

Success in Uganda:

A Review of Programmatic
Approaches to AIDS
Prevention and Their Impact
1986 - 1995



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Introduction

Uganda is widely considered to be one of the world's earliest and greatest success stories in subduing a generalized HIV epidemic.^{1,2} The first AIDS cases were identified in Uganda in 1982 among fishermen and traders in a rural district on the shores of Lake Victoria.³ The number of HIV infections increased rapidly throughout the country and by 1988, Uganda had the highest rate of HIV infection in Africa. By 1992, HIV prevalence in major urban areas was as high as 30% among women receiving antenatal care (ANC) at sentinel surveillance sites.¹ Beginning in 1993, there was a rather consistent decline in HIV prevalence among these antenatal women in urban sites and by 2001, prevalence had declined by more than half in both urban and rural areas. According to the Uganda AIDS Commission (UAC), estimates of national prevalence in Uganda fell from 18% in 1992 to 6% in 2002.⁴ No other country has experienced such high rates of HIV infection followed by such large declines.

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Although contaminated blood, improperly cleaned needles, unclean knives used during circumcision ceremonies and other factors contributed to HIV transmission, HIV was transmitted primarily through unprotected sexual intercourse and reductions in sexual risk behaviors were the most important factors producing the large decrease in HIV incidence.⁵

Beginning about 1987, people in Uganda began restricting their sexual behavior outside of marriage or cohabiting relationships.⁶ All women and men, regardless of marital status, became less likely to have sex outside of marital or cohabiting relationships and became less likely to have one or more casual sexual relationships.⁷ Married women maintained low levels of extramarital sex, while married men became less likely to have extramarital sex. Both single men and single women became less likely to have sex during the past year and less likely to have sex with multiple sexual partners. Also important, both women and men became more likely to use condoms, especially with non-marital/non-cohabiting partners. This was particularly true in urban areas and among those who were most at risk. These changes in behavior — **A**bstaining from sex, **B**eing faithful to long-term partners, and using **C**ondoms — later became known as “**ABC**.”

Given Uganda's success in changing sexual behavior, it is important to understand the policies, interventions and other environmental and individual factors that led to these changes in sexual behavior. That is the focus of this report.

This report is one of a family of reports based on a study of the success in Uganda. All are available at www.etr.org/uganda. The other reports include:

- 1) a three-page summary of the campaign to reduce HIV transmission in Uganda and its success,⁸
- 2) a more in-depth summary of the major findings that have policy implications for other countries with generalized epidemics,⁹

- 3) an analysis of the evidence for behavior change,¹⁰
- 4) this analysis of Uganda's HIV prevention efforts and other factors that affected perceptions of HIV risk and helped to change sexual behavior, and
- 5) a detailed historical summary of events in Uganda that undoubtedly affected the epidemic.¹¹

Methods Used in This Study

The entire study analyzed eight different types of evidence, including:

- 1) models of HIV prevalence and incidence in Kampala and other sentinel sites in Uganda,
- 2) reports of behavior change in the primary newspaper in Uganda,
- 3) surveys with questions about perceptions of personal behavior change,
- 4) large demographic and health surveys (DHS) collected in 1988/9 and 1995 and large Global Program on AIDS (GPA) surveys in 1989 and 1995 with questions about reported sexual behavior,
- 5) smaller, less representative surveys of reported sexual behavior collected in other years,
- 6) interviews with key informants and focus groups,
- 7) reports of numbers of condoms shipped to Uganda, and
- 8) historical documents describing the implementation of HIV prevention programs in Uganda.

Perhaps the most important sources of evidence for this particular report were the numerous documents from the Uganda AIDS programs and from the investigators conducting research in Uganda. These sources described the development of Uganda's AIDS programs; surveys of knowledge, attitudes and behaviors; and other topics related to AIDS in Uganda. Newspaper articles supplemented these reports and provided detailed accounts of the development of different aspects of Uganda's approach.

Also important were the more than 60 key informant interviews and focus group discussions conducted in Uganda in 2003. These were conducted in urban and rural areas and in different parts of the country. Because of the study's interest in the late 1980s and early 1990s, those who were interviewed who were at least teenagers in the early 1980s and thus were at least in their forties when interviewed.

During these interviews, an historical approach was used in which respondents were asked to remember events, possible behavior change, and other changes during three time periods: 1) before President Museveni came to power (roughly when many people first learned that many people were dying from AIDS and that HIV was a sexually transmitted

disease), 2) after Museveni came to power, but before condoms became readily available, and 3) after condoms were readily available.

What was the impetus for programmatic efforts?

While it is obvious that high rates of HIV infection and AIDS deaths motivated the programmatic efforts to reduce those rates, the magnitude of the problem should be fully recognized. As early as 1986, President Museveni learned that 60 soldiers who happened to go to Cuba for training were tested there for HIV; 18 (or 30%) tested positive. Thus, AIDS threatened the Ugandan military.¹² In the following years, very large numbers of people became sick and died of AIDS. In 1990, it was estimated that more than one million people were infected with HIV in Uganda and that more than 12,000 people already had died of AIDS.^{13 14} By 1995, the UAC reported that about 1.5 million people, or 7.7% of the population, were infected with HIV¹⁵ and about 100,000 people were dying each year.¹⁶ In 1996, it was estimated that nearly 500,000 people had died of AIDS.¹⁷ In sum, during the late 1980s and early 1990s, the number of people who were sick with AIDS or died of AIDS in Uganda appeared to be growing exponentially and large majorities of people quickly knew someone in their own families or in other families who had died of AIDS.

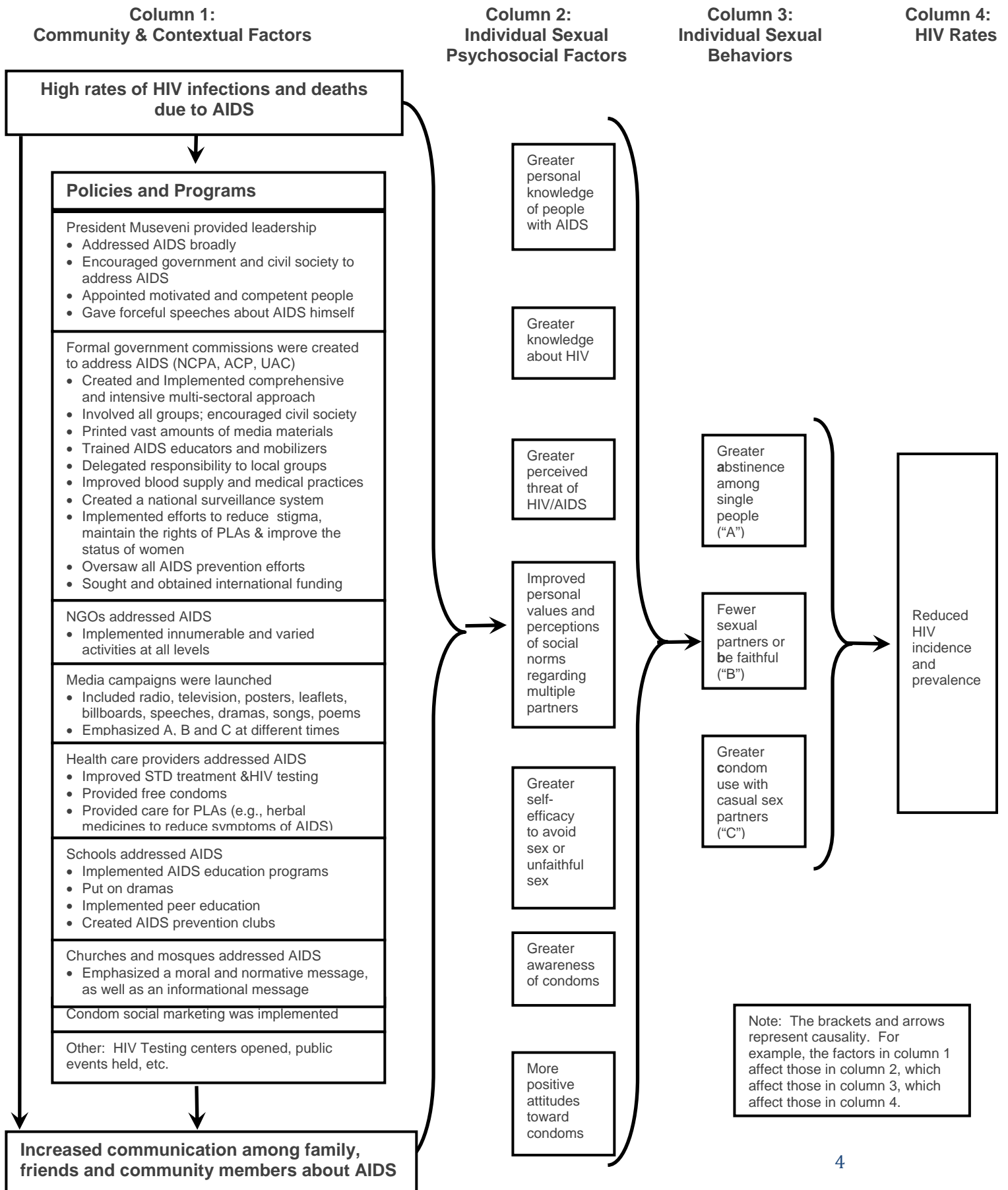
Consequently, many people felt vulnerable. In Kampala and other communities there was great concern, sometimes even panic. As a result, the country mobilized.

