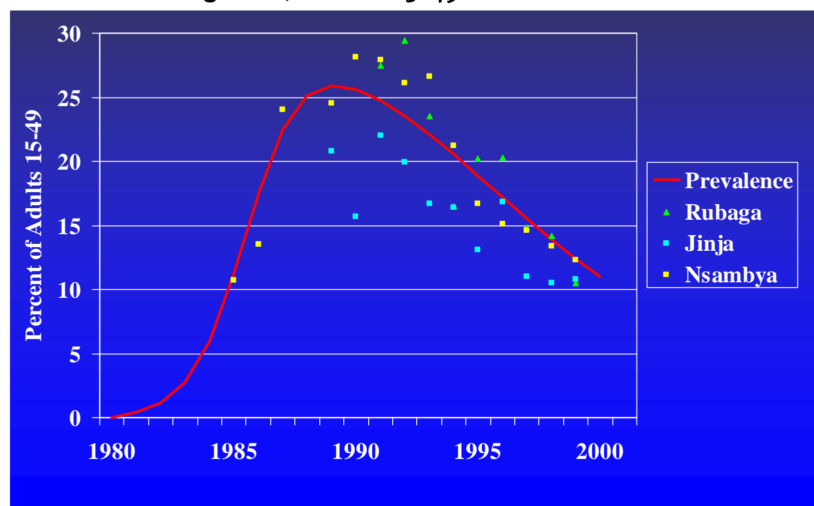
Extract from Bridging Research and Policy on HIV/AIDS in Developing Countries – Country Study: Uganda

Background

Uganda provides one of the most interesting and surprising success cases in terms of response to HIV/AIDS. It is, as a result, also interesting as a case study for the bridging research and policy project. This section provides an outline of what happened in Uganda, and key issues that seemed to be significant.

Officially, the first case of HIV/AIDS was identified in Uganda in 1982. This was in the context of the civil war, economic collapse and instability that had characterised the country through the 1970s and 1980s. By the mid-1980s, Uganda had a major HIV problem owing to the economic and political context and to untreated STIs (Putzel, 2003). However, prevalence was estimated to have peaked in 1992 at about 18.3% nationally, and at 30% in some areas of the country. By 2002, prevalence nationally was estimated at around 6.2% (UAC, 2000).

Figure 3: Prevalence of AIDS in Uganda, adults 15-49



Source: The Synergy Project, USAID.

Why was Uganda such a 'success'? The Uganda AIDS Commission (2003) notes a number of key policy-related issues, including: use of condoms, abstinence, faithfulness, safer blood, PMTCT, health sector improvements and broader improvements in living standards. Other analyses point to the importance of 'mainstreaming' HIV throughout government (Putzel, 2003). Policy responses regarding HIV in the military were also important (ICG, 2004). But the extent of government response also depended on the specific issue as related to HIV. Although government policy prioritised surveillance and prevention, provision of care occurred mostly at home, carried out by family religious groups and CSOs with little government involvement. Interestingly, Low-Beer demonstrates that key behavioural changes preceded many conventional interventions (condom social marketing, VCT, etc.) Along with Stoneburner (2003), he emphasises the importance of AIDS communications via personal networks rather than the government.

But what led to these changes? What made the difference? What role did research have – if any? These questions will be addressed through the lens of the RAPID framework. To complement the analysis, please refer to Table 1, listing milestones for each of the main arenas for Uganda.

Context

The Uganda case highlights a number of interesting findings regarding the impact of context issues on bridging research and policy. It reinforces general RAPID conclusions on the importance of context, and Putzel's (2003) specific finding for HIV that 'success or failure in the fight against HIV/AIDS is determined significantly within the realm of politics'. There are a number of aspects here.

