

A Paper on Thematic areas in HIV/AIDS

Programming in Uganda

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January, 2009

Background to HIV/AIDS Programming

HIV/AIDS programming refers to overall program areas (strategic behavioral communication, voluntary counseling and testing, care and treatment, monitoring and evaluation, orphans and vulnerable children, antiretroviral therapy, etc.,) that are designed together to achieve a large impact on HIV/AIDS goals: reducing incidences, preventing new infections and developing patterns of behavior in program recipients. In HIV/AIDS programs, the program areas or components are: voluntary counseling and testing, orphans and vulnerable children, prevention of mother-to-child transmission, strategic behavior communication, home-based care, and monitoring and evaluation.

Uganda is experiencing a mature and generalize epidemic with high HIV prevalence rates at 6.4%. This is worrying considering the grave impacts of the epidemic at individual, household and community levels and national development generally. While Uganda has witnessed improvements in AIDS related mortality and morbidity due to deliberate efforts to provide access to antiretroviral therapy, the basic pattern of the epidemic is determined by the rate at which new infections are occurring. The trends in increasing numbers of people being infected with HIV year after year are of major concern and a real threat to the whole HIV/AIDS response. Research has revealed a multitude of drivers of the epidemic and gaps in the prevention response that call for stepped up responses.

The Modes of Transmission study that was conducted last year indicate that, there have been shifts in the risk factors and drivers of the epidemics. The bulk of new infections are now arising from couples in long-term marriage- like relationships and discordant couples-where one partner is HIV-positive and the other is HIV-negative. In many cases the two do not know each other's status. In the 1990s, the bulk of cases were in casual sexual partnerships.

The AIDS National Strategic Plan 2007/8 to 2011/12 estimated that in 2005 alone; there were 132,500 new HIV cases. The modes of transmission study projected for the year 2008 that 43% of all new HIV infections were among mutual monogamous sexual relationships, while 46% were among persons involved in multiple sexual partnerships. Commercial sex contributed 22%, while heterosexual casual sex contributed 14%.

According to the Modes of transmission study, the greatest need for HIV prevention is among persons with multiple concurrent sexual partners, whether in casual or long-term marital or cohabiting relationships, yet current programmes and delivery channels are targeting the general population. They are not effective for married couples. Also the bulk of new infections are now in the 35-39 year age category for men and 30-34 years for women, yet focus of interventions has not expanded from younger people of the 15-24 age groups.

HIV/AIDS epidemiological trends in Uganda

After a quarter a century of a generalized HIV epidemic, Uganda continues to experience a severe and mature HIV epidemic. Currently 6.4% of adults and 0.7% of children are infected with HIV that is about one million people nationwide. The magnitude of the epidemic has geographic, socio-demographic and socio-economic heterogeneity; women, urban residents and people residing in Kampala, central and mid-northern regions are most disproportionately affected.

Uganda was among the first hard hit countries. The first HIV/AIDS case was identified in the country along the shores of Lake Victoria in 1982. Superstitions and witchcraft characterized the initial response from communities amidst lack of clear government response to HIV/AIDS. Consequently, the epidemic progressed very fast to all parts of the country initially concentrating in urban and semi-urban centres. By end of 1992, the national prevalence rate was estimated at 18.3% with some centres registering rates above 30%. This was followed by a period of steady decline in prevalence rates from the mid 1990s to 2002 to around 6%, attributed to favorable prevention policies. The country has since experienced stabilizing prevalence rates over the last years with threats of increases in some parts of the country.

The 2004/05 National HIV/AIDS sero and behaviour survey by the Ministry of Health Surveillance Unit estimated about 915,400 adults and children were living with HIV/AIDS in 2005. Prevalence among adults aged 15-49 yrs was estimated at 6.4%, 0.7% among children less than 5 years, and 5.8% among those aged 50-59. The Ministry of Health estimated 132,500 new infections in 2005 alone. The survey revealed regional, rural/urban, and gender variations in HIV prevalence. The Kampala, central, and North-central regions registered the highest infection rates at around 8% while the West Nile region was at 2.3%. Overall infection rates higher in urban areas compared to rural areas, amongst urban women almost twice as high (13%) compared to women in rural areas at 7%. The Ministry of Health also

estimated the national HIV prevalence rate (pooled antenatal figures) at an average of 6.2% of the total Ugandan population by end of 2002 while new infections were estimated at 70,170 cases, new AIDS cases at 73,830 and AIDS deaths at 75,290 in 2002 alone.

Heterosexual HIV transmission accounts for 75-80% of the total new infections, Mother to Child Transmission including breast feeding accounts for 15 –25% and use of infected blood and blood products and transmission in health care settings accounts for 2-4%.

ABC trends among young people (2004 – 2006) indicate that: the median age of sexual debut among both young men and women increased by about one year over the course of the decade. There are no significant changes for young women; men age 15-19 who have never had sex increased from 58% to 65%; men age 20 -24 who remained faithful increased from 45% to 53%; men age 20 -24 who had multiple partners in the past year and did not use a condom at last sex decreased from 14% to 9%; and among faithful men age 20 -24 the proportion who used a condom at last sex decreased slightly. The study further reveals that, there is a large decline in sexual activity among unmarried 15- to 24-year-old females (from 35% to 22%) and males occurred during the first half of the decade (although there was an increase among young women to 27% during the second half of the decade).

Impact of HIV/AIDS

In Uganda HIV/AIDS has affected both rural and urban dwellers, adults and children and the impacts cut across regions and occupational groups in the country with varying magnitude. HIV/AIDS, especially in resource-constrained settings, results in physical and psychological suffering of the infected and eventually the affected. Consequently HIV/AIDS morbidity and mortality has negatively affected development initiatives at individual, household, sector and eventually national levels as individual and household savings are depleted to access care for the sick while income inflows from affected adults are cut off due to sickness and attending to the sick.

Since 1982 when the country's first cases of HIV were detected on the shores of Lake Victoria in Rakai District, cumulatively an estimated 2.6 million Ugandans have been infected and 1.6 million have lost their lives to HIV/AIDS related illnesses including 76,000 in 2005 alone. For many years, AIDS has been and is still a leading cause of adult disease and deaths. It is the fourth leading cause of under-5 mortality,

directly influencing the realization of MDG goals. Adult life expectancy currently is at 48.9 years (50 years for females and 48 years for males) yet it is projected to have been 56.9 years without AIDS. AIDS is cited among the leading causes of poverty in the country.

The epidemic has had a devastating social and economic impact at individual, household and community levels. Besides the physical suffering from opportunistic infections, most people living with HIV/AIDS (PHAS) experience trauma, distress, stress and depression which affect their social lives. Although direct stigmatization has greatly reduced, PHAs are still indirectly isolated and denied support or access to services in various settings.

There is increased morbidity due to the upsurge of opportunistic infections some of which requiring even more complex expensive treatments than can be afforded. Reviews have established that 50-70% of hospital admissions are HIV related. HIV has ignited the upsurge of an equally threatening tuberculosis epidemic. About 50-60% of TB cases are co-infected with HIV.

Children and young people form one of the heavily affected population groups in communities. They are withdrawn from schooling to care for the sick or due to lack of school dues, denying them access to information and bright future opportunities. This is especially so for the girl child.

Most of the AIDS deaths occur among men and women of childbearing age resulting in unmanageable increases of Orphan and Vulnerable Children (OVCs). About 46% of Orphans in Uganda are due to effects of HIV/AIDS (Sero-survey 2004/05) (Source: NHS 2006). And approximately 105,000 children 0-14 are HIV positive.

The NHSBS estimated a total of 2.18 million Ugandan orphans by end of 2005. About 47% of these and 81% of the 567,700 dual orphans are due to AIDS. UNAIDS estimated over 880,000 children below 14 years AIDS orphaned by AIDS in the country constituting about 51% of all orphans of that age by 2000. Results from a national action research study of 2002 reflected that communities perceive orphan care among the greatest burdens of the epidemic.

HIV/AIDS has increased the costs on drugs, human capacity development and expenditure in the health sector generally due to the increasing demands from HIV-related ailments yet limited access to health care facilities makes the epidemic more devastating at individual level.

In the health sector, HIV infection has led to the resurgence of other diseases like tuberculosis, pneumonia and meningitis. Providing appropriate healthcare to the increasing PHAs exerts a lot of pressure on the fragile health infrastructure that is struggling to with tropical disease and the poverty-related diseases of malnutrition and poor hygiene. A health facility inventory by the Ministry of Health in 1997 revealed that HIV/AIDS-related patients occupied more than 55% of hospital beds. A World Bank study (Armstrong, 1995) predicted gradual adverse economic implication due to the magnitude of the epidemic and the fact that HIV selectively affects adults in their sexually active ages coinciding with prime productive years. This is resulting into an impact on the size and quality of the labor force. Loss of skilled labor in the public and private sectors is increasingly affecting productivity and increasing expenditure on the labor force. Preliminary findings of a survey on the trends and impact of HIV/AIDS on the public service in the country reflect that 15.2% to 27.4% of public officers are suspected to have died of AIDS between 1995 and 1999. The study estimates PHAs between 4.6-13.2% of all the public officers.

The epidemic was, in the year 2000, declared a security and development crisis in the country that demands for inclusion on the agendas of all development efforts.

Drivers of the Epidemic

Higher Risk Sex

Despite high levels of knowledge on HIV/AIDS, there is evidence that higher risk sex may still be the main driver of the HIV/AIDS epidemic in Uganda. Higher risk sex includes sex with multiple partners especially non-marital, non-consensual; inconsistent or no condom use; commercial, transactional and intergeneration sex including sex for survival; alcohol consumption and drug abuse before sex; unprotected sex with someone whose status one does not know; sex without testing and disclosure and early sex. It has also been argued that from the above definition, the majority of the population is thus having higher risk sex as normal sex and may not know that they are at risk. It has also been further argued elsewhere that knowledge of one's sero-status may or may not influence sexual behavior (AIM, 2006; Matovu et al., 2005; UNIVAF/UAC, 2003; Nyblade et al., 2001; The VCT Efficacy Study Group, 2000; UNAIDS, 1999).

The main factor that influences the continuation of higher risk sex despite the high levels of knowledge and risk of transmission is the lack of internalization and personalization of HIV risk. There is evidence to suggest that having been within the population for now 20 years, HIV/AIDS may be viewed by some

people as no longer an immediate threat of death or serious illness, but something normal in life; a concept referred to as normalization. Secondly, IEC strategies have focused more on AIDS as a threat to life but have not paid any attention to the social role of sex or the concepts of sex and sexuality in the design of intervention strategies.

Extra-marital sex

Extramarital sex has been a tolerated practice for men (but not for women) since traditional times. Recent data shows that the proportion of men reporting extramarital sex has not declined substantially since 1995 (Kirungi et al, 2006). Moreover, according to secondary data analysis of the UHSBS, approximately 60% of new infections are occurring within married relationship. This is a very significant finding that points to higher risk sex occurring in this cherished cultural institution, especially by the men, including multiple extra-marital partners, very low condom use, lack of testing and disclosure as well as a high rate of discordance.

It appears that even in the event of HIV/AIDS, some beliefs and perceptions about “maleness” in relation to sexuality have largely remained. Male partners tend to justify extra-marital relationships in terms of unsatisfying sexual relationships and thus seek satisfaction outside their marital or regular relationships (Sengendo, et al. 2001; IPPF, 2005). Further the practice is perpetuated due to cultural beliefs; a number of women continue to accept that it is by nature that men have such “privileges” in marriage.

Mother to Child transmission of HIV

Transmission of HIV from an infected mother to a child is the second most common means of transmission of HIV in Uganda. Available data shows that MTCT including breastfeeding accounts for 15-25% of new infections (UAC, 2004-a). At the end of 2000, a cumulative total of 58,165 AIDS cases had been reported to the STD/ACP in Uganda and 4,286 of these were children below 12 years, 90% of whom had acquired infection through MTCT. Studies in Mulago have shown that only 1/3 of babies infected with HIV live to see their second birthday which inadvertently affects progress made in reduction of childhood mortality (MoH, 2003-a).

MTCT has continued to drive the epidemic despite availability of an effective and affordable PMTCT intervention using Nevirapine. The number of women enrolling for PMTCT as a primary prevention approach is very low. This is due to some socio-cultural and economic factors that have been identified as major deterrents of women towards utilization of PMTCT services and their failure to come back to the health facilities for deliveries as recommended under PMTCT. Although over 80% of pregnant

women attend ante-natal care at least once during pregnancy, only about 30% deliver in health facilities (UDHS, 2000). The social cultural factors include lack of or limited male involvement in PMTCT programs, stigma and the quality of services provided by service providers compared to TBAs. The community attachment and trust of the community towards the TBAs need to be addressed. PMTCT program is also affected by staff level and quality of counseling at the health facilities as well as by the low level of community awareness and mobilization for PMTCT services.

HIV discordance and non-disclosure

The 2004-05 Uganda HIV-sero Behavioural Survey (MoH and ORC Macro, 2006) shows that overall, 5% of the cohabiting couples, are HIV discordant, that is one partner is infected and the other is not. Of all couples where at least one partner is infected, nearly 50% are HIV discordant. Data from the Rakai Health Sciences Program also shows that HIV sero-discordance among couples is high (Serwadda et al., 1995). Moreover, most of these discordant cohabiting couples are not aware of their HIV status and therefore not motivated to take action towards prevention such as using condoms consistently. Studies show that couples who test individually are more likely to disclose to persons other than their spouses and even when they do disclose to their partners they may take as long as two years to disclose (Oundo and Siu, 2005). Moreover, females may not disclose to their spouses for fear of domestic violence and marital disruption (Koenig et al., 2003). This may be a significant driver of the epidemic since the low level of testing among couples, the lack of disclosure HIV status to the partner and the low condom use in marriage put the uninfected partner at a very high risk. In these situations sex in marriage may become higher risk sex. Studies have shown that the risk of HIV transmission among discordant couples is as high as 10 times the risk of transmission among the general population (Serwadda et al., 1995). Lack of couple counseling, failure of disclosure and fear of domestic violence among couples or discrimination among OVCs may hamper prevention intervention programs such as comprehensive VCT and PMTCT. The Ministry of Health and the Centers for Disease Control and Prevention in Uganda are conducting secondary analysis on HIV discordance using the UHSBS data.

Economic factors

Poverty is a leading economic driver of the HIV/AIDS. It influences people to engage in commercial sex, transactional sex and intergenerational sex. Some poor and vulnerable people especially girls may be forced into difficult economic situations and may thus engage in these sexual activities for survival (survival sex). On the other hand for some young people engagement in these sexual activities may not be for survival but for “setting standards” or improving their status in society. This has been mainly

described in the type of sexual activity occurring in some of the tertiary institutions of learning. The UNHSBS survey shows the intergenerational sex remains a key factor; 10 percent of women aged 15-19 who had higher-risk sex in the 12 months preceding the survey had sex with a partner who was 10 or more years older. Age groups 15-17 and 18-19 have roughly the same proportion of young women who had sex with a non-marital, non-cohabitating partner more than 10 years older. Ever-married women were more than three times more likely than never-married women to have had higher-risk sex with a partner who was more than 10 years older. Studies conducted by UNAIDS (2004) and UNESCO (1999) observed poverty as the most common explanation why girls in Sub-Saharan Africa engage in transactional sex with older sexual partners.

Conversely, HIV/AIDS is a driver of poverty. The age-group most affected by HIV/AIDS is the most economically productive and ill health contributes to sickness absenteeism from work leading to lost wages and income. Moreover, the expenditure on health care by the individuals and families affected by HIV, leads to catastrophic consequences on household budgets and assets.

The 2004/05 HIV/AIDS Sero Behavioural Survey (MoH and ORC Macro, 2006) shows a gradual increase in HIV prevalence rate from 4% among those in the lowest quintile to 9% among the wealthiest quintile. This trend occurs for both males and females and has been described elsewhere in sub-Saharan Africa. Wealth is known to be associated with high mobility, a factor which influences indulgence in higher risk sex. The Sero Behavioural Survey also shows that the percentage of men who had two or more sexual partners in the past 12 months increased from the middle to the highest quintile and for women the increase in multiple sex partnerships occurred among those in the fourth and highest quintile. Further socio-economic analysis needs to be done on this issue, to better understand the link between wealth and HIV risk.

Socio-cultural factors

The two key cultural institutions in most African societies are marriage and family. While the institution of marriage has its strengths, it may also expose some people to vulnerability due to cultural expectations with negative consequences on the transmission of HIV/AIDS that may drive the epidemic. These negative cultural expectations include; condoning early marriages; glorifying non-marital sex and multiple sexual partners; looking for children especially male children outside marriage; expectation to have unprotected sex whatever the circumstance. Furthermore, construction of male and female sexuality or in non-technical language, what it takes to be a man or a woman influences sexual behavior with negative consequences on HIV risk. It is not uncommon for “manliness” to be equated with the

number of women one has conquered or “womanliness” to be equated with submissiveness such as the notion that “a woman does not refuse a man”. The latter erodes confidence and assertiveness of women in marriage and other relations. This may influence adoption of preventive measures against HIV transmission such as condom use especially in marriage.

Historically, the family has served as the major vehicle for socialization, including on issues related to sex and sexuality. Moreover, the extensive kin network with an extended family system enabled sex education to be performed by the extended family members, such as the sengas (fathers’ sisters). With increasing urbanization and exposure to foreign media this concept of the African family is being dropped in favor of the more western-type nuclear family network. Yet with HIV/AIDS, the family should play a more pivotal role as it has a key influence on social stigma, isolation and secrecy, stress and coping, social support, communication and disclosure, responses to illness, and changing structure and roles in families (Bor et. al., 1993) . There has been a strong case for regulation of the media to prevent further erosion of our family and cultural values.

Cultural values and traditional gender roles increase the vulnerability of women to HIV infection. Women are expected to be obedient to men, cannot question infidelity of their husbands nor can they deny them sex. Sex is obligatory for married women, and there is little communication between spouses about sex and no negotiation. Furthermore, gender relations and power dynamics in marriage favor the man over the woman as regards decision affecting economic needs, health care seeking and number and gender of children. In this situation domestic violence is common and may influence risk of HIV transmission (Koenig, 2003).

Human rights, stigma and discrimination

Human rights are defined as natural or civic rights or basic entitlements accorded to every human being. They include the right to health, education, shelter, employment, property, food, freedom of expression and movement. Aspects related to HIV transmission risk include the right to determine one’s own sexual preference and sexual future; the right to access information and health care services and the right to confidentiality. In ensuring the protection of human rights it is important to balance individual rights vis-à-vis benefits to or protection of communities. For example, the right to confidentiality of an HIV infected individual in a discordant relationship needs to be weighed against the right to protection from adverse health consequences of the sero-negative partner in the discordant couple. Similarly, adolescents and young people may not yet be of legal age but may need to be protected in their rights to privacy and access to adolescent friendly services.

Stigma derives from negative thoughts based on a prejudiced position (out casting). It affects the thinking and behavior of people whereby a person is looked at in a negative and judgmental way. Stigma has deep roots in culture, personal and social fears, denial, misconceptions, myths and even religious beliefs. It is mainly due to limited knowledge about HIV transmission or fear of risk of HIV infection. Persons most affected by stigma include; PLWHA, OVCs, adolescents especially if pregnant or single mothers. Discrimination on the other hand includes those actions that negatively impact on the rights and entitlements of others based on prejudiced viewpoints or positions. It ensues when a distinction is made against a person resulting in unfair or unjust treatment based on their HIV sero-status or risk status. Whereas there is little evidence to suggest that stigma reduction leads to preventive behavior Vs normalization and risk perception, it is well known that stigma affects access to health care services including HIV prevention. On the other hand, it has been conjectured that stigma reduction may lead to heroism and glorification due to being positive with negative consequences on HIV transmission.

High risk population and vulnerable groups

According to a rapid assessment conducted by the Uganda AIDS Commission and its partners (UAC, 2006), the HIV epidemic in Uganda may be driven by populations with high HIV prevalence and incidence since they are more prone to higher risk behavior. These populations include commercial sex workers (CSW), those who are widowed, divorced and separated, persons living in internally displaced persons (IDP) camps, the uniformed forces and fishing communities. As expected, CSWs serve several clients a day, and every sexual encounter is associated with some form of risk so the higher the client turnover the higher the risk. There is also evidence that while 99% of CSWs report ever use of condoms, consistent use is very low (STD/AIDS Control Program, 2003). Such sexual practices of multiple partners a day, with inconsistent condom use, make CSWs not only high risk groups but also profound drivers of HIV, given the fact that some (12.3%) of the CSWs reported having stable partners (married or cohabiting) as well.

In IDP camps, both men and women are reportedly involved in risky sexual behavior that may predispose them to HIV infection. This is exacerbated by high rates of STDs, sexual interaction with uniformed personnel (another high risk group), alcohol use, idleness, child abduction and defilement as well as lack of access to preventive services including IEC and VCT. Uniformed personnel face increased risks of contracting or spreading HIV infection through risky sex during deployment away from home. Some of them experience long separation from spouses or partners. For those affected, and in the absence of family and community support systems, they are more likely to engage in risky behaviors and

potentially pass those risks on to their own family and community members including IDPs. People living in fishing communities are highly mobile; moving between fish landing sites, and is thus strong drivers of the epidemic. Given their migratory nature, fishing communities have limited social cohesion, and socio-cultural norms that regulate behaviour in stable communities are non-existent. Moreover, a culture of 'hyper-masculinity' has been reported among fishermen. Allison and Seeley (2004) reveal how fishermen's beliefs and expectations about the number and type of sexual contacts increase men's susceptibility to HIV/AIDS. In the fishing communities, having more than one wife is a sign of man-hood, and it attracts respect.

Given the burden shouldered by society towards the care of OVCs, several children have been compelled to participate in paid work to cater for themselves or other siblings, while others are heads of households. As a result, orphans and vulnerable children (OVC) are likely to be at greater risk in various aspects of life including early sexual initiation. The MoH Uganda and ORC Macro (2006) indicate that orphans and vulnerable children are slightly more likely to have sex by age 15 than other youth. Young female children classified as OVC are 1.5 times more likely to initiate sex before age 15 than other younger women, while young men who are OVC are 1.1 times as likely. 14.6% of female orphans had had sex before age 15 while 18% of male orphans had had sex by age 15 (MoH Uganda and ORC Macro, 2006).

Concurrent STIs

There is both biological and epidemiological evidence linking concurrent STIs to the risk of HIV transmission. Genital ulcer diseases, such as herpes simplex are very common and yet are associated with an increased risk of HIV transmission and acquisition (Serwadda et al., 2003; MoH and ORC Macro, 2006). Data from the Uganda Sero-behavioral survey indicate that HSV-2 is widespread with close to 50% of Ugandans infected. Approximately 49% of women and 38% of men aged 15 – 49 were infected. Of all couples in which at least one partner is infected with HSV-2, almost half (45%) were discordant. Furthermore, HIV increases severity and duration of herpes symptoms and may reduce efficacy of treatment.

Other potential factors driving the epidemic

Other factors which may be driving the epidemic include the following:

- Lack of prevention programs targeting men
- Lack of focus on programs for married and cohabiting couples

- Lack of programs for the protection of rape and domestic violence victims
- Inadequate legislative and policy framework to ensure reduction of vulnerability
- Inadequate programs for the prevention of HIV transmission in the health care and other work settings
- Inadequate focus on gender in designing interventions
- Inadequate focus on programs that emphasize prevention for positives

Scope, intensity and uptake of interventions

Over the last 10 years, there has been extensive evaluation of new prevention strategies. These included vaccine trials, vaginal microbicides, use of antiretroviral drugs to prevent infection, suppression of herpes simplex virus (HSV-2) and medical male circumcision. Of these, only male circumcision has so far provided overwhelming evidence for efficacy as a preventive intervention for HIV transmission. WHO/UNAIDS in March, 2007, recommended circumcision as a method of HIV prevention. It was, however, emphasized that this is to be used as part of a package of prevention services that include HIV testing and counseling and Health Education.

HIV messaging for Behavior Change:

The number of actors involved in HIV messaging for behavior change in the context of HIV/AIDS prevention has decreased over the years. Currently only 17% of agencies implementing HIV/AIDS interventions have a component for community sensitization and education for prevention, a fall from 78% in 1997. Furthermore, support to relevant institutions and structures dealing with life-skills training has not been provided priority attention in recent times.

There has been a shift of focus towards service access messages as opposed to behavior change messages which were at the centre of the life skills education programs. The few actors who have remained in provision of IEC for behavior change have limited contact with the communities; there is an apparent shift towards impersonal channels of IEC e.g. media.

While the available data indicates the epidemic has shifted from single young people to married monogamous couples, the messages still target cross-generational sex and casual relationships.

Moreover, there is evidence showing a shift towards more risk-taking behaviour among men; more men are involved in casual sex and sex with multiple partners.

Messages on abstinence and condom use do not have any practical promise for married couples either, Sexual abstinence and cross generational sex programmes are well supported largely by donor initiatives, and the gap remains in addressing issues in monogamous stable marriages and discordant couple relationships, where condoms may not be very practical, and are most times not used. Abstinence messages are not appropriate for married people and the messages on cross generational sex and causal sex are not comprehensive as well

The ABCs of HIV Prevention:

Abstaining from sexual activity, mutual monogamy, and condom use are three key behaviors that can prevent or reduce the likelihood of sexual transmission of the AIDS virus. These behaviors are often included together under a comprehensive "ABC" approach - A for abstinence (or delayed sexual initiation among youth), B for being faithful (or reduction in number of sexual partners), and C for correct and consistent condom use, especially for casual sexual activity and other high-risk situations.

Understanding and effectively promoting these behaviors are crucial elements in combating the spread of HIV/AIDS. Based on a growing body of evidence from a number of developing countries, USAID supports the ABC approach because it can target and balance A, B, and C interventions according to the needs of different at-risk populations and the specific circumstances of a particular country confronting the problem

Nevertheless, it has been observed that comparatively, 'Be faithful' has not been emphasized in programming and funding within prevention interventions

Condom Promotion:

Most populations are reached with freely distributed condoms. However, recently there have been interruptions in supply due to concerns about the efficacy of the Engabu brand of condoms. Despite high knowledge and awareness levels about the efficacy of condoms, use of condoms has remained markedly low in the country. More still, most at risk populations like the commercial sex workers are not targeted by any special interventions. Even condom use which is one of the most widespread interventions has not been able to cover these populations to desirable levels. Thus the need to focus on couple counseling and promote condom use in marriage – especially for discordant couples,

continued counseling for people on ART and special programmes for commercial sex workers and other most at risk populations.

Voluntary Counseling and Testing (VCT):

HIV counseling and testing services are a central component of HIV/AIDS programs in developing countries generally and Uganda in particular. Program data, client testimonies and other anecdotal experiences indicate that HIV counseling has had significant impact on improving HIV risk perception and subsequently access to prevention, care and treatment services in the country at another level counseling and testing facilitates development and or adoption of HIV/AIDS-sensitive policies.

HIV Counseling and testing serve the following two principal purposes: 1) determining who requires care and treatment. 2) Help prevent HIV acquisition and transmission, as knowing one's HIV status may encourages infected people to avoid transmitting the virus to others, as well as motivate those who are uninfected to remain so through risk reduction counseling.

HIV counseling was introduced into the country 20 years ago when HIV/AIDS was identified in Uganda in late 1980s. This was when individuals living with or affected by the disease discovered that counseling provided an opportunity for a person living with HIV to overcome stigma, cope with daily life challenges of living with HIV and improved motivation to access prevention, care and treatment services promptly. The AIDS Support Organization (TASO) was born of such perceived and actual value of counseling. Five years later, the demand for HIV counseling increased and so did the need to train HIV counselors to respond to the growing need of HIV counseling. In this regard, a number of institutions including TASO, The AIDS Information Center (AIC) as well as many other providers began to train HIV counselors to help people living with or affected by HIV and AIDS. With time, as the number of HIV counseling training service providers increased, it was clear that there was little coordination of curriculum or quality control. Counseling skills were not routine element of pre-service training for medical professionals.

With the ever changing needs in HIV prevention, care and treatment, many service providers developed different curricula and trained counselors in varied contents and training period in the areas of antiretroviral therapy (ART), prevention of Mother to Child Transmission (PMTCT), home based counseling and testing, basic preventative care, routine counseling and testing (RCT) in clinical settings, and prevention with positives (PWP) counseling.

The result is that individuals or organizations providing HIV counseling services have varied knowledge and skills levels; offer heterogeneous HIV counseling services; recipients of HIV counseling receive

mixed, often confusing messages from the different HIV counseling service providers; not all individuals or organizations are well prepared to respond to the ever emerging and complex needs in HIV prevention care and treatment. The implication of all this is that providers as well as recipients of HIV counseling are ill-prepared to respond to the ever-changing face of the AIDS epidemic.

Tremendous progress has been made with regard to expansion of service coverage for VCT services however the services have been limited in linking to other services including care and support systems. A significant proportion of providers of VCT operate in isolation or without prior knowledge of MoH. Consequently, the practice has been to pronounce HIV status of people and make verbal referrals to district hospitals for treatment without follow up.

Key challenges in the provision of VCT services have included; lack of adequate infrastructure and personnel, as well as stock-out of HIV testing kits and reagents which have characterized the service in recent years. There has also been limited progress in the promotion of couple testing and dealing with discordant couples at service level.

Prevention of Mother to Child Transmission (PMTCT):

The Ministry of Health developed and disseminated PMTCT policy guidelines: “Policy for reduction of Mother to child HIV transmission in Uganda.” This document emphasizes the fact that the most effective way to reduce the incidence of HIV transmission to infants and reduce childhood morbidity and mortality is to prevent HIV infection in women in the first place, through primary prevention. This can be achieved through ensuring greater access to information about HIV, treatment of STIs, access to condoms, high quality, consistent voluntary counseling and HIV testing; and social measures to reduce women’s vulnerability. The women who are HIV positive are to be counseled and supported to avoid getting pregnant; the policy document recommends offering a package of care to reduce MTCT as well as counseling and giving support to them to avoid a subsequent pregnancy. The Ministry of Health also developed and disseminated the ‘Policy guidelines on feeding of infants and young children in the context of HIV’. This document aims at preventing HIV transmission through breastfeeding while at the same time ensuring optimal infant and young child nutrition

However, there is need to review the current program implementation approach with the aim of defining and implementing a comprehensive package of PMTCT services. As is, there is a lack of

continuum from antenatal services to postnatal services. Presently postnatal care services for PMTCT clients do not exist and the mothers and infants are left hanging. Sustainability issues within the PMTCT program are still a challenge. Throughout the country, implementation of the program and therefore delivery of services is more project-based and has not been integrated adequately into the minimum health care package or the reproductive health services.

Sexually Transmitted Infection (STI) treatment:

Sexually transmitted infections are very high and yet health care seeking behavior for STIs is still low among Ugandans. Moreover, many of the STIs are asymptomatic especially among women. Secondly, cases of stock-out of STI drugs at lower level health units have been reported as more apparent in recent years. The key challenge is to adopt an effective strategy for the treatment and control of STIs especially those causing genital ulceration such as herpes simplex virus type.

National Response to HIV/AIDS in Uganda

Apart from the dramatic decline in HIV prevalence between 1992 and 2002, one of the reasons why Uganda has been cited as one of the world's most compelling national success stories is the nature of its response. Between 1989 and 2002, the hallmark of Uganda's HIV control efforts was prevention intervention to curb the further spread of HIV supplemented by care and support for those infected and affected. HIV prevention in the late 1980s and early 90s was a politically driven agenda that compelled patriotic responsibility at individual, community, organizational and leadership levels. There was political involvement from all levels of society and political, religious and civic leaders used every opportunity to deliver HIV prevention messages to the community. Furthermore, HIV/AIDS related national policies and strategies were systematically translated into actions at sector and decentralized levels through a multiplicity of actors that ensured universal coverage especially with targeted information and education services utilizing local resources supplemented by external funding. This targeted multi-sectoral approach seems to have contributed immensely to the dramatic decline in HIV prevalence rates.

This vigilance however appears to have waned towards the end of the century with a shift away from the more personal methods of communication opting for both electronic and print media to disseminate

prevention messages. Unfortunately, it is apparent that this waning of prevention efforts at individual, programme and organizational levels is coinciding with a period of stabilization and threatened increase in HIV prevalence rates in the wake of changing environments. One key aspect of the changing environment is the availability of ARVs which some believe may have contributed to some complacency as regards the prevention response. Prior to 2003, HIV treatment using ARVs was deemed economically unfeasible and unsustainable. This was due to the high costs of the drugs required for treatment using HAART. With time, dramatic price reductions in the cost of ARVs, combined with multiple treatment access initiatives through MAP, PEPFAR and Global Fund, have made HIV treatment in Uganda a possibility. In June 2004 the Ministry of Health launched an integrated program for Universal Access to Free Antiretroviral Treatment in Uganda and to date over 75,000 patients are on ARVs. It is therefore crucial that the country learns from past experiences and the dynamics of the epidemic to revive the prevention response.

Partnering for Success

The President's Emergency Plan for AIDS Relief (PEPFAR)

The emergency Plan aims to support treatment for at least two million people living with HIV/AIDS, prevent seven million new infections, and support care for 10 million people infected with and affected by HIV, including orphans and vulnerable children. The emergency plan works in over 120 countries around the world with special emphasis on 15 countries in Africa, Asia and the Caribbean. These countries which are home to approximately 50 percent of HIV infections world wide- are Botswana, Cote divoire Ethiopia, Guyana, Haiti, Kenya, Mozambique, Namibia, Nigeria, Rwanda, South Africa, Tanzania, Uganda, Vietnam and Zambia.

PEPFAR is currently the largest funding programme in Uganda. It covers various interventions in all the major thematic areas of prevention, treatment and care and support. It focuses on families and communities, where changes in behavior take place and are supported. It has supported many programmes in the various sectors including the PIASCY programme under the Ministry of Education. PEPFAR activities are hinged on agreed country planning frameworks and aligned to national priorities. For more information visit

USAID's Office of HIV/AIDS

The Office of HIV/AIDS at the U.S. Agency for International Development (USAID) is the focus of HIV/AIDS technical leadership for the Agency and has primary responsibility for leading the Agency's efforts within President George W. Bush's Emergency Plan for AIDS Relief (PEPFAR). The Emergency Plan — a \$15 billion multifaceted approach to combating the disease in more than 120 countries around the world — is the largest commitment ever by any nation for an international health initiative dedicated to a single disease. In cooperation with the U.S. Department of State's Office of the U.S. Global AIDS Coordinator, other U.S. Government partners, international organizations, and nongovernmental organizations, USAID provides global technical leadership on the full range of issues related to HIV/AIDS prevention, care, and treatment; manages numerous research and field support programs; and monitors the impact of the Agency's HIV/AIDS programs.

USAID Support of the Emergency Plan

USAID support of Emergency Plan HIV/AIDS programs extends to nearly 100 countries through a combination of direct in-country presence and a variety of regional programs. As an international development agency, USAID has focused for many years on strengthening primary health care systems to prevent and more recently treat a number of communicable diseases, including HIV/AIDS. Under the Emergency Plan, USAID's staff of foreign service officers, trained physicians, epidemiologists, and public health advisors works with governments, nongovernmental organizations, and the private sector to provide training, technical assistance, and supplies — including pharmaceuticals — to prevent and reduce the transmission of HIV/AIDS and provide care and treatment to people living with HIV/AIDS. As the HIV/AIDS epidemic in most countries outside of the Emergency Plan's 15 focus countries is still limited to high-risk groups, USAID focuses considerable resources on reducing high-risk behaviors in high-risk groups and the general population.

USAID is uniquely positioned to support multi-sectoral responses to HIV/AIDS that address the widespread impact of HIV/AIDS outside the health sector in high-prevalence countries. In these countries, USAID is supporting programs in areas such as agriculture, education, democracy, and trade that link to HIV/AIDS and mutually support the objective of reducing the impact of the pandemic on nations, communities, families, and individuals.

Under the Emergency Plan, USAID also supports a number of international partnerships; provides staff support to the Global Fund to Fight AIDS, Tuberculosis and Malaria; and works with local coordinating committees of the Global Fund to improve implementation of the Fund programs and their complement to U.S. Government programs. Finally, USAID supports targeted research, development, and dissemination of new technologies, and packaging and distribution mechanisms for antiretroviral drugs.

Conclusion

Uganda has made a considerable dent in the progress of the epidemic. However, compared to the magnitude of the epidemic, this can only be regarded as modest progress not 'success'. There is therefore no room for complacency. There are still more gaps. AIDS must be a priority in all social and economic development efforts. Substantial progress can only be achieved through expanding intervention and service coverage to all corners of the country by bringing all potential sectors and actors on board to fight the epidemic.