Acronyms	
ACP	AIDS Control Program
AIC	AIDS Information Centers
AIDS	Auto-immune deficiency syndrome
ANC	Antenatal Care
CHUSA	Church Human Services AIDS Prevention Program
CMS	Commercial Marketing Strategies
DHS	Demographic and Health Surveys
DISH	Delivery of Improved Services for Health
EEC	European Economic Community
GPA	Global Program on AIDS
HIV	Human Immunodeficiency Virus
ICASA	International Conference on AIDS and Sexually Transmitted Diseases
MOH	Ministry of Health
NGOs	Non-governmental organizations
NOP	National Operational Plan
NRA	National Resistance Army
PLAs	People living with AIDS
PWAs	People with AIDS
RC	Resistance Committee
SOMARC	Social Marketing for Change
STD	Sexually transmitted disease
TASO	The AIDS Service Organization
THETA	Traditional & Modern Health Care Providers Together Against AIDS
UAC	Uganda AIDS Commission
UNDP	United Nations Development Program
UNICEF	United Nations Children's Fund
UNLA	Uganda National Liberation Army (UNLA)
USAID	United States Agency for International Development
WHO	World Health Organization

What was the overall approach used to change sexual behavior and prevent HIV/AIDS in Uganda?

The leaders concerned about AIDS in Uganda relied on a public health approach to reduce it. That approach is summarized in Figure 1.

Figure 1:
A Causal Model Identifying Important Factors That Led to Changes in Sexual Behavior and Reduced HIV Incidence and Prevalence



Once they learned that HIV was being transmitted primarily sexually in Uganda, they identified three sexual behaviors — A (abstain), B (be faithful) and C (use condoms) — that they believed should be followed to prevent HIV transmission (Columns 3 and 4 in Figure 1). Second, after identifying these behaviors, they identified a variety of sexual psychosocial factors that affected these three sexual behaviors. These included factors such as personal knowledge of someone with AIDS, knowledge about HIV and its transmission, perceived threat of HIV/AIDS, self-efficacy to avoid sex, stronger social norms consistent with being faithful and avoiding sexual risk, greater awareness of condoms and more positive attitudes towards condoms (Column 2 in Figure 1). People and organizations involved with AIDS prevention then designed and implemented a wide variety of interventions (Column 1) that would increase communication about HIV/AIDS within communities, with friends and within families and would change these sexual psychosocial factors in Column 2. These interventions were implemented by numerous groups in a broad, comprehensive, multi-sectoral approach.

President Yoweri Museveni addressed AIDS personally and explicitly. He strongly encouraged government and civil society to tackle AIDS. He appointed motivated and competent people to prevent the spread of AIDS and he delegated authority to them.



In reality, different people implemented somewhat different approaches and gave different emphases to different factors. For example, some people and institutions placed more emphasis on abstaining or being faithful while others later put more emphasis on using condoms; some put more emphasis on knowledge and perceptions of risk, while others put more emphasis on getting people to talk about HIV/AIDS, changing norms and attitudes about condoms, or reducing stigma associated with being HIV-positive. Moreover, the models that people had in their minds typically were not as comprehensive, concrete or specific as the one presented in Figure 1. Nevertheless, Figure 1 does incorporate and reflect many of the important concepts in their combined thinking, as well as the causal relationships among those concepts.

What AIDS prevention programs and policies were implemented to change the sexual psychosocial factors that, in turn, changed behavior?

Uganda's mobilization against AIDS was truly comprehensive. Multiple groups implemented different AIDS prevention policies and programs, which contributed to people's awareness of and communication about AIDS. The specific policies, programs and messages are summarized below, organized by sector or actor.

Presidential Leadership

President Yoweri Museveni addressed AIDS personally and explicitly. He strongly encouraged government and civil society to tackle AIDS. He appointed motivated and competent people to prevent the spread of AIDS and he delegated authority to them.

In addition, he himself spoke forcefully about AIDS to the public. In speeches to communities, schools and other groups, he gave impassioned pleas for people to change their behavior and used stories to give clear behavioral messages that people could understand and remember. For example, he emphasized to his soldiers that they had been victorious in the war and he did not want them to then die of AIDS. He told stories of people sticking their fingers in ant holes and being occasionally bitten by snakes in the ant holes, or of hyenas that successfully resisted temptation — concluding that if hyenas could resist temptation, then they (the people) could also do so.¹⁸

Government Activities

In response to the problem of AIDS and with President Museveni's encouragement, the government initiated many efforts to stop AIDS. These evolved into a multi-sectoral approach to fight AIDS with planned activities incorporated into nearly every branch of government.

In 1986, the 30-person National Committee for the Prevention of AIDS was formed. The following year, the AIDS Control Program (ACP) began operations. In 1988 and 1989, with the help of the World Health Organization (WHO), Uganda developed an excellent plan to change sexual behavior and reduce HIV transmission and began implementing it in 1989.

The efforts delineated in the plan were very systematic. They involved every sector and nearly every group with an infrastructure (e.g., district health teams, the media, schools, faith communities, local councils, youth organizations, women's groups, non-governmental organizations (NGOs), prisons, and other groups). They also involved groups without an infrastructure, such as traditional healers. The ACP created a training structure, including trainers and trainers of trainers, so that all groups would be trained. It also began printing huge number of materials (e.g., training manuals, pamphlets, posters and other educational materials).¹⁹

In 1991 and 1992, the Uganda AIDS Commission (UAC) was created. The ACP and UAC focused on the community, emphasizing that AIDS prevention should not be the sole responsibility of the government or a few organizations, but instead needed to be the responsibility of neighborhood support systems, schools, religious associations, professional groups, family networks and other community groups. This became the multi-sectoral approach emphasized by both the ACP and UAC.

In addition, the government sought and obtained the involvement of international organizations and funding from international donors. The involvement of international organizations provided funding, enhanced the scientific basis for work on AIDS in Uganda, provided commodities (e.g., blood tests, surgical gloves, syringes and condoms) and increased the variety of approaches to addressing AIDS.

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To help women resist unwanted sex or to avoid being forced to have sex for economic reasons, the government also tried to empower women. In particular, it passed legislation mandating that one-third of the members of Parliament be women. President Museveni appointed women to key cabinet offices. The government legislated and partially provided universal education, enacted affirmative action for women for higher education, and passed strict laws against sex with minors.

Finally, the government tried to reduce stigma and discrimination against people living with AIDS. It continually encouraged people to recognize the rights of people with HIV and to avoid discrimination in the workplace and elsewhere. This effort reflected ethical concerns about fellow citizens and a desire to reduce stigma, allow and encourage HIV-positive individuals to acknowledge their infection, and thereby to reduce denial of the problem and increase the public's awareness of individual risk.

