
Uganda is one of the countries in Sub-Saharan Africa worst hit by HIV/AIDS, but at the same time among the few nations that have successfully stemmed the escalation of the epidemic. HIV prevalence among the adult sexually active population is estimated to have dropped from 18% in 1992 to 5% in 2001. Consequently Uganda is internationally considered a leader in responding to HIV/AIDS and many countries are keen to learn the approaches that have been used and where possible replicate them. The early political commitment spearheaded by President Museveni provided ground for mobilizing communities against HIV/AIDS, harnessing donor support and the efforts of government and civil society. These, together with the multi-sectoral approach, are some of the factors commonly cited to be behind Uganda’s success. However, it is noted that these same approaches have been applied by some other countries in Africa, but have not resulted into similar success as seen in Uganda. It is therefore believed that only country and context specific factors such as cultural norms and social patterns of people and communities could have played significant roles in Uganda’s success.

It is against this background that the Ministry of Finance, Planning and Economic development supported by UNDP launched this study. The primary objective of the study was to establish the social and cultural factors that have impacted on HIV/AIDS in Uganda and, in particular, their role in enhancing behaviour change. The study was two fold: First it sought to verify the “Cautious Shift” Model in terms of its relevance to the HIV/AIDS context in Uganda purposely to establish whether the model provided a viable theoretical framework for explaining HIV/AIDS interventions in Uganda. The second was an empirical study using data collection methods of Focus Group Discussions and Key Informant Interviews to establish the extent to which social cultural factors contribute to reduction in HIV/AIDS. The study was carried out in six districts of Uganda, selected on the basis of regional and ethnic representativeness (see Map of Uganda).

Following a comprehensive search and review of the literature by the internationally accredited HIV/AIDS researchers and behavioural scientists, it was established that the “Cautious Shift” Model did not exist as a behaviour change model, but rather a theoretical framework developed to explain HIV/AIDS behaviour change that has occurred in Uganda. Notwithstanding, the framework was analysed in detail but still found incomplete and inappropriate to the HIV/AIDS context in Uganda. Consequently, a new “Integrated Behaviour Change Framework” was developed, building on the merits of the Health Belief and Planned Change models.

The Integrated Behaviour Change Framework, discerns a complex interrelationship between the individual and contextual factors through which behaviour change is achieved and maintained. In this inter-relationship, the precursor to behaviour change is perception, which is itself a product of an individual’s socio-demographic characteristics and his/her immediate environment. With the help of cues to action, the individual’s perception is transformed into action, which, when supported by the requisite infrastructure, is consolidated and maintained as a desired form of behaviour. The framework therefore provides a retrospective theoretical grounding of HIV/AIDS interventions in Uganda and possible springboard for future planning and replication of similar interventions. The framework also formed a basis for the design and implementation of the study.
The findings from the empirical study indicate that there was a strong link between information, awareness, knowledge, perception and behaviour change. For example, although knowledge of HIV/AIDS (measured by people’s knowledge of how HIV is transmitted and how it can be prevented) was found to be near universal, big gaps were noted, especially in areas where access to information was limited.

In some remote rural areas, HIV transmission is still associated with witchcraft and some people believed that HIV/AIDS is unavoidable. In extreme cases, some rural women reported that they have even never seen a condom.

Information was reported to be accessible to communities through a number of channels including radio, newspapers, workshops, posters, churches/mosques, and institutions. Radio was reported to be the major source of information, especially with the increase in private FM stations that broadcast in local languages. There was general appreciation that this has increased people’s knowledge on HIV/AIDS, consequently improving people’s risk perception, knowledge of where to seek services and being updated on new interventions such as PMTCT.

There was also universal willingness and determination to change behaviour especially among adolescents and women. Factors reported to be prompting people to change behaviour included the desire to live long and fulfil life long plans and fear of consequences deriving from HIV infection such as long and agonizing illness, stigmatisation and the high cost of drugs such as Anti-Retro-Virals (ARVs). Personal experiences with HIV/AIDS such as loss and burial of close relatives and friends were also reported to be a critical factor influencing people to avoid infection.

Despite the reported zeal to change behaviour, communities also perceived significant contextual barriers to behaviour change. Most prominent of these was poverty that impacts negatively on people's efforts to change behaviour. Women, particularly single mothers and youth out of school, are severely affected by poverty that increases their vulnerability to HIV/AIDS. Poverty was also reported to be limiting access to information and services. Alcoholism was reported to be a major limitation to behaviour change, as it deters people’s efforts to abstain, remain faithful to their partners or correctly and consistently use condoms. Other barriers included illiteracy, especially inability to read and interpret HIV/AIDS messages, negative peer pressure and cultural inclinations that perpetuate gender inequalities and failure of parents to address sexual issues with their children.

The sprawling orphan crisis was the most commonly reported problem as a result of HIV/AIDS affecting families and communities. The increased number of orphans lacking access to basic needs like shelter, food, health and education poses a potential future challenge for Uganda. As these children grow in such a harsh environment, communities must be prepared to pay heavily through crime and lawlessness that will emerge as a consequence. HIV/AIDS was reported to exacerbate poverty through spending family resources on care, loss of jobs by breadwinners and family members devoting productive time to support and care for the sick.

