Most at Risk Populations – Long Distance Truck Drivers and HIV/AIDS in Uganda: Synthesis of Information and Evidence to Inform the Response

October 2014
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<tr>
<td>AMICAALL</td>
<td>Alliance of Mayors and Municipal Leaders on HIV/AIDS in Africa</td>
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<td>AIC</td>
<td>AIDS Information Centre</td>
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<td>AIDS</td>
<td>acquired immunodeficiency syndrome</td>
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<td>ART</td>
<td>anti-retroviral therapy</td>
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<td>ATGWU</td>
<td>Amalgamated Transport and General Workers Union</td>
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<td>ATWU</td>
<td>Amalgamated Transport Workers Union</td>
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<td>BCC</td>
<td>behaviour change communication</td>
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<td>CSO</td>
<td>civil society organisation</td>
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<td>GLIA</td>
<td>Great Lakes Initiative on AIDS</td>
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<td>FHI</td>
<td>Family Health International</td>
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<td>FPAU</td>
<td>Family Planning Association of Uganda</td>
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<td>FSW</td>
<td>female sex workers</td>
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<td>HBC</td>
<td>home-based care</td>
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<td>HCT</td>
<td>HIV counselling and testing</td>
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<td>IDP</td>
<td>internally displaced person</td>
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<td>IEC</td>
<td>information, education and communication</td>
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<td>IGAD</td>
<td>Intergovernmental Authority on Development</td>
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<td>IOM</td>
<td>International Organization for Migration</td>
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<td>IRAPP</td>
<td>IGAD Regional HIV and AIDS Partnership Program</td>
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<td>M&amp;E</td>
<td>monitoring and evaluation</td>
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<td>MAKACODA</td>
<td>Malaba Kyosimba Onaanya Community Development Association</td>
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<td>MARP</td>
<td>most at risk population</td>
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<td>NACAES</td>
<td>National Committee on AIDS in Emergency Settings</td>
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<td>NAFOPHANU</td>
<td>National Forum for PLHA Networks in Uganda</td>
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<td>OSBP</td>
<td>one-stop border post</td>
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<td>PEPFAR</td>
<td>United States President’s Emergency Plan for AIDS Relief</td>
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<td>PLHIV</td>
<td>people living with the human immunodeficiency virus</td>
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<td>RHU</td>
<td>Reproductive Health Uganda</td>
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<td>ROADSSII</td>
<td>ROADS to a Healthy Future</td>
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<td>STAR-EC</td>
<td>Strengthening TB and HIV &amp; AIDS Responses in East-Central Uganda</td>
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<td>STD</td>
<td>sexually transmitted disease</td>
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<td>STI</td>
<td>sexually transmitted infection</td>
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<td>TB</td>
<td>tuberculosis</td>
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<td>TASO</td>
<td>The AIDS Support Organisation</td>
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<td>TONASO</td>
<td>Tororo Network of AIDS Service Organizations</td>
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<td>UAC</td>
<td>Uganda AIDS Commission</td>
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<td>UAIS</td>
<td>Uganda AIDS Indicator Survey</td>
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<td>UHMG</td>
<td>Uganda Health Marketing Group</td>
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<td>ULDAHDTA</td>
<td>Uganda Long Distance and Heavy Truck Drivers’ Association</td>
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<td>UNAIDS</td>
<td>Joint United Nations Programme on HIV/AIDS</td>
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<td>URTI</td>
<td>urinary tract infection</td>
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<td>WC</td>
<td>wellness centre</td>
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About KMCC
The Uganda HIV/AIDS Knowledge Management and Communications Capacity building initiative (KMCC) aims to improve the communication of knowledge around HIV prevention in Uganda. KMCC does this through: comprehensive knowledge syntheses and the sharing of this information across all stakeholders; working with key stakeholders to demonstrate creative communication methods and to encourage a culture of transparency and collaborative working within the sector; and by providing best practice guidance and capacity building to partners for a more effective HIV/AIDS prevention response in Uganda.

Three in depth syntheses have already been conducted by KMCC: Virtual Elimination of Mother-to-Child Transmission in Uganda, disseminated in 2012; Behaviour Change Communication (BCC) Responses to HIV in Uganda, disseminated in October 2013; and MARPs: Fishing Communities and HIV, disseminated in June 2014. The third synthesis on fishing communities is the first in a series examining most at risk populations (MARPs), begun after consultation with stakeholders, and in accordance with national priorities. This, the fourth synthesis and second in the MARPs series examines long distance truck drivers while the third of the series examines sex workers.
Executive summary

The HIV/AIDS Knowledge Management and Communication Capacity building initiative (KMCC) and its partners have gathered, reviewed and synthesised information about HIV/AIDS and long distance truck drivers in Uganda. In preparing the synthesis, the second in a series dealing with populations at risk, KMCC interviewed experts who have been active in HIV prevention and mitigation in most at risk populations (MARPs), including long distance truck drivers in Uganda and other East African countries.

Levels of HIV prevalence and infection among long distance truck drivers are high, mainly because people in this group engage in high-risk behaviour and have limited access to health services. There is an urgent need for HIV prevention to target this vulnerable group.

HIV/AIDS and most at risk populations in Uganda

Uganda, one of the countries most affected during the early years of the initial AIDS epidemic in the 1980s, has successfully fought back. The prevalence of HIV (the proportion of the population infected) fell from 18% in the late 1980s to 6.4% in 2005, earning Uganda an international reputation for combating the epidemic. However, by 2011, HIV prevalence had risen to 7.3%. Uganda is one of the few countries where the prevalence of HIV is rising.

The HIV epidemic in Uganda is widespread. However, within the population there are groups who are more vulnerable to HIV, partly due to risky behaviour, and who have a higher than average risk of acquiring HIV. The groups disproportionately affected by the overall burden of HIV/AIDS in the country are referred to as MARPs, and include long distance truck drivers and their assistants, among others.

Transport is considered a ‘high-risk’ occupation. Overall, the transport sector is considered a major vector in the spread and transmission of HIV/AIDS for two broad reasons:

- The movement of people enabled by transport routes and improvements in the efficiency of transportation enables HIV to spread between high and low prevalence areas
- The sexual behaviour of transport sector workers and the populations that interact with them, such as sex workers, mean they can carry a high risk of contracting or transmitting HIV

Long distance truck drivers in Uganda

The term ‘long distance truck drivers’ refers to truck drivers and their assistants, individuals who earn a living transporting goods along major transport corridors within the country and across national boundaries. Due to their sexual networks along the road transport corridors, often related to long periods away from home, long distance truck drivers have gained a reputation as a ‘risk group’.

Prevalence of HIV among long distance truck drivers

Studies have revealed a high prevalence of HIV/AIDS among long distance truck drivers and their assistants in East Africa. Over 31,588 long distance truck drivers are estimated to be living in Uganda at any given time of the year. The HIV prevalence among long distance truck drivers ranges between 25% and 32%. Further research demonstrates that long distance truck drivers are at a higher risk of contracting HIV than the general population. Additionally, studies have shown that people living in
the vicinity of truck stops along major highway corridors tend to have higher HIV prevalence than the general population.

**Effects of HIV on the transport sector**

HIV/AIDS is one of the key challenges to the transport sector because it not only affects the availability, motivation and productivity of workers but, indeed, threatens the efficiency and productivity of the sector as a whole. Work in the transport sector can be physically taxing and dangerous, may require long hours, infrequent breaks, limited access to food and water, and frequently uncomfortable conditions and dangerous roads. The death of transport workers due to HIV-related illnesses can lead to serious declines in transport sector productivity, loss of earnings, and the attrition of skills and experience. The spread of HIV in the transport industry is especially significant for the economy because truck drivers are largely responsible for transporting produce, raw materials, supplies needed for daily subsistence, and import and export products.

**Knowledge of HIV among long distance truck drivers**

HIV knowledge among long distance truck drivers is quite high. Truck drivers are aware that multiple sexual partners (98.5% aware) and unprotected sex with an infected partner (98% aware) increase the risk of acquiring HIV. The awareness of these facts about HIV suggests that truck drivers have the level of knowledge necessary to prevent HIV/AIDS, although isolated pockets of misconceptions are still around. However, knowledge about HIV among long distance truck drivers does not always translate into safer sexual behaviour.

**Sexual behaviour of long distance truck drivers**

In East Africa, long distance truck drivers were identified as having HIV and sexually transmitted infections (STIs) very early on in the HIV epidemic. The relatively large number of unprotected sexual acts and low availability of condoms indicates inadequate prevention programming and unacceptably low risk perception among high-risk groups. Behaviours among truck drivers operating along major transport corridors in Uganda include high rates of multiple sexual partnerships, low consistent condom use and delayed STI treatment-seeking behaviours.

**Vulnerability to HIV of long distance truck drivers**

Many factors give rise to the vulnerability of long distance truck drivers to HIV. Of the main ways in which HIV can be transmitted, heterosexual sex is the most prevalent channel in which HIV spreads among truck drivers. Complex combinations of biological, social, cultural and economic factors determine the susceptibility of truck drivers to HIV. Vulnerability of truck drivers to HIV stems from several known or hypothesised HIV-risk factors that converge around the nature of transport drivers’ work:

- Long distance truck drivers are mobile or migratory; the social structures that constrain sexual behaviour in stable communities may not apply
- Cash income, irregular working hours and working away from home mean that truck drivers have disposable income and leisure time (when not driving), factors that favour the consumption of alcohol and casual sex; the corollary of this is that sex workers and low-income women are drawn to trading hubs precisely because of the opportunities to sell food, alcohol or sex
- Alcohol and other drugs are widely used among truck drivers to help them cope with boredom and stress
• Truck drivers are vulnerable to HIV due to limited prevention, treatment and mitigation measures as well as low health-seeking behaviour
• The nature of the work is full of risks; long distance truck drivers spend most of their time travelling along dangerous and remote highways, and face exhaustion, health problems, road accidents, attacks and mechanical failures

Models of service delivery addressing HIV/AIDS in long distance truck drivers
Various agencies and organisations in Uganda have addressed HIV/AIDS among long distance truck drivers in different ways and at different levels. However, agencies and organisations seldom provide comprehensive reports on their activities, outcomes and lessons learned. Models of care offered by various agencies and organisations include:
• Increasing HIV knowledge among long distance truck drivers, their sexual partners and other vulnerable community members
• Expanding access to HIV prevention services, including diagnosis and treatment for STIs, condom distribution, and HIV counselling and testing, including moonlight clinics that operate evenings and nights at transit stations
• Supporting technical assistance to provide services
• Facilitating referrals to community- and facility-based HIV care, support and treatment services
• Organising peer education, including holding health education sessions at parking yards, in bars and lodges, and during mass sensitisation campaigns in the community
• Educating sex workers for greater knowledge, empowerment and condom negotiation skills with long distance truck drivers
• Converting shipping containers into semi-mobile structures for housing clinics that deliver public health programmes for long distance truck drivers and sex workers, and primary healthcare to communities with limited or no access to medical services
• Developing roadside health clinics (roadside wellness centres) at truck stops and borders that stay open late and are located near parking facilities, and which also provide access to healthcare, counselling and health education for long distance truck drivers, sex workers and the surrounding communities

Gaps and challenges
Several gaps and challenges were identified including:
• Limited HIV programming in transport corridor hot spots
• Inadequate coordination
• Inadequate funding for HIV programmes targeting most at risk populations along transport corridors
• Limited sexual behaviour change interventions
• Limited HIV care and treatment services
• Structural issues/drivers

National level recommendations
The information reviewed for this synthesis shows that the current national response for long distance truck drivers to HIV/AIDS is disjointed and uncoordinated; often if programmes exist, they are run by individual, independent organisations. To tackle this we recommend the following:
• Conduct a nationwide sero-behavioural survey to establish HIV prevalence and behavioural patterns of long distance truck drivers and their assistants
• Form a cohort of long distance truck drivers to test and monitor an evidence-based package of interventions to establish their effectiveness
• Implement the UAC Multi-Sectoral HIV Response for MARPs in Uganda to guide HIV prevention, care and treatment among MARPs, focusing on long distance truck drivers and their partners (both casual and regular)
• Allocate appropriate funding and resources to enhance access to and utilisation of HIV services, specifically focusing on hot spots
• Support action-oriented, operational research and evaluation
• Build the skills of healthcare workers and ensure a more appropriate infrastructure for delivering HIV services and information to the target group, realising its mobile nature as the main challenge
• Sensitise managers of businesses linked to transport corridors to make the creation, funding and operation of HIV/AIDS and health programmes a matter of primary concern and part of their corporate responsibility
• Strengthen coordination between government institutions and civil society organisations working with MARPs to improve access to the services they need
• Improve referral systems and increase access to HIV/AIDS healthcare for MARPs
• Address legal issues, including anti-retroviral drug refills, in the region, focusing on cross-border coordination
• Supply technical information and advice to employers and employees on how to address HIV/AIDS in the workplace
• Address structural issues, such as lack of sanitation facilities and safe water, at border points
• Provide guidelines on medical examinations to ensure fitness for work to employers and health personnel

Implementation level recommendations
In developing this synthesis, it became clear that implementing partners seldom document the programmes they carry out, meaning that valuable lessons are lost. As long distance truck drivers are mobile and have unique needs, partners would benefit from getting together to understand what others are doing, where they are operating and to learn from each other’s best practices, gaps and challenges. Implementing partners could:
• Document programme activities in a format that allows comparison with other programmes
• Adopt a community-led approach to help hot spots, trading hubs and local governments to create context-specific programmes to cater for their particular needs
• Mobilise communities of mobile people to take action on matters that affect them directly. Given the necessary tools and resources, members of sex work groups, truck drivers, or any other key population can provide peer education and support behaviour change in a community
• Involve truck drivers and sex workers in designing, implementing and evaluating community-specific outreach programmes. HIV prevention activities are most effective when undertaken by those for whom they are intended
• Tailor services to the needs of long distance truck drivers, including setting up more moonlight clinics
Focus on risk zones; the sites or areas where risks may occur. Target interventions to places through which a large number of mobile people pass. These places should include hot spots, truck stops, trading hubs, bars and other areas truck drivers frequent.

Acknowledged language barriers when producing information, education and communication (IEC)/BCC materials by using infographics in place of text.

Programme level recommendations

Behaviour change programming should focus on four important areas: sexual health-seeking behaviour, condom use, number of partners and alcohol use. Though all four areas must be addressed, in a setting in which commercial sex is one of the mainstays of the economy and social life, interventions may need to focus more on condom use than reducing the number of partners.