First, the post-conflict context was characterised in this case by hope rather than chaos. The National Resistance Movement (NRM), which had fought and won a civil war, came into government with little to lose economically or politically and everything to gain from the fight against HIV/AIDS (UAC, 2003; Putzel, 2003). 'Fighting HIV/AIDS became a test of political legitimacy' (Putzel, 2003). Secondly, most analyses stress the role of high-level political leadership. Putzel notes Museveni's 'charisma, his closeness to ordinary people and his rhetorical skills played a crucial role in the HIV/AIDS campaign'. Thirdly, the strong central authority played a crucial role. The fact that the NRM was based on a military organisation helped with implementation. For example, once Museveni came to power, key messages about HIV were rapidly disseminated to as many villages as possible.

Finally, there was an interesting interaction between the extent of strong government control and the participation of other groups in the fight against AIDS. Uganda seemed to manage this very well. The government was pivotal in: i) providing an enabling environment for associational actors; ii) mobilising social organisations, NGOs and the private sector during the early stages; and iii) actively engaging religious groups. NGO participation was also strongly encouraged in policy bodies – e.g. Uganda AIDS Commission (Putzel, 2003; Parkhurst, 2001; UAC, 2003). The government 'allowed everyone to participate in the fight against AIDS within their own mandate' (UAC, 2003).

Table 1: Uganda HIV/AIDS milestones and the RAPID framework

Date	Context	Evidence	Links	External influences
Early 1980s	Context of civil war; political authorities and health officials are in denial.	Informal research (by Carswell) shows HIV to be present in Uganda. Museveni and advisors hear of HIV via BBC and international media.	NGO sector filling critical gap in health services during 1980s.	AIDS issues increasingly prominent in West. Museveni and advisors hear of HIV via BBC and international media.
Late 1985 - early 1986	Yoweri Museveni becomes president. HIV made a clear priority.	Carswell et al. report – the first authoritative study on HIV/AIDS in Uganda (1985).	NGO sector filling critical gap in health services during 1980s.	Carswell and Downing – external 'champions' at various points.
1986	Museveni establishes the National Committee for the Prevention of AIDS – chaired by him.	Health Minister Rugunda announces that the country faces an HIV epidemic.	Very limited media sector within Uganda.	
1986	Aggressive public media campaign.	Museveni warned by Castro of HIV in Ugandan military.		
1987	Government (Ministry of Health) launches first AIDS Control Programme in Africa.	Government publishes five-year action plan.	The AIDS Support Organisation (TASO) founded.	WHO mission; WHO helps prepare action plan.
1987	Ministry of Defence develops an HIV/AIDS programme.	Donor community pledges support for huge research effort.		Donor conference.
Late 1980s	Museveni visits all 55 areas of the country highlighting the AIDS programme (UAC 2003).		NGOs and church organisations encouraged to deliver healthcare as efforts are made to reconstruct public sector.	
1988	Uganda implements the first national sero-survey in Africa.	Uganda implements the first national sero-survey in Africa.		

Date	Context	Evidence	Links	External influences
1990	Formation of the AIDS Information Centre (AIC), an NGO for voluntary testing and counselling services.			
1992	Uganda AIDS Commission established.		c.1,000 CSOs engaged in HIV control.	
1994-5	AIDS Control Programme Units are established in the many ministries.		Liberalisation of the media in Uganda (HIV radio programmes very popular).	UNAIDS set up.
Late 1990s	Confusion and conflict within government over AIDS coordination and funding.	Vaccine trials begin; MTCT trials begin.		Uganda receives the first UNAIDS Country Programme Adviser.
2000	JCRC begins importing low-cost generic ARVs.	HIV evidence used in preparing Poverty Eradication Action Plan.	NGO sector is almost entirely dependent on donor funds.	Government gets 93% of HIV funding from donors.
2003		Worries about implications of the large funding boost – will policies reflect evidence?	2,500 NGOs working on HIV/AIDS. CSOs providing 80% of VCT and 90% of post-test counselling/care.	Global Fund finance for Uganda.

Sources: UAC (2003); Putzel (2003); UNDP (2002).

Evidence

A striking factor of the Uganda case is that future policymakers first heard about HIV on the radio while fighting the civil war. Needless to say, this did not lead to an automatic policy response, but nevertheless it was relatively soon after gaining power that Ugandan political leaders 'came to act on the basis of medical and scientific evidence'. Museveni was apparently reluctant at first (Putzel, 2003), but he did eventually listen to local and international medical advice on HIV/AIDS – and responded strongly.