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Local Councils (LCs)

Although multiple national campaigns were implemented to reach people across the country, sometimes these campaigns could not reach everyone, especially people in rural areas. Accordingly, the government used the local council (LC) system both to inform people and to assure that prevention programs were implemented in communities. The local council system is a hierarchical administrative structure spreading from the district to the village. The ACP trained people at the district and sometimes the sub-county levels, who in turn trained their counterparts at lower levels. In addition to training materials, LC committees were given information leaflets, condoms and, in some cases, HIV testing services.

Non-governmental Organizations (NGOs)

By 1993, more than 600 NGOs were registered to address AIDS in Uganda and *New Vision* (the primary English newspaper in Uganda) estimated that roughly 400 additional unregistered NGOs also addressed AIDS.

First the ACP and then the ACP and UAC together strongly encouraged and facilitated the creation of innumerable other groups outside of government to develop and implement their own approaches to stopping AIDS, even if they had different beliefs and different strategies. They made registration easy and gave the NGOs a considerable amount of freedom.¹ As a result, beginning in the late 1980s and throughout the 1990s, there was an exponential growth of organizations, including NGOs and others addressing AIDS in Uganda. Whereas there were few, if any, organizations addressing AIDS in 1986, by 1993, more than 600 NGOs were registered to address AIDS in Uganda and *The New Vision*

(the primary English newspaper in Uganda) estimated that roughly 400 additional unregistered NGOs also addressed AIDS.²⁰

Some of these NGOs were existing organizations in Uganda that chose to begin addressing AIDS; others were new. Some were indigenous; others were international.

NGOs conducted their efforts throughout Uganda. One measure of the dispersion of their efforts was the total number of organizations addressing AIDS in each of Uganda's 38 districts in 1991. Kampala, having by far the largest population, had the greatest number of agencies (66). However, all 38 districts had at least 15 different agencies addressing AIDS by 1991.

These NGOs implemented a very wide variety of activities to educate people about HIV and AIDS, increase their awareness of the risks of unsafe sex and support those with AIDS.

Although most focused on AIDS prevention, some focused on helping those with AIDS. For example, the AIDS Support Organization (TASO) grew rapidly and provided counseling, material support and therapeutic herbs and drugs to people who were HIV-positive or living with AIDS. It encouraged people to openly acknowledge that they were HIV-positive and to speak out about AIDS.

Media

Uganda implemented mass information and education campaigns in the media. As a result, the mass media were one of the two most commonly cited sources of information about AIDS in Uganda.

Initially, Uganda had only one radio station as well as one television station, which only broadcasted in Kampala. However, over time, both the number of radio and television stations and the number of people with access to radios and televisions greatly increased.

One of the earliest and most remembered elements in the campaign was a somber drumbeat heard on the radio many times every day, signifying the country was in crisis and emphasizing the severity of the epidemic.

In 1989, Philly Lutaaya, a very popular Ugandan musician, made an announcement at Makerere University that he had AIDS. More than 10,000 students and workers attended the event. Many were stunned. Throughout 1988-89, after his announcement, Lutaaya talked about AIDS in concerts, in records, on radio and television, and in film. He emphasized, "Today it is me; tomorrow it could be you."

Although these were among the more memorable elements in the media at that time, the media carried frequent news stories about HIV/AIDS that informed people and continually reemphasized the "ABC" message. Over time, these messages became more sophisticated and were portrayed through music, plays and television miniseries. The plays commonly

Alone by Philly Lutaaya

Today it's me
Tomorrow someone else
It's you and me
We've got to stand up and fight
We'll take a light in the fight against AIDS
Let's come on out
Let's stand together, fight AIDS
In times of joy, in times of sorrow
Let's take a stand and fight on to the end
With open hearts, let's stand up and
speak out to the world
We'll save some lives,
save the children of the world.



depicted people engaging in sexual risk behaviors, becoming infected, and sometimes infecting loved ones. They also modeled people being tempted to engage in sexual risk behaviors and then effectively resisting those temptations. Many of the plays and miniseries were designed to capture audiences' interests and to get them to personalize the AIDS messages. Sometimes, a short televised drama was followed by a discussion among a cross-section of people. These were very real and engrossing, allowing multiple views to be aired.²¹

However, because of limited access to radios and televisions in the early years, the media campaign also relied on many posters, billboards signs, plays and music performances about AIDS. Competitions were held in which the public competed for prizes by writing poems, songs, or plays about AIDS.

An important characteristic of these messages and plays is that they were not delivered only in English; rather, they were presented in multiple indigenous languages.

An important characteristic of these messages and plays is that they were not delivered only in English; rather, they were presented in multiple indigenous languages. This greatly helped spread information about AIDS.

Perhaps one of the largest and most well-known projects was "*Straight Talk*," a print, radio and television media campaign launched in 1993 by the Ministry of Information. In the largest English-language newspaper, *The New Vision*, it was a four-page insert that appeared monthly. In subsequent years, copies of *Straight Talk* were mailed to every secondary school in Uganda. *Straight Talk* was written for parents and teachers, as well as for youth. It included very explicit discussions of questions and issues facing youth about body changes, friendships, relationships, love and sex. One of its successful approaches for reaching youth was to include letters from young readers or listeners. These letters clearly tapped the concerns of young people and motivated young people to listen to or read *Straight Talk*. *Straight Talk* emphasized that abstinence was the safest approach, but that youth should use condoms if they had sex.²²

In general, the media campaigns emphasized vulnerability and prevention of HIV transmission. They included messages both to the general public and to more vulnerable, high-risk groups. First the messages focused primarily on being faithful and abstaining, but after condom promotion began, they focused much more on condoms.

These mass media campaigns are sometimes credited with greatly increasing people's general awareness of AIDS, as well as increasing their communication about both sex and HIV/AIDS.

Health Care Providers

Uganda's health infrastructure had greatly deteriorated during the 20 years of turmoil, so Uganda's leaders made multiple efforts to rebuild it after the conflict ended. In addition, the government sought to strengthen its family planning services, prevent and treat STD, and address AIDS specifically. All of these efforts positively affected AIDS prevention.

Upon learning that HIV could be transmitted by blood and that their blood supply was contaminated by HIV, hospitals and clinics began testing blood and thereby improved the

safety of the blood supply. They also began to improve clinic conditions more generally through proper sterilization of needles and medical instruments, use of sterile gloves and improvements in other clinic procedures.

During the early 1990s, the number of family planning clinics increased. The clinics improved their family planning services and increasing numbers of people attended them. Clinics provided condoms to people free of charge. Although these were initially provided for family planning and not to prevent AIDS, the clinics nevertheless remained a source of condoms and information about condoms.

Health care providers were central to the provision of information about AIDS, its prevention and treatment.

Health clinics also improved their testing and treatment of sexually transmitted disease, and some of them launched education campaigns to prevent STD transmission.

Perhaps most important, health care providers were central to the provision of information about AIDS, its prevention and treatment. Both formal health care providers and traditional healers such as herbalists, midwives and bonesetters provided information about AIDS and also herbal medicines to alleviate the symptoms of AIDS.

Schools

In 1987, with the support of the Swedish AID Society (SIDA), Danish AID (DANIDA) and UNICEF, Uganda's School Health Education Program (SHEP) began to emphasize the risk of AIDS and methods of avoiding it. The program's goal was to reach youth before they became sexually active. While the emphasis was on delaying the initiation of sex, condoms also were promoted. In addition to didactic material, students were actively involved, summarizing material, drawing posters, telling stories, putting on plays, singing songs, presenting puppet shows and engaging in other activities to engage students and help them personalize the information. In addition, they were encouraged to take information home to their parents.

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While UNICEF trained teachers and schools began implementing AIDS prevention programs as early as 1987, many additional teachers were trained in the early 1990s and schools implemented more AIDS prevention activities.

Schools also began forming clubs to prevent AIDS. In 1993, the ACP established "Say No" clubs in schools.

Different organizations also launched broad initiatives for youth, both in and out of school. For example, in 1993 UNICEF decided to focus on saving the future generation in Uganda by focusing on the age group 5 to 15. Together, the UAC and UNICEF launched the "Safeguard Youth from AIDS" campaign.