Behaviour change programming should:

- Target specific risk behaviours among truck drivers
- Promote consistent condom use with casual and regular partners and encourage treatment-seeking behaviour, including completing STI treatment regimens
- Tackle fatalism by promoting a positive attitude to life, improving health and discouraging HIV-risk behaviours
- Provide and encourage alternative entertainment options other than drinking alcohol at hot spots and trading hubs
- Set up ‘sex worker-friendly’ and ‘long distance truck driver-friendly’ health services providing access to integrated services, paying particular attention to location and operating hours, and the preferences of long distance truck drivers and sex workers regarding service packages

Conclusion

Evidence from this comprehensive literature review suggests that mobile populations in Uganda are at a higher risk of HIV infection than the general population. For instance, HIV prevalence among key populations (that are known to be mobile), such as long distance truck drivers, ranges between 25 and 32%, which is significantly higher than the national average prevalence of 7.3%.

Although mobility in and of itself is not a risk factor for HIV infection, the situations long distance truck drivers encounter and the behaviours they engage as a result of their mobile occupation increase their vulnerability to HIV and their risk of HIV infection. The role of long distance truck drivers in the spread of HIV is mainly a result of their mobile occupation, which provides opportunities for high-risk behaviour and limits access to healthcare services. There is an urgent need to target HIV prevention and research efforts to this vulnerable group.
1.0 Background

1.1 The global HIV epidemic

At the end of 2013, there were approximately 35 million people living with HIV (PLHIV) worldwide. This number is rising as more people are living longer because of anti-retroviral therapy (ART). The number of new HIV infections, although declining, is still very high. An estimated 0.8% of adults aged 15–49 years worldwide live with HIV, although the burden of the epidemic continues to vary considerably between regions and countries. Of the 35 million PLHIV, approximately 24.7 million live in Sub-Saharan Africa, the region hardest hit by the epidemic (UNAIDS, 2014).

The 24.7 million PLHIV in Sub-Saharan Africa account for nearly 71% of the global total. Ten countries—Ethiopia, Kenya, Malawi, Mozambique, Nigeria, South Africa, Uganda, the United Republic of Tanzania, Zambia and Zimbabwe—account for 81% of all PLHIV in the region (UNAIDS, 2014).

1.2 The HIV epidemic in Uganda

Uganda was one of the countries most affected during the early years of the initial AIDS epidemic in the 1980s, but has since successfully fought back and earned an international reputation for combating the disease. The prevalence of HIV (the proportion of the population infected) fell from 18% in the late 1980s to 6.4% in 2005 (Ministry of Health, 2006). However, by 2011, the prevalence had risen to 7.3% (Ministry of Health, 2012). Uganda is one of the few countries where the prevalence of HIV is rising.

Figure 1. Trends in the prevalence of HIV among women and men aged 15-49 in Uganda

Several reasons have been put forward to explain rising prevalence, such as the increasing number of individuals on ART who are living longer, an increase in risky sexual behaviour and possibly less focus on HIV/AIDS prevention programmes (Ministry of Health, 2012). The Joint United Nations Programme on HIV/AIDS (UNAIDS) estimated the number of new infections at 150,000 in 2011, up from 120,000 in 2004 (PEPFAR, 2014).

The priority for HIV prevention in Uganda is to align interventions with the drivers of the epidemic (Uganda AIDS Commission, 2011). HIV is predominantly transmitted heterosexually; heterosexual sex accounts for 75-80% of new infections. However, the groups most affected, the risk factors and the drivers of HIV infection have changed in recent years. Over a third (35%) of new infections occur
among individuals who say they are monogamous, but actually have multiple concurrent sexual partners (PEPFAR, 2014). Studies show an HIV prevalence of 1.2% among university students, 15-40% in fishing communities, 37% among sex workers, 18% among the partners of sex workers and 13% among men with a history of having sex with men (Uganda AIDS Commission, 2011). The prevalence of HIV is largely due to high risk sex. The urgency for Uganda is to address the key driver of the epidemic, that is, HIV transmission through unsafe sex.

1.3 Most at risk populations in Uganda

The HIV epidemic in Uganda is widespread. However, within the population there are groups that are more vulnerable (partly due to risky behaviours) and that have a higher than average risk of acquiring HIV. These groups are disproportionately affected by the overall burden of HIV/AIDS in the country. People in these groups are often the first to become infected, run more risk of being infected than people in the population at large (Low et al., 2006) and can play leading roles in spreading infection. When responding to the epidemic, it is important to identify the populations that are most vulnerable to HIV.

UNAIDS lists people with behaviours that put them at greater risk of HIV infection—those who have frequent unprotected sex with partners, those who have unprotected anal sex with multiple partners, and those who inject drugs and drug preparations with multi-user equipment. The groups at risk include sex workers, clients of sex workers, people who inject drugs and men who have sex with men (UNAIDS, 2008). In Uganda, these groups of people are also affected by harsh legal and social environments, which may hinder their access to healthcare.

UNAIDS provides guidance for dealing with key populations at risk, while acknowledging sub-populations that may also be vulnerable to HIV and, in some settings, should be the focus of HIV prevention interventions. The sub-populations vary by country and context, and should be considered for potential monitoring when developing a national or sub-national monitoring and evaluation (M&E) plan (UNAIDS, 2008). The sub-populations identified as most at risk in Uganda, are fishing communities and men in uniformed services (Uganda AIDS Commission, 2011), migrant workers, slum dwellers, internally displaced people and people with disabilities (Makerere University School of Public Health, 2010). Although UNAIDS uses the term ‘key populations’ to describe these groups, in this synthesis we use the term ‘MARPs’, the term currently used in Uganda for most at risk (or key) populations.

The Uganda National HIV Prevention Strategy 2011-2015 takes the dynamics of epidemics into account when formulating interventions to significantly decrease new HIV infections in the country. As such, the strategy states the need to provide MARPs with services tailored to their needs, in addition to providing services for the general population (Uganda AIDS Commission, 2011).

A 2006 review found that MARPs can play a role in the occurrence of new infections in the general population (Uganda AIDS Commission, 2006). More recently, research study results show that individuals engaged in multiple partnerships contribute 24% of new infections while the partners of individuals reporting multiple partnerships account for 22%. Sex work may account for 11% of new infections, of which clients of sex workers contribute 8%, sex workers 1% and partners of clients account for 2% (Makerere University School of Public Health, 2010).

However, there are few policies or guidelines for interventions to prevent HIV/AIDS in these vulnerable, at risk groups and health services for these groups are inadequate. According to the
Modes of Transmission study of 2009, outreach services for MARPs have not been satisfactorily rolled out and the coverage is sub-optimal (Uganda AIDS Commission, 2009). According to the Global AIDS Response Progress Report for Uganda January 2010–December 2012, behavioural, biomedical and structural HIV prevention interventions did not achieve universal coverage (Uganda AIDS Commission, 2012) and MARPs continue to be particularly underserved. The KMCC MARPs synthesis series therefore reviews the HIV/AIDS situation in Uganda, the drivers, current interventions and responses to these underserved groups, and recommends programmes and strategies for reducing new infections.

This synthesis is the third in a series dealing with underserved populations at risk of HIV and focuses on long distance truck drivers. It synthesises literature on HIV and long distance truck drivers in order to contribute quality knowledge to the HIV/AIDS sector. Sharing information gained from the literature among stakeholders informs evidence-based policy and practice and, thereby, contributes to lessening annual HIV infections.

The specific objectives are to:
1. Define and describe long distance truck drivers in Uganda
2. Describe how long distance truck drivers have been affected by the HIV epidemic in Uganda
3. Identify the major responses targeting key HIV/AIDS issues affecting long distance truck drivers, highlighting key successes, lessons and best practices in specific areas of behaviour change
4. Identify prevailing gaps and challenges relating to current prevention interventions relating to long distance truck drivers in Uganda
5. Make recommendations for more effective prevention interventions with respect to long distance truck drivers in Uganda

1.4 Long distance truck drivers at risk

Transport is considered a ‘high-risk’ occupation (World Bank, 2003). Long distance truck drivers have a robust but diverse sexual culture (Marck, 1999). Overall, the transport sector is considered a major vector in the transmission of HIV/AIDS for two main reasons. The high mobility of workers enables HIV transmission between high and low prevalence areas, while the sexual behaviours of transport sector workers and the populations that interact with them, such as sex workers, carry a high risk of contracting or transmitting HIV. The risky behaviour of transport sector workers, and of the populations that interact with transport sector workers, also puts their partners and communities at risk. In East Africa, long distance truck drivers were identified very early in the epidemic as a group at risk of HIV and STIs. The relatively high number of unprotected sexual acts and low availability of condoms indicates inadequate prevention programming and low risk perception among high-risk groups (International Organization for Migration, 2009).
2.0 Methodology

KMCC identified, reviewed and catalogued approximately 50 documents related to long distance truck drivers and HIV in Uganda and East Africa. The documents included papers in online bibliographic databases (PUBMED, Google Scholar), Uganda AIDS Commission and Ministry of Health reports, Uganda AIDS Indicator Surveys (UAISs), the Uganda Modes of Transmission study, the National HIV Prevention Strategy, the National HIV/AIDS Strategic Plan, project reports, and published and unpublished papers from Uganda and East Africa.

The comprehensive literature review was backed up with qualitative methods. Ten key informants were selected for their knowledge of the transport sector in relation to long distance truck drivers and their relationships to HIV/AIDS and the health system in Uganda. The key informants included experts in HIV, researchers, long distance truck drivers and policy makers, as well as planners and implementers of interventions in Uganda. An interview guide was designed to explore the synthesis objectives. The interview guides were reviewed by the quality assurance group and pre-tested before data collection. Key informant interviews were used to complement the literature review, as well as to verify information previously collected from the documents reviewed. Quotes are included to illustrate typical responses of informants and the context of responses.

Two facilitated community dialogues on ‘Vulnerability of HIV among long distance truck drivers’, in Malaba and Kasese, provided further information.
3.0 Long distance truck drivers in Uganda

The transport sector in Uganda consists of a wide range of agencies, actors and populations working in transport-related infrastructure and providing transport services. The transport network moves millions of people and goods every day, both within and across borders. These movements can either continue to widen the spread HIV/AIDS or can be a powerful channel for disseminating the information, knowledge and understanding upon which effective HIV prevention depends. Every truck driver, taxi driver, bus driver, commuter or passenger can be either part of the problem or part of the solution to the problem.

3.1 Definition and demographics

The term ‘truckers’, as defined by the International Organization of Migration, refers to long distance truck drivers and their assistants. These include individuals who earn a living transporting goods along major transport corridors within a country and across national boundaries (International Organization for Migration, 2009). Due to their sexual networks along road transport corridors, often related to long periods away from home (Bwayo et al., 1994; Marck, 1999), long distance truck drivers have gained a reputation as a ‘risk group’ (Bwayo et al., 1991). This reputation is also due to reports of high HIV prevalence among long distance truck drivers (Mbugua et al., 1995) and among people in the truck stops they frequent. The reputation was echoed in key informant interviews:

“These are drivers driving commercial trucks between two cities but in most case[s] across borders and [they] spend long periods of time away from their homes and families. They are employed to deliver goods and services. The definition also takes care of the assistants.”

“A truck driver is someone who doesn’t have a permanent home- always driving on highways, through border crossings and in country. They can be heavy trucks or small vehicles, as long as they are constantly moving. When speaking of truck drivers, one must also consider turn boys (their assistants).”

“Long distance truck drivers are males between the age group 15-60 years hired by transport companies or individuals to move goods in trucks for long distances from one town to another within a country or, across borders from one country to another. In the process the drivers and their assistants stay away from their homes for a number of days or even months.”

“Truck drivers are people who spend a lot of time on the road and drive long distances—spending nearly half the year away from home. They tend to have multiple partners as a result of this. These are usually older men—above age 30, with some education, at least primary, some with secondary—and many can read.”

“Long distance truck drivers, actually I would prefer the term long distance truckers as these include driver, turn boys who are their assistants, manual labourers at parking bays etc. A long distance truck driver would then be defined as the individual, usually a man, who controls a vehicle, normally six-wheeler onwards, and drives it from one place to another, transporting goods for trade purposes over long periods and long distances within and across countries.”

For the purposes of this paper, we refer to truckers or long distance truck drivers and their assistants simply as long distance truck drivers.
Demographics
The Northern Corridor is the busiest and most important transport route in East and Central Africa. It links the Great Lakes countries of Burundi, Democratic Republic of Congo, Rwanda and Uganda to the Kenyan sea port of Mombasa. The corridor also serves Northern Tanzania, Southern Sudan and Ethiopia. The majority of long distance truck drivers described in this synthesis work along this route.

An International Organization of Migration (IOM) study in Uganda found that the majority of long distance truck drivers were aged 30 years and above (69%) and the rest were aged 20-29 (31%). Most long distance truck drivers and their assistants had completed primary or secondary education (39% and 49% respectively). As for marriage, 70% were currently married (International Organization for Migration, 2009).

Another IOM study along the Kampala-Juba transport route found that over half of the long distance truck drivers interviewed were currently married, but a significant number were widowed, separated or divorced. The long distance truck drivers had a median of four children to support, with a range of none to 18 (18 being exceptional). Around half of those interviewed had more than 8 years of schooling. With an age range of 21-50 years, and mean and median ages around 33 years, the long distance truck drivers are in the most vulnerable male age group for contracting HIV (International Organization for Migration, 2008).

3.2 Number of long distance truck drivers in Uganda
There is a wide range of estimates of the number of long distance truck drivers in Uganda at the national and sub-national levels. In the UAC Multi-Sectoral HIV Programming for MARPs in Uganda: Review of Profiles, Sizes and Programme Coverage, these estimates are provided. In 2011, a Monitoring and Evaluation of the Emergency Plan Progress (MEEPP) report established that there were 31,588 long distance truck drivers living in Uganda. A 2013 IGAD baseline survey estimated that there were 313 living in Bibia and Oraba, while Strengthening TB and HIV & AIDS Responses in East-Central Uganda (STAR-EC) estimated that there were 191 long distance truck drivers in their nine programme districts. A study by IOM and Makerere University estimated that there were 240 long distance truck drivers in five hot spots (centres of trade and business activity that also contain areas of transactional sex described below), Arua Park, Migyera, Bweyale, Karuma and Bibia (UAC, 2014).

As stated above, the estimates of the number of long distance truck drivers in Uganda in most studies vary in size for different regions. Most studies are sub-national and give estimates from areas covered by specific programmes. Only the MEEPP currently covers the whole country, estimating that nationally 31,588 long distance truck drivers live in Uganda (UAC, 2014).

3.3 Trading hubs and hot spots
Trading hubs are points where goods are loaded and/or off loaded. They are commercial or business centres that attract people from different areas and regions. Long distance truck drivers take breaks at these hubs and other roadside stops because refreshments, food, accommodation and sex are easily available. The truck stops benefit because drivers spend money and bring goods for trading. The roadside bars are frequented by men who are economically well off. There, they can drink cold beer, served in clean glasses, while seated on sofas or chairs at tables. Though the owners of the bars are often women, and all those serving are women, the bars are frequented mainly by men (Gysels et al., 2001).
Centres of trade and business activity that also contain areas of transactional sex are termed ‘hot spots’. A hot spot has been defined as an area along a transport corridor that is frequented by sex workers and long distance truck drivers, and which is usually characterised by high levels of commercial sex. Hot spots are typically trading centres along transport corridors where truck drivers park for the night. In a town approximately 100 km south west of Kampala, where the sexual behaviour of sex workers was documented, approximately 60 lorries stop each day and around half stay overnight (Pickering et al., 1997). However, another study reported that a typical hot spot can have more than 100 trucks parked overnight (Matovu & Ssebadduka, 2012).

