HIV and AIDS in Uganda

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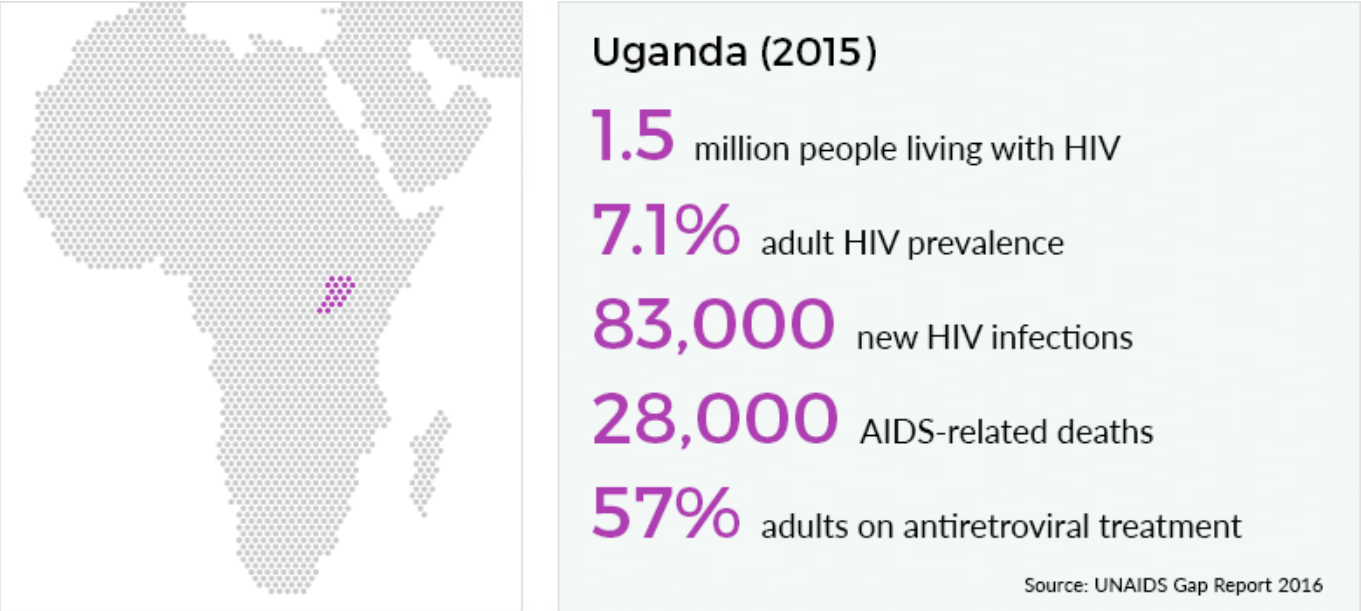

In 2015, an estimated 1.5 million people were living with HIV, and an estimated 28,000 Ugandans died of AIDS-related illnesses.[1] As of 2015, the estimated HIV prevalence among adults (aged 15 to 49) stood at 7.1%.[2]

The number of new HIV infections in Uganda increased by 21% between 2005 and 2013. [3] However, infections are now reducing and fell from 140,000 in 2013 to 83,000 in 2015.[4][5] The number of AIDS-related deaths decreased by an estimated 19% over the same period.[6]

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Robust treatment and prevention initiatives have been implemented in recent years, leading to improved conditions for people living with HIV. Due to the implementation of antiretroviral treatment throughout the country there has been a gradual increase in the number of people living with HIV receiving treatment. In 2013, Uganda reached a tipping point whereby the number of new infections per year was less than the number of people beginning to receive antiretroviral treatment.[7]

However, as of 2015 around 40% of adults living with HIV were still not on treatment.[8] Persistent disparities remain around who is accessing treatment and many people living with HIV experience stigma and discrimination.[9]

Key affected populations in Uganda

A number of key affected populations exist in Uganda who are at high risk of HIV infection. A few of these populations are discussed below.