An interesting issue is that *informal* (but powerful) evidence, communicated in a personal manner from a credible source, had much more impact than formal research. A key 'tipping point' was the pivotal meeting between Museveni and Fidel Castro, when Castro delivered an HIV warning. It was after this that Museveni started to take a personal interest in HIV issues. The powerful evidence was that 18 of 60 officers (around 30%) sent to Cuba for high-level military training had tested HIV-positive (UAC, 2003).

Another key issue could be that Uganda has better research systems than many other places in Africa. The evidence still suffers from problems of quality, fragmentation and geographic patchiness, and there remains today very little policy or operational research. However, it has an established indigenous research community. It is not so much that formal research played an important role in Uganda, but rather that Uganda has a small medical community. Several senior Ugandan doctors publicly highlighted the public health challenge posed by HIV, and became key authorities on AIDS for the Ugandan government, the public and even the international community (Panos, 2003): 'Ugandans could turn to their own experts for analysis and explanations, and take pride in the fact that these experts, as well as their government, were increasingly informing the international response to the pandemic.' Saying this, international research also played a very important part in contributing to the Ugandan policymaker response.

A challenge for the future is the sense of pride in the success of controlling HIV/AIDS – not just among Ugandans, but also among donors who promote the success of Uganda. This understandable and

strong sense of pride can have negative implications for the linkage between research and policy, for several reasons. For example, any criticism, however constructive, may be taken badly. An example here was the uproar around Justin Parkhurst's work. Samantha Smith notes that the main message of the article was missed by many – that it is important to make the data as accurate as possible in order to direct policy responses better. Furthermore, the exportation of the apparent success of the Ugandan response has led to a dramatic simplification of the model, into what is recognised today as the 'ABC' strategy (first, **a**bstain, secondly, **b**e faithful, and lastly use a **c**ondom). The relevance of this model both within Uganda and externally is questioned vehemently today, yet is still highly promoted by donors, since it is an easy model to capture and promote.

Looking forward, there may be quite some scope for improving linkages between research (including trials currently being conducted in Uganda) and the policymaking and budgeting arenas of the Ministry of Health and the Ministry of Finance. In particular, clinical researchers – focusing on their groups of patients and the individual hospital setting – need to become more conscious of the broader picture as seen from the government's perspective. They must take further into consideration the fact that the health system (planning and resource units) is trying to allocate very limited resources across a wide range of activities, and also that it is necessary to ensure a sustainable health system for the future.[1]

Links

The Uganda case highlights the importance of an open context for associational life and the impact that CSOs and religious groups can have. Activities at community and grassroots levels have been key to the success. The Uganda case reinforces existing evidence about trust, 'champions', legitimacy and the importance of networks. There are a number of points here.

Associational life has been very important in Uganda's success in raising awareness of HIV. Through social networks, NGOs, religious groups, community groups and professional associations, everyone knows someone with HIV and talks about the disease. The extent of such AIDS communications is seen as unique in Africa. Stoneburner et al. (2000) argue that awareness of HIV/AIDS in Uganda leading to behaviour change was achieved more through social/personal networks than through mass media campaigns. Similarly, Lucas notes that 'horizontal communication' (communication among peers rather than state-citizen) is particularly important for behavioural change. Low-Beer notes that this communication on acknowledging and preventing HIV/AIDS may be the secret to Uganda's success.

Religious organisations are particularly influential in Ugandan society – their actions on communication, behavioural change, care and treatment were vital in fighting the stigma of HIV/AIDS. The clergy are particularly trusted members of society; networks of religious organisations could 'reach far into the rural communities, perhaps where even the NRM could not' (Putzel, 2003). Religious organisations have been major providers of healthcare and education in the absence of public authorities' ability to do so. What we know less about is their use of research in the process.

Regarding CSOs, TASO in particular was very important in the bridging research and policy story in Uganda, and probably one of the reasons that Museveni's early AIDS Council included CSOs. TASO was working at community level in a number of centres throughout the country and already had testing and counselling by the time others began to support community initiatives. It was also important in terms of the 'living positively' message (Lucas).