It has been reported that hot spots along transport corridors can be seen as ‘risk zones’. Hot spots are areas of relative economic prosperity where a number of different categories of people converge for different reasons. These localities comprise not only truck drivers and sex workers, but also a broad cross section of people, resulting in environments that are conducive to engaging in HIV-risky sexual behaviour (International Organization for Migration, 2009). These major transport corridors tend to have a higher HIV prevalence than the general population (Bwayo et al., 1994).

Key informants confirmed the information on hot spots:

“Hot spots are community settings that attract leisure and welfare activities like bars, lodges, restaurants, and hotels and discotheques. They tend to attract sex workers because of the availability of potential customers.”

“They are small towns or trading centres along the main transport corridors with high economic activity, attracting huge numbers of people. This activity includes transactional sex/commercial sex and the spots have a high rate and risk of HIV transmission. Typically these are areas close to the borders, main truck packing lots or in land where truck drivers prefer to park and rest.”

3.4 Other transport workers

Although this synthesis focuses on long distance truck drivers and their assistants, there are other categories of transport workers that are also at risk of HIV infection, including boda boda motor cyclists, taxi drivers, water transport workers and rail workers.

**Boda boda cyclists**

Boda boda cyclists have an HIV prevalence of 7.4%. The proportion reporting having had at least one STI, including HIV, syphilis, gonorrhoea, chlamydia and trichomoniasis, was 14%. Same-sex or bi-sexual attraction in boda boda cyclists was reported to be 4% and sexual intercourse 3.4%. These findings suggest that boda boda cyclists may have a somewhat higher risk of HIV infection than other men (Makerere University School of Public Health, 2010).
4.0 HIV prevalence among long distance truck drivers

Studies show a high prevalence of HIV among long distance truck drivers and their assistants in East Africa (Bwayo et al., 1994). Over 31,588 long distance truck drivers are estimated to live in Uganda at any given time of the year and HIV prevalence among them ranges from 25% to 32% (UAC, 2014). Research demonstrates that long distance truck drivers have a higher risk of contracting HIV than the general population (Morris & Ferguson, 2006). Additionally, studies have shown that the prevalence of HIV among people living in the vicinity of truck stops along major highways tends to be higher than the prevalence of HIV among people in the general population (Serwadda et al., 1992). Gysels et al. (2001) reported that the prevalence of HIV in a town where truck drivers stop along the Trans-Africa highway in southwest Uganda was 40%.

Carswell et al. (1989) assessed the sexual behaviour and history of STIs of 45 Ugandan and Kenyan long distance truck drivers, and 23 long distance truck driver assistants who passed through a transport depot in Kampala. The overall HIV prevalence was 35%, compared with 9% in a control group. Bwayo et al. found that, in Kenya, the prevalence of HIV in Ugandan men attending a research clinic along a transit route was 36%. The prevalence of HIV was similar among long distance truck drivers, assistants and mechanics. Infection with HIV correlated directly with the hours driven (time away from home) and the number of trips outside Kenya, and correlated inversely with the number of trips a month. The HIV-positive drivers reported fewer visits to their wives at home and more frequent visits to prostitutes than men who were not HIV-positive (Bwayo et al., 1994).

With high levels of HIV prevalence among long distance truck drivers, we must examine the effects this could have on the transport sector.
5.0 Effects of HIV on the transport sector

HIV/AIDS is one of the key challenges to the sector because it not only affects the availability, motivation and productivity of workers, but also threatens the efficiency and productivity of the sector as a whole. HIV/AIDS compromises the effectiveness and reliability of the transport sector by affecting its labour force. Labour is an essential input in the transport sector. In many areas, including long distance truck driving, and transporting goods and transport services, the industry is very labour intensive. The work can be physically taxing and dangerous, and can require long hours, with infrequent breaks, limited access to food and water and, often, uncomfortable conditions and bad roads.

Long distance truck drivers in the transport sector can experience disruption of their social support mechanisms and family structures. This disruption, in turn, can create situations conducive to the establishment of new casual sexual relationships. For transport workers, a lack of control over their life circumstances results in a risk-taking mentality, which advocates high levels of sexual activity as a way of dealing with danger and stress, which can lead to negative effects in their work and on the sector.

The evidence suggests that HIV among long distance truck drivers and sex workers is rising more rapidly than among the general population in Africa. Long distance truck drivers could be lost to AIDS at a rate faster than they can be replaced, a loss which would have a serious impact on the transport sector of the economy (Kribs-Zaleta et al., 2005). The deaths of transport workers due to HIV-related illnesses could lead to serious deterioration in transport sector productivity, loss of earnings, and attrition of skills and experience. By striking down people in their adulthood, HIV/AIDS limits the pool of potential recruits and diminishes the pool of skilled labour the sector needs to be productive (World Bank, 2003). The spread of HIV in the transport industry is especially significant to the economy because truck drivers are largely responsible for transporting crops and supplies.

A key informant agreed with this assessment and said:

“The transport sector is characterised by works away from home (construction sites, road construction sites and long distance truck drivers) hence separation from regular sexual partners, a situation which increases the vulnerability of such workers to get involved in extra marital affairs/relationships which expose them to HIV infection. The vulnerabilities have led to loss of irreplaceable experienced labour both skilled and unskilled. This in the end has affected efficiency, effectiveness and mentoring of upcoming labour/human resource in the sector.”
6.0 Knowledge of HIV among long distance truck drivers

People need to know the facts about HIV in order to prevent its spread and control the epidemic. Knowledge of how HIV is transmitted is a prerequisite for adopting risk-reducing behaviours and seeking health services. Knowledge about HIV can also reduce discrimination against people already living with the virus and lessen the stigma they suffer. Moreover, people need knowledge to encourage them to change to positive behaviours or to adopt risk-reducing behaviours.

The Uganda AIDS Indicator Survey (UAIS) defines comprehensive knowledge as:

- Knowing that consistent use of condoms during sexual intercourse and having just one uninfected faithful partner can reduce the chance of getting AIDS
- Knowing that a healthy-looking person can have AIDS
- Knowing that mosquito bites and sharing food do not transmit AIDS (Ministry of Health, 2012)

Many studies show that long distance truck drivers have heard about STIs, HIV and AIDS. In a survey of truck drivers by IOM, 82% of truck drivers questioned disagreed with the statement “I can tell who has HIV by looking at them,” suggesting that the majority knew that it is not possible to tell if a person has HIV by looking at them. However, 16% agreed with the statement, suggesting that around a sixth of those surveyed believed they could tell if a person had HIV by looking at them.

Truck drivers were aware that the risk of acquiring HIV increased with multiple sexual partners (98.5%) and unprotected sex (98%) with an infected partner, suggesting that they had enough knowledge of HIV/AIDS to prevent infection. However, isolated pockets of misconceptions abound (International Organization for Migration, 2009). Some findings show that misconceptions about HIV transmission, and awareness of STIs and how they are transmitted, are not always consistent. Though transport sector workers are generally aware of HIV/AIDS, some believed or were unsure that HIV is transmitted by mosquitoes and by sharing food (14.2% and 11.1% respectively).

The percentage of long distance truck drivers with these misconceptions was much lower than the national average. Nationally, 59% of men knew that AIDS cannot be transmitted by mosquito bites and 80% of men knew that people cannot get AIDS by sharing food with a person who has AIDS (compared to 85.8 and 88.9% among truck drivers respectively) (Ministry of Health, 2012).

An investigation of knowledge of preventive strategies against HIV/AIDS was undertaken by Ntozi et al. (2003) using focus groups of long distance truck drivers. The respondents knew that the only remedy was prevention through protected sex using condoms. Despite their awareness of ways to protect themselves against HIV, participants reported that not much had been done on this front. The study reported that regular messages had been broadcast by radio stressing that using condoms protects against HIV. In their responses, truck drivers said, “those with multiple sexual partners are at a high risk of getting AIDS because even condoms may fail...some women may even convince you not to use condoms pretending they are safe” (Ntozi et al., 2003).

In another study by Matovu and Ssebadduka, long distance truck drivers’ knowledge of condom use as an HIV-prevention strategy suggested a high level of awareness of the effectiveness of condoms if used properly and consistently. Nearly all long distance truck drivers (95%) agreed with the
statement, “using condoms correctly and consistently reduces the risk of HIV infection” (Matovu & Ssebadduka, 2013).

National data shows that knowledge of HIV-prevention methods is widespread across the country, but less widespread than among long distance truck drivers. Among men age 15-49, 84% indicated that the chance of getting the AIDS virus can be reduced by using condoms every time they have sex (Ministry of Health, 2012).

It is also important to point out that although long distance truck drivers reflected on the need for female company to relieve stress while on long, lonely travels across Africa, they were all aware that people with multiple sexual partners can be highly vulnerable to contracting HIV. They reported that they had adopted condoms as a strategy to prevent HIV. They also observed that married people can be at high risk of contracting HIV if condoms are not used in marital sex and if spouses are unfaithful. However, some truck drivers also reported “we indulge in sex with any person regardless of status” (Ntozi et al., 2003).

Knowledge about HIV among transport workers does not, however, always translate into safer sexual behaviour (Ministry of Works and Transport, 2011).
7.0 Sexual behaviour among long distance truck drivers

Behavioural factors are those related to individual behaviour over which an individual has a great amount of control. The role of behavioural factors in the transport sector is of critical importance given that most of the workers in the sector and in sector-relevant populations are in the sexually active age range (Ministry of Works and Transport, 2011).

In East Africa, long distance truck drivers whom were HIV positive and had STIs were found very early on in the epidemic. The relatively large number of unprotected sexual acts and limited availability of condoms indicates inadequate prevention and low perceptions of risk among this high-risk group (International Organization for Migration, 2009). A study of sexual risk behaviours, condom use patterns and STI treatment-seeking behaviours among long distance truck drivers operating along major transport corridors in Uganda found a high proportion of drivers had multiple sexual partnerships, did not use condoms consistently and delayed seeking treatment for STIs (Matovu & Ssebadduka, 2012).

7.1 Long distance truck drivers and sex workers

Transport workers and sex workers, both considered MARPs, have long been associated with risky sexual behaviour and the spread of HIV in East Africa, in Africa and in other parts of the world. Transport workers spend prolonged periods of time away from home and, due to a combination of loneliness, peer pressure, alcohol use and to satisfy their sexual needs, may resort to casual sex or develop regular non-marital sexual relationships while in transit (Ntozi et al., 2003). Some studies (Gysels et al., 2002; Ntozi et al., 2003; Pickering et al., 1997) have also reported that long distance truck drivers often comprise approximately 28-30% of the clientele of sex workers (International Organization for Migration, 2008).

Great numbers of sex workers, many of whom lack other livelihood options, frequent stopping points along transport corridors. This situation creates an environment where individuals engage in sexual acts with multiple concurrent partners, thereby increasing their chance of contracting HIV and other STIs. Through sexual networks, people with multiple concurrent partners have the potential to spread HIV infection from high-risk groups to the general population. Because long distance truck drivers normally spend nights away from home they may engage in sex with many casual and semi-regular partners along their transport routes, sometimes without using condoms (Morris & Ferguson, 2006), exposing themselves to the risk of acquiring or transmitting HIV.

Commercial and casual sex can be easily available in the many bars around towns, from high-class sex workers, women selling food on the street or in markets, and the many women with no reliable income who are willing to provide sex very cheaply. High-class prostitution generally takes place in lodges, where overnight clients pay for a room in which they sleep with a woman with whom they had earlier made an appointment. Cheaper sex is extremely casual and can take place with little or no negotiation in a banana plantation, the man or woman’s home or any other convenient place (Pickering et al., 1997).

Morris and Ferguson estimated that there are 8,000 female sex workers on the Trans-Africa highway between Mombasa and Kampala a year. The number of different sexual partners per sex worker was 129 a year and the number of sexual acts per sex worker was 634 a year. The percentage of sexual acts protected by condom use was reported to be 77.7%. Based on this data, an estimated 3,200 to
4,148 new HIV infections occur on this stretch of the Trans-Africa highway in one year (Ferguson & Morris, 2007; Morris & Ferguson, 2006).

Mapping of hot spots along the Kampala-Juba highway by IOM found that 72% of the long distance truck drivers interviewed had had two or more sexual partners over the past year, despite the fact that 66% had stable sexual partners at home (either married or cohabiting). Up to 32% of the truck drivers reported at least one liaison with a sex worker during the recall period. The difference between the behaviour of the married and the non-married long distance truck drivers with a commercial sex worker was not significant (International Organization for Migration, 2008).

### 7.2 Other forms of transactional sex

Sex work can be difficult to distinguish from other sexual relationships. Money may not always be exchanged. Commodities, favours or other goods may substitute for money. Long distance truck drivers are attractive clients to commercial sex workers; however, many other women may also have casual or regular sexual relationships with long distance truck drivers. Besides commercial sex workers, transport workers also tend to develop sexual networks with other local young girls and women who provide services along transport corridors, as bar attendants and street traders. The economic opportunities offered in truck stops and along transport routes often attract girls and women from rural areas. Some studies show that such women may offer sex to transport workers in exchange for free transport or other favours (Anarfi, 1997).

Pickering et al. (1997) described three ‘types’ of sex workers in a Ugandan trading town on the Trans-Africa highway in south west Uganda. The author classified the women into ‘high’, ‘middle’ and ‘low’ socioeconomic status, based on the sum charged for a sexual act. Results of the study showed that the types of client corresponded with the women’s status, for example, women with ‘high’ status only interacted with clients from out of town whereas the clients of women with ‘low’ status were mainly locals. Another study, completed years later in the same town, found that women and a group of waitresses who exchanged sex primarily with long distance truck drivers could be grouped into similar socioeconomic groups (Gysels et al., 2002).

A woman with a low status wishing to visit her family in a town on the main road would consider herself lucky to get a free lift with a lorry driver in exchange for sex. A woman with a high status, on the other hand, would not only make sure that she had a free lift but would also double her normal charges and insist on being given a return taxi fare (Pickering et al., 1997). Women with a low status still partake in transactional sex, but may do so for commodities, favours or other goods for daily subsistence and survival.

