UGANDA AIDS COMMISSION

REPORT

DISTRICT HIV/AIDS SUPPORT SUPERVISION AND FOLLOW UP OF HIV/AIDS ACTIVITIES IMPLEMENTED IN LOCAL GOVERNMENTS

March 2014
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List of Abbreviations and Acronyms

ADPs  AIDS Development Partners
ART  Anti-retroviral Therapy
ARVs  Antiretroviral Drugs
CBOs  Community-Based Organizations
CSF  Civil Society Fund
CSOs  Civil Society Organizations
DACs  District HIV/AIDS Committees
GF  Global Fund
GHI  Global Health Initiative
GoU  Government of Uganda
HAART  Highly Active Antiretroviral Therapy
HCT  HIV Counseling and Testing
HMIS  Health Management Information System
HRH  Human Resources for Health
HSSIP  Health Sector Strategic and Investment Plan
M&E  Monitoring and Evaluation
MARPs  Most At Risk Populations
MDGs  Millennium Development Goals
MDR  Multiple Drug Resistance
MoGLSD  Ministry of Gender, Labour and Social Development
MoH  Ministry of Health
MoLG  Ministry of Local Government
MOT  Modes of Transmission Study
MSM  Men who have Sex with Men
MTCT  Mother to Child Transmission
NGO  Non-Governmental Organization
NPAP  National Priority Action Plan
NSP  National Strategic Plan (for HIV/AIDS)
OVC  Orphans and other Vulnerable Children
PEP  Post-Exposure Prophylaxis
PEPFAR  US Presidential Emergency Fund for AIDS Relief
PHA  People Living with HIV
PHA  People Living with HIV/AIDS
PHDP  Positive Health Dignity and Prevention
PIASCY  President’s Initiative on AIDS Strategy for Communication to Youth
PICT  Provider Initiated HIV Counseling and Testing
PMTCT  Prevention of Mother to Child Transmission (of HIV)
PrEP  Pre-Exposure Prophylaxis
PWDs  Persons with Disabilities
STAR  Societies Tackling AIDS through Rights
STAR-EC  Strengthening TB and HIV/AIDS Responses in East Central Uganda
STD  Sexually Transmitted Diseases
TB  Tuberculosis
<table>
<thead>
<tr>
<th>Acronym</th>
<th>Full Form</th>
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<tr>
<td>TERUDO</td>
<td>Teso Rural Development Organisation</td>
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<tr>
<td>TWG</td>
<td>Technical Working Group</td>
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<tr>
<td>UAC</td>
<td>Uganda AIDS Commission</td>
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<tr>
<td>UDHS</td>
<td>Uganda Demographic and Health Survey</td>
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<tr>
<td>UHSBS</td>
<td>Uganda HIV/AIDS Sero-Behavioral Survey</td>
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<tr>
<td>UNAIDS</td>
<td>The Joint United Nations Programme on HIV/AIDS</td>
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<tr>
<td>UNGASS</td>
<td>United Nations General Assembly Special Session</td>
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<tr>
<td>USAID</td>
<td>United States Agency for International Development</td>
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<tr>
<td>VCT</td>
<td>Voluntary Counseling and Testing</td>
</tr>
<tr>
<td>WHO</td>
<td>World Health Organization</td>
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<td>YEAH</td>
<td>Young Empowered and Healthy</td>
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Executive summary

Uganda AIDS Commission (UAC) is mandated by law to coordinate and lead the National HIV and AIDS response in the country. In effort to achieve this, the institution conducts routine quarterly supervision visits to HIV and AIDS implementing partners in Uganda.

This report details the 3rd quarter support supervision activity that was conducted 27 districts of Uganda.

The purpose of conducting the exercise was to provide a forum for joint discussion of HIV/AIDS Coordination in the district, identify challenges and make recommendations to different stakeholders for improved response to the epidemic.

Supervision teams were allocated based on nine identified regions in the country i.e. Busoga, Bugisu, West Nile, Lango & Acholi, Teso & Karamoja, North Buganda, South Buganda, Toro & Buyoro and Ankole & Kigezi from these regions 3 districts were selected. The selection criteria were based on the previous support supervision visits and issues raised in the regional review meetings. Districts which had more problems and critical issues to follow up were prioritized. Each region was visited by 2 – 3 technical officers from UAC. Other stakeholders (Ministries, SCE and CSO) were not included this time because of limited funding.

There is general HIV/AIDS awareness creation in the districts conducted by mostly IPs and but also Local government staff. Sensitization is done at all levels particularly through health talks, Drama and radio talk shows. Most at Risk Populations (MARPs) are mobilized by Village Health Teams (VHTs) and reached through HIV Counseling and Testing (HCT) outreaches with some districts with highways e.g. Luuka conducting ‘Moonlight’ services.

