Managing HIV/AIDS at the Local Level in Africa

Project outputs and achievements

UGANDA LOCAL GOVERNMENT ASSOCIATION (ULGA)

2006

- *ULGA Activity and Progress Report*
- *ULGA HIV/AIDS Work Place Policy*

UGANDA LOCAL GOVERNMENT ASSOCIATION

HIV / AIDS DECENTRALISED RESPONSE

Accelerating Decentralised (Local Level) Response to HIV/AIDS in Uganda, Within the Programme Managing HIV/AIDS Pandemic At The Local Level in Africa.

December 2005 – June 2006

Urban indicators / basic city data

A total of about 22 million people, have been killed by HIV/AIDS and over 13 million children have been orphaned worldwide since early 1980s due to AIDS related causes. Over 15,000 new infections occur each day or 10 new infections every minute, six of which occur in young people. UNAIDS and WHO estimate 40 million people infected with HIV by the end of 2001, including 15.7 million women and 1.3 million children less than 15 years old. Over 95 per cent of HIV cases occurred in the developing countries of Sub-Saharan Africa and South East Asia. Sub-Saharan Africa is by far the region most affected by HIV in the world (UN-HABITAT 2002).

In Uganda, the latest data showing variations in HIV prevalence rates of infection between urban and rural reveals the figures standing at 4.2% in rural areas and 8.8% in urban centers (UNDP 2002). The country's prevalence rate is 6.5%.

Uganda has a total population of 24.7 million people. 12.6 million are females and 12.1 million males. The population growth rate per annum is 3.4% whereas fertility rate stands at 7 children per woman. !2% of the population lives in urban areas, and of this, over 41% live in Kampala alone (UBOS 2002). The population of Uganda is currently estimated at 27m

The UNAIDS report (June 2002) estimates that, is a projected total human population of 22 million Ugandans (December 2001), 1.050,555 million were HIV+ and about 120,000 had developed AIDS. Sentinel surveillance figures indicate higher prevalence rate of HIV/AIDS infection in urban sentinel sites as opposed to those located in rural areas. Nearly 80% of those infected with HIV are in the 15-45 years age group, a group that is most economically productive and often fenders of families.

Background Information and Introduction: What is HIV/AIDS Decentralised Response?

The HIV/AIDS Decentralised response refers to local level response to HIV/AIDS. It looks at how local governments handle matters of HIV/AIDS, the challenges they face and the reasons why they are best suited to handle the local response.

In Uganda, the Decentralised Response is considered one of the self coordinating entities (SCE) of the Partnership Committee of the Uganda AIDS Commission. The ULGA is the Secretariat for the SCE whose membership includes all NGOs, Local and International, and CBOs operating in the Local Governments in Uganda. The people having HIV/AIDS (PHAs) are represented in the SCE by select PHA Forum members. The Ministry of local government and ULGA chair this SCE on a rotational basis.

ULGA consists of all the Local Governments of Uganda and their affiliate organizations and professional bodies.

The ULGA is a legal body, duly registered under its Constitution and Articles of Association. The Association derives its mandate from the voluntary adoption of the Constitution of the Association by the member Local Government Councils.

The authority of ULGA is vested in the Executive Committee (EC), and the General Assembly as the overall policy-making organ of the Association.

The Uganda Local Governments Association, (ULGA), the Alliance of Mayors and Municipal leaders on HIV/AIDS in Africa, (AMICAALL), and the Uganda Network of AIDS Service Organizations, (UNASO) have been jointly undertaking a project supported by UNAIDS, referred to as Poverty Alleviation Fund, (PAF). The objective of the project was to strengthen the decentralized response to HIV/AIDS through building the synergy between Local Governments and Non Government Organization (NGOs) working together to collectively respond to HIV/AIDS at the local level. The ULGA has since decided to ensure a continuation of this collaboration and thus requested support from UN–Habitat to continue as UNAIDS funding has come to a close.

The purpose of this cooperation is to empower local leaders on HIV/AIDS Programming and workplace policy, and to address issues of coordination of HIV/AIDS activities. It aims to bring together District and Municipal leaders in order to disseminate information on current interventions, and their role as local leaders.

ULGA aims to facilitate an interface between the actual implementers on the ground and the District based NGO'S and other stakeholders who each have an important role to play. Ultimately, the aim is to empower local leaders to coordinate HIV/AIDS activities and this will contribute towards strengthening institutional capacity to respond to HIV/AIDS. The program will also provide an opportunity for learning and sharing experiences.