### 7.2.1 Use of middlemen and women

Mediation in casual sexual relationships through middlemen is common at truck stops throughout the region. Middlemen have an important economic role, buying goods from long distance truck drivers and selling them on to individuals or retailers locally. They also provide advice to long distance truck drivers who are unfamiliar with a town, translate for those unable to speak the local language and put long distance truck drivers in contact with local women who sell sex (Gysels et al., 2001). It is also reported that long distance truck drivers often rely on middlemen to identify unmarried and ‘safe’ (HIV-negative) women with whom they can have casual sex. Sex workers use middlemen because they assure discretion (Gysels et al., 2001) and guarantee that long distance truck drivers will pay well.
Though initially middlemen were mostly male, more middle-women are emerging. They are usually older commercial sex workers who promote younger, attractive women for the long distance truck drivers to engage with in order to maintain sex networks (MoH, 2009). Data indicated that, in the past, older women dropped out of commercial sex work and engaged in other income generating activities. However, this was reported to have changed, with the older sex workers taking up new roles, including recruiting commercial sex workers, providing accommodation for sex work, mentoring new sex workers and acting as middle-women between sex workers and clients (MoH, 2009).

Easy access to commercial and casual sex makes it possible for workers in the transport sector to acquire HIV in hot spots, spread it to regular or casual partners along their route, and infect regular partners when they return home. Because of their potential to spread HIV to a wide network of partners along transport routes and on their return home, long distance truck drivers have been considered a ‘core transmitter group’ for HIV/AIDS (Great Lakes Initiative on AIDS, 2006).

### 7.3 Multiple sexual partners

One of the risk factors for HIV transmission is engaging with multiple concurrent and casual sexual partners. Long distance truck drivers move from place to place as part of their jobs. This mobility increases the number of potential sexual contacts that long distance truck drivers may engage in. Transport hubs are also associated with the influx and interaction of people from different backgrounds and with different sexual histories and networks. Long distance truck drivers may make new sexual contacts and, in the process, may facilitate the transmission of HIV (Ministry of Works and Transport, 2011).

Documented evidence indicates that long distance truck drivers have many partners along transport routes, many of whom may be sex workers. The finding that long distance truck drivers engage in sex with multiple sexual partners suggests that they can act as a bridge to transmit HIV and other STIs to the general population (Matovu & Ssebadduka, 2012).

Ntozi et al. found that long distance truck drivers attributed having multiple sexual partners to the nature of their job (travel), to excessive alcohol consumption and to money, which they normally carry. They travel a lot, live in different lodges and meet many women along the way. Women believe that trucks belong to the long distance truck drivers, therefore that they have a lot of money. Long distance truck drivers reported, “*When a vehicle breaks down on safari we drink and sleep with women...we have sexual partners scattered all along the routes we follow on safari.*” Ntozi et al. probed further to determine whether long distance truck drivers in Uganda had made any changes in the number of sexual partners they engaged with. The results of observations, however, indicated that the practice of engaging with multiple sexual partners continues among long distance truck drivers. “*It is the same...women in lodges look for us, HIV-infected women are desperate and multiple sexual partnership is increasing*” (Ntozi et al., 2003).

Sexual patterning has advantages over more traditional methods of recall, which are influenced by social desirability and recall biases. In another study, long distance truck drivers were asked to recall all their sexual partners over the 12 months prior to being interviewed by name, nickname or description, as well as by frequency of contact, type of partner and consistency of condom use. A total of 210 different sexual partners were recorded by the 101 men reporting. A range of 1 to 4 partners and no abstinences were recorded. Around 72% of the men reported having had more than...
one sexual partner over the period. Currently-married men reported an average of 2.16 partners compared with 1.96 partners for all other men (International Organization for Migration, 2008).

The number of sexual partners varies greatly, depending on the study area. In a study of 12 hot spots in Uganda, 75% of sex workers and 39% of long distance truck drivers reported engaging in sex with 50 or more sexual partners over the past year, and 55% of sex workers and 23% of long distance truck drivers reported a similar number of partners (50+ partners) over the past six months. In the 30 days preceding interviews, 19.2% of long distance truck drivers reported engaging in sex with one sexual partner, 52.9% reported engaging in sex with 2–9 partners and 27.6% reported sex with 10–49 partners. Long distance truck drivers also reported a mean of 44.7 partners in the past year, 28.1 partners in the past six months and 7.4 partners in the past 30 days (Matovu & Ssebadduka, 2012).

Table 1. Sexual partners reported by female sex workers (FSWs) and long distance truck drivers in Uganda, 2008

<table>
<thead>
<tr>
<th>No. of sexual partners</th>
<th>Past 12 months n</th>
<th>Past 12 months %</th>
<th>Past 6 months n</th>
<th>Past 6 months %</th>
<th>Past 30 days n</th>
<th>Past 30 days %</th>
</tr>
</thead>
<tbody>
<tr>
<td>FSWs</td>
<td></td>
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</tr>
<tr>
<td>1</td>
<td>0</td>
<td>0.0</td>
<td>04</td>
<td>1.5</td>
<td>08</td>
<td>3.1</td>
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<tr>
<td>2–9</td>
<td>07</td>
<td>2.7</td>
<td>15</td>
<td>5.8</td>
<td>66</td>
<td>25.5</td>
</tr>
<tr>
<td>10–49</td>
<td>59</td>
<td>22.8</td>
<td>98</td>
<td>37.8</td>
<td>174</td>
<td>67.2</td>
</tr>
<tr>
<td>50+</td>
<td>193</td>
<td>74.5</td>
<td>142</td>
<td>54.8</td>
<td>11</td>
<td>4.2</td>
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<tr>
<td>Mean number of partners</td>
<td>74.5</td>
<td>54.8</td>
<td></td>
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<td></td>
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<tr>
<td>Truck drivers</td>
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<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>25</td>
<td>9.6</td>
<td>31</td>
<td>11.9</td>
<td>50</td>
<td>19.2</td>
</tr>
<tr>
<td>2–9</td>
<td>43</td>
<td>16.5</td>
<td>75</td>
<td>28.7</td>
<td>138</td>
<td>52.9</td>
</tr>
<tr>
<td>10–49</td>
<td>90</td>
<td>34.6</td>
<td>94</td>
<td>36.0</td>
<td>72</td>
<td>27.6</td>
</tr>
<tr>
<td>50+</td>
<td>102</td>
<td>39.2</td>
<td>61</td>
<td>23.4</td>
<td>01</td>
<td>0.4</td>
</tr>
<tr>
<td>Mean number of partners</td>
<td>44.7</td>
<td>28.1</td>
<td></td>
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</tr>
</tbody>
</table>

(Source: Matovu & Ssebadduka, 2012).

The numbers quoted by Matovu and Ssebadduka (2012) differ greatly from national averages. Nationally, the UAIS found that nearly 20% of all men surveyed aged 15–49 reported having two or more sexual partners in the previous year (Ministry of Health, 2012).

### 7.4 Condom use

According to Matovu and Ssebadduka (2013), knowledge of condom use as an HIV-prevention strategy is generally high. Attitudes towards condom use were generally favourable as well, with 91% of sex workers and 82% of long distance truck drivers agreeing with the statement, “Condom use is the best method for HIV prevention”. However, one-third of long distance truck drivers and 28% of sex workers agreed with the statement, “Condoms kill the mood for sex”. In addition, 18.4% of long distance truck drivers agreed with the statement, “I don’t like to use condoms myself”. Long distance truck drivers cited the need to “please the lower part of the body” as one of the reasons why they normally do not like to use condoms (Matovu & Ssebadduka, 2013). One long distance truck driver said, “...you drive a vehicle from here up to Sudan, there are many potholes, they hit
you...if you are back to Malaba, there is need to make your lower body happy because you have been sitting for a long time and the vehicle has over hit you in the potholes...the moment you get a woman you don’t want to use a condom” (Matovu & Ssebadduka, 2013). Another long distance truck driver expressed similar sentiments, “For us who are on the road, we don’t mind about diseases. We go to Mombasa, we come back to Nairobi, go to Kampala. We don’t like condoms” (Gysels et al., 2001).

In a survey carried out by Morris and Ferguson (2005) along the Mombasa-Kampala highway, 84% of the 381 long distance truck drivers surveyed reported using condoms during their last commercial sexual contact. However, the use of condoms with occasional partners was 71%.

**Facilitated community dialogue**

When asked why long distance truck drivers do not want to use condoms a community member responded, “It is because these truck drivers had never been sensitised. They come at night very tired, and just go to the lodge to rest and later go out to please themselves.” The facilitator asked if the men did not know that a person can get HIV if they do not use condoms. A respondent replied, “They know, but what they are doing is now going for young girls because they think young girls are safe.”

In a study of 12 hot spots in Uganda, 96.6% of long distance truck drivers and 99.2% of sex workers reported that they had used condoms; 99.2% of sex workers and 88.9% of long distance truck drivers reported that they had used condoms in the past year; while 98.8% of sex workers and 94.6% of long distance truck drivers reported that they had used condoms in the past six months. Condom use in the past 30 days was reported by 93.7% of sex workers and 86.8% of long distance truck drivers. Despite these rates of condom use, consistent condom use (assessed among those who reported condom use in the past 30 days) was low with only 44.9% of sex workers and 21.1% of long distance truck drivers reporting consistent condom use during this period (Matovu & Ssebadduka, 2012). In the 30 days preceding the survey, of 261 long distance truck drivers, 54% reported using condoms with casual partners, 56% with regular partners and 26% with spouses. When asked about consistent condom use, 47% reported consistent condom use with casual partners, 39% with regular partners and 12% with spouses (Matovu & Ssebadduka, 2012).
Table 2. Use of condoms by female sex workers (FSWs) and long distance truck drivers in Uganda, 2008

<table>
<thead>
<tr>
<th></th>
<th>Percentage reporting any condom use (n = 261), (%)</th>
<th>Percentage reporting consistent condom use in past 30 days (n, %)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Truckers</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Casual partner</td>
<td>54.0</td>
<td>66/141 (46.8)</td>
</tr>
<tr>
<td>Regular partner</td>
<td>56.6</td>
<td>56/145 (38.6)</td>
</tr>
<tr>
<td>Spouse</td>
<td>25.7</td>
<td>8/67 (11.9)</td>
</tr>
<tr>
<td>FSWs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Casual partner</td>
<td>85.7</td>
<td>n / 160 (72.1)</td>
</tr>
<tr>
<td>Regular partner</td>
<td>75.7</td>
<td>80 / 196 (40.8)</td>
</tr>
<tr>
<td>Spouse</td>
<td>6.2</td>
<td>1 / 16 (6.3)</td>
</tr>
</tbody>
</table>

*Consistent condom use determined as a proportion of those reporting any condom use in the past 30 days

(Source: Matovu & Ssebadduka, 2012)

The findings of Matovu & Ssebadduka (2012) highlight the trade-off between degree of intimacy and condom use. Condom use with close partners is very low. Consistent condom use is highest for liaisons with sex workers and lowest with spouses. Although condom use is high initially for ‘other regular’ partners, use at last liaison and consistent use are only around 40% (International Organization for Migration, 2008). The reasons advanced for this pattern include protection against possible contraction of HIV from casual partners, and a desire to have children with wives and other regular partners. Some long distance truck drivers also reported that they did not use condoms with regular partners or spouses in order to build trust. Respondents reported “We do not think any of us can use condoms with a wife, how then could one get children”, “it is not wise to use condoms with a regular partner, she can think you do not trust her and she can also lose trust in you, which is not good” (Ntozi et al., 2003).

In a Kenyan study, teams visited six trucking companies once a week for three years. At the beginning of the study, HIV tests were given to 1,500 employees; 17.8% were found to be HIV-positive and counselled about their situation. The 999 HIV-negative employees who returned for their test results were invited to enrol in the study, which provided sexual health services and counselling on HIV-risk behaviour. When employees enrolled in the study, details of their risk behaviour in the past were taken, medical examinations were given and health educators held group discussions on reducing risk. The rate of commercial sexual encounters fell somewhat: 31% of employees enrolled reported sex with a prostitute in the year before enrolment and 25% during the months or years of follow-up. Only 15% of the men who had sex with prostitutes used condoms (Marck, 1999).

A study of East African long distance truck drivers and their assistants in Kenya found that, although 93% of the men knew that AIDS may be prevented by using condoms, only 40% reported a history of ever having used condoms (Bwayo et al., 1994). Putting in place a programme to raise condom use to 90% could possibly prevent almost two-thirds of infections and the cumulative incidence would decline from 1.29% to 0.42% (Morris & Ferguson, 2006).
This review found instances of efforts to distribute condoms through non-traditional channels so that they would be available at locations frequented by MARPs. However, there is overwhelming evidence to show that condoms are not easily accessible to MARPs. A study by IOM found that long distance truck drivers and sex workers find it difficult to access condoms, especially at night; poor access to condoms leads to unnecessary unprotected sex. The existing distribution mechanisms do not guarantee a continuous condom supply to MARPs (International Organization for Migration, 2009).

Sexual behaviour among long distance truck drivers and the general population is different. Certain factors make long distance truck drivers more vulnerable to risky behaviours than the general population.
8.0 Vulnerability to HIV among long distance truck drivers

The overarching result from studies undertaken on risk behaviours among long distance truck drivers in the region is that the environment along transport corridors places transport and sex workers at particularly high risk of HIV, and that this may, in fact, be a significant driver of Uganda’s HIV epidemic among MARPs and the general population. Although long distance truck drivers may only comprise approximately half of the sex workers’ clients, long distance truck drivers have spouses and children back home who may become infected (International Organization for Migration, 2008). It is logical to suggest that the sexual activities of long distance truck drivers along highway corridors can drive new infections, both in MARPs and in non-MARPs (International Organization for Migration, 2008).

There are many lifestyle factors that can make long distance truck drivers vulnerable to HIV. Of the ways in which HIV can be transmitted, heterosexual sex is the prevalent channel as regards long distance truck drivers. In addition, complex combinations of biological, social, cultural and economic factors determine the susceptibility of long distance truck drivers to HIV. This vulnerability stems from several known or hypothesised HIV-risk factors that converge around the nature of transport drivers’ work:

- Long distance truck drivers are mobile or migratory; the social structures that constrain sexual behaviour in stable communities may not apply
- Cash income, irregular working hours and spells away from home mean that long distance truck drivers have disposable income and leisure time (when not driving), factors that favour the consumption of alcohol and casual sex; the corollary is that sex workers and low-income women are drawn to trading hubs precisely because of the opportunities to sell food, alcohol or sex
- Alcohol and other drugs are widely used by long distance truck drivers to help cope with boredom and stress
- Long distance truck drivers are vulnerable to HIV due to limited prevention, treatment and mitigation measures as well as low health-seeking behaviour
- The nature of the profession makes it full of risks; long distance truck drivers spend most of their time travelling along dangerous and remote highways, and experience exhaustion, health problems, road accidents, attacks and mechanical problems with their vehicles.

