



The National Strategic Framework for HIV/AIDS Activities in Uganda: 2000/1 – 2005/6

Mid-Term Review Report

THEME 1: PREVENTION, BEHAVIOR CHANGE AND ADVOCACY REPORT

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December 2003



1. Executive Summary

Background and Methodology

All the prevention strategies and activities are under goal 1 of the NSF and the mid term review was performed in October and November 2003. The overall objective of the review was to assess progress towards fully achieving the goal, objectives, outcomes and all the preventive strategies and activities in the NSF.

The status of the various components was assessed through document reviews by the consultant, interviews with various stakeholders including implementers and policy makers, and during the deliberations of a technical working group, which consisted of experts that are active in various HIV prevention programs.

Key Findings

Goal 1 of the NSF is to reduce HIV prevalence by 25% by the year 2005/6. With a prevalence of 6.5% in 2000/01, the target HIV prevalence among adults is 4.8% in 2005/06. The target prevalence for June 2003, which is half way through the NSF, should be 5.7%. At a prevalence of 6.2% in 2003, progress has been slower than was projected. The objectives under this goal that were reviewed include: 1. To promote behavior change among the sexually active population; 2. To reduce the risk of blood borne HIV transmission; 3. To reduce STDs; 4. To reduce the risk of mother to child transmission and 5. To promote HIV vaccine development.

Under objective 1 (to promote behavior change), significant progress has been made in IEC. There are large numbers of posters and pamphlets in many parts of the country, radio and TV announcements are common and many studies have documented behavior changes. AIDS education and counseling in schools and colleges has been promoted by holding advocacy seminars with the heads of education institutions and significant amounts of AIDS education materials have been distributed to schools. Training of trainers for teachers in AIDS education and counseling has started. There is unfortunately no similar strategy for children out of school in the NSF although a lot has been done.

Regarding condom promotion, a National condom policy and strategy are in place and condom use continues to rise. Procurements meet current demand, but easy access has been attained only in urban areas while most rural areas have got very low access to condoms. Promotion of the female condom has stalled but supplies meet current demand.

VCT services have spread to 51 districts but access is low because active sites are few. The VCT program needs to be significantly scaled up to enable others that depend on it to expand. Unfortunately the program, and the health sector in general, faces major constraints of shortages of manpower, equipment, supplies and physical infrastructure.

Objective 2 is to reduce the risk of blood borne transmission (3% in 2000) by 50% by the year 2005/6. The target for 2003 is 2% and the current risk in donated pre-screened blood stands at 2.1%, making this objective almost fully achieved. There is now a nationally coordinated blood transfusion service, which is functioning well, but shortages in blood supply remain a frequent problem. The program to sensitize health workers about the proper handling of sharps to prevent HIV transmission is ongoing but needs strengthening.

Objective 3 is to reduce prevalence of STDs. While the prevalence of STD is difficult to measure and monitor, the syndromic management of STD has been strengthened throughout the country by regular training of health workers and availing STD management algorithms to all health facilities in the country. Procurement of STI drugs has slowed down since the end of the STI Project in 2000 and most districts report severe shortages of STI drugs.

The program to prevent maternal transmission of HIV (PMTCT) is expanding rapidly into the districts (now in 35 districts) but only a tiny fraction (about 2%) of mothers have access to it because of limited sites in each district. The objective “to reduce the risk of MTCT by a third by the year 2005/6” looks too ambitious. Future strategies will need to define expansion more explicitly than is the case in the current NSF.

Vaccine development is a slow process. One trial has been completed in the country, one is ongoing and two are being planned. All of them are phase one trials (for assessing safety and immunogenicity), implying that establishing efficacy levels is not yet in sight.

Conclusions

There has been significant progress in all the prevention objectives and strategies in the NSF. After 3 years of implementing the current NSF, the progress towards the goal to reduce HIV prevalence among the sexually active adults by 25% over 5 years has been slower than was projected. Most of the prevention programs are performing quite well, but the health sector, which is the lead sector and main implementer of preventive programs, is facing major constraints in finances, human resources and physical infrastructure that need urgent attention. The constraints are also evident at district level and in the communities. The other implementing sectors including Education, Local Government and Gender face constraints of shortage of skilled manpower and finances.

2. Description of the Technical Working Group (TWG)

Members of the TWG were drawn from relevant sectors and agencies that have been greatly involved in implementing HIV prevention interventions. The persons that constituted TWG 1 are shown in Table 1.