Men who have sex with men (MSM) and HIV in Uganda

HIV prevalence among men who have sex with men (sometimes referred to as MSM) in Uganda was an estimated 13% in 2013, the most recent data available.[10]

For many men who have sex with men, Uganda's HIV epidemic brings with it significant social

burdens. A pervading social stigma and high levels of homophobic violence caused by enduring conservative attitudes result in men who have sex with men feeling less inclined to access HIV services. However, some progress is being made with the Uganda AIDS Commission (UAC) reporting that more men who have sex with men are testing for HIV (44% tested and knew their results in 2009, compared to 70% in 2011). It should be acknowledged that these findings are based on a survey of greater Kampala only.11

The Uganda Anti-Homosexuality Act was passed by parliament in December 2013 and officially signed into law in February 2014. Although the law was annulled in August 2014 due to a technicality based on the number of MPs present during the vote, it is thought to have resulted in increased harassment and prosecution based on sexual orientation and gender identities. It has also triggered negative discussions from the general population on social media, in which violence and anti-homosexual discrimination are advocated.12

HIV outreach workers and services providers working in Uganda with men who have sex with men have also reported heightened challenges in reaching this population.

Sex workers and HIV in Uganda

HIV prevalence among sex workers was estimated to be between 35% and 37% in 2014.13 This figure is a harsh reminder of the HIV epidemic among sex workers – it is more than the highest national average among the general population in sub-Saharan Africa (Swaziland - 27.4%).

It is estimated that sex workers and their clients accounted for 16% of new HIV infections in Uganda in 2014. The partners of the clients of sex workers then account for an additional 3%.14

A 2013 study with female sex workers in Uganda found the refusal to use condoms by clients remained a key barrier to consistent condom use. Poverty was cited as the main reason female sex workers engage in unprotected sex for money.15

...you could be in a bad situation yet you are sick and on medication. At the same time you may not have anything to eat... you look for a man who can help you. Then that man will give you conditions... if you are going to have sex with him with a condom he will give you Uganda Shillings (UGX) 2,000/ =, then he says that if it is without a condom he will give you 20,000/=. Because you can't help yourself, there is no way you can leave UGX 20,000/= and go for UGX 2,000/=

- Female sex worker, Malaba16

In addition to the criminalisation of sex work, entrenched social stigma means sex workers often avoid accessing health services and conceal their occupation from healthcare providers. In particular, stigma towards male sex workers who have sex with men is exacerbated by homophobia. Indeed, many sex workers in Uganda consider social discrimination as a major barrier in their willingness or desire to test for HIV.17

Adolescent girls, young women and HIV in Uganda

The HIV epidemic in Uganda continues to disproportionately affect young women. In 2014, HIV

prevalence among young people aged 15-24 in Uganda was estimated at 3.72% for women and 2.32% for men.18

In Uganda, 570 young women aged 15-24 acquire HIV every week, according to 2014 data from UNAIDS. UNAIDS further reports that one in every four new infections among women aged between 15 and 49 years in Uganda occurs in women aged between 15 and 24 years old.19

The issues faced by this demographic include gender-based violence (including sexual abuse) and a lack of access to education, health services, social protection and information about how they cope with these inequities and injustices. Indeed, young Ugandan women who have experienced intimate partner violence are 50% more likely to have acquired HIV than women who had not experienced violence.20

The lack of sexual education is telling. In 2014, only 38.5% of young women and men aged 15-24 could correctly identify ways of preventing the sexual transmission of HIV and rejected major misconceptions about HIV transmission.21 Although the percentage of young men with this knowledge rose from 39.3% in 2011 to 42.3% in 2104, it fell among young women during this time, from 38.6% to 35.7%.22

People who inject drugs (PWID) and HIV in Uganda

In sub-Saharan Africa, people who inject drugs (sometimes referred to as PWID) are grossly stigmatised and open to harsh discrimination. In many cases this marginalisation can be felt on a governmental level, leaving this group with very little in the way of adequate HIV and health services.

A 2016 survey of 425 people who use drugs in Uganda by the Most At Risk Population Network and Uganda Harm Reduction Network reported a substantial number of female as well as male injecting drug users. It also reported a growing network of injecting drug users beyond those interviewed that included some young adolescents in schools and rich adults that operate in a hidden network. 23

In recent years the Ugandan government has displayed hesitancy in providing substantial financing for health services for people who inject drugs. However, since The Global State of Harm report in 2014 estimated HIV prevalence among people who inject drugs at 16.7% in Uganda, the government has pledged to prioritise innovative approaches to help this population.24 An earlier analysis from the World Bank suggests that access to antiretroviral treatment among people who inject drugs lags far behind other people living with HIV, especially so in low-income countries such as Uganda.25

HIV testing and counselling (HTC) in Uganda

Knowledge of one’s HIV status through HIV testing and counselling (HTC) is a key driver in tackling Uganda’s HIV epidemic. HTC services have been expanded and the number of people testing for HIV is increasing as a result, from 5.1 million in 2012 to 9.5 million in 2014.26