8.1 Mobile lifestyle

The mobility of long distance truck drivers is a potentially significant driver of new infections. The association between HIV and human mobility has been documented. In many parts of the world, a higher incidence of HIV has been observed in areas with considerable migration along major transport corridors. In Tanzania and Uganda, for example, it was found that people in roadside settlements were more affected by HIV than the general population (Barongo et al., 1992). Evidence confirms that there is a higher rate of HIV infection in ‘communities of the mobile’. The key issue is that population mobility, and the HIV-risky environments associated with transport corridors, provide opportunities for several sexual partners at the same time (International Organization for Migration, 2009).

Vulnerability has two aspects. First, being away from regular partners may make long distance truck drivers look for alternative sexual partners. Secondly, being away from home frees long distance truck drivers from the family and community norms that would otherwise prevent casual sex. The
mobile lifestyle of transport workers means that they leave behind the social norms and ties that normally regulate their sexual behaviour. Isolated working conditions and living environments also create a sense of anonymity that engenders more sexual freedom (Matovu & Ssebadduka, 2013).

In some countries, long distance truck drivers have been found to spend less than one month at home a year. One study in Uganda even reported that it is shown that some long distance truck drivers spend no more than a week at home in four months (Bikaako-Kajura, 2000). Similarly, mapping by IOM (2008) of hot spots along the Kampala-Juba highway found that long distance truck drivers have a high tendency to lead a ‘life on the road’. Only 38% of long distance truck drivers reported that they had spent 40 nights or more at home over the previous year, and 27% reported that they had spent less than 20 nights at home. Such lifestyles provide fertile ground for a flourishing sex industry.

**Facilitated community dialogue**

“Most of the time we are on transit or on safari and we don’t have enough time to stay with our family and you know, nature has no formula. Some of us drink, take alcohol. You can find a very beautiful girl and you relate. Ladies target truck drivers because we have money, and what they demand, we give them.”

Long distance truck drivers and their assistants spend prolonged periods away from home and, therefore, may resort to casual sex or develop non-marital sexual relationships while in transit. A key informant agreed that this can happen, “They stay away from their homes and are separated from their regular sexual partners, be it a spouse or girlfriend, for a period of time.” Another informant said, “People who spend a lot of time on the road and drive long distances—spend nearly half the year away from home and tend to have multiple partners.”

As stated previously, there is some suggestion that there is a trend for those ‘on the road’ for long periods to have more recourse to sex workers than those who spend less time on the road and more time at home (International Organization for Migration, 2008).
Figure 2. Time spent at home by long distance truck drivers in the 12 months prior to interview

A survey of health-seeking behaviour was carried out at four locations on the Mombasa-Kampala Trans-Africa highway. At the four stops in Kenya, it was found that few long distance truck drivers spent significant periods of time at home; more than half (51.3%) spent fewer than 40 nights a year at home (Morris & Ferguson, 2007).

Border points often lack strong community cohesiveness. The anonymity created by the fluid social environment at one-stop border posts (OSBPs), as well as the diversity of migrants, affect adherence to social norms that regulate behaviour in stable communities. Moreover, lengthy delays at border crossings can make those areas into hot spots for high-risk sexual activities.

Focus group discussion by IOM
“For me if I start from Mombasa to Sudan, it can take me about one full month on average. The same applies to other trips across East Africa... I am looking for a second wife because I take too long to go back to my family. I think I need to have another wife that I can spend time with when am away from home... Like I told you it takes me too long to get back to my family and I cannot control myself” (focus group discussion with truck drivers, Katuna) (International Organization for Migration, 2013).

The nature of ‘life on the road’ is, by definition, highly mobile. This factor alone means long distance truck drivers travel widely within the region. The potential of long distance truck drivers to transmit HIV over wide areas is well documented. It is this mobility, in addition to the social and economic circumstances of long distance transport, which can lead to the spread of HIV. Sex workers along transit routes are less mobile than long distance truck drivers. However, it is suggested that, over long periods, sex workers are also mobile, and respond to supply and demand along highways or in other places (International Organization for Migration, 2008).
Most studies of the effect of mobility in HIV transmission tend to concentrate on those who are mobile. Spouses at home, however, may play a role in transmitting HIV. Partners who stay at home may engage in risky sexual behaviour because they are lonely, because of peer pressure or because they lack financial support. Understanding risk behaviours in both mobile partners and partners at home is essential for the successful implementation of HIV interventions (Matovu & Ssebadduka, 2013).

### 8.2 Alcohol and other drug use

While driving, long distance truck drivers may take stimulants and other mind-altering drugs. This practice was described by key informants:

> Long distance truck drivers have the tendency to use and abuse substances which are aimed at keeping them awake to drive for long hours but have other effects which increase risky behaviour.

As previously mentioned, long distance truck drivers are regular patrons at drinking places, including bars and hotels. Drinking for long distance truck drivers is social, sharing alcohol after finishing a day’s work, but is also a pick-up strategy. A key informant explained:

> To keep away from boredom, they find alternatives to entertain themselves such as drugs and alcohol and discos which exposes them to risky sexual behaviour e.g. unprotected casual sex or commercial sex.

Alcohol consumption, particularly before sex, impairs a person's judgment with regard to protected sex, resulting in many instances in failure or inconsistency in use of condoms. Long distance truck drivers reason that the sexual stimulation that alcohol arouses (“All you think about is sex and whichever woman crosses your way, you don’t care”) and the presence of female bar tenders who dress provocatively, probably to lure long distance truck drivers into having sex, leads to unprotected sex following alcohol consumption:

> What I have noticed is that most of us truck drivers take alcohol as a way of spending our leisure time. When we get drunk, we start thinking about sex... You cannot even think about a condom when you are drunk,” (Matovu & Ssebadduka, 2013).

Beer drinking is conspicuous consumption, and by observing how much a long distance truck driver consumes, a woman can determine how much she may expect to receive if she spends the night with him. In this context, when a woman allows a man to buy her a drink, she implicitly accepts his sexual advances. Drinking enables men to invite women to join them, and this is part of the sexual transaction—it signals that she is ready to reciprocate (Gysels et al., 2001). In some situations, when a woman asks a man to buy her a drink she implicitly invites him to have sex with her.

In Kenya and Uganda, most transactional sex in the Northern Transport Corridor occurs in bars and lodges. Of the three main types of male and female clients that patronise bars and lodges on the Kampala-Juba transit route, 60.8% were long distance truck drivers and 98.7% were sex workers. Sex workers, in particular, are major clients in all but one of the 79 bars and lodges surveyed (International Organization for Migration, 2008).
Facilitated community dialogue

“Here, the women get more excited and even dress differently. The men from other countries, particularly the truck drivers, also get excited and look for a woman to take for the night. So, they go to bars and get drunk. There’s a beer...that comes from Congo and is enjoyed by everybody here. Give a woman...and she will give you what you want. That’s what is happening here and it is what has led to the increase in HIV in this area. We have a lot of fun.”

Kenya’s Long Distance Truck Drivers Union and Uganda’s Amalgamated Transport and General Workers Union indicate that addressing alcohol abuse among members in transit is key to preventing HIV.

8.3 Limited access to HIV care and treatment

Although it is acknowledged that MARPs along transport corridors are among the groups that are most affected by HIV/AIDS, studies show that long distance truck drivers and other MARPs in Uganda have inadequate access to prevention programmes, voluntary counselling and testing (VCT), ART and basic health services (Uganda AIDS Commission, 2009). This gap is attributed to poor targeting, inadequate services and weak coordination.

An IOM study of OSBPs, including posts on the Uganda/Rwanda, Rwanda/Uganda and South Sudan/Uganda borders, showed that cross-border populations in East Africa had health and epidemiological profiles characterised by disease, and other social and economic vulnerabilities. The health and social problems at OSBPs extend beyond obvious infectious and non-infectious diseases. The shortage of safe water, unhygienic sanitary facilities and poor housing worsen the already precarious status of communities at border points in East Africa (International Organization for Migration, 2013).

Cross-border communities, including both migrants and members of host communities, have a high risk of ill health and other health-related vulnerabilities (International Organization for Migration, 2013). Limited access to healthcare was also reported to contribute to vulnerability. The transient nature of populations at border posts limits their access to healthcare services, such as HIV prevention, care and treatment; TB diagnosis and treatment; and screening and treatment of STIs (International Organization for Migration, 2013).

The availability and access to healthcare services at OSBPs varies from one to another. In some, formal public health services are limited and in some areas almost non-existent. For instance, at the Elegu border point there are no public health facilities. At the Elegu border post there was only one dispensary (on the Uganda side) run by the police. In South Sudan there was a health centre run by a non-governmental organisation (NGO) contracted by the South Sudan government to cater for cross-border communities. Other facilities were available in Atiak and Gulu which are 40 km and 70 km away from Elegu respectively (International Organization for Migration, 2013).
At several truck stops and hot spots, health facilities are located far away. The map (Figure 3) shows that there are many health facilities, however, they are usually not near truck stops, meaning that they are inaccessible to long distance truck drivers. While stopovers include a wide range of fuel and repair services for long distance truck drivers, they often lack appropriate health facilities. Morris and Ferguson (2005) surveyed 47 hot spots along the Mombasa-Kampala highway and observed that VCT facilities for HIV were only accessible in one-third of the spots. Few remained open after 5 pm, with the result that long distance truck drivers who may only have free time in the evenings have no
access. In addition, there were very few health facilities on the highway where anti-retroviral therapy was available (Morris & Ferguson, 2005).

Mapping of hot spots along the Kampala-Juba highway by IOM (2008) found that at over half of the health facilities in key stop points the most senior member of staff was a nurse. Out of the 64 health facilities identified, only six were health centres; the rest were private clinics and shops selling drugs. The high proportion of shops selling drugs (almost one-third of all existing facilities) could indicate a high level of self-medication among long distance truck drivers, commercial sex workers and other populations along the highway. Although treatment for STIs was found to be available in most facilities, only 44% had testing services. The mobility of transport sector workers makes it difficult for them to access health information and services. It is common, for instance, for long distance truck drivers to treat themselves with traditional medicinal herbs or pills bought in markets en route. They have trouble with more formal medical facilities as their mobility makes it difficult to keep appointments at clinics and make regular follow-up visits. Those being treated may also find it difficult to adhere to a treatment regime (International Organization for Migration, 2008).

In 2009, IOM conducted a study to: identify existing HIV/AIDS responses or interventions targeting MARPs along transport corridors and, specifically, to identify key actors in responses (who); take an inventory of projects and programmes for MARPs in transport corridors, their objectives and achievements (what); and; establish the reach of existing programmes (where). They found that, in general, prevention interventions favoured sketchy information, education and communication (IEC) and behaviour-change communication (BCC); distributing condoms; and, in rare cases, HIV counselling and testing (HCT). There was a clear lack of interventions that offered life skills education for youth in hot-spot communities, and weak capacity for BCC in providers of HIV services and couples counselling, IEC/BCC for people living with HIV/AIDS among MARPs, etc. (International Organization for Migration, 2009).

HCT services were available for MARPs at static sites as well as through mobile outreach. Service providers had devised means of reaching MARPs by mobilising their peers and by moonlight VCT carried out at night. These services were, however, available in less than half of the hot spots visited. The analysis of responses found scattered efforts by NGOs operating in the various hot spots to offer home-based care (HBC) to MARPs. HBC services are provided through collaboration between civil society organisations (CSOs) and communities, using community volunteers (International Organization for Migration, 2009).

8.4 Health-seeking behaviour

Mobility also affects access to and use of health services. Specifically, mobility is associated with delays in seeking treatment, especially during transit. Consequently, there is potential for minor health problems to turn into life-threatening illnesses. For example, long distance truck drivers interviewed reported that, on several occasions, they had failed to seek healthcare services in a timely manner due to a perception that this would delay their travel schedules. It was also reported that long distance truck drivers and other migrants delay seeking healthcare and miss opportunities for health education and BCC campaigns. They also face challenges in adhering to treatment regimens (International Organization for Migration, 2013).

Five major themes emerged from the narratives of participants in the IOM study of healthcare-seeking behaviour of migrants at OSBP: (i) acceptable and unacceptable pain/discomfort, (ii) preference for private healthcare facilities, (iii) self-medication, (iv) trans-national health-seeking
behaviour, (v) postponement of treatment in order to seek healthcare at ‘home’. IOM found that migrants’ decisions to seek and to continue to use healthcare services were influenced by:

- The presence and degree of pain; many often ignore and tolerate illness for a long time and do not seek professional healthcare until pain becomes unbearable
- The type of facility; the majority of participants indicated a preference for private healthcare facilities, as they perceived that these provided faster and better quality services than public health facilities. Common explanations for not seeking health services at government health facilities included: long distances, busy business schedules, high transport costs, long queues, corruption and the absence of prescription drugs and stock outs (lack of availability of drugs)
- The convenience and perceived lower cost of self-treatment
- The accommodation and acceptance of non-nationals in access to healthcare and other social services. For instance, in Tanzania, participants reported that some categories of migrants, such as long distance truck drivers, were allowed to access healthcare services such as resupply of anti-retroviral drugs. This was, however, not the case in Zambia and South Sudan
- Postponing seeking treatment while on the move until they returned to their countries of origin; migrants would under use or delay accessing health services in order to seek care at ‘home’ (International Organization for Migration, 2013)

Other factors can also create barriers to long distance truck drivers seeking health services. These include language barriers, financial constraints, limited knowledge of how to access healthcare, unfriendly attitudes of facility staff, especially in hospitals, and confusion about their eligibility for treatment (International Organization for Migration, 2013).

IOM conducted a study of 103 long distance truck drivers at eight sites on the Kampala-Juba highway. The study documented their perception of health problems and health services, and their experience of health problems associated with their occupation, including their recent experiences of STIs. While on the Kampala-Juba route, 49% of long distance truck drivers had sought medical treatment for a condition in the past year. The long distance truck drivers’ responses indicated the main ailments: 40% reported malaria, 12.5% STIs, 8.3% urinary tract infections (URTIs) and 12.5% headaches. The latter could possibly reflect fatigue (International Organization for Migration, 2008).

