

Uganda's HIV/AIDS Success Story: Reviewing the Evidence

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Once the frontline of global concerns and efforts against the HIV/AIDS pandemic, Uganda now stands as a global model of successful intervention against the epidemic. The storyline of success has been argued on claims of declining rates of prevalence and incidence, themselves attributable to specific and deliberate government policy and related interventions. While the story has captivated policymakers, practitioners, and academics, few have dared to challenge its validity. The aim of this article is to subject to critical analysis the foundation on which such a narrative has been constructed. Both epidemiological studies and literature on policy and programs is analyzed. Also discussed is the HIV/AIDS policy itself and the potential influence of politics in telling the success story. The article concludes that the evidence is not as conclusive as the rhetoric suggests, and suggests that celebrations of success may be premature.

Introduction

The 2007 Joint United Nations Programme on HIV/AIDS (UNAIDS) update on the global AIDS epidemic indicated that the epidemic has claimed over 25 million lives around the world since it was first diagnosed in the early 1980s. Such a figure is more than four times those who died in the Holocaust and more than twenty times the 1.7 million lives lost during the 1975-1979 Khmer Rouge genocide in Cambodia. Sub-Saharan Africa remains the ground zero of the HIV/AIDS epidemic, with an estimated total of 22.5 million; representing 69% of the reported cases world-wide (UNAIDS, 2007). As the virus continues its lethal match around the globe, policymakers, practitioners and researchers continue to search for effective intervention models.

However, amidst the gloom of increasing HIV infections, let alone the social and economic effects of the pandemic, rays of hope apparently have emerged from Uganda. Once the frontline of global concerns and efforts against the HIV/AIDS pandemic, Uganda now stands as a global reference point for its reported success in reducing the levels of HIV-1 infection from 30% in the mid 1990s to 10% within a decade (Asingwire & Kyomuhendo, 2003; Green, 2003; Hogle, Green, Nantulya, Stoneburner, & Stove, 2002; UNAIDS, 2000). Such decline has been hailed as the first, most extensive, and largest scale of decline globally (United States Agency for International Development [USAID], 2002). Uganda's story of success has so captivated policymakers, practitioners, and academics that questions regarding its validity appear almost anathema (Parkhurst, 2002; Stoneburner & Lowe-Beer, 2004). Instead, it has become an international template for effective HIV/AIDS intervention particularly in developing countries (Allen, 2005). It is not the aim of this article to refute Uganda's narrative of success against HIV/AIDS. Rather, it is to subject to critical analysis the basis on which such claims have been formed. Particular attention will be

paid to evidence from epidemiological data and the alleged correlation between government policy and intervention outcomes. Such a task is particularly important because of recent questions regarding the reliability of surveillance systems and data analysis methodologies (UNAIDS, 2007) as well as allegations that the HIV/AIDS story in Uganda might have been distorted for political ends (Allen, 2005; Cohen & Tate, 2005; Tumushabe, 2006). The coherence of the HIV/AIDS policy will also be discussed.

Telling the Story

If there was a transcript of Uganda's success story as told in many policy circles, it would predictably read as follows: The first known HIV/AIDS case was registered in the southwestern district of Rakai between 1982/83. While its origins remain shrouded in mystery, by the mid-1980s Silimu (as it was locally known) had grown into a full blown epidemic that left many families decimated on its lethal match through the different parts of the country. In almost messianic style, Yoweri Museveni's National Resistance Movement (NRM) captured power in January 1986 and immediately made HIV/AIDS a national political issue (Hogle et al., 2002; Uganda AIDS Commission [UAC], 2000, 2003; Younde, 2007). Museveni proactively instituted an AIDS Control Programme (ACP) in 1986, which was followed by the establishment of the Uganda Aids Commission (UAC) in 1992. It was UAC that oversaw the design and implementation of a Multi-Sectoral Approach and National Operational Plan as guidelines for HIV/AIDS interventions. The government's open and aggressive campaign galvanized local, national, and international bodies and individuals to fight against the epidemic. Around 1995 HIV/AIDS rates began to show signs of significant decline from the reported rates of 30% in 1992 (Asingwire & Kyomuhendo, 2003; Okware, Kinsman, Onyango, Opio, & Kaggwa, 2005; UAC,

2000; USAID, 2002), even though there were still reasons for caution (Mulder et al., 1994). Since 2000 the country's HIV-1 incidence has been reported at 6.5 % (UAC, 2000), a clear indication of significant progress in the country's fight against the epidemic.

