Ugandans. Primary sources of information that were authored by Ugandans or included their perspective on PEPFAR's influence and HIV/AIDS policy were very limited and difficult to acquire. I have attempted to include the perspective of some Ugandans through Ugandan newspaper articles as one of the secondary sources of research material.

I have applied Habermas' critical theory framework to this thesis by examining the relationship between PEPFAR, Uganda's political administration, and the influence they have on the HIV/AIDS prevention policies of Uganda.

Justification for the study

Current data suggest a significant correlation between HIV/AIDS prevention policy and program implementation and the HIV/AIDS infection rate in the communities in which they are implemented. Policies and programmes which are broadly implemented, government supported, encompass several different approaches, use a variety of messages and are implemented early in the epidemic have a significant impact on the rate that HIV/AIDS spreads in a community versus those policies which do not approach prevention programming with these fundamentals or are narrow in scope (Kirby, 2007; Barnett and Parkhurst, 2005; Cohen and Tate, 2006; Parkhurst and Lush, 2004).

The foreign transaction whether in cash or in-kind and the expertise provided by international organizations and overseas governments often have policy and programme requirements attached. These requirements can lead to changes in a recipient country's policies and programming.

This thesis conducted a thorough scope of the literature available on U.S. aid and its impact on recipients' HIV/AIDS prevention policies. To fully understand the impact of

donor policies on aid recipient countries, Uganda's HIV/AIDS prevention policies were examined before and after receiving substantial funding through PEPFAR. For this thesis I studied the relationship between Uganda and the U.S. and identified the structures of power dynamics that exist between them. The case study I used is the adoption of the U.S.'s abstinence-only sexual health programme by Uganda. By examining the mechanisms of political agendas and foreign aid I analysed the interplay between the U.S. and Uganda during the HIV/AIDS epidemic.

Uganda is not the only country to have accepted PEPFAR funding with abstinence-only programming restrictions attached. Many countries in the Global South received PEPFAR funding. However, there were several reasons why Uganda was chosen. Firstly, Uganda was one of the first countries to acknowledge HIV/AIDS was in their country and to begin prevention programming to halt its spread (WHO, n.d.). The initial response time by Uganda is important because it provided over a decade of research on the effects of a homegrown Ugandan HIV/AIDS prevention programme (1989-2002).¹¹ Secondly, Uganda was one of the first countries to establish HIV/AIDS testing at antenatal and Sexually Transmitted Infection (STI) sites.¹² These sites have been recording rates of

¹¹ Uganda did receive funding from the Global Fund and other multilateral and bilateral organizations before PEPFAR funding became available. But funding from other sources did not attach requirements of abstinence-only education and multiple studies report that the "no grazing" campaign of 1989-2002 was a Ugandan homegrown response.

¹² Pisani (2008) questions the reliability of HIV/AIDS rates coming out of the global south for two reasons. The first, she suggests, is that HIV/AIDS rates have been exaggerated to attract more international funding (2008). The second is that most, if not all, of the patients at antenatal and STI clinics are having sexual intercourse and she warns that you cannot generalize an HIV/AIDS epidemic to the wider public when you are only testing your sexually active population (2008). However, because the HIV/AIDS rate is based from these clinics samples and they are used in the

HIV/AIDS since the early 1990s (WHO, n.d.). This gives this thesis an ability to compare HIV/AIDS infection rates before and after PEPFAR interventions. Very few, if any other, countries in the Global South have been recording HIV/AIDS rates for as long as Uganda (Commonwealth Regional Health Community Secretariat, 2002). Thirdly, Uganda was chosen because it has received PEPFAR funding that was tied to the implementation of abstinence-only prevention education and this made it possible to study the impact of PEPFAR tied funds (PEPFAR, 2003). Lastly, Uganda was chosen because it has been extensively written about and studied. The large volume of available research meant that such a study was within the scope of a Master's thesis.

It would have been interesting to compare Uganda with other Global South countries that are recipients of PEPFAR funding. However, literature on the homegrown prevention programmes of these countries is very limited. This is often the case because countries did not act quickly to create their own internal response to their HIV/AIDS epidemic ("History of HIV & AIDS in Africa", n.d.). This made comparing countries responses before and after receiving PEPFAR funding more challenging and is perhaps outside the scope of a Master's thesis as much more preliminary and field research would be required to piece together countries' initial responses to HIV/AIDS. By focusing this research on one country, I could provide a more in-depth analysis of Uganda's response to the epidemic before and during their reception of PEPFAR funding.

This thesis scoped secondary sources of published literature on HIV/AIDS in Uganda and sexual health information, education, and communication. A review of the literature on foreign aid for international health, American foreign aid policies, and

international HIV/AIDS prevention efforts was completed. Additionally this thesis examined relevant government documents (Ugandan and American), reports from Uganda's Ministry of Health, PEPFAR policy documents and bilateral country reports, PEPFAR guidelines and policies, HIV/AIDS prevention evaluation reports, newspaper articles (both Ugandan and American), political speech transcripts, academic journals, and books.

Researchers have studied the effectiveness of Uganda's initial "no grazing" campaign to prevent the spread of HIV/AIDS. Other research has been conducted on the American-style of abstinence-only prevention programs. However, looking at why Uganda has switched from a "no grazing" campaign to an A-only campaign is a relatively new area of research. This study provides a critical piece in the understanding of how donor governments can impact the policies and programmes of successful homegrown approaches in developing countries.

This thesis is largely qualitative; however, quantitative material was used to illustrate the fluctuation in the HIV/AIDS epidemic in Uganda and to correlate those numbers with the amount of foreign aid sent from the U.S. to Uganda.

Limitations of this study

The most significant limitation to this research is that in the 1980s the methods of prevention and the weight given to each method may have differed throughout the country. This is likely the result of both a civil war (until 1986) and the urgency to stop the HIV/AIDS epidemic which was a new virus at the time. Documenting the initial responses to HIV/AIDS was likely not high on the government's priority list. As a result monitoring of the initial HIV/AIDS prevention campaign called "zero grazing" was weaker than the monitoring of the abstinence-only approach is today.

Data on rates of HIV/AIDS in Uganda from the 1980s and early 1990s can be unreliable and unavailable. Some data is available from antenatal clinics was collected and reported in varying settings using various methods and this could have an impact on their results (Black and White, 2003; Tumushabe, 2006). AIDS surveillance developed and improved substantially between the 1980s-2000s. In the 1990s, Uganda began a door-to-door testing campaign which offered Ugandans free HIV/AIDS testing and counselling without them having to travel to clinics, hospitals or public testing locations (Mukisa, 2013). HIV/AIDS testing also improved from blood tests at clinics to saliva tests with near instant results (authors own experience working in a health clinic in Misufini, Kenya).

I have attempted to find data that is the most reliable, accurate, and comprehensive. Whenever possible, I have tried to use only one source for HIV/AIDS rates (prevalence and incidence) so as to mitigate the impact of various HIV/AIDS rate collection methods. I have also chosen to use UNAIDS datasets as they are most often referred to in the literature and this keeps my research consistent with the literature I am using. The greatest impact of various methods of collecting HIV/AIDS rates could put question to how much impact A, B, and C played on Ugandans in the initial decline.

Required information

Information was obtained through a variety of secondary sources. To answer Uganda's relationship with foreign aid for HIV/AIDS prevention programming, it was necessary to complete a historical review of Uganda's original homegrown HIV/AIDS prevention programming called "zero grazing". That information needed to be compared with Uganda's HIV/AIDS prevention policies after the receipt of PEPFAR funding to see

what, if any, changes were made. Further research into the policies of PEPFAR needed to be completed to understand the changes and restrictions being placed on recipient countries. To understand what impact new policies could have on Uganda, an analysis of the evidence behind these changes (such as the outcome of abstinence-only sexual health education) was conducted.

Data Collection Techniques

To collect the data required for this thesis the scoping method was utilized. Scoping was used to find books, case studies, NGO and government reports, and newspaper articles on foreign aid, HIV/AIDS prevention techniques, and behavioural change programmes. Scoping was also used to discover PEPFAR reports and evaluations. Lastly, scoping was employed to gather Ugandan's perspectives on the changes to sexual health education through online newspaper articles and NGO reports.

After an initial review of the literature, it became apparent that research from the Global North dominates the academic material especially that which is found in peer-reviewed journals on sexual health behavioural change. I needed to research both the impact of sexual behaviour change programs in the U.S. and in Uganda to understand the changes made to HIV/AIDS prevention from the perspective of those inside the country who experienced programming changes firsthand. Whenever possible, sources from Uganda were used, such as Ugandan Ministry of Health reports and Ugandan governmental operational plans. The need for Ugandan specific research on sexual health behavioural change programmes prompted a wider search for research. It was decided that the adoption of a scoping methodology would allow for rapid mapping of key information such as main sources of information and the types of literature available, as

suggested by Arskey and O'Malley (2005). This method allowed the inclusion of secondary materials from highly reputable NGOs such as Human Rights Watch and AVERT and Ugandan newspaper articles.

The time period under investigation follows the epidemiological trend in Uganda (early-1980s to present day) and empirical data (1990s-2011). This time period is combined with on-going reviews of the literature to draw historically informed lessons about political context for future policy development.

Many of the online Ugandan newspaper sites such as the Monitor and New Vision do not store material past a certain number of years (2006 for the Monitor and 2000 for New Vision). Occasionally articles had pay walls preventing access to archived material. For these reasons, I did not need to set and apply a range of dates to the information I gathered (as suggested by Askery and O'Malley, 2005). Instead I was limited by dates imposed on the research through the news websites.

At the writing stage of this thesis it became evident that the American and Ugandan Evangelical movement was having a strong influence on the policies and programmes of PEPFAR. After conducting an initial scope of the available literature, few peer-reviewed academic papers were found. The terms "Evangelical HIV/AIDS Uganda" were entered into the Saint Mary's University library database and 19 results were found. Of those only 7 results contained all 3 keywords. One of these studies was removed because its full text was not available. After reading the remaining 6 articles, 4 others were removed because they were not the best fit to assist with answering the research question. Askery and O'Malley suggest that in cases "where an area is complex or has not been reviewed comprehensively before" the researcher should conduct a scoping study (2005, 5). Askery and O'Malley suggest that bibliographies be used to find additional sources (2005). After

searching through both of the relevant articles references two additional relevant sources were discovered and a saturation point was reached where no new relevant literature was found.

I did not feel that four studies was enough to support a discussion on the evangelical influence over the politics and policies of HIV/AIDS prevention programming in Uganda, so additional electronic databases were used. Through Google scholar I further refined my search query and 17 results were shown and of those an additional 4 were included in this thesis.

This same method of scoping was then completed with 12 other search queries including: “foreign aid policy and global health donor influence”, “American foreign aid policy and global health donor influence”, “PEPFAR”, “PEPFAR Prevention”, “PEPFAR HIV/AIDS Uganda Prevention”, “international foreign aid donor HIV/AIDS”, “school based sexual health education behavioural change United States Uganda”, “Evangelical HIV/AIDS Uganda prevention”, “evangelicals international development Africa”, “Janet Museveni”, “Janet Museveni HIV/AIDS”, and “Janet Museveni abstinence” (see appendix 3 for full list of search terms, databases, refining terms, and result). Each time I would narrow the results by finding key words in titles or abstracts to eliminate until the search was narrowed to a more manageable number of articles.

The decision of which books or articles to borrow, download or obtain through interlibrary loan was made after reading titles and abstracts to determine ‘best fit’, as recommended by Askery and O’Malley (2005).

Askery and O’Malley suggested that when conducting research through the method of scoping, an Information Officer be employed to help keep track of searches, dates, and results. The resources available to hire an Information Officer were not available and as

such I did my best to keep track of searches, dates, and results (see appendix 3).

In addition to scoping, content analysis was performed on PEPFAR funding documents and Ugandan country profile documents to find patterns showing preference for abstinence-only or comprehensive sexual health programming (see appendix 2). To analyse what, if any, changes had been made to Uganda's successful homegrown prevention approach to HIV/AIDS, analysis of Uganda's Ministry of Health Operational Plans and Guidelines was conducted. Any policy changes noted were then compared with PEPFAR funding guidelines. This was used to help determine if PEPFAR's funding criteria could have influenced Uganda's HIV/AIDS prevention programming.

Through the collection of government documents I was able to conduct research on PEPFAR policies and funding restrictions. Analysing the text allowed me to extract what was included and what was excluded from prevention programming and funding policies (such as condom distribution).

Government documents also allowed me to retrieve information on HIV/AIDS statistics—both People Living With HIV/AIDS (PLWHA) and newly acquired infections. The use of government documents made it possible to research how much prevention funding was available to Uganda from multiple sources including the U.S. U.S. government documents allowed me to follow the money from PEPFAR to Uganda and analyse who was receiving the money in Uganda to implement sexual health prevention programming. Analyzing the prevention policies of PEPFAR donation recipients in Uganda reveals the distribution of PEPFAR funds to abstinence-only or comprehensive sexual health education programs. This analysis allowed me to reveal patterns in PEPFAR funding.

Documents

The documents used in this thesis include: both aid donor and aid recipient government reports and policies, books, peer-reviewed journal articles, PEPFAR funding guidelines, NGO reports from the field, and newspaper articles.

Chapter 2: Literature Review

A study of foreign aid and the role aid plays in both health and development is necessary to understand the interaction between aid donors and recipients. Drawing upon the literature on foreign aid and development, this chapter will examine the role of aid donors and recipients and the asymmetric power relation that gives donors the ability to direct recipients HIV/AIDS prevention policies.

Following a review on foreign aid, part two of this chapter will provide an understanding of the debate on the prevention of HIV/AIDS. The literature examines foreign aid and its role in international health, the power relations between foreign aid donors and recipients, foreign aid and U.S. interests, foreign aid and HIV/AIDS, and foreign aid and Uganda. All of these areas help establish a better understanding of historic and current relations between foreign aid donors and foreign aid recipients with an emphasis on health and HIV/AIDS. This allows for better understanding of the relationship between PEPFAR and Uganda in the case of HIV/AIDS prevention.