Matovu and Ssebadduka (2012) assessed sexual risk behaviours, condom use and sexually transmitted infection (STI) treatment-seeking behaviours among long distance truck drivers and sex workers operating at 12 hot spots along two major transport corridors in Uganda. The assessment found that 56% of long distance truck drivers and 72% of sex workers reported that they had suffered from an STI at some time. Of those reporting a history of STIs, 58% of long distance truck drivers and 77% of sex workers reported having suffered from STIs in the past 12 months. When respondents were asked about treatment-seeking behaviours, 92.9% of long distance truck drivers and 93% of sex workers had sought treatment for STIs in the past 12 months, mainly from private and government clinics. When asked how soon they sought treatment after recognising symptoms, 2.6% of long distance truck drivers sought treatment within one day, 19.2% sought treatment within one to two days, 33.3% sought treatment within three to five days, 24.4% sought treatment after one week, while 20.5% sought treatment after more than one week. This suggests that the majority (78.2%) delayed seeking treatment by three or more days (Matovu & Ssebadduka, 2012).
Table 3. Sexually transmitted infection (STI) and treatment in female sex workers (FSWs) and long distance truck drivers in Uganda, 2008

<table>
<thead>
<tr>
<th>Variable</th>
<th>FSWs</th>
<th></th>
<th>Truckers</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><em>n</em></td>
<td>%</td>
<td><em>n</em></td>
<td>%</td>
</tr>
<tr>
<td>Ever had an STI (yes)</td>
<td>187/259</td>
<td>72.2</td>
<td>147/261</td>
<td>56.3</td>
</tr>
<tr>
<td>Had an STI in the past 12 months (of those who had ever had an STI)</td>
<td>143/187</td>
<td>76.5</td>
<td>85/147</td>
<td>57.8</td>
</tr>
<tr>
<td>Sought treatment (of those who had an STI in the past 12 months)</td>
<td>133/143</td>
<td>93.0</td>
<td>79/85</td>
<td>92.9</td>
</tr>
<tr>
<td></td>
<td><em>n</em></td>
<td>%</td>
<td><em>n</em></td>
<td>%</td>
</tr>
<tr>
<td>Place where treatment was sought</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Private clinic</td>
<td>68</td>
<td>51.1</td>
<td>50</td>
<td>83.3</td>
</tr>
<tr>
<td>Government clinic</td>
<td>43</td>
<td>32.3</td>
<td>15</td>
<td>19.0</td>
</tr>
<tr>
<td>Pharmacy</td>
<td>05</td>
<td>3.8</td>
<td>02</td>
<td>2.5</td>
</tr>
<tr>
<td>Drug shop</td>
<td>10</td>
<td>7.5</td>
<td>08</td>
<td>10.1</td>
</tr>
<tr>
<td>NGO/herbal clinic</td>
<td>07</td>
<td>5.3</td>
<td>04</td>
<td>5.1</td>
</tr>
<tr>
<td></td>
<td><em>n</em></td>
<td>%</td>
<td><em>n</em></td>
<td>%</td>
</tr>
<tr>
<td>How soon did you seek treatment?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Within a day</td>
<td>3</td>
<td>2.3</td>
<td>2</td>
<td>2.6</td>
</tr>
<tr>
<td>Between 1 and 2 days</td>
<td>16</td>
<td>12.0</td>
<td>15</td>
<td>19.2</td>
</tr>
<tr>
<td>Between 3 and 5 days</td>
<td>31</td>
<td>23.3</td>
<td>26</td>
<td>33.3</td>
</tr>
<tr>
<td>1 week later</td>
<td>25</td>
<td>18.8</td>
<td>19</td>
<td>24.4</td>
</tr>
<tr>
<td>&gt;1 week later</td>
<td>58</td>
<td>43.6</td>
<td>16</td>
<td>20.5</td>
</tr>
<tr>
<td></td>
<td><em>n</em></td>
<td>%</td>
<td><em>n</em></td>
<td>%</td>
</tr>
<tr>
<td>Did you complete the treatment?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>104</td>
<td>78.2</td>
<td>65</td>
<td>83.3</td>
</tr>
<tr>
<td>No</td>
<td>29</td>
<td>21.8</td>
<td>13</td>
<td>16.7</td>
</tr>
</tbody>
</table>

(Source: Matovu & Ssebadduka, 2012)

Other studies have investigated the sexual and health-seeking behaviour of MARPs including long distance truck drivers and sex workers in East Africa. Most notably, a study by Ferguson and Morris along the Mombasa-Kampala transport route provided reliable data, including detailed information on the number of trucks parked overnight at stops, the number of female sex workers present, STI prevalence, and access to condoms and health services such as HIV testing and STI treatment. The research found that more than 6,000 long distance truck drivers stop overnight along the Mombasa-Kampala highway corridor. Approximately 8,000 sex workers have sex with multiple concurrent partners in a variety of occupations and demographic groups. Rates of self-reported STIs were 15% for long distance truck drivers, and reported condom use averaged 79% (90% with casual clients and 69% with regulars) among sex workers. Access to treatment for HIV and STIs by long distance truck drivers and sex workers was limited as were VCT services targeted to these most at risk and vulnerable populations (Ferguson & Morris, 2007; Morris & Ferguson 2007). Limited access to treatment for HIV and STIs and VCT services, coupled with the reluctance of long distance truck drivers and sex workers to seek healthcare are likely to contribute to the spread of HIV and other STIs.
8.5 Other dynamics of the long distance truck driving profession

People with fatalistic attitudes tend to believe that whatever has to happen, will happen, regardless of what action is taken or what decisions are made. The high risk of death in occupations such as fishing or the military prompts these kinds of attitudes. The literature indicates that long distance truck driving is an occupation full of risks. Long distance truck drivers spend most of their time travelling along dangerous and remote highways. They face exhaustion, boredom, health problems, road accidents, attacks and mechanical failure of their vehicles. Driving requires long working hours with little rest, and poor living conditions that offer little or no privacy and are highly insecure. Stressful conditions such as these may play an important role in long distance truck drivers’ sexual risk-taking behaviours, and on their perceptions of HIV/AIDS (Great Lakes Initiative on AIDS, 2006).

During a facilitated community dialogue, when asked about fond memories of work, most participants mentioned surviving accidents. One participant responded, “I remember one day we were coming from Mombasa when my driver fell asleep and our truck went off the road, but I thank God that we were not hurt.” Another respondent said, “Five years ago I was in an accident, and my truck was badly damaged and I spent some good time in a coma.” Another spoke of his friend and pregnant wife dying while in his truck, yet the baby survived. The respondents had to be asked specifically to name positive experiences.

A key respondent stated, “You are driving and hear of a friend dying on the road that day and it changes your perspective. You look for immediate pleasure which is usually more risky. Whatever has to happen will happen, regardless of what you try to do to prevent it?”

Hard work and daily physical risks are also believed to reinforce the culture of masculinity among long distance truck drivers that promotes toughness and a sense of invincibility, but also fatalism. As a result, long distance truck drivers are likely to see HIV as a very distant threat compared to the more immediate dangers they face in their jobs (Mupemba, 1999). In spite of the dangers that HIV poses to long distance truck drivers, several studies have found that HIV is just one of the many concerns they have. Risks of immediate concern are more likely to include potential unemployment, road accidents and robbery. Partly because HIV is not a key concern to those at most risk of infection, HIV-risk behaviour is prevalent along East Africa's highways (International Organization for Migration, 2009).

Some of the work in the transport sector involves idle periods, in some cases brought about by bureaucratic customs and border crossing procedures, and redundancy. Some categories of workers in the sector reported that their work often involves idle spells lasting a couple of days caused by delays in customs procedures and long queues. While waiting, long distance truck drivers and their assistants have nothing much to do apart from drinking alcohol and sleeping with women (Ministry of Works and Transport, 2011). This is in addition to daily income and availability or access to disposable cash. Self-risk perception and fatalistic mentality also contributed to the spread of HIV (UAC, 2014; Ministry of Works and Transport, 2011).
Facilitated community dialogue

“The reason why HIV is high among our people living on the Uganda-Congo border is the truck drivers arrive here from long distances such as Congo, Kinshasa, Goma, Mombasa, and they all come here. After they park, it usually takes a long time for the Revenue Authority to get them cleared. So they go to restaurants, hotels, bars and start drinking and dancing to Lingala music with beautiful women seated around them, the end result is sex but the danger with that kind of sex, is that these men usually do not have condoms. Businesses, the drivers, the prostitutes and the bars all operate in the night. By this time all the clinics and drug shops have already closed and there is nowhere to buy condoms and this causes a big problem.”

The long periods of travel and the general societal perception that long distance truck drivers are among the most badly behaved occupational groups do not create a supportive environment for long distance truck drivers to reduce the number of sexual partners they engage with. Other factors that discourage long distance truck drivers from limiting the number of sexual partners they have include: work that involves separation from family; work that involves night duty; work that involves idleness; and redundancy (Ministry of Works and Transport, 2011). Although long distance truck drivers may desire to change, there is little social space in which to do so. Sex workers are plentiful in the roadside settlements where most long distance truck drivers spend the night. The sex workers find long distance truck drivers when they are drunk, lonely or otherwise vulnerable and can be very persistent. The long distance truck drivers sometimes pay for sex with them just so they will go away (Marc, 1999).

As discussed, sexual behaviour and vulnerabilities arise from the long distance truck drivers’ occupation. The next section reviews service delivery, both by government and from service providers.
**9.0 Models of service delivery in addressing HIV/AIDS in long distance truck drivers**

Even in general HIV/AIDS epidemics, such as in Uganda, responses targeting particularly vulnerable populations are essential. Long distance truck drivers are one of these groups. Studies have outlined the need and usefulness of targeting such particularly vulnerable populations. A study in Mombasa of an intervention involving condom promotion, peer education and access to high quality care for sexually transmitted infections in 556 male transport workers showed clear evidence of decreasing high-risk sexual behaviour and decreasing sexually transmitted infections (Jackson et al., 1997).

Given this finding, it is surprising that coordinated programming to address transport workers and sex workers in East Africa has been limited. The focus of programmes in the region has been on responding to the general HIV epidemic. Transport workers and sex workers have been neglected (Morris & Ferguson, 2006). IOM stated that the national response to HIV in MARPs along transport corridors in Uganda is fragmented, uncoordinated, and of insufficient scale and strength to stem the epidemic. Although a number of actors support or implement HIV interventions for MARPs along transport corridors, it is not clear who is doing what, where and how (International Organization for Migration, 2009). It is imperative to bring national partners together in terms of programming to ensure coordination and collaborative strategic planning to meet national priorities.

Many different organisations work with long distance truck drivers on HIV and health issues. The list is by no means exhaustive, but provides some insight to different programmes.

**9.1 Hot-spots response (Malaba)**

**9.1.1 Malaba hot spot in Tororo District**

Malaba is a town in Tororo District, situated along the Northern Corridor, and is a busy crossing point between Uganda and Kenya. Like the nearby town of Busia, Malaba has a very transitory population. Several civil society organisations provide HIV services to long distance truck drivers, including Malaba Kyosimba Onaanya Community Development Association (MAKACODA), the Tororo Network of AIDS Service Organizations (TONASO) and the Amalgamated Transport Workers Union (ATGWU).

**Malaba Kyosimba Onaanya Community Development Association (MAKOCODA)**
The Malaba Kyosimba Onaanya Community Development Association (MAKOCODA) is a community-based organisation, formed in 1999, to protect the interests of female sex workers. The association is involved in HIV-prevention activities among sex workers, long distance truck drivers, bar and lodge attendants, and community members. MAKOCODA trains peer educators and counsellors, and facilitates volunteers who participate in drama shows. The shows are an avenue for disseminating HIV-prevention information and encouraging positive behavioural change.

MAKOCODA also distributes condoms through 15 strategic outlets (bars and lodges). The selected bars and lodges have become popular among sex workers and long distance truck drivers in Malaba town. In addition, MAKOCODA is involved in mobilising sex workers and their clients for the moonlight VCT project (IOM, 2009).
Identified best practice: working with MARPs in Malaba, the case of MAKOCODA

An IOM analysis identified a best practice that could be replicated in programmes that target MARPs. The Malaba Low-Income Women Cluster/MAKOCODA started as an informal association of sex workers in Malaba in 1999. The association worked with the Family Health International (FHI) ROADS to a Healthy Future project to mobilise sex workers against HIV/AIDS. MAKOCODA is involved in distributing condoms among sex workers and their clients, mobilising HCT services for MARPs and providing referrals. To avoid the stigma associated with sex work, in activities, members of the association are referred to as low-income women. Working with existing organisations of MARPs provides opportunities for easy mobilisation, and building of confidence and trust in service providers. Working with existing associations of vulnerable populations also makes it possible to easily understand their unique needs and respond appropriately (International Organization for Migration, 2009).

The Tororo Network of AIDS Service Organizations (TONASO)

The Tororo Network of AIDS Service Organizations (TONASO) is an NGO that brings together all CSO actors targeting HIV and AIDS in Tororo. TONASO’s overall goal is to expand access to clinical and non-clinical services for people living with HIV and AIDS (PLWHA); reduce stigma and discrimination in the community; and promote prevention among HIV-positive individuals.

The Amalgamated Transport Workers Union (ATWU)

The Amalgamated Transport Workers Union (ATWU) is a transport workers’ union providing HIV-prevention services to long distance truck drivers in Malaba, Busia, Naluwerere, Mbuya and Katuna along the Northern Corridor, and in Arua District in West Nile. ATWU provides information on preventing HIV and STI, distributes condoms and refers long distance truck drivers to agencies providing HCT and ART.

9.2 National policy and programming

9.2.1 Ministry of Works and Transport (MoW&T)

The mandate of the Ministry of Works and Transport (MoW&T) is to promote an adequate, effective, safe and maintained transport infrastructure and services in order to contribute to the socioeconomic development of Uganda. In line with this mandate, the Ministry, in collaboration with the Uganda AIDS Commission and development partners, has formulated an HIV-prevention strategy and implementation plan for the sector.
The HIV-Prevention Strategy provides a framework to mainstream HIV prevention interventions in the sector. The strategy aims to provide direction for decision-making and interventions that promote HIV prevention in the works and transport sector. The HIV-Prevention Strategy and Plan for the Works and Transport Sector sets out opportunities and guidance for intensifying efforts to stem the number and rate of new HIV infections. The strategy aligns with the overall development framework of the country, in particular the Uganda National Development Plan and the National Strategic Plan, and is multi-pronged, focusing on sector workers, their families and the communities they interact with in the course of their work. The vision is “A healthy workforce in the works and transport sector, free from new HIV infections, and a supportive and non-discriminatory working environment for those infected or affected by HIV and AIDS” (Ministry of Works and Transport, 2011).

The strategy provides a framework for providing quality, effective HIV-prevention information and services to works and transport sector workers and stakeholders. The overall goal of this strategy is “to reduce new infections in the sector by 30% by 2015” (Ministry of Works and Transport, 2011).

MoW&T acknowledges the need to target MARPs along transport corridors. However, MoW&T draws attention to the need to build skills for delivering HIV services and information to the target group, citing its mobile nature as the main challenge. Other acknowledged challenges include: inadequacy of HIV information in some workplaces; sketchy HIV policy and HIV statistics specific to the transport sector; and lack of funds to implement the current strategic plan. In terms of coordinating HIV responses within the transport sector, MoW&T has a coordination structure, although it needs strengthening (Ministry of Works and Transport, 2011).

9.2.2 Ministry of Health STD/AIDS Control Programme

The Ministry of Health (MoH) provides policy guidance and standards for health services, and facilitates delivery of health services nationwide. The MoH acknowledges that existing HIV programmes for MARPs along transport corridors, and MARPs in general, are inadequate as regards quality and quantity. Currently the MoH works with partners to address MARPs HIV needs and has established several networks to do so.

