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AIDS and Empire: Setting: the Conditions of a Pandemic

Cora Walsh

When we come to you
Our rags are torn off us
And you listen all over our naked body.
As to the cause of our illness
One glance at our rags would tell you more.
It is the same cause that wears out our bodies and our clothes.

The pain in our shoulder comes
You say, from the damp, and this is also the reason
For the stain on the wall of our flat.
So tell us:
Where does the damp come from?

-Bertolt Brecht, from "A Worker's Speech to a Doctor"

Within this poem we hear the voices of those infected and affected by HIV, crying out from where AIDS has lodged, among the poor, the marginalized, and the oppressed. The most recent UNAIDS Report states that 40.3 million people worldwide are currently living with HIV; 10,000 of these individuals will die each day due to AIDS (89). The most drastic impact of this pandemic has been in Sub-Saharan Africa. While it makes up only 10% of the world's population, this region is home to 60% of all people living with HIV (UNAIDS 2004a). HIV prevalence rates are still rising disturbingly quickly in this region, facilitated by weak socioeconomic structures, inadequate public health dissemination systems and some cultural practices, such as the importance of fertility, polygamy, and the suspicion of condom use (Craddock 2004, Schoepf 2004, Hope 1999).

Sub-Saharan Africa contains some of the poorest nations of the world, where basic survival is the greatest daily concern. For these individuals, the more immediate issues associated with obtaining food, shelter and security may overshadow any concern for HIV transmission (Liddell et al. 2005). Additionally, a low income, lack of economic stability, or lack of an independent income practically forces risky behavioral choices on some individuals, especially women; for example, women may enter into prostitution or sexually based friendships to

ensure economic security. Poor socioeconomic conditions leave "poor women more constrained in their choices about relationships and living situations, so they may not feel the freedom and comfort to negotiate their sexual practices or leave their partners (Heffernan 2002)."

Structural adjustment policies and the poor economic status of many sub-Saharan Africa governments have resulted in public health structures unable to meet the needs of the population. Little to no primary health care is either available or affordable for a majority of the population, making it near impossible to disseminate HIV/AIDS prevention information, services, or products through a traditional health care setting. The confluence of cultural factors, poor socio-economic structures and inadequate public health systems that have already compromised the standard of living in these areas provide an open door for the HIV/AIDS epidemic, producing a vicious cycle of disease transmission that reinforces the social structures it feeds on. "A disease that creates the conditions that favor its spread is the most dangerous disease of all (Economist 2004)." If these are the conditions that pave the way for the rampant spread of HIV, the essential question is who and what is setting the conditions? As the struggling worker sagely asked of his physician, "the pain in our shoulders comes, you say from the damp…so tell us, where does the damp come from?"

Globalization- of markets, nation-states, and cultures- has become the defining trend of our time. Central to this system are the concepts of commoditization and free trade, placing a monetary value on all aspects of life, privatizing their ownership, and "freeing" the marketing and trade of these commodities (including capital) from any regulations or legal barriers in order to maximize profit (Moe-Lobeda 2002). The basic tenant of this system is that through the deregulation of foreign trade and "free" markets, economic growth will be maximized that will benefit all individuals (Moe-Lobeda 2002). Certainly, when measured in terms of foreign investment, GNP or GDP, substantial growth has occurred in this global economy. Yet, in this system, over half of the world's largest economies are corporations, and "the world's 225 richest people have a combined wealth of over $1 trillion, equal to the annual income of the poorest 47 percent of the world's people (2.5 billion people, Moe-Lobeda 2002)." Clearly, the current global system does not increase the economic and social well-being of all global citizens as promised. Instead, the harsh reality is that the global gap between the wealthy and the poor increases by the day, increasing benefits for the economically powerful who create the system that threatens the very survival of those whom the market tramples.