What makes HIV/AIDS Decentralised Response Important?

Local Government (LG) is at the level of government closest to the people and their communities. LG is responsible for ensuring that the people get good quality of life and for promoting sustainable social and economic development. LGs provide political leadership and vision for the area. It embraces partnerships in order to further enhance implementation and achievement of its goals and mission.

HIV/AIDS has become a key factor in LG activities and has a strong effect on service delivery. Moreover, as an employer, LG's will be adversely affected if some of their employees develop AIDS and become constrained in their performance.

Originally, AIDS programmes and initiatives focussed at the National level. However, it has been established that multi sectoral responses are better suited to address the HIV/AIDS epidemic. LG by nature and responsibilities at the local level provides the best conduit for this to take place as the community will participate in the program and own it, paving a way for sustainability.

Opportunities arising from the Decentralised Response

(i) Mobilizing Local Resources

The Local Government system provides substantial funding from local and external sources. Some Local Governments have moved fast to provide a budget line for HIV/AIDs. It is important that the Local Government Budget Framework Paper and Development Plan clearly highlight HIV/AIDs as a priority to the Local Governments.

(ii) Support to Local Networks against HIV/AIDs

The partnership effort at the national level can only be effective if local area networks are strengthened. Local Governments are at the center of bringing together and supporting the persons living with HIV/AIDs, Civil Society Organizations, Community Based Organizations, Faith Based Organizations initiatives within their area of jurisdiction, for joint planning and co-ordination.

(iii) Supportive Bye-Laws and Ordinances

The decentralization policy empowers local authorities at the various levels to enact and enforce bye-laws and ordinances to ensure development in their areas. Bye-laws are important in limiting events and circumstances that are unsafe, especially to the youth.

(iv) Community Mobilization and Sensitization

The Councillors are the most effective mobilizers of their communities. They use organized meetings, leaflets posted on community notice-boards, local FM Radios and impromptu gatherings at market places, Churches and recreation areas. They need to be helped to refocus such discussions on HIV/AIDs as a governance issue and to agree on appropriate interventions in their communities.

Proposed Outputs

Objective:

Enhance the capacity of local actors including local governments to respond to, and coordinate HIV/AIDS issues at the national and decentralised level, and to address policy and other interventions

Expected Outputs:

- Institutional capacity for leadership and coalition building to respond to HIV/AIDS strengthened at national and decentralised levels
- Coordination, partnership and networking for HIV/AIDS response at various levels enhanced
- Information generation and dissemination among various stakeholders at various levels improved
- Resource mobilization and utilization for HIV/AIDS response enhanced
- Policy and bye laws/ordinances on OVC and for the work place produced
- A Monitoring and Evaluation Plan and Reports produced jointly by the implementing agencies
- Reports from meetings, policy and planning sessions, workshops, policies, information posted on ULGA, UAC and other websites, newsletters, brochures, flies and a documentary

Expected Outcomes

- Strengthen coalition among the organisations i.e ULGA, AMICAALL
- To empower local leaders on HIV/AIDS programming, workplace policy, dissemination of information on the interventions on OVC

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Results and Impacts

The immediate activity was to be centred on strengthening ULGA capacity and coalition building to enhance involvement of local leaders in the local response. The activity that was carried out was consultative regional workshops to involve local leaders at the regions on planning, involving vision, goals and mission.

The regional workshops took place in the Districts of Kitgum for Northern Region, Mubende at Mityana for Central Region, Mbale for Eastern Region and Mbarara for the Western Region. The activity was part of a Consultative workshop on the Regional Tier Constitutional Amendment which was being disseminated at the local level by ULGA. The participants at the workshops included all District Chairpersons, Chief Administrative Officers, and District Council Speakers of the Regions. Other participants included Representatives of Cultural and Religious Leaders, of Chief Administrators and of the Sub Counties. The Executive Committee members of the host Districts also participated fully.