Table 1: Members of TWG 1

Name	Organization	Title	Telephone	Email
Dr. Onyago Saul ¹	MOH / ACP	SMO	077-508669	pmtct@utlonline.co.ug
Kataaha P Dr.	UBTS	Director	077-431880	director@ubts.go.ug
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Ochola D. (Dr)	UNICEF	P/O (PMTCT)	077-305987	dochola@unicef.org
Enginyu S	MOH/ACP	IEC Coordinator	077-416302	soenginyu@yahoo.co.uk
Musinguzi A (Dr)	UPDF	DPIF	077-454843	akmusinguzi@hotmail.com
Nvule Rebecca	TASO	Adv. & Mob.	077-684446	mail@tasouganda.org
Kirunda P	Fasert	Prog. Officer	071-836741	
Kasedde Susan	UNICEF	HIV/AIDS Advisor	041-234591	skasedde@unicef.org
Lisulo Lucy	UNICEF	Youth advisor	077-473404	lawlisulo@hotmail.com
Buyinza Sarah	MOEd.	Ed. Officer	077-426967	
Kagimba Jesse	OoP	Senior Advisor	077-432656	
Bazaala M Mugisha E	MGLSD UVRI	ACDO Coordinator Comm. Ed.	077-339459 077-657777	bazaalamartin@yahoo.com emugisha@iavi.org
Tatwebwa L	UAC	APO	077-479402	
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3. Approach to the task of the TWG/methodology

TWG 1 scheduled and held five meetings, all of them at the UAC. The consultant carried out an extensive document review and also interviewed key informants. Some members of the TWG assisted with conducting interviews with key informants. The TWG reviewed the NSF sections dealing with prevention and behavior change in goal I. Progress towards achieving the goal, outcomes, strategies and activities was discussed during the meetings. On the basis of the information that was provided by various stakeholders, especially the implementers, combined with what the TWG members knew about the different items, the extent of progress was arrived at by consensus.

¹ This was elected Chairperson of the TWG

² Served as Secretary to the TWG

Key informants interviewed include the following:

1. Mr. Paul Kaggwa MOH
2. Dr. Elizabeth Madra Project Manager ACP/MOH
3. Dr. Kambugu STD Unit Manager
4. Dr. Peter Nsubuga UACP Coordinator
5. Dr. Zainab Akol ACP/MOH
6. Dr. J. Twa Twa MOH
7. Mr. Y. Nsubuga HIV/AIDS focal person MOE
8. Dr. G.B. Oundo DDHS Busia district
9. Dr. R. Mayanja DDHS Rakai district
10. Dr. David Kitimbo DDHS Jinja district
11. Dr. J.R Wayira D/DDHS Kampala district
12. Dr. Emer Mathew DDHS Hoima district
13. Dr. Kabagambe DDHS Kabarole district
14. Dr. Donna Kabatesi CDC Uganda (formerly STD unit)
15. Mr. Kusemererwa HIV School Health Program MOES
16. Ms. Catherine Barasa School Health Program MOES
17. Mr. Byenkya UACP
18. Prof. J. Rwomushana UAC
19. Ms. Vastha Kibiringe ACP/MOH

4. NSF Progress To Date

4.1 NSF Progress To Date Thematic area = Behaviour Change

[TWG 1] GOAL I: TO REDUCE HIV PREVALENCE BY 25% BY THE YEAR 2005/6

Objective 1: To promote behaviour change (abstinence, faithfulness and safer sex) among sexually active population particularly young people aged 15-24

Outcome: By the year 2005/6, at least 90% of the sexually active population shall have access to information, education and services

(condoms, voluntary counselling and testing and follow up) required to reduce the vulnerability to HIV infections

Strategies	Activities	Indicators	Progress towards each activity	Progress towards strategy and comments
1. Promote IEC on HIV/AIDS for sexual behaviour change.	a) Conduct a national KABP survey and IEC impact assessment of the general population	a) Availability of KABP survey IEC impact assessment results for different categories of the population.	National study not done, but many local ones available. KABP in sec. schools done by MOH. KABP will be included in national sero-survey	Significant progress has been made. Technical leadership from MOH is still needed by many groups and should be strengthened
	b) Review/develop IEC messages for the different population groups.	a) Number of messages/materials reviewed and developed in different languages by type of medium.	Done for forces, schools and others. Much progress in IEC for children and young people. Score = [3]	Communication strategy has been developed and a consensus meeting to disseminate it held.
	c) Repackage and disseminate IEC messages in appropriate form for the different categories of the population.	a) Number of IEC dissemination fora and audiences reached through the various IEC activities b) % of men, women, youth and children having access to information required to reduce HIV infection	Significant progress has been made for school goers. Peer educators have used existing materials to reach those out of school. Score= [3]	Stakeholders have reviewed IEC materials Efforts need to be sustained because younger generations are joining the sexually active group all the time -Activity f too broadly stated
	d) Procure mobile film vans for all districts.	a) Number of mobile film vans procured	8 vans are with MOH, 1 with MOD, 1 MGLSD A proposal for more vans developed: Score = 2	Score = 3