A print media campaign that became widely used in schools was "*Straight Talk*," which is discussed above. In 1995,

Straight Talk clubs began springing up in schools and colleges. During club meetings, youth discussed one or more topics presented in the monthly *Straight Talk* paper.

Faith Communities

Faith communities became very involved in AIDS education. They strived to educate people about the risk of HIV/AIDS, give a message about sexual behavior, get people to recognize their responsibilities to those who had AIDS, and provide support for those with AIDS. Given Uganda's emphasis on being faithful to avoid AIDS, the faith communities embraced the message and became very much involved in its promotion.

Given Uganda's emphasis on being faithful to avoid AIDS, the faith communities embraced the message and became very much involved in its promotion.

In Uganda, most people belonged to one of three religious organizations: the Roman Catholic Church, the Anglican Church (Church of Province of Uganda), or the Islamic Umma (or "community of Islam"). There were very few independent churches or sects in Uganda. When the three communities developed programs to encourage behavior change, each of them developed trainings and materials. They were able to act in an integrated fashion; collectively, they reached a large majority of Ugandans.

At the local level, efforts varied, but in some communities, pastors or imams spoke about AIDS and faithfulness, both during their regular services and sometimes during or after funerals for people who had died of AIDS. Faith communities may have more effectively conveyed moral or normative messages rather than just informational messages.

The Catholic Church resonated to the "A" and "B" messages and initially opposed the promotion of condoms. However, as the number of deaths increased, the Catholic Church reasoned that condoms prevented HIV transmission and thereby prevented death; given that it is important to prevent death, condoms were permissible, especially when married couples were serodiscordant. Accordingly, the Catholic Church agreed to emphasize abstinence and being faithful. They did not advocate for condoms, yet agreed not to oppose them.

Employers

As the effects of morbidity and mortality due to AIDS increased, employers lost valued employees and became increasingly motivated to prevent AIDS. Some of them implemented educational programs and a few provided condoms free of charge. To further their efforts, the Federation of Uganda Employers, working with international organizations, developed AIDS trainings and a documentary to help disseminate information about AIDS.²³

The Military

In Uganda, men in the military had some status and money, enabling them to have sex with multiple women. In addition, they were often away from home and sometimes transferred from one area to another, thereby increasing their numbers of potential sexual partners

and their possible exposure to AIDS.²⁴As a result, they did, in fact, have high HIV prevalence. Because of this high rate, the military played an early and leading role in attacking AIDS. It trained 400 army commissioners in AIDS prevention who, in turn, informed others. At various times, the army also provided free condoms in the soldiers' kits. In addition, the army helped mobilize communities more generally and supported research.¹

Condom Distribution and Social Marketing

By early 1987, condoms were made available free of charge at family planning clinics and at other places such as Makerere University in Kampala.²⁵Students could receive one gross of condoms per student from the university clinic. After large shipments of condoms arrived in Uganda, they were also more available and visible in big pharmacies and open markets, where they were sold for the equivalent of 25 cents.²⁶

In late 1991, Social Marketing for Change (SOMARC), an NGO, began developing condom social marketing campaigns in Uganda.

Beginning in late 1991, Social Marketing for Change (SOMARC), an NGO, began developing condom social marketing campaigns in Uganda. It brought together different groups to generate support for condoms, purchased advertisements for condoms in newspapers and on the radio, and produced posters and billboards promoting condoms. It subsidized the price of condoms and made condoms more readily available through numerous outlets.

In January 1992, the ACP produced a play called *Ndiwulira* that promoted condom use and included a song to promote their use. The play was performed in English and Luganda.

During the following years, condoms were also promoted on leaflets, posters, billboards and the radio. During the early 1990s, numerous groups provided information about condoms. They varied from faith-based groups (e.g., CHUSA) to sectarian groups (e.g., the Philly Lutaaya Initiative).

Although SOMARC was by far the largest social marketing project in Uganda in the early 1990s, there were others. For example, the German Technical Operation Agency (GTZ) developed and distributed a special brand of condoms called "Engabu" in the Kabarole District. According to the Ministry of Health, many other agencies also imported condoms.

Content of Messages

Some of the earliest messages were designed to increase general awareness of AIDS and perceptions of risk. For example, one poster showed a skull and crossbones and the message "AIDS Kills." Another poster showed a vulture carrying away someone with AIDS and a third included a boat in a lake with people flailing in the water and the message, "Don't drown in the AIDS flood, always be on board." As discussed above, on



the radio, programs repeatedly played somber drumbeats that culturally symbolized danger.

Messages quickly became more directive and began encouraging people to change their sexual behavior. Multiple informants told a story about a mouse that illustrated the approach Uganda used: “If a mouse is cornered by a cat, it becomes paralyzed. But if you give the mouse a way out, it will move quickly through that route.” Thus, Uganda’s leaders promptly began telling people what they needed to do to avoid AIDS.

Their underlying theme was relatively simple: AIDS is transmitted mainly through heterosexual contact in Uganda, has no cure and leads to death. Therefore, people should “love carefully” and “be faithful.” More specifically, this meant that young unmarried people should abstain from sex until marriage; married people should have sex only with their marital partners; and those who take risks and have sex outside of marriage should always use a condom to reduce their chances of infection.

This message was emphasized by President Museveni, his ministers, government officials, and nearly all programs in Uganda. Notably, it was delivered frequently and consistently; for the most part, there was relatively little opposition to it.

Although Museveni, church leaders and others sometimes defined this message quite clearly, some of the common slogans such as “love carefully,” “behave responsibly,” and “be faithful,” meant different things to different people. Although most people realized that these messages precluded casual sex with multiple people, they were not always clear about how restrictive the messages were. For example, not everyone interpreted the message to mean that people should only have sex within marriage. Even “abstinence” was interpreted differently by different people. Some thought it meant totally abstaining from sex, while some focus group participants laughed at this notion and thought it meant abstaining from sex outside of marital/cohabiting relationships.

A review of all articles about AIDS and its prevention in *The New Vision* newspapers through 1995 revealed that a clear majority of messages focused favorably on “A” and “B” (with almost no negative messages about “A” or “B”), but that there were also favorable messages about “C.”¹¹

Furthermore, the relative emphasis on “A,” “B” and “C” varied over time. There is no question that prior to condom social marketing in the early 1990s, Uganda placed a much greater emphasis on “A” and “B” than on “C.” According to the content analysis of *The New Vision* articles, before 1991, between 70% and 90% of the messages each year were about either “A” or “B.” Clearly, “A” and “B” were more strongly emphasized during that time.

Messages quickly became more directive and began encouraging people to change their sexual behavior . . . People should “love carefully” and “be faithful.” More specifically, this meant that young unmarried people should abstain from sex until marriage; married people should have sex only with their marital partners; and those who take risks and have sex outside of marriage should always use a condom to reduce their chances of infection.

Of these two behaviors, being faithful was given greater attention than abstinence. For example, very popular slogans were “be faithful” and “zero grazing.” “Zero grazing” referred to the practice of farmers tethering their animals to a stake and restricting them from straying away to neighbors’ greener grass. Furthermore, when people talked about abstinence during focus groups, they often meant abstinence outside of marriage, which, in the “ABC” formulation, technically would be classified as “B,” not “A.”

After the beginning of condom social marketing in the early 1990s, the relative emphases on “A,” “B” and “C” changed dramatically and there was much greater emphasis on “C.” This does not mean that people recommended using condoms *instead of* being faithful; it simply meant that many more messages encouraged people to use condoms. According to the content analysis of *The New Vision* newspapers, by 1994, about 43% of the favorable messages were directed toward condoms. According to a review of paid radio and television spots in 1994 and 1995, nearly all involved condoms.²⁷

After the beginning of condom social marketing in the early 1990s, the relative emphases on “A,” “B” and “C” changed dramatically and there was much greater emphasis on “C.” This does not mean that people recommended using condoms *instead of* being faithful; it simply meant that many more messages encouraged people to use condoms.