The result of this meeting was that once again the regions pledged and re emphasised their commitment to fighting HIV/AIDS. They made declarations and reiterated their mission of embracing the MDG goal on HIV/AIDS among others. Participants from the region endorsed the following as the role of the Local Leaders on HIV/AIDS:

Role of Political And Other Leaders

- Advocacy
- Legislation
- Resource mobilization and allocation
- Oversight
- Representation
- International collaboration and partnerships

Advocacy

- Ensure that right information, concrete opportunities, key resources and positive messages are given to the public to overcome societal and cultural encumbrances
- Use of position, prestige and networks to mobilize support for HIV/AIDS
- Redoubling of efforts to mobilize high-profile personalities and other leaders to advocate for increased awareness of, and support for HIV
- Encouragement of pro-active action to draw the attention and support of the mass media to increase awareness and dissemination of information
- Promote intra-country dialogue and sensitization of political leaders and inter-country meetings of politicians and specialists in HIV/AIDS
- Work as role models and agents of change in order to promote education and behavioral change at the grass root level, and mobilize participation
- Support and advocate for better and more youth friendly HIV/AIDS services
- Capacity to be enhanced through sensitization and provision of appropriate well researched and analyzed information
- Need for a simple tool kit for local leaders
- Have unparalleled forums and opportunities

Legislation

- Government initiated bills
- Private members bills
- Within the human rights framework need to review and revise current laws, policies and practices related to public health legislation. HIV/AIDS, criminal laws and draft new laws e.g. domestic relations including domestic violence and inheritance rights, discrimination in employment, care and support, malicious spread of HIV, child abuse etc.

Oversight

- An effective oversight of public policy and utilization of public resources
- Monitor implementation programmes and policies
- Issue Health and HIV/AIDS policy statements annually
- Ensure value for money monitoring, human resources, training, equipment, drugs, VCT & PMTCT services
- Field visits; supervisory and mentoring visits

Resource Mobilization

- Authority to borrow money is with LG/Parliament
- Input into resource allocation early in the budget
- Review of spending priorities and appropriate funds to Central Governments ; Local Governments and other bodies
- Advocate and appropriate increased levels of limited resources for HIV/AIDS
- Lobby for grants rather than loans for HIV/AIDS from the World Bank and Development partners

Representation

- A united and coordinated response by leaders to the HIV/AIDS pandemic that reflects the voices of the local people
- Elected leaders are spokes persons for all; the marginalized, orphans, youths, women, PHAs, consumers and providers of health and HIV/AIDS care services
- Present views and concerns of the people to the Executive
- Speak for and dialogue with CSOs and private sector as Patrons or leaders of NGOs/CBOs can influence

Current Challenges

- Stagnation of HIV prevalence at slightly over 6%
- Population prevalence estimated at 5%
- National sero-survey to be done – not district specific – challenge to decentralized
- Need for more innovative strategies – not business as usual.

Young People

- Many surviving HIV positives are now adolescents
- Pressure of adolescence, peer pressure, lack of life skills education and breakdown of family values
- Emerging culture and lifestyles e.g. drug abuse, anal sex, tattooing, pornography on the Internet, video and newspapers, nudity shows (commonly known as kimansulo) and dressing
- Sexual abuse including defilement and rape
- Sex at school and for recruitment and promotion
- Unemployment – weak private sector, vacant positions even in public service not filled as yet

Orphans

- Nearly 2.1 million orphans most due to AIDS
- Many child headed families
- Food, shelter, education, health, clothing and security greatly needed

- Psycho-social problems
- No clear welfare polices
- OVC policy and implementation plan established but implementation still underway

ARVs

- Provision of ARVs – increased quality of life and productivity, reduced opportunistic infections, decreased orphans, reduced HIV sexual and MTC transmission,
- ARVs – have to keep eye on the ball of prevention
- Human rights issue and denial to be addressed
- Ministry of Health plan is to provide ARVs for 100,000 people by 2007
- Few VCT services in many districts due to either lack of VCT centers or testing kits
- Lack of laboratory capacity but WHO recommends low cost monitoring
- Problem of delayed procurements
- Challenge of Ministry of Finance; Macro-economics versus Micro-economics and social services; own staff on treatment a

Disbursement Of Funds

- Global Fund;
- CHAI;
- Donor projects e.g. AIM also have some problems
- President Bush Initative

Parliamentary Response

- Standing committee formed in august 2002 to coordinate and enhance capacity of members to effectively discharge their legislative advocacy, oversight and representative functions in the expanded national response to the epidemic
- To recognize some of the heroes in HIV/AIDS fight
- Constituency AIDS Task Forces
- Establish Communication tool kit for Parliamentarians and other political leaders

Sessions were held on responsibilities, roles especially of the Focal Point Persons and other local leaders. It was established that there is no need to have a substantive officer for HIV/AIDS but instead mainstreaming was emphasized. They submitted that the HIV/AIDS function should be part of a factor for job evaluation and promotion.

