Ambassador Eric Goosby
Office of the Global AIDS Coordinator
2100 Pennsylvania Ave NW
Washington DC 20037

Re: PEPFAR and the national response to HIV in Uganda in 2012-13

Dear Ambassador Goosby,

We are a team of civil society organisations in Uganda, writing to you with urgent concerns and recommendations about the status of the national response to HIV. We understand that Uganda, like several countries, has some unspecified 'pipeline' of unspent PEPFAR funding, so we assume that discussions are underway about how to invest those resources in light of Uganda's recently submitted Country Operational Plan.[1]

We appreciate the effort and support of PEPFAR, as well as the initiatives being taken by the Government of Uganda in response to HIV. But major gaps remain—preliminary results from the most recent AIDS Indicator Survey make this clear. We recognize that 2012-13 provides an extremely important opportunity to dramatically improve the response to HIV in Uganda—the only PEPFAR focus country with rising HIV incidence. This is the year for the national government and the US government to work together to operationalize President Obama's announcement of the U.S. commitment to begin to end AIDS by reaching 6 million people on treatment by 2013 along with other high impact interventions. As you know, President Obama's announcement was accompanied by a commitment from the Government of Uganda to reach 100,000 additional people this year with HIV treatment. Below is a description of our highest priority concerns regarding the national response to HIV, and specific recommendations for action by PEPFAR.

• **Aggressive increase in the pace of HIV treatment scale up, including: Option B+ for PMTCT, ensuring all patients at CD4<350 receive treatment while beginning earlier treatment initiation for prevention as well as clinical benefit:** Game-changing new evidence shows that rapid scale up of a package of interventions—earlier HIV treatment, voluntary safe medical male circumcision, PMTCT including treatment for life for the mother, and others—hold the promise of halting new infections and bringing about an end to the AIDS epidemic. Unfortunately, PEPFAR funded treatment scale up in Uganda has been slower than in neighboring countries. The 2012-13 COP should be setting a course for rapid identification of new patients and expansion of treatment coverage both to save lives and dramatically reduce the rates of new infections. We believe that putting more people on treatment, faster, will require additional up-front spending, but will be cost neutral in the short term and should be cost-saving within as few as 5 years, according to recent modeling using PEPFAR and country data from Kenya and Zambia.[2]

We are particularly concerned that Uganda's ART Committee was recently informed by the MoH and PEPFAR that there is not enough money to roll out Option B+, and the country will have to revert to Option A until additional funds are raised. PEPFAR can correct this crisis by ensuring sufficient funds are available for PMTCT regimens that are most likely to be successful in elimination of pediatric HIV in a country where timely access to CD4 testing is extremely challenging for pregnant women in rural areas,

[1] See for example: "PEPFAR: Next Steps on Investment Plan" (April 2012) and "Pipeline Talking Points" (April 20, 2012)
[2] Blandford, John et al. "The Impact of Treatment as Prevention—Models to Guide Ending the Epidemic." Presentation to the PEPFAR Scientific Advisory Board meeting, September 2011.

one in five new infections is from mother to baby, and where the total fertility rate is about 7—one of the highest in the world. Option B+ also allows Uganda to begin operationalizing the findings of HPTN 052.

In addition, optimized adult first line treatment using tenofovir-based regimens has been put on hold. Increased investment in more durable first line treatment is urgently needed, and PEPFAR should prioritize working with the Government of Uganda to address this funding shortfall.

• **Ensuring the Government of Uganda "steps up" its national response**: We are extremely concerned that the national budget for health for financial year 2012-13 is poised to shrink by 6%, while the national investment in ARTs and ACTs has flatlined at 100 billion Ugandan shillings (approximately $43 million). We recognize that real partnership is needed to strengthen the national response, and we urge PEPFAR to work with the Government of Uganda at the highest political levels to deliver substantial increases in investment in priority areas, such as ART, PMTCT, safe medical male circumcision, and evidence based behavioral prevention efforts.

• **Protect ART program quality—reverse the rapid withdraw of "outreach services":** PEPFAR in Uganda has made a transition away from funding HIV treatment "outreaches" in rural areas and toward a service delivery model where ART patients use public sector facilities. This has resulted in widespread reports about the lack of capacity of these facilities to absorb the increased patient load and the poor quality of treatment, care and support from the health workforce.[3] High volumes of patients are refusing to use public sector facilities and instead are seeking out remaining NGO facilities or, unfortunately, are defaulting rather than not being assured of a minimum standard of treatment provision. We call on PEPFAR to urgently revisit this policy shift and develop an integration approach that ensures gains in treatment scale up are protected and expanded, rather than compromised and undermined.

• **Budgeting should follow targets:** We understand that a recent draft COP indicates a likely 12.5% budget reduction—we are concerned that expanded targets will not be achieved without the budget required. Efficiency gains should be realized to the greatest extent possible, but additional resources should also be secured.

• **Take voluntary medical male circumcision to scale:** In spite of hosting one of the pivotal trials on VMMC, Uganda has been very slow in implementing this highly-effective strategy. It is critical that VMMC is scaled up with a pace, targets, and budget specifically identified to maximize the reduction in incidence in Uganda. We also note with concern that initial messages approved for communication strategies regarding VMMC in Uganda implied a direct protective benefit to women—a misconception that has already emerged in countries that are moving more quickly than Uganda.[4] We request PEPFAR work with Ministry of Health to urgently revise national messages on VMMC to ensure they are accurate, clear, and do not contribute to misinformation.

• **HIV prevention priorities and key populations:** fishing communities, commercial sex workers, discordant couples, migrant populations, men who have sex with men and other key populations are all populations with disproportionately high HIV prevalence and extremely low prevention and treatment program coverage. We ask the US government to substantially invest in programs targeting these populations, working on consultation with Ugandan experts from all sectors to ensure the design and expansion of high impact programs. Conversely, according to Uganda's National Prevention Strategy

[3] The New Vision. "30,000 at risk as TASO closes treatment centers" 18 May 2012. Elvis Basudde.

[4] Kenya: Male circumcision - women need counselling too. 23 January 2012. PlusNews.

(NPS), prevention funding is out of alignment with the drivers of the epidemic, for example in areas such as abstinence and being faithful.[5]

We look forward to your response to this request.

Sincerely,

International HIV/AIDS Alliance – Uganda
The AIDS Support Organization (TASO)
Action Group for Health, Human Rights and HIV/AIDS (AGHA Uganda)
Sexual Minorities Uganda (SMUG)
National Forum for People Living with HIV/AIDS in Uganda
International Community for Women Living with HIV/AIDS – East Africa
National Community for Women Living with HIV/AIDS – Uganda
Uganda Network for AIDS Service Organizations
Coalition for Health Promotion and Social Development (HEPS Uganda).

cc: Ambassador Jerry Lanier

[5] National HIV Prevention Strategy for Uganda 2011-15, p. 13