Strategies	Activities	Indicators	Progress towards each activity	Progress towards strategy and comments
	e) Conduct community AIDS education through mobile film shows and theatre activities.	a) Number of community AIDS education film shows and theatre activities conducted per sub county. b) Proportion of community members having access to AIDS education through mobile film shows and theatre activities.	Shows have been done in each of 20 districts. This is happening at a low scale because of no funds [2]	Progress on goal: Reducing HIV prevalence from 6.5% to 4.8% by 2005/6 has been slow since the 2003 prevalence is 6.2% Although film vans are few each district has received video equipment UACP plans to buy 10 more vans.
	f) Sensitise the public on the dangers of early sex, infidelity, and unprotected sex and substance/alcohol abuse in relation to HIV/AIDS.	a) Number of community sensitisation conducted b) % of sexually active persons reporting abstinence, faithfulness and condom use.	Activity too broad a. on going, but funds limit activity levels b. no data – needs special studies [3]	
2. Promote AIDS education and counselling in schools, colleges and institutions of higher learning	a) Conduct advocacy seminars for AIDS education and counselling in schools, colleges and institutions of higher learning	a) Number of advocacy seminars with heads of education institutions held	Many head teachers have been guided by the MOE [2]	M.O. Education has promoted life skills development in schools but progress is slow.
	b). Produce and distribute AIDS education manuals/materials to schools.	a) Number of AIDS education counselling materials produced b) Proportion of schools having access to AIDS education materials	Data on indicators not available, but significant progress has been made. [3]	Measurable targets should be developed. This strategy should also be mirrored and developed for community implementation to ensure that the activity is actively planned for the out of school children who are the majority.
	c) Train trainers for teachers in AIDS education and counselling.	a) Number of trainers of teachers of AIDS counsellors trained b) Number of lecturers trained as AIDS counsellors	No specific data, but some progress made [2]	
	d) Equip one lecturer/teacher per school with techniques and skills of providing AIDS information to students/children	a) % of students having access to AIDS information and counselling services at each education level	[2] one teacher per school is not enough 15,000 teachers have been trained	

Strategies	Activities	Indicators	Progress towards each activity	Progress towards strategy and comments
3. Increase condom accessibility and affordability with particular emphasis to rural areas	a) Train communities based distribution agents (CBDs) on condom distribution practices, and establish condom distribution networks in rural areas.	a) The number of condom distribution outlets established in rural and urban areas. b) % of sexually active rural residents reporting easy access to condoms. c) % of men, women and youth reporting consistent and correct use of condoms.	Male condom = [2] Female condom = [1]	Condom policy and strategy in place. -Access good in urban areas -Access to condoms in rural areas is not satisfactory Condom access in emergency situations e.g. camps, needs to be tackled. Male condoms: score = 2 Female condom is still in pilot phase and has not had programmatic activity. score = 1 recommendation: Monitoring condom access should become a separate activity. All progress should reflect male or female condom separately
	b) Procure condoms.	a) Number of condoms procured and distributed each quarter	Large numbers of male condoms being imported [4]	
	c) Advocate for appropriate condom education.	a) Number of advocacy seminars conducted on appropriate condom education.	Some advocacy sessions have been held [2]	
	d) Distribute condoms to all outlets at subsidised and affordable cost.	a) Proportion of sexually active partners having access to condoms	[2]	
	e) Conduct community sensitisation and education on correct use of the female condom.	a) % of women reporting consistent and correct use of female condoms	No data but very slow progress [1]	
4. Expand HIV voluntary counselling and testing (VCT) services to all districts	a) Develop and provide VCT guideline to all districts and NGOs extending VCT services.	a) Number of leaflets and messages produced b) % of men, women, youth and children having access to VCT information and education and services.	The MOH has developed VCT guidelines; Distribution is going on [4]	Slow but sure progress being made. VCT currently in 51 districts (each one with at least one site). Training is needed for lab technicians, counsellors. Testing kits run out from time to time
	b) Train VCT Counsellors for each additional VCT site	a) Number of VCT Counsellors trained for each VCT site	Training is difficult and expensive. [2]	
	c) Establish additional HIV VCT sites in other districts and sub-counties.	a) Number of VCT sites per district.	Slow progress because of logistical and financial problems. Districts have moved at different rates. Score = [3]	

Strategies	Activities	Indicators	Progress towards each activity	Progress towards strategy and comments
	d) Conduct VCT outreach activities.	a) Number of VCT outreaches conducted per year. b) Number of clients accessing VCT services through outreach activities.	Some activity is supported by partners, but there are personnel and finance constraints. [2]	GAPS: -Refresher courses for counsellors, -Post test support e.g. Through clubs Score = 2
	e) Integrate VCT into IEC messages related to HIV/AIDS.	a) Number of IEC messages related to VCT disseminated.	Being introduced [2]	
	f) Conduct community sensitisation seminars on VCT.	a) % of men, women and youth in under served areas that report having had HIV VCT.	Very slow progress [2]	

Objective 2: To reduce the current 2 – 4% risk of blood borne HIV transmission by at least 50% by the year 2005/6

Outcome: By the year 2005/6, the risk of blood borne HIV transmission would have been reduced to less than 1 - 2 %.