When the reality of the economic model of globalization is exposed, it becomes clear that the market is not truly "free." Free for whom? Who has the power to set the conditions of life? The market is "free" for those with the economic power to access the market, and the power to set the conditions of life and choices available to the masses. Moe-Lobeda (2002) argues that "globalization removes from more or less democratically constituted and accountable political bodies the power to influence decisions that shape common life and places that power into the hands of relatively few unaccountable economic players." The decisions made by those at the center define the conditions by which billions of individuals at the peripheries are able to live their lives. For example, free trade policies (e.g. NAFTA, CAFTA) affect the ability of small-scale local farmers to stay in business as agribusiness takes over. These farmers are forced by the market to sell-out, often resulting in urban migration for work (Moe-Lobeda 2002). Multiple studies have now linked the social and economic pressures of migration to increased risk for numerous conditions, including HIV/AIDS (Craddock 2004, Hope 1999). Reality tells us that these conditions of life are increasingly worse for those at the peripheries of these global economic policies, a trend that physician/anthropologist Paul Farmer defines as structural violence. The unequal levels of suffering experienced between the rich and poor are historically given and economically driven macro-forces that combine to constrain personal agency through the harsh realities of life for those at the peripheries. Individual choice is constrained by the instability, which is further manifested through the social problems of racism, sexism, political violence and overarching poverty (Farmer 2005).

Embedded within these global structures of inequality is the AIDS pandemic. As the economic empire of global capitalism sets the conditions of life for those at the periphery, it sets as well the conditions for the AIDS pandemic. While the specifics of the situation vary by cultural and geographical location, the underlying mechanisms by which individual agency is constrained by socio-economic inequality, poverty, structures of gender inequality and racial/ethnic inequality, cross-culturally leads to the pre-disposition of entire populations to HIV transmission. The inequitable social conditions of life set by the economic empire result in the inequitable distribution of HIV/AIDS. This is clearly visible among the nations of sub-Saharan Africa where a social history of colonialism and pre-colonial cultural beliefs meet with the restructuring of these recently independent nations according to the policies and markets of the economic empire.

In Tanzania, located on the eastern coast of sub-Saharan Africa, 1.5 million adults (15-49 years) are infected with HIV. Of those infected, 840,000 are wom-

en. There is in total, an 8.8% (6.4-11.9%) adult prevalence rate. Additionally, an estimated 140,000 children are living with HIV; another 980,000 children under the age of 17 are living as orphans of AIDS (UNAIDS 2004).

These horrifying statistics are coupled with equally striking socio-economic statistics. As a nation, Tanzania continues to be one of the poorest in the world, with a gross domestic product of $23.71 billion (2004 est.) and a gross national product (per capita) of just US$270 (2000), placing it among the twenty poorest nations of the world (CIA 2005, Kagaruki-Kakoti 1998, Parker 1997). Thirty-six percent of the population lives below the poverty line (2002 est) (CIA 2005). Unemployment falls at 25% (Parker 1997). Life expectancy in Tanzania for females is 44.1 years of age, and for males is 42.5 years (2001 estimate) (UN 2004).

Government spending on public services, such as health care, has been drastically curtailed by the structural adjustment programs (SAPs) imposed by the World Bank and International Monetary Fund. SAPs were designed to "fix" the floundering economies of the nations they were imposed upon; this was defined as building the nation's place in the global economy as a producer and exporter (of primarily agricultural products in the case of Tanzania) and as an importer of manufactured goods (Earth 1996). In 1986, Tanzania became fully committed to a structural adjustment program (SAP) led by the IMF. Economic failure across the region was blamed by the IMF and World Bank on "corrupt" African bureaucracies; SAPs were used to "fix" these issues by restructuring the nation's economic system and government spending.

While business privatization and a move towards laissez faire, capitalism has been touted by the World Bank/IMF as highly successful means for economic growth. The story for the majority of Tanzanians is much different (Sanders 2001). The drastic reduction in government spending required by SAPs resulted in massive layoffs in state jobs (previously, a major employer), as well as major cuts in funding for government programs (e.g. education, health care). In Tanzania, the per capita annual income dropped to $120 USD (1991) as a result of SAPs, which was further worsened by a loss of government subsidies and new user costs imposed upon health care and education. Once again, as a result of decisions made by a few in power at the top of the economic ladder, it is the poor, women, and children at the peripheries who suffer the most from this economic restructuring (Earth 1996). While the few at the top may have benefited from the economic changes, the reality is that SAPs greatly widened the gap between the (newly) wealthy and poor, resulting in a situation in which 40 percent of Tanzanians now live on less than $0.65 per day (Sanders 2001).