Presidential Initiative on AIDS and Communication for Young (PIACY) programmes are still conducted in some schools in the Karamoja region. There is need to avail more translated IEC materials in the local language to these districts. The talking compound sign posts in the schools are old and with massages fading away. There are Behavioral Change Communication (BCC) activities done. An estimated 49,653 people were in Katakwi district. Other districts could not estimate their target populations and those who are reached.

TASO has supported some districts in the Ankole region by training peer educators and community structures to deliver health and HIV services. Family planning and sexual reproductive health are activities being for inclusion onto the curriculum for VHTs. The Civil Society Fund is said to be supporting Behavior Change Communication interventions in districts where it exists.

In most districts, World AIDS and Philly Lutaaya days are the most commemorated advocacy events. This was made possible by support from partners. During those events, most districts reported conducting HCT alongside other activities. District leaders reportedly always incorporated HIV/AIDS in their addresses to the congregations.
Most districts with Local FM radio stations had an allocation of free airtime or discounts for HIV/AIDS. For instance, a regional program funded by STAR EC was aired on NBS every Monday attracting DHOs from the region for discussions issues on HIV/AIDS.

Districts reported high HIV/AIDS related stigma levels and called for strengthening of advocacy. It was noted that there is also fear among some women who tested positive disclosing to their spouses for fear of domestic violence.

There was no much variance amongst drivers of the HIV epidemic in the districts visited. The reported epidemic drivers included alcoholism, multiple sexual partnerships, commercial sex work, low condom use, etc. However those established in Karamoja region were unique and included unsafe procedures during Female Genital Mutilation (FGM), forceful early marriages (without knowing the spouse’s sero-status), widow inheritance and Sexual and Gender Based Violence (SGBV) especially rape.

IEC/BCC materials were reported not well designed to suit the affected communities and that some of them had contradicting and misleading messages. Frequent reference was made to the messages of the 1990s which seemed to have impacted on people’s behaviors. Many districts suggested that the ‘drum’ advert should be replayed on radios and TVs.

HCT services were available in most health facilities including some Health center II. However, districts reported frequent stock outs of HIV testing kits and inadequate human resource to offer the services. This was despite presence of Implementing partners that provided buffers stocks. Uptake of general HCT services in the health facilities was reportedly fair in most districts. Populations considered at higher risk of HIV acquisition and transmission varied in between Districts. All the regions in the country however reported presence of Commercial Sex Workers, long distance truck drivers and Boda-boda riders.

In Busoga region, access to the lake made Fisher folk as a most at risk population in all the districts. All districts, which had fisher folk, decried the high HIV prevalence coupled with limited service delivery. It was for example reported that the population on islands in Namayingo was about 500,000 people with an estimated HIV prevalence of 28%, and some islands in Kalangala have a prevalence of 100% with the district average of about 27%. Services available were however from the mainland in Namayingo, only through outreaches supported by Star EC. Despite high transport costs since accessing such islands requires boats which are very expensive to hire.

PMTCT services in most Districts is offered at General hospitals, Health Centre (HC) IV and III with just a few at HCIIs. Ministry of Health rolled Option B plus to all districts and health workers have been trained to manage the activity. However some of the health facilities especially Health Centre IIIIs are not providing the service because of lack of drugs therefore referring the mothers to higher levels.

All districts reported very low levels of male involvement in PMTCT despite the incentives attached in some districts like Mama Kits and immediate attention for the women accompanied by their spouse. It was also reported that even those who come with ‘partners’ a big percentage
of them are not couples but a brought to shorted the long waiting time and also to benefit from the incentives.

Most Districts reported improved results of children born negative to HIV positive mothers. The statistics could not however be verified. Only Kole district reported about a 95% success rate (i.e. 5% babies’ positive despite mothers embracing PMTCT).

All the districts reported an overwhelming demand for safe male circumcision services. The youth reportedly demanded for the services more than other men, with some of them escaping from schools to seek the service. They were though unable to satisfy the demand due to limited human resource and supplies.

It was established that accessibility to condoms in all the districts had greatly improved in all the districts since the last supervision exercise. This was attributed to the presence and functionality of condom focal persons in all the districts visited and improved supply from NMS and some NGOs. Condom supply was reportedly good especially in districts that had programs supported by NGOs in all the districts. These programs were credited to have scaled up awareness about condoms. The Youth were said to be more consistent with the use of condoms compared to the adults (and or married). Unfortunately, it was reported that some clients to sex workers like fishers in Namayingo district could pay more for sex without a condom because they feared the lake more than HIV. The female condoms were found to be very unpopular compared to the male condoms that even some health workers confess to never seeing a female condom.

All district hospitals, HCIV and some HCIII were found offering Anti-retroviral Treatment (ART). Anti-retroviral drugs (ARVs) were in good supply over the last 6 months. However some health facilities at times run out of some formulations but managed through redistribution amongst the health facilities. The Ministry of health together with partners have accredited several health facilities to provide ARVs but some of them are not yet functional because of lack of drugs and trained personnel.