The Prevalence Debate

While the above is a simplistic representation of a rather complex history of Uganda's struggle against HIV/AIDS, it captures some of the talking points of the country's success story. Taunted as the poster child of successful intervention policies, Uganda's success account has in large part been built on the reported drop in HIV-1 infection rates from 30% in the early 1990s to 10% in 1996 and 6.5% by the end of 2006. Reports of such steep decline continue to appear in official government presentations and reports. For instance, The National Strategic Framework for HIV/AIDS in Uganda—2000/1-2005/6 stated that between 1992 and 1996 HIV sero-prevalence declined from 30% to 10% (UAC, 2000). At the 2000 African Development Forum in Addis Ababa, Ethiopia, President Museveni was quoted as asserting that "Uganda's estimated prevalence rate reduced from around 30 percent in the early 1990s to around 8 percent in the late 1990s" (Tumushabe, 2006, p 7).

Yet, there remains no definitive evidence that the country ever experienced a 30% prevalence rate (Allen, 2005; Parkurst, 2002; Tumushabe 2006). Some have pointed out that HIV/AIDS demographic and health data prior to 1995 were both limited and fragmented (Allen, 2005; Asingwire & Kyomuhendo, 2003; Green, Halperin, Nantulya, & Hogle, 2006; Hogle et al., 2002). Accordingly, much of the data generated during this time were either limited to a particular region or a particular portion of the population. For instance, some authors have pointed out that prior to the 1990s much of the information and knowledge about HIV/AIDS in the country concerned targeted 'high risk' groups such as commercial sex workers and truck drivers (Allen, 2005; Carswell, Llyond, & Howells, 1989; Slutkin et al., 2006). One such survey was conducted by Carswell et al. (1989) in Rakai district—then known as the epicenter of the epidemic—among truck drivers and sex workers. The survey revealed a 33% and 67% HIV positive rate for truck drivers and sex workers respectively. These figures were quoted in an Economist Intelligence Unit Country Report in 1990 as representative of 'high-risk' groups in Uganda (Bond & Vincent, 1997). In brief, it is clear that the first generation of HIV prevalence data can hardly be relied upon to provide a valid picture of the number of people infected with the virus.

Not even empirical evidence supports the 30% prevalence rate that figures prominently in Uganda's success account. A number of controlled sample sero-surveys since 1988 show a prevalence rate of no more

than 12% outside urban areas. In a review of the earliest sentinel surveillance data from 15 clinics around the country, Parkhurst (2002) found that the 30% prevalence rate was recorded only at the Mbarara site; even though both Nsambya and Rubaga sites recorded comparable rates. Mbulaiteye et al. (2002) cited a study by the British Medical Research Council in Rakai district, which reported a prevalence rate of 12% among young men. A community randomized controlled study among 18 rural communities in Masaka district to assess the impact of sexually transmitted diseases (STD) management yielded similar results (Kamali et al., 2002). The study reported the prevalence rate in 1994 to be 10% among 15,000 adult participants.

Perhaps the main form of evidence against claims that Uganda ever reached a 30% prevalence rates comes from the earliest rural cohort studies in Masaka (Mulder, Nunn, Kamali, & Kengeya-Kayondo, 1994) and Rakai (Serwadda et al., 1992; Waver et al., 1991a; Waver et al., 1991). In their Masaka district cohort study of 9,820 participants, Mulder and colleagues found a combined HIV-1 prevalence rate of 4.8% among all age groups, even though the rate for those 13 years and older was found to be 8.2%. Serwadda et al. (1992), in their Rakai study, examined the risk factors for HIV-1 infection in three geographic strata (trading centers along main roads, small trading villages along feeder roads, and agricultural villages off main and secondary roads). Results revealed prevalence rates of 15% and 24% for men and women in a sample that included 1,292 adults. It is important to note that both Rakai and Masaka districts were in the late 1980s and early 1990s considered epicenters for the HIV/AIDS epidemic. The fact that the 30% prevalence rate was recorded no where in these districts is telling and provides credence to Allen's (2005) observation that the 30% prevalence rate remains more of a myth than a reality.

