On the theme: Strengthening Competencies for Participatory Planning and Budgeting for Effective Local Level Delivery of Services

Participatory Health Service Delivery: The fight against HIV/AIDS in Uganda

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PARTICIPATORY HEALTH SERVICE DELIVERY: THE FIGHT AGAINST HIV/AIDS IN UGANDA.

1.0 HIV/AIDS OVERVIEW:

The history of the HIV/AIDS epidemic in Uganda dates back to 1982 when the first case of ‘slim’ – wasting disease was reported in a fishing village in Rakai District, Southern Uganda. Progressively more cases of ‘slim’ were reported but not much was known about the disease till in 1984 when it was confirmed as the Acquired Immuno-deficiency Syndrome (AIDS) caused by the human immuno-deficiency virus (HIV). Progressively and rapidly, the disease spread from major towns along the busy highways into the small towns and subsequently to the rural areas. To date HIV/AIDS has been reported in all districts in Uganda. Infection rates peaked in 1992 with the worst affected urban areas registering rates of over 30%. However, there has been significant decline from 18% (1992) to 6.4 % (2005).

The National Resistance Movement (NRM) took over power in 1986. In the same year, Uganda’s Minister of Health announced the existence of HIV/AIDS in the country during the World Health Assembly in Geneva. This admission though not welcomed by most African leaders, marked the beginning of openness about the epidemic and served as a springboard for mass awareness campaigns spearheaded by President Museveni himself. This slowly demystified the disease as people gained more insights about their vulnerability to the infection as well as information about prevention measures.

1.1 Government Response

A structured Government response to the HIV/AIDS epidemic dates back to 1986 when an AIDS Control Programme was established in the Ministry of Health. The Health sector has since been the backbone of the country’s response. Later, in recognition of the fact that HIV/AIDS had multi-sectoral causes and consequences beyond the mandate of

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the health sector, the Uganda AIDS Commission (UAC) was established in 1992 by a Statute of Parliament and placed under the Office of the President. The mandate of UAC is to coordinate all activities related to the epidemic in the country. Immediately after its establishment, the UAC prepared the Multi-sectoral Approach to the Control of AIDS (MACA) to provide a policy direction to national efforts for fighting the AIDS epidemic and also produced a National Operational Plan to implement the policy. The underlying principle of the MACA was that persons individually or collectively have a responsibility to fight the epidemic. The main features of MACA were; to emphasize the involvement of private and public actors, individuals and groups from highest political level to the grassroots and stressing the need for organizational/institutional capacity building for sustaining the activities at all levels.

Uganda’s participation in the international fora and being party to the declarations enabled the country to respond to the epidemic early and continuously through the development of appropriate strategies. The above strategies were guided by the WHO strategic Plan of 1985/86 that was developed to respond to the disease.

1.2 Health service delivery system in Uganda

In the mid 1960s, Uganda had one of the best health care systems. However, the military coup of Idi Amin in 1872 followed by the civil war, economic decline and structural adjustment related cuts that took place between 1976 and 1988 adversely affected public health service delivery systems.

As a response to such problems, Government embarked on, health sector reforms in 1987 in form of broad decentralization of health services, privatization, broadening the health financing to introduce user charges and community prepayment schemes on public facilities and broadening the provider mix with emphasis on effective use of non governmental resources, which all aimed at freeing resources that could eventually be spent on the poor.
The decentralization process on the other hand started in 1986 with power decentralized through Resistance Councils and reinforced as a government policy for effective service delivery in the 1995 Constitution. The Local Government Act, which put into effect the provisions of the Constitution was passed in 1997 and substantially devolved powers previously exercised by the central government to the District Local Authorities.

With the restoration and rehabilitation of social services by the NRM Government, Uganda has witnessed a complex relationship of Health Care Delivery System involving public and private sector provision, thus relieving the Ministry of Health the burden of solely providing health care services to the populace. The MOH through the Decentralization development Policy was restructured to perform more of a coach role than as a player; hence making the Ministry of Local Government a key intermediary between Local Authorities and the Central Government.