Strategies	Activities	Indicators	Progress towards activities	Progress towards strategy
1. Strengthen blood quality control, supply and appropriate use of blood and blood products in all health service delivery sites.	a) Support a nationally coordinated blood transfusion service.	a) Proportion of government and private hospitals having access to centrally/regionally supplied blood.	Has been achieved [5] All hospitals have got access	Note: -The risk in the objective refers to prevalence in donated blood before screening. -Current risk = 2.1% -Not all transfused blood is screened but extent is not known -Studies should be done to estimate actual risk of infection from blood transfusion in Uganda. UBTS needs to be further strengthened to eliminate
	b) Develop and distribute the national policy and guidelines on blood transfusion	a) National policy and guidelines on blood transfusion. b) Number of stakeholders having access to the national policy and guidelines on blood transfusion	The guidelines exist but are not continuously available in all health facilities. Score = [4]	
	c) Conduct regular training for health staff on the changing technologies of blood management.	a) Number of health staff trained on changing technologies of blood management	Some training is going on Score = [2 / 3]	

Strategies	Activities	Indicators	Progress towards activities	Progress towards strategy
	d) Recruit non-remunerated blood donors/volunteers from schools and the community.	a) Number of blood donors recruited by location per year.	Has been largely achieved Score = [4]	shortages of blood.
	e) Sensitise community members on procedures of blood donation, testing and transfusion, and privileges of donors.	a) Number of community sensitisation seminars conducted b) % of community members aware of the procedures of blood donation, testing, transfusion and privileges of blood donors.	Emphasis has been on schools Score = [3]	
2. Strengthen the prevention of blood borne HIV transmission through sharing sharp non-sterile skin-piercing instruments.	a) Sensitise and supervise health staff, traditional healers, TBAs and individuals engaged in activities that involve sharing sharp non-sterile skin-piercing instruments on the new techniques of preventing blood borne HIV transmission.	a) Number of health staff, traditional healers, TBAs and individuals sensitised on blood born HIV transmission.	Not clear whether TBA training manual covers these issues Health staff score = 3 TBAs score = 2	-Infection control guidelines were made by MOH and distributed to many units especially hospitals and HC IV. -On site inspection and training is done -Guidelines are not easily available in health units.
	b) Guide, support and monitor the implementation of HIV infection safety precautions at various levels.	a) Number of monitoring visits conducted b) % of the different categories of service providers using HIV infection safety precautions. c) Number of health facilities with appropriate equipment and materials for universal precautions	On site supervision is done by MOH/ACP especially to hospitals and HC IV Infection control guidelines for school clinics were made by MOH Constraints of funds and equipment reported Score = 2	Disposal of sharps in health facilities is still problematic Score = 2

Objective 3: To reduce sexually transmitted infections by 25% by the year 2005/6

Outcome: To have reduced STI prevalence by one quarter in the various age groups by the year 2005/6

Strategies	Activities	Indicators	Progress towards activity	Progress towards strategy
1. Strengthen syndromic management of STD	a) Conduct refresher and on-site training for health workers in the private and government sectors (with emphasis at lower levels) in syndromic STD management.	a) % number of government and private health workers trained through refresher and on-site courses.	Each health facility has got at least one person trained The STD has lead the process to develop training materials and has provided technical support to many other players including NGOs involved in training. All districts have at least 5 trained trainers each Score =4	Syndromic management has been strengthened in all districts of Uganda. A quality of care survey (2003) shows a 40% improvement since a 1998 survey. Score = 3-4 The objective and outcome look rather ambitious and are difficult to measure
2. Integrate STD prevention and treatment into other health services.	a) Provide information and education on symptoms of STD, alongside antenatal/FP clinics, immunisation, PHC and other services.	a) % of new clients who report STIs b) % of service providers who reported having access to and c) Utilised guidelines in syndromic treatment of Std	STD management algorithms are in all health facilities About 50% of patients who attend for STD management are free of any STI. Score = 4	Integration has been largely achieved in all public facilities. Score = 4
	b) Conduct school and community visits on the syndromic treatment of Std.	a) Number of schools and communities visits. b) % of young people and community members who report having access to syndromic treatment of Std.	STD education is now in the primary school curriculum. Indicator (a) is not a good indicator while indicator (b) needs a special study	
3. Strengthen the STI drug procurement, delivery	a) Generate list of drug requirements for each health unit (the list should be in consonance	a) A comprehensive list of STI drug requirements by sub-county/health unit.	The drug needs in the country have been quantified. Procurement is done through tendering. But procurement has been poor since end of STI proj.	This is done through the National Medical Stores, which procures and distributes drugs to all districts with drug kits to all health units on a quarterly basis.