Validity of Sentinel Samples

Beyond the general controversy around prevalence rates, a number of validity issues have been raised regarding the manner in which prevalence data have been obtained and analyzed. Strickler, Hoover, & Dersimonian (1995) highlighted two problems associated with sentinel samples in general, namely the use of non-probability samples and the use of point prevalence as a measure of the proportion of the sample that is seropositive. The main drawback for non-probability samples is the lack of random selection of participants, which means that there is no way of estimating the probability of selection for each member of a given population. As it relates to HIV, point prevalence, unlike period prevalence, only provides a snapshot of the epidemic in time. Yet HIV is known to have a dynamic and unpredictable life course.

In Uganda, as is the case in much of sub-Saharan Africa, surveillance of women attending antenatal care (ANC) has often been used as to measure both prevalence and HIV infection trends (Allen, 2005; Rice et al., 2007; Tumushabe, 2006). However, such data is replete with a number of reliability issues including structural and self-selection biases. One salient structural bias is that only pregnant women are eligible for testing at ANC clinics, which requires that data generated from such testing be limited to those specific samples. This is particularly warranted because of the finding in some studies of lower fertility rates among HIV-positive women than in HIV-negative women; even though the difference is insignificant in women aged 15-19 years (Fabiani, Nattabi, Ayello, Ogwang, & Declich, 2006; Rice et al., 2007). It is therefore erroneous to extrapolate ANC-based data to other samples including those of pregnant women in general and the general Ugandan population.

Besides structural biases, some authors have pointed out a number of purposive selection biases that limit the generalizability of results to other settings and contexts. Some authors (Allen, 2005; Tumushabe, 2006) have pointed out that most ANC sites in Uganda are located in urban and semi-urban centers, making them inaccessible to the majority of the 87.7% rural population (Uganda Bureau of Statistics [UBOS], 2002). Results from rural studies conducted on rural populations have been various and as such provide no singular picture. In addition to both the Masaka (Mulder et al., 1994) and Rakai (Serwadda et al., 1992) district studies, the 1991-1997 sero-survey among antenatal attendees in Kabarole district revealed a prevalence rate of just over 10% (Kilian, 2002). However, the same study found higher rates of prevalence among the urban population.

In addition to concerns over geographical representation, Tumushabe (2006) made the point that most rural mothers have limited access to antenatal services, an issue that raises questions regarding the representativeness of the results even among the rural population. Additionally, sixteen of the twenty-five surveillance sites are located in the southern part of the country, which may result in exaggeration of HIV prevalence levels not only in the population of pregnant mothers, but also in the general population (Allen, 2005). For instance, only recently has the northern part of the country has hardly been included in national surveys owing to political insecurity which has ravaged the area since 1987. Yet the region accounts for 26% of the country's total population (UBOS, 2002).

Self-selection of participants is yet another issue that calls for caution in using sentinel surveillance data as indicator of HIV/AIDS prevalence. Allen (2005), for instance, pointed out that in Uganda only 25% of deliveries actually take place in a health facility. He questioned the validity of data provided in the 2001

Uganda Demographic Health Survey (UDHS), which indicated that only 1% of women in Uganda receive antenatal care from traditional birth attendants. Indeed, the most recent UDHS data indicated that 58% of Ugandan women give birth in their homes, even though the percentage of those giving birth in an institution increased from 37% in 2000-2001 to 42% in 2006 (UBOS, 2002). Caution therefore is necessary in generalizing ANC surveillance data to the general population in Uganda. Not only is it not representative of pregnant women in different geographical contexts, it fails to provide a general picture of HIV/AIDS prevalence in the general population that includes sub-groups of men, children, non-pregnant women, and those pregnant women that do not access antenatal services at government sites (Allen, 2005).

