**UGANDA**

The history of AIDS in Uganda can be divided into three distinct phases.

The first stage saw the rapid spread of HIV through urban sexual networks and along major highways from its origin in the Lake Victoria region. Doctors in this area had become aware of a surge in cases of severe wasting known locally as ‘slim disease’, as well as a large number of fatal infections. In 1982, the first AIDS case in Uganda was diagnosed, and the link between ‘slim disease’ and AIDS was clinically recognised. It was not until 1986 when the Ugandan civil war ended and President Museveni was firmly in power that the country had a major HIV prevention programme. By this time the country was in the midst of a major epidemic, with a prevalence of up to 29 percent in urban areas.

Uganda’s first AIDS control programme was set up in 1987 to educate the public about how to avoid becoming infected with HIV. The programme promoted the ABC approach (abstain, be faithful, use condoms), ensured the safety of the blood supply and started HIV surveillance. Strong political leadership and commitment to tackling the rampaging AIDS epidemic was a key feature of the early response to AIDS in Uganda.

Prevention work at grass-roots level also began in this era, with a multitude of small organisations educating their peers about HIV. One of the first community-based organisations formed was TASO, The AIDS Support Organization, which was run by sixteen volunteers who had been personally affected by HIV/AIDS. TASO later became the largest indigenous AIDS service organisation providing HIV/AIDS services in Uganda and Africa, and providing emotional and medical support to many thousands of people who are HIV positive.

The second phase of the Ugandan HIV epidemic ran from 1992 to 2000. During this period the HIV prevalence fell dramatically, from a peak in 1991 of around 15 percent among all adults, and over 30 percent among pregnant women in the cities,to around 5 percent in 2001.

It is thought the government’s ABC prevention campaign was partly responsible for the decline in prevalence. However, as treatment was not widely available in Uganda during this time the high numbers of AIDS-related deaths also contributed to the reduction in the number of people living with HIV.

The Ugandan government’s prevention initiatives continued throughout the nineties with high levels of funding from both the government and international donors such as the World Bank. In 1998, the government ran a trial to test the feasibility of rolling out antiretroviral treatment to people in developing countries.

The third phase of HIV/AIDS in Uganda has seen the stabilisation of prevalence from 2000-2005, and reports of a slight increase in prevalence since 2006.

Free antiretroviral drugs have been available in Uganda since 2004. It is thought that the introduction of HIV drugs may have led to complacency about HIV as AIDS is no longer an immediate death sentence.

**Why might prevalence have declined?**

The number of people living with HIV in Uganda fell dramatically during the 1990s. The interesting questions are what caused this decline, whether other countries can adopt similar methods, and whether the lower rates of transmission are sustainable.

The drop in HIV prevalence in Uganda in the 1990s cannot be attributed to a single factor. It is likely to have been a result of both a fall in the number of new infections (incidence), and a rise in the number of AIDS-related deaths.

**Deaths:** It has been suggested that the high number of AIDS-related deaths in the 1990s may have been largely responsible for the decline in the number of people living with AIDS in Uganda during this period. The reason so many people died in this decade is that there was no available treatment to delay the onset of AIDS, and high numbers of people infected with HIV in the 1980s were reaching the end of their survival period. In 2000 the Ugandan health ministry estimated that 800,000 people had died of an AIDS-related illness since the beginning of the epidemic.

However, the high death rate alone may not account for the significant reduction in the number of people living with HIV in Uganda. Many other countries in sub-Saharan Africa experienced similar patterns of HIV incidence and death but did not experience a similar decline in prevalence.

**New infections:** It is likely that the number of new HIV infections in Uganda peaked in the late 1980s, and then fell sharply until the mid 1990s. This is generally thought to have been the result of behaviour changes such as increased abstinence and monogamy, a rise in the average age of first sex, a reduction in the average number of sexual partners and more frequent use of condoms. Uganda's entire population was mobilised in the fight against HIV and everyone was made aware of the consequences that risky behaviour could have for their country.

President Museveni encouraged input from numerous government ministries, NGOs and faith-based organisations. He relaxed controls on the media and a diversity of prevention messages spread through Uganda's churches, schools and villages.

This frank and honest discussion of the causes of HIV infection seems to have been a very important factor behind the changes in people's behaviour. Music and educational tours by popular musician Philly Lutaaya (who was the first prominent Ugandan to openly declare he was HIV positive) also spread understanding, compassion and respect for people living with HIV.

Much of the prevention work in Uganda occurred at grass-roots level. Many organisations were often made up of people living with HIV educating their peers. These groups worked to break down the stigma associated with AIDS, and encourage an open discussion of sexual subjects that had previously been taboo.

The sheer scale of the HIV epidemic in Uganda is also thought to have been a major driver of behaviour change and the reduction in the number of new infections. The epidemic was very visible: in the 1990s the majority of Ugandans knew somebody who had died from AIDS and in 1995, 91 percent of Ugandan men and 86 percent of women knew someone who was HIV positive. Many villages experienced high numbers of deaths each month, houses stood empty, funerals were frequent and grandparents were increasingly becoming carers for their orphaned grandchildren. As antiretroviral treatment was not yet widely available in the 1990s, many people equated AIDS with a death sentence and it is believed that fear may have driven change in behaviour.

**The current situation**

The current HIV prevalence in Uganda is estimated at 6.5 percent among adults and 0.7 percent among children. HIV prevalence is higher in urban areas (10 percent) than rural areas (6 percent). An estimated 43 percent of new infections occur among people engaged in mutually monogamous heterosexual relationships.

Women are disproportionately affected, accounting for 57 percent of all adults living with HIV. Ugandan women tend to marry and become sexually active at a younger age than their male counterparts, and often have older and more sexually experienced partners. This (plus various biological and social factors) puts young women at greater risk of infection.

The number of new infections (an estimated 120,000 in 2009) exceeds the number of annual AIDS deaths (64,000 in 2009), and it is feared HIV prevalence in Uganda may be rising again. There are many theories as to why this may be happening, including the government’s shift towards abstinence-only prevention programmes, and a general complacency or ‘AIDS-fatigue’. It has been suggested that antiretroviral drugs have changed the perception of AIDS from a death sentence to a treatable, manageable disease; this may have reduced the fear surrounding HIV, and in turn have led to an increase in risky behaviour.