To define foreign aid this thesis will be using Official Development Assistance¹³ which is defined by the OECD as: grants or loans to developing countries and territories and to multilateral agencies which are: (a) undertaken by the official sector (b) with promotion of economic development and welfare as the main objective; (c) at

13 David Sogge, 2002 claims that Official Development Assistance is a condescending term used when aid is given to low-income countries of Asia, Africa and Latin America. The same aid is termed 'official aid' when it is given to Eastern Europe, the ex-Soviet Union, and other 'transitioning' countries (27). The use of the term 'official development assistance' in this paper is not meant to cause offense. This paper has adapted the language of the UN, OECD, World Bank, and USAID for the purposes of clarity and data collection. As the author, I apologize if the use of ODA is offensive to some. When confusion is not a concern, 'foreign aid' will be used in ODA's place

concessional financial terms (if a loan, having a grant element of at least 25 per cent). In addition to financial flows, technical co-operation is included in aid. According to the report *International Assistance for HIV/AIDS in the Development World: Taking Stock of the G8, Other Donor Governments, and the European Commission*, published by UNAIDS, official assistance includes grants and loans both in currency and in-kind.¹⁴

It needs to be noted that some of the research sources used in this thesis do not specify if they include in-kind donations or how they determine the value of in-kind assistance in ODA. PEPFAR does offer in-kind donations, especially as a part of their public-private partnership program. However, there is an inconsistency in reporting in-kind donations and many non-governmental organizations and some government papers do not include in-kind donations. In this thesis, every measure possible is taken to alert the reader when foreign aid numbers do not include in-kind assistance or when it is unclear as to whether the original source included both currency and in-kind assistance in their valuations of aid.

Foreign Aid and Development- Who gets to decide

The practice of giving aid to developing countries as a form of financial or in-kind assistance has always been controversial. Some authors believe donor countries use aid to wield power and influence over developing countries (Teresa Hayter, 1971; Raymond Hopkins, 2000; Tina Wallace et al., 2006; Stephen Browne, 2006; Paul Collier, 2007; William Easterly, 2007; and Glennie, 2008) . These authors see a need to reduce the dependency of developing countries on foreign aid and to scale back many of the policies,

¹⁴ For further discussion on the definitions of foreign aid, please see Kates and Lief, 1996, p.3

programmes, and donor involvement. With a radical shift in the politics of aid, these authors see aid as having the potential to play a positive role (Teresa Hayter, 1971; Raymond Hopkins, 2000; Tina Wallace et al., 2006; Stephen Browne, 2006; Paul Collier, 2007; William Easterly, 2007; and Glennie, 2008).

Moyo is one of the few authors who call for an ending of all aid except during humanitarian crisis such as the often cited Tsunami of 2004 or during times of global epidemics such as the global experience with HIV/AIDS (2010). Sachs argues that aid is still worthwhile to recipient countries and plays an important role in global poverty alleviation (2005). While Lancaster sees aid as not having a single purpose, but rather one that has continually evolved and must be re-examined by each governing party (2007).

Hayter (1971), Hopkins (2000), and Hudson and Goulet (1971) see aid as more beneficial to donor countries than to developing ones. They all use the U.S. as their example of a country that is using foreign aid to serve political interests of their own rather than to fulfil the interests or needs of recipient countries. Hayter sees foreign aid as a form of imperialism (1971). She notes that countries of interest to the U.S. receive flexible financial aid, whereas countries of less importance to the U.S. receive aid tied to strict conditions and policies (1971). Hopkins uses the period of the cold war to show that the U.S. gives money to the countries it is strategically aligned with (2000). Hayter calls for a revolution in aid, but believes that aid policies will likely remain with the status quo because the U.S. is too powerful (1971).¹⁵ Hudson and Goulet show that the U.S. prefers bilateral relationships with recipient countries because it achieves U.S. self-interest. They

¹⁵ Although Hayter's *Aid as Imperialism* is quite dated now, I believe it is important to include her assessment of the U.S.' power and influence because it shows that the U.S. has held for decades a powerful position in the foreign aid community.

find that the U.S. only supports multilateral organizations when they promote U.S. policies. Hudson and Goulet suggest that more multilateral aid projects may further assist recipient countries (1971).

Gordenker sees international organizations as having conscious and subconscious influence on recipient countries which Gordenker argues leads recipients to tailor programming to attract increased aid rather than designing programmes for the best outcome in each recipient country (1976). Gordenker could not find any “rational means” for how the governments of donor countries select recipient countries. He writes that “the decisions therefore can be placed in the category of political, rather than technical, choices” (1976, 92). Like Hayter (1971), Gordenker sees aid establishing a dependent relationship that leads to neocolonialism (1976).

Riddell argues that aid can play an important role in accelerating development but it cannot create development (2004). He cautions developing countries to not become dependent on aid and he sees aid as most favourable to donor countries and their interests (2004 and 1996). He argues that aid's purpose and aid's motives should not be confused (1996). Riddell calls for more research on how aid could be effective, more unity in donor objectives for aid and for aid to focus on where it is required rather than on how much should be given¹⁶ or to whom (2004 and 1996).

Wallace, Borenstein and Chapman write about the aid chain (2006). They see aid as having potential to help developing countries grow, but only if it is locally managed,

16 Here Riddell is criticizing Lester Pearson's suggestion that 0.7 per cent of GDP should be given to developing countries. Riddell calls for the need to analyze what the needs of the countries' are and to give an amount appropriate to the need, rather than something arbitrary.

responsive to the needs of the recipient community, and allows for local innovation and creativity (2006). Wallace et al., see power flowing from North to South with no feedback loop for the South to be involved in the decision making. They argue that for development to occur the system as-is needs to be evaluated and decision making power needs to be re-distributed to the recipients, practitioners, and local communities (Wallace et al., 2006). As a result, Wallace et al., see aid as weakening and potentially undermining local democracy and decision making (2006).

Not everyone agrees that aid can simply be reformed. Moyo sees aid as harmful to developing countries. She argues that aid is given for the benefit of donor countries¹⁷ and that development experts know aid is “crap, but it sells the t-shirts” (2009). For recipients, aid has facilitated corruption, created bloated governments and is the reason for development stagnation and regression (2009). Although Moyo sees a need for some aid now, particularly in the case of health epidemics, Moyo's ultimate hope is that aid “will dwindle to zero” (2009).

Although not differing from Moyo's concentration on the negative impact that aid has made, other researchers such as Browne (2006) and Kankwenda (2005) see little or no positive impact made by foreign aid on the development objectives of recipient countries. Instead aid had been used by donor countries for donors' commercial and political advantage (Hjerlhom & Wgute, 2000 as quoted in Browne, 2006. p. 22.; Kakwenda in Erero, 2004). Kankwenda sees foreign aid as a distraction from the “real task of development” (Erero, 2004).

17 Moyo sees aid as creating jobs for the civil servants of donor countries

Easterly sees a need to transform development agencies. He is critical of the way donor governments and agencies operate because they spend their energy on fundraising and pleasing their donors rather than focusing on how and where the money for development is spent (2002). He sees donors as often hindering development (2007). He claims donors want to plant their country's flag on each development initiative and this prevents collaborative work (2002). He warns that aid agencies are not critical of themselves or others because they fear that will give a bad name to all of aid (2002). Easterly reminds his readers that those working for aid agencies in their country may not have an incentive to see their country come out of poverty, and he feels like this is another hindrance to development (2002). Easterly offers a solution to change the agencies' role from what he calls "planners" into "searchers" (2007). He defines searchers as people and organizations that find new ways to assist developing countries (2007). Although commonly cited as an aid critic, Easterly does note that aid has played a positive role in some areas of development, notably education and health (Sachs, 2006).

Collier places the blame for a lack of development on the feet of developing countries' leaders. He argues that recipients' governance has been inappropriate and calls on donor governments to reinstate aggressive policy programmes that focus on aid, trade, security, and governance reform (2007). Unlike Moyo (2009), Collier argues that aid has increased the economic growth of the bottom billion (2007). Therefore, Collier sees aid as part of the solution, but heavily tied aid needs to be offered to ensure appropriate governance (2007).

Glennie, like Collier, calls for an adjustment of aid policies and not the abolishing of aid entirely (2008). But similar to Moyo, Glennie argues that aid decreases democracy

and can cause more harm than good (2008). He suggests that instead of setting targets for how much aid donor countries give, we should set targets for developing countries to get off aid dependency and decrease their aid income (2008).

Dollar and Pritchett of the World Bank write that development with aid is possible as long as aid is given to “good governments” (1998). Dollar and Pritchett do raise concern with donors’ self-interest (1998). Donors’ tie aid to ensure their own products are purchased (1998). According to Dollar and Prichett tied aid reduces the value of aid by twenty-five per cent because donor prices or transportation fees may be higher than they could access if they were able to shop around with their aid money (1998). Additionally, Dollar and Prichett have concern with the political and security interests of donors (1998). They argue that these interests push aid to countries that are not necessarily in most need of aid, but rather, are of interest to donor countries (1998). They see the motivation to give foreign aid as a combination of economic and political self-interest along with some degree of altruism (1998).

Walt et al., see aid as an opportunity for donor countries to have power and control. They look at the relationship between donors, recipients and NGOs and find that the power grab by donor countries often manifests itself by going through NGOs rather than official government channels (1999). Donor countries avoided aid coordination with recipient countries and their ministries because they found them too time consuming, with too much ceremony involved, too many participants which made decision making ineffective, sometimes recipient countries have too little expertise in particular areas, and finally, Walt et al., found that many donors were wary of becoming subjected to too much recipient control (1999). Bypassing donor governments and using NGOs allows donor

countries to implement the policies they desire, rather than cooperating with recipient countries (1999).

Looking more at donor control in HIV/AIDS programming, Woods finds that the U.S. prefers bilateral to multilateral funding so it can retain control over program development on the ground (2005). Although several multilateral organizations have been established (many even by the U.S.) including the Global Fund, Woods argues that the Bush administration in particular is more interested in controlling foreign aid and allocating it strategically (2005). Woods suggests that some of this strategic expenditure of aid is driven by security interests to the U.S. and not on recipients needs (2005). Woods sees the additional delivery mechanisms and lack of coordination as challenges to aid's effectiveness (2005).

Although previously opposed to foreign aid (1992, as mentioned by Wallace et al. 2006. p. 24), in his book, *The End of Poverty: Economic Possibilities for our Time* (2005), Sachs changes his view and argues in favour of continuing foreign aid. He recommends that donor countries drop the debt of recipient countries and increase their foreign aid programmes to the 0.7 per cent of GDP which was agreed to at the Monterrey Consensus (2005). Sachs sees aid as a way to fight terrorism, free countries and their people from the trap of poverty, and improve global health (2005). He sees a strong role for both bilateral and multilateral aid programs (2005).

All of the authors argue that aid is complex and the purposes and intent of aid are often even more complicated and varied. Lancaster suggests the purpose of giving aid differs between donors, private organizations, diplomacy and development (2007).

Foreign aid establishes a neo-colonial relationship whereby the recipient (usually a country in the global south) is dependent upon the donor country (often a country in the global north). Through the giving or lending of financial aid the donor country consciously or unconsciously, influences both the culture and the politics of the recipient country.¹⁸

In relation to aid spent specifically on HIV/AIDS, donors want more control over the spending and allocation despite the needs or best interests of the recipient country (Woods, 2009).

U.S. and Foreign Aid

As a percentage of Gross National Income, the U.S. gives a modest 0.21 per cent in foreign aid, but in net official development assistance disbursements the U.S. is the largest international donor (OECD, 2010). Being the largest donor of international aid, changes in U.S. foreign aid policy has the potential to greatly impact recipient countries and multilateral agencies. This next section will review the motives of the U.S. foreign aid programmes and the political strategy behind their policies as suggested through the literature.

Goldwin et al, wrote that American aid started as an emergency relief program providing food, shelter and clothing to areas devastated by World War II (1965). Aid quickly became a political tool when American interests were threatened by a communist takeover and Europe needed to rebuild to become a lucrative trading partner with the U.S.

18 Often the donor country's objective is to influence the recipient country to adopt different practices or to encourage continuing a practice (ie, democracy, capitalism, foreign trade). But sometimes, as Wallace et al, suggested, recipient countries may tailor their culture to attract more aid.

(Goldwin et al., 1965). The first goal of the 1950 Point Four Program was to create markets for the U.S. (USAID, n.d.). In 1964, McNamara said the “foreign aid program...has now become the most critical element of our overall national security effort...” (Hudson, and Goulet, 1971). And in the post 9-11 world USAID claims that foreign aid has:

the same overarching goals that President Kennedy outlined 50 years ago – furthering America's foreign policy interests in expanding democracy and free markets while also extending a helping hand to people struggling to make a better life, recover from a disaster or striving to live in a free and democratic country. It is this caring that stands as a hallmark of the United States around the world. (USAID, n.d.)

The U.S.'s government can be found explaining and rationalizing aid to their citizens by arguing two things, either: it is the moral thing for them to do, or, it is good economics because it will open new trading routes. However, while USAID admits there is some self-interest to aid, they continue to highlight the former moral and humanitarian need to give aid. The literature debates the merits of American foreign aid programmes and often concludes that aid is mostly designed for the benefit of America.

Hudson and Goulet (1971) and Walt et al. (1999) show that foreign aid is designed for donors and not recipients. Hudson and Goulet look at foreign aid using a political economy framework. They suggest that foreign aid has been designed to implement the donors' political policies rather than considering the needs and capabilities of recipient countries (1971). They point to the U.S. in particular for wanting countries to become dependent on foreign aid rather than on their home market (1971). Using several points in history when the U.S. withdrew from multilateral funding because they were not personally benefiting, Hudson and Goulet suggest that the U.S. prefers bilateral relationships with recipient countries because it achieves U.S. self-interest (1971).

With a similar point-of-view on the U.S.' interests and foreign aid, Gill Walt et al. (1999) look specifically at USAID's funding of family planning activities in Bangladesh and the U.S.' desire- or lack thereof- to coordinate funding with other donors. Walt et al. conclude that despite research showing that recipient-led programmes are better implemented, USAID and other external funders would rather pursue their own agenda than try to coordinate and compromise (1999). This leaves ministries of health in a weak and dependent position vis-a-vis the donors (1999).

Kolko adds a unique perspective to the U.S.' interests in aid by focusing on foreign trade opportunities (1988). He argues that the U.S. was upset that it did not have a colony in Africa because they were not able to get products from the continent directly and instead needed to buy through a colonizer (Kolko, 1988). The U.S. saw aid as an opportunity to better relations between themselves, Europe, and Africa and gain access to raw materials (Kolko, 1988). He argues the U.S. foray into foreign aid was for the purpose of creating a trading relationship rather than focusing on the best development strategy for newly independent African countries (Kolko, 1988). Kolko uses the example of the U.S. staying out of concerns over mistreatment and racism (such as during South Africa's apartheid) because they wanted to preserve their trading relationships (1988).