From Prevalence to Incidence?

Researchers agree that incidence—the number of new infections per population within a specified period (Kilian, 2002)—provides the best indicator of success for any program. Yet Kilian (2002) conceded, as do many others, that incidence is extremely difficult to measure. Gray, Serwadda, Kigozi, Nalugoda, and Wawer (2006) made the point that the absence of any reliable population-based data prior to 1989 makes claims about decline in incidence rates more conjectural than empirical. Despite such acknowledgements, reports of declining HIV-1 incidence rates have been central to Uganda's success story (Abdool, Tarantola, Sy, & Moodie, 1997; Parkhurst, 2002; Stoneburner & Low-Beer, 2004). In general, decline in prevalence rates based on sentinel surveillance data has been used as a correlate of a fall in incidence (Stoneburner & Low-Beer, 2004). Strickler et al. (1995) pointed out that whilst a common practice, use of sentinel seroprevalence data as a measure of HIV incidence often leads to skewed results because of such confounds as migration and mortality. If the sample under investigation is assumed to be under a steady state of equilibrium, for instance, incidence would falsely be indicated as zero.

While steady-state equilibrium has been an unstated assumption in some studies, some researchers have found migration and mortality to be key factors to understanding incidence in Uganda. In a two-year follow up study to assess whether HIV-1 prevalence rates were reflective of trends in incidence in an open cohort of 15-59 year olds living in 31 community clusters in Rakai district, Wawer et al. (1997) found a significant decline in prevalence rates but no corresponding decline in incidence. The authors cautioned against using decline in HIV-1 prevalence as a proxy measure of HIV incidence. Instead, the authors reported high HIV-1 related mortality (13.5%) as well as net-out migration to be the more salient factors in falling cases of incidence.

It is therefore safer to say that there remains no conclusive evidence of a decline in HIV-1 incidence. Indeed, improvements in methodology and HIV/AIDS surveillance systems have led to a significant revision in global estimates from 40 million in 2006 to 33.2 million in 2007. In particular, UNAIDS (2007) pointed to improvements in country data collection and analysis as some of the key elements that have aided more accurate and precise information. The shift from reliance almost exclusively on data from antenatal surveillance and high-risk groups to large population-based and household surveys has already resulted in significant revisions in India and China (UNAIDS, 2007). It would be a fair assumption that collection and analysis of HIV/AIDS data in Uganda is not immune to methodological and surveillance flows evident elsewhere, leading to either overestimation or underestimation of prevalence and incidence rates. Nevertheless, the data does demonstrate declining rates of HIV prevalence and incidence. What remains a point of contention is the magnitude of such decline. Questions of the magnitude of decline are particularly relevant because they relate to the effectiveness of Uganda's policy interventions.

From Epidemiological Evidence to Programmatic Evidence: As Easy as ABC?

Another issue central to Uganda's HIV/AIDS success narrative relates to the mechanisms behind the reported decline in prevalence and incidence. The official explanation prevalent in literature and policy discourses is that the decline has been due to specific and deliberate government interventions (Kilian, 2002; UAC, 2000, 2003). The Abstinence, Be faithful, and Condom use (ABC) model has almost become synonymous with successful HIV/AIDS interventions (Slutkin et al., 2006; Wawer et al., 2005). Such attribution of success to the ABC model has come to influence both national and international policy recommendations as well as funding and aid allocation decisions (Cohen, 2003; Cohen & Tate, 2005). Yet the evidence is at best contested and far from conclusive.

In their population cohort study, Wawer et al. (1997) found emigration and mortality to be the most salient variables related to observed decline in prevalence rates. In a study to assess the impact of HIV-1 infection on mortality within a cohort of 9,777 rural residents in southwestern Uganda, Nunn et al. (1997) reported mortality rates of 41% for all adults and over 70% for men between the ages of 25-44 within a period of five years. In a more recent longitudinal study on a population cohort in Rakai district, researchers found premature death among HIV-1 positive people to be the most significant explanatory factor for observed decline in prevalence rates among the cohort (Wawer et al., 2005). Even more, declining rates of infection had little to do with

the abstinence and be faithful programs. Gray et al. (2006) concluded that "the declines in prevalence can be attributed, in part, to an excess of mortality among persons infected on average 9-10 years earlier, relative to the rates of new infections occurring in 1990s" (pp. 347-8).

