ANALYSIS OF HIV/AIDS PREVALENCE AND TREATMENT PROGRESS IN UGANDA.

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OVERVIEW OF THE AIDS EPIDEMIC.

1.1 Introduction

HIV/AIDS is currently one of the biggest human life threats in Africa. In Uganda, HIV/AIDS claimed for over 64,000 lives in the year 2009. This paper explores its trends of prevalence in the general population and among specific groups, its modes of transmission and the magnitude of the impact using multiple data sources, including the Uganda UNGASS (United Nations General Assembly Special Session) Progress Report, Jan 2008- Dec 2009 and the Ugandan Ministry of Health (MoH,2009).

1.2 Status of the epidemic in Uganda

1.2.1 Overview

Epidemiology review indicates that the previous heralded decline in HIV prevalence from a peak of 18% in 1992 t0 6.1% in 2002 may have ended. There is stabilization of prevalence between 6.1 and 6.5% shown in some antenatal care (ANC) sites and indicating a slight rise in others. This is accompanied by worsening of behavioural indicators especially an increase in multiple concurrent partnerships. There has also been a shift in the epidemic from people in single casual relationships to those in long-term stable relationships.
Incidence modelling reveals that 43% of new HIV infections are among monogamous relationships while 46% are among persons reporting multiple partnerships and their partners. See Table 1.

Table 1: Populations and Percentage of incidence by Mode of Transmission

Mode of Transmission	Total number with risk behaviour(n)	Percentage with risk behaviour	Incidence per 100,000	% of incidence
Injecting Drug Use (IDU)	994	0.0%	258	0.28%
Sex workers	32,652	0.3%	833	0.91%
Clients to sex workers	189,381	1.5%	7,172	7.83%
Partners of clients	108,676	0.8%	1,660	1.81%
MSM	3,976	0.0%	559	0.61%

Female partners of MSM	1,569	0.0%	92	0.10%
Multiple partnership	1,808,919	13.9%	21,722	23.73%
Partners to MP	1,417,881	10.9%	19,925	21.76%
Mutual monogamous heterosexual sex	6,022,317	46.1%	39,261	42.89%
Medical injections	13,060,787	100.0%	54	0.06%
Blood transfusions	134,053	1.0%	0	0.00%

1.2.2 HIV prevalence by sex and age

The Uganda HIV Sero-Behavioural Survey (UHSBS) of 2004-05 (MoH & ORC Macro, 2006) found that HIV prevalence was higher in women compared to men and that it increased with age until it reaches a peak, which for women is attained at ages 30-34 (12%) and for men at ages 35-44 (9%). Women are more highly affected at younger ages compared with men. As shown in Figure 1, at ages 50-59, the pattern reverses and prevalence is slightly higher among men than women.