As of 1990, annual government spending on health was $109 million U.S. dollars, amounting to just $4 per capita annually. International development assistance in health aid funding provided only another $2.1 USD per capita. Just 50% of the population has access to safe water, and 64% access to adequate sanitation (Muth 1997). As of 1984, just one physician was available per every 19,421 people (Earth 1996).

Amidst these impoverished social conditions, HIV has flourished, resulting in a public health catastrophe that is clearly a social and cultural phenomenon. Until recently though, biomedical studies have dominated the field, creating a representation of AIDS as a product of "multiple instances of individual risk resulting from lack of information or poor decisions" (Craddock 2004). These studies have proposed theories in which behaviors placing individuals at risk for HIV are conceived as a result of rational decisions by autonomous individuals. Built into these theories is the assumption that individuals informed about sexual behavior risks will be able to choose to avoid such risky behavior (Haram 2005). These interpretations fail to account for the social and cultural contexts within which individual decisions are made, contexts that all too often operate as constraining forces on individual health behavior decisions. This discrepancy surfaces most distinctly within the HIV prevention campaigns for condom usage.

The vast majority of prevention programs in sub-Saharan Africa, including Tanzania, focus on increasing condom usage (among other methods of prevention, as dictated by the Abstinence, Be Faithful and Condom Usage model) through education. Statistical analyses of prevention programs' condom education components indicate otherwise. There is a substantial difference between individuals' acceptance/understanding of condoms as a means of prevention and the actual use of condoms by program participants (Walsh 2006). This illustrates a gap between the level of knowledge program participants have and the actual implementation of that knowledge into practice. The high rates of condom acceptance indicate a sufficient level of knowledge about condoms to understand their importance in prevention. It would be expected that this understanding would translate into similar levels of condom usage; however, this is not even remotely the case. This large discrepancy has been a source of much frustration among the HIV/AIDS prevention community. Clearly, health education alone is insufficient to increase condom usage. The decision to utilize condoms, choose abstinence, of be faithful to one partner must be placed in the conditions of daily life. As these conditions have worsened in response to macro-level forces of globalization, the conditions of life have increasingly become constraints on the health behavior choices of individuals.

The Chagga society, in the Kilimanjaro region in Tanzania, illustrates the effects on individual lives across sub-Saharan Africa of the socio-economic trends associated with globalization and its link to the spread of HIV. In pre-colonial times, Chagga society was structured around the *kihamba*, a small subsistence farm plot passed through the patrilineages that established the social and cosmological structures of society (Moore 1977). Prior to the introduction of the cash-economy of coffee production and export, life revolved around the kihamba, a system based on the subsistence of the entire patrilineage, as well as sharing with neighbors. This pre-colonial system was strikingly similar to the "Economy of Grace" advocated by Kathryn Tanner (2005). Property belonged to the entire patrilineage (including the ancestors) to be used for the good of all; any accumulation of goods was extremely suspect of witchcraft or immoral means of acquisition. Excess goods were to be shared with the patrilineage and society through feasting and ceremonial giving. The kihamba system exemplified noncompetitive possession, in which goods were not exclusively owned, but cultivated for the good of the group (Moore 1977, Tanner 2005). This system reflects principles central to Tanner's theology. In her "Economy of Grace" giving is inclusive, designed to extend benefits to others without conditions placed on the giving (2005). This unconditional giving must be preceded by noncompetitive ownership, as seen in the Chagga economy based on subsistence, not profit. While Tanner's system is based in a Christian theology, here we see that the same principles may also be exhibited through other spiritual beliefs. As can be seen in Chagga society today, the disruption of these pre-colonial cultural beliefs by modern Western capitalism and its accompanying social patterns has locally been blamed for the instability of Tanzanian society and high rates of HIV transmission.

Just as economic systems have changed, pre-colonial Chagga women also held a much different position in society as compared to today. As the tenders of the kihamba garden plot, preparers of food, and facilitators of neighborhood markets, women consequently had a good deal of control over food production and processing (Moore 1977). At a subsistence level of production, this accorded pre-colonial women with sufficient autonomy and control over resources to ensure their own and their children's health and security (Turshen 1984). With the shift to an export economy, and diminishing access to the land and resources, women have lost this important degree of control. As has been shown in cultures around the globe suffering similar circumstances exacerbated by structural adjustment programs, these societal changes are often gender-blind; the macro-economic policies formulated to reallocate resources rely on the implicit

assumption that the process of social reproduction (normally carried out unpaid by women) will continue regardless of how the resources are reallocated, i.e. it assumes that women will continue to just "make it work," even with substantial cuts in public welfare programs (Earth 1996). It has been noted numerous times that women in general cope with this phenomenon by placing their own needs last (Earth 1996), including their own sexual health.

