

HIV and AIDS in Uganda



Uganda (2018)

1.4m people living with HIV

5.7% adult HIV prevalence (ages 15-49)

53,000 new HIV infections

23,000 AIDS-related deaths

73% adults on antiretroviral treatment*

66% children on antiretroviral treatment*

*All adults/children living with HIV

Source: UNAIDS Data 2019

KEY POINTS

- In a country where 1.4 million people are living with HIV, women and young women in particular are disproportionately affected.
- There are many political and cultural barriers which have hindered effective HIV prevention programming in Uganda. As a result, new HIV infections are expected to rise in coming years.
- While there have been increased efforts to scale up treatment initiatives in Uganda there are still many people living with HIV who do not have access to the medicines they need.
- Punitive laws and stigmatising attitudes towards men who have sex with men, sex workers, and people who inject drugs has meant that these groups most vulnerable to infection are far less likely to engage with HIV services.

Explore this page for more information on [populations most affected](#), [testing and counselling](#), [prevention programmes](#), [antiretroviral treatment availability](#), [civil society's role](#), [HIV and tuberculosis](#), [barriers to the response](#), [funding](#) and the [future of HIV in Uganda](#).

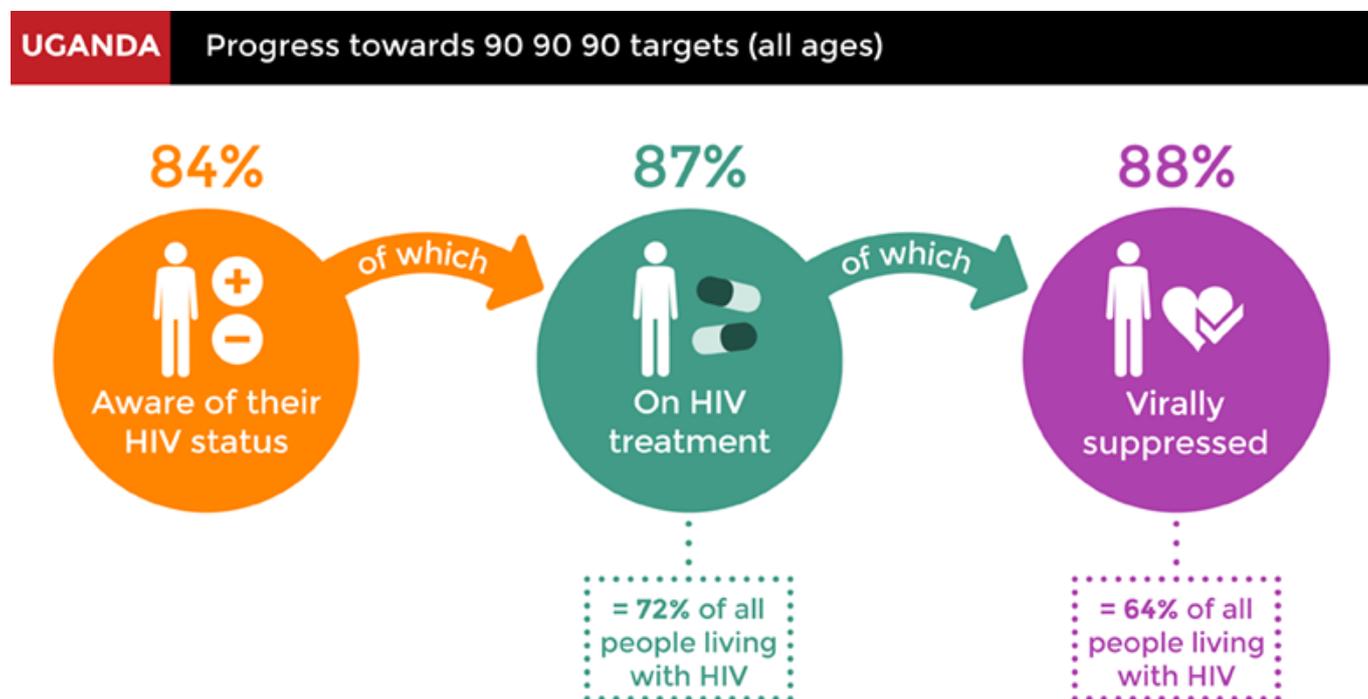
In 2018, an estimated 1.4 million people were living with HIV, and an estimated 23,000 Ugandans died of AIDS-related illnesses.¹