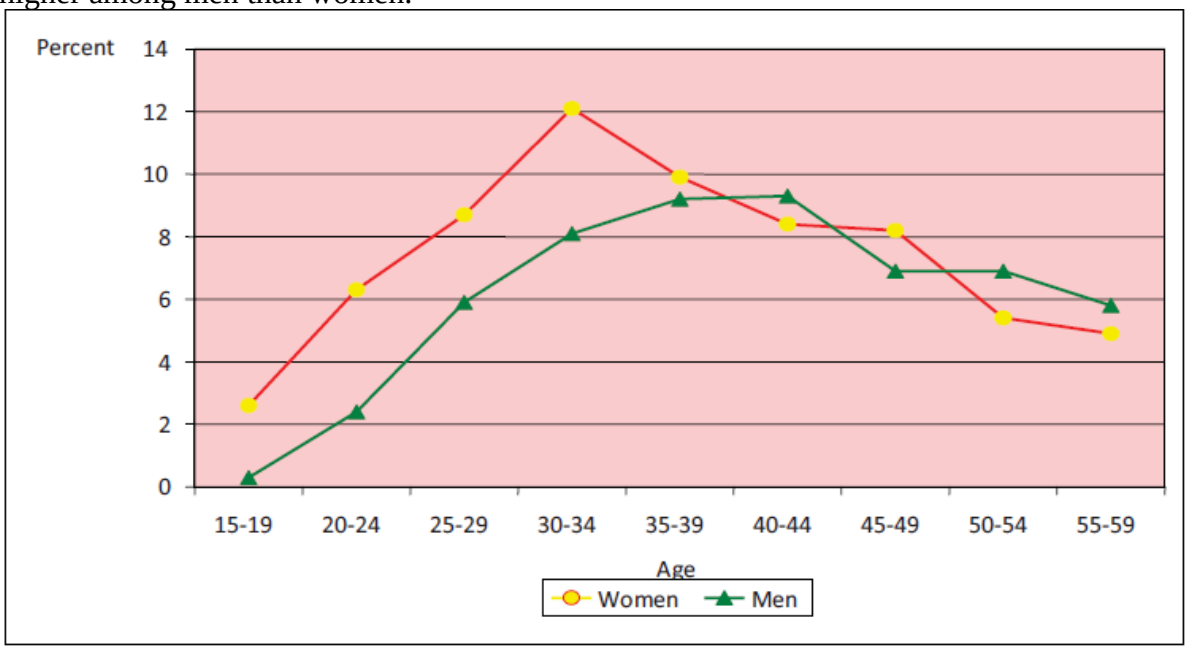

Figure 1: HIV prevalence by sex and age

1.2.3 HIV prevalence by locality; urban and rural

Since the onset of the epidemic in Uganda in the early 1980s, the prevalence has remained high in major urban areas compared to small urban centres and villages, although this gap started narrowing sharply since 2000 as shown in Figure 2.

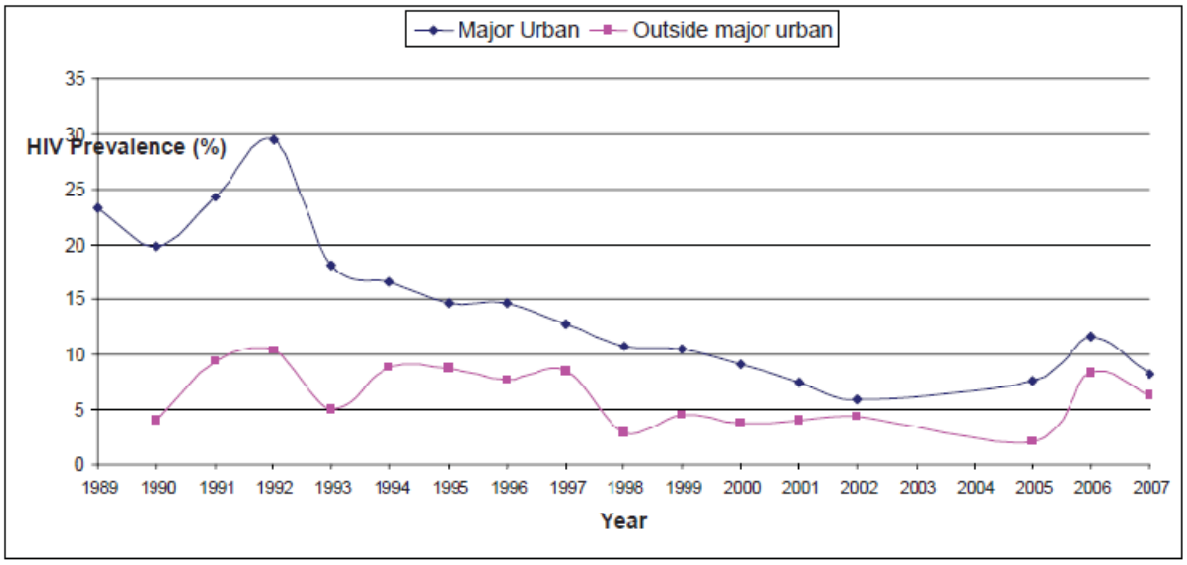

Figure 2: HIV prevalence in major urban and rural communities

The prevalence has been provided by the analysis of the social, biological and behavioural factors associated with HIV. The analysis shows that at a prevalence of 10%, urban residents have a significantly higher risk of HIV infection than rural residents (6%).

1.2.4 HIV prevalence by region

The HIV epidemic shows regional variations. Central, Kampala, and North Central regions all have rates of infection above 8% while West Nile and Northeast regions have the lowest prevalence at 2% and 4% respectively. In all regions, women have a higher prevalence of HIV infection than men. HIV prevalence is higher among those who are working than those who are not.