The changing emphasis of messages was strongly reinforced by nearly all key informants and focus groups. When asked what the most important messages were during the late 1980s and 1990s, the consensus was that initially, the greatest emphasis was on being faithful and being abstinent if single, with less emphasis on condoms. According to these respondents, after condom promotion began, a much greater emphasis was placed on condom use.

HIV Testing — AIDS Information Centers (AICs)

Uganda opened AIDS Information Centers (AICs) to provide free, voluntary HIV testing and counseling to the general public.²⁸ People were concerned about their own health, the health of their fiancés, and the health of others and accordingly many people were tested at the AIC centers. The demands for testing increased after religious leaders encouraged people to be tested before marriage and after some people needed proof that they were not HIV-positive so that they could study abroad.²⁸

The AIC’s primary efforts were directed to providing HIV testing and pretest and posttest counseling, which was conducted both individually and in small groups. However, these services were expanded and the AIC centers played a significant role in prevention by disseminating information about AIDS through drama, music, poems and riddles.²⁹

Special Public Events

In addition to the wide variety of efforts already discussed, multiple organizations held many special events, including annual celebrations of internationally recognized days.

Each May, people celebrated the International AIDS Candlelight Memorial to publicize the discrimination faced by people with AIDS. The President’s wife, officials from the ACP, NRC members, security officials, religious leaders, medical practitioners, members of local and

foreign AIDS organizations, students, the young and old, citizens and foreigners all marched solemnly together.

World AIDS Day on December 1 was a second internationally celebrated day that was honored across Uganda. In the capital, leaders called on families to talk openly about AIDS, educate their children, and encourage “good conduct.”³⁰In another district, organizations held a bike race.

In addition to nationwide events surrounding special days devoted to AIDS, international AIDS-related meetings sometimes were held in Uganda. Probably the largest and most important during the first half of the 1990s was the IXth International Conference on AIDS and Sexually Transmitted Diseases (ICASA) meeting held in Kampala in 1995, which was attended by over 3,500 people.³¹ While these meetings mostly involved leaders in the fight against AIDS, they nevertheless were discussed in the media and typically involved sharing the latest research and information about AIDS.

Innovations in AIDS Prevention Efforts

The focus of Uganda’s initial AIDS prevention campaigns was on increasing awareness of HIV and the risks of contracting it. However, as years passed and insufficient behavior change was observed, leaders in the campaign to prevent AIDS adopted innovative approaches with greater potential for actually changing behavior.³²For example, they:

- Conducted mobilization at the grassroots level, so that more people at the local level became actively involved
- Held smaller community sessions so that the participants could be more interactively involved
- Focused on how to change actual behavior rather than merely increase awareness³³
- In classroom and community meetings, used HIV-positive speakers who shared their life stories, increased perceptions of susceptibility and severity, and made AIDS more real and more personal³³
- Implemented activities to increase personal risk assessments for HIV and STD, taking into account factors such as numbers of sexual partners and contacts, use of condoms, and use of alcohol¹
- Discussed situations that placed women at risk of having unwanted or unprotected sex and options for avoiding or getting out of those situations³⁴
- Used dramas in the classroom to illustrate the risks of unprotected sex and to model desired behavior³³
- Created films, videos and television miniseries to help people personalize risks and consequences of AIDS³³

- Implemented activities to increase skills to avoid unsafe sex¹
- Implemented activities to increase confidence purchasing condoms and using them properly¹
- Actively involved people in group discussions and other group activities in order to 1) create focused messages for the particular target group, 2) generate peer support for behavior change, and 3) convey skills for behavior change^{1 33}
- Developed materials in multiple languages
- Created AIDS prevention clubs run by youth in schools and communities and
- To a lesser extent, tried to increase the protection of the rights of women and children through legislation, public support for the rights of women and changes in bride prices.

Communication with Friends about AIDS and Exposure to AIDS Prevention Messages

As a result of both the AIDS deaths and the comprehensive AIDS prevention efforts discussed above, people talked openly and frankly about AIDS (See Column 1 in Figure 1). As early as 1986, people were talking about AIDS, or “Slim.” According to Hooper (p. 17):²⁶ “In Kampala’s offices, bars and night clubs, it had become the latest topic of conversation. Whether people spoke in English, in the East African *lingua franca* of Kiswahili, or in Uganda, the language of the country’s heartland, there was one word which kept cropping up, an incessant sibilance, a persistent whisper on everyone’s lips. The word was ‘Slim.’”² There was also considerable communication about AIDS in more rural districts where people were dying of AIDS, particularly Rakai and Masaka.

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These observations by Hooper were repeated by innumerable key informants who emphasized first that many people talked about AIDS and second that they talked about AIDS in a more informed manner. It was not a topic to be avoided; rather, it was a topic of great interest to be discussed.

Empirical studies of sources of information about AIDS in Uganda support two conclusions. First, friends and the media were typically the most commonly identified sources of information about AIDS. Second, people had many reinforcing sources of information, not just one or two sources. This reflects the multi-sectoral approach Uganda adopted. These conclusions are supported by many studies (Table 1).

Table 1:

Summary of Evidence for Changes in Behavior

Evidence	Strength of Evidence	Conclusions
Modeling of HIV incidence and prevalence	Moderately strong for timing	<ol style="list-style-type: none"> 1. Suggest incidence peaked about 1987/8 and began to decline 2. Suggest incidence declined more rapidly about 1993
Reports of behavior change in newspaper articles	Strong for timing Very weak for representativeness	<ol style="list-style-type: none"> 1. Indicate behavior change began in 1987 in Kampala and some other places in Uganda 2. Suggest initial primary behavior change was greater faithfulness (fewer casual partners) and not greater condom use
DHS and GPA surveys with questions about personal behavior change	Strong for representativeness Weak for validity	<ol style="list-style-type: none"> 1. Indicate large percent decrease in sex before or outside of marriage 2. Indicate small percent began using condoms
DHS survey data	Very strong for representativeness	<ol style="list-style-type: none"> 1. Demonstrate small increase between 1988/89 and 1995 in all women who abstained from sex during the previous year 2. Demonstrate large increase between 1988/89 and 1995 in young single women who abstained from sex during previous year 3. Demonstrate large increase in condom use during sex with non-marital and non-cohabiting partners by 1995, especially in urban areas
GPA survey data	Modest for representativeness	<ol style="list-style-type: none"> 1. Among all women, suggest large decrease between 1989 and 1995 in percent who had sex with non-marital or non-cohabiting partners 2. Among married women, suggest very low and stable percent who had extramarital sex 3. Among young women, suggest large decrease between 1989 and 1995 in percent who had premarital sex 4. Among single women, suggest decrease between 1989 and 1995 in percent who had two or more partners 5. Among all women, demonstrate large increase in condom use during sex with non-marital and non-cohabiting partners by 1995, especially in urban areas 6. Among single men, suggest large decrease between 1989 and 1995 in percent who had premarital sex 7. Among all men, suggest large decrease between 1989 and 1995 in percent who had sex with non-marital or non-cohabiting partners 8. Among married men, suggest large decrease between 1989 and 1995 in percent who had extramarital sex 9. Among young men, suggest decrease between 1989 and 1995 in percent who had premarital sex 10. Among single men, suggest decrease between 1989 and 1995 in percent who had two or more partners 11. Among all men, demonstrate large increase in condom use during sex with non-marital and non-cohabiting partners by 1995, especially in urban areas

Evidence	Strength of Evidence	Conclusions
Other surveys of sexual behavior	Weak for representativeness	<ol style="list-style-type: none"> 1. Suggest decrease in the number of sexual partners. 2. Suggest delay in the initiation of sex 3. Suggest increase in the use of condoms 4. Suggest moderately high level of condom use during casual sex in Kampala and other selected places by 1993
Interviews with focus groups and key informants	Weak for representativeness Weak for validity	<ol style="list-style-type: none"> 1. Suggest decrease in casual sex and numbers of sexual partners followed by increase in condom use
Reports of shipments of condoms to Uganda	Strong for timing Strong for validity	<ol style="list-style-type: none"> 1. Suggest relatively few condoms in Uganda prior to 1989 2. Demonstrate the number of condoms received in Uganda grew roughly exponentially 3. Demonstrate that there was a substantial number of condoms in Uganda by 1993
Historical documents describing programmatic efforts to address AIDS	Strong for timing Strong for validity	<ol style="list-style-type: none"> 1. Demonstrate that beginning about 1986 programmatic efforts focused primarily on being faithful and partner reduction 2. Demonstrate that beginning in the early 1990s condom promotion and provision encouraged condom use

What was the impact on the sexual psychosocial factors?