Strategies and management system	Activities with the prevalent STIs by location).	Indicators	Progress towards activity All facilities including hospitals down to HC II used to receive STI drugs from the NMS quarterly. After closure of STI Project most districts have not received STI drugs (for about 2 years). They purchase from allocated funds.	Progress towards strategy Strengthening of the STI drug procurement, delivery and management system was substantially achieved until the STI Project closed.
	b) Integrate syndromic management of Std in pre-service training.	a) % of trainees reporting syndromic approach in case management of STD.	Syndromic management has been integrated in all training curricula, and it is examinable. Score = 4	The UACP Project has apparently not yet performed to the same level. The districts report that there are no regular drug supplies and stock outs of supplies are common.
	c). Procure and avail drugs for STI.	a) Proportion of health delivery points and persons accessing STD drugs.	All public and NGO facilities used to have STI drugs delivered quarterly. Most health units have no STI drugs now. Score = 3	Score = 3 The UACP has got less funds for drug procurements (less than STI Project) and procurements are being streamlined
	d). Distribute STI Drugs to health units.	a) Proportion of health delivery points having access to STI drugs	All facilities used to have drugs all the time – but not now Score = 3	
	e) Develop and distribute guidelines for dispensing of STI drugs.	a) Number of health delivery points and providers having access to dispensing guidelines of STI drugs.	All health facilities have got treatment guidelines charts and protocols. Score = 5	
	f) Monitor the drug dispensing and resistance	a) Number of persons who report STI drug resistance due to inadequate treatment.	There is an ongoing study on drug resistance Score = 2	

Strategies	Activities	Indicators	Progress towards activity	Progress towards strategy
	g). Conduct special STD studies in core groups	a) Data on STD prevalence and trends in core groups.	Studies are ongoing among CSWs, drivers and among the forces. Score = 3	

Objective 5: To reduce the current 15 – 25% incidence/risk of mother to child HIV transmission (MTCT) by a third by the year 2005/6

Outcome: To have reduced MTCT of HIV to 10- 17% by the year 2005/6

Strategies	Activities	Indicators	Progress towards each activity	Progress towards strategy
1. Initiate a phased implementation of PMTCT in selected health units	a) Conduct a cost analysis for phased implementation of PMTCT in selected health units.	a) Cost analysis report on phased implementation of PMTCT in selected health units.	Not yet done [1]	Progressing well. Program is now in 35 districts; target is 38 for end 2003. [3] access to individuals is still poor because many districts have got only one site.
	b) Sensitise policy makers on PMTCT at national and district levels.	a) Number of PMTCT advocacy seminars held and policy makers sensitised	Being done: National level and all districts completed [4]	
	c) Sensitise district local councils and health workers at pilot sites on PMTCT interventions.	a). Number of seminars monitoring DLC and health workers held regarding MTCT intervention b) Number of DLC and health workers sensitised	Largely done [4]	
	c) Develop and	a) Proportion of selected health		

Strategies	Activities	Indicators	Progress towards each activity	Progress towards strategy
	distribute guidelines for implementation of PMTCT including use of ARV to selected health units.	units having access to guidelines for implementation of PMTCT including use of ARV	Progress towards each activity Guidelines were developed 2002 but not yet distributed. [3]	Progress towards strategy The term “selected units” makes assessment of progress difficult because even one unit in a district means full achievement
	d) Procure and avail anti-retroviral drugs for PMTCT to pregnant women who are HIV positive in selected health delivery points.	a) Number of pregnant women who are HIV positive having access to anti-retroviral treatment at selected health delivery points.	On going (3) Indicator should be proportion	More specific terms should be used in the NSF
	e) Monitor occurrence of side effects of ARV therapies among the HIV positive women and their babies at PMTCT sites	a) Number of HIV positive mothers reporting side effects as a result of using ARV. b) Number of HIV positive mothers reporting their infants having had access to follow up services	Being done [3] Indicator should be better stated	
2. Strengthen sensitisation and awareness on PMTCT to reduce pregnancies and facilitate informed decision making among HIV positive and discordant couples.	a) Conduct community sensitisation seminars and media discussions on PMTCT of HIV and positive living.	a) Number of community sensitisation seminars held b) Number of media discussion on MTCT held. c) % of people/ couples having access to information on MTCT of HIV.	This has been started [2]	This promotion forms part of the health workers' training for PMTCT. Activity b should read “counsel mothers and sensitise communities”
3. Promote utilisation of disposable or sterile and other	a) Develop and avail usable materials on HIV/AIDS medical precaution vis -avis MCH and Safe motherhood.	a) % of mothers having access to MCH/family planning and safe motherhood IEC materials with HIV/AIDS information. b) Number of maternity established	Materials were developed distribution less successful Score = 2	Score = 2