The Social support and protection thematic area is poorly facilitated by districts and implementing partners. Few Implementing partners are involved in social support and protection and the data is very scanty.

The political leadership in most of the Districts was supportive of the HIV/AIDS response. Most Districts had therefore established coordination structures (i.e. DHACs, DATs). Some of these coordination structures were functional with support from implementing partners. For instance, in Karamoja region, AMICAALL supported the merging of DATs and DHACs and facilitated periodic meetings. West Nile region, some districts were supported by BAYLOR (U) to conduct district coordination meetings.

All in all though, the majority of district and sub county coordination structures were not functional due to lack of facilitation and induction of newly elected or appointed officers. The 10 Million grants from Partnership fund will be of great use to revitalize the Coordination structures

Most Districts where in the process of revising their HIV/AIDS strategic plans and aligning them to the National strategic Plan UAC has distributed the planning guidelines.
PLHIV networks in most Districts were active and supported by NAFOPHANU and NACWOLA. They reported regular meetings were members of DAC. In several districts, they were involved as expert clients at ART sites, where they offered counseling and patient follow up.

With Exception of Amudat district in Karamoja region, all districts in the country have HIV/AIDS implementing partners. Implementing partners included (not limited to); STAR E, STAR- EC, PREFA, Baylor, UNICEF, MJAP, Goal, ICOBI, STAR SW and AMICAALL in several some Urban Local Governments.

It was noted that most district activities are still Donor driven and districts lack strategic and operational plan to guide the implementation. Therefore this calls for joint planning between partners and districts so that both strategic and operational plans are in place after consensus with an agreed up roadmap for implementation.
INTRODUCTION
The Uganda AIDS Commission has a mandate to coordinate and lead the National HIV and AIDS response. In so doing, UAC developed strategic documents to guide the National HIV/AIDS response. These include the National Strategic Plan, National priority Action Plan, National Prevention Strategy and the M&E Plan. These documents were disseminated to all Stakeholders in the National Response including the Local Governments. All players are to align their activities to these key documents to ensure harmony. To ensure coordination of implementation of HIV and AIDS activities at Local Government level, Coordination Committees were established. Guidelines were developed and disseminate to guide the process.

In this regard, Uganda AIDS Commission carries out Quarterly Support Supervision visits to assess the levels of implementation of HIV/AIDS activities in the Local governments and also follow up the functionality of these coordination structures. These support supervision visits also help in generating information for compilation of annual reports for the National response as is required of the Coordinating body (UAC).

Purpose
The purpose of conducting the exercise was to provide a forum for joint discussion of HIVAIDS Coordination in the district, identify challenges and make recommendations to different stakeholders for improved response to the epidemic.

Specific objectives
1. Disseminate the 2013 Aide Memoire with 10 key undertakings
2. Provide feedback in respect to previous support supervision conducted.
3. Establish the progress on implementation of commitments following the dissemination of the UAC HIV prevention messages in the regions.
4. Share challenges and propose recommendations for improvement.

Methodology
Supervision teams were allocated based on nine identified regions in the country i.e. Busoga, Bugisu, West Nile, Lango & Acholi, Teso & Karamoja, North Buganda, South Buganda, Toro & Buyoro and Ankole & Kigezi from these regions 3 districts were selected. The selection criterion was based on the previous support supervision visits and regional review meetings. Districts which had more problems and critical issues to follow up were prioritised. Each region was visited by 2 – 3 technical officers from UAC. Other stakeholders (Ministries, SCE and CSO) were not included this time because of limited funding.

A standard tool was developed and shred among the team which acted as a guide for quality control and uniformity.
Joint meetings with District AIDS stakeholders were held with members of the District AIDS Committee (DAC) in all districts visited. Each meeting was chaired by either CAO, DHO or a representative. The meetings were highly consultative and participative. The Focal Persons shared updates on all activities for all the four thematic areas of the NSP.

Site visits to selected implementing partners were also made. During such visits, one on one discussion was held with the partners. Observation of the implementing sites was also done.

UAC gave feedback on the following: JAR undertakings, support to the 60 districts under the Decentralised Response and the upcoming dissemination of the coordination and planning guidelines scheduled for March 2014, E-mapping (phases 1 and 2) and HIV/AIDS information User needs assessment.

**FINDINGS**

The report highlights findings in relation to the UAC mandate in the national HIV/AIDS response and the supervision guide developed.

**PREVENTION**

*Community structures, Advocacy, Behavior Change, MARPs and HCT*

There is general HIV/AIDS awareness creation in the districts conducted by district staff, supported by major implementing partners. Sensitization is done at all levels particularly through health talks, Drama and radio talk shows. MARPs are mobilized by VHTs and reached through HCT outreaches.