More recently, Rick Travis wrote "Problems, Politics, and Policy Streams: A Reconsideration of U.S. Foreign Aid Behaviour Toward Africa" (2010). Travis explores the relationship between internal American politics and their foreign aid programs and policies. Instead of foreign aid being distributed based on recipient need, Travis finds that U.S. aid policies change as different parties come into power (2010). This leaves recipients with unstable funding futures and a need to tailor their reports and requests for

funding to each party, rather than to concentrate on funding effective programmes or policies.

Farmer, a physician, activist, Deputy Special Envoy for Haiti from 2009 to 2012, and Special Adviser for Community-based Medicine and Lessons from Haiti to United Nations Secretary-General Ban Ki-moon writes about the relationship between Haiti and American foreign aid (2005). Farmer uses the example of U.S. money going to Haiti to fund President Duvalier and his rebel groups, but when President Aristide won his first election with ninety-three per cent of the vote, no aid went to Haiti from the U.S. and instead a trade embargo was implemented (2005). Farmer argues that the U.S. was looking out for their interests over the needs of Haitians and achieved this through aid and military power (2005).

Attaran and Sachs write that the American government has largely disappeared from the foreign aid scene and in their place American philanthropists and non-profit groups have implemented aid programmes (2001). Sachs believes the retreat on “soft stuff” (aid) is in favour of “hard stuff” (military) to create stability and security overseas and for themselves (Attaran and Sachs, 2001; Sachs 2006 (2)). He argues that the neglect of foreign aid has been bipartisan as both the Clinton and Bush Administration spent \$3 billion or less on aid a year, while spending hundreds of billions of dollars (\$550 million during George W. Bush's administration) on military (Sachs, 2006).

The literature is strongly suggests that U.S. national interest are the primary objective of the country's foreign aid programs. The U.S. government does not deny that national interests are involved in foreign aid decisions, however there seems to be a

disconnect between the emphasis placed upon assisting others in the U.S. government's rhetoric and the implementation of self-interested policies as seen in the literature.¹⁹

Foreign Aid and Health

Health is an important indicator of how a country is developing. Authors, such as Burnside and Dollar, use health measurements because it provides “indirect evidence of whether the benefits of development are reaching the broad mass of the population” (1998, 2).²⁰ Improving health in a country can be a significant sign of development.

Recipient countries need to be careful when using foreign aid to improve their health services. Oftentimes recipient countries become dependent on foreign aid and this affects their health care services and delivery. Health care funded by donor countries is focused on the desires and political theories of the Global North and may not be culturally appropriate for the recipient.

Politics in foreign aid is not new. The first known comprehensive public health treatise, *A System of Complete Medical Police*, was written in 1779. Johann Peter Frank, author of the treatise, was writing during the time of the enlightenment and saw a need for

19 While researching past and present annual development letters from Presidents as well as mission statements of USAID, it was noted by the author that the transparency in self-interested motivation for foreign aid is increasing in the United States. Perhaps there is a need to sell Americans on the continuation of the aid program and therefore the government is promoting the benefits to Americans? Whatever the reason may be, this question of transparency in self-interested aid policies will need to be left to future study.

20 In the 1998 study, Burnside and Dollar use the health indicator of infant mortality to take a broad look at how or if a country is benefiting from development programmes.

better public hygiene and sanitation not for moral reasons, but rather in order to create a healthier labour force for capitalist production (Birn et al., 2009).

As Europe increased its interest and investment in production overseas, concerns over public hygiene and healthcare in the colonies arose. International healthcare was first implemented to ensure the safety of foreign militaries (De Campos, 1988) and European settlers and to improve productivity of local workers in the colonies (Birn et al, 2009, 41-quoted MacLeod and Lewis, 1998; Bashford, 2004).

Today global health has many more players, international organizations, NGOs, multilateral and bilateral agencies are now involved in the delivery of health care services. Bodies such as the World Health Organization, UN agencies like UNAIDS, and the Global Fund for HIV/AIDS, Malaria and Tuberculosis have been founded to oversee and at times coordinate international health programming.

Crane and Dusenberry (2004) offer the most controversial and recent examples of U.S. interests being promoted overseas through health policy, the Mexico City Policy.²¹ They argue that in Kenya, the American position on international abortion influenced the Kenyan government to create their own anti-abortion law in hope that doing so they would attract more U.S. financial assistance (Crane and Dunsenberry, 2004). The need or desire for foreign aid by recipient countries can be so great that laws and policies are changed to align themselves with the policies and laws of donors. One could argue that

21 The Mexico City Policy (also known as the Global Gag Rule, by those who oppose it) stopped all American government support for overseas abortions. The policy withdrew money from any organization willing to support (by making abortions available or simply educating women on their options) abortions overseas.

the health interests of Kenyans and in particular Kenyan woman came secondary to attracting more foreign aid.²²

Dollar and Pritchett (1998), and Green (2003) would find the changes made by the Kenyan government concerning and yet predictable. They looked at health programmes in aid recipient countries and found that many of the implemented programmes were designed by and for donors who may not have understood the culture of the recipient country (Dollar and Pritchett, 1998; Green, 2003). As such, these authors argue that many aid programmes are culturally inappropriate and at times harmful (1998 and 2003).

Moyo (2010) and Navarro (1974) challenge modernisation in health because “underdevelopment” is not due to the scarcity of values, capital or technology, but rather, it is due to the inappropriate application of donor finances relative to local needs. Much of the foreign aid for health is spent on adapting the Global South to the North’s biomedical approach to health care (heavily weighted on technology) (Birn et al, 2009). Navarro argues that a high-tech health care model is inappropriate in much of the Global South and results in less health care for patients and a dependency on foreign aid for the country (Birn et al., 2009).

Justice (1986), De Campos (1998), and Dodd et al., (2007) argue that the Global North is interested in the health of people living in the Global South out of concern for

22 Further information on the Mexico City Policy can be found at: Neier A. *The Rights to Free Expression under International Law: Implications of the Mexico City Policy*. New York University Journal of International Law and Politics. 1987; 20 (1): 229-250; Population Action International. <http://populationaction.org/topics/global-gag-rule/>; ABC News. *Obama Overturns 'Mexico City Policy' Implemented by Reagan*. Jan. 23, 2009

their own national security interests.²³ They establish a link between donor countries' interest in international health and global pandemics. Justice and De Campos argue that this has been happening since the 1940s, starting with smallpox and malaria (1986 and 1998, respectively). Today both HIV/AIDS and influenza pandemics bring the international community together on health initiatives and financial aid increases (Dodd et al, 2007).²⁴

Glennie argues that foreign aid is most effective when given for the purposes of improving health. He suggests this is because foreign aid for healthcare often bypasses the government and is given directly to the service provider or service providing agency (2008). When foreign aid is given to the government for the purposes of health, Dollar and Pritchett suggest that it is not well used (1998). Dollar and Pritchett argue that sector specific aid is fungible- meaning if a donor gives aid to a particular sector it will simply replace current government expenditure- which will get spent elsewhere- thereby not increasing the money to that sector (1998). For this reason, Dollar and Prichett argue in

23 Much has been written on health and international security. One of the reasons why developed countries become interested in the area of global health is to ensure the safety and health of their own citizens. While this thesis may offer some examples of this, especially regarding HIV/AIDS, it will not be a major focus of this thesis. For more information on this topic, please refer to: Shereen Usdin. *The No-Nonsense Guide to HIV/AIDS*. 2003. p. 27; Steven Radelet. *Bush and Foreign Aid*. Foreign Affairs, Sept/Oct 2003.; Ulf Kristofferson HIV/AIDS as a human security issue: a gender perspective. November 7th, 2000. <http://www.un.org/womenwatch/daw/csw/hivaids/kristoffer-sson.htm>; Kristiana Powell. HIV/AIDS and Security. *The Ploughshares Monitor*. Summer 2003 Volume 24 Issue 2.

24 There are numerous examples of this. Many of them can be found in: De Campos, André Luiz Vieira. The Institute of Inter-American Affairs and Its Health Policies in Brazil during World War II. *Presidential Studies Quarterly*. Vol. 28, No. 3.; Going Global: The Presidency in the International Arena (Summer, 1998), p. 523-534.

favour of donor money being spent on the improvement of service delivery by strengthening sectoral and local institutions (1998).

Taylor in his research *Changing Patterns in International Health: Motivations and Relationships*, looks at the history of foreign aid for health from the American government to international recipients (1979). He found several concerns with the current system. The first was that foreign donors get recognized for the money that they donate but local donors do not, this drives away local donors and increases the dependency of a country on foreign assistance (1979). The second concern Taylor found was that the American government fails to recognize the complexity of international health and as a result the programmes implemented are often culturally inappropriate (1979). Lastly, Taylor finds that the U.S. structures its aid programmes so that they benefit more than the recipient (1979). Taylor recommends that the U.S. government work with the local communities where they are implementing these health programmes and allow the local community to set their own health priorities (1979).

Sachs and Attaran (2001) agree with Taylor (1979). In their paper, *Defining and refining international donor support for combating the AIDS pandemic*, they conclude that allowing foreign aid recipients to design "anti-AIDS" programming is superior to allowing donors to set the priorities because recipients better understand the cultural and social practices (2001). However, to control the aid priorities for HIV/AIDS, Sachs and Attaran suggest an independent panel of experts²⁵ run under the auspices of UNAIDS review recipients' HIV/AIDS plans and determine the plan based on scientific-evidence

²⁵ Sachs and Attaran do not mention the background of these experts. This means that the experts may be from the donor countries and therefore the power of the recipients to design their own prevention programming is reduced greatly.

for prevention and its level of potential success (2001). These experts would have the ability to amend prevention programming and although Sachs and Attaran suggest that the panel should not outright reject any recipient country proposal, they would have the power to recommend to donors which programmes should receive funding (2001). In this way, the panel of experts could undermine much of the intention of the proposal for recipient country-led HIV/AIDS programming and response design.

In a more positive spin on why donors might control health care funding, Kickbusch suggests that developing countries have been restricted in their internal health sovereignty since post-Cold War because donors are under increasing pressure to prove to their constituents that foreign aid works (2000). In order to keep donor countries' citizens supportive of foreign aid, donors had to show that aid was “efficient, made a difference on the spot, and fuelled a national interest 'back home’” (2000, p. 982). For health policy this meant recipient countries were restricted in their internal health sovereignty and had to implement the policies and programmes that were designed by donors (2000). Kickbusch describes how donors and agencies competed over delivery approaches in HIV/AIDS and other areas of health programming (2000). For recipient countries like Uganda, the approach described by Kickbusch would mean the loss of homegrown approaches to HIV/AIDS programming in favour of donor preferred methods.

Much of the literature demonstrates that U.S. interest in health care is tied to ensuring the safety of their own citizens. The motive for U.S. participation might at first appear a peripheral concern when recipient countries are receiving aid for health care. However, donating money that is tied to culturally inappropriate programmes can do more harm than good (Moyo, 2010; Sogge, 2002).

Despite the research outlined above, PEPFAR continues to dictate the prevention and treatment programming for HIV/AIDS in recipient countries (Institute of Medicine, 2013). The Institute of Medicine's recent research on PEPFAR strongly recommends that PEPFAR look at each country individually and understand their challenges with HIV/AIDS programming (2013). They then continue to recommend that recipient countries "have a say in programming" and increase collaboration between donor and recipient (Institute of Medicine, 2013).

Foreign Aid and HIV/AIDS: Where is the money going?

"There are other, more complicated reasons why we fail to turn more information into less HIV. They involve ideology, politics, money and history." (Pisani, 2008)

HIV/AIDS has received unprecedented international funding and attention.²⁶ Billions of dollars have been transferred from donor to recipient countries and organizations for the purpose of halting the spread of HIV/AIDS and combating the disease. The money that is transferred from donors to recipient countries or organizations may be earmarked by the donors for specific use or given to recipients to use as they see fit.²⁷ Akin to the

26 The large amount of attention and financial resources on just one (HIV/AIDS) of many global health concerns has been widely criticised. Several authors feel that the focus on HIV/AIDS is to the detriment of other diseases and virus needing international funding. It is not within the scope of this paper to join that debate, but readers who are interested in learning more should read: Jeremy Shiffman. *Has Donor Prioritization of HIV/AIDS Displaced aid for other Health Issues?* Health Policy Plan. (2008) 23 (2):95-100; B. Swartlander, J. Stover, N. Walker, L. Bollinger, J.P. Gutierrez, W. McGreevey, M. Opuni, S. Forsythe, L. Kumaranayake, C. Watts, S. Bertozzi. *Resource Needs for HIV/AIDS. Vol. 292 (continued from previous page) no. 5526 pp. 2434-2436. Science. 29 June 200.1; Green. Rethinking Aids Prevention: Learning from Successes in Developing Countries. 2003.*

27 These uses may include: methods of prevention, purchasing ARVS or other treatment options, or for wider community relief efforts.

argument above on foreign aid for development funding, money transferred for HIV/AIDS prevention and treatment creates debate as to whether tied or flexible funding leads to better outcomes and whether donor governments have their own political interests or the welfare of recipients as the goal of their decision making.

Similar to Taylor (1979), Justice (1986), Dollar and Pritchett's (1998) argument for health programming to be made culturally appropriate, Green (2003) and Shelton et al (2004) call for culturally appropriate uses of international HIV/AIDS funding. These scholars call for recipients to play more of a role in directing the allocation of HIV/AIDS funds and the development of culturally relevant and appropriate HIV prevention campaigns. Green (2003) and Pisani (2008) are concerned about the level of involvement and influence donor countries have on recipient countries' HIV/AIDS programming.

Green focuses on the global spread of U.S. HIV/AIDS education and prevention programmes (2003). Not only does he see these programmes as culturally incompatible on continents such as Africa because they focus on U.S. solutions such as condoms, but he argues they are outdated- having been designed in the 1980s²⁸ - and therefore they are not complimentary with modern policies or programmes (2003).