The epidemic is firmly established in the general population. As of 2018, the estimated HIV prevalence among adults (aged 15 to 49) stood at 5.7%.² Women are disproportionately affected, with 8.8% of adult women living with HIV compared to 4.3% of men.^{3 4}

Other groups particularly affected by HIV in Uganda are sex workers, young girls and adolescent women, men who have sex with men, people who inject drugs and people from Uganda's transient fishing communities.⁵

There has been a gradual increase in the number of people living with HIV accessing 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.⁶

However, as of 2018 around 27% of adults living with HIV and 33% of children living with HIV were still not on treatment.⁷ Persistent disparities remain around who is accessing treatment and many people living with HIV experience stigma and discrimination.⁸



Source: UNAIDS Data 2019

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Groups most affected by HIV in Uganda

Adolescent girls and young women

HIV prevalence is almost four times higher among young women aged 15 to 24 than young men of the same age.⁹

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.¹⁰

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.¹¹

Sex workers

HIV prevalence among sex workers was estimated at 37% in 2015/16.¹²

It is estimated that sex workers and their clients accounted for 18% of new HIV infections in Uganda in 2015/16.[13](#)

A 2015 evidence review found between 33% and 55% of sex workers in Uganda reported inconsistent condom use in the past month, driven by the fact that clients will often pay more for sex without a condom.[14](#)

...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, Malaba*[15](#)

Violence is common, with more than 80% of sex workers experiencing recent client-perpetrated violence and 18% experiencing intimate partner violence. More than 30% had a history of extreme war-related trauma.[16](#)

The criminalisation of sex work and 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](#)

Men who have sex with men (MSM)

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.[18](#)

A 2017 study among men who have sex with men in Kampala reported high risk behaviours to be common, including 36% of respondents reporting regular unprotected anal sex, 38% selling sex, 54% having multiple steady partners, 64% having multiple casual partners, and 32% injecting drugs.[19](#)

Pervasive HIV-related social stigma and high levels of homophobic violence caused by conservative social attitudes and stigmatising legislation result in men who have sex with men feeling less inclined to access HIV services. The 2017 study mentioned above found 40% had experienced homophobic abuse and 44.5% had experienced suicidal thoughts.[20](#)

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.²¹

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.

People who inject drugs (PWID)

In sub-Saharan Africa, people who inject drugs (sometimes referred to as PWID) are highly stigmatised and open to severe 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.

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.²² In 2017, the Ugandan Ministry of Health authorised a number of needle and syringe programmes to be piloted.²³

Fishing communities

HIV prevalence among Uganda's fishing communities is estimated to be three times higher than the general population. A 2013 study of 46 fishing communities found HIV prevalence to be at 22% with no variation between men and women.²⁴

The reason for such high prevalence among this community is thought to be the result of a complex range of factors including a high degree of mobility, a high rate of fisherman who pay for sex, injecting drugs use, and a lack of access to HIV prevention and testing services.²⁵

HIV testing and counselling (HTC) in Uganda

Increasing knowledge of HIV status through HIV testing and counselling (HTC) is a key route to tackle 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 10.3 million in 2015.²⁶

Testing is conducted in health facilities, in community settings and in people's homes. In recent years there has been more emphasis to promote HTC services for couples, workplaces testing, outreach to most at risk groups, and mobile or mass testing, especially during testing campaigns.²⁷ In 2017, the Ministry of Health piloted oral HIV self-testing kits among fishermen, female sex workers and the male partners of women attending antenatal care.²⁸

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.²⁹

As a result of this discrepancy, only 55% of men and boys living with HIV know their status, compared to 82% of women and girls. Some men report they would rather avoid knowing their HIV status because they associate being HIV-positive with 'emasculating' stigma.³⁰

Sustainable East Africa Research on Community Health

The Sustainable East Africa Research on Community Health (SEARCH) combined HIV testing with screening and treatment for diabetes, hypertension and malaria in rural communities in Kenya and Uganda.

Multi-disease health fairs were planned and conducted by elected village leaders, with services provided by local clinical staff, in close proximity to where people live. For people who test positive for HIV, SEARCH adopts a client-centred model of HIV treatment, offering things such as flexible hours, a telephone hotline, appointment reminders (by phone or SMS) and client counselling.