1.2.5 Trends in antenatal HIV sero- prevalence

Studies show that vertical transmission of HIV accounts for 18.1%. This provides a partial picture since a significant proportion of births in Uganda take place outside health facility settings.

During the period of July 2007- June 2008, 739,656 pregnant women attended antenatal care at health facilities providing prevention of mother to child transmission (PMTCT) services. Of those, 700,471 (95%) received HIV counseling, 600,682 (82%) were tested for HIV, 39, 328 (6%) tested HIV positive, 31,990 (81%) pregnant HIV positive women & 16,304 (41%) babies born to HIV positive pregnant women received antiretroviral drugs for PMTCT.

1.0 INPACT OF THE EPIDEMIC

The impact of the epidemic is epitomized by HIV&AIDS related morbidity and mortality in the country. Based on the triangulation of antenatal HIV population sero prevalence and population as well as demographic parameters, it is estimated that 1,101,317 people were living with HIV&AIDS in Uganda as of December 2008, of whom, 120,000 were children 0-14years. During 2008, an estimated 110,694 new HIV infections occurred countrywide. And approximately 61,306 people died from AIDS in 2008.

2.1 HIV prevention roadmap

- Prevention of the sexual transmission of HIV.
- Prevention of mother-to-child transmission of HIV.
- Promotion of greater access to HIV counselling and testing (HCT) while promoting principles of confidentiality and consent.
- Integration of HIV prevention, care and support services with other health and social services.
- Integration of prevention into care and support programs for People living with HIV & Aids (PHAs)
- Prevention and treatment of STIs.
- Focusing prevention on vulnerable and higher risk groups including young people.
- Advocating for protection of rights of women, girls, children, PHAs, IDPs and other minority groups within existing policy and legal frameworks.
- Preparation for access to and use of promising new technologies for HIV prevention
- Consideration of appropriate and safe response to new evidence such as circumcision.
- Ensuring blood safety and reduce HIV transmission in the health care and other settings.

The number of facilities providing routine HIV counselling and testing for pregnant women has continued to increase, raising the uptake of HIV testing from 70% of all clients attending ANC at health facilities providing PMTCT in 2005/06 to 80% in 2006/07. By December 2007, 43% of health facilities had PMTCT services available. This has since been scaled up. The scale up plan targets availability of PMTCT services in all health units that provide MCH services up to HC III level. The programme scaled up to 314 HC III's and 148HC II's in the FY 2008/09. By the end of June 2009, 947 health facilities up to HC III level were providing PMTCT services in the country. Overall 87% of hospitals, 93.2 % of HC IV's, 73.2% of HC III's and 12.4% of HC II's offer PMTCT services.

2.1.1 HIV testing in the general population

In Uganda, there are various categories of HCT. These include voluntary counselling and testing (VCT). In 1999 MoH started a voluntary door-to-door HIV screening programme using rapid tests in an effort to make HIV screening services accessible to more people, especially in rural areas where there were neither modern laboratories nor electricity to run standard HIV tests. Routine Counselling and Testing (RCT) has also been scaled up to enable the health care system introduce patients found to have HIV to appropriate clinical care early enough. Uganda has revised the VCT policy and included RCT and home-based counselling and testing (HBCT). The HCT services are now available in all districts but uptake is still low, though the numbers are slowly increasing. More has to be done since reports show that only 20% of Uganda's population know there sero status.

2.1.2 Most-at- risk- populations (MARPs): Prevention programs

Although, the HIV epidemic has become generalized, there are still sections of the population that are at relatively higher risk of HIV infection compared to the general population. Within the Uganda context, the MARPs have been identified to include commercial sex workers (CSWs); fishing communities; internally displaced people (IDPs), refugees; and persons with disability (PWDs). Prevalence of HIV&AIDS is overwhelmingly high among the MARPs. Although, national data on the prevalence rate of HIV is not available.

2.1.3 Life skills based HIV education in schools

A number of Information Education and Communication/Behavioural change communication (IEC/BCC) programmes have been implemented in schools at all levels including President's Initiative on AIDS Strategy for Communication to Youth (PIASCY), Straight Talk Foundation (STF) and anti-cross generational sex campaign. PIASCY is premised on the belief that, if parents did not want to talk to children about sex, their teachers would teach them about it. This program includes some aspects of the ABC program i.e. Abstain, Be faithful, or *Condomize*. There are different messages for Peer 1-3, Peer 3-5, and Peer 5-7. STF has been implemented in secondary schools since 1993.