As discussed above, as the numbers of deaths due to AIDS grew in Uganda, multiple AIDS prevention programs were launched and communication about AIDS increased within communities, among friends and within families. What was the impact of these factors? The following sections review the evidence for their impact on individual or cognitive factors that are included in Column 2 in Figure 1. In general, various theories and reviews of survey data have demonstrated that these factors commonly affect health behavior.³⁵⁻³⁹

Personally Knowing Someone with AIDS

Multiple studies demonstrate that many people knew someone who was sick with AIDS or had died of AIDS. Although large percentages of people in some areas knew someone with AIDS in the late 1980s, the percentages throughout Uganda grew very rapidly during the very late 1980s and early 1990s.

In 1989, according to the Global Program on AIDS (GPA) survey data, among 15- to 24-year-olds, 50% of women and 55% of men knew someone who had HIV or had died of AIDS.⁴⁰ In 1995, according to the DHS data, 85% of all women in Uganda knew someone with HIV or who had died, and 91% of the men did so.

People not only knew someone personally with AIDS, they often had a relative or family member with AIDS. For example, a 1994 study of students in Kabale found that 46% of the students had a family member with AIDS.⁴¹ According to a large 1995 survey of primary students from Kabale and Rukungiri, 32% had a family member with AIDS.⁴²

Personal knowledge of someone with AIDS was one of the more important factors leading to behavior change. According to a 1988 survey of 204 men and women in Kampala and

Kabale, people who knew someone with AIDS were much more likely to change their behavior than those who did not. Remarkably, of those people who personally knew someone with AIDS, 100% of the men and 71% of the women reportedly changed their behavior.⁴³

Similarly, when the sexual behavior of students decreased between 1992 and 1994, teachers attributed the decrease in part to “pupils seeing or even nursing AIDS patients that have become rampant in every community.”⁴¹

Of course, the large percentages of Ugandans knowing someone with AIDS reflected the large number of people who had AIDS. Here, the contrast with other sub-Saharan countries is instructive. In other countries with large numbers of deaths due to AIDS, people affected by AIDS — those infected, their families and even their communities — often denied that their illnesses or deaths were due to AIDS. Perhaps the single most important reason that there was less denial about AIDS in Uganda was the openness and frankness with which the government and civil society addressed it. In addition, the government, faith communities, NGOs and other organizations explicitly discouraged people from discriminating against people who were HIV positive. They also encouraged people who were HIV-positive to seek help and to admit openly that they were HIV-positive. As a result, when people died of AIDS, friends and relatives were more likely to realize that AIDS caused their deaths, rather than attributing their deaths to other diseases.

In other countries with large numbers of deaths due to AIDS, people affected by AIDS — those infected, their families and even their communities — often denied that their illnesses or deaths were due to AIDS. Perhaps the single most important reason that there was less denial about AIDS in Uganda was the openness and frankness with which the government and civil society addressed it.

Knowledge about HIV/AIDS

Many people, especially those living in urban areas, learned the basic facts of HIV transmission and the consequences of HIV infection very early after Ugandan authorities first learned that people were dying of AIDS in Uganda. Multiple studies demonstrated this gain in knowledge.

As early as August 1987, only a year after authorities began informing the population about AIDS, 92% of the population in sub-counties not far from Kampala knew that infection could be transmitted through sexual relations. The greatest areas of ignorance involved people incorrectly believing that AIDS could be transmitted in other ways — e.g., sharing clothes (47%), living in the same household (30%), touching a person with AIDS (21%), or being cursed by another person (24%).⁴⁴ When asked about specific methods for avoiding infection, 92% knew that avoiding prostitutes would do so, 89% knew that reducing the number of sexual partners would do so, and 41% believed that using condoms would do so.⁴⁴ Thus, near Kampala, people knew the primary ways in which HIV was transmitted and most knew effective methods of reducing the risk of sexual transmission.

Two years later, in 1989, the GPA survey revealed high levels of knowledge about AIDS nationwide. Results indicated, for example, that 96% of the population had heard of AIDS

and knew that HIV was sexually transmitted.⁴⁵ Furthermore, this percentage did not vary significantly by residence, indicating that knowledge about AIDS had spread almost equally to rural areas. It also did not vary significantly by gender, indicating that both males and females were well informed.

In addition, a large majority of people had more in-depth knowledge about HIV and its transmission. About 70% of men and 68% of women in urban areas could correctly answer 80% or more of the items on a 9-item knowledge test, and 55% and 44% of men and women in rural areas could do so. Thus, more in-depth knowledge about HIV was more common in urban areas where behavior first changed than in rural areas where it typically changed later. Percentages were higher among men and women 15-39 years old than among older people. Notably, the behavior of younger people also changed more rapidly than did behavior of older people.

When asked about condoms in 1989, 79% of Ugandans agreed that condoms, if properly used, could prevent STD. Respondents aged 15-39 were most likely to know this.

Results showing that people became knowledgeable about AIDS by the late 1980s were confirmed by numerous other studies as well⁴¹.

Perceived Threat of AIDS

The perceived threat of AIDS — both the perceived probability of contracting it and its perceived severity — can be among the most important factors leading to behavior change. Multiple kinds of evidence demonstrated that people recognized the threat of AIDS, that the perceived threat increased during the early 1990s, and that it varied considerably from community to community.

A few newspaper accounts talked about the fear of AIDS and its consequences. For example, a 1987 issue of *The New Vision* described the behavior changes in Kampala that resulted from fear of AIDS⁴⁶ and a December issue used the headline, “The fear of Aids [sic] has reportedly changed social behavior in Arua drastically.”⁴⁷ Other subsequent stories talked about the impact of AIDS on sexual behavior and either implicitly or explicitly stated that it was the fear of AIDS that produced this change.

Similarly, in nearly all focus groups and interviews with key informants, people described how the fear of AIDS changed behavior. Some people described how in their communities, “everyone was dying,” “everyone was afraid,” and “there was panic.” They then described how this led to behavior change. On no other topic was there such unanimity as there was on the belief that fear of AIDS dramatically changed behavior in Uganda. This was true in both urban and rural focus groups and among focus group participants of different ages.

For example, a 1987 issue of *New Vision* described the behavior changes in Kampala that resulted from fear of AIDS and a December issue used the headline, “The fear of Aids [sic] has reportedly changed social behavior in Arua drastically.” . . . Some people described how in their communities, “everyone was dying,” “everyone was afraid,” and “there was panic.” They then described how this led to behavior change.

According to the DHS findings, by 1995, 78% of women and 61% of men felt they were at risk of HIV.¹² These percentages were higher in urban areas than in rural areas.

A few empirical studies also indicated that the perceived threat of STD and especially AIDS affected behavior. In a study conducted in 1991 of secondary school pupils in Kampala, by far the most commonly given reason for using condoms was protection against AIDS and STD.⁴⁸ In both 1992 and 1994, fear of disease was the single most frequently mentioned reason that young students gave for not having sex.⁴¹ In 1995, when a large sample of primary 7 students in Kabale and Rukungiri districts was asked why females and males should remain abstinent until marriage, the overwhelming response was “fear of STDs.” Whereas about 66% selected fear of STDs as a reason for not having sex, no other response, even including fear of pregnancy, was selected by as many as 10% of students. When asked about the harmful effects of sexual activity, the two most commonly checked responses were STDs and death.⁴⁹

A few studies examined the relationship between perceived threat and reported change in behavior. For example, Moodie et al., (1991) found that respondents who thought they were at risk of being infected with HIV were three times more likely to report changing their behavior, mostly by reducing their numbers of sexual partners.