9.2.3 Uganda AIDS Commission (UAC)

The Uganda AIDS Commission (UAC) was established in 1992 with the primary goal of providing oversight and coordinating the multi-sectoral response to HIV/AIDS and a mandate to coordinate those working with MARPs. UAC developed the National Strategic Plan, which indicates the different MARPs and the priority groups for HIV interventions. They have recently developed the Multi-Sectoral HIV Response for MARPS in Uganda: Programming Framework 2014-2016. However, UAC faces many challenges in coordinating this response.

The key challenges UAC faces in improving HIV response for MARPs along transport corridors are inadequate information on the magnitude of the HIV problem among the population group in question and difficulties in programming HIV services for mobile MARPs, given that the existing HIV/AIDS services are mostly facility-based. Extra resources would help in offering services that are convenient to MARPs in high-risk zones along transport corridors. Developing models and approaches for targeting MARPs would help service providers and programme managers acquire
specialised knowledge on how to reach mobile populations (International Organization of Migration, 2009).

9.3 National service providers

9.3.1 AIDS Information Centre (AIC)

The AIDS Information Centre (AIC), established in 1990, was a pioneer for VCT in Uganda. The organisation works in over 30 districts and has regional branches country wide. AIC initiated MARPs interventions in 2007 and provides services using facility-based, static clinics, outreach and home-based approaches. AIC also carries out HIV-prevention outreach, distributes condoms and carries out targeted VCT among MARPs.

Long distance truck drivers are also a target group that AIC serves during evenings and at night in transit stations. This HCT service is referred to as the ‘Moonlight HCT service’.

9.3.2 Amalgamated Transport and General Workers Union (ATGWU)

The Amalgamated Transport and General Workers Union (ATGWU), a member of the Uganda Long Distance and Heavy Truck Drivers Association, was established in 1974. It is one of the labour unions in Uganda which leads interventions to mitigate the impact of HIV/AIDS on its members and affiliated communities.

ATGWU has been implementing HIV/AIDS programmes since 2001. Interventions target primarily MARPs such as long distance truck drivers and community men with whom they interact. Through the ROADS project, ATGWU has established HIV/AIDS resource facilities, called SafeTStop centres, at major truck stops. ATGWU has established similar knowledge rooms or roadside wellness centres at other truck stops. These centres offer long distance truck drivers and other MARPs an environment for relaxation and rest as an alternative to the bars and brothels where they spend most of their time at stopover points. The ATGWU resource centres mainly implement community-based activities, such as recreational activities including peer education/counselling, mentoring/coaching peer educators, HCT, case referrals, free condom distribution and other community-related health interventions.

Best practice: The Friendly Project

The Friendly Project was a collaborative project implemented by IOM and the Amalgamated Transporters and General Workers’ Union at three hot spots, Kigumba, Bweyale and Karuma, along the Kampala-Juba route between May and August 2010. The aim of the project was to evaluate effective modes of HIV service delivery to most at risk populations including FSW, long distance truck drivers and neighbouring communities. The project was implemented in three private clinics, one at each hot spot, using a combination of approaches including peer education, condom distribution, and provision of HIV counselling and testing services. Peer educators held health education sessions at the parking yards, in bars and lodges, and during mass sensitisation campaigns in the community. As part of project activities, 30 peer educators were trained. The educators reached 3,004 people with HIV-prevention messages during the project. In addition, IOM procured 3,000 test kits that were distributed to the three private clinics in Kigumba Medical Centre, Lacor Allied Medical Centre and Karuma Medical Centre.
Twelve HCT mass campaigns reached 2,112 people (270 long distance truck drivers, 252 FSW and 1,590 community residents) with HIV counselling and testing services. Project activities were promoted through mass sensitisation meetings, peer educators and distribution of IEC materials, including T-shirts and stickers with HIV-prevention messages. Over 30 condom pick-up points were established at roadside kiosks, bars, lodges, fuel stations, clinics, restaurants and mechanical workshops. A campaign logo was placed at each campaign pick-up point. Over 60,000 condoms were distributed to FSW, long distance truck drivers and community residents over the four-month project. As a result of these efforts, the proportion of individuals who were aware of facilities where they could obtain condoms increased from 83% at the beginning of the project to 93% at the end of the project. Additionally, the number of MARPs accessing condoms increased and the proportion testing for HIV increased by 32% over the project period.

9.3.3 Alliance of Mayors and Municipal Leaders on HIV/AIDS in Africa (Uganda Chapter)

The Alliance of Mayors and Municipal Leaders on HIV/AIDS (AMICAALL) is a national NGO, registered in 2000. Low levels of access and uptake of services by MARPs is one of the major gaps in urban HIV/AIDS responses. AMICAALL interventions therefore aimed to raise awareness of the availability of convenient services in close proximity to MARPs in urban and peri-urban areas.

Between 2010 and 2012, AMICAALL implemented a project to scale up HIV-prevention interventions in local urban governments. The project aimed to reduce the rate of HIV infection and targeted MARPs (sex workers and long distance truck drivers), high-risk groups (boda boda cyclists, taxi/bus drivers, market vendors, salon operators) and vulnerable groups (university students). The project was unique in designing approaches appropriate to urban population groups, such as peer-to-peer education, anti-AIDS music, dance and drama activities, community outreach, condom distribution and HCT services.

9.3.4 Reproductive Health Uganda (RHU)

Reproductive Health Uganda (RHU), formerly the Family Planning Association of Uganda (FPAU), was established in 1957 to provide reproductive health services. RHU implements MARPs activities along both the Busia-Katuna route and the Kampala-Juba route. The MARPs programmes target long distance truck drivers, other transient traders and sex workers. RHU currently implements two MARPs projects: the Breaking the Ice Project, in Kawempe Division, Kampala, which targets sex workers and their clients, and the Transient Traders Project, implemented in Mbarara municipality, which targets transient traders, sex workers and low-income women. Key activities in these projects include: information dissemination on HIV prevention; distribution of condoms to commercial sex workers and transit traders; and training peer educators.

9.3.5 The MARPs Network

The MARPs Network is a network of organisations that work with commercial sex workers and their clients—uniformed services personnel, long distance truck drivers, fishing communities, migrant workers and other mobile populations in Uganda.

The MARPs Network has the following objectives:

Knowledge management

1. Annual research to establish trends in behaviour and biomedical aspects of MARPs relating to sexual health and HIV
2. Sharing knowledge with stakeholders for better understanding of issues affecting MARPs in order to respond appropriately

**Strengthening beneficiaries**
1. Assessing the capacity of individuals and organisations to implement effective programmes for MARPs
2. Skills and competency training to fill gaps and ensure effective programming

**Advocacy**
1. Providing a platform for interaction between grassroots MARPs, policy makers and programme stakeholders
2. Representing MARPs’ interests in national, regional and international fora

**9.3.6 Uganda Health Marketing Group (UHMG)**
The Uganda Health Marketing Group (UHMG) is a private, not-for-profit organisation established in 2006. Since 2008, UHMG has implemented HIV programmes that target sex workers, long distance truck drivers and fishing communities. UHMG implements its programmes through sub-grantees. Through Advocacy for Social Development and Environment, UHMG supports the Putting on the Brakes’ project, which aims to: increase awareness of STIs and HIV among long distance truck drivers and their sexual partners; improve access to VCT; and increase the availability of condoms. UHMG has trained volunteers, who distribute condoms and audio tapes carrying prevention messages to long distance truck drivers in parking yards and their sexual partners.

**9.3.7 National Forum for PLHA Networks in Uganda (NAFOPHANU)**

*Great Lakes Initiative on AIDS (GLIA) Project*
The National Forum for people living with HIV/AIDS Networks in Uganda (NAFOPHANU) is the national umbrella organisation for people living with HIV. NAFOPHANU was established in May 2003 to coordinate networks of PLHIV in Uganda. NAFOPHANU implemented the Great Lakes Initiative on AIDS (GLIA) Project in partnership with ATGWU between 2008 and 2010. The Ugandan component of the project focused on Component 2 of the GLIA project, support to HIV and AIDS-related networks. The main activity was establishing and operating of wellness centres (WCs), which also functioned as resource centres.

The main purpose of the WCs was to provide information, education and counselling. The WCs provided long distance truck drivers, sex workers and surrounding communities with guidance and hope. The WCs served as communication centres by providing internet services. A review of activities implemented under Component 2 suggested that WCs were well used and achieved their intended purpose. Long distance truck drivers, sex workers, PLHIV and the surrounding communities had easy access to the services provided at the centres. The WCs served as rest spaces, provided referrals to health services, provided access to basic HIV/AIDS services such as counselling and testing, and distributed condoms. In summary, the project was very relevant to the situation. Hot spots were linked to HIV service points. Collaboration and cooperation between the GLIA countries and agencies in the Great Lakes Region, and between partners engaged in HIV/AIDS, was strengthened.
9.3.8 The AIDS Support Organisation (TASO)

Founded in 1987, TASO Uganda seeks “To contribute to a process of preventing HIV infection, restoring hope and improving the quality of life of persons, families and communities affected by HIV infection and disease”.

In Tororo, TASO initiated the night VCT campaign targeting prostitutes and long distance truck drivers, among others. The intention was to reduce the prevalence of HIV/AIDS. The target groups are encouraged to embrace safer sex and seek medical attention for those living with HIV/AIDS. The campaign, ‘Moon Light Operation’, is conducted at night and very early in the morning, since the parties involved do not want to be identified. The campaign started with a very low turnout of clients, but has picked up. A number of clients who were found to be HIV-positive have been enrolled in anti-retroviral drug treatment.

9.3.9 Uganda Long Distance and Heavy Truck Drivers’ Association (ULDAHTDA)

Uganda Long Distance and Heavy Truck Drivers’ Association (ULDAHTDA) was formed in 1998. ULDAHTDA is a representative body for all long distance drivers in Uganda. Its main aims are: to enhance working relationships between long distance truck drivers and owners; to carry out policy dialogue with government, donors, stakeholders and other development actors to promote harmonious haulage of goods and services; and to regulate and streamline the activities of long distance truck drivers and transporters in East and Central Africa.

ULDAHTDA has carried out activities to combat the spread and effect of HIV on the lives of its members. However, ULDAHTDA admits to doing this without any structural guidance or long-term strategic plan. As a result, activities tend to be spread too thinly and the impact has not been felt among ULDAHTDA members as much as anticipated.

9.4 Regional HIV programming for long distance truck drivers along transport corridors

9.4.1 Family Health International (FHI)

Family Health International (FHI) 360 is a non-profit human development organisation dedicated to improving lives by advancing integrated, locally driven solutions. FHI staff include experts in health, education, nutrition, environment, economic development, civil society, gender equality, youth, research and technology—a unique mix of capabilities to address today’s interrelated development challenges. FHI 360 serves more than 70 countries and all US states and territories.

FHI 360 implemented ROADS to a Healthy Future (ROADS II) 2008-2013. In Uganda, ROADS II aimed to reduce the spread of HIV among mobile transport workers and community members through HIV-prevention programming in two key sites: Katuna, on the Uganda-Rwanda border, and Mbuya-Kinawataka, on the outskirts of Kampala. In Uganda, ROADS II programming:

- Increases HIV knowledge among mobile transport workers, their sexual partners and other vulnerable community members
- Expands access to HIV-prevention services, including diagnosis and treatment for sexually transmitted infections, condom distribution, and HIV testing and counselling
• Facilitates referrals to community- and facility-based HIV care, support and treatment services in Katuna, and extends or refers clients to such services in Mbuya-Kinawataka
• Identifies programme innovations that can be piloted, evaluated and adapted for other settings in east, central and southern Africa
• Links sites with ROADS II programming in Kenya and Rwanda, with Strengthening TB and HIV and AIDS Response (STAR) partners within Uganda and with the US Agency for International Development’s bilateral HIV programme (also managed by FHI 360) in South Sudan.

9.4.2 International Organization for Migration (IOM)
The International Organization for Migration (IOM) is committed to the principle that humane and orderly migration benefits migrants and society. As the leading international organisation for migration, IOM acts with its partners in the international community to:
• Assist in meeting the growing operational challenges of migration management
• Advance understanding of migration issues
• Encourage social and economic development through migration
• Uphold the human dignity and well-being of migrants.

IOM Uganda, in partnership with the National Committee on AIDS in Emergency Settings (NACAES) and the Southern Sudan AIDS Commission, conducted HIV hot-spot mapping and situational analysis along the Kampala-Juba transport route. The study revealed unsafe sexual practices among long distance truck drivers, their assistants and female sex workers. Data collection started in September 2007 and, by July 2008, the study findings had been widely disseminated. Following the study, IOM embarked on a consultative and participatory process to address the study recommendations. This included developing a behaviour-change communication (BCC) toolkit and assessing modes of service delivery for most at risk populations along transport corridors.

Since 2012, IOM Uganda has implemented the HIV-prevention project, Health Promotion and Assistance to Migrant/Mobile Populations in Uganda. The project focuses on migrant and mobile populations, including sex workers, long distance truck assistants and long distance truck drivers in four districts. The project works to dispel the idea that sex with condoms is boring.

In 2014, to further tackle the high prevalence of HIV/AIDS, IOM launched a behaviour-change campaign, ‘You and I can prevent HIV/AIDS’, to raise awareness. The pilot project engages long distance truck drivers, fishermen, sex workers and migrants in preventing HIV/AIDS, STIs and unplanned pregnancies.

9.4.3 The Intergovernmental Authority on Development (IGAD)
The Intergovernmental Authority on Development (IGAD) in Eastern Africa was created in 1996. IGAD comprises seven member states. IGAD’s mission is to assist and complement the efforts of member states through cooperation to achieve: food security and environmental protection; promotion and maintenance of peace; security and humanitarian interaction; and economic cooperation and integration.

In terms of HIV programming, the IGAD Regional HIV and AIDS Partnership Program (IRAPP), a programme funded by the World Bank, addresses among other things, HIV issues among sub-regional cross-border and mobile populations. The objectives of IRAPP are to:
• Improve access to HIV/AIDS prevention, care, treatment and mitigation programmes for cross-border and mobile populations (refugees, internally displaced persons, returnees and surrounding host communities) in selected sites in IGAD member states
• Enable the scaling-up of this approach and the sustainability of the provision of services to these populations by strengthening IGAD and establishing a common approach to supporting these populations within IGAD member countries.

9.4.4 Great Lakes Initiative on HIV/AIDS (GLIA)
The Great Lakes Initiative on HIV/AIDS (GLIA) is a regional body comprising six countries, namely Burundi, Democratic Republic of Congo, Kenya, Rwanda, Uganda and Tanzania. The GLIA HIV programme focuses mainly on migrants and mobile populations, a group of MARPs that are rarely targeted. GLIA’s work is coordinated primarily though the GLIA Secretariat in Kigali, which then works through national AIDS commissions.