Presidential Initiative on AIDS and Communication for Young (PIACY) programmes are conducted in some schools in the Karamoja region e.g. In Kaabong, PIACY activities are conducted twice a week in schools (52 primary schools, 16 Community Schools, 11 Alternative Basic Education in Karamoja (ABEK) centers and 3 secondary schools). The few available IEC materials are written in English language. There is need to avail more translated IEC materials in the two districts. The talking compound sign posts in the schools are old and with faded messages. There is Behavioral Change Communication (BCC) activities done. An estimated 49,653 people in Katakwi district in 6 sub counties of Toroma, Majoro, Usuk, Ongongoja, Omodi and Amiyo were reached with BCC messages by Teso Rural Development Organization (TERUDO) supported by Civil Society Fund by the third quarter.

In Kanungu, Peer educators were formally supported by TASO but unfortunately closed out services. It was indicated that about 1,933 VHTs were trained, equipped with bags, boots, T shirts and contraceptive boxes. Family planning and sexual reproductive health are activities
being for inclusion onto the curriculum for VHTs. It was also noted that AIC carries out HIV testing community outreaches. The Civil Society Fund is said to be supporting Behavior Change Communication interventions in districts where it exists.

In some districts like Kanungu, UNFPA was reported that have worked in collaboration with AIC to provide youth friendly corners where a number of activities are undertaken including In door games.

There is was good participation of political and civic leaders during advocacy for HIV/AIDS in all districts. In Jinja District for instance, the CAO had dedicated an hour during every last Friday of the month for discussion about HIV/AIDS to enable create awareness and formulate ideas for responding to the Epidemic.

In most districts, World AIDS and Philly Lutaaya days are the most commemorated advocacy events. This was made possible by support from partners. During those events, most districts reported conducting HCT alongside other activities. District leaders reportedly always incorporated HIV/AIDS in their addresses to the congregations.

Most districts with Local FM radio stations had an allocation of free airtime or discounts for HIV/AIDS. For instance, a regional program funded by STAR EC was aired on NBS every Monday attracting DHOs from the region for discussions issues on HIV/AIDS.

Districts reported high HIV/AIDS related stigma levels and called for strengthening of advocacy. It was reported that due to stigma, some people secretly access ARVs and other services. It was noted that there is also fear among some women who tested positive disclosing to their spouses for fear of domestic violence.

There was no much variance amongst drivers of the HIV epidemic in the districts visited. The reported epidemic drivers included alcoholism, multiple sexual partnerships, commercial sex work, low condom use, etc. However those established in Karamoja region were unique and included unsafe procedures during Female Genital Mutilation (FGM), forceful early marriages (without knowing the spouse’s sero-status), widow inheritance and Sexual and Gender Based Violence (SGBV) especially rape, which was a norm. Similarly, the pastoral Bahima in Kyankwanzi district were reported to have a cultural practice of sharing of wives with relatives putting them at high risk of infection.

IEC/BCC materials were reported not well designed to suit the affected communities and that some of them had contradicting and misleading messages. Frequent reference was made to the messages of the 1990s which seemed to have impacted on people’s behaviors. Many districts suggested that the ‘drum’ advert should be replayed on radios and TVs.

HCT services were available in most health facilities including some Health center II. However, districts reported frequent stock outs of HIV testing kits and inadequate human resource to offer the services. This was despite presence of Implementing partners that provided buffers stocks. Uptake of general HCT services in the health facilities was reportedly fair in most districts. Moonlight testing services were found at Paidha, Zawa in Zombo, Naluwere in Bugiri and some other hot spots. These were reported to offer good opportunities for MARPS whose operations were at night.
Populations considered at higher risk of HIV acquisition and transmission varied in between Districts. All the regions in the country however reported presence of Commercial Sex Workers, long distance truck drivers and Boda-boda riders.

The districts which are traversed by highways e.g. Jinja, Buikwe, Iganga, Bugiri, Tororo, Kampala, Masaka, Mbarara, Kabale, Lira, Gulu; reported high levels of sex work in hot spots. Commercial sex work was attributed to presence of long distance truck drivers. Some control measures were present in the hotspots but district authorities along the Sudan highway reported absence of services.

In Busoga region, access to the lake made Fisher folk common amongst all the districts. However some other districts like Rakai in North Buganda, Apac in Lango region and Kasese in western region also had fisher folk at fishing villages. All districts, which had fisher folk, decried the high HIV prevalence coupled with limited service delivery. It was for example reported that the population on islands in Namayingo was about 500,000 people with an estimated HIV prevalence of 28%, and some islands in Kalangala have a prevalence of 100% with the district average of about 27%. Services available were however from the mainland in Namayingo, only through outreaches. Despite high transport costs since accessing such islands requires boats which are very expensive to hire.