Pisani also argues that cultural appropriateness is important (2008). She discovers that many of the HIV/AIDS programmes that are tied to donor funding and implemented in several African countries are from Brazil and the U.S. (2008). She argues that the epidemics in these countries are significantly different from those on the African

²⁸ For a fuller understanding of the history of abstinence-only education programmes, please refer to:
<http://www.siecus.org/index.cfm?fuseaction=page.viewPage&pageID=1340&nodeID=1>

continent (2008). Using an epidemiological assessment of the HIV/AIDS spread, Pisani argues that HIV/AIDS programmes and policies must target high risk populations first (2008). She proposes that donor countries look to successful government interventions on the continent- she offers the example of Uganda in the 1980s- to implement programming that is more culturally appropriate and targeted to higher-risk and vulnerable populations (2008). Both Green (2003) and Pisani (2008) agree that today's HIV/AIDS programming is based not on science but rather entrenched in politics. However, they disagree on what a Ugandan culturally-appropriate and homegrown campaign looks like.

Green believes that AB is a culturally appropriate HIV/AIDS prevention programmes for Uganda (2003). He argues that the U.S. is wrong to export policies like condom use that they used to control the spread in North America because it was used in very specific U.S. locations with high-risk and vulnerable groups (2003). For the general Ugandan population he calls for more culturally appropriate HIV/AIDS prevention programmes, like AB. He claims that AB policies are based on science, not just politics or theology (2003).

Pisani looks at which groups in developing countries are receiving the most HIV/AIDS funding (2008). Through her personal experience and anecdotal examples, Pisani tries to make the point that high-risk groups are often denied funding because the activities they engaged in are culturally taboo and therefore risky for politicians to get involved. Pisani argues that to curb the epidemic politics needs to be put aside, and high-risk populations need policies and resources that will keep them safe (2008). Pisani sees both internal (recipient) and external (donor) politics needing to change before the HIV/AIDS epidemic will be halted (2008).

It is interesting to note that while Green sees the AB approach as culturally appropriate and homegrown in Uganda, Pisani, argues that condoms are culturally appropriate and a comprehensive HIV/AIDS approach (which includes condoms) is the homegrown approach. The literature can be conflicting with opposing sides arguing that science and culture is more in their favour.

Médecins Sans Frontières sees foreign aid as necessary to cover the costs of HIV/AIDS care and treatment (2009). However, they raise concern with the reliance of developing countries on foreign aid for HIV/AIDS because of the volatile and unpredictable nature of aid (2009). For example, in 2009 HIV/AIDS funding flat lined and PEPFAR decreased their funding to treatment programmes (MSF, 2009). Countries relying on this aid needed to quickly find additional resources or cut treatment and prevention services -which makes curbing an epidemic challenging. MSF encourages donor money to be spent on both treatment and prevention and they raise concerns that one may be chosen over another when the donors- instead of the recipients- are allocating funds (2003).

The debate within and outside the academic literature on where HIV/AIDS money is being spent goes beyond who is making the spending decisions on HIV/AIDS programming and focuses on where the money has gone. Helen Epstein says there are two types of AIDS: slim AIDS and fat AIDS (2007). She uses the metaphorical pejorative fat AIDS to describe corruption of those receiving HIV/AIDS funding who then redirect those funds for personal gain- which results in your wallet becoming fatter (hence 'fat AIDS') (Epstein, 2007). Slim AIDS is the literal description of people infected with HIV/AIDS as the disease causes you to become slimmer and slimmer (Epstein, 2007).

Much of the foreign aid that should be directed to prevention and treatment for HIV/AIDS is instead ending up in the ‘fat wallets’ of corrupt government and NGO agencies (Epstein, 2007). In fact, Wallace et al. claim that the money that can be made through attracting foreign aid for HIV/AIDS has played a strong role in elections in several countries of the Global South (2006). If a candidate can show to voters that their election will result in the country receiving increased foreign aid, that candidate is much more likely to be elected (Wallace et al., 2006). Slim AIDS might kill you, Fat AIDS will make you rich and perhaps put you in elected office.

Whether the debate is about where the foreign aid is spent or who controls the money, there is concern that the money dedicated to HIV/AIDS is being spent in areas politically comfortable to donors and recipients and not on areas that would be most effective- like on high-risk populations. However, there are debates within the literature as to what is a “homegrown” Ugandan approach to HIV/AIDS prevention and what a culturally appropriate prevention programme would include.

Aid for HIV/AIDS is used as a policy tool to please business and political interests rather than invest in proven strategies to decrease the spread of HIV/AIDS. Although there are multiple studies showing the effectiveness of a comprehensive approach to HIV/AIDS prevention, there is some literature that ignores this evidence and continues to argue for a AB-only approach.

Foreign Aid and Uganda

There is a concern that Uganda has become too dependent on foreign aid. Several authors like Gordenker (1976) and Hayter (1971) caution recipient countries that establishing a relationship with donor countries will lead to dependency. This is what has happened to Uganda.

Gordenker (1976) describes international donors as having a conscious and subconscious influence on recipient countries. This influence leads recipients to tailor programming to attract increased aid rather than designing programmes for the best outcome in each recipient country (1976). Gordenker could not find any “rational means of selecting donor targets”, by which he means, recipient countries were choosing donors based on availability of funds and with whom they held political favour, rather than on the technical ability of the donor to assist them (1976, 92).

As of 2010, Uganda had received \$1.7 billion in foreign aid. In that same year, the amount of foreign aid given to Uganda was equivalent to 10.4 per cent of their gross national income (Global Humanitarian Assistance).

Uganda is dependent on foreign aid (Wallace et al, 2006). According to Wallace et al., Ugandans have even elected their President based on their ability to attract foreign aid (2006). This dependency has left Uganda vulnerable to the whims and programming desires of donors. Extreme aid dependency has created a government agenda that is more responsive to donor demand than to their local needs (Wallace et al., 2006).

The Ugandan government contributes 9.8 per cent to the country’s health care budget. They rely on international donors for the rest (Leahy and Akitobi, 2009). Seventy per cent of the money Uganda spends on HIV/AIDS prevention comes from international

donors (USAID, 2002) and this means that donors have control over how 70 per cent of the HIV/AIDS funding is spent (Wallace et al., 2006).

There have been several shortages of HIV testing kits in Uganda. Some people blame this on corruption occurring among Ugandan politicians (Kityo, 2013), others say the issue lies with the Ugandan government's supply-chain management ("Uganda running out of ARVs, HIV test kits", 2013). Whatever the cause, Uganda is now in need of assistance from foreign donors to support the procurement of these kits (UNGASS, 2007; IRIN, 2013). If donor funds were to be withdrawn, Uganda may not be able to continue testing for HIV/AIDS.

Uganda's dependency on aid also leaves them with less culturally relevant policies and programmes. Wallace et al., (2006) and Oomman et al.,(2007) found that Uganda had similar aid conditionalities placed upon them, as several other African countries despite their unique challenges and different epidemiological trends.

If the research by Wallace et al., Oomman, Leahy and Akitobi, and Gordenker are correct and foreign aid can lead to dependency on donor countries, Uganda's acceptance of significant funding from PEPFAR would leave them vulnerable to the whims and desires of the U.S. This is particularly concerning when the effectiveness of donor funded programming is a matter of life or death.

Hopkins reminds us that donors have a motivation to donate (2002). And Lancaster tells us that foreign aid is granted to recipient countries often on the basis of who is important or valuable to the donor country (2007). This leaves the question of why is Uganda important to the U.S. and what motivation is behind their donation?

In the next chapter this thesis will explore why Uganda in particular is seen as diplomatically important to the U.S. and why the U.S. is willing to send vast amounts of foreign aid to Uganda for HIV/AIDS prevention.

Chapter 3: Findings

PEPFAR has dramatically changed the face of HIV/AIDS sexual health programming in developing countries such as Uganda through policies attached to foreign aid. Below I will discuss how and in which ways Uganda's HIV/AIDS programming was altered as a response to PEPFAR.

Uganda's HIV/AIDS prevention programme: Before PEPFAR

Uganda's HIV/AIDS campaign in the 1980s has been recognized as a tremendous success by the international development community, epidemiologists, and governments around the world. The main features of the campaign were behavioural change (abstinence and partner reduction), destigmatization, and political leadership (Goliber, 2000; USAID, 2002; Black and White, 2003; Green, 2003; Parkhurst, 2004; Cohen and Tate, 2006; Green et al., 2006; Pisani, 2008; Parkhurst, 2010; Halperin, 2011; Avert, 2013). There are also reports that show condoms played an extensive role in the 1990s campaign (Goliber, 2000; Cohen and Tate, 2006; Kirby and Halperin, 2008; Wawer, 2005; UAC, 2007; and Pisani, 2008).

The Ugandan government and President Museveni

wallpapered the country with posters telling people exactly how AIDS was spread and exactly how it could be prevented. The state (Senegal and Uganda) presidents talked about the disease, they talked about old men having sex with young girls, they talked about people's penchant for having several partners at once. That allowed everyone else in the country to start talking, too. In Uganda, 'zero grazing' became something of a mantra...the presidents urged people to use condoms. Their rhetoric was eventually backed with massive distribution of well-packaged, cleverly marked condoms (Pisani, 2008, 145).

When Uganda first fought the AIDS epidemic in the 1980s, infection rates were approximately 29 per cent (Avert, 2013). Most people knew a family, friend or community member that was infected by HIV/AIDS. Celebrities like musician Philly

Lutaaya, President Museveni, Dr. Noerine Kaleeba and Reverend Gideon Byamugisha, among others, spoke out about being infected and/or affected by HIV/AIDS (Basude, n.d.). Having multiple messages and people from different organizations and backgrounds is thought to have helped decrease the stigma of having the disease (Green et al., 2006; Mubang, 2011).

The initial campaign in Uganda happened before antiretroviral drugs were available. People saw their friends, family, community members and celebrities die of AIDS. It was a frightening time and a diagnosis of HIV/AIDS was fatal. Behavioural change campaigns may have been successful because people were terrified and willing to adopt new behaviours such as abstinence, partner reduction, and/or condoms (Pisani, 2008; Parkhurst, 2010).

Parkhurst offered a comparison of Uganda and South Africa's HIV/AIDS prevention programmes. In *The Political Environment of HIV*, Parkhurst finds Uganda's diversified and varied approach to prevention, which included multiple actors, was the key to its initial success (2004). Parkhurst argues for a continuation of diversified messaging, the engagement of a variety of participants- NGOS, churches, aid organizations, international governments- and for the community to control the campaign, not just the government (2004).

The results of a varied and comprehensive campaign for Uganda (that may have also been effective because of people's fear) were: extramarital partnership declined,

young people waited longer to have sex²⁹, and condom use rose (Pisani, 2008; Avert, 2013).

The start of the HIV/AIDS Epidemic in the U.S.

According to accounts by C. Everette Koop, who served as the American Surgeon General from 1982 until 1989, the U.S. has put politics before people in the fight against HIV/AIDS (National Library of Medicine; CDC). From the beginning of the AIDS epidemic, the U.S. government was focused on the political consequences of their involvement in what was called “gay-related immune deficiency syndrome” (National Library of Medicine, n.d.; AGEIS, 2004). In the early 1980s, when AIDS first emerged it was highly stigmatized. Being a virus that was thought to only affect homosexual men and intravenous drug users, the U.S. President at the time, Ronald Reagan, distanced himself as much as possible from AIDS (AGEiS , 2004; AVERT n.d.). Reagan submitted requests to cut the government's AIDS budget as his government pretended not to be aware of AIDS (AGEiS, 2004; AVERT n.d.). Despite recommendations by his Surgeon General to implement comprehensive sexual education in schools throughout the country (National Library of Medicine, n.d.; Boston Globe, 1986; AVERT, n.d. c; AGEiS, 2004), Reagan's administration promoted abstinence-only sexual education (AEGiS, 2004).

The National Library of Medicine houses some of C. Everette Koop's correspondence during the early to mid-1980s. His letters to government officials show that he requested to address Americans on AIDS: “if ever there was a disease made for a Surgeon General, it was AIDS,” Koop said (National Library of Medicine, n.d.). Koop

29 This is often referred to as “delaying sexual debut” or “delaying sexual initiation” in the literature.

was not granted permission to act on AIDS until 1986- five years after the American AIDS crisis began. The reasons for initially denying Koop the opportunity to speak publicly about AIDS was never made clear, but Koop insists that it was political (National Library of Medicine, n.d.).

C. Everette Koop was very concerned that politics would interfere with his report on AIDS and prevention, particularly on his recommendation for condom use (National Library of Medicine, n.d.; The New York Times, 2003). To protect his report, Koop severely limited his number of advisers and did not submit drafts to the American government before publication (National Library of Medicine, n.d.).

Despite facing an epidemic that was expected to kill 179,000 people (Chicago Tribune, 1986), the Reagan administration chose to keep quiet about HIV/AIDS for the first five years of the epidemic. They implemented abstinence-only education against the advice of the Surgeon General (AEGiS, 2004) and despite the ability of condoms to save lives if people were educated on their use, the Administration forwent promoting them (Schenectady Gazette, 1987; Daily Beast, 2013). Many of the Republican supporters were opposed to homosexual activity and pre-marital sex (Milburn and Conrad, 1996). Condoms were seen as promoting premarital sex and therefore working on HIV prevention programming was too politically contentious for Reagan.

While the U.S. battled internally with right-wing and religious beliefs over abstinence and condom use to fight HIV/AIDS, Uganda had created a comprehensive approach to HIV/AIDS prevention which included messaging on abstinence, partner reduction, and condoms. AIDS in the U.S. was highly stigmatized because political leaders (William Dannemeyer, Senator Jesse Helms, William Bennett and Garry Bauer)

and religious leaders (Pat Robertson and Jerry Falwell) were speaking out against many prevention efforts, particularly comprehensive sexual health education that included condoms (Forward, 2003). Meanwhile, Uganda's leadership was very involved in HIV/AIDS prevention efforts. A diverse group of leaders (clergymen, celebrities, and politicians) vocally supported prevention efforts. The initial effort to slow the spread of HIV in the U.S. and Uganda were vastly different.

The Rise of HIV/AIDS in Uganda and the U.S.

During the late 1980s even into the very early 2000s, Uganda had great success in lowering their HIV/AIDS rates. But by 2004, HIV/AIDS were on the rise again. One of the more popular theories as to why HIV/AIDS rates were once again rising suggested that seeing HIV positive people living long and healthy lives decreased peoples' concerns about contracting HIV and led to riskier sexual behaviour (Cohen and Tate, 2005; Pisani, 2008; the Ugandan AIDS Commission, 2012; Do not backtrack on HIV/AIDS fight, 2012; and Nantulya, 2013).