Strategies	Activities	Indicators	Progress towards each activity	Progress towards strategy
necessary MCH/FP and safe motherhood equipment	b) Carry out follow-up counselling for HIV positive and discordant couples	a) Number of HIV positive and discordant couples having access to follow-up counselling.	Being done Score = 2	
	c) Sensitise pre-service and in-service health care providers including private and traditional health practitioners on HIV/AIDS medical precautions in service delivery.	a) Percentages of pre-service and in-service care providers sensitised.	Carried out as part of the training for PMTCT In service score = [2] Pre-service score = 1 Private practitioners = 2 TBAs score = 1	
	d) Train health workers especially TBAs and mid wives on MTCT	a) Number of refresher courses conducted b) Percentage of health personnel trained on treatment of opportunistic infection and use of anti-retroviral drugs.	Emphasis is on health workers not TBAs Health workers =[2], TBAs =1	
	e) Equip service providers (TBAs & Midwives) with disposable or sterile and other necessary MCH/FP and Safe Motherhood equipment and materials	a) % of service providers having access to disposable/sterile equipment and materials every year.	Focus is on health workers [3] some TBAs are getting support from some donors TBA score = 2	
	4. Promote education on cheaper alternative feeding programs to breast feeding for children of HIV positive mothers	a) Identify/introduce cheap and nutritive locally available food stuffs for children in different communities	a) % of HIV positive mothers having access to information on breast feeding replacement programs	
	b) Sensitise mothers and community members on the available foodstuffs/cheaper alternatives to breast feeding	a) Country/district profile on cheap and nutritive locally available foodstuffs for children born of HIV positive mothers.	Alternatives are generally expensive. There is a team that is in the process of developing guidelines [2]	One recommendation is to change "cheap" to "appropriate" alternative – because the alternatives are actually not cheap.
	c) Provide safe water for mothers and children	a) Number of mothers and children having access to safe water supplies.	Access to safe water is improving in the country	Score = [2] Male involvement should be reflected in the framework

Objective 6: To promote therapeutic and preventive HIV vaccine development and trials in different categories of the population
 Outcome: To have established the efficacy levels of the therapeutic and preventive HIV vaccines by the year 2005/6

Strategies	Activities	Indicators	Progress towards each activity	Progress towards strategy and comments
1. Strengthen therapeutic and preventive HIV vaccine development and trials in different categories of the population.	a) Review the National Vaccine Plan.	a) Number of meetings conducted to review the national vaccine development plan. b) A comprehensive analysis of the issues related to HIV/AIDS vaccine.	Being done. The HIV vaccine plan (2003-2008) is in advanced stages of being developed. [2]	Work has been mainly on preventive vaccines trials. Good progress being made. The outcome looks to be too ambitious (to have established efficacy levels). It is out of step with the activities. The outcome should be revised Score = 2
	b) Conduct consensus workshops/meetings on the revised Vaccine development plan.	a) Agreed upon HIV/AIDS vaccine development plan.	Not yet done [1]	
	c) Sensitise stakeholders about the ethical issues and progress in vaccine trials.	a) Number of stakeholders sensitised on the ethical issues and progress in vaccine trials.	Parliamentarians were sensitised Score = 2	
	d) Prepare for phase I trial of other therapeutic and preventive vaccines	a) Number of volunteers enrolled for therapeutic and preventive vaccine trials	[2] one trial completed, one ongoing	
	e) Start new HIV vaccine development initiatives.	a) Number of new HIV vaccine development initiatives	Two trials being planned [2]	

4.2 Progress in Advocacy

Advocacy is a term with broad meaning and various stakeholders understand it differently. For the purpose of the MTR of NSA, advocacy is regarded as all those activities and efforts that lead to development of policies or regulations whose aim is the prevention and control of HIV/AIDS. Advocacy is therefore the process of lobbying policy-makers or those in positions of authority to make the pertinent policies and regulations. Although information is scanty, different stakeholders at various levels have been involved in advocacy in Uganda.

Regarding national policies, the interested parties have got to lobby Parliament to enact the various policies that are currently in draft form. Examples include: The National AIDS Policy (draft); The draft Antiretroviral treatment policy; The draft orphans and vulnerable children policy; and The draft National Condom Policy and Strategy among many others. In view of the fact that there are currently many draft policies at various stages of completion that will need Parliament's approval in the near future, the various lead sectors will need to go through a lot of advocacy. The UAC, Ministry of Health, Ministry of Gender and Ministry of Education will have to carry out advocacy sessions with Parliament so as to get the policies approved and enacted.