Many new districts in Karamoja, Teso, Lango, and Acholi regions reported low levels of Sex work though also noted its’ progressive increase in the urban slums. In some districts, the youth at school who reside in Hostels were considered ‘modern’ sex workers because of their vulnerability. This was reportedly due to failure of parents and schools to manage the youth’s behaviors coupled with insufficient HIV/AIDS interventions at schools. Targeted interventions for sex workers were reportedly conducted by partners in some districts of Karamoja region, Bugiri, Jinja among others.

**Biomedical interventions**

**Prevention of Mother to Child Transmission (PMTCT)**

PMTCT services in most Districts is offered at General hospitals, Health Centre (HC) IV and III with just a few at HCIIIs.

Ministry of Health rolled Option B plus to all districts and health workers have been trained to manage the activity. However some of the health facilities especially Health Centre IIIs are not providing the service because of lack of drugs therefore referring the mothers to higher levels.

All districts reported very low levels of male involvement in PMTCT despite the incentives attached in some districts like Mama Kits and immediate attention for the women accompanied by their spouse. It was also reported that even those who come with ‘partners’ a big percentage of them are not couples but a brought to shorted the long waiting time and also to benefit from the incentives.
Most Districts reported improved results of children born negative to HIV positive mothers. The statistics could not however be verified. Only Kole district reported about a 95% success rate (i.e. 5% babies’ positive despite mothers embracing PMTCT). High stigma levels were reported to deter mothers from adherence to pre and post-delivery treatment/services. Most districts reported good turn up for ANC services but poor turn up for delivery; with most deliveries done by TBAs and private facilities where HCT is not provided.

Even after enrolment to the PMTCT program, there was a high level of loss to follow up. Most districts do not proper follow up structures at community level.

**Safe Male Circumcision**

All the districts reported an overwhelming demand for safe male circumcision services. The youth reportedly demanded for the services more than other men, with some of them escaping from schools to seek the service. They were though unable to satisfy the demand due to limited human resource and supplies.

Most of the districts were supported by partners in capacity building, facilitating outreaches and providing supplies to health facilities, especially hospitals and HCIV. Due to shortage of staff, some of the health facilities only conducted static services. Disposal of the instruments used is a big challenge although the Jinja Steel rolling mill has been contacted to collect and recycle the equipment but there is limited awareness among stakeholders.

Some misconceptions were reported about SMC. They included:

- Some Communities belief that circumcision is 100% protective against HIV
- Some people associate SMC with Bagisu culture and Islam religion
- In order to avert bad omen, circumcised men should have sex with a person who is not their marital partner

**Condoms**

It was established that accessibility to condoms in all the districts had greatly improved in all the districts since the last supervision exercise. This was attributed to the presence and functionality of condom focal persons in all the districts visited and improved supply from NMS and some NGOs. Condom supply was reportedly good especially in districts that had programs supported by NGOs in all the districts. These programs were credited to have scaled up awareness about condoms.

Male Condoms were found distributed through PMTCT, HCT sites and outreaches. VHTs, expert clients, PLHIV networks and community resource persons were engaged to distribute at community level. Some districts had targeted distribution to lodges, fishing communities, trading centres, armed forces among others.

The Youth were said to be more consistent with the use of condoms compared to the adults (and or married).
Unfortunately, it was reported that some clients to sex workers like fishers in Namayingo district could pay more for sex without a condom because they feared the lake more than HIV. Poverty was said to be a key driver forcing women into unprotected sex because of the immediate extra financial rewards for unprotected sex. Meeting participants also noted that use of condoms in stable relationships was difficult because it was associated with ‘cheating’.

**Female condoms:** Female condoms were not much known to the communities except among the elites. Their distribution and utilization was also very low in all the districts. This was largely attributed to the low levels of awareness.

With exception of Karamoja region communities, most districts had no negative attitudes towards condoms. The major challenges were condom stock outs as well as publications reporting 'fake' brands on the market. It was also reported that condoms sold in shops were expensive while those supposed to be free were also sold. Entertainment hotspots in all districts were noted as never targeted for condom distribution.

**Care and Treatment**

All district hospitals, HCV and some HCIII were found offering Anti-retroviral Treatment (ART). Anti-retroviral drugs (ARVs) were in good supply over the last 6 months. However some health facilities at times run out of some formulations but managed through redistribution amongst the health facilities.