Overall gains have been remarkable: after just two years, SEARCH had achieved all 90-90-90 targets in the communities it was serving. Especially noteworthy were the results achieved among men and young people, groups that have been historically difficult to reach with HIV testing and treatment services.³¹

HIV prevention programmes in Uganda

There were 50,000 new HIV infections in Uganda in 2017,³² mainly among adolescents and young people, women and girls, and key populations.³³

The country's 2015/2016-2019/2020 prevention strategy identifies three objectives:

- to increase adoption of safer sexual behaviours and reduction in risk behaviours
- to scale up coverage and use of biomedical HIV prevention interventions (such as voluntary medical male circumcision and PrEP), delivered as part of integrated health care services
- to mitigate underlying socio-cultural, gender and other factors that drive the HIV epidemic.³⁴

Condom availability and use

Data reported by UNAIDS in 2017 suggest 55.5% of men and 41.2% of women used a condom the last time they had higher-risk sex (defined as being with a non-marital, non-cohabiting partner).³⁵

The number of male condoms distributed by the government rose from 87 million in 2012 to around 240 million by the end of 2015. However, this is far below the number of condoms required, given the population size.³⁶ 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.

HIV education and approach to sex education

In 2015/16, more than 2 million people were reached with prevention information through religious congregations and cultural institutions programmes. Millions more were reached with HIV prevention messages through mass media channels including billboards, radio, television, and print media.

Modules for life learning, with particular focus on sexuality education, were developed as part of the curriculum review process for lower secondary school classes. In addition, outreach to over 800 primary and secondary schools was conducted to provide HIV prevention information, with a focus on the risks of multiple partnerships, cross-generational, transactional and early sex. In total, just under 360,000 children were reached with 1 hour HIV and health education sessions in 2015/16.[37](#)

Prevention of mother-to-child transmission (PMTCT)

In 2017, more than 97% of HIV-positive pregnant women received antiretroviral drugs to reduce the risk of mother-to-child transmission (MTCT), equating to over 115,000 women.[38](#) [39](#)

In 2016, around 3,637 health facilities were providing antiretroviral treatment for pregnant women, new mothers and breastfeeding women living with HIV.[40](#)

The positive strides Uganda has made towards PMTCT is evident by the 86% reduction in new infections among children between 2010 and 2016.[41](#) However, the proportion of HIV-exposed infants tested for HIV remains low at 38% due to low retention of mother-and-baby pairs in PMTCT programmes.[42](#)

Voluntary medical male circumcision (VMMC)

Voluntary medical male circumcision (VMMC) is a proven bio-medical HIV-prevention intervention, reducing female-to-male sexual transmission of HIV by 60%. In 2011, the most recent data available, HIV prevalence stood at 4.5% among circumcised men and 6.7% among uncircumcised men.[43](#)

Although the percentage of eligible men receiving VMMC has risen to 40% in 2014 from 26.4% in 2011, problems with coverage and funding are hampering access.[44](#)

As a result, annual circumcisions declined in 2015 and 2016.[45](#) While traditional and religious circumcisions continue, they are far too limited in their coverage and safety to contribute to the success of this intervention.[46](#)

In 2017, 847,633 male circumcisions were performed, falling short of the country's projected annual coverage target of 1 million.[47](#)

Access to PrEP (pre-exposure prophylaxis)

There are currently only an estimated 400-500 user of PrEP in Uganda. However, through a combination of clinical trials, demonstration projects, and implementation initiatives, this number could increase to 12,000-14,000.[48](#)

Antiretroviral treatment (ART) availability in Uganda

In 2016, around 1,730 health facilities in operation in Uganda were offering antiretroviral treatment (ART). In the same year, nearly 898,200 people living with HIV were enrolled on treatment.[49](#)

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 damage to the body's immune system). However, in 2016 only 67% of adults and 47% of children eligible for access were enrolled on ART.[50](#)

Just under 60% of adults living with HIV on treatment are virally suppressed. Increasing this percentage is a key target for the HIV response, as people who remain virally suppressed are unable to pass HIV on to others. Ugandan men on treatment are less likely to be virally suppressed than their female counterparts, with viral suppression rates standing at 53.6% and 62.9%, respectively. Children (aged 0-14 years) fare the worst in this respect, with just 39.3% virally suppressed.⁵¹

Staying on treatment is difficult for certain groups. In particular, young people aged 15–19 in Uganda are more likely to drop out of HIV care, both before and after starting antiretroviral treatment, than are those aged 10–14 years or those older than 20 years. Studies suggest that stigma, discrimination and disclosure issues, as well as travel and waiting times at clinics, are among the reasons. ⁵²

Civil society's role in Uganda

Civil society organisations (CSOs) play an active role in Uganda and many are dedicated to the protection of rights. The legal framework for civil society in Uganda is supportive of CSOs but only if their sphere of activity is politically and socially acceptable to the government.