Social and cultural factors were said to have significant impact on HIV/AIDS related behaviour. Discos, traditional dances, films, wedding parties, religious gatherings, games, sports and
alcoholism were reported to be the main social factors impacting on HIV/AIDS. Circumcision, early marriages, widow inheritance, twin ceremonies, appeasement of spirits, cleansing ceremonies as well as funeral rites and traditional rituals were some of the cultural factors mentioned. It was reported that all social and cultural ceremonies gather many people in a celebrative atmosphere and with the drinking, dancing and the resultant excitement; the risk for casual sex becomes high. Though salvation was widely reported as a coping strategy for many people infected with HIV/AIDS, some religious functions particularly night prayers were also reported to increase risk for casual and unprotected sex as they gather many people some with intentions of having sex.

Interestingly, it was noted that some of the social and cultural factors reported to be enhancing HIV transmission were at the same time contributing to reduction of the risk of HIV transmission. For example, marriage ceremonies, religious gatherings and funerals were reported to be major avenues for intensive HIV/AIDS education. Cultural norms such as preservation of virginity until marriage, culturally arranged marriages and the paternal aunt institution promote abstinence and mutual faithfulness.

Districts local governments were found to be the nucleus of HIV/AIDS services, providing leadership and oversight to community level initiatives. The districts were also found to be playing a big role in HIV/AIDS service provision, but mainly focusing on those that are facility based such as treatment of opportunistic infections, VCT and PMTCT. The role of districts was considered crucial in providing technical guidance, mobilizing resources and coordinating interventions. And support of development partners such as UNDP, USAID and other local and international NGOs. New institutional structures such as the District AIDS Task force (DAT) and the District HIV/AIDS Committee (DHAC) have been formed to enhance coordination of the multi-sectoral approach and resource mobilisation. However, human and financial resource constraints still hamper districts efforts in performing such roles.

Communities have initiated various strategies to respond to HIV/AIDS. HIV/AIDS information is shared at community gatherings such as village meetings, burials and other functions. As the challenges of HIV/AIDS increase and household resilience weaken, the community has responded by making care and support of those affected by HIV/AIDS a shared responsibility. Community organised support groups have evolved that offer mutual support in times of illness and death. Community level efforts also have been made to safeguard youth from HIV/AIDS through counselling and education. Local leaders in some communities have enacted village level bylaws against risky behaviour such as loitering at night, regulating hours for night events and enforcement of laws against rape and defilement. Other important strategies include increased the role of PLWHA in HIV/AIDS education, parents’ protection of their children from risks and equipping the youth with livelihood skills to support them avoid risky behaviour. Life skills mentioned by adolescents and youth were noted to be significant in helping them to minimise their vulnerability. Some of these critical skills include ability to resist sexual demands, insistence on condom use, desire to live, avoidance of risky peer groups and financial independence.

Though some of the services were reported to be available in some communities, in rural areas, access varied, ranging from poor to no access at all. PMTCT in particular was widely unknown in most communities covered by the study. Poverty and lack of supportive services such as VCT, care and support, print and electronic media and reliable condom outlets that critical to behaviour
change and sustenance remain the major limitations especially for the youth to sustain behaviour change.

The study revealed that a number of significant changes have occurred at both the individual and community level with regard to HIV/AIDS related behaviour. Cultural and social ceremonies that increase the risk of HIV transmission have largely been abandoned or modified. HIV/AIDS related stigma has drastically reduced and there was increased information sharing on HIV/AIDS among community members and between parents and children. HIV/AIDS was regarded a community problem and there was a developed culture of mutual care and support in the face of HIV/AIDS. Parents were increasingly coming up to openly discuss sex and HIV/AIDS with their adolescent children in order to prevent them from getting into compromising situations.

With regard to sexual behaviour change, there was general consensus that condom use was the major behaviour change contributing to reduction in HIV transmission. Others were mutual faithfulness/reduction in number of sexual partners and abstinence.

However, abstinence was largely seen to be unsustainable and faithfulness to sexual partner was mostly being practiced by women. Condom use was more prevalent among adolescents in urban areas as cost, availability, unreliability and inappropriate distribution mechanisms hindered condom use in rural areas. Use or non-use of a condom has also remained more of a male domain.

In conclusion, the study established that communities in Uganda are still bound by their cultural, social and religious beliefs, which are passed on to generations and continuously renewed through performance of rituals and rites. Although some of these rituals and rites increase risk of HIV infection, it is the activities associated with them such as alcohol and dancing that makes them risky. Effective preventive strategies still remain those that are culturally and socially sensitive. Therefore these practices need to be made safe through appropriate interventions and to consolidate the social factors, cultural norms and practices that are found to be useful in promoting desired behaviour.

Faced with a lethal epidemic and inadequate institutional services, communities initiated several coping and survival strategies to fight HIV/AIDS. However, contextual factors such as poverty, illiteracy, inequitable distribution of services and gender inequalities encumber communities to adopt and continuously practice protective behaviour. For instance, women who are faithful to their husbands may still get infected because they are not in position to negotiate for safe sex even when they know their husbands engage in risky sexual practices. Similarly, adolescents and youths who would have wished to get married after an HIV test are unable to do so because VCT services are not easily accessible. To consolidate the gains made so far, Uganda will need to address HIV/AIDS simultaneously with poverty and gender issues.

Despite the universal awareness and high level of knowledge of HIV/AIDS, misconceptions about HIV/AIDS still persist especially in the rural areas where information and other services are inadequate. These misconceptions continue to distort people’s perceptions of the HIV/AIDS problem and consequently hamper behaviour change. There is therefore need for specific and targeted interventions to tackle such misconceptions using a variety of approaches especially through effective means that is easily accessible by a big cross section of the population.