Pediatric formulations for anti-TB medications and Nivrapine Syrup were reported out of stock some districts visited. Other challenges noted under care and treatments were:

- There was a high loss to follow ups of mobile populations on treatment. This was reportedly due to non-functional community structures like the VHTs
- The burden of offering ARVs was very high resulting from insufficient human resources. Staff attrition was also high hence challenging sustainability of services.
- The districts reported insufficient capacity for quantification and management of ARVs
- Some accredited health facilities were not yet functional due to management inefficiencies. Almost all the newly accredited health facilities are not functional reportedly due to lack of drug because they have not yet accessed the credit line from National Medical Stores.
- TB and HIV collaboration has improved with every TB patient investigated for HIV and vice versa in places where both services are available. GeneXpert Machines at Regional Hospitals, Rakai Health Services and St. Anthony Hospital in Tororo have improved the diagnosis of TB in Children and Multi Drug Resistant TB.

**Social Support and Protection**
The Social support and protection thematic area is poorly facilitated by districts and implementing partners. Few Implementing partners are involved in social support and protection and the data is very scanty.

- In Otuke PACE Positive Living Project has been implemented at Orum HC IV project site, distributing starter kits to PLHIV, involving PLHIV in peer education and counseling amongst others.

- In Kole the known support provided is by Social Assistance Grant for Empowerment (SAGE) programme supporting the elderly who take care of orphans and World Vision who have a nutrition component for malnourished HIV+ children at Aboke HC IV.

- AWARE Uganda is offering social support to the needy orphans in Kaabong and over 250 orphans are supported. However no partner is targeting psychosocial support to the communities.

- OVC benefited from Livelihood activities under Northern Uganda Social Action Fund (NUSAF), however the district cannot verify the numbers supported.

- ADRA has supported 30 HIV positive members of “Atoma youth groups” in Kaabong Town Council.

- TERUDO and KGWDI have supported 40 OVC In total (40 and 20 ) respectively with income generating activities in areas of piggery and goat rearing in Katakwi district.

- In Kween district, Compassion International supports OVC in Kaberone sub-county while in Sironko district SPEAR/ World Vision Program provided some nutritional support. In all the three districts, support for OVC is in

- In Maracha district, nutrition is provided as treatment component to malnourished HIV+ children although there is no support given in Nebbi District.

- Kanungu reported that SDS supports a complete program for OVCs but indicated a limitation in Food and Nutrition. It was reported that some Food Supplements are also given to OVCs.

**Systems Strengthening**

**Coordination Structures**

The political leadership in most of the Districts was supportive of the HIV/AIDS response. Most Districts had therefore established coordination structures (i.e. DHACs, DATs). Some of these coordination structures were functional with support from implementing partners. For instance, in Karamoja region, AMICALL supported the merging of DATs and DHACs and facilitated periodic meetings. West Nile region, some districts were supported by BAYLOR (U) to conduct district coordination meetings.
All in all though, the majority of district and sub county coordination structures were not functional due to lack of facilitation and induction of newly elected or appointed officers. The 10 Million grants from Partnership fund will be of great use to revitalize the Coordination structures

**Human resources for HIV**

The districts report improvement in the staffing levels at the health facilities following the recruitment drive to fill the approved posts to 100% at Health Centre III. Some districts report up to 90% of the posts being filled. Important to note is that some of the health workers recruited have not been trained in provision of ART and Option B+

- Generally supply chain management has improved as trainings were supported by NUHITES and supply of ARVS are somewhat, stable. Test kits remain a problem as there are frequent stock outs reported in Most Districts. STI drugs are always inadequate supposedly due to the push system.

- In Northern Uganda, NUHITES supported the recruitment of critical health workers in these Districts and are paying their salaries for the project period. Districts have signed Memoranda of Understanding with NUHITES Committing to take over payment of salaries at the end of the project period, but will the wage provision given by Ministry of Finance and Public Service be adequate to bear this responsibility?.

- Training of Health workers on SMC, Option B+, health records management and QI were supported by NUHITES in Northern Uganda.

- World vision has supported trainings on Nutrition in Kole while Ministry of Health trained in EPI and syndromic management of STI’s.

- CUAM had trained 14 health workers in lower centers in the management of EMTCT activities in Kaabong district

- In Sironko District, 21 people were trained as VHTs in every sub-county in areas of HIV and malaria and proposal was submitted to SDS to scale up the training of health workers and community resource parsons.

- The Village Health Teams are very functional in some districts. In Maracha district 75 village health teams have been trained by Baylor.

**Planning, reporting and accountability mechanisms**

Most Districts where in the process of revising their HIV/AIDS strategic plans and aligning them to the National strategic Plan UAC has distributed the planning guidelines.
PLHIV networks in most Districts were active and supported by NAFHOPANU and NACWOLA. They reported regular meetings were members of DAC. In several districts, they were involved as expert clients at ART sites, where they offered counseling and patient follow up.

The major challenge in all districts was the insufficient integration of HIV/AIDS with development programs like NAADS, Education sector etc. as would be expected with full mainstreaming.

Ministry of health provided a revised web based Health Management System (DHIS II) that captures health facility HIV/AIDS data. It was found that All Districts had trained data entrants for the web based system with improved reporting noted.