Participants from the region endorsed the following as the role of the HIV/AIDS Focal Person:

<u>Terms of Reference for HIV/AIDS Focal Persons</u>

Management Issues

A Focal Point Person should be a new or existing full time employee of the Local Government

He/she should be formally designated as a focal point person by Management and endorsed by the Executive Committee to which he/she is accountable. The performance and time allocated to HIV/AIDS of the FPO should be clearly indicated. Tasks should be clearly indicated as they contribute towards the officer's evaluation.

The roles of the FPO shall include:

1. Information sharing and dissemination among all the HIV/AIDS stakeholders at all levels in the districts
2. Coordination of all HIV/AIDS issues and programs in the districts. He should report on the development, implementation, monitoring and evaluation of the HIV program in the District
3. Planning and budgeting for HIV/AIDS and ensuring integration in the District Development Plans.
4. Monitoring and where practicable evaluating the mainstreaming of HIV/AIDs issues.
5. Streamlining and harmonising operational issues e.g. training, reporting requirements, resources, IEC materials, etc.
6. Assisting in resource mobilisation for HIV/AIDS.
7. Assisting councils in policy formulation and legislation for HIV/AIDS.
8. Assisting councils in advocacy campaigns for HIV/AIDS
9. Conducting analysis of potential partners with CBO's
10. Managing and facilitating the work of the HIV/IAIDS Task Team
11. Support supervision within the districts and sub-counties.

Qualifications:

1. Seniority within the LG; and influence within the LGA and community due to good reputation
2. Good organisational abilities
3. Commitment to the fight against HIV/AIDS
4. Good leadership qualities and ability to relate well with others communicate easily and facilitate training programs
5. Knowledge of planning and basic financial management

The regions also agreed to include deliberations and planning opportunities at the budget conferences to be held in May in preparation for the passing of LG budgets in June/July when the Financial Year commences. The ULGA used the workshop recommendations to include training of HIV/AIDS as one of the generic modules for the training of newly elected Local Government Councilors.

The following were some observations at the workshops:

1) Evidence of Joint declarations made by Local Leaders
2)Report/sessions on responsibilities, tasks and roles available on request
3) HIV/AIDs workplace policy though adopted should be in place in most District/Municipal Councils by June 2006
4) HIV/AIDS has been mainstreamed in most departments
5) Most District/Municipal HIV/AIDS strategic plans available but should be in place by June 2006
6) Funds must be earmarked and budgeted for HIV/AIDs during the passing of budgets in June 2006
7) Training materials/publications and sessions on specific/strategic management issues must be available on request

8) Report/sessions on organisation/planning events but be in place
9) Maintain strong networks established with UNASO, PHAs, FPO, etc
10) Functional and effective coordination mechanisms are in place but need to be strengthened
11) Joint activities/workshops with NGOs etc.
12) Joint planning and budgeting must continue to be emphasized
13) Bi annual and quarterly regional coordination meetings held

Products and Outputs

The activity resulted into the development, analysis and adoption of the HIV/AIDS Workplace program and policy. The document is hereby appended to this report. Other reports are available on request.

Gender

Women Councilors and Cultural leaders participated in the consultations and their views were included in the reports and in the policy

Lessons Learned

The activity was successful. It resulted into identification of management gaps especially in making the HIV/AIDS Committees operational at all levels

It resulted into discussions of other cross cutting issues and relating it to HIV/AIDS eg. The response in border towns, among long distance truck drivers, fishing villages near the lake regions, in towns among prostitutes, and in the Northern Region where insurgency has prevailed for the last twenty years, and the pandemic is rampant.
This offered a challenge to ULGA as other key players expressed keen interest to join the SCE. NGOs challenged LGs to establish closer working links with them and to support their activities in terms of policy and direction.

Conclusion/Next Steps

Several activities are yet to be carried out. It is believed that at the closure of cooperation on this proposal, new ideas and a way forward will be established for action.