Advocacy can also start from the top to lower levels. A high level institution, such as a Ministry headquarters, may move to persuade its lower level institutions to introduce specific programs or regulations. For example the Ministry of Education has persuaded head teachers to introduce AIDS education into schools. Other interventions such as the President's initiative, through which head teachers have been asked to address students about AIDS prevention at least two times a month, can also be classified as advocacy.

5. Process Lessons Learned

The Technical Working Group (TWG) was a very useful forum for obtaining consensus especially regarding the level of progress on various activities and indicators. The discussions during the meetings were frank and very informative. A lot of information was collected from the members' contributions during the meetings. Some TWG members also conducted key informant interviews. This turned out to be a very effective way of undertaking the review and monitoring the progress of the NSF.

The role of the TWG was clearly defined and the members fully understood their roles. The level of attendance of scheduled meetings was good and most members were regular at attending meetings. All the members took the task seriously and fulfilled their assigned responsibilities to the best of their abilities. Some members who had initially been identified to be members of the TWG could not attend because of busy schedules. The consultant then took on the responsibility of tracking them down and interviewed them as key informants.

Recommendations for an improved process in the future:

All persons who get selected for any technical working group should be informed well in advance so that they plan for the exercise. Letters of appointment for TWG members and letters of introduction for the consultants to the various organizations should be made.

6. Constraints

These are constraints hindering progress towards obtaining the projected outcomes for various objectives.

The Ministry of Health AIDS Control Program is the technical lead sector for many of the prevention strategies and activities. It has fulfilled this role very well in spite of significant constraints. The major constraints faced by the MOH/ACP include scarcity of both human and financial resources, a physical infrastructure that is in need of rehabilitation and a difficult coordination process for the very many stakeholders.

Human resources

The Ministry of Health has got a major manpower shortage, almost reaching crisis level, especially after the Ministry restructuring that saw many positions eliminated in all the departments of the Ministry. All the units in the ACP/MOH are understaffed. The IEC unit for example, is expected to provide technical support for many other sectors and to the ever increasing numbers of stakeholders who wish to participate in IEC activities. Currently the technical team in the IEC unit is small and sometimes fails to meet all the demands made to it. The same is true for other units including Surveillance and Clinical Care and Support. Some development partners have supported some positions in the ACP/MOH in order to prevent a crisis but the shortage of manpower still remains a big problem.

Capacity building is also required in other Ministries. Most of the other ministries have got only one focal person each, who has got a full schedule of work outside of AIDS activities. This leads to overload and reduced efficiency.

In the districts, their capacity to implement HIV/AIDS control activities is likewise hampered by lack of adequately trained manpower. This was a major handicap for all the districts from which information was obtained. Most districts cannot develop their own IEC materials or adapt those from the center to their own environments or languages because of very limited human resources at the district level. A need for refresher training or continuing medical education was identified. The low capacity extends down to the community level, where communities may be very keen to participate in the fight against AIDS, but are hampered by lack of skills to develop work-plans or account for funds in the required manner. A few districts have managed to adapt or translate s 15 materials. An example of a district that has adapted and designed IEC materials is Kabarole district, which is among those that have benefited from significant NGO support. The severe shortage of skilled manpower leads to a low absorptive capacity generally.

Financial resources

The shortage of financial resources is a major constraint for all prevention programs both at the national and district levels. While the situation has seen some improvements recently, all the major prevention programs are facing financial constraints and this is likely to have a negative impact on other programs. For example an expanded VCT program would help to speed up the PMTCT program and drug treatment. The programs that are particularly affected include VCT, IEC, and STD management. The lack of funds leads to inability to hire appropriate personnel, to buy testing equipment and supplies, to print the various visual aids, and to buy airtime on radios and television stations. The mobile film vans, which are very popular in the districts, are still running but they are getting old and their maintenance is becoming problematic because of the high costs involved. There are plans however, to buy another 10 vans by the UACP. The severe shortage of finances could slow down the progress that has recently been observed in AIDS control.

7. Emerging issues, including opportunities

There is a rapidly changing HIV/AIDS environment in Uganda as is the case in many other countries. The increasing availability of ARVs and the planned acceleration of access to ARVs will need services such as VCT to be significantly accelerated before ARV treatment can itself be accelerated. The ARVs on their part, however, are likely to make an impact on preventive outcomes. If the drugs should become easily and freely available then many more people are likely to take up VCT and this should in turn accelerate preventive programs such as PMTCT. While there is a worry among some stakeholders that easy access to ARVs could make people relax and become more vulnerable to HIV, experience from countries such as Brazil has been that the widespread availability of ARVs resulted into declining total numbers of people with HIV rather than higher numbers. This strengthens the case for accelerating ARV access from a prevention perspective. Acceleration of ARV access is an important prevention strategy which is in line with disease control principles for other communicable diseases. As drugs become more easily available, however, the public needs to be continuously sensitized about the possibility of the negative effects.