Some like Mayuge, Mbale, Jinja, Mbarara, Luwero among tohers had established libraries with HIV/AIDS information. Similarly, most Districts were supported by partners like NUMAT and STAR-EC, to conduct LQAS Surveys.

The major challenges reported included:

- Varying reporting needs from the partners created a desire for a more harmonized National response reporting
- Apart from the HMIS, the other sectors’ Management Information Systems were almost non-functional in all districts
- Some hard to reach districts like Namyingo and Otuke lacked; computers, access to internet as well as reliable power sources to run the equipment
- Despite training of VHTs, community reporting did not feed into the M&E system of the Districts

**Partner Availability**

With Exception of Amudat district in Karamoja region, all districts in the country have HIV/AIDS implementing partners. Implementing partners included (not limited to); STAR E, STAR- EC, PREFA, Baylor, UNICEF, MJAP, Goal, ICOBI, STAR SW and AMICALL in several some Urban Local Governments.

Several CBOs and CSOs; funded by Civil Society Fund (CSF) and other organizations, were also present in the districts. Overall though, coordination of the implementing partners as well as their operations was sub optimal in all districts due to insufficient funding.

With exception of AMICAAL and TASO that were reported targeting sex workers in Moroto district, other districts which ably identified their key populations did not report any implementing partner targeting MARPS. They generally programed for MARPs amongst the general population rendering services inappropriate for those who worked at night. The list of partners found in different districts can be accessed from the E- mapping database on the UAC website (www.aidsuganda.org)
CHALLENGES TO THE SUPERVISION EXERCISE

- The protracted planning exercise hindered access to Partnership funds therefore not allowing the extended supervision involving partners and few districts being covered.

- Some vehicles are not in good mechanical conditions often requiring repairs yet the budget does not cater for emergency repairs.

CHALLENGES TO THE DECENTRALIZED HIV/AIDS RESPONSE

- It was noted that most district activities are still Donor driven. This posed concerns about sustainability of the interventions

- Majority of the districts do not have strategic plans which would be used as a resource mobilization tool, however, some districts have draft plans while others are in the process of developing them.

- Districts are just in the process of harmonizing the coordination structures, so some extend they have not been fully functional.

BEST PRACTICES

The following best practices were observed during the supervision period.

1. Collaboration between district local governments and media centres to provide audience and airtime for dissemination of information and dialogue on HIV/AIDS

2. Engagement of Implementation Partners in the development of Strategic Plans
## RECOMMENDATIONS

<table>
<thead>
<tr>
<th>Investment framework</th>
<th>Recommendations</th>
<th>Responsibility</th>
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</table>
| Community structures and behavioral interventions | • Map out all the key populations by their respective districts for targeting during planning and implementation  
• Harmonize and disseminate IEC and BCC messages  
• Craft messages which instill fear like 'the drum' to initiate positive behavior change  
• Districts should implement the resolutions arising from the dissemination of HIV prevention message dissemination.  
• Provide comprehensive service packages for MARPs | Districts and Partners, UAC and MOH |
| Condoms                                           | • Procure and distribute adequate quantities of male and female condoms  
• Establish and strengthen condom distribution channels in communities | MOH and NMS |
| PMTCT                                             | • Roll out Option B plus to all districts up to HCIIIs  
• Build capacity for both ART and option B+ provision | Districts, MOH Partners |
| Care and Treatment                                | • Functionalize all the accredited Health centres for ART provision  
• Improve the supply chain for ART commodities (Pediatric formulations inclusive)  
• Establish community structures for follow up of patients on treatment | Districts, MOH and NMS |
| HCT                                               | • Procure and distribute adequate test kits and other supplies  
• Intensified community mobilization and sensitization for HCT | MoH, UAC & Districts |
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<tr>
<td></td>
<td>services utilizing the established methods like MOH Vans and community structures.</td>
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<tr>
<td>Safe Male Circumcision</td>
<td>• Institutionalize and develop capacity for SMC targeting sustainability</td>
<td>UAC and MOH</td>
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<td></td>
<td>• Develop harmonized messages to deliver correct information about SMC</td>
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<td>Coordination structures</td>
<td>• Review coordination guidelines and induct members</td>
<td>UAC</td>
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<td>• Engage all leaders in the response e.g. The President’s support is key and a motivator to all stakeholders involved</td>
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<tr>
<td>Planning and Mainstreaming</td>
<td>• Review and disseminate planning guidelines at district level</td>
<td>UAC and partners</td>
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<td>• Support districts to develop Strategic Plans</td>
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<td>• Build decentralized capacity for mainstreaming of HIV/AIDS</td>
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<td>• Fund the district HIV/AIDS strategic plans</td>
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<td>Advocacy</td>
<td>• Support districts to commemorate all advocacy events</td>
<td>UAC and partners</td>
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<td>• Strengthen district linkages with cultural and religious institutions</td>
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<td>• Solicit partners and strengthen social support interventions</td>
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<tr>
<td>Monitoring and Evaluation</td>
<td>• Build Capacity and retool districts for M&amp;E</td>
<td>UAC, MOH and partners</td>
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<td>• Harmonize data collection tools and strengthen all sector MIS systems</td>
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CONCLUSIONS

1. Though there has been progress in the implementation of HIV/AIDS activities in the districts visited, there are still challenges especially in the Behavioral interventions as very few partners are implementing them. This is worsened by the fact that there are no data collection tools for targeting behavioral interventions.