It is interesting that the role of the local media was less significant during the early stages. Since media liberalisation (including radio), its role has been considered critical in stimulating public debate, promoting awareness, encouraging responses and challenging long established social norms that have prevented broader changes in behaviour, such as conservative attitudes to sex and the position of women in Ugandan society (Panos, 2003). The lesson from Uganda is that engaging with existing community-level actors is a very effective means of promoting change.

A future challenge facing CSOs is that, while they remain an important partner in the health sector, they have lost much of their external funding – and are hence reliant on the collection of user fees and

[1] Discussion with Samantha Smith, formerly of Ministry of Finance, Uganda.

transfers from the government. There is a specific grant allocated within the health sector budget to CSO health units in order to help them meet their costs (Smith, 2004).

External influences

The external context has had a major impact on HIV issues in Uganda – and is likely to continue to do so. It has been noted how international evidence and international media sources helped make Museveni and his colleagues aware of HIV issues. International donors have also provided crucial funding to government, researchers and CSOs, affecting all sets of actors in research-policy linkages.

However, there are increasing concerns about the international influences on HIV research and policy in Uganda, including most prominently the issues around ownership and prioritization. There is concern that some US government and NGO programmes are either ideologically driven, or simply more suited to Northern contexts (rather than driven by local contexts and evidence). At the International HIV/AIDS Conference in Bangkok (July 2004), there was outcry when Museveni, having always had a very close relationship with donors, including notably the US, publicly announced abstinence as the primary factor in Uganda's policy success in reversing HIV/AIDS in line with the PEPFAR agenda. Declaring this statement as a lesson to export, without recognition of other more important factors that had led to Uganda's apparent success in behaviour change caused much upset among HIV policy advocates from across the world. A further example of inappropriate policy is the push to provide ARVs at a monthly price of US$24 in a country where the total per capita health expenditure, including household out-of-pocket spending, is around US$15 per annum. The health budget is around US$5 per annum. Not surprisingly, there is a concern that new funding available for HIV does not necessarily reflect the priorities within the health sector or more generally for development outcomes.

International influences may have also affected the extent to which external funds could be received by the government in order adequately to finance AIDS programmes. Ooms (2004) implies that the refusal of the Ugandan finance ministry to increase the health budget to accommodate the grant Uganda received from the Global Fund had been influenced by the IMF and public health expenditure ceilings.

Conclusion

Uganda provides what many consider to be a good model of HIV/AIDS policy response. The framework used in this study has revealed the interaction of optimal factors within the political context, links, evidence and external influences. A respectful relationship existed between Museveni and civil society, which allowed knowledge from civil society to infiltrate the policy process. The political context consisted of strong political leadership, which has provided an enabling environment in which the mobilised, pre-organised (from recent civil war) and committed civil society sector could take true ownership of the response and translate the policy into local context-specific responses. This was made possible by the existing social capital within society, by using local networks, and was further stimulated by an open, vibrant media environment.

The international arena provided necessary resources and data with which to carry out these activities. However, it is important to recognise that, despite the proliferation of international funding and organisations, an important national and local level of ownership to the policy response had already existed from an earlier stage, initiated by a personal communication from Castro, local (alongside international) research and the existence of CSOs (e.g. TASO). Behaviour change had occurred before conventional donor responses such as mass media campaigns had arrived on the scene; under Museveni's leadership, donor funds were manipulated to a certain extent to support country-led processes.

Uganda in this way is quite unique, as compared with other countries, including case studies to follow. The success of Uganda is particularly important in the global fight against HIV/AIDS. Its apparent success has led many other countries and donors to learn lessons from the policy response. For this reason, it is important to analyse critically what it was that led to policy impact and, ultimately, behaviour change. This case study has shown that the bridge between research and policy was affected by the interaction of many factors from the political context, evidence, links and international influences, but perhaps the most important factor was the participation in the policymaking process of those most directly affected by the virus at the community level, those who witnessed daily the impact and were acutely aware of the most appropriate responses.