Good practice

The various HIV/AIDS prevention programs that have been implemented in Uganda since programmatic AIDS control activities were started in the country were assessed in order to identify an example of a “good practice”. The programs that were assessed include: IEC, condom promotion, VCT expansion, blood quality control, infection control through sharp instruments, STD control, PMTCT and vaccine development.

The performance of the different programs was assessed by the TWG and also by many of the key informants, especially those in charge of districts. Most key informants identified IEC as the leading example of good performance in their respective districts. This is probably due to the fact that in addition to a sustained production of IEC materials from the centre, capacity has been strengthened at many other levels and across sectors. Posters and pamphlets are visible in many places, radio and TV messages are always seen or heard and many stakeholders held the view that among preventive programs IEC is the one that has made the biggest impact on the population in spite of the constraints related to human and material resources. There was a general feeling, however, that the IEC programs have somewhat declined from what was an apparently higher performance during the decade of the nineties. Brief reviews of the other programs that were initially identified as possible examples of good practices are as follows.

STD Control

There was a strong opinion that STD Control had been a shining star until the closure of the STI Project some 2 years back. Since then many achievements that had been recorded under this strategy have either stagnated or back slid. For example drugs are no longer being supplied regularly. The outstanding performance of the STI control programs until the turn around is probably attributable to the then sustained high levels of funding that the program enjoyed. Although many stakeholders had expected the UACP to pick up from where the STI Project ended, this has not happened.

The PMTCT program

This program has spread quickly into many districts in spite of the persistent shortages of supplies. Many district key informants, however, expressed similar concerns with the national level implementers that this rapid spread was rather deceptive because the coverage

in each district is very low. Many districts have got only one or two sites and the proportion of pregnant mothers having access to PMTCT is as low as 2% in many of these districts.

Condom promotion

Condom promotion is probably a star in urban areas but it is still a disappointment in rural areas.

8. Recommendations: Strategic priorities and interventions

The NSF in general

The NSF is very well laid out but in most instances the indicators need to be modified so as to be measurable and directly related to the activity. Some activities are very broad and should be divided up to make several activities. All the indicators need to be reviewed and appropriately modified. Many of the indicators would require special studies in order to be measured and the coordinating body should initiate such studies.

Programs

- There is a general complaint about shortage of funds to fight AIDS in all the lead sectors that have got to implement programs. This is something that could be addressed through the appropriate budgetary processes.
- The comprehensive rehabilitation of the health physical infrastructure is overdue and in as much as is feasible should be speeded up.
- Strengthening human resources is an issue cutting across all the sectors involved with HIV / AIDS prevention. A comprehensive review of manpower requirements needs to be done especially for the health sector.
- In view of the widespread shortage of skilled manpower it is recommended that government should, where feasible, purchase services from the private sector in deserving situations.

IEC

- A strategy for interventions among the out of school children should be included in the NSF.
- Tertiary institutions are reflected in the NSF and the education sector should target more interventions at them rather than focusing mainly on schools only.
- Interpersonal interventions should be promoted to complement the mass media
- IEC has got very many players working independently. Some of them produce or broadcast messages that need improvement or that are not in line with the mainstream thinking. There is therefore an urgent need to strengthen coordination in this field of behavior change communication. A national forum should be formed and a national strategy developed.

VCT

- Since VCT is a forerunner of other programs it needs to be strengthened by way of funds, human resources and all the services that are linked to it such as laboratory, test kits, support groups and drugs.
- For the purpose of attaining significant improvement in access to VCT, it is recommended that VCT services should be availed to HC III level from where outreaches may be organized.

Condom promotion

There is a need to improve condom distribution capacity in districts with innovative practices e.g. use of markets etc.

Blood supply

The national program has performed very well with regard to recruiting safe donors and establishing the infrastructure for distributing safe blood to health facilities. In many areas, however, stock-outs are common. It has been pointed out that this is one of the reasons why some patients receive unscreened blood. While the extent to which this happens is unknown, the solution is to increase the amount of available safe blood. The UBTS needs to be strengthened to enable it to handle larger amounts of blood.

Infection control

The program has got good strategies but logistical constraints have prevented it from becoming fully operational and its impact is still limited.

STD control

- There is a shortage of STI drugs in the public sector that needs to be addressed.
- The community needs further sensitization to seek treatment early

PMTCT

- Inclusion of males should be reflected in the NSF
- Scaling up should be monitored by percentage of health facilities at the level of HC III and above with the program.

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