Wawer et al. (2005) finding of an insignificant relationship between abstinence and faithfulness programs speaks to lingering questions and controversies regarding the relative impact of each aspect of the much acclaimed ABC model (Green et al., 2006). Two schools of thought are evident in the debate: one school contends that it is the Abstinence (A) and Be faithful (B) factors that account for the observed success against HIV/AIDS in Uganda (Green et al., 2006; Hearst & Chen, 2004; Kilian, 2002; Stoneburner & Low-Beer, 2004). The second school of thought espouses and emphasizes Condom use (C) and other larger structural factors (e.g., poverty reduction, women empowerment, stability, etc.) as largely responsible for the decline (Fenton, 2004; Wawer et al., 2005). Proponents of the Abstinence and Be faithful factors argue that various demographic and health surveys, particularly through the mid-1990s, indicated that condom use was relatively low. For instance, Hogle et al. (2002) argued that increases in condom use have been relatively small, ranging from 1% in 1989 to 6% in 1995 and 16% in 2000 for females and from 16% in 1995 to 40% in 2000 for males. Given that most significant declines in HIV-1 prevalence had already occurred by 1995, so goes the argument, it is highly improbable that condom use played any significant part. The authors however admitted that HIV/AIDS related demographic and health survey data were scanty prior to 1995, a point similarly noted by Cohen and Tate (2005). This is perhaps why other authors have reported different figures for condom use within the same time frame. For instance, Cohen (2003) reported that condom use for females increased from 1% in 1989 to 14% in 1995 and from 2% to 22% for males within the same time period.

Beyond speculative statistics, however, some empirical studies have posited Abstinence as the primary factor in reducing HIV-1 prevalence in Uganda. Stoneburner and Low-Beer (2004) found that, among the 13-19 year old age group, early age of sexual debut was positively correlated with increased risk for contracting HIV-1. The authors went on to claim that faithfulness, colloquially known as 'zero grazing', "is equivalent to a vaccine of 80% effectiveness" (p.714). Similar claims have been made by others such as Kinsman et al. (2001), who asserted that abstinence as a primary HIV control method has a protective value that is unrivalled by other methods among adolescents. Based on these and similar studies, some authors have suggested that 'zero grazing' should be the linchpin of

any comprehensive HIV prevention program (Okware et al., 2005).

Indeed, a number of studies commissioned by the United States government between 2002 and 2004 concluded that increased rates of abstinence and fidelity were responsible for reported decline in HIV prevalence in Uganda in the 1990s (Hogle et al., 2002; Green, 2003; MEASURE Evaluation Project, 2004; USAID, 2003). The MEASURE Evaluation Project (2004), a collaborative study involving Uganda HIV/AIDS partnership, Uganda Ministry of Health, UAC, and researchers at the Carolina Population Center, claimed to have discovered 12 “protective factors” between 1989 and 2000 that account for the declining HIV rates among young people. The “protective factors” include: premarital sex, age at first sex, sexual debut before age fifteen, age at first marriage, past year abstinence, abstinence among the sexually active, non-marital partnerships, extramarital sex, and multiple partners. All but three of the twelve factors are categorized under abstinence and/or fidelity. “It is likely,” the study concluded, “that a combination of abstinence and partner reduction resulted in decline in prevalence, but that the increase in condom use helped maintain the low prevalence levels throughout the rest of the nineties” (p. 49).

The study has been forcefully discredited on both methodological and policy grounds. In a voluminous document, Human Rights Watch (Cohen & Tate, 2005) criticized the study on grounds that: a) it did not establish the causes of observed changes in behavior, nor attempted to establish relative impact of different behavior changes; b) it suffered from the potential confounds usually associated with survey as a method of data collection; c) it lacked comparative data on attitudes, intentions, and behaviors over time within participants and with comparison groups; and d) that it provided legitimacy to abstinence only programs which are generally ideologically rather than scientifically driven.