Although the most serious threat of contracting AIDS was sickness and death, some people also feared the shame associated with being HIV positive. In a 1987 survey of two communities near Kampala, 72% of the respondents said that “it would be very shameful for me” if a close relative got AIDS.⁴⁴ As noted above, there were efforts to reduce stigma associated with AIDS and there was less stigma than in other countries, but stigma still remained.

Although the perceived threat of AIDS contributed greatly to sexual behavior change, this does not mean that all people felt vulnerable to AIDS even after AIDS was epidemic in Uganda.

Although the perceived threat of AIDS contributed greatly to sexual behavior change, this does not mean that all people felt vulnerable to AIDS even after AIDS was epidemic in Uganda. For example, in 1988, few people in villages in the Kigezi region and in Kabale identified AIDS as a problem in Uganda and fewer than half identified it as one of the three most serious diseases.⁴³ Indeed, one of the most common laments of leaders in the AIDS prevention efforts during the early 1990s was that for one reason or another, people did

not perceive that they, themselves, were at risk of AIDS and they therefore did not change their behaviors. Especially during the late 1980s, some people felt that AIDS was only a problem in distant communities (such as Rakai, Masaka and Kampala) and was not a problem in their own communities. Others believed that AIDS was only a problem for those men who frequented sex workers. According to focus groups and a few informants, during the late 1980s, some men believed that young girls were not likely to be infected with AIDS and that therefore they were not at risk if they had sex with young girls. Other people, for whatever reasons, simply felt invulnerable and did not personally believe AIDS to be a threat to them.

Social Norms about Sexual Practices

Multiple kinds of evidence also indicated that social norms about sexual behavior changed as a result of AIDS. According to the nationwide 1989 GPA survey, Ugandans said that they disapproved of many sexual practices that place individuals at risk of HIV infection. While about half approved of sex with a girlfriend and about half approved of polygamy, between 75% and 90% disapproved of having multiple sexual partners before marriage, extramarital sex during a wife's or husband's absence, sex with strangers, or sex with prostitutes.⁵⁰

The GPA survey also revealed that 62% of the respondents said that some of their friends' sexual behavior had changed because of AIDS. The actions of their friends essentially modeled the change in social norms and thereby reinforced the change in those norms.

Both interviews with key informants and focus group interviews also described the change in social norms. Some people described how having gonorrhea had been perceived as a "badge of honor" or a "badge of manliness and sexual prowess" before the advent of AIDS, but after AIDS, people looked down upon those who contracted an STD because it meant they were engaging in sexual risk-taking that placed them at risk of AIDS.

Awareness of and Attitudes about Condoms

According to the 1988/89 DHS survey, 62% of women in Uganda were aware of condoms and 48% knew where to get them. (Data were not available for males, but in 1995 the percentages were higher for males than females.) By the fall of 1989, 79% of Ugandans agreed that condoms, if properly used, could prevent STD; young people aged 15-39 were most likely to be aware of condoms.⁴⁵

Despite their knowledge of condoms, people's initial attitudes toward condoms in the late 1980s were often quite negative. According to the 1989 GPA survey, few respondents felt that condoms were easy to use. Large percentages felt that condoms were dangerous and that the most effective method of protection was being faithful to one partner. Large percentages of people also felt condoms were "offensive." Women and village residents were least likely to know of sources for condoms.⁵⁰

Other studies of particular districts found similarly negative findings. When asked why they did not use condoms if they had sex, students in Kabale and Rukungiri Districts provided numerous reasons: condoms can burst, they are dangerous, they can harm the body, they can kill, they can remain in the vagina, they are not 100% effective, they reduce the pleasure of sex, they are expensive, my penis is too small, I don't know how to use it, and we trust each other.⁴⁹

Despite their knowledge of condoms, people's initial attitudes toward condoms in the late 1980s were often quite negative . . . after social marketing of condoms began, awareness increased and attitudes toward condoms became more favorable. According to many respondents, young people especially developed more favorable attitudes towards condoms and using condoms became the social norm for young people.

Figure 2
A Chronology of HIV/AIDS and the Response in Uganda

- 
- 1982** First case of AIDS (called “Slim”) is reported in Rakai District.
- 1985** Experts confirm a new disease in the Rakai and Masaka districts, but do not know its modes of transmission or its cure. People in some Rakai and Masaka villages know numerous people who died of “Slim.”
- 1986** Experts learn that “Slim” is caused by AIDS and can be transmitted sexually. Ministry of Health acknowledges AIDS in Uganda and seeks international help. Blood testing machines are installed in some hospitals. Government launches “Zero Grazing” (fidelity) and “Love Carefully” messages and campaigns. Much discussion in Kampala focuses on AIDS; some reports of panic. Changes in sexual behavior (fewer sexual partners and greater condom use) observed in Rakai.
- 1987** Presidential rallies held in each district, exhorting behavior change (and sometimes criticizing condoms). First 5-year plan to address AIDS is launched; \$21 million pledged by donor agencies to implement plan. AIDS Control Program (ACP) established within Ministry of Health. Additional ministries (Defense, Education, Information and Broadcasting) enlisted. UNICEF initiates AIDS education in some schools. Faith communities and NGOs become involved. The AIDS Support Organization (TASO) formed to help people with AIDS. Major newspaper reports behavior change (e.g., less casual sex) in Kampala and elsewhere due to AIDS. HIV incidence in Kampala and major towns possibly peak during this year or following two years and then declines slowly.
- 1988** District health educators trained. Blood testing machines put in place in 28 screening centers. Radio stations begin playing a drum, signifying AIDS.
- 1989** Singer Philly Lutaaya becomes first public figure to announce he has AIDS; he dies in December. 400 Army commissioners trained in AIDS prevention. District Muslim leaders trained to educate all Muslims at religious gatherings about avoiding AIDS. 15 million condoms shipped to Uganda. 90,000 Ugandans estimated to have AIDS. Throughout Uganda, people have a high level of AIDS awareness. An estimated 10% of Ugandans have changed their sexual behavior or expect to do so, mostly by avoiding casual sex.
- 1990** First AIDS Information Center (AIC) established (for HIV counseling/testing). Uganda AIDS Commission and Task Force on AIDS draft second 5-year plan. First International Candlelight Memorial held to commemorate Ugandans who have died of AIDS. An estimated 12,000 people have died of AIDS in Uganda.
- 1991** Social mobilization to reduce the spread of HIV has been launched in 14 of the 33 health districts. Multi-sectoral approach launched with full-fledged programs in key sectors. SOMARC begins social marketing campaign to promote “Protector” condoms. 12 million condoms shipped. Religious groups oppose the promotion of condoms outside of marriage; “quiet promotion” continues.
- 1992** AIDS prevention programs for youth begin to include discussions, videos and presentations by people with AIDS. Islamic Medical Association of Uganda train imams. The Ministry of Health creates television dramas on AIDS. 10 million condoms shipped.
- 1993** Implementation of second 5-year plan begins with \$125.4 M from donors and \$37.5 M from Uganda. Church of Uganda forms Church Human Services AIDS Program (CHUSA). Ministry of Information launches “Straight Talk” campaign (print, radio, TV). AICs expand and add drama and music to testing portfolio. 22 million condoms shipped. 1,000 NGOs address AIDS. HIV prevalence in urban areas begins to decline markedly; incidence probably declines faster this year.
- 1994** “True Love Waits” campaign (focused on abstinence until marriage). Promotion of condoms expands. About 100,000 people die from AIDS each year.
- 1995** Reverend Gideon Byamugisha becomes first practicing priest to announce he is HIV-positive. Comparisons of 1989 and 1995 survey data reveal large changes in sexual behavior, mostly less casual sex outside of marriage; also greater condom use, especially in urban areas.

Parents and others also believed that condoms would encourage sexual promiscuity.⁴⁹ According to one survey, “teachers and parents are hostile to condom use.”⁴⁹

However, after social marketing of condoms began, awareness increased and attitudes toward condoms became more favorable. According to many respondents, young people especially developed more favorable attitudes towards condoms and using condoms became the social norm for young people.

Did these changes in sexual psychosocial factors affect behavior?