UGANDA LOCAL GOVERNMENT ASSOCIATION (ULGA)

ACCELERATING DECENTRALISED RESPONSE TO HIV/AIDS

HIV/AIDS WORKPLACE PROGRAM/POLICY

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Acronyms

AMICAALL	Alliance of Mayors' Initiative for Community Action on AIDS at the Local Level
ART	Anti-Retroviral Therapy
CBOs	Community Based Organizations
HIV/AIDS	Human Immune Deficiency Virus/Acquired Immunodeficiency Syndrome
ILO	International Labor Organization
NGOs	Non Governmental Organization
PMTCT	Prevention of Mother to Child Transmission (of HIV)
UNGASS	UN General Assembly Special Session on HIV/AIDS
VCT	Voluntary Counseling and Testing
WHO	World Health Organization
CAO	Chief Administrative Officer
DDHS	District Director of Health Services
DHAC	District HIV/AIDS Committee
DHAT	District HIV/AIDS Technical Committee
FPO	HIV/AIDS Focal Point Officers
LGs	Local Government(s)
M&E	Monitoring and Evaluation
MoLG	Ministry of Local Government
PLWHA	People Living with AIDS
PHA	People Having AIDS
SCE	Self Coordinating Entity
UAAU	Urban Authorities Association of Uganda
ULGA	Uganda Local Governments Association
UAC	Uganda AIDS Commission
UNASO	Uganda Network of AIDS service Organization
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UN HABITAT	United Nations Human Settlements Programme

Acknowledgement

ULGA would like to thank all organizations and individuals who contributed towards the development of this document.

We acknowledge the contribution of the Uganda AIDS Commission and Local Government leaders both political and technical. We appreciate all those managers and workers in the different workplaces for sharing their ideas with us and ensuring the enrichment of the document with information that we may not have easily come across.

We however wish to thank, in a special way the UN HABITAT, UNAIDS and Danida for providing the necessary financial assistance to support both the study and the development of this document.

We also pay tribute to all our development partners in scaling up HIV/AIDS response in Uganda by supporting government efforts in every manner possible to fight the scourge. We will forever be grateful for their commitment to resource mobilization and strategic planning by Local Governments in the decentralized response to HIV/AIDS.

Captain Otekat John Emily
President
Uganda Local Governments Association

1 Introduction and Background

This document gives the policy of the Uganda Local Governments Association (ULGA) to enhance and expedite the intervention by Local Governments in the fight against HIV/AIDs in Uganda. It is intended to give the stakeholders insight into the role of Local Governments in this regard and the mechanism for co-coordinating the Local Governments within the mandate and structure of their Association. The key issue in this document is to address the challenges posed by HIV/AIDS at the Association and to ensure a conducive HIV/AIDS workplace program and policy both at ULGA and as developed by member LGs.

2. Brief about ULGA

ULGA consists of all the Local Governments of Uganda and their affiliate organizations and professional bodies.

The ULGA is a legal body, duly registered under its Constitution and Articles of Association. The Association derives its mandate from the voluntary adoption of the Constitution of the Association by the member Local Government Councils. The membership of ULGA District is Local Governments and lower local councils. The authority of ULGA is vested in the Executive Committee (EC) as the overall policy-executing organ of the Association.

The Executive Committee has 14 members, who include the President, Vice President, 4 Regional Chairpersons, 4 Regional CAOs, and 4 Regional Speakers. Following ULGA's Sub-division, the Regions of Uganda are Central, Eastern, Western and Northern.

The 4 committees of ULGA are:

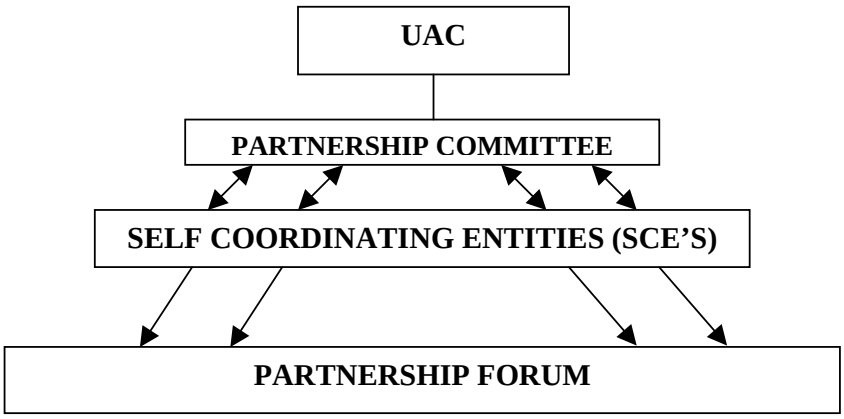
1. Finance and Management Committee
2. Training and Capacity Building Committee
3. Conflict Management and Resolution Committee
4. HIV/AIDS Committee

The Committees are composed of 3-4 members of the Executive Committee. They have Chairpersons and are serviced by members of staff as secretaries. The Executive Committee is serviced by a Secretariat, housed on Floor 8, NIC Building, Plot 3 Pilkington Road.