Advocates of condom use have put forth equally compelling anecdotal and empirical data as proof that it is condom use and other factors, not abstinence and faithfulness, that account for observed decline in prevalence and incidence. In a 10-year study involving 10,000 participants living in 44 villages in Rakai district, Wawer et al. (2005) found that the number of men reporting two or more sexual partners increased from 28% to 35% between 1994 and 2003, while the percentage of teenagers who were not sexually active declined from 60% to 50% within the same time frame. Yet the researchers found that such a reduction in sexual abstinence and monogamous relationships did not result in new HIV infections as expected, even though there was a slight increase in HIV incidence for both men and women ages 15-25. The authors pointed to increased condom use as a possible explanation for

the unexpected finding. This is particularly plausible since the number of men reporting condom use with non-marital partners increased from 10% to 50%.

From ABC to AB

Amidst controversy and competing accounts, Uganda's approach to HIV/AIDS prevention appears to have shifted exclusively toward Abstinence and Be faithful aspects of the ABC model. To what extent U.S. government sponsored studies have bolstered Uganda's ‘new’ abstinence-only approach can hardly be established. What is evident is that there has been a significant shift in government driven intervention particularly with regard to young people. Toward the end of 2003, UAC released a draft policy guide titled Abstinence and Being Faithful (AB), which called for nationwide implementation of abstinence-until-marriage programs (UAC, 2003). As indicated in the document, side-by-side promotion of abstinence and condom use would be “confusing” to young people. And while abstinence-only programs have received high-level political support and substantive amounts of funding from the U.S. President's Emergency Plan for AIDS Relief (PEPFAR), President Museveni has since 2004 publicly denounced condoms and branded them as an inappropriate improvisation and disastrous recipe rather than a viable solution to Uganda's HIV/AIDS problem (Schuettler, 2004; Ssejjoba, 2004). The President's wife, Janet Museveni, has been an even more vocal critic of condom use as an effective preventative strategy particularly for young people. Mrs. Museveni has questioned the morality of condom promotion particularly and suggested that such a strategy is likely to promote sexual promiscuity. Consequently, she has been on nationwide campaigns to promote virginity among adolescents as a counter measure to the ‘vague messages’ of condom use (Namutebi, 2004). Thus, as one commentator put it, ABC in Uganda has come to mean ‘Anything But Condoms!’

In summary, not only is the evidence regarding the magnitude of reported decline in both prevalence and incidence rates inconclusive, it is almost impossible to disaggregate the relative contribution of specific behavioral programs embedded in the ABC model to any decline in the epidemic.

Policy and Politics of HIV/AIDS

From the foregoing, a few questions may be asked: if as a deliberate government policy the ABC model worked to reduce rates of HIV-1 prevalence and incidence, what has happened that some of its core aspects are now considered ineffective by the same government that has for long been credited for its introduction? A skeptic may wonder whether the reported decline in rates of prevalence and incidence have been a function of deliberate government policy interventions or a

combination of other factors? Such questions are pertinent because one of the enduring explanations for Uganda's 'success' has postulated a policy of openness, political will, and commitment as the key elements that led to increased awareness and understanding among the population about the epidemic and its effects and means of prevention. It is this awareness that in turn leads to a reduction in HIV/AIDS prevalence and incidence (UAC, 2000, 2003). Often cited in this narrative are the personal efforts of President Museveni, the founding of the AIDS Control Program in 1986 which was followed by the UAC in 1992, and the much heralded multisectoral approach that established HIV/AIDS desks in various government ministries.