2. The Ministry of Health together with partners made great strides in accrediting many health centres for provision of ARVs but most of them have not been operationalized. With plans of implementing the New WHO guidelines for initiation of ARVs, there will be increased demand for ARVs requiring functional health facilities.
Annex 1

Comments from Focused Group Discussions (FGDs)

‘HE The President’s comments on interventions like condom use, SMC have a big impact on the strategy. His support is key and a motivator to all stakeholders involved’ (FGD, HIVFP, Bugiri)

‘The UAC Secretariat should be more involved in supporting the Districts to Engage the Partners working in the various locations. In addition, Districts should map out all partners operating in their areas to ensure that no duplication, mediocrity and fronting of Partners personal agenda rather the National response should be supported by all stakeholders’ (FGD, Kaliro)

‘At District level, coordination need to be strengthened for active dialog, advocacy and the mainstreaming’ (DAC meeting, Luuka)

Emerging issues from most districts

Intensifying community health education through community mobilization and sensitization

- **IECs:** The initial messages of the 1990s were more informative and painted the real picture about HIV/AIDS (aggressive campaign). The current message are well colored yet carry less impact
- **Community mobilization and sensitization** It was noted that Film vans made impact in the 1990s in sensitizing communities
- **Village drama groups of PHAs** Also passed on the message so articulately when they were still very vibrant however, with phasing out of funding, these interventions also died out
- **Positive parenting:** Tertiary institution hostels and self renting female students identified as MARPs (commercial sex), the need to engage parents to positive parenting to save the youth
- **Need to have another CHAI Project to economically empower those affected by the Epidemic**
Annex 4: The support supervision tool for Q 3 2014

Support supervision tool/checklist

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<th>DISCUSSION WITH DAC MEMBERS</th>
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**Community outreaches**
- Presence of community HIV/AIDS programme
- Access to HCT services and referall (availability at lower level health facilities such as HC IIIs, community outreaches)
- Behavioural Change interventions
- MARPs and interventions targeting them (by who, future plans)

**Boimedical interventions**

**EMTCT/SRH**
- eMTCT services (Option B+)
- Assess ANC visits vs. number of deliveries in the health facility. (Innovations to improve ANC, eMTCT).

**SMC**
- SMC services
- Training of teams, availability of logistics
- Success and challenges

**Condom services**
- Distribution mechanisms (Availability, sources, outlets)
- Challenges and success stories

**Care and treatment**
- Access to ART and support services (for both adults and children)
- Accreditation process
- ARVs and drugs for treatment opportunistic infections
- TB and HIV Collaboration

**Social Support and protection**
- OVCs and livelihood support services including food and nutrition
- Who supports OVCs
- GBV services
**Systems**

**Human resources for HIV/AIDS**
- Overall human resources for health at health facility
- Cadres of staff/staffing levels
- Health infrastructure

**Coordination of district HIV response**
- Coordination structures (Existence and functionality)
- What strategies has the district put in place to fund and sustain HIV interventions
- The functionality of VHT
- PHA networks and activities

**Accountability mechanisms**
- Existence and implementation of HIV strategic/action plans
- Mechanisms for reporting/IPs aspects/Overall data generation and use
- Review of IPs plan and sharing of budgets
- How would you propose ADPG to better focus their support
- How has the district integrated and mainstreamed HIV services

**Supply chain management/commodities**
- Availability of commodities and supplies (condoms, ARVs, HIV test kits)
- Performances of the EMHS supply chain (timely ordering, timely delivery, completeness of orders vs. supply, updates on available funds).
- Assess performance of the push system to Health Centre IIIs and IIs.

**Others**
- Media, Religious and Cultural leaders involvement
- HIV/AIDS Research
- Implementing partners and their coverage

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**C: DISCUSSION WITH IMPLEMENTING PARTNERS, CSOS AND PLHIV**

- Share experiences on how IPs have supported the district in coordination and reporting
- Mechanisms for programme sustainability
- In which areas would IPs need ADPs to engage LG and Government

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**Report summary**

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<th>Area of focus</th>
<th>Recommendation/Action(s)</th>
<th>Responsibility</th>
<th>Time frame</th>
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<td>Commitments during the dissemination of the HIV Prevention message</td>
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