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Bridging the Gap from Data to Evidence-Based HIV Prevention in Uganda

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Abstract

Uganda's current HIV prevalence rate of 7.2 % shows an increase in the number of new HIV cases (UNAIDS, 2012), with 80% of new infections accounted for by heterosexual transmission (Uganda AIDS Commission, 2012). Risky behaviors associated with HIV in Uganda include having multiple sexual partners, inability to negotiate safer sex strategies and an increase in systematic commercial sex especially among elite students (Aluzimbi et al., 2012; Muhenda, 2013; Ortega, 2013). However Uganda has continuously ignored the mode of transmission and risky behaviors associated with new HIV cases and instead focus on the biomedical perspectives of HIV prevention (Pisani et al., 2003). Our analysis therefore calls for the need to focus on behavioral and transmission dynamics of HIV based on the available data. This will then form the basis of evidence-based approach to reducing new HIV infections in Uganda.

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Keywords: HIV prevention, Evidence-based, Risky Behavior, Heterosexual transmission.

1. Introduction

Over 30 years of HIV/AIDS research in Uganda have yielded both positive and negative outcomes. Currently we know the cause of HIV, risky behaviours associated with HIV, dominant modes of HIV transmission, at risk groups with respect to HIV and effective HIV prevention strategies and so forth (Uganda AIDS Commission, 2012; UNAIDS, 2012). Uganda hailed for reduction of HIV prevalence rates from 30% to 5% in 2001 (Hogle, Green,

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Nantulya, Stoneburner, & Stover, 2002). Based on the Uganda's success in HIV prevention many explanations were provided. Sexual behaviour change, adoption of the A (abstinence or deferred sexual debut), B (being faithful, partner reduction and avoiding high-risk partners), C (condom use) and the recently added annex D (diagnose/know your status) HIV prevention model and decline in sexual partners among other (Green, Halperin, Nantulya, & Hogle, 2006; Shelton et al., 2004; Wilson, 2004). Critiques of Uganda's HIV prevalence decline have questioned the scientific basis of such claims (Allen & Heald, 2004; Parkhurst, 2002, 2008), point to critical issues in the applicability of the ABC approach (Murphy, Greene, Mihailovic, & Olupot-Olupot, 2006). Current HIV prevalence rate of 7.2% is still high, with new infections associated with heterosexual transmission and with risky behaviours. Therefore Uganda HIV prevention strategies have to take a keen interest in finding out who is being infected and how, and move from that knowledge to evidence based interventions.

2. HIV in Uganda

Uganda previously viewed as a county with the highest rates of HIV in the world is a success story in HIV prevention (Hogle, et al., 2002). There was a reduction in the prevalence of HIV and an eventual increased to 7.2 % according to the latest data from UNAIDS (2012). Critical analysis of data presented from Uganda presents some flaws in the data collection process. Data collection was at urban surveillance site in antenatal clinics. The sample consisted of only expectant mothers mainly from urban areas. This selective reliance on a single population to represent a nation is more than misleading. Little information shows the prevalence of other populations like males or other regions in Uganda (Allen & Heald, 2004; Parkhurst, 2002). Data collected from health facilities does not accurately present the prevalence of HIV among all groups of the population especially those who do not seek health services.

Risky behaviour associated with transmission dynamics of HIV/AIDS in Uganda include many sexual partners, transactional sex, inability to negotiate safer sex strategies, and low social economic status. Heterosexual behaviour is the dominant mode of HIV transmission in Uganda accounting to 80% of new HIV infections especially among female sex worker and married couples (Uganda AIDS Commission, 2012). Concurrent sexual relationships where one or both partners have overlapping sexual relationships with more than one sexual partner are common in Africa. These concurrent partnerships vary in timing of occurrence, duration, present a high coital frequency and inconsistent condom use, factors that increase risk of HIV transmission (Mah & Halperin, 2010). Concurrent partnerships are common among poor urban dwellers in Kampala (Kajubi et al., 2011) and student (Lule & Gruer, 1991; Muhenda, 2013). Overall men had more concurrent partnerships contrast to women. Incentives of being in concurrent partnerships among students include fear of losing a partner, source of goods of value and money, and sex for prestige or recognition (Aluzimbi et al., 2012; Muhenda, 2013; Ortega, 2013). At risk, groups in relation to HIV include students and married couples.

3. HIV prevention

Uganda adopted the ABC strategy (abstinence, being faithful to one sexual partner and condom use), voluntary counselling and testing programs, routine and home based HIV counselling and testing, and access to antiretroviral therapy services among others. The Ugandan government and development partners have been supportive to the health section in the fight against the AIDS epidemic through funding, research, the creation of policies, and institutions to curb the spread of this incurable epidemic (Uganda AIDS Commission, 2012). There is no doubt Uganda made tremendous progress in the HIV/AIDS prevention strategies over the years. However, the increase in the prevalence rates of HIV/AIDS calls for the evaluation of HIV preventive strategies.

Abstinence and delayed sexual debut was advocated for the younger generation. Earlier research findings noted that abstinence from sex among educated university students was not among their preferred HIV prevention strategies (Lule & Gruer, 1991). Being faithful and partner reduction was the preferred mode of HIV prevention for sexually active adults. Some authors argue that partner reduction was a significant factor in Uganda s' HIV success story (Green et al., 2006; Hogle et al., 2002; Shelton et al., 2004).

Condom promotion and social marketing in Uganda started in the late 1990s. Religious and government leaders resisted condom use in the initial stages of the condom campaign. Condom use to be effective requires consistent