However, a causal link between government policy and decline in HIV-1 prevalence is difficult to establish even for its most ardent proponents. This is particularly because of the multiplicity of players and programs involved in the country's long fight against HIV/AIDS. Parkhurst (2002) pointed out that behavioral change may have no direct or even indirect relationship with government policy. And such an argument seems to have some empirical grounding. In a multinational study examining the factors that influence those behavioral changes (use of condoms, abstinence, monogamy, etc.) that are said to be key in slowing the spread of HIV, Macintyre, Brown, and Sosler (2001) found personal experience of AIDS to be the most salient predictor of behavior change in working and married men aged 24-40. Such a finding is plausible considering that it is a widely accepted notion in Uganda that almost everyone has in some way been affected by the HIV/AIDS epidemic. The study is even more significant because it compared data from three demographic and health surveys in Uganda (1995) with similar surveys from Zambia (1996) and Kenya (1998). The experience of knowing someone who has died from AIDS or is carrying the HIV virus may itself be a rival explanation for the observed behavior changes, leading to the reported reduction in prevalence. Githongo's 1993 interview with President Museveni (as cited in Tumushabe, 2006) presented a similar line of thinking. Museveni is quoted as saying:

I am worried about other things. AIDS is not really such a big crisis. Voluntarily you go and look at it. What will happen is that many people will die and then others will begin to fear...The population of Uganda is now 17 million. Even if you assume that 2 million will die, you will still remain with 15 million which is higher than the population of 1956 (p. 17).

A correlation between government policy and reported decline in HIV prevalence and incidence becomes even murkier when the role of non-

government entities is considered (Allen, 2005; Parkhurst, 2002; Tumushabe, 2006). Tumushabe (2006) argued that while the government of Uganda has undoubtedly done some important work in its response to HIV/AIDS, giving prominence to the political and policy interventions not only distorts the country's 'success story' but also reduces the work of non-state actors to mere auxiliary role. As a consequence, some community efforts and programs have not only received limited funding, but also been left out of related programs of national concern. Indeed, the government of Uganda has itself recognized the role played by non-government organizations (NGOs), people living with HIV/AIDS (PLWHA), and community-based organizations (CBOs). Such recognition means that any success achieved in the struggle against HIV can hardly be attributed to a single factor or player.

Science at the Service of Politics?

One question that remains largely implicit in the foregoing analysis is why analysts and policymakers have made such definitive statements when available data reveals no such firm conclusions about Uganda's success against HIV/AIDS. Responses to such a question have been more speculative than empirically driven. Parkhurst (2002) pointed to various pressures experienced by developing countries from donor countries as some of the key influences behind the success story. In particular, the notion of donor fatigue—the frustration of donors with funding unsuccessful international programs—may have played a significant role in pressuring Uganda to show results in order to attract more funding. Tumushabe (2006) made an even more compelling argument about the centrality of politics in describing and promoting Uganda's HIV/AIDS success story for both strategic and ideological reasons. He argued that the Museveni government maintained a lackluster attitude toward HIV/AIDS prevention prior to 2000. A range of factors explain the motives behind Museveni's change in attitude and his subsequent exploitation of the HIV/AIDS success story for largely political reasons. Economic mismanagement and the high levels of corruption, rising military expenditure due to the war in the north and the invasion of Congo, and increasing scrutiny and criticism of Uganda's one-party rule by the international community all necessitated a counter message focusing on positive achievement. The story of reduction in HIV/AIDS prevalence, therefore, helped to "galvanize support for the flagging fortunes of the NRM government, especially with regard to sustaining donor support" (Tumushabe, 2006, p. iv).

It has been suggested that Uganda's success story was viewed as a welcome recourse to the international community that was itself under some pressure to present successful examples of HIV prevention. Both Parkhurst (2002) and Tumushabe (2006) insinuated that

the international community was badly in need of a success story particularly amidst the increasingly dismal atmosphere clouded by the devastating effect of the epidemic on the African continent. As Parkhurst (2002) went on to note, “The standard of proof for policy recommendations seems to have been lowered to provide the international community with the African success story it wants, or even needs” (p.79).

If health policymakers, analysts, practitioners, and academics, have underestimated the potential influence of political factors in national and international responses to the HIV/AIDS pandemic, then Uganda’s ‘success’ narrative calls for a more critical analysis of political dynamics and motivations. It is important to analyze how politics becomes a factor in decisions and approaches toward the epidemic. It is even the more important given that political will—the character of political leadership at the highest level of government—has been cited one of the key elements of effective strategies against HIV/AIDS (Hogle et al., 2002; Putzel, 2004; UAC, 2003).

