The Social Geography of the Spread and Impact of HIV/Aids in Uganda

Abstract

Since the first identification of HIV/Aids in Uganda in 1981, at Kasensero and Rukunyi locations of Rakai District on the shores of Lake Victoria, the government of Uganda has demonstrated an open and supportive response to the epidemic. The Uganda Aids Control Programme (ACP) was established in 1986 with a mandate to control the spread of HIV and to assist people and families infected and affected by HIV/Aids. In 1991 the Ugandan government adopted a multi-sectoral approach to fighting HIV/Aids by establishing the Uganda Aids Commission (UAC). Despite these efforts HIV/Aids has continued to seriously affect Uganda. At the beginning of 1998 an estimated 800,000 people out of a population of 17 million were HIV-positive. This included at least 25,000 children. By 2002 approximately two million out of a population of twenty-two million were thought to be infected. Most are between 15 and 35 years old, Thus the epidemic affects the most productive age group and greatly hinders development. Uganda has a mainly young population with a tremendous dependency burden. The economy is based on labour-intensive agriculture with the agrarian sector contributing 54 percent of GDP and accounting for 90 percent of exports (MFPED 1998).

The terrible irony of Aids is that HIV infection is concentrated in the countries that are least able to cope with the sickness, death and loss of productivity it brings. Close to 90 percent of all people with HIV live in sub-Saharan Africa and other developing countries. Yet these countries account for a mere eight percent of global economic production. Moreover the gap between rich and poor countries with regard to HIV/Aids is increasing. Investment in HIV prevention and access to expensive life-prolonging drugs are cutting new infection rates and progression to Aids in industrialised countries, but in the developing world infection rates are still on the rise, and drugs to slow the progression from HIV to Aids are largely unavailable. In Uganda the rural labour force is expected to fall by two million by the year 2010 due to Aids (Stover 1990). The loss of so much of the economically most active population, along with their skills and experience, further increases the dependency burden as the children and old people left behind are unable to contribute meaningfully to economic activity.

HIV/Aids and Gender

The nature of the Aids pandemic in Uganda can only be understood in the context of the country's cultural norms, values and customs. There are a varied array of cultural constructs that pose a potential threat to the lives of both male and females. For example in some cultures in Eastern Uganda female circumcision is widely practised and involves sharing knives as a symbol of sisterhood. A study carried out on circumcision practices among the Bagisu found a relationship between the circumcised age group and an increase in Aids cases in this group (Ankrah 1993). Another potential danger is posed by the fact that circumcision ceremonies are crowned by overnight celebrations that have sex as part of the menu. Another important aspect of culture related to the spread of HIV/Aids has to do with the traditionally unlimited access of husbands to household resources, including the sexuality of the wife. Sex is the prerogative of the man regardless of the feelings of the woman. This effectively negates concepts such as safe sex in marriage, therefore increasing the incidence of infection if the man is infected with HIV. Even if a wife suspects her husband to have a sexually transmitted disease, she cannot request that he use a condom; this would contravenes her cultural obligation of submission. Moreover failure to produce a son and heir is blamed on the woman, and in such cases the man is expected to find himself an heir outside marriage. Indeed extramarital relations are generally expected and accepted for men, but not for women. This helps explain why more teenage girls are infected than boys. Nuwagaba (1999) found that girls are being harassed by older men ("sugar daddies") as well as by their age mates. In any case polygamy is acceptable in most Ugandan traditional cultures. All these factors put women at higher risk of HIV infection.

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The Ugandan legal regime has not been fair to women either. Under the divorce law, for example, proof of adultery by the wife is sufficient for a man to secure a divorce, but a woman requires, in addition to proof of adultery by the husband, proof of neglect or cruelty before she can obtain a divorce. Thus the same double standards evident in the socio-economic and political fabrics are institutionalised in the law. With regard to HIV/Aids the law effectively confines a woman in a risky relationship. Moreover the husband is sole owner of the household property and assets. As a result most women are economically dependent on their husbands and would rarely even contemplate separation. Seventy-five percent of Ugandan women do not work outside the home (Ministry of Gender, Labour and Social Development 1999), and those who are in paid employment are mainly in low-paid occupations where they are equally dependent on men, but now as employers instead of husbands. To get or keep their jobs they often have to give in their employers' or supervisors' sexual demands.

Aids and Poverty

The Aids pandemic has tremendous effects on aggregate expenditure, especially in meeting the costs of health care. The total expenditure on the care of Aids patients in Uganda has been projected at five million US dollars by the year 2013. This compares with a projection of 1.5 million in the absence of HIV/

Aids. The high cost of care is compounded by the prolonged, serious illnesses that characterise Aids. Patients need constant attention and care which in the absence of affordable alternatives is normally provided by other members of the household (Armstrong 1995). In a country where small-scale, labour-intensive agriculture is the mainstay, caring for family members with AIDS has an enormous impact on agricultural productivity. The reduced productivity then culminates in lower incomes and savings, which constrain capital formation for further development. Indeed household assets often need to be sold off to meet the costs of treatment and care of Aids patients. The situation is similar in most of sub-Saharan Africa. Governments are increasingly withdrawing from social service provision, and poor households are selling even key assets such as land and cattle in order to meet increasing health costs (Nuwagaba and Lucas 1999).