2.2 KNOWLEDGE & BEHAVIOUR: Changes in key programs

2.2.1 Knowledge about HIV & AIDS

Percentage of young women and men aged 15–24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission are, women 15- 24 years 31.9% and men 15 -24 years being at 38.2% according to the Uganda Demographic and Health Survey (UDHS 2006).

Percentage of MARPs who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission (Based on KAPB and Sero Survey on HIV&AIDS and STDs among CSWs 2003=82.6%.

A number of sex education programmes even for young people that are outside the school system are in place including Young Empowered and Healthy (Y.E.A.H) and STF Outreach and Training Programme. Faith Based Organisations (FBOs) under their Umbrella of Inter-Religious Council of Uganda (IRCU) are notably active in prevention efforts. Their approach basically emphasizes abstinence and faithfulness in marriage, and care and support for PHAs.

2.2.2 Casual sex and condom use

The percentage of adults aged 15-49 who had had sex with more than one partner in the last 12 months of 2005 were 3.8% women and 29.3% among men, based on Uganda HIV sero behavioural survey 2004/05 (UHSBS).

3.0 CARE AND TREATMENT: Changes in Key Programs and strategies

3.1 HIV treatment; antiretroviral therapy

Significant progress has been registered over the last couple of years in provision of treatment and care for People Living with HIV&AIDS (PHAs). This includes providing Antiretroviral Therapy (ART), Cotrimoxazole Prophylaxis (CPT), treatment of Tuberculosis (TB) and other related opportunistic infections and related support services. Initially there was a fee-for-service programme, but in June 2004 Uganda started offering free ARVs with support from the World Bank and Global Fund for AIDS, TB & Malaria (GFATM). US President's Emergency Plan for AID Relief (PEPFAR) and United States Agency for International Development (USAID) projects later supported Uganda with free ARVs.

An UNGASS indicator put the percentage of adults & children with advanced HIV infections receiving antiretroviral therapy by Sept 2009 at 53% for men and women, signifying an increase from 39% by the end of 2006.

4.0 CONCLUSION:

HIV/AIDS prevention in Uganda has taken a relatively fair decline which reflected from the peak of 18% in 1992 to 6.1% in2002, although at this lower peak, it has since then stabilized. HIV/AIDS has again affected more women than men and women being affected at a relatively younger age. It has also shown a higher prevalence in urban areas than rural areas and those who are working than those which do not. But AIDS is also still showing a higher vertical antenatal mother-to-child-transmission of 18%.

Under the prevention and treatment measures, a prevention road- map has been implemented by both local commitment, national, and through international aid. Thus with a fair provision of free antiretroviral therapy, care and treatment has been fairly successful.

HIV/AIDS testing, VCT, RCT and HBCT have all greatly increased national awareness and induce early treatment. Also adoption of life based HIV education in schools advocating for behavioural change has fairly been fairly implemented.

4.1 RECOMENDATION:

It has been recommended that Uganda clearly needs to revive HIV prevented from only abstinence, fidelity and condom use, but also to draw more attention to prevention of Mother- to-child-transmission, advocate for behavioural change, encourage early treatment and testing in the general population, in addition to fighting the risking factors like drug abuse and prostitution.

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RESUME:

I am Kagumba Alex, a Ugandan young man of 23 years old. Born on the 24th of April in 1987, in a small village of Butenga in Masaka District.
I grew up mostly with my mother, Florence Namata. In my father's family of over 40 children and only 11 of my mother's, I being her third last born.
I completed primary education in the year 2000; in 2004 I completed my ordinary senior secondary school at Kako Secondary School and therefore completing my Advanced Secondary level in Dec of 2006. This is where I got certified by the Ugandan Ministry of Education and Sports, through the Uganda National Examinations Board (UNEB).
In September 2007, I joined Mulago Paramedical Training Schools, enrolling in a three year high diploma course of occupational Therapy.
I personally have natural skills in Music, Art and Drama; I do all arts ranging from hand arts, crafts to graphics. Iam a music and movie/ story writer which I do for my leisure and pleasure, and particularly much interested in acting in live stand-up comedy.