Of those who received HTC in Uganda in 2014, more than 90% were adults (aged 15 years and over) and two-thirds (66%) were women.27

The proportion of women (ages 15-49) who have tested for HIV and received their results in the past 12 months increased from 47.7% in 2012 to 57.1% in 2014 and from 37.4% to 45.6% among men.28

HIV prevention programmes in Uganda

Prevention of mother-to-child transmission (PMTCT)

Since it was launched in 2011, the UNAIDS Global Plan has had a marked effect on bringing HIV services to children and women in Uganda. In 2015, more than 95% of HIV-positive pregnant women received antiretroviral drugs to reduce risk of mother-to-child transmission (MTCT), equating to 117,887 women.29

In 2014, around 3,000 antenatal care facilities were providing HIV testing and counselling services and of these 1,970 were dispensing antiretroviral treatment.30

The positive strides Uganda has made towards PMTCT is evident by the 50% reduction in new infections among children between 2009 and 2013.31 However, only 56% of those infants exposed to HIV were tested in 2012/13 and of these, only 28% of received an effective level of treatment.32 Of the 22 countries prioritised by UNAIDS, in 2013 Uganda had the fourth highest number of new infections among children.33

High-level advocacy for elimination of MTCT was supported at both the national and district level. Not only did it draw participation of the political, cultural and religious leaders, but the First Lady of the Republic of Uganda also championed it. However, in spite of this support, between 2012 and 2014 Uganda experienced a stalling of the number of pregnant women receiving antiretroviral prophylaxis or treatment.34

Voluntary medical male circumcision (VMMC)

Voluntary medical male circumcision (VMMC) is recognised as an aid to preventing the transmission of HIV. Indeed, in 2011, the most recent data available, HIV prevalence stood at 4.5% among circumcised men and 6.7% among uncircumcised men.35

Although progress has been made, with the percentage of eligible men receiving VMMC rising to 40% in 2014 from 26.4% in 2011, problems with coverage and funding are hampering access. In the same year, Uganda achieved 80% of its annual coverage target, which equates to just over 878,000 men, but this is still below the annual target of 1 million.

The cumulative total of men receiving VMMC since 2010 is 2.1million. This suggests the 2015 target of 4.2 million will be missed, although this is yet to be confirmed.36

As of 2015, funding for only 321,000 circumcisions had been committed to by international donors, the main funding source for this intervention While traditional and religious circumcisions are ongoing they are far too limited in their coverage and safety to contribute to the success of this intervention.37

Condom use

Uganda’s 2011 National AIDS Indicator survey reported declining rates of condom use during higher risk sexual encounters. Data from selected districts in Uganda in 2013, reported by UAC in 2014, report around 60% of adults (aged 15-49) who had with more than one sexual partner in the past 12 months used a condom the last time they had sex.38

There was an observed decline in the proportion of married and co-habiting individuals who used condoms, with 54% reporting condom use in the last casual sex encounter in 2013 compared to 71% in 2011.39

The number of male condoms distributed by the government rose from 87 million in 2012 to around 230 million by the end of 2014. However, this is far below the number of condoms required, given the population size.40 Strengthening the supply chain for both male and female condoms, and a coordinated approach to consistent condom promotion is an integral element in preventing the transmission of HIV in Uganda.

Antiretroviral treatment (ART) in Uganda

In 2014, around 1,660 health facilities in operation in Uganda were offering antiretroviral treatment (ART). In the same year, nearly 751,000 people living with HIV were enrolled on treatment.41

In 2015, Uganda introduced World Health Organization treatment guidelines which state that all people testing positive for HIV should be enrolled on ART regardless of their CD4 count (which indicates the level of the virus in the body). This means ART access now only stands at 57% of eligible adults and 63% of eligible children.42

Barriers to HIV prevention programmes

Social stigma and discrimination

Prejudices and social discrimination are some of the leading causes for certain groups of Uganda's population, such as sex workers and men who have sex with men, to avoid seeking health care or HIV testing. However, even the general population of people living with HIV are subjected to excessive amounts of negative judgement.

A 2015 survey conducted by HIV support organisations, in partnership with the National Forum of People Living with HIV/Aids (NAFOPHANU), of people living with and affected by HIV in central and south-western Uganda found stigma, both internal and external, to be high. When the study began, more than half (54%) reported experiencing some form of discrimination or prejudice as a result of having HIV.43

During this survey, we found out that internal stigma, characterised by loss of hope, self-condemnation and suicidal thoughts, were predominant especially among those…who had just been tested positive.