The existence of a strong viable, representative Local Governments Association is a major element in the sustainability and further development of a democratic decentralized society in Uganda, and the secretariat advocates for and negotiates on behalf of the Local Governments to achieve strengthened local governance, and now to respond to HIV/AIDS issues.

The Uganda AIDS Commission established a Partner ship Committee that comprises all stakeholders, and Local Governments were identified as key players in this multi sect oral response. ULGA acts as the Secretariat for the Self Coordinating Entity for the Decentralised Response, (SCE/DR), while the Ministry of Local Government Chairs this SCE.

HIV/AIDS PARTNERSHIP COMMITTEE



In 2005, ULGA carried out a study and came up with the following findings:

Institutional capacity to address HIV/AIDS

- Leadership in all districts is committed to the fight against HIV/AIDS
- There are established District AIDS Taskforces (DATs) and District HIV/AIDS Committees (DHACs). These are good implementation structures for responses considered effective in the fight against HIV/AIDS through the partnership structure, a system of health service institutions and CBOs. However, coverage of services for surveillance, treatment of OIs, STI and TB management, IEC, Condon promotion, VCT and others is still limited. Many are yet to benefit from PMTCT and ARV therapy.
- There are district HIV/AIDS Focal Persons who coordinate all HIV/AIDS related activities. These are technical persons under the office of CAO or Town Clerks
- Mobilization of resources from international development partners and NGOs has been largely progressive
- Most of the funding of HIV/AIDS activities in the local authorities is by the international NGOs and the central government. Little support from local government is realized due to inadequate resources and competing areas requiring financial allocations from locally generated revenue
- Duplication of activities is very common and at times the local administration through relevant departments in some districts does not actively supervise the work of lower structures, nor coordinate programs of CBOs and other organizations involved in HIV/AIDS work at the grass roots.

Sensitization in the HIV/AIDS response

- Most of the people are aware of preventive measures through ongoing IEC strategies in all communities.
- Sensitization about HIV/AIDS has become multi-sectoral; implemented by all departments of District/Municipal Local Governments. NGOs and CBOs, too, have taken up the task of sensitizing communities including LG officials in their areas of operation.
- The most common source from which people receive information and sensitization about HIV/AIDS include the mass media, mainly radio, formal assemblies by local community leaders and other officially designated persons, visits by agents of government and NGOs, and local CSOs.

- Actors in HIV/AIDS work have found FM stations to be an effective medium of communication in form of short adverts and talk shows. It is almost impossible to ignore the messages since they are played on each station quite frequently
- Media houses are very active in as far as dissemination of HIV/AIDS messages on mainly prevention and control as well as treatment is concerned
- A common approach for scaling up sensitization in different socio-demographic and special population groups is the setting up of a network of peer educators
- Drama groups have been formed within the communities to further the work of sensitization about HIV/AIDS.
- The process of learning and sharing is reinforced by grapevine communication channels already existing in almost every community.

HIV/AIDS Policy In LGs

- That a clear workplace policy on HIV/AIDS was conspicuously lacking in most local governments and where there are a few on provision of drugs eg. in Kampala City, the implementation was poor
- That although the Decentralisation Policy empowers local governments at the various levels to enact and enforce bye-laws and ordinances to ensure development in their areas, and now to enforce HIV/AIDS interventions eg. in limiting events and circumstances that are unsafe, especially to the youth, LGs have not been sufficiently empowered to/have not taken the initiative to enact these laws.

HIV/AIDS has resulted into:

1. A risk of reduced productivity, with possible decline on returns to investment, which may negatively impact on investor confidence.
2. Loss of revenue from such would be investments.
3. Loss of skilled workers. Absenteeism together with the entry into the labor market of orphaned children, who have to support themselves, may lower both the average working age and the skill level.
4. Conflicts at workplaces that result from stigmatization and discrimination of PLWAs can lead to declining morale, and hence consequent collapse
5. Threat of social stability. Aggravating social inequality
6. Impoverishment
7. Threat to productivity due to absenteeism, loss of skills, higher employment benefits
8. Hiring replacement workers
9. High costs of treatments and funerals
10. Retraining of workers
11. Provision of family pensions.