GLIA completed a three-year project to:
• Establish HIV/AIDS prevention, care, treatment and mitigation programmes for mobile and vulnerable groups, such as refugees, transport sector workers and infected/affected populations
• Enhance prospects for coordinated approaches to HIV/AIDS prevention, care, treatment and mitigation.

9.4.5 North Star Alliance
The mission of North Star Alliance is to provide mobile populations and related communities with sustainable access to high quality health services. North Star Alliance takes health services to hard-to-reach people across Africa in ‘Blue Boxes’. The project converts shipping containers (painted blue) to house clinics that deliver public health programmes for people with increased health risks, such as long distance truck drivers and sex workers, and primary healthcare to communities with limited or no access to medical services.

This ‘containerised-approach’ was chosen because semi-mobile structures with a standard layout could be rapidly produced and deployed, enabling continuous expansion of the project’s reach. As a result, since 2007, North Star Alliance has grown from one clinic with 5,000 visitors, to a network reaching over 280,000 people in 13 countries every year. Each drop-in clinic is run by well trained clinical and outreach teams, and supported by an electronic health passport system, which allows patients to access their health records at every clinic within the network. The daily data feed also helps to maintain quality standards and to monitor shifting disease patterns across entire regions.

In Africa, North Star Alliance has established a growing network of roadside health clinics (roadside wellness centres) at truck stops and borders across the continent. These centres, which are open late and located near parking facilities, provide long distance truck drivers, sex workers and the surrounding communities with access to healthcare, counselling and health education. In Uganda, North Star Alliance has established two roadside wellness centres at Malaba and Katuna.
10.0 Gaps and challenges

10.1 Limited HIV programming in transport-corridor hot spots

Even in generalised HIV/AIDS epidemics, vulnerable populations, such as long distance truck drivers, require special attention in programming (Ferguson & Morris, 2006). IOM (2009) found it is evident that the national response to HIV for MARPs along transport corridors, including long distance truck drivers, is of insufficient scale and intensity to stem the epidemic both within the transport sector and nationally. There is a lack of a common programme model or framework that meets the needs of these highly affected population groups in a comprehensive manner (International Organization for Migration, 2009).

To combat this, IOM suggests that guidance is needed for a programme of comprehensive service package of integrated health services, targeted behaviour change, vulnerability reduction interventions, partnership building, multi-sectoral communication, advocacy, and monitoring and evaluation. This programme should be harmonised in content and coordinated nationally (and regionally), such that actors working in geographically separate hot spots work together in a common programmatic approach. Support to improve stakeholder coordination, monitoring and evaluation, and advocacy is needed for national ownership and harmonised programming that will make a significant impact on stopping the epidemic along corridors of mobility (International Organization for Migration, 2009).

In addition to limited programming, personnel with the skills needed to respond to MARPs' HIV issues are few in number and, thus, are challenged to deliver and monitor services to these clients. IOM found that a number of district and NGO officials stressed that the human resources with the skills needed to offer MARPs-friendly services were inadequate. Officials pointed out that there were difficulties in designing messages as well as in providing services for mobile populations. Skills and capacity gaps of health and other workers to effectively address prevention, care, treatment and support in these hard-to-reach populations yet most at risk populations were also noted (International Organization for Migration, 2009).

10.2 Inadequate coordination

In terms of coordinating HIV responses in the transport sector, the MoW&T has a coordination structure, although the Ministry acknowledges that it needs strengthening. The national HIV response in transport corridors is fragmented and uncoordinated, both within and between hot spots. The coordination mechanisms at the district level are largely non-functional. For example, IOM found local government structures such as district AIDS committees do not meet regularly and, when they do meet, there is insufficient focus on MARPs. Where HIV responses are coordinated, the focus is on the general population and MARPs in transport corridor hot spots are not a priority (International Organization for Migration, 2009).

Although funding constraints have been cited as the key reason for weak coordination, further analysis by IOM showed that coordination problems also stem from weak targeting at national and district level, as well as gaps in collaboration between NGOs and local government. In some districts, local governments know little about the interventions of civil society organisations that work in districts. Key stakeholders in HIV responses find coordination efforts unsatisfactory (International Organization for Migration, 2009).
A key informant said, “There is limited data on figures relating to how many truck drivers exist in Uganda. Hence planning for them is difficult. The fact that long distance truck driving is also cross-border makes it much harder. Due to its cross-border nature, interventions, programming and policies for HIV interventions for truck drivers should be similar but this does not seem to be the case. Programming for truck drivers is multi-sectoral. This requires a joint, well-coordinated, well knitted planning and implementation at all levels. This seems to be lacking.”

10.3 Inadequate funding for HIV programmes targeting MARPs along transport corridors

A human and national development tragedy is that programming for the most affected and infected long distance truck drivers, sex workers and populations along transport corridors in Uganda remains largely insignificant 25 years after identifying that these populations can be drivers of the epidemic. An assessment of truck stops in the Great Lakes Region (Great Lakes Initiative on AIDS, 2006) found that health programmes cited the lack of funding and high expectations of local communities as the main challenges. Limited funding for targeted programming in transport-corridor risk zones, despite the evidence, is partly accounted for by the lack of prioritisation at policy level.

Recent epidemiological data on drivers of new infections and a number of transport-specific studies indicate that governments and development partners (including donors) have not prioritised funding to address key drivers of infections, including sexual behaviours and services provided in hot spots along national and regional transport networks. There is a need for practical targeted funding for most at risk populations (International Organization for Migration, 2009).

10.4 Limited sexual behavioural change interventions

The behaviour-change interventions targeting MARPs in hot spots are inadequate. Some of the OSBPs almost had no public facilities and/or civil society organisations providing health awareness and BCC (International Organization for Migration, 2013). IEC and BCC interventions targeting the general population focus on abstinence, being faithful and condom use. Apart from condom use, these messages do not appeal to long distance truck drivers. Given long distance truck drivers’ vulnerability to HIV infection, the need for MARP-specific sexual behaviour-change strategies cannot be over emphasised. There must be an examination of how and where information is disseminated. Information is usually provided through television spots, radio jingles, leaflets, brochures, billboards and sensitisation campaigns targeting the general public. Innovative IEC/BCC interventions can target populations engaging in HIV-risk behaviour in transport-corridor hot spots (International Organization for Migration, 2009).

10.5 Limited HIV care and treatment services

There is no known minimum service package specific to transport-corridor hot spots at regional, national or district levels. Existing care and treatment services are accessed mainly through permanent public and private health facilities. Without information on available services and referrals, some populations, particularly mobile groups like long distance truck drivers, are unlikely to use permanent facilities. Furthermore, permanent public and private health services are open at inconvenient locations and at inconvenient times of day. Access to HCT is of special importance to MARPs in transport-corridor risk zones, both for effective prevention and for facilitating access to treatment, care and support. Available evidence indicates that mobile groups like long distance truck
drivers are highly affected and infected by HIV, but that voluntary counselling and testing (VCT) is limited (International Organization for Migration, 2009).

Additional health facilities examined in selected OSBPs had deficiencies in service delivery, mainly due to a shortage of qualified health workers. Health facilities assessed at OSBPs were largely operated by staff with few qualifications. It was also found that some of the OSBPs had almost no public facilities and/or no civil society organisations that provided health awareness and behaviour-change communications (International Organization for Migration, 2013).

Many border towns do not have access to much-needed health services. Factors hindering access to health services at border posts are varied, complex and include the following:

- Distance to health facilities
- Inability to pay for basic healthcare
- Inadequate medicines, supplies and human resources at health facilities
- Non-availability of health services at some border posts
- Stigma and fear of female sex workers and irregular migrants in particular, regarding accessing health services
- Limited knowledge of how to access healthcare
- Unfriendly attitudes of facility staff, especially at public health facilities
- Different national policies on access to healthcare by migrants, particularly access to anti-retroviral therapy

A review of the approaches taken by health facilities to reach out to communities at OSBPs showed that most largely rely on static/facility-based methods to provide health education to individuals who visit health facilities. These methods are not appropriate for most migrants, long distance truck drivers, sex workers, construction workers and cross-border traders. Language and cultural differences were also found to affect health education at OSBPs. At Katuna, most long distance truck drivers found it difficult to communicate with health workers and local inhabitants because they speak Swahili, which is not commonly used by health service providers, particularly in Uganda (International Organization for Migration, 2013).

10.6 Structural issues/drivers
HIV prevention efforts cannot succeed in the long term without addressing the underlying drivers of HIV risk and vulnerability in different settings. HIV prevention programmes for MARPs must therefore incorporate structural approaches. Structural factors include physical, social, cultural, organisational, economic, legal or policy features of the environment (Gupta et al., 2008) and must be addressed for HIV prevention to truly have an impact.

Perceptions of exclusion, discrimination, communication barriers, exploitation and poor physical protection impede access to healthcare services and, thus, exacerbate vulnerability. For instance, in Elegu, long distance truck drivers from Uganda and Kenya felt that their physical safety was threatened in South Sudan where a quality health facility within a reasonable distance was located due to potential violence in the area. Together, these perceptions appeared to reduce healthcare-seeking behaviour (International Organization for Migration, 2013).

Given that long distance truck drivers and other migrant workers are not able to predict the time they will spend travelling away from home, due to delays in clearing goods at border posts and other unforeseen circumstances, the inability to replenish anti-retroviral drugs in transit makes it difficult
for them to adhere to treatment regimens. This gap in harmonising universal access to healthcare has been reported previously in East Africa (International Organization for Migration, 2013).

A key informant said, “Long distance truck drivers on ARVs need to be assisted to access their medication while on transit to solve the problem of going with[ou]t them for days or weeks because they are away from the centres that usually provide it to them.”
11.0 Recommendations
There is a need for a much larger and more coordinated effort by a wide range of organisations and groups to develop, resource, and implement policies to reduce and counter the effects of HIV/AIDS in long distance truck drivers, and to provide programmes and services. In the absence of policies, programmes and services to counter HIV/AIDS, many countries, including Uganda, will continue to be hard-hit by the epidemic, with the suffering, loss of life and falling productivity this entails.

11.1 National level recommendations
The information reviewed for this synthesis shows that the current response for long distance truck drivers to HIV/AIDS is disjointed and uncoordinated; often if programmes are in existence, they are run by independent organisations. As long distance truck drivers are mobile, surveillance is extremely difficult and national surveillance systems, sero-behavioural surveys for example, do not accurately describe the current situation. Also, due to the mobility of long distance truck drivers, HIV can easily spread through the country and across borders.

Recommendations
- Conduct a nationwide sero-behavioural survey to establish HIV prevalence and behavioural patterns of long distance truck drivers and their assistants
- Form a cohort of long distance truck drivers to test and monitor an evidence-based package of interventions to establish their effectiveness
- Implement the UAC Multi-Sectoral HIV Response for MARPs in Uganda to guide HIV prevention, care and treatment among MARPs, focusing on long distance truck drivers and their partners (both casual and regular)
- Allocate appropriate funding and resources to enhance access to and utilisation of HIV services, specifically focusing on hot spots
- Support action-oriented, operational research and evaluation
- Build the skills of healthcare workers and ensure a more appropriate infrastructure for delivering HIV services and information to the target group, realising its mobile nature as the main challenge
- Sensitise managers of businesses linked to transport corridors to make the creation, funding and operation of HIV/AIDS and health programmes a matter of primary concern and part of their corporate responsibility
- Strengthen coordination between government institutions and civil society organisations working with MARPs to improve access to the services they need
- Improve referral systems and increase access to HIV/AIDS healthcare for MARPs
- Address legal issues, including anti-retroviral drug refills, in the region focusing on cross-border coordination
- Supply technical information and advice to employers and employees on how to comply with HIV/AIDS in the workplace
- Address structural issues, such as lack of sanitation facilities and safe water, at border points
- Provide guidelines on medical examinations to ensure fitness for work to employers and health personnel

11.2 Implementation level recommendations
In developing this synthesis, it became clear that implementing partners seldom document the programmes they carry out, meaning that valuable lessons are lost. As long distance truck drivers are mobile and have unique needs, partners would benefit from getting together to understand
what others are doing, where they are operating and to learn from each other’s best practices, gaps and challenges. In developing responses, it is paramount to involve long distance truck drivers to understand their needs, as they are best placed to define the changes that will lessen their vulnerability to HIV/AIDS.

**Recommendations**

- Document programme activities in a format that allows comparison with other programmes
- Adopt a community-led approach—help hot spots, trading hubs and local governments to create context-specific programmes to cater for their particular needs
- Mobilise communities of mobile people to take action on matters that affect them directly; given the necessary tools and resources, members of sex work groups, or long distance truck drivers, or any other key population can provide peer education and support behaviour change in a community
- Involve long distance truck drivers and sex workers in designing, implementing and evaluating community-specific outreach programmes
- Tailor services to the needs of long distance truck drivers, including setting up more moonlight clinics
- Focus on risk zones—the sites or areas where risks may occur. Target interventions to places through which a large number of mobile people pass. These places should include hot spots, truck stops, bars and other are areas long distance truck drivers frequent
- Acknowledge language barriers when producing information, education and communication (IEC)/BCC) materials by using infographics in place of text

**11.3 Programme level recommendations**

Like other categories of workers, long distance truck may be reluctant to behaviour change, but behavioural change programming should focus on in four important areas: sexual health-seeking behaviour, condom use, number of partners and alcohol use. Though all four areas must be addressed, in a setting in which commercial sex is one of the mainstays of economic and social life, interventions may need to focus more on condom use than reducing the number of partners (Marck, 1999).

Activities should include:

- Target specific risk behaviours among long distance truck drivers
- Promote consistent condom use with casual and regular partners and treatment-seeking behaviour including completing STI treatment regimens
- Tackle fatalism by promoting a positive attitude to life, improving health and discouraging HIV-risk behaviours
- Provide and encourage entertainment options other than drinking alcohol
- Set up ‘sex worker-friendly’ and ‘long distance truck driver-friendly’ integrated health services providing access to integrated services, paying particular attention to location and operating hours, and the preferences of sex workers and long distance truck drivers regarding service packages
12.0 Conclusion
Evidence from this comprehensive literature review suggests that mobile populations in Uganda are at a higher risk of HIV infection than the general population. For instance, HIV prevalence among key populations that are known to be mobile, such as long distance truck drivers, ranges between 25% and 32%, whereas the national average is 7.3%.

Although mobility in and of itself is not a risk factor for HIV infection, the situations long distance truck drivers encounter and the behaviours they engage as a result of their mobile occupation increase their vulnerability to HIV and their risk of HIV infection. The role of long distance truck drivers in the spread of HIV is accentuated by the conditions in which they move, conditions during transit, and those when they eventually return home. This is mainly explained by high-risk behaviour and limited access to services. There is an urgent need to target HIV prevention and research efforts to this vulnerable group.
Citations