In January 2016, the President assented to the Non-Governmental Organisations Act, 2016 which is a threat to the right to freedom of association. It prohibits CSOs and non-governmental organisations from carrying out activities in any part of the country unless they have approval from the government.

The Prohibition of Promotion of Unnatural Sexual Practices Bill, which was introduced in October 2014 poses grave threats to NGOs engaging in any advocacy work with men who have sex with men or others from the LGBT community.⁵³

We must come together. Anything that is targeting NGOs—for human rights, for oil, for LGBT rights—we must come together and fight for the space to discuss our views. Closing that space will affect us all.

- NGO staff member, June 2012⁵⁴

HIV and tuberculosis (TB) in Uganda

Tuberculosis (TB) remains a major issue for people living with HIV in Uganda. HIV is the leading risk factor for development of TB, and TB is the leading cause of death among people with HIV. In 2016, HIV prevalence in Uganda was estimated at 7.3%, and 24% of people with TB were co-infected with HIV.⁵⁵

As a result, a focus on delivering integrated TB/HIV services began in 2010. Between 2011 and 2017, the USAID-funded programme Strengthening Uganda's Systems for Treating AIDS Nationally (SUSTAIN) has resulted in a 13% increase (from 85% to 98%) for HIV testing and counselling for TB patients, and a 41% increase (50% to 91%) in initiation onto ART for people with TB who test positive

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Barriers to the HIV response in Uganda

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 social stigma and 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.⁵⁷

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 NAFOPHANU⁵⁸

The People Living with HIV Stigma Index 2013 found the most common forms of external stigma and discrimination directed at people living with HIV were:

- gossip – experienced by 60% of survey participants
- verbal harassment, insults and threats – experienced by 37%
- sexual rejection – experienced by 21.5%.⁵⁹ Experiences of all forms of internal stigma were higher among women than men.⁶⁰

Gender barriers

Since the Domestic Violence Act and the Prohibition of Female Genital Mutilation Act were both enacted in 2010, there has been a promising decline in rates of gender-based violence (GBV).

Nevertheless, the 2011 Uganda Demographic and Health Survey, the most recent available, shows 50.5% of ever-married women reporting physical or sexual violence from a spouse in the preceding 12 months.⁶¹ Women aged 20-24 are worst affected, with 40% experiencing recent intimate partner violence, compared to 31% of women aged 15-19 and 30% of women aged 25-49.⁶²

Legal barriers

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 major revisions to the Anti-Homosexuality Bill – 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.⁶³

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.⁶⁴

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.⁶⁵

Structural and resource barriers

All Ugandan districts report frequent stock outs of HIV testing kits and inadequate human resource to offer comprehensive testing and treatment services. This is despite the presence of implementing partners that provide buffers stocks. Other prevention interventions such as VMMC and PMTCT services have been disrupted by a lack of drugs, medical supplies and staff. In general, the supply chain for antiretroviral drugs is good. However, at times some health facilities will run out of specific formulations.⁶⁶

Services are further constrained by lack of tools and health workers trained to meet the specific needs

of key population groups, weak data management and tracking of clients who are on treatment, and limited coordination of efforts by the numerous implementing partners involved in Uganda's HIV response.⁶⁷

Funding for HIV in Uganda

Uganda's experience has shown that donor funding is not guaranteed, 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% of 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, even this assumes domestic funding will rise to at least 40% of the NSP requirements from the current 11%.⁶⁸

So more efforts need to be made by Uganda to increase their domestic resource mobilisation. In July 2014, the government passed a law establishing the AIDS Trust Fund to mobilise domestic resources for the national HIV and AIDS response. It is estimated the government will contribute around USD \$2 million each year towards the AIDS Trust Fund through money raised by taxing alcohol and bottled water. However, as of 2016, regulations for the Trust were still awaiting approval by parliament.⁶⁹

The concentration of donor funding for HIV among a very small number of international donors in Uganda suggests potential vulnerability should the magnitude of their funding commitments change in the future.

The future of HIV in Uganda

Annual new infections are projected to grow rapidly to around 340,500 in 2025 - up from 52,000 in 2016.⁷⁰

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.⁷¹

To reduce the impact of the epidemic among 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.⁷²

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Last full review:

24 January 2018

Next full review:

23 January 2021