The Nature of Uganda’s HIV/AIDS Policy

Let us assume for once that Uganda’s HIV/AIDS policy has been instrumental in combating not only the spread but the effects of HIV/AIDS. What makes it, one may ask, a reference point for other developing countries faced with the same epidemic? It is common place to present Uganda’s policy as coherent and comprehensive and therefore of utility to other countries that are developing a national policy. But some have argued that the policy may be far from what it has been portrayed to be (Tumushabe, 2006). In 1993 UAC embarked on the work of developing and drafting a national HIV/AIDS policy which resulted into HIV/AIDS Policy Guidelines (March 1993) that were revised in 1996. While most of the administrative aspects of the policy were implemented, its legislative aspects were never approved by Parliament, prompting the UAC to note that “the policy guidelines have not been backed by any law and hence difficult to enforce” (UAC, 2003, p.1).

Consequently, the country’s leading HIV/AIDS body continues to face major constraints in its work due to lack of a national HIV/AIDS policy. Tumushabe (2006) pointed out several areas in which the current policy guidance on HIV/AIDS is missing. Such areas include department guidelines, implementation mechanisms and resource allocation to HIV/AIDS activities, and protection for PLWHAs, property rights of AIDS orphans and widows.

Besides areas of inadequacy, the UAC itself has identified as problematic some areas in the policy proposal or guidelines. These include: mandatory testing for all students admitted under public sponsorship to tertiary institutions, compulsory HIV testing for all inmates and staff, as well as counseling

and testing of individuals suspected of being HIV positive. A lack of a national HIV/AIDS policy has led to a proliferation of several implicit and explicit policy guidelines issued by different authorities. But as Tumushabe (2006) argues, many of these are mere draft guidelines that can hardly be traced to the original issuing authorities or departments. It is however the shift from a more comprehensive ABC approach to the new AB model that raises more questions regarding the coherence and political motivations behind the country’s approach.

Conclusion: No News Is Good News

It is probable that HIV/AIDS prevalence rates and, potentially, incidence rates have declined in Uganda. It is also plausible that the government through its policy interventions has played a significant role in this decline. What remains far from clear is whether national prevalence ever were as high as they have been portrayed in national and international policy discourse. This paper has discussed some evidence that is commonly put forth by both those who agree and those who question Uganda’s success story. Indeed as Hogle et al. (2002) put it, “we may never fully know what really happened in Uganda” (p.13). Even though the history of HIV/AIDS in Uganda is sufficiently murky that we may never fully know what really happened, advancements in surveillance methods and means of data analysis can help in clearing the present and future landscape of the epidemic.

There is a need for more comprehensive studies that are representative of the different regions and sub-populations in the country. This is particularly imperative in light of new evidence which suggests that celebration of Uganda’s success story may be premature and misplaced optimism. In their longitudinal study in a southwestern Uganda rural cohort, Shafer et al. (2008) revealed increasing rates of prevalence since 2000 among women and men in the age group 40-49. More specifically, investigators found that HIV-1 prevalence rose to 7.7% in 2004/2005 from 6.2% in 1999/2000. They also reported that while there was a significant decline in incidence rates from 5.0% in 2004 to 2.5% in 2005, there were indications that it was once again on the rise. Together with increasing prevalence rates, investigators reported a corresponding change in risk behavior in the cohort. The investigators did mention that the results warranted more investigation since data analysis revealed limited statistical significance. However, the results call for serious re-evaluation of existing policy guidelines as well as decontextualized universal and blanket recommendations of Uganda’s policy to other developing countries. As Gray et al. (2006) pointed out, it is important not only to focus attention to the present rather than the past, but also to continue with a multipronged approach in dealing with

a possibly resurgent epidemic. This is particularly salient because of difficulties associated with any attempts to disaggregate the contribution of specific government prevention strategies and other programs. It is imperative that the apparent abstinence versus condom wars be decided on the basis of science rather than ideology and political calculations. The success story may just be unraveling!

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