The theory supported by Cohen and Tate (2005), Pisani (2008), the Ugandan AIDS Commission (2012), the Editor of the Daily Monitor (“Do not backtrack on HIV/AIDS fight”, 2012) and Nantulya (2013) is called: prevention fatigue and disinhibition (Cohen, 2005). Prevention fatigue argues that people who have changed behaviour due to some risk will eventually become tired of the new behaviour and return to their riskier previous behaviour. The theory of disinhibition, as Katz et al. notes, further complicates the situation as it states that “the perception of reduced risk itself makes risk-taking more attractive” (2002, 388).

The occurrence of prevention fatigue in Uganda is noted in the literature for monogamous couples. Incidence modelling has shown that 43 per cent of new HIV infections have been occurring in faithful relationships (UAC, n.d; Uganda Ministry of Health, 2006). According to Hogle et al., once a country has achieved a significant seroprevalence decline- like Uganda- a complex set of socio-cultural, epidemiological, and political elements affect the course of the epidemic (2002).

In the field of sexual behaviour change, prevention fatigue and disinhibition translates into people no longer practicing safe sex because they are tired of having to do so, they are not witnessing mass deaths due to HIV/AIDS, and they believe the risk is reduced to a point where it is worth having unsafe sex (Katz et al., 2002).

Prevention fatigue and disinhibition (although not always referred to in name) was widely reported in the early 2000s in San Francisco among men who have sex with men (MSM) (The San Francisco Department of Public Health, 2000). In 2002, a study by Katz et al., found that MSM in San Francisco increased their risky sexual behaviour after beginning HAART (highly active anti-retroviral therapy) treatment. Through community surveys they found that: “as a result of the availability of HAART, HIV-negative men who have sex with men (MSM) are less concerned about contracting HIV, HIV-infected MSM are less concerned about transmitting HIV, and both groups are more likely to engage in unsafe sex. Also, because HAART decreases mortality and improves the quality of life of persons with AIDS, it has increased the number of persons living with HIV/AIDS who are engaging in sexual relations” (2002, 388).

Studies conducted outside of San Francisco and within the wider HIV positive community have found AIDS-fatigue and disinhibition did not contribute to a rise in

HIV/AIDS in Europe (Bouhnik & Moatti et al., 2002), Côte D'Ivoire (Moatti et al., 2003) and Uganda (Bunnell et al., 2006; Biraro et al., 2013). Instead these studies concluded that HIV negative partners in steady HIV serodiscordant partnerships (a partnership in which one partner is HIV positive and the other is HIV negative) are at high risk for HIV acquisition if the HIV positive partner is not on ART or HAART.

In a longitudinal study (1989-2007) conducted in rural Uganda, evidence was found that supported ARVs ability to reduce transmission of HIV to an HIV negative partner (Biraro et al., 2013). “Counselling and testing for HIV, condoms, treatment of opportunistic infections and antiretroviral treatment have become increasingly available in recent years and are likely to explain the reduction in seroconversion rates over time. No seroconversions occurred among couples in which the HIV positive partner was on HAART. Reduced risk of HIV transmission in the present (sic) of HAART has been reported in other observational studies,³⁰ and recently confirmed in a randomised clinical trial”³¹ (Biraro et al., 2013). In Côte d'Ivoire, patients receiving treatment or those who have access to ART were less likely to engage in unprotected sex than individuals not receiving therapy (Moatti et al., 2003).

³⁰ Biraro et al., are citing these studies:
Ruzagira , R, Wandiembe, S., Abaasa, A., Bwanika, A.N., Bahemuka, U., Amornkul, P., Price, M.A., Grosskurth, A., and Kamali., A. Tanser F (ed.). (2011). *HIV Incidence and Risk Factors for Acquisition in HIV Discordant Couples in Masaka, Uganda: An HIV Vaccine Preparedness Study*. PLoS One 6(8): e24037.

Attia S, Egger M, Müller M, Zwahlen M, Low N.(2009). *Sexual transmission of HIV according to viral load and antiretroviral therapy: systematic review and meta-analysis*. AIDS. Jul 17; 23(11):1397-404.

³¹ Cohen MS, Chen YQ, McCauley M, Gamble T, Hosseinipour MC, et al. (2011) *Prevention of HIV-1 infection with early antiretroviral therapy*. N Engl J Med Aug 11 365(6): 493–505.

In Uganda, risky sexual behaviour and risk of HIV transmission both decreased after the first six months of at least one partner beginning ART and attending prevention programmes (Bunnell et al., 2006).

In the Bunnell et al. (2006) study, the period of study was limited to six-months. But the more recent study (2007) by Biraro et al., has shown that over a period of 20 years, access to prevention counselling and treatment decreases seroconversions of discordant couples in Uganda (2013).

While Cohen and Tate (2005), Pisani (2008), the Ugandan AIDS Commission (2012), and Nantulya (2013) may be correct that in some places seeing PLWHAs lead healthy, long lives decreases fear of contracting the virus and this leads to increased risk-taking sexual behaviour, this has not proven to be the result of prevention and treatment programmes in Uganda.

What these studies did not look at was the risk of prevention fatigue among discordant couples when the PLWHA cannot access ART. There is very little literature available on the risk taking behaviours of discordant couples where the PLWHA is not on ART. This is likely due to the ethics involved in such a situation. What we do know is that HIV/AIDS is rising among discordant couples, but there is a gap in the literature to tell us more about this situation: is the HIV-positive partner aware of their status? Why is that person not on ART (problems with access, affordability)? Why does that couple not practice safer sex with the use of condoms?

It does not appear that HIV/AIDS rates have risen solely as a result of AIDS fatigue and disinhibition among discordant couples involved in ART in Uganda. However, rates may be rising because of untreated HIV-positive partners who are either unable to access

safer sex options or who are ignoring those options. Further research into this area needs to be completed,

PEPFAR Changes the Global Response to HIV/AIDS

The U.S. Global AIDS Coordinator, Eric Goosby, claims that “the role of the U.S. health programs under the President's GHI (Global Health Initiative) is never to lead another nation’s response” (Goosby, 2010). Despite these words from Goosby, I will discuss how the U.S. has changed the prevention programmes of countries like Uganda. Being the largest financial donor for HIV/AIDS treatment and prevention, the U.S. has incredible influence on countries hoping to receive that funding. Many developing countries will want or need PEPFAR funding and when that funding is earmarked to specific activities, and, as such, it is reasonable to assume that a hopeful recipient would tailor their programming to meet the donor's funding requirements. It is one of the strongest arguments as to why the Ugandan government altered one of the most successful HIV/AIDS prevention programmes for a programme that was shown to be much less effective.

To understand why the American government is promoting a programme that has been shown ineffective at worst, or controversial at best, it is important to describe the fight for abstinence-only education in the U.S., as well as exploring how the American government may have influenced the Government of Uganda to promote abstinence-only sexual health prevention programmes.

A Local Fight goes Global

In 2008, the U.S. congress was still was politically divided on whether comprehensive prevention programmes or abstinence-only sexual health education should

be taught in schools and promoted to the public. Despite several studies showing that only comprehensive sexual health education and programming could lead to significant and long-term behavioural change (Martiniuk et al., 2002; Gupta, 2004; Kirby, 2007; Kohler et al., 2008; Cheng et al., 2008), the U.S. federal government was still fighting nationally for abstinence-only sexual health education.

Kirby's 2007 study on comprehensive sexual health versus abstinence-only programming is one of the most extensive studies in the U.S. It reviews 54 case studies of U.S. sexual health programmes. Kirby showed that comprehensive sexual health programmes resulted in increased abstinence, a reduction in the number of sexual partners, increased condom use, and fewer students engaging in unprotected sex (2007). By contrast, abstinence-only programming had very little to no significance on long-term behaviour change because it did not eliminate risk, delay sexual initiation, or have an effect on the number of sexual partners, condom use, or rates of abstinence for participants (Kirby, 2007).

Although Kirby's 2007 study is the most in-depth to-date, earlier studies (Kirby, 2000; Martiniuk et al., 2002; Gupta, 2004) were reporting that sexual health education needed to be comprehensive. They were also laying doubt on the effectiveness of an abstinence-only approach.

Despite those earlier studies and their evidence, the U.S. *continued* their fight for an abstinence-only approach to HIV/AIDS prevention:

In 2002, the U.S. Centers for Disease Control and Prevention removed a fact sheet on the effectiveness of condoms from its website and replaced it with a new fact sheet which, while factually accurate, eliminated instructions on how to use a condom properly and evidence indicating that condom education does not encourage sex in young people...Information on condom effectiveness was similarly altered on the website of the U.S. Agency for International Development (USAID). Guidelines proposed by the CDC

in 2004 require that AIDS organizations receiving federal funds include information about the “lack of effectiveness of condoms” in any HIV prevention educational materials that mention condoms. In 2002, the CDC erased from its website an entire section entitled “Programs that Work,” which had highlighted the effectiveness of comprehensive sex education programs. (Cohen and Tate, 2005, p. 23)

Not only were government websites censored, but American NGOs, such as the Union of Concerned Scientists, accused the government of limiting evidence-based research (n.d.). Instead of allowing scientists to report on the effectiveness- or lack thereof of A-only sexual health education programmes, the government changed the criteria for determining effectiveness:

The Bush administration distorted science-based performance measures to test whether abstinence-only programs were proving effective, such as charting the birth rate of female program participants. In place of such established measures, the Bush administration required the CDC to track only participants' program attendance and attitudes (Union of Concerned Scientists, n.d.).

According to the Union of Concerned Scientists, the Bush administration ended the project Programs that Work (n.d.).³² Before its funding was cut, Programs that Work had identified five sex education programs found to be effective. None of the effective programmes listed were abstinence-only and it is believed that because only comprehensive sexual health education could be found effective, Programs that Work was cancelled (Union of Concerned Scientists, n.d.; Act Up, 2003).³³

³² For more information on Programs that Work, please see: Collins, J; Robin, L; Wooley, S; Fenley, D; Hunt, P; Haber, D; and Kolbe, L (2002). Programs-that-work: CDC's guide to effective programs that reduce health-risk behavior of youth. *J Sch Health*. 2002 Mar; 72(3):93-9.

³³ Through a search on the Centre for Disease Control website (www.CDC.gov) you can find a programme called: Chronic Disease Prevention and Health Promotion. This new programme promotes “school health” which includes sexual risk prevention. However, there does not seem to be any information comparing comprehensive sexual health education

Multiple studies and programmes all showed the effectiveness of comprehensive sexual health programmes. With little or no scientific evidence on the effectiveness of an abstinence-only approach to sexual health education, the Bush Administration's continued push for abstinence-only sexual health education programming is based only on political ideology and theology.

The Need for Evidence

Bendavid and Bhattacharya offer one of the few studies of PEPFAR's impact on HIV/AIDS treatment and prevention in several African countries (Uganda was not included in this study) (2009). Bendavid and Bhattacharya compared African countries rates of HIV-related deaths, number of PLWHA, and prevalence of HIV/AIDS (2009). They conclude that while treatment in countries receiving PEPFAR funds (as opposed to their control countries which are not receiving PEPFAR funding) has reduced HIV-related deaths, prevalence trends between control countries and PEPFAR funded countries did not differ (2009). To affect a reduction in HIV prevalence, both HIV incidences must be reduced and the population size must increase to offset the reduction in deaths from HIV/AIDS. If the control countries have a higher HIV-related death rate, their HIV prevalence should be decreasing when compared to focus countries that have significantly lower (10 per cent) HIV-related deaths. Bendavid and Bhattacharya suggest further research needs to be conducted into the effectiveness of PEPFAR funded HIV prevention (2009). While specific conclusions on PEPFAR's effectiveness to prevent HIV/AIDS in Uganda cannot be drawn from Bendavid and Bhattacharya's research (2009), it does

highlight the need for further research into the effectiveness of PEPFAR's prevention programming.

The Institute of Medicine conducted a ten-year study on the effectiveness of PEPFAR in the countries it donated to and where they implemented programming (2013). The research found no information from PEPFAR on the HIV cases they managed to avert because of their prevention funding (Institute of Medicine, 2013). Similar to Bendavid and Bharracharya, the Institute of Medicine concluded that PEPFAR needed to study its effectiveness with averting further HIV transmission (2013).

In 2003, the American government announced the PEPFAR regulation that earmarked 33 per cent of PEPFAR funding to Abstinence-until-marriage and faithfulness programming only- not comprehensive sexual health campaigns. Because studies were just beginning in the area of sexual health education and behavioural change at that time, it is fair to allow the government to claim ignorance. But by 2008, despite numerous studies showing that only comprehensive programming is able to curb an HIV/AIDS epidemic (Martiniuk et al., 2002; Gupta, 2004; Kirby, 2007; Cheng et al., 2008), the U.S. government increased its 33 per cent target of PEPFAR funds to 50 per cent of PEPFAR's HIV/AIDS prevention funding to be spent on only abstinence and fidelity programmes (Kaiser Family Foundation, 2008).

From both studies in the U.S. on the effectiveness of comprehensive sexual health programmes and from case studies of Uganda's early success in the 1980s and 1990s it is clear that a comprehensive sexual health prevention program is effective and the U.S. government's push for an abstinence-only prevention agenda both at home and overseas is not based on best-practices research.

Spreading the ‘Good’ Word

Gusman suggests that the Ugandan reduction in HIV/AIDS rates and its emphasis on “family values” as a way to prevent the spread was “useful for right-wing politics in the U.S., supported by evangelical Christians.” (2009, 71) Gusman argues that Uganda’s initial success was a “victory of religious moralism: of persuading people to become born again, “saved,” and therefore to live “safe” lives.” (Gusman, 2009, 72)

Butler describes the renewed interest in the international arena as an opportunity for the Christian Right to find allies in other religious movements. She uses the term “religious right” to describe a coalition of conservative protestant evangelicals, Pentecostals, Charismatics , and fundamentalists of the Christian Right. Aziz and Glaubman note that religious boundaries are changing and now even right-wing agents of Catholics, Mormons, Orthodox Jews and increasingly (although still more marginalized) Muslims feel they are more likely to find support overseas than among U.S. liberals on their issues of family and motherhood (Aziz and Glaubman in Butler, 2000).