HIV/Aids and Infant Mortality

HIV can be passed from mother to child in the womb, at birth or through breastfeeding. Some 3.8 million children have been infected with HIV since the start of the epidemic, and over two-thirds of these have already died. Most infected children live in the developing world, and the proportion is growing all the time In wealthy countries fewer than 1,000 children were born with HIV in 1997. In the same year over half a million children in the developing world were infected with the virus (WHO 1999). In Uganda as in most of sub-Saharan Africa this situation is compounded by the fact that most women do not know their HIV status and cannot make choices about pregnancy or breastfeeding that might reduce the number of infected children. They have limited access to safe, affordable alternatives to breast milk or to the drugs that can dramatically reduce the transmission of the virus from mother to baby. Children born to HIV-positive mothers are far more likely to die in infancy than children born to uninfected mothers. HIV is thus reversing gains in infant and child survival in Uganda and many other sub-Saharan countries. In Uganda it is estimated that infant and child mortality rates are expected to more than double (WHO 1999).

Discrimination, Stigma and Denial

At the onset of the Aids epidemic in the early 1980s many people died "mysteriously" as far as the rest of the community was concerned. Little was then known by ordinary people about HIV/Aids, and a great deal of fear was instilled among the population. Not knowing how to respond to the epidemic, people stigmatised those with Aids, who were seen as "marked for death" or as "walking corpses." However stigma did not disappear as more was learned about HIV/Aids. Instead people with HIV/Aids were associated with promiscuity, prostitution and "perversion." When they became ill, this was seen as punishment for sin.

Stigma increases the infected person's sense of isolation and encourages him or her to withdraw from society. Fear, ignorance, lack of knowledge and denial of Aids have severely affected individuals, families and whole communities. Thus there is an urgent need for psychosocial and values-based responses to Aids. As the famous Ugandan musician Philly Bongoley Lutaya put it in the last song he wrote before dying of Aids, "Today it's me, tomorrow it's someone else…' For Africans there cannot be worse torment than being disowned by one's very own. Predictably it has been shown that the poor suffer more discrimination than the rich (Nuwagaba 1998).

Planning a Multi-Sectoral Response

In a few years Aids has destroyed decades of steady improvement in life expectancy in sub-Saharan Africa. Since three times as many people are currently infected as have died so far, it is expected that life expectancy will continue to deteriorate in most regions (USAID 1997). Projections indicate that it will take decades to recover the levels of life expectancy achieved in the mid-1980s. In Uganda as in most developing countries new infections are still on the rise, especially among young people. Yet young people are all too rarely equipped with the knowledge, skills and services they need to avoid HIV infection. The full impact of Aids on society in terms of adult deaths, lost investment and productivity, overwhelming health care costs and huge numbers of orphans will only be felt years or even decades after new infection rates have started to fall. This should compel us to intervene to equip the younger generation with life-saving skills while the toll of HIV/Aids is still reversible. Vigorous and focused programmes to cut new infections must go hand in hand with forward planning to meet the inevitable rise in demand for services by infected families and communities.

Tragically even the information that does exist is frequently not taken into account when planning prevention policies and programmes to slow the spread of HIV and minimise its impact. The potential for Aids to thwart decades of development must be clearly communicated to leaders at all levels of the political and religious hierarchy, as well as to community opinion shapers throughout the country. Information about the potential effects of the disease in different sectors must be made available to policy makers, business and community leaders. The Ugandan government acknowledged this as early as 1991:

> [T]he fight against Aids is the responsibility of all individuals. It is not only directed at the prevention of the spread of HIV but [must] also address the active response to and management of all perceived consequences of the epidemic (Republic of Uganda 1991).

The single most important objective in this fight is to reduce the toll of HIV/Aids on the productive population, especially those most at risk, while critically rethinking interventions to mitigate the effects of HIV/Aids on the populace. Specifically an appropriate hub for research and innovation should be established for the better understanding of HIV/Aids impacts on the labour market and production relations. Eclectic and multidisciplinary forums for information-sharing, along with inter-institutional collaboration and linkages are also required.

References

Ankrah, 1993

Armstrong, 1995

MFPED, 1998,

Ministry of Gender, Labour and Social Development, 1999

S*tover, 1990,*

Nuwagaba, 1998

Nuwagaba, 1999

Nuwagaba and Lucas, 1999

Republic of Uganda, 1991

USAID, 1997

WHO, 1999