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Except for northern Uganda where the twenty years of armed conflict have no equal, it is a matter for debate whether anything has disrupted development, decimated communities, and changed the destinies of entire populations as much as AIDs has, since the end of slave trade – and for Uganda there are a number of contenders for this notoriety, such as the eight years of Idi Amin. But catastrophic as the pandemic has been, AIDS created a whole new economy that grew and thrived, even as people continued to die. First, there were the clinicians who quickly realized that they were onto something big – something far beyond themselves, beyond Uganda. Something at once frightening and monstrous, something impossible to contain, that begged to be respected and understood. Very quickly followed the public health people. Historically, public health was the poor relative at Makerere Medical School. Most people did not consider it medicine at all. It was understood that if one wanted to remain in medicine and in academia, they did not apply to join the Institute of Public Health. That was for those content to spend their days teaching communities about good nutrition and the value of a latrine. That, it was agreed, did not require too much academic rigor. The public health diploma took all of nine months to complete, compared to the three years for a master's degree in medicine.

Then comes AIDS. With the epidemic came new research and research grants. It did not take long for clinicians to figure out that while in the short run the research might not help their patients – there were no remedies for HIV and AIDS for more than a decade after its onset – the research grants did not hurt their financial fortunes. As the saying goes, those that set out to do good, did well. Some did so well that the AIDS work expanded to fill their entire workspace, and their lifetime careers. And as might be expected, this sudden and almost total focus on HIV and AIDS was at the expense of other areas of medicine. Soon, the top brains in any graduating class were heading, not to surgery or pediatrics, not even to internal medicine, but to epidemiology, and to – yes, public health. The AIDS economy was roaring, it was global, and Uganda had the unenviable reputation of being close to, if not at, the very heart of the epidemic. Where the 1970s saw the exodus of academics and health professionals following Idi Amin's infamous expulsion of Asians, the 1980s and 1990s saw, first a trickle, and then a steady stream of international researchers, before the dam burst to let in the flood in the early 2000s. Where in many European and American hospitals one might see one or two gay men with immunosuppression in several months, in Uganda there was an entire population begging to be studied. The President was being open about the HIV threat, and he was saying some right things most of the time.[1] The country had a fairly well-trained but barely-paid health workforce, eager to drop whatever they were doing to join paid research teams. Uganda was set to become the HIV and AIDS research capital of the world. It was a match made in global research heaven.

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[1] President Museveni did not start off being open about HIV. Very early in the epidemic when Dr. Wilson Carswell, a British surgeon working at Mulago, wrote a research paper on 'Slim disease' based on his research in Rakai, he was asked to leave.

The noble, the ignoble, and the outright sinister were all headed for Uganda, and for every international agent that came, there were probably several Ugandans waiting to collaborate in the work. Rules were being made up as the work went along. There were ethical dilemmas at every turn – should doctors tell their patients that their spouses had the virus? Should doctors disclose their own HIV status to their patients? What did ‘informed consent’ mean when dying people were lining up to take whatever was being offered as a possible remedy? What did you do when a patient’s choices were either a blood transfusion or death – and the blood probably had the virus in it? How were research grants to be managed? One professor hired his wife, a nurse, as the study coordinator. She supervised doctors, made payments, signed off and dispatched blood samples to foreign institutions, and only she and her husband knew what was in the research grant budget. A few people frowned on this kind of unethical behavior, but that would soon be seen as kindergarten homework once the serious profiteering set in. It did not take long for Makerere to start topping the charts in the volume of research publications, never mind that at least initially; most of the lead authors were not Ugandans.

With time though, research started to pay off, both in terms of preventing infection, and treating established infections. After many false starts and the use of highly toxic and ineffective medicines, researchers gave the world the medicines that transformed HIV from a death sentence to a chronic disease. Anti-retroviral drugs, or ARVs as they became widely known, were literally life giving, to individuals, communities, and to countries like Uganda. Scientists in labs and hospitals around the world had worked for years against great odds to arrive at this success. Because the cost would have put the medicines out of reach of the millions of people that needed them, phenomenal efforts were made at global levels to avail the drugs either free or at greatly subsidized prices, and to put in place elaborate systems to get them safely to those in need. The stage was set for the dark side of the Ugandan AIDS economy to be brought to the fore.

As the clinical and public health researchers described the horrifying extent of the AIDS epidemic in the country – in some communities as many as one in every five people were said to be infected - and the extreme vulnerability of communities; as agencies like the World Health Organization and Global Fund (for HIV, Tuberculosis and Malaria) put together substantial sums of money to counter the disaster, highly placed individuals in the Ministry of Health readied themselves for the kill.

The looting of the Global Fund money in Uganda was not an impulsive grab of a few million shillings, or the systematic siphoning off of the infamous ‘ten percent’ by the financial managers of the grant, leaving the rest of the money to do the work. Even years after the scale of the theft was discovered, it still boggled the mind that it happened in the manner that it did, and that some of the perpetrators were walking about as free men and women, never having spent a day in jail.