To collect the money that is needed to continue to grow their movement and build their political influence, the religious right has been lobbying both internationally and domestically (Butler, 2000). On the international level, Christian organizations (conservative Protestant Evangelicals, Pentecostals, Charismatics, and fundamentalists) have increased the power of their ‘pro-family’ voice by working with Islamist, Muslim, and Jewish countries and organizations to have their opinions heard at international conferences and meetings (Butler, 2000). The religious right have staged protests, and filled conference floors at UN meetings arguing against feminist policies, sexual liberation, abortion, and LGBTQ rights (Butler, 2000).

Domestically, evangelicals banded together and began lobbying for policies of religious freedom which would limit the interference of the state (Hofer, 2003). They were successful in 2002, when money that was earmarked for international HIV/AIDS work was withheld from NGOs that had reproductive health programmes in developing countries or taught HIV/AIDS education in Afghanistan (Hofer, 2003). They won again when the Bush administration redirected international funding from multilateral groups to Faith Based Organizations (Hofer, 2003).

The 2003 United States Leadership Against HIV/AIDS, Tuberculosis and Malaria Act – the act which created PEPFAR- required 33 per cent of PEPFAR funding to be spent on abstinence-only programming. This requirement opened the door to groups that promote A-only sexual health education, mostly faith-based organizations, like American evangelicals (Office of the U.S. Global AIDS Coordinator, 2006; Hensarling, 2008).

Non-secular NGOs that work in HIV/AIDS prevention have found themselves in compromising positions by accepting PEPFAR funding. In 2003, the requirement that 33 per cent of funding go to abstinence-only education put pressure on NGOs to comply and ensure that 33 per cent of their funding was spent on a-only programming even if they considered themselves followers of evidence-based programming. In 2008, the focus on A-only prevention was increased to 50 per cent and PEPFAR's primary partners found in non-compliance with this requirement had to report to congress (PEPFAR, 2008).

The introduction of the Anti-Prostitution Pledge in 2003, forced foreign NGOs accepting PEPFAR funding to sign and agree to not work with sex workers. This placed many of the NGOs working on comprehensive sexual health programmes in a challenging position. They had to decide to sign the waiver and stop working with groups that are the

most vulnerable to HIV/AIDS, or not sign the pledge and become ineligible for the largest source of international funding ³⁴(Middleburg, 2006; Centre for Health and Gender Equity, 2008).

Due to the APP, both the Brazil National AIDS Commission and the BBC World Service Trust withdrew applications for PEPFAR funding and returned the previous money they had received for HIV/AIDS programming. They decided that signing the APP would compromise their work (Middleburg, 2006).

Similar to PEPFAR's abstinence-only policy, the APP did not come from evidence-based research that showed that ignoring sex workers would decrease a country's rate of newly acquired HIV/AIDS infections. Instead, according to Pisani, it would increase those rates (2008). The APP was once again an ideologically driven policy being aggressively marketed to developing countries by tying the pledge to foreign aid from the world's largest funder.

PEPFAR's funding requirements (APP and abstinence-only education) have excluded some groups from receiving PEPFAR money because they are unwilling to adopt anti-prostitution policies or offer abstinence programming. With less groups competing for funding, there are more funds available for religious and conservative organizations (Centre for Health and Gender Equity, 2008).

PEPFAR is seen as a major accomplishment for many faith-based organizations:

...prior to PEPFAR, the U.S. Government and other Western donors only supported condom prevention programs, even in generalized epidemics. Faith-based organizations,

³⁴ It should be noted that the APP was also implemented in the U.S. in 2005. It was challenged in court and the APP was struck down. However, the court ruling applied only to U.S.-based AIDS funding recipients, meaning that many international PEPFAR aid recipients still need to sign the APP to receive PEPFAR funding.

including both large organizations such as Catholic Relief Services and small organizations working within local communities, assert that before 2004 it was impossible for them to obtain U.S. funding for prevention programs that focused on abstinence and be faithful behavioral change. Representatives of the U.S. Agency for International Development working in the field admit privately that they laughed at the thought of funding abstinence programs (Hensarling, 2004, 3-4).

Not only has PEPFAR provided funds to Faith Based Organizations (FBOs) already in existence, but it lead to the creation of many more:

There are numerous organizations in existence that would benefit from PEPFAR funding for HIV/AIDS programs—organizations that do not perform and/or promote abortion. Many of these organizations may not have existed prior to PEPFAR, but have developed since U.S. aid to Africa has increased (Hensarling, 2004, 3).

PEPFAR was launched with much fanfare, particularly by the faith-based and religiously conservative community. However, critics were immediately vocal on the emphasis placed on abstinence-only sexual education .

How PEPFAR is changing the HIV/AIDS policies of Uganda

PEPFAR was founded in 2003 and known then as the 'U.S. Global AIDS Initiative' (Avert, n.d. e). In 2004, the Initiative was renamed "PEPFAR". The 2004-2006 budget earmarked 33 per cent of PEPFAR funding to AB only prevention methods. The Office of the U.S. Global AIDS Coordinator (OGAC) reported in 2006 that PEPFAR country teams felt restricted by the earmarked funds because they did not allow the teams enough flexibility to respond in a culturally appropriate manner to the threat of HIV/AIDS in recipient countries (United States Government Accountability Office, 2006).

American funding for HIV/AIDS prevention, offered through PEPFAR, has immense control over the allocation of funds in recipient countries by tying money to the implementation of American policies such as abstinence-only. Recipient countries, like Uganda, must conform to U.S. preferences if they wish to receive funding from the

largest global funder for HIV/AIDS. U.S. funding has likely played a role in Uganda's recent adoption of the American AB model of HIV/AIDS prevention despite their earlier success with more comprehensive approaches to prevention.

The American government claims to recognize the important role condoms have played in decreasing the HIV/AIDS rate in Uganda:

USG (United States Government) recognizes success of early comprehensive (including condoms) prevention programmes...USG resources have supported all components of the Ugandan response (to the HIV/AIDS epidemic) (PEPFAR, Country Operational Plans: Uganda, 2004).

But despite their stated recognition of the importance of comprehensive prevention programming (which should include condoms), PEPFAR's 2004 Country Operational Plan (COP) for Uganda calls for the inclusion of several new items:

...an increased focus on A (abstinence-only) for youth...a (new) system for delivering AB programs, and a new partnership will fund grants to Uganda faith-based and non-governmental groups. Up to eight grants will be given to groups focused on AB (2004, page 29).

The COP did not mention any funds to groups focusing on comprehensive or condom-inclusive prevention programmes. Of the twelve groups receiving grants from PEPFAR, three groups focused on comprehensive programming, eight groups focused on AB, and one group focused on B-only (author's own counting from PEPFAR's COP for Uganda, 2004- see the chart on the next page) Many of these partners are faith based organizations or work with sub-partners that are FBOs. Those that may indicate that they are not a FBO may still conduct religious practices such as praying and approach programming from a religious perspective. PEPFAR does not argue that sending money to FBOs is a better policy than sending it to a non-faith based organization, because there

is no evidence to support this. It is simply a matter of politics that FBOs receive a large percentage of PEPFAR funding for program implementation.

Prime Partner	Abstinence/Be Faithful	ABC	Faith Based?
Ministry of Health		Yes	No
AIM³⁵	Yes		Some ³⁶
AIDSMARK	Yes		Most ³⁷
UPHOLD	Yes		Some ³⁸
CRD³⁹	Yes		Most ⁴⁰
TASO⁴¹		Yes	No
HCP⁴²	Yes (B only)		No
MoES⁴³	Yes		No
CARE⁴⁴	Yes		Half ⁴⁵

³⁵ AIDS/HIV Integrated Model District Program

³⁶ AIM is a PEPFAR prime partner meaning that they support many sub-partners. Of their sub-partners, 27 are Faith Based Organizations and 28 are not.

³⁷ AIDSMARK (like AIM) is a prime partner. AIDSMARK currently has 9 sub-partners of which 7 are FBOs.

³⁸ UPHOLD is a prime partner. UPHOLD has 13 sub-partners of which one is a FBO.

³⁹ Community Resilience Dialogue which includes: Catholic Relief Services, International Rescue Committee, and SAVE

⁴⁰ CRD is a prime partner. They have 6 sub-partners of which 4 are FBOs.

⁴¹ The AIDS Support Organization- this is one of the organizations mentioned on the previous page that while is not a FBO, they do still have religious practices.

⁴² The Health Communication Partnership

⁴³ Ugandan Ministry of Education and Sports

⁴⁴ The first part of the title followed by “care” has been redacted. The full name of the organization is not known.

⁴⁵ ____ CARE has 6-8 sub-partners of which 4-6 are FBOs.

<u> </u> ⁴⁶	Yes		No
Rakai	Yes		No
<u> </u> ⁴⁷		Yes	No

According to the Government of Uganda's own research, HIV/AIDS is spreading fastest among older populations (Wabwire-Mangen, 2009). The main driver of the epidemic is high risk sex which is defined as having unprotected sex with two or more concurrent partners (PEPFAR, 2008b; UNGASS, 2010). While the Government of Uganda does mention that they will work on increasing access to condoms, they do not include a plan or policy on condom education or promotion (PEPFAR, 2008b).

The government of Uganda also states that they will continue with abstinence-only education programs aimed at youth, even though HIV/AIDS is spreading fastest amongst an older population (PEPFAR, 2008b). This project (youth abstinence) is a personal passion of Uganda's first lady Janet Museveni (Kalembe, 2005; Nyanzi & Nsangi, 2007; Masumbuko, 2007; Businge, 2009; Naturinda, 2009; Kalinaki, 2010) and yet it disregards the evidence that comprehensive planning provides a safer future for these youth. A-only education does not educate Ugandans on how to correctly use condoms. When youth become sexually active they will not have the skills to practice safe sex.

Hogle, et al., disagreed with PEPFAR's emphasis on A and AB-only sexual health education. When writing in 2002 they saw the increasing need for condoms: "in more recent years, increased condom use has arguably contributed to the continuing decline in prevalence" (2002, 8). PEPFAR's choice to fund AB is once again a political decision.

⁴⁶ This name has been redacted.

⁴⁷ This name has been redacted.

Kamwi et al. wrote in defence of PEPFAR's focus on AB only (2006). They argued that there were many other donors offering funding for condoms and therefore recipients had options without needing PEPFAR funding (Kwami et al., 2006). Kamwi et al. did not see PEPFAR as restricting Uganda or other African countries' from offering comprehensive programming; instead, recipient countries just needed to achieve a comprehensive programme through a variety of funding sources (Kamwi et al., 2006).

However, Kamwi et al. (2006) did not consider the vast amount of money that PEPFAR offers in comparison to other donors. Nor did they consider the influence a large donor like PEPFAR has over small NGOs (Wallace et al, 2006; Rauh, 2010). It is unlikely that a small NGO would keep condoms in their prevention programming if they knew it would negatively impact their chances of getting money from the largest donor. In 2004, 56 per cent of PEPFAR's funding for the prevention of sexual transmission of HIV/AIDS was given to AB-only programmes (PEPFAR, 2005). Fifty-six per cent does not include the money spent on an additional 200 abstinence-only programmes (PEPFAR, 2005).⁴⁸ There is enormous financial pressure on NGOs to conform to the AB-only policies of PEPFAR if they wish to be eligible for over 50 per cent of the largest foreign aid donations to HIV/AIDS.

But PEPFAR is not appealing to those NGOs to conform; instead they wrote the funding allocation policies to benefit faith-based organizations. "The legislation's strengthened conscience clause (A or AB-only programming and the APP) is critical to ensuring continued participation by faith- and community-based partners, which are uniquely positioned to promote HIV/AIDS stigma reduction and prevention messages...

⁴⁸ The amount of money spent on the 200 programmes was not available, nor were the programmes listed.

The bill ensures that these organizations will not be required to participate in or refer to any program or activity to which they have a religious or moral objection and ensures that they will not be discriminated against in procurement for refusing to do so” (PEPFAR, 2008).

With PEPFAR being the largest provider of funding for international HIV/AIDS activities, groups that wanted to be able to access funds were given the strong message to conform. To have the best chance at getting PEPFAR grants, NGOs and countries needed to adopt abstinence and be faithful approaches to HIV/AIDS prevention.

Other than relying on the influence that they have as the largest donor, PEPFAR also earmarks funds to encourage countries like Uganda to commit to an A-only approach. In 2003, PEPFAR earmarked 33 per cent of its funding to Abstinence-until-marriage programming. In 2008, 50 per cent of PEPFAR's HIV/AIDS prevention funding needed to be spent on abstinence and fidelity programmes. The remaining 50 per cent was to be spent on male circumcision, addressing multiple concurrent sexual partnering, research on microbicides, and supporting female and male condoms (Kaiser Family Foundation, 2008).

PEPFAR's earmarking of funds and the funding of projects which were AB-focused, groups working on HIV/AIDS prevention that needed funding were indirectly pressured to change their programming to meet the requirements of PEPFAR. The groups that benefitted most from PEPFAR's funding requirements were faith-based organizations- the base of the Republican vote.

Uganda Adopts AB

In 1981, the U.S. under Republic President Ronald Reagan pioneered “abstinence until marriage” programmes (Hardee et al., 2008; Parkhurst, 2010). These programmes were implemented before the HIV/AIDS epidemic by the religious community as a way to discourage youth from engaging in premarital sex (Howell and Keefe, 2007). Since then there has been much political praise to the effectiveness of abstinence education despite the scientific-evidence that shows abstinence-only education does not work (Martiniuk et al., 2002; Gupta, 2004; Kirby, 2007; Cheng et al., 2008).

While the Republican Party was trying to win the fight for Abstinence-only education in their home country, Uganda was running a campaign which focused on abstinence ("zero grazing"), being faithful (monogamy), and condoms. According to Tumushabe, the Ugandan government had made condoms the third part of their HIV/AIDS prevention programme, thereby de-emphasising their importance in combating HIV/AIDS. This proved favourable to the Republicans- who wanted the focus on AB- and they began to advocate Uganda's "success story" as proof that the ABC model works (Tumushabe, 2006).

Having no successful U.S. examples of abstinence-only education being able to delay sexual debut or protect people from STIs, lobbying politicians would be a difficult job (Kirby 2000, 2007, 2008). It is much easier when you have a case study to point to. Fortunately for evangelicals and the religious right, both President and First Lady Museveni are well known and outspoken Evangelicals who just happen to live in the only African country that dramatically reduced its HIV/AIDS rate.