The workplace represents an ideal forum for tackling the epidemic because it is a place where diverse groups of people come together on a regular basis and have existing structures and facilities that can be used for prevention, care and support programs.

In response to the above findings, ULGA has decided to carry out the following activities:

- Facilitate LGs to enact clearly defined non-discriminatory HIV/AIDS policies/bye-laws and ordinances to protect the rights of all individuals.
- Advocate for and conduct training and equipping of workplace peer educators with all the relevant skills to sensitize, counsel and make referrals so as to increase awareness levels about HIV/AIDS at the workplaces.

- Encourage mobilizalisation of resources locally through establishment of budget lines for HIV/AIDS activities to cater for treatment and care needs of PLWA
- Ensure provision of correct information about HIV/AIDS, home based care, VCT, PMTCT and ART, care for orphans and PLWAs from the workplaces both in the formal and informal sector.
- Oversee the development of a mechanism to facilitate the establishment and coordination of workplace HIV/AIDS programs/policies in LGs

Objective, expected outputs and outcomes

Enhance the capacity of local governments and local actors to coordinate HIV/AIDS issues at the decentralised level and to address policy and other interventions

Expected Outputs:

- Institutional capacity for leadership and coalition building to respond to HIV/AIDS strengthened at national and decentralised levels
- Coordination, partnership and networking for HIV/AIDS response at various levels enhanced
- Information generation and dissemination among various stakeholders at various levels improved
- Resource mobilization and utilization for HIV/AIDS response enhanced
- Policy and bye laws/ordinances on OVC and for the work place produced
- A Monitoring and Evaluation Plan and Reports produced jointly by the implementing agencies
- Reports from meetings, policy and planning sessions, workshops, policies, information posted on ULGA, UAC and other websites, newsletters, brochures, fliers and a documentary produced

Expected Outcomes

- Strengthen coalition among the organizations i.e ULGA, AMICAALL, etc….
- To empower local leaders on HIV/AIDS programming, workplace policy, dissemination of information on the interventions on OVC etc.

3 Situational Analysis of HIV/AIDS in LG Work Places

AIDS has killed a total of about 22 million people and orphaned over 13 million children worldwide since early 1980s. Over 15,000 new infections occur each day or 10 new infections every minute, six of which occur in young people. UNAIDS and WHO estimate 40 million people infected with HIV by the end of 2001, including 15.7 million women and 1.3 million children less than 15 years old. Over 95 per cent of HIV cases occurred in the developing countries of Sub-Saharan Africa and South East Asia. Sub-Saharan Africa is by far the region most affected by HIV in the world (UN-HABITAT 2002).

The latest data showing variations in HIV prevalence rates of infection between urban and rural reveals the figures standing at 4.2% in rural areas and 8.8% in urban centers (UNDP 2002). The country's prevalence rate is 6.5%.

Uganda has a total population of 24.7 million people. 12.6 million are females and 12.1 million males. The population growth rate per annum is 3.4% whereas fertility rate stands at 7 children per woman. !2% of the population lives in urban areas, and of this, over 41% live in Kampala alone (UBOS 2002).

The UNAIDS report (June 2002) estimates that, is a projected total human population of 22 million Ugandans (December 2001), 1.050,555 million were HIV+ and about 120,000 had developed AIDS. Sentinel surveillance figures indicate higher prevalence rate of HIV/AIDS infection in urban sentinel sites as opposed to those located in rural areas. Nearly 80% of those infected with HIV are in the 15-45 years age group, a group that is most economically productive and often fenders of families.

However, we must acknowledge the existence of committed NGO's and other partners on the struggle for HIV/AIDS awareness and other programs for mitigation.

3.1 Gaps and Barriers to HIV/AIDS Interventions in Work Places

3.1.1 Openness/denial

The national response to HIV/AIDS has been a policy of openness and political commitment. Although wrong attitudes like prejudice, stigma, denial, and discrimination are still mildly prevalent and may hinder openness about HIV/AIDS among workers, a lot has been attained. This encourages the leadership to address any issues of apathy and suppress this. The most affected are the elite or senior staff who fear exposure and still fear to speak out unlike in the rural setting where many now go for VCT services. There is also insufficient treatment facilities for AIDS related infections and this too is a major hindrance to openness. The lack of free (or subsidized) treatment largely contributes to unwillingness to attend VCT services by majority of the urban workforce.