Gender roles among the Chagga also dictate the nature of the relationship between a man and woman. Due to the cultural values assigned to fertility combined with Chagga women's economic dependence on men, women have little control over sexual decisions. In the marriage relationship, the husband holds significantly more power, due to cultural constructions of his role as decision maker and his position of greater socio-economic power (i.e. land and property holdings, and responsibility for major productive work). Men have more freedom to be sexually active and more power in sexual health decision making, yet women are often held responsible for the consequences of their husband's actions (Mgalla et al. 1997). Women are expected not to question their partner's behavior, leaving them unable to realistically negotiate the sexual relationship or usage of STD protection and contraceptives. If women do attempt to raise these issues, they run a high risk of being accused of unfaithfulness (i.e. why else would a woman request the use of condoms, unless she had been unfaithful and now had a disease?), and may be beaten or abandoned for their behavior (Mgalla et al. 1997). In societies where a woman's economic survival and social status are assured through her partner (whether marital, or a boyfriend), the risks of losing this partner commonly take precedence over risks of HIV (Haram 2005). As noted through work in Uganda, "the risk of offending or losing a male partner by suggesting a check-up or a condom may be more significant than the risk of one more infection in an infectious environment (Haram 2005)." Women in compromised living situations will often secure what they can, if not their health, then at least the support of their partners, their economic and social survival and that of their children.

These multifaceted contributors to HIV risk (i.e. poverty, gender inequity, and a lack of social stability), come into direct conflict with typical methods of HIV prevention education. The ABC method of abstinence, being faithful, and condom usage advocated by many major HIV/AIDS programs, including the Bush administration's President's Emergency Plan for AIDS Relief, fails to address the feasibility of implementing these methods in a context rife with other risks (e.g. economic insecurity) and cultural values (e.g. fertility importance). While

it is critical that HIV prevention programs be designed such that participants are assisted, supported, and prepared to reconcile messages of HIV prevention with the context in which their daily decisions are made, it is painstakingly obvious that the impoverished conditions of daily life as created by the economic empire are both creating the conditions for the spread of HIV and greatly hindering the ability of informed individuals to choose a healthy lifestyle. Drastic change must occur in the global and national policies that are creating these socio-economic conditions. Macro-level issues advocated by the HIV/AIDS non-government organization community and representatives of UNAIDS include:

- debt forgiveness in developing nations, so that government resources may be spent on the health and education of their people rather than making payments on debts they will never be able to repay;
- the abolishment of school fees, so that every child may have access to at least a primary school education, as dictated by the Millennium Development Goals;
- universal access to treatment through the provision of generic AIDS medications,
- a global focus on the eradication of gender inequality, including establishing quotas for women in government, to generate legal change such as the inclusion of women in property rights;
- a significant increase in global funding for HIV prevention through the Global Fund to fight AIDS, Tuberculosis and Malaria;
- greater alleviation of world hunger;
- and AIDS orphan care, to provide these forsaken children with the education and resources necessary to break the cycle of HIV transmission (Lewis 2005).

Without a global focus on these issues, grassroots efforts will continue to be merely a bandage on a massive pandemic fueled incessantly by macro/global injustices. However, with greater global attention to the above issues, bottom-up efforts can be unified with top-down approaches to create an HIV prevention response of unprecedented scale that is both structurally attuned to global forces and culturally specific at a local level.

2006 marks the 25th year of the HIV pandemic and rates of HIV infection continue to skyrocket around the globe. How can this be after 25 years of efforts to halt this pandemic? An understanding of AIDS must be reached that allows for the design of interventions that will practically and successfully address the root causes of a pandemic that causes such inequitable suffering around the globe. Our ears must be turned preferentially to the voices of the oppressed

to understand the distortions and human rights abuses perpetrated through the current system of economic globalization. This idea is what Mark Lewis Taylor terms prophetic spirit, a persistent voice speaking truth to power to create justice and peace for the oppressed, and dislodging the willful blindness of the powerful to the oppressed (Taylor 2005). This idea, stemming from the teachings of Jesus, has been accompanied by other Christian social activists critically examining their religious tradition in light of the current disorder of the world today. In reading Richard Horsley's *Jesus and Empire*, it becomes clear through the contextualization of Jesus' life work in the face of the Roman Empire that Jesus called for the subversion of Empire that by its very nature was in direct opposition of the theological principles of Christianity (Horsley 2003). The teachings of Jesus, through the lens of Christian theology or humanitarianism, when contextualized with the Empire like practices of the United States and global capitalism today, once again make clear that action must be taken to subvert Empire.

This becomes even more critical as much of the global funding for the HIV/AIDS response comes from the United States or organizations heavily influenced by the U.S. government. Recently, the largest financial commitment by a single nation towards international health was made through President Bush's Emergency Plan for AIDS Relief (PEPFAR). This five year strategy promises $15 billion to aid 120 countries, with a particular focus on 15 of the nations most affected by HIV/AIDS (U.S. Dept. of State 2003). However, if the voices of those whose lives depend on these policies are heard, it becomes clear that the impressive amount of PEPFAR funding is overshadowed by the misallocation and regulation of these promised funds by the political power of the Christian right. As a result of the current unification of the Christian right with the power of the Bush administration, much of this funding is allocated to bilateral and faith-based organizations (rather than the Global Fund for AIDS, TB and Malaria, the largest global funding source of locally designed HIV/AIDS programming), and is regulated to be available only to those programs which denounce sex-work, and stress abstinence-only education (Basu 2003, Lewis 2005). Brazil, noted globally as having one of the most successful prevention and treatment responses, recently turned down a $40 million U.S. grant because the stipulations attached to the use of the money interfered with the type of response the government is providing (Lewis 2005). The United States is now is utilizing its Empire-like power to set not only the conditions that facilitate the spread of the epidemic, but also the conditions of the global response.

Under this dual control, the concept of prophetic spirit through the voices

of the oppressed becomes essential for the creation of alternative responses by an alternative global community that have preferential social justice for the oppressed. This will require the mobilization of the oppressed, united with those benefiting from the system around their common humanity to put pressure on the American Empire and speak truth to power. AIDS is a symptom of the inequalities and human rights abuses perpetrated through the legitimizing forces of both economic and ideological empire. If we do not speak truth to power, AIDS will continue to claim life after life, leave orphan after orphan, and destroy the social fabric of society. We can no longer exert a willful blindness to the suffering of millions, from sub-Saharan Africa to the inner-city streets of America. Our common humanity calls us to promote justice, equity and compassion in human relations and respect for the interdependent web of all existence of which we are a part (Unitarian-Universalist Principles and Purposes 2005), and through this lens, subvert the Empire that allows one person to thrive on the suffering of another.

> *It is we who are sick; it is therefore we who take the responsibility to declare our suffering, our misery, and our pain, as well as our hope…And in addition to our health problems, we have other tribulations. We still have problems paying for housing. We have trouble finding employment. We remain concerned about sending our children to school. Each day we face the distressing reality that we cannot find the means to support them. Not being able to feed our children is the greatest challenge faced by mothers and fathers across the country of Haiti. We have learned that such calamities also occur in other countries. As we reflect on all these tragedies we must ask: is every human being not a person?*
>
> *Yes, all human beings are people. It is we, the afflicted, who speak now. We have come together…to discuss the great difficulties facing the sick…The right to health is the right to life. Everyone has a right to live. If we were not living in misery, but rather in decent poverty, many of us would not be in this predicament today…*
>
> *We have a message for the people who are here and for all those able to hear our plea. We are asking for your solidarity. The battle we're fighting-to find adequate care for those with AIDS, tuberculosis, and other illnesses- is the same as the combat that's long been waged by other oppressed people so that everyone can live as human beings.*
>
> *~Rural Haitians living with HIV/AIDS,in association with Partners in Health (Farmer 2005)*

Works Cited

Basu, S. 2003. AIDS, Empire, and Public Health Behaviorism. Accessed 4/20/2006. www.globalpolicy.org

Central Intelligence Agency. 2005. Tanzania. In: The World Factbook.

Craddock, S. 2004. Introduction. In: HIV and AIDS in Africa: Beyond Epidemiology. Blackwell Publishing Ltd., MA.

Douglas, K.B. 2005. What's Faith Got to Do with It? Black Bodies/Christian Souls. New York: Orbis Books.

Earth, B. 1996. Women and Health Education in Rural Tanzania: Lessons in Empowerment. Ohio University: Dissertation.

Economist. 2004. The New Face of AIDS. Economist Print Edition.

Farmer, P. 2005. Pathologies of Power: Health, Human Rights, and the New War on the Poor. California: University of California Press.

Haram, L. 2005. AIDS and risk: The handling of uncertainty in northern Tanzania. Culture, Health & Sexuality 7(1): 1-11.

Heffernan, C. 2002. HIV, Sexually Transmitted Infections and Social Inequalities: When the Transmission is More Social than Sexual. International Journal of Sociology and Social Policy 22(4/5/6): 159-176.

Hope, K. R. Sr. 1999. The socioeconomic context of AIDS in Africa: a review. In: AIDS and Development in Africa: a Social Science Perspective. Hope, Kempe Ronald Sr. (Ed.). New York: Haworth Press, Inc.

Horsley, R.A. 2003. Jesus and Empire: The Kingdom of God and the New World Disorder. Minneapolis: Fortress Press.

Kagaruki-Kakoti, G. 1998. Chagga. In: WorldMark Encyclopedia of Cultures and Daily Life. Volume 1: Africa. Gall, Timothy L. (editor). New York: Gale.

Krehely, J. 2005. Funding the Culture Wars. Accessed 4/20/2006. www.globalpolicy.org

Lewis, S. 2005. Race Against Time. Toronto: House of Anansi Press Inc.

Liddell, C., Barrett, L., and M. Bydawell. 2005. Indigenous representations of illness and AIDS in sub-Saharan Africa. Social Science and Medicine 60: 691-700.

Mgalla, Z., Wambura, L., and M. Bruyn. 1997. Gender and HIV/AIDS/STDs. In: HIV prevention and AIDS care in Africa: a district level approach. Ng'weshemi, Japheth (ed.). Amsterdam: Royal Tropical Institute.

Moe-Lobeda, C.D. 2002. Healing a Broken World: Globalization and God. Minneapolis: Augsburg Fortress.

Moore, S.F. 1977. The Chagga and Meru of Tanzania. London: International African Institute.

Muth, A. (editor). 1997. Statistical Abstract of the World. Detroit: Gale.

Parker, P. M. 1997. National Cultures of the World: a Statistical Reference. Connecticut: Greenwood Press.

Pui-lan, K. 2005. Postcolonial Imagination and Feminist Theology. Louisville: Westminster John Knox Press.

Sanders, T. 2001. Save our Skins: Structural adjustment, morality and the occult in Tanzania. In: Mafical Interpretations, Material Realities: Modernity, witchcraft and the occult in postcolonial Africa. Henrietta L. Moore and Todd Sanders (ed.). London: Routledge.

Schoepf, B.G. 2004. AIDS, History and Meaning. In: HIV and AIDS in Africa: Beyond Epidemiology. Kalipeni, Ezekiel; Susan Craddock; Joseph R. Oppong; and Jayati Ghosh (ed.). Massachusetts: Blackwell Publishing Ltd.

Tanner, K. 2005. Economy of Grace. Minneapolis: Fortress Press.

Taylor, M.L. 2005. Religion, Politics, and the Christian Right: Post 9/11 Powers and American Empire. Minneapolis: Fortress Press.

Turshen, Meredeth. 1984. The political ecology of disease in Tanzania. New Brunswick, N.J.: Rutgers University Press.
UNAIDS. 2004. United Republic of Tanzania: Epidemiological Fact Sheets. New York: UN.
UNAIDS. 2004a. UNAIDS Epidemic Update. Geneva: UNAIDS.
UNAIDS. 2005. UNAIDS Epidemic Update. UNAIDS.
United Nations. 2004. Statistical Yearbook: forty-eighth issue. New York: UN.
U.S. Department of State. 2005. The President's Emergency Plan for AIDS Relief. Washington.
Walsh, C. 2006. HIV/AIDS in sub-Saharan Africa: Determining Successful Prevention Strategies. Unpublished Senior Honors Thesis. Denison University.