Although Uganda's use of comprehensive sexual health (including condoms) programming early in their HIV/AIDS campaign is confirmed in the literature (Avert, n.d.d; Goliber, 2000; Wawer, 2005; Cohen and Tate, 2006; UAC, 2007; Kirby and Halperin, 2008; and Pisani, 2008) in 2002, Ugandan First Lady Janet Museveni, flew into Washington to the Congressional debates and presented Republicans with a formal letter that stated abstinence was the key to Uganda's initial HIV/AIDS prevention success (Epstein, 2005). The timing could not have been better for the Republicans as they were in the midst of heated debates with the democrats about a \$1 billion proposal to spread abstinence-only sexual health programming to other countries through PEPFAR (Epstein, 2005).

On June 11th, 2003, President Bush invited Museveni to the U.S. to showcase his success in Uganda. That same day Bush announced the \$15 billion global AIDS bill that Congress had approved a month earlier (Tumushabe, 2006). Bush was trying to show that AB focused campaigns could work and that success in HIV prevention could be found in Africa (Tumushabe, 2006).

In 2004, President Museveni shocked the participants at the International HIV/AIDS conference being held in Bangkok by downplaying the role of condoms in Uganda's campaign and suggesting that they played a small role when compared to abstinence and being faithful (Wendo and Odyek, 2004). Museveni also claimed that in some instances condoms were harmful: "in some cultures sexual intercourse is so elaborate that condoms are a hindrance" (Joshi, 2004).

The U.S. government began promoting Uganda's success and claimed that the ABC programme they were implementing in the Global South through PEPFAR funding was based off of Uganda's original and successful homegrown HIV prevention programme.

The Ugandan government agreed that the ABC strategy was their own, but claim that they underemphasised the 'C' (condoms) (Avert, n.d.f; Munaabi. 2007). Avert disagrees with this claim and argues that the Ugandan response in the 1990s gave equal weight to A, B and C (n.d.G) although it was called the "no grazing" campaign (Parkhurst, 2004; Hardee et al, n.d.) or "live and love faithfully" (Hardee et al., n.d.).

It was not condoms themselves that the Ugandan government was adamantly against, but rather the idea that promoting condoms was promoting sexual promiscuity among young people (Ssejoba, 2004). When talking about sexual education in schools, President Museveni said: "Be careful with some of these messages from foreign NGOs. For them they are saying a child can become a wife as long as she uses a condom. This is not the way to counsel our children." (Okello & Okaba, 2012).

The term "ABC" to refer to a comprehensive sexual health programme was created by Dr. Juan Flavier, Secretary of Health, Philippines in 1992 (Hardee et al, n.d.). The term was quickly accepted by the international community (Hardee et al, n.d.) but not used in Uganda until 2001 (Cohen and Tate, 2005) when the U.S. began to promote it internationally. According to Hardee et al, who conducted interviews with multiple people involved in the early HIV/AIDS epidemic in Uganda (pre-2000s), no one had used 'ABC' in the Uganda campaign prior to the U.S. introduction of it (n.d.).

ABC may also have roots in the US' sexual health education programs (Hardee et al, n.d.). In 1984 sexual health education material, the U.S. referred to abstinence,

monogamy, and condoms as the “ABCs of STDs” (Hardee et al., n.d., 12). Cohen and Tate refer to the definition of ABC- Abstinence for youth, Be Faithful for married couples, and Condoms for high-risk populations- as “uniquely American” (2005, 177).

By 2003, when PEPFAR was launched, the ABC model of HIV/AIDS prevention was widely recognized as a method for successful interventions (Hardee et al, n.d). Although PEPFAR’s version of ABC placed strong emphasis on AB and often condemned C, by naming the programme ‘ABC’ Bush could argue that a comprehensive strategy with international support was being implemented globally.

When facing criticism about PEPFAR’s programming actually being AB only, President Museveni’s claim that it was actually ‘AB’ that led to Uganda’s success story gave Bush needed ‘proof’ that his programme works.

Even if AB sexual health education has not proven effective and its apparent success cannot be supported by evidence, the Bush administration has finally found a country willing to promote their cause. Uganda was used as a case study to support abstinence-only sexual health programmes which were favoured by the republicans since the days of Reagan.

The Condom Shortage

In 2004, Uganda experienced a condom shortage. Due to complaints about the smell of the government subsidized condoms, the condoms were returned (later testing of the condoms in the U.S. showed them to be safe and effective). Uganda usually requires 120 to 150 million condoms annually. In 2005, less than 40 million were provided (Avert, n.d. f).

For people wanting to use condoms, the only option was to purchase condoms shipped into the country from elsewhere. The Ugandan government then levied a tax on condoms shipped in from outside the country, which raised the price significantly and made those condoms unaffordable for many Ugandans (Altman, 2005).

In 2005, 2006 and 2010 more condom shortages occurred. This time the Ministry of Health's officers advised the public to start practising other forms of prevention, namely abstinence and monogamy (IRIN, 2010). From news reports, Ugandans were getting frustrated: "Why do they [the government] tell us to use condoms and then fail to make them available? It defeats their own HIV campaign" (IRIN, 2010).

Some international non-governmental organizations began to blame Uganda's condom shortages on the U.S. and PEPFAR's policies against condom use (Altman, 2005). Uganda HIV/AIDS prevention workers were suspicious of the coincidental timing of PEPFAR restrictions on condom expenditure and the recall of Uganda's condoms (Higgins & Norton, 2010). They felt that the U.S. government was encouraging Uganda to create barriers to condom access (Higgins & Norton, 2010).

Stephen Lewis, former Canadian Ambassador to the UN and then United Nations secretary general's special envoy for HIV/AIDS in Africa, said that "there is no question that the condom crisis in Uganda is being driven and exacerbated by PEPFAR and by the extreme policies that the administration in the United States is now pursuing" (Altman, 2005). Both he and Barbara Lee, U.S. Congresswomen spoke out at the XVI International AIDS press conference by stating that PEPFAR has placed "an inordinate emphasis on abstinence at the expense of condoms as part of the prevention dimension of PEPFAR... no government in the Western world has the right to dictate policy to African governments in how they structure their response (to AIDS)." (News9.com, 2006)

Randall Tobias⁴⁹, U.S. Global AIDS Coordinator, spoke at the International AIDS conference in Bangkok (2004), he reassured the audience that the U.S. believed in condoms: “abstinence works, being faithful works, condoms work. Each has its place” (Human Rights Watch, 2004). But just three months earlier, Tobias stated that: “statistics show that condoms really have not been very effective...It's been the principal prevention device for the last twenty years, and I think one needs only to look at what's happening with the infection rates in the world to recognize that it has not been working.” (Kaiser Family Foundation, 2004. As quoted in: Human Rights Watch, 2004).

By 2004, President Museveni- who had been praised for his quick reaction to HIV/AIDS in the 1980s and 1990s and his early adoption of a comprehensive prevention campaign that focused on partner reduction, abstinence, and condom use was now

49 An interesting note about Randall Tobias: Randall Tobias used to be the Chairman and CEO of Eli Lilly, a major US pharmaceutical company (CNN, 2007). In 2004, Eli Lilly's president was speaking at major conferences around the world about the potential for a new HIV vaccine. In speeches that year, he was mentioning that 80 potential new medicines for HIV/AIDS had been or were in the processing of being developed (Eli Lilly, 2004). It is not clear if Eli Lilly was working on one of these vaccines. Tobias spent three years with PEPFAR promoting abstinence and being faithful and asking recipient countries to sign anti-prostitution pledges. In 2007, news broke that Tobias, a married man, was a client of an escort service- allegedly involved in prostitution. He promptly resigned.

threatening to “open war on the condom sellers.” (The Monitor, 2001) Museveni said, “instead of saving life they are promoting promiscuity among young people...When I proposed the use and distribution of condoms, I wanted them to remain in town for the prostitutes to save their lives,” (New Vision, 2004), suggesting that condoms are not appropriate for the wider public but only for use by prostitutes and furthering the stigmatization of condoms.

By 2013, the Ugandan government was comfortable with neglecting condoms in their HIV/AIDS prevention strategy and suggesting that condom use can lead to an increased risk of contracting HIV/AIDS. According to the Uganda AIDS Commission (UAC), a strong contributing factor in the rise of HIV/AIDS was the promotion of condoms: “the use of condoms, for instance, led to increased high risk sexual behaviour amongst high risk populations in New York, driven by the perception that as long as you wear a condom it does not matter who you sleep with” (Nantulya, n.d.).

Oomman et al., compared three different PEPFAR funding recipients in Africa including Uganda (2007). They found that despite having different epidemiological contexts, the three countries had remarkably similar responses to HIV/AIDS programming (2007). The authors conclude that the earmarking of PEPFAR funds disallows prevention efforts to reflect the local context and recipient countries' priorities (2007).

How PEPFAR might have affected Uganda’s HIV/AIDS prevalence

There are several limitations to this research. One of which is the ability to get accurate HIV/AIDS rates (Tumushabe, 2006). AIDS surveillance developed and improved substantially between the 1980s-2000s. In the 1990s, Uganda began a door-to-

door testing campaign which offered Ugandans free HIV/AIDS testing and counselling without them having to travel to clinics, hospitals or public testing locations (Mukisa, 2013). HIV/AIDS testing also improved from blood tests at clinics to saliva tests with near instant results (authors own experience working in a health clinic in Misufini, Kenya).

Given these limitations, this thesis can still draw upon some general observations from the data to show how PEPFAR's HIV/AIDS policies might have affected Uganda's HIV/AIDS prevalence.

PEPFAR entered Uganda in 2004 and began a widespread HIV/AIDS treatment and prevention campaign. That year, treatment was rapidly scaled up, the price of antiretroviral drugs fell, and laboratory services improved (Ugandan Ministry of Health, 2007/2008-2011/2012). Access to more treatment would have prevented deaths meaning more PLWHAs would be counted in the country and that could offset the impact of behavioural change programmes. People living longer with HIV/AIDS which may have been one reason the HIV/AIDS rate was stabilizing in the mid-2000s.

There was a need to examine new incidences (the number of new people found HIV positive) of HIV/AIDS to acquire a clearer picture of how prevention programmes were affecting the HIV/AIDS rate (UNAIDS, 2010b). Hogle and her team conducted a study that found that HIV/AIDS incidence peaked in the 1980s and fell in the 1990s. A fall in seroincidence⁵⁰ meant that less people acquired HIV/AIDS (2002).

⁵⁰ According to The AIDS Education and Training Centres National Resource Centre, seroincidence is "the rate of new infections within a specific target population in a time period (<http://www.aidsetc.org/aidsetc?page=home-00-00>) . Hogle et al., had to rely in seroincidence rates because general incidence numbers were very challenging to find

But by 2009, the HIV prevention strategies of the past had been losing momentum, according to UAC (UAC, n.d.). The UAC found HIV incidence and prevalence rates stagnating and a threat of a re-surg-ing epidemic in some parts of Uganda (UAC, n.d).

Incidence modelling has shown that 43 per cent of new HIV infections have been occurring in monogamous relationships (UAC, n.d). According to Hogle et al., once a country has achieved a significant seroprevalence decline- like Uganda- a complex set of socio-cultural, epidemiological, and political elements affect the course of the epidemic (2002). This is the time when condoms are most important.

We also know that intercourse between discordant couples (one partner is HIV negative and the other partner is HIV positive) is one of the leading ways HIV/AIDS has been transmitted in recent years (Uganda Ministry of Health, 2006) and explains why 43 per cent of new HIV infections are happening in monogamous relationships. The ABC campaign promotes C to be used when A and B are not an option. But couples who are monogamous are being faithful and yet they are often the people being infected. Condoms should be promoted to keep people in discordant relationships safe.

For those who know that they and their partners have a discordant HIV/AIDS status, the condom shortage and increased taxes on condoms may make obtaining condoms near impossible (New York Times, 2005). Further research needs to be done on the stigmatization of condoms that could be occurring with the new policies being introduced by PEPFAR, the Ugandan government, and through President and First Lady Museveni's "war" against condoms (Nyanzi and Nsangi, 2007).

In 2003, PEPFAR announced that they would offer their first grants to developing countries for HIV/AIDS prevention in 2004. Knowing that PEPFAR was offering \$15 billion in HIV/AIDS funding would have encouraged countries like Uganda to change their prevention programmes and meet the requirements of PEPFAR.

The first year the HIV/AIDS prevalence rate stopped falling and stabilized at 6.4 per cent in Uganda was in 2004. This may have been because access to antiretrovirals was increasing due to new funding for treatment provided by PEPFAR and that was combined with rising HIV/AIDS incidence.

HIV/AIDS prevalence and incidence rates in 2004 might also have been affected by PEPFAR's prevention policies. It was the first year Uganda had been given PEPFAR funding (PEPFAR had just started) and PEPFAR funds were very focused on AB-only prevention.

One year might be too short an amount of time for PEPFAR to have made such an impact in Uganda that it changed the rates of incidence. According to the OGAC behavioural change programmes can take some time to show their affect (2006). The OGAC uses the example of life skills programmes given to children under the age of sexual maturity. They suggest that the impact of these life skills programmes on sexual delay may not be present for some years (2006).

It is possible that even after one year of PEPFAR funds, more PLWHA were alive than would have been otherwise because of the increasing availability of ARVs and this could have made some impact on the HIV/AIDS rates.

It is possible that incidence rates were already on the rise before PEPFAR's policies were implemented. However, since PEPFAR started donating to Uganda in 2004,

HIV/AIDS prevalence and incidence rates stopped their decline and either stabilized (for the first time in Uganda's HIV/AIDS epidemic) or rose. HIV/AIDS prevalence rates remained stable at 6.4 per cent from 2003-2006. By 2007, both prevalence and incidence rates were on the rise (see page 14).

PEPFAR's prevention policies and programmes were implemented just as HIV/AIDS rates in Uganda were stabilising. The literature suggests that rates may be a reflection of people's fatigue from behavioural change programming (Cohen and Tate, 2005; Pisani, 2008; the Ugandan AIDS Commission, 2012; Do not backtrack on HIV/AIDS fight, 2012; and Nantulya, 2013). This thesis suggests that funding restrictions from PEPFAR may have exacerbated the situation by narrowing prevention programmes and limiting people's prevention options.