In August 2005 the Global Fund announced that it was suspending all grant funding to Uganda, totaling US $367 million.[2] An audit by PriceWaterhouseCoopers had raised concerns of 'inappropriate expenditures and improper accounting' with regards to the Global Fund money. President Museveni set up a commission of inquiry in the mismanagement of the Fund. The public hearings held from September 2005 to April 2006 heard testimonies from more than 130 witnesses and reviewed some 500 exhibits tendered as evidence.[3] The public was appalled by what had happened. Key project managers had been irregularly appointed. The Minister of Health Jim Muhwezi was said to have negotiated with DFCU bank to exchange dollars at a lower-than-market rate so that they could pocket the difference. Junior minister of health Captain Mike Mukula, together with his two colleagues, were accused of siphoning hundreds of millions of Global Fund money for political mobilisation. Fictitious non-governmental organisations and companies had been set up as service providers, and payments were being shared without any work done. Even where some work happened, expenses were inflated and false receipts presented. Allowances going into tens of thousands of dollars had been paid out to ministers for supervision work that was not done. Justice James Ogoola who headed the Commission called the Fund's management "a pile of filth".[4,5]

The appointment of the Commission of Inquiry might not have recovered much money, but it had the desired effect on the donors. Richard Feachem, then executive director of the Global Fund, probably spoke too soon. "The openness and thoroughness with which President Yoweri Museveni addressed the Global Fund's concerns about the management of the grants it finances in Uganda has set an example for how allegations of corruption should be dealt with. By conducting a public inquiry under the competent leadership of Justice Ogoola, Uganda has given a clear message that abuse of money meant for those suffering the consequences of malaria and AIDS is unacceptable," wrote Feachem, Executive Director of the Global Fund, 2006.[6]

The health sector was still reeling from the Global Fund scandal when it came to light that the same leadership at the Ministry of Health had superintended over another colossal loss, this time with money from GAVI (Global Alliance for Vaccines and Immunization) meant for the country's immunization program.

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[2] The Global Fund Welcomes Ugandan Corruption Inquiry Report. https://www.theglobalfund.org/en/news/2006-06-02-the-global-fund-welcomes-ugandan-corruption-inquiry-report/

[3] The New Humanitarian. Uganda: Misuse of funds revealed as global fund inquiry quizzes ministers. 24 Mar 2006

[4] IRIN / PlusNews. Uganda: Global Fund probe reveals massive graft. 03 April 2006. https://reliefweb.int/report/uganda/uganda-global-fund-probe-reveals-massive-graft accessed 09 July 2019

[5] David Wendt. $12 Million Lost, But Has Anything Changed for the Global Fund in Uganda? Center for Global Development. 14 November, 2008. (https://www.cgdev.org/blog/12-million-lost-has-anything-changed-global-fund-uganda accessed 9 July 2019)

[6] Peter Nyanzi. Uganda: Global Fund Praises Museveni Over Probe. *The Monitor* 2 June 2006.

On Thursday 26 April 2007, Brigadier Noble Mayombo was ill enough to accept an admission to Kololo Hospital, a private hospital in the heart of Kololo. The doctors diagnosed acute pancreatitis, a raging inflammation of the pancreas, a small organ in the depths of the abdomen that makes digestive juices. The following day his condition continued to worsen, prompting his doctors to transfer him to International Hospital Kampala, where he was immediately admitted to the Intensive Care Unit. Here, despite the most sophisticated medical interventions that the ICU could offer, it was evident that Mayombo's pancreas was disintegrating and destroying other organs in the process. By Sunday 29 April 2007 he had slipped into coma and was on life-support. The doctors were under tremendous pressure to do any and everything necessary to fix Mayombo's health. He was only 42 years old, was among the most powerful men in the country, and had, as far as the public was concerned, enjoyed perfect health until the current sudden illness. He held the very sensitive position of Permanent Secretary for the Ministry of Defense, was the Board Chair of the New Vision Corporation, and was known to be a close confidant of the President. He had previously headed the dreaded Chieftaincy of Military Intelligence (CMI). There had been talk in some circles of his being a possible successor to President Museveni.

As though to remind the doctors that this was no ordinary patient, there was security presence everywhere in the hospital, including the ICU itself. There were uniformed officers in the parking lot, there were uniformed and plain-clothes security agents in the corridors, and close family and trusted colleagues camped at the entrance of the ICU. In the quiet room with patient monitors beeping constantly, Mayombo lay motionless, unaware of the drama unfolding around him. And if there was drama in the hospital, there was even more drama outside the hospital, with conspiracy theories flying around Kampala and beyond. 'Mayombo has been poisoned! The doctors are trying to figure out how to neutralize the poison,' went one of the stories. It was said that the doctors working on Mayombo were under surveillance.

The doctors held frequent meetings in the ICU to review his status, and to determine if anything should be changed or added. A doctor from State House checked in constantly to get updates of Mayombo's progress. Plans were already underway to fly him to Israel. A team at a top hospital in Israel had been contacted, and they were waiting to receive him. Because his condition was deteriorating very rapidly however, Israel started to look unlikely. Nairobi was a more realistic destination. Mayombo was on a respirator, his systems were being closely monitored, and he was on medications to keep his major organs from shutting down. Nairobi was at least 45 minutes away by the presidential Gulfstream, but on either end of the flight were the most hazardous segments of the journey. He would have to be moved into the most advanced ambulance available, and the journey from IHK in Namuwongo to Entebbe would be rough. The first five hundred meters from IHK in any direction alone would be a test to less critical patients. Kampala roads, even when paved, were notoriously narrow and irregular. An ambulance ride for the acutely inflamed abdomen and an evolving multiple organ failure was going to be a very high risk transfer, but IHK had considerable experience evacuating critically ill patients. Once the decision was made, the wheels were set in motion. Aga Khan Hospital in Nairobi was contacted, detailed consultations were done, and evacuation plans shifted to Nairobi, at least initially.

Having done all that they could, the IHK doctors prayed that their patient would make it to their Kenyan colleagues no worse than when he left them.