3.1.2 Integration Of HIV/AIDS/ Mainstreaming HIV/AIDS in Departments

The existence of HIV/AIDS strategic plans does not mean that they have been integrated into the District Development Plans, (DDP) Organizations carrying out health related work have made attempts to include HIV/AIDS strategies in their programs, including caring for the sick, provision of medical care and nutritional support. There is need to integrate HIV/AIDS at the workplace in all aspects of local government operations. Mainstreaming has been steadily taking root as many now understand how this can be implemented.

3.1.3 Resource Mobilization and Allocation

LGs have taken the initiative to mobilize resources for HIV/AIDS and the allocation made towards HIV/AIDS intervention has been minimal, if at all. Availability of funds would support the establishment of polices, awareness raising programs, treatment and care and putting in place facilities like information brochures, condoms and gloves. The resource envelop is limited but LGs are trying their best to commit even more resources to HIV/AIDS, in close collaboration with other NGOs.

3.1.4 Social-Cultural Practices

LGs should have a clear policy on the above. Cultural practices may be positive; while others are risky and can increase or encourage HIV infection to an individual. A data base on these cultural practices should be made. Cultural practices that predispose or increase the risk of infection with HIV in urban (as well as rural) areas include:

- Infidelity among married persons; (if it does happen)
- Boyfriend-girlfriend affairs;
- Sexual harassment (sex demanded as a precondition to recruitment and promotion);
- Denial
- Circumcision including female circumcision (Imbalu)
- Widow inheritance
- Unsafe sex; and
- Prostitution as a form of earning income.

3.1.5 Poverty

In Uganda, 35% of the population lives on less than 1US$ per day (UNDP 2002). 5%, 23% and 16% of the population in urban areas in Uganda lack access to health care, safe water and are illiterate respectively. Poverty is reported to have increased commercial sex work. Most commercial sex workers are reported to be from urban workplaces including markets, restaurants and lodges

3.1.6 Insurgency and Migration

Urban areas, urban growth centres and Camps for people displaced by insurgency are critical epi-centres of the disease. They deserve special attention and focus by ULGA and other stakeholders.

For over 20 years now, parts of Uganda have been insecure due to insurgency. Many have migrated to urban areas which are believed to provide sanctuary, and serve as safe havens during insurgency. Many families close to areas of insurgency, rebel activities and cattle rustling usually seek refuge in urban areas. Redundancy, poverty and weakening society norms that are characteristic of internally displaces people's, (IDP) camps conspire to force some women and girls into commercial, and mostly unprotected sex to cope with the difficult living conditions including food shortage and lack of shelter, and survival generally.

The high mobility of this population abets the spread of HIV and also makes impact mitigation responses difficult. For example, the CHAI (Community-led HIV/AIDS Initiative) as a strategy to combat the spread of HIV/AIDS may not thrive in such areas eg the program in Lira Municipality is increasingly finding it difficult to benefit IDPs in their camps.

Long distance drivers and fishermen in fishing villages and landing sites have also been identified as a group to be handled by LGs in the decentralized response as their working conditions may offer a challenge to HIV/AIDS interventions.

4.0 HIV/AIDS Workplace Program

Communities are in dire need for strong Local Government response to the struggle against HIV/AIDS, especially at the community level. LG should set an example of best practice and

caring for its members. LGs should express their determination in supporting the fight against HIV/AIDS in all its functioning, with emphasis on mainstreaming.

Key stages of developing an HIV/AIDS strategy in guiding Local Governments:

- Discussing and analyzing the HIV/AIDS problem
- Identification of core values and guiding principles for LG
- Identification of priority areas for action as well as roles and responsibilities
- Compilation of indicators to monitor success
- Resource identification, mobilization, allocation and utilisation

Key future areas of strategic policy interventions by LG

1. Provision of foster care or child care institutions for orphans and other vulnerable Children.
2. Review of social welfare policies with a view to address issues raised by HIV/AIDS eg. age to access grants
3. Care for PHA and the terminally ill, at home or in Institutions
4. Decreasing locally raised revenue, and ability to afford LG services eg. water, sanitation, refuse
5. Poor school attendance due to failure to pay school fees and children becoming care takers of the ill, and emergence of child providers
6. Promotion of increase in household incomes
7. Reduction of violence against women and children

4.1 Developing an HIV/AIDS Policy in Workplaces of Local Governments

An HIV/AIDS policy is a written document that sets out an organization's position and practices as they relate to HIV/AIDs.

Core Principles (mainly based on The ILO Code of Practice on HIV/AIDS) that cannot be omitted in an HