

Mechai says, “Humor has kept the issue alive. And in areas where there is possible embarrassment, it has helped tremendously.”

The way these and other lessons are adopted and adapted within the East Asian region will determine the future of the epidemic and the social and economic landscape of Asian society. As Jemal ud-din Kassum, the regional vice president for the East Asia and Pacific Region at the World Bank, says: “Political leaders and the public have to acknowledge that it’s a problem. Then they have to move swiftly and deeply on prevention for all risk groups, build capacity, and address health system issues. They also need to prepare for treatment and support. And in doing all of this, we need to continue to keep the focus on achieving results.”

Uganda: Scaling up HIV/AIDS Prevention

Uganda’s early enthusiasm to combat the HIV/AIDS menace was occasioned by the threat it posed to the NRM government through its impact on the army. As early as 1986 Uganda was sending troops to Cuba for training, and 40 percent would be returned for being HIV positive. (Interview with Maj. Rubaramira Ruranga, National Coordinator of the National Guidance and Empowerment Network of People Living with HIV/AIDS, also chair to the 11th International Conference of People Living with HIV/AIDS, October 19, 2003.) Cuba’s President Fidel Castro called Museveni and told him, “You have a problem. Your army is going to be wiped out, not by the bullets of the enemy, but by HIV.” (Discussion with President Museveni, State House Nakasero, December 31, 1999.) The NRM realized that an intensive countrywide campaign against the pandemic was critical. The cabinet resolved as early as 1987 that whenever government officials address any function, they should take time to “advise” people on the virtues of abstinence, safe sex, and faithfulness to one partner.

The Ministry of Health established the AIDS Control Program to combat the malady. But Museveni felt this was not enough and in 1990 established the Uganda AIDS Commission in president’s office to coordinate the fight against AIDS. The government also created the Joint Clinical Research Center as an arm of the army to spearhead research into finding a cure for HIV/AIDS. But realizing that the military did not have the adequate facilities and personnel to manage the research, a partnership was formed with the Ministry of Health.

An extensive public sensitization campaign, using print and electronic media and billboards, broke the taboo of openly talking about sex. The campaign opened doors for parents and teachers to teach about safe sex, abstinence, and faithfulness to students and children. It also allowed condoms to be freely distributed in schools, advertised in the media, and widely sold in shops. Indeed, Uganda’s approach of openness to the AIDS/HIV pandemic and massive public awareness campaigns has paid off handsomely—the HIV prevalence rate declined from 30 percent in 1986 to 6 percent in 2002. The approach is a model for other countries and development partners in designing initiatives to address the problem, such as the World Bank’s multicountry AIDS program.

Uganda: Conquering “Slim”—Uganda’s War on HIV/AIDS *World Bank Development Dialogue on Values and Ethics*

From Bwindi Forest and its fabled gorillas, to the Bujagali Falls, to Jinja, the source of the Nile on Lake Victoria, Uganda is a country of exceptional physical beauty, the “Pearl of Africa.” Immediately following independence in 1962, its prospects looked bright. For nearly a decade, Uganda witnessed a rapidly expanding economy, comparable to some in Southeast Asia. However,

following this initial period of hope, profound internal strife and turmoil marked much of the period through the mid-1980's. The period 1971–86 was marked by constitutional crisis, economic collapse, and civil war. During this time, it is estimated that more than one million Ugandans were killed.

Midway through these difficulties, silently, at first at least, the worst scourge to attack the 20th century was quietly assaulting Uganda's population. In 1982, Uganda was the first African nation to identify HIV/AIDS within its borders and would become one of the worst-hit countries on the African continent.

The first cases of HIV in Uganda were confirmed in Rakai District in the fishing village of Kasensero on the shores of Lake Victoria in 1982. The first to be infected were fishermen and traders, many alleged to be smugglers, who were trafficking goods between Uganda and Tanzania. The disease, popularly known as "Slim" because of its emaciating effect on its victims, appeared at a time when there was a paucity of scientific knowledge about the disease in Africa. Its early symptoms were general malaise and sporadic fever, followed several months later by diarrhea, weight loss and skin rash and discoloration, frequently accompanied by sexually transmitted diseases and tuberculosis. Most commonly, the source of "Slim" was thought to be witchcraft and ancestor revenge. Many of the afflicted came from the more affluent traders, promoting the notion that the disease was a curse from God, retribution for past illicit business practices. Most commonly, early treatment was sought from traditional healers and herbalists, many of whom encouraged the belief in witchcraft as the source. As its true cause came to be known, as was the case in other countries, HIV/AIDS became shrouded in a haze of stigma, shame, and discrimination, associated with promiscuous sexual behavior, homosexuality, drug use, and, still, witchcraft.

Today, Uganda is regarded as one of the few success stories in Africa's effort to combat HIV/AIDS. The country has reversed the rising tide of AIDS, where many of its neighbors have failed. What accounts for its success? Among the facets of Uganda's national strategy to combat HIV/AIDS—social, political, and economic—the role of faith leaders and faith-based organizations, Christian and Muslim, stands out as critical in every aspect of Uganda's HIV/AIDS programs. Despite success, challenges, present and future, confront the country as it attempts to consolidate past success and reduce HIV incidence even further.

After the first cases were identified in 1982, HIV/AIDS rapidly developed into an epidemic in Uganda. A national sero-survey undertaken in 1987–88 suggested a national infection rate of 6–8 percent. This increased rapidly until 1992, when national prevalence (based on sentinel surveillance sites) peaked at just over 20 percent. Since then, the rate has declined steadily. By 2002, the estimated national prevalence was estimated at about 6 percent.

In January 1986, Yoweri Museveni became president of a country emerging from two decades of the ravages of civil war, state-sponsored terrorism, an economy in tatters, social services devastated, and the confidence of its people at low ebb. Among the challenges facing the new government, HIV/AIDS could easily have been ignored or at least postponed. Instead, Museveni appointed an AIDS Surveillance Sub-Committee and openly disclosed his anxiety to the people and the press. In 1986, the National Commission for the Prevention of AIDS was established and, in October of the same year, in collaboration with the World Health Organization, the AIDS Control Program (ACP) was launched. The ACP met weekly under the chairmanship of President Museveni. ACP organized an extensive program of seminars and training, introduced AIDS education into school curricula from late primary onwards, and encouraged political leaders from the President on down to become active advocates.

This program, situated in the Ministry of Health was presented to a donor's conference in May 1987 held in Kampala where seven major objectives were identified: health education, blood

screening, rehabilitating blood transfusion facilities and services, surveillance and data collection, distribution of condoms, research and patient care. The stress on AIDS education, with its attendant plea for open public discussion won special praise, as the best response to the epidemic. The program was recognized internationally as a model for other countries, not only in Africa but as far away as Thailand.

The foundations of Uganda's national strategy to combat HIV/AIDS are many and multifaceted. They include strong political commitment led forcefully by President Museveni; massive mobilization and education efforts that contributed to public debates; openness about the problem and active efforts to mitigate stigma within society; an extraordinary range of partnerships with special outreach to all of Uganda's main faith communities; and a conception of the disease that almost from the beginning diagnosed it as a threat to development and not just a health problem. The interrelations among the elements of Uganda's program are complex and dynamic.

The "ABC" prevention model pioneered in Uganda—**A**bstinence, **B**e faithful, use a **C**ondom—is considered the cornerstone of its success. How precisely these components have combined, and what have been their individual relative contributions, has been the subject of much debate and analysis. However, two points are especially worthy of note. First, prevalence rates began to fall in the early to mid-1990's, implying that incidence rates had begun to decline several years earlier, perhaps even in the late 1980s. Second, while knowledge about condoms and distribution of condoms has increased since 1991, the use of condoms has remained relatively low, suggesting that the messages of abstinence and faithfulness targeted toward high-risk groups early in the campaign played a pivotal role.

The Ugandan government authorities, in formulating and implementing their policy, reached out to a wide spectrum of partners, and did so in a particularly nonconfrontational way. Every player—government, private sector, civil society, and faith communities—was encouraged to join the fight against HIV/AIDS, to contribute in a manner consistent with their basic values and beliefs, and to exploit their respective comparative advantages. Great care was taken to guard against pitting the moral precepts of one group against another, particularly with respect to the faith communities and their views on condoms. Every constituency was given space, but in a nonthreatening way that gradually allowed the consolidation of consensus.

Uganda's success in combating HIV/AIDS is the result of the cascading effect of multiple interventions. This series of activities, appropriately sequenced and gradually scaled up, was built on a foundation of strong political commitment, openness to civil society (with a special outreach to faith communities), and complementary measures beyond ABC, such as networking and support groups for people living with AIDS, blood screening, voluntary counseling (at least in urban areas), and training.

The role of faith leaders and faith-based organizations merits special mention. Early in the campaign, a special appeal went out to all church leaders to help in the struggle against AIDS. One early role which was especially important was health service provision. Years of civil conflict had left state provided health services in a largely dilapidated state. Christian mission health networks had continued to function throughout the period of conflict and in many areas were the only source of health clinics and hospitals. While there existed no formal relationship between the Ministry of Health and these faith based health services (there was no requirement in the 1980's for nongovernmental providers to formally be registered) there was generally good cooperation and exchanges between the two services. Government doctors in fact were often posted to mission hospitals. Mission hospitals were quick to join the ranks of the front line attack on HIV/AIDS, taking up a major responsibility for care of people living with AIDS.

Faith-based organizations did not assume an isolated role, but were intimately involved in all aspects of HIV/AIDS interventions. Partnerships with faith-based organizations have permeated virtually every aspect of Uganda's HIV/AIDS program from its inception. Many of Uganda's key organizations—TASO, AID, UNASO—while not directly faith-based themselves, have had longstanding and deeply rooted partnerships with faith-based organizations, Ugandan and international. The Uganda AIDS Commission has estimated that about half of the approximately 2,000 nongovernmental groups engaged in HIV/AIDS initiatives are faith-based—spanning the range of education, prevention, counseling, care and treatment.

While most faith communities were opposed in principle to the use of condoms, few openly opposed the government's distribution programs. The churches and mosques did not allow their initial reticence with respect to condoms to hinder their active contribution to the overall program. In parallel, the government was sensitive to the concerns of the faiths concerning condoms and avoided overly aggressive promotion. Thus the religious communities generally focused on the need to change behavior and the underlying values involved, while the government (and other nongovernmental groups) promoted the use of condoms as a part of their programs.

Thus, each and every element of the overall program and a wide spectrum of stakeholders have been vital in Uganda's success in reversing HIV/AIDS trends. Their strength is in their combination: none would have been sufficient on its own to yield such favorable outcomes. What stands out in the Uganda story is the respect for different views, the flexibility of the partners in addressing the issue, the adaptation of messages and programs continuously over time, and the early and continuing forthrightness in addressing the range of issues raised by HIV/AIDS. It is a rare case of such dynamic partnership linking the very senior tiers of leadership with the communities of those affected, their families, men and women, young and old.

Despite widely acknowledged success, Uganda still faces a huge challenge in reducing HIV/AIDS prevalence. In Kampala, the estimated rate is still about 8 percent. For Uganda as a whole, this is still the leading cause of death among its most productive age groups, those 15-49.

Prevention vs. treatment

Many policy makers and service providers have recognized that past efforts in Uganda's program have concentrated heavily on prevention. Among the more prominent challenges will be antiretroviral drug treatment. Along with Cote d'Ivoire, Uganda was the first country to pilot test ARVs in Africa. Costs have plummeted, generics have become more available, and there are substantially increased resources available. The challenge for Uganda's health system will be to build capacity to deliver treatment, including training of staff, assurance of quality control, reinforcement of distribution systems, and appropriate storage facilities. It is estimated that about 18,000 people are receiving ARV treatment at present. The "3 X 5" target is 60,000 which many see as feasible. Faith-based groups seen by many as likely key players in the expansion of ARV treatment since they are regarded as having sound logistics and accountability and they are able to reach the poor better. Some programs already have established community adherence teams to monitor patients on treatment.

The challenge of coordination

With Uganda's success has come an ever increasing number of agents and organizations anxious to become engaged. Several observers point to a particular need for improved coordination especially at the district and subdistrict levels between the local government authorities and health services and the whole gamut of nongovernmental partners, especially the multitude of faith based organizations, with respect both to an equitable distribution of services and in terms of medical standards and protocols. This will be particularly important with increased access to ARVs.

Stigma

Stigma continues to be a significant challenge. While the degree of openness which Uganda has fostered has no doubt been a major factor in its success in combating HIV/AIDS, stigma persists, posing high economic and social costs to many HIV+ people. Women are especially vulnerable to stigma, both within the family and within the workplace. Women continue to risk being thrown out of the house and separated from their children by their husbands if they reveal HIV+ status. Faith communities have a special role to play in continuing to broaden and deepen their efforts to combat stigma, discrimination, and exclusion. Income-generating projects, especially for women are an additional avenue to provide empowerment and independence.

Funding

While there is and will be significant incremental resources from multiple sources available, especially for treatment, at the national level, at the level of individual grassroots, community-based projects, inadequate funding poses a significant constraint to efforts to expand and scale up the scope of their activities. Ironically, a number of projects reported that the process of decentralization was compounding this situation, since funding processes, and in some cases accountability procedures, were particularly weak between central, district, and subdistrict levels.