

Uganda has earned international recognition for its leadership in the fight against HIV.

Over more than three decades, the country has demonstrated that determined political leadership, community mobilisation and evidence-based interventions can change the course of an epidemic.

New HIV infections have declined substantially and Uganda remains firmly on track to end AIDS as a public health threat by 2030.

This progress has been guided by consistent national leadership, including the personal commitment of President Yoweri Museveni, who has championed the HIV response since the earliest days of the epidemic and the leadership of the First Lady, Janet Museveni, whose stewardship of elimination of mother-to-child transmission (eMTCT) campaigns helped place women and children at the centre of our national response.

Yet, despite these achievements, Uganda continues to register an average of about 4,000 new HIV infections among children each year.

These infections – transmitted during pregnancy, childbirth, or breastfeeding – are almost entirely preventable. In a country that helped shape the global science of prevention, this number should be close to zero.

Uganda is not merely an implementer of global HIV strategies; it is a contributor to global HIV science. Some of the earliest breakthroughs in preventing mother-to-child transmission, including the use of nevirapine, were studied and demonstrated in Uganda, informing policies that have since saved millions of children worldwide. Our universities,

Ending Paediatric HIV: Uganda has done the science – now we must deliver zero infections



clinicians and communities helped prove that paediatric HIV could be prevented even in resource-limited settings. Science is no longer in question.

Today, Uganda has comprehensive PMTCT policies, near-universal HIV testing in antenatal care, lifelong antiretroviral therapy for women living with HIV, early infant diagnosis and clear follow-up protocols for mother-baby pairs.

More than 95% of pregnant women who attend antenatal services are tested for HIV and if positive, initiated on treatment.

These investments have yielded undeniable results. Compared to the early 2000s, paediatric HIV infections have declined dramatically. Thousands of children have been born HIV-free, and maternal survival has improved due to expanded access to antiretroviral therapy.

Even more compelling is the evidence that zero

transmission is already happening in some geographical locations in Uganda. Centres of excellence, including collaborations involving Makerere University and Johns Hopkins University, have consistently recorded zero HIV infections among infants born to mothers under their care. These are routine public health settings, not experimental projects. Their success is driven by disciplined follow-up, strong adherence support, effective tracking of mother-baby pairs and close community engagement.

Why, then, do new paediatric infections persist? The challenge is no longer scientific or policy-related. It lies in delivery at the community level. Late or inconsistent antenatal attendance, home deliveries, loss to follow-up during breastfeeding, stigma, economic hardship and limited male partner involvement continue to undermine otherwise effective interventions. Women who acquire HIV during pregnancy or breastfeeding remain at particularly high risk of transmitting the virus to their infants. These are not failures of medicine; they are failures of connection, support and continuity.

The next phase of Uganda's response must, therefore, be community-centred. Strengthening peer mother programmes, empowering village health teams, integrating HIV services with broader maternal and child health support and engaging

men and families are now the most critical interventions.

Differentiated service delivery models must work for women where they live, not only where clinics are located.

Among the HIV services that can help us get to zero mother-to-child infections is the Long-acting injectable pre-exposure prophylaxis (PrEP). This is particularly among women who are HIV-negative, but at ongoing risk of infection during pregnancy and breastfeeding. When integrated into antenatal, postnatal and maternal health services, injectable PrEP can complement existing PMTCT interventions and play a critical role in closing the remaining gaps on Uganda's path to zero mother-to-child HIV infections.

Ending paediatric HIV is both a national obligation and a moral imperative. Uganda has already done the hardest work: Generating the evidence, building the systems and demonstrating that zero transmission is achievable.

What remains is to ensure that every woman and every child, regardless of geography or circumstance, benefits equally from these advances.

Uganda can end paediatric HIV. The science has been done. The leadership has been shown. The final mile now belongs to our communities and we must walk it with urgency.

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