The need for a culturally appropriate HIV/AIDS response

This study finds that PEPFAR's sexual health policies are counter to modern understandings of health education. Instead of focusing on comprehensive sexual health programmes that include abstinence, being faithful, condoms, and strong political leadership, PEPFAR implements narrow prevention programmes that are acceptable to their political supporters at home.

During the 1990s when the HIV/AIDS epidemic was spreading quickly, Ugandans reacted by reducing their sexual partners and adopting less risky sexual activities. By the mid-2000s, Ugandans may have grown less fearful or been fatigued by the AIDS scare and by the start of the 21st century Ugandans were increasing their multiple partnerships (Cohen and Tate, 2005; Pisani, 2008; the Ugandan AIDS Commission, 2012; Do not backtrack on HIV/AIDS fight, 2012; and Nantulya, 2013).

As the numbers of discordant couples rose and there became clear data on the need for condoms (Pisani, 2008), the U.S. applied stricter regulations on PEPFAR funding limiting its availability for programming outside abstinence and monogamy and restricting outreach to sex workers.

The literature suggests that comprehensive sexual health programming is the most effective prevention programme (Silva, 2001; Kirby et al., 2006; Kirby, 2007), yet PEPFAR restricted NGOs from offering a diversity of prevention programming and messages by placing limits on non-AB expenditures. PEPFAR also choose to give money to mostly faith-based organizations that promoted AB and signed the APP. According to the Daily Monitor, in 2013, the September round of funding for mother-to-child HIV/AIDS prevention in Uganda was given only to faith-based organizations (Efforts against HIV commendable, 2013).

NGOs that wanted to receive PEPFAR funding were placed in challenging positions with their ethics and their ability to continue to serve their communities. Uganda's political leadership changed their view and opinions on comprehensive programming and even tried to re-write history by suggesting that condoms played a minor role in the initial HIV/AIDS decline (Munaabi, 2007; Butagira, 2012), even when the literature shows the strength of comprehensive programming (Hogle, J.A., et al., 2002; USAID, 2002; Black and White, 2003; Ruteikara, 2005; Parkhurst, J. O., 2010). It is clear that PEPFAR influenced a politically volatile public health landscape by introducing prevention programs that do not always rest on solid evidence-based prevention methods prevention methods.

Chapter 4: Conclusions and Recommendations

HIV/AIDS has become a development crisis for countries in the global south (World Bank, 2000). While treatment of HIV/AIDS is of significant importance to assisting developing countries, this thesis focused on methods and policies of HIV/AIDS prevention. To prevent future transmission of HIV/AIDS the literature recommends that comprehensive sexual health programmes be implemented everywhere. This thesis discussed Uganda's initial decline in HIV/AIDS transmission which resulted from a comprehensive and homegrown approach to HIV prevention. However, since 2004, Uganda has been adapting their approach to adopt the U.S. government preferred, yet ineffective, sexual health education policy (namely the abstinence and be faithful method). The Government of Uganda did change its position on the use of condoms in the campaign against HIV/AIDS. Originally they promoted the use of condoms and provided them throughout the country. Uganda was influenced to deviate from evidence-based programming because of financial aid from the U.S. which was tied to the adoption of A-only sexual health education and anti-prostitution policies and because of the strong lobbying efforts on behalf of the First Lady of Uganda. This thesis argued that the influence of donor countries through the giving of aid leads to policies that are politically driven and not always in the interest of development or the recipient country.

Not always does policy follow the evidence. In the case of American sexual health education programming and now (since 2004) Uganda's HIV/AIDS prevention programming, policy has not been written on the basis of evidence. Comprehensive sexual health education programmes has resulted in at delaying the age of first sexual initiation or debut, decreasing teenage pregnancy and safer sexual practices for

participants later in life. Abstinence-only sexual health education has not proven effective in the literature. Despite the scientific-evidence supporting comprehensive sexual health education, The Government of Uganda has proceeded with an abstinence and be-faithful model of prevention programming.

Uganda's change in strategy from an evidence-based comprehensive sexual health model to an AB strategy known to be ineffective is a result of a complex process which includes internal and international politics and religion. Upon further study it was apparent that Ugandan President and First Lady Museveni were further persuaded to adopt AB only strategies because of their own religious beliefs and the strong interests and financial support of the evangelical community. The combination of religious lobbying, personally held religious beliefs (particularly for Janet Museveni) and financial aid through the adoption of PEPFAR policies culminated with the Ugandan leadership being willing to forgo effective HIV/AIDS prevention strategies to the detriment of Ugandan's health.

Ugandans have also had a role to play. Prevention fatigue and disinhibition may be contributing to the rise in HIV/AIDS rates among serodiscordant couples. However the literature suggests that the availability of ART and HAART increases safe sex practices and decreases the risk of transmitting the virus to the HIV negative partner (Bunnell et al., 2006; Biraro et al., 2013). Uganda needs to focus on increasing access to ART, HAART and condoms.

Outside the scope of this research, there are other factors that could have played a role in changing Ugandan HIV/AIDS prevention policy and that includes the policies of other donors. Countries other than the U.S., along with non-governmental organizations,

charities, religious organizations, and large international donors like the Global Fund and UNAIDS could also influence the behaviour and policies of Ugandans and their government. One of the recommendations coming out of this research would be to look at other major donors and financial contributors to the fight against HIV/AIDS in Uganda and examine their policies and impact on Uganda's HIV/AIDS epidemic.

This thesis found that the power relationship between donor and recipient was unequal. The donor country tied financial aid to the adoption of their programming and policy objective with little, if any, recognition of different cultural approaches to HIV/AIDS. Uganda was asked to adopt the same HIV/AIDS prevention programming as other PEPFAR recipients despite recommendations in the literature for culturally relevant programming. All PEPFAR recipients have the same funding restrictions placed on them.

In this study of the U.S. and Uganda, it was found that the U.S.' internal politics were being brought to an international stage. Desperate to show that abstinence-only education can be effective, the U.S. government tied HIV/AIDS prevention policies to their PEPFAR funding. This policy action combined with complex internal politics and religious ideology influenced changes to Uganda's HIV/AIDS prevention programming and policies.

Recommendations

To address the problems of donor power in global health, this study recommends:

1. Multilateral funding

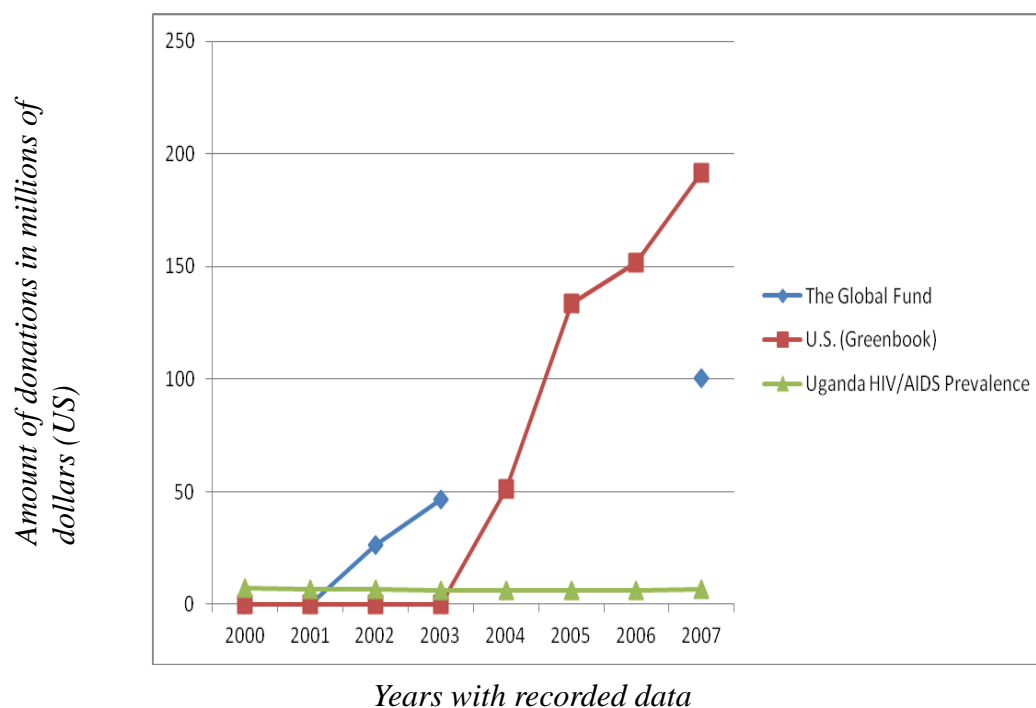
Several research articles conclude that bilateral funding is often the source of many problems between donor and recipient. Bilateral funding can strip recipients of their autonomy and create culturally irrelevant programming and policies. When the U.S. announced its creation of PEPFAR, shortly after withdrawing some support from the Global Fund many people were concerned that this was an attempt by the U.S. to control the global response to HIV/AIDS. Money funnelled through multilateral organizations is often less controversial than money given bilaterally.

Further research would need to be done on the effectiveness of large multilateral organizations especially when dealing with pandemics. But this study would recommend that when possible multilateral organizations work with recipient countries to create culturally relevant and flexible responses to health epidemics (see the discussion in the literature review on Micheal Hudson and Denis Goulet, 1971 and Leon Gordenker, 1976).

2. Donor impact on campaign outcomes

If bilateral funding continues, this study recommends further discussion of an international review panel as suggested by Attaran and Sachs (2001). Attaran and Sach do not explain who would sit on the international panel of expert they are proposing as an intermediary between aid donor and recipient. However, Attaran and Sachs suggest that such a panel be involved in the foreign aid policies and operational plans of donor and recipient to ensure programming is based on evidence. It is a proposal that merits further consideration.

Appendix A1:



*Data compiled by the author is from the Global Fund, The Green Book, and UNAIDS⁵¹.

⁵¹ The Global Fund Data shows how much money was given to Uganda from The Global Fund for HIV/AIDS from 2002-2007 (Rounds 1, 3, and 7- funding was not distributed between years 2004-2006 due to allegations of corruption). Source: <http://theglobalfund.org/fundingdecisions/>
 The U.S. Funding data is gathered from The Greenbook- U.S. Overseas Loans & Grants: Custom Program Report Global HIV/AIDS Initiative Obligations (amount is in constant 2010 US dollars). Bilateral American funding for HIV/AIDS prevention programming began in 2004.
 Data on the national prevalence rates of HIV/AIDS in Uganda was taken from UNAIDS, as noted above.
 For further information on the challenges in collecting data from PEPFAR and the Global Fund, please see: "Follow the Funding for HIV/AIDS: A Comparative Analysis of the Funding Practices of PEPFAR, the Global Fund, and World Bank MAP in Mozambique, Uganda, and Zambia". Nandini Oomman, Michael Bernstein, Steven Rosenzweig. October 10, 2007.; McCoy et al., 2009, p.408; and Walt et al., 1999, p. 208.

Appendix A2: Chart of international HIV/AIDS funding and HIV/AIDS prevalence in Uganda

Year	Rate of HIV/AIDS prevalence in Uganda	The Global Fund contribution to Uganda (millions U.S. \$)	PEPFAR contribution to Uganda (millions U.S.\$)
2000	7.2	N/A	N/A
2001	6.9	N/A	N/A
2002	6.6	\$26.2	N/A
2003	6.4	\$46.4	N/A
2004	6.4	\$0	\$51.0
2005	6.4	\$0	\$133.5
2006	6.4	\$0	\$151.6
2007	6.6	\$100.2	\$191.3
2008	6.7	\$0*	\$228.88*
2009	6.9	\$24.17*	\$269.83*
2010	7.0	\$4.35*	\$256.99*

Data taken from UNAIDS, The Greenbook, and PEPFAR. Asterix (*) indicates data that as taken from the Uganda Country Progress Report (2012).⁵²

52 Several sources were needed for data collection as none of the sources used had a complete set of data for the years 2000-2010.

**Appendix A3: Collection of data technique:
Scoping**

Date	Terms	Results	Database	Refining Terms	Best Fit	Final number
14/09/2012	foreign aid policy and global health donor influence	242	Saint Mary's Library	Full text	American	20
14/09/2012	American foreign aid policy and global health donor influence	80	Saint Mary's Library	Full text	Global health policy	5
30/11/2012	International foreign aid donor HIV/AIDS	125	Saint Mary's Library	Full text	Prevention, American, Ugandan, not geographically specific	13
12/12/2012	PEPFAR Prevention - chains -chest -botswana - labs -"south africa" - evaluating -dental - workers -child - circumcision -palliative - men -Zambia -gender - blood -Obama -malaria - PMTCT -head -injecting - drug -treatment -women -children	51	Saint Mary's Library	Full text	Gender inclusive, national level, English	10
17/02/2013	PEPFAR HIV/AIDS Uganda Prevention	2	PubMed	Full text available	Not just MSM	1

17/02/2013	PEPFAR -ARV -TB -drugs - lab –homosexuality	47	New Vision		prevention, ABC, abstinence, condoms, U.S. , funding, Museveni, written by Ugandans	8
17/02/2013	PEPFAR -Stores -gays - ARV –drug	39	Daily Monitor		prevention, ABC, abstinence, condoms, U.S. , funding, Musenveni, written by Ugandans	5
03-Feb-13	school based sexual health education behavioural change United States Uganda	37	Saint Mary's Library	Full text	1990-current	2
02-Mar-13	Evangelical HIV/AIDS Uganda prevention - madagascar -India -gay - Nigeria -Namibia -malawi -PMTCT -Ghana -gender – treatment	17	Google Scholar	English		4
02-Mar-13	evangelicals international development Africa	76	Saint Mary's Library	English, money, monetary	why Evangelicals were expanding internationally	0
28-Apr-13	Janet Museveni HIV/AIDS -Gallery -40 -MTCT - mother -circumcision – Ruhaama	138	New Vision		HIV/AIDS, abstinence, condoms, AB, national policies	39
28-Apr-13	Janet Museveni	11	Saint Mary's	None	Aids, bibliography	2

28-Apr-13	Janet Museveni abstinence	15	Monitor	English	condoms, abstinence, donors, ABC	7
10-Dec-13	HIV/AIDS prevention fatigue among discordant couples no ART Uganda	3	Saint Mary's	ART	Uganda	1
10-Dec-13	HIV/AIDS prevention fatigue among discordant couples no ART Uganda	104	Google Scholar	English, ART	No access to ART, refused ART, Uganda, Africa, serodiscordant	4

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