2.0 The Fight against HIV/AIDS in Uganda: A local level Perspective

2.1 Decentralization and the provision of health services

The decentralized system is based on the district as a unit under which there are lower local Governments and administrative units. The health care delivery system was designed along this decentralized public system, with a corresponding health unit for each level of local government or administrative unit

2.2 Levels of health service delivery at local levels

The health care delivery system at local levels in Uganda is multi layered with services provided from Health Centre 1-1V as lower units, and with each district having a hospital at the top of the hierarchy. This structure plays a critical role in health care service delivery. For example, the implementation guidelines for scaling up ARV treatment in Uganda outline primary and community home based care model with the
The ultimate goal of ensuring that ARV therapy services are expanded down to Health Centre IV level, with follow up and support extending to Health Centre levels III to I as explained below.

a. Health Center IV, which is the outpatient department refers the PHAs to a physician for assessment or to be reassessed, Counseling and psychosocial support, revises treatment plan and refers back the patient to the health centre. (ARV therapy). This is normally run by the District Health Services Department.

b. Health Centre III at the sub county level, carries out follow up of people in therapy, supplies drugs, carries out check ups, on going counseling and encouragement, identifies problems and makes referrals to hospital outpatient department. Its facility based with a nurse in charge with a maternity delivery service and a midwife in charge.

c. Health Centre II is run at the parish level, facility based, with a nurse in charge and some few community volunteers who carry out follow ups and other support exercises to PHAs

d. At level I are community based organizations/Initiatives and groups mainly composed of Community Health Workers who carry out such functions as motivation to PHAs, Educating PHAs and their families in therapy, applying an approach of using directly observed therapy for TB, informing Health Centers of the problems as well as linking with community organizations and groups for social and material support.
The above graphic model illustrates how support services are extended to the most remotely located PHAs and at the basic level, management of opportunistic infections is carried out regardless of whether one is on ARVs or not. In this case, community health workers identify clients and refer them to more comprehensive services at higher health care service levels, linking communities through CBC, to access palliative care and management of pain for PHAs.
3.0 Role of the Central Government

At national level, the Ministry of Health is largely responsible for policy and technical guidance. All national referral and regional Hospitals provide ARVs and TB therapy, treatment of other opportunistic infections as well as providing palliative care for those in need of it.

However with increasing numbers of PHAs it’s a necessity that other stake holders are brought in to assist Government to provide similar services thus through the guidance and coordination by UAC on issues of HIV/AIDS, under the NSF, the 3 ones are made meaningful at local Government level.

Within the Ministry of Health, the Drug Access Initiative, set up by the national advisory board, carries out the following functions below:

- Recommends to government on HIV related drug policy for instance the currently available therapies
- Estimates the country’s needs for HIV related drugs
- Recommends policy for the public health sector in relation to the rationale prescription, distribution and use of HIV related drugs as well as advising on regulations for privately funded purchases
- Recommends objective criteria for the profile of people who may participate in the above initiative
- Suggests an action plan for the improvement of health care infrastructure where necessary to make ARV therapy widely accessible in the country

3.1 The national policy framework and plans

- Uganda adopted the multi- sectoral approach to the control of HIV/AIDS and calls upon participation by all sections of society to respond to all aspects of causation, effects and disease management.
- Development and application of MACA: The National Aids Policy (NAP) and the national Strategic Frame work on HIV/AIDS activities
- Introducing sector specific and thematic policies guidelines and standards at all levels driven from the NAP and NSF
- Formation of AIDS Partnerships to bring all stake holders (in different categories) on board
- Established a coordination mechanism of HIV/AIDS response at local level aimed at translation of the 3-ones principle at decentralized level
- The Decentralized Response through the framework of Self-Coordinating Entities of AIDS Partners exists at the national level to streamline and strengthen coordination of HIV/AIDS response at decentralized level

4.0 Role of Local Governments

Local governments are important players in the fight against HIV/AIDS for they are the level of government closest to communities. They constitute the level of service delivery where the causes of vulnerability to HIV/AIDS and the consequences on the grassroots communities are much more felt and can at the same time be addressed.

With in the national response, the local governments are mandated to guide and coordinate AIDS mainstreaming at district and lower levels and to promote a multi-stakeholder response to the epidemic.

The Decentralization Act 1997 (Part2, second schedule), provides for roles by local governments to directly manage HIV/AIDS at decentralized level, as well as monitoring the delivery of services within their areas of jurisdiction. The Act, under section 81 also provided for the delegation of responsibilities from the higher local government to a lower one as long as any extra obligation transferred was fully financed.

The above mentioned section of the law provides an opportunity in the efforts to fight HIV/AIDS because it is an avenue through which higher local governments or central government could delegate a lower local government to undertake certain activities.
4.1 Coordination framework for HIV/AIDS activities in local governments

This framework was developed in 2002 and issued in 2003 by MOLG. They are provided in a two way system: Politically and Technically. The political side is led by Task Forces carrying out advocacy for attention to HIV/AIDS issues, Policy guidance, and community mobilization, strategic direction, partnership development and social mobilization.