- Stella Katutsi, Executive Director of NAFOPHANU44

The People Living with HIV Stigma Index 2013 found the most common forms of external stigma and discrimination directed at people living with HIV are gossip at 60%, followed by verbal harassment, insults and threats at 37%, and sexual rejection at 21.5%.45 Experiences of all forms of internal stigma were higher among women than men.46

Gender

In recent years the prevalence of gender-based violence (GBV) has seen a promising decline since the Domestic Violence Act and the Prohibition of Female Genital Mutilation Act were both enacted in 2010. Nevertheless, a sizable percentage of women in Uganda have been sexually or physically abused by a male partner in their lifetime.

The 2011 Uganda Demographic and Health Survey, which is carried out every five years, states that the overall prevalence of domestic GBV remains high, with 50.5% of ever-married women reporting physical or sexual violence from a spouse in the preceding 12 months.47

A number of programmes, implemented by the Ugandan government and international agencies, exist to address GBV. For example, in post conflict Northern Uganda, USAID's Gender Roles, Equality and Transformation project prmotes gender-equitable attitudes and behaviours among

10-19 year olds and their communities. Through a radio serial drama, group discussions, activities and games it helps married and unmarried adolescents understand and challenge gender norms, and increases understanding of sexual and reproductive health issues.48

Legal

In Uganda, a number of laws and policies exist that constrain HIV and AIDS responses. However, the capacity to challenge these laws has been enhanced through the training of government officials and law enforcement officers on HIV, stigma and discrimination. This process contributed to the major revisions to the Anti-Homosexuality Bill, as reflected in the Act that was initially passed in 2013. Although the Anti-Homosexuality Act is thought to have resulted in increased anti-gay sentiment, the training scheme also led to Ugandan authorities implementing effective policies prohibiting the spread of GBV.49

The passing of the HIV Prevention and Control Act in 2014 has been a cause for concern. The bill includes mandatory HIV testing for pregnant women and their partners, and allows medical providers to disclose a patient's HIV status to others. UNAIDS and other international agencies have discouraged such laws, which can disproportionately target women, who because of health care during pregnancy may be more likely to know their HIV status.50

The bill also criminalises HIV transmission, attempted transmission, and behaviour that might result in transmission by those who know their HIV status. Human Rights Watch, HEALTH Global Advocacy Project, and Uganda Network on Law, Ethics & HIV/AIDS have criticised the act. They point to the fact that mandatory HIV testing and the disclosure of medical information without consent are contrary to international best practices and violate fundamental human rights. They also described the criminalisation of HIV transmission, attempted transmission, and behaviour that might result in transmission by those who know their HIV status as overly broad, and difficult to enforce.51

Funding

Uganda's experience has shown that donor funding is not a guarantee, is unpredictable and is becoming less available. Additionally, funding often comes with conditions that may not be in accordance with Uganda's national goals.

Funding for Uganda's current National Strategic Plan (NSP) (2015/2016 to 2019/2020) is projected to require US $ 3,647 million. Care and treatment accounts for 55% this, prevention interventions accounts for 23%, while social support and system strengthening account for 4% and 18% respectively. The cost of the NSP for the next five years is set against projected resources of US $2,868 million from domestic and international spending, which leaves a financing gap of US $ 918 million by the year 2019/2020. However, this assumes domestic funding will rise to at least 40% of the NSP requirements from the current 11%.52.

With this being the case, more efforts have to be made by Uganda to increase their domestic resource mobilisation. The concentration of donor funding for HIV among a very small number of donors in Uganda suggests potential vulnerability should the magnitude of their funding commitments change in the future.

The future of HIV and AIDS in Uganda

At the current rate, annual new infections are projected to grow to around 340,500 in 2025.53.

For Uganda's severe HIV epidemic to be reduced, a series of comprehensive health, political and social strategies will need to be implemented. There is also an urgent need to invest in impactful combination interventions to drastically reduce the number of new infections. This will require more government commitment and for tough decisions to be made at multiple levels - political, technical and operational. This includes domestic funding for the national response, which is

currently underfunded and heavily donor dependent.54.

For people who inject drugs and men who have sex with men in particular, both political and cultural conditions need to be redressed, starting with transforming punitive laws that criminalise people from these groups. One important step will be to make drug users a focus of national HIV strategies, which will result in better health outcomes, not only for drug users but the population in general.55

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