As a result of the changes in the factors above, and probably others as well, people in Uganda did change their behavior consistent with “A,” “B,” and “C.” Despite important limitations, the large nationwide DHS surveys conducted in 1988/9 and again in 1995 and the GPA surveys conducted in 1989 and 1995 provide the best evidence for the magnitude and types of behavior change.⁷ The results from the DHS surveys have fewer methodological concerns than those from the GPA surveys and should be given greater consideration.

Abstaining from Sex

According to the DHS surveys, between 1988/9 and 1995, the number of women aged 15-54, regardless of marital status, who had sex during the previous year decreased slightly, from 82% to 75%. This small decrease reflected the fact that most Ugandan women marry at an early age and have sex after marriage. Comparable data were not available for men.

Among never-married women, there were much larger changes, especially in urban areas. The percent of never-married 15- to 24-year-old women who had sex in the previous 12 months decreased significantly, from 36% in 1988/9 to 22% in 1995.

Extramarital Sex and Sex with Casual and Multiple Non-marital Non-cohabitating Partners

Only the GPA surveys included questions about sex outside of marriage or about multiple partners in 1989 and 1995. These results should be viewed cautiously because of changes in the sample and questionnaire design.

GPA survey data indicate that the percent of women engaging in extramarital sex was always quite low (about 6% or less) and remained stable during this period. For men, however, the GPA data suggest there were declines in extramarital sex from 23% in 1989 to 16% in 1995.

According to the GPA data, between 1989 and 1995, the percent of women both married and unmarried who had sex with a non-marital/non-cohabitating partner in the last 12 months decreased from 23% to 9%. Among men, the percent decreased from 41% to 21%. Similarly,

Between 1989 and 1995, the percent of women both married and unmarried who had sex with a non-marital/non-cohabitating partner in the last 12 months decreased from 23% to 9%. Among men, the percent decreased from 41% to 21%.

between 1989 and 1995, the percent of all women who had one or more casual partners in the last year decreased from 16% to 6%, while the percent of men who had one or more casual partners decreased from 35% to 15%. In addition, both *single* women and *single* men became much less likely to have sex with two or more sexual partners during the last year (from 22% to 17% among single women and from 54% to 33% among single men).

Condom Use

According to the DHS data, the percentage of sexually experienced women who had ever used a condom was very low (1%) in 1989. By 1995, it had increased to only 6%. Among men in 1995, it increased to only 16% from a low (but unknown) percent in 1988/9. (Men were not sampled in 1988/9.)

In urban areas in 1995, 62% of men used a condom the last time they had sex with a casual partner.

These results may give misleading impressions about the possible impact of condoms because most adults were married and most married couples rarely used condoms, if at all. More relevant to HIV transmission is the use of condoms with casual partners outside of marital/cohabiting relationships. According to DHS data, the percent of women throughout Uganda who used a condom at last sex with a non-marital/non-cohabiting partner increased to 20% in 1995; among men, it increased to 36%. While these increases may have been too low to markedly reduce HIV incidence, increases in reported condom use were greater among males, people in urban areas, young adults, and people with more education. For example, in urban areas in 1995, 62% of men used a condom the last time they had sex with a casual partner. These higher rates may have had a greater impact on HIV transmission.

In sum, between 1989 and 1995:

- Young men and women became less likely to have premarital sex.
- Single men and women became less likely to have multiple partners.
- Men and women became less likely to have sex with a non-marital/non-cohabiting partner.
- Men and women became more likely to use condoms if they had sex with a non-marital/non-cohabiting partner.

Conclusion

In sum, many Ugandans saw firsthand numerous other people suffering and dying from AIDS. As a result, nearly everyone (from the President himself, to government ministries, to multiple organizations, to individuals in their communities) acknowledged AIDS and talked about it. In addition, multiple groups provided accurate information about AIDS and clear and consistent messages about how to prevent it.

Because of their own vision, as well as support from many international organizations, Ugandans ended up implementing most, if not all, of the important elements in public health initiatives to prevent disease transmission. Although people often view the story of Uganda from their own perspectives and see particular elements in the Uganda initiative that they believe made the greatest contribution to ultimate success, in reality, it was not any single one or two of these elements alone that produced behavior change. Rather, it was the total comprehensive and intensive package that made a difference. This does not mean that all elements were equally important. The clear and consistent emphasis on behavior, such as being faithful, was a particularly critical element, but many elements also contributed.

As a result of this message and the comprehensive efforts to change behavior, people actually did change their behavior. First, they began being more faithful to their marital or long-term partners or became more likely to remain abstinent if single. Then, the smaller number of people engaging in sex outside of marital/cohabiting relationships began using condoms more consistently. This was a powerful combination. As a result, HIV incidence and prevalence began to decline, and they declined in an unprecedented manner for a generalized epidemic.

It was not any single one or two of these elements alone that produced behavior change. Rather, it was the total comprehensive and intensive package that made a difference . . . The clear and consistent emphasis on behavior, such as being faithful, was a particularly critical element, but many elements also contributed.

Implications for Other Countries

Uganda's experience has several significant implications for AIDS policy in other countries with generalized epidemics. The Ugandan experience suggests that:

- Countries with generalized epidemics should acknowledge the problem of AIDS and attack it early, vigorously and comprehensively.
- There was no “silver bullet” — no single element of the Ugandan experience — that produced the behavior change and that, on its own, would change behavior elsewhere. Rather, the Ugandan experience suggests that the more elements and components of the Ugandan initiative that countries implement, the more likely they are to succeed in changing sexual risk behaviors.

- Both national and local leaders should address AIDS and provide leadership. While guidance and resources should be provided at the national level, many activities must be implemented at the local level. In addition, all relevant sectors of the government and organizations and institutions in civil society also should address AIDS. Countries should strongly encourage NGOs to become involved in AIDS prevention and should facilitate rather than thwart their efforts.
- AIDS prevention activities should encourage people to discuss AIDS themselves — within their communities, among friends and within their families. This open, honest communication can increase awareness and behavior change.
- Countries with generalized epidemics should strive to reduce sex outside of marriage or long-term cohabiting relationships, increase abstinence among people not in such relationships, reduce casual sex and the number of sexual partners, and increase condom use with casual partners. It is possible to change these behaviors; it is possible to change sexual behavior among both youth and adults and among both single and married people. And, when all these behaviors are changed significantly and simultaneously among all these groups, HIV incidence and prevalence can decline quickly.
- Government and civil society should provide accurate information about HIV and its transmission and emphasize people's susceptibility to AIDS and the severity of AIDS, both for the individual and for society. Government and civil society should emphasize that avoiding sexual risk-taking is consistent with cultural values and strive to increase people's confidence in their ability to avoid sexual risk-taking. If condoms are not widely available, their availability should be increased and their effectiveness and methods of use should be taught. In addition, any specific traditions (such as widow inheritance) that facilitate the spread of HIV should be identified and specifically discouraged.
- Not all organizations need to address all behaviors proportionately; some organizations may wish to focus on those behaviors most consistent with their own values or mission. For example, faith communities may wish to focus more upon abstinence and faithfulness, while health clinics and drug stores may wish to focus more on condoms. However, the overall message from all organizations should be reasonably balanced, and the message from one organization should not undercut the messages others.
- Countries should encourage people to be tested for HIV and should encourage those who are HIV positive to lead as healthful a life as possible, obtain appropriate and available care, and openly acknowledge their HIV status so that others will be more aware of the widespread nature of HIV infection.
- Countries should encourage people at all levels to acknowledge and talk about HIV/AIDS.

Uganda's success demonstrates that it can be done.

- To the extent feasible, countries should try to improve the status and rights of women and increase women's ability to avoid unwanted sex by providing them with education, increasing their employment opportunities, increasing their role in government, and increasing enforcement of laws against sex with minors, sexual abuse and rape. Such efforts may have only limited short-term effects, but may also have other beneficial long-term effects.

If countries' leaders do all of these things, it is much more likely that they will help people remain faithful within marital or long-term relationships, reduce casual sexual relationships and increase condom use, thereby reducing HIV transmission. Uganda's success demonstrates that it can be done.

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