On the other side, the technical side is concerned with planning, monitoring activities and resources and information sharing. At the Parish Level, both political and technical arms, these functions are combined.

They are mandated to carry out these activities by section (97) of the Local Government Act CAP 243. This kind of recommendation is aimed at promoting the application of Uganda’s Partnership Principles.

District HIV/AIDS coordination structures

District council  \(\rightarrow\) District AIDS task force  \(\rightarrow\) district AIDS committee

Sub county  \(\rightarrow\) SC AIDS task force  \(\rightarrow\) SC AIDS committee

Town council

Parish council  \(\rightarrow\) Parish AIDS taskforce

Village council  \(\rightarrow\) Village AIDS taskforce
4.2 Coordination functions – taskforces (dtfs)

- **Advocacy** – enhance and sustain cross-sectoral leadership, mobilization, commitment
- **Partnership development** – ensure all sectors are represented, have a voice and participate.
- **Knowledge management** – ensure that accurate data is received, documented, disseminated and utilized
- **Policy**
  - interpret national policy
  - identify policy gaps
  - ensure policy implementation
  - formulate byelaws to aid implementation

- **Planning**
  - Participate in and lead strategic planning, M&E
  - Submit reports to council

- **Resource Mobilization**
  - Assisting in resource mobilization for HIV/AIDS

- **Monitoring and Evaluation**
  - Coordinate support supervision with in the District Sub-counties

4.3 Coordination functions-committees

- Ensure a participatory approach at all LC planning levels in: situational analysis and needs assessment
- Develop an all encompassing district-wide integrated strategic plan for HIV/AIDS
- Submit annual work plans/action plans to taskforce
- Establish a practical monitoring and evaluation framework and report the processes.
- Ensure accountability, reporting and review of programmes
- Provide timely information to taskforce and other partners and obtain feedback
- Provide secretarial support to taskforces.

4.4 Role of the HIV/AIDS Focal Point

The AIDS Focal Point is appointed by the District Appointing Authorities and recommended by the Chief Administrative Officer (CAO) to the District Service Commission for endorsement with clear Terms of reference. The HIV/AIDS Focal Point finally reports to the CAO and District Technical Planning Committee. His/Her Office acts as the secretariat to the District AIDS Committee (DAC) and specifically handles such functions as advocacy, policy, planning, knowledge management partnership development, resource mobilization and Monitoring and Evaluation.

4.5 Why base on local council structures

- Because it responds to the threat to the people
- Mainstream HIV/AIDS activities in LG system
- Access to institutional resources
- Sustainability of response
- District ownership
- Stakeholders exchange ideas in democratic forum at same level
- Equity of services and resource provision to those in greatest need based on evidence
- Avail information to the district to measure district performance
- Work in a result-focused way
- Shared responsibility to promote coordination and to put these into practice.
4.6 Role of Civil Society Organizations

Openness, political support and commitment marshaled tremendous support, especially from the non-government, non-profit sector. By 1997, over 1200 agencies were implementing HIV/AIDS related activities in the country. These organizations were set up to respond to the needs of specific groups such as women, youth, children, People With Disabilities and workers/employees. The organizations range from; national NGOs with branches at various levels, district based NGOs, e.g. religious based hospitals, international NGOs, CBOs PHA networks, and the private business sector.

Private, non-profit organizations like The AIDS Support Organization (TASO) and faith-based organizations have greatly contributed to the well being of PHAs through provision of integrated services for care and prevention. This involves treatment of opportunistic infections, on-going social and spiritual counseling, home based care to relieve pressure on hospitals and provision of credit facilities for income generating activities and vocational skills building for affected family members especially orphans. Formation of post-test clubs at most of the centers provides the much needed social support to PHAs and is key in prevention and support activities in communities.

Some partners have focused on the issues of ethics and human rights generally and more especially for those infected and affected. The CSOs have systematically sensitized the public on the rights of an individual in the context of HIV/AIDS. Along with other awareness interventions, this has greatly reduced on PHA stigmatization and discrimination and reduced on the number of cases where relatives deprive widows and orphans of the deceased of their property.

These and more interventions by CSOs largely compliment the central efforts by Government and are supported in areas of advocacy to recruit more players and sustain action, information sharing to promote exchange of ideas and experiences and formulation of appropriate policies, standards and guidelines to guide implementation.
The Uganda AIDS Commission brings together these partners to review progress, identify gaps and set national priorities and strategies for implementation to ensure timely delivery and even coverage of prevention and care services. Over the years partners have made invaluable inputs into the coordination roles of the UAC and implementing sectors to promote harmony amongst key partners and unify the response.

4.7 Role of Private Sector

The advent of HIV/AIDS epidemic became a concern of private sector due to its impact. At broadest level, the private sector is dependant on the strength of the economies they operate in. As part of the multi-sectoral approach, the private sector is one of the self-coordinating entities in the Uganda HIV/AIDS partnership, which is an innovative coordination mechanism that brings together several players working in the area of HIV/AIDS in the country.

Through this mechanism the private sector shares their experiences, develop responsive interventions and organize peer support. In addition, they are able to coordinate and facilitate the implementation of the national HIV/AIDS policy in the world of work place, undertake resource mobilization, strengthen their capacity to respond to HIV/AIDS epidemic and monitor and evaluate their responses.

4.8 Role of AIDS Development Partners

As already mentioned above, the openness of Government about HIV/AIDS in Uganda made it easy for several development partners to join in the fight against the epidemic. It was then possible for Uganda to attain the level of awareness observed within relatively short period of time; make available and popularize the use of condoms; and involve the various actors in HIV/AIDS interventions.

Most donor agencies targeted their support mainly to specific thematic areas. For instance, in 1980’s and 90’s EU consistently financed the provision of safe blood
including rehabilitation of the National Blood Transfusion Services. Similarly, other partners, such as UNICEF has continuously focused on children interventions while UNFPA has addressed adolescents in the context of HIV/AIDS. WFP provides food to families affected by HIV/AIDS. UNDP and other development partners such as USAID assisted with the multi-sectoral approach.

Furthermore, international development partners such as bi-laterals, multi-laterals and UN agencies such as UNDP, UNAIDS, and UNIFEM, have since 1986 funded many HIV/AIDS related Programmes and projects. The Government has also dealt with the funding gap through external borrowing from such institutions as the World Bank to implement such Project as UACP and STIP (Sexually Transmitted Infections) which have all proved successful.

Participation in the UNAIDS pilot project on provision of ARV therapy facilitated the development of the necessary infrastructure for administering ARV drugs. However, the major hindrance to access has been the cost of these drugs. The National and global advocacy for price reductions has played a big role in enhancing the PHAs access to ARVs from around 1,200 since 1996 to above 60,000 in 2006.

6.0 Lessons learnt

a) Involvement of People living of HIV/AIDS has contributed greatly in the prevention and reduction of HIV/AIDS in Uganda. PHAs participate in sensitization and sharing experiences as a way of reducing stigma, denial and discrimination.

b) The Multi-Sectoral Approach to HIV/AIDS Control has helped government to provide services extensively hence a good example that a holistic approach to the epidemic is important

b) An understanding of local and religious values of various communities is essential for any successful strategy.
d) The involvement of civic, cultural and religious leaders as an approach used by the Government of Uganda has helped to deliver the message to many Ugandans thus an important approach

e) The political support and commitment by government and the president has created a great impact to Ugandan masses. The poor and illiterate have accessed HIV/AIDS related information through proper channels of communication in form of HIV/AIDS campaigns and debates.

f) A proper and well streamlined coordination system is a necessary approach to the fight against HIV/AIDS. Uganda has succeeded because of this kind of system which is regarded a best practice.

g) Sharing experiences and scaling up successful interventions through training workshops conferences and seminars is an important factor in the transfer of knowledge and skills to the different parts of the country to fight HIV/AIDS.

7.0 Conclusion

Uganda has made considerable milestones in addressing the epidemic. However, compared to the magnitude of the epidemic, there is still a lot left to be done to bring the epidemic farther down. The message here is “there is no room for complacency”. There are still more gaps. AIDS must be a priority in all social and economic development efforts. Substantial progress can only be achieved through universal access to prevention, treatment, care and support services. HIV prevention interventions need to be integrated into all other health services including sexual and reproductive health, family planning, maternity and primary health care. People need to have access to a full range of reproductive choices in accordance with the Cairo/ICPD Agenda; reliable and sustainable access to essential sexual and reproductive health commodities including condoms and STI treatment and access to ART and other proven treatments such as prophylaxis for
HIV associated illness. To achieve this we need to strengthen the public sector and embrace the mult-sectoral approach. But more importantly to improve on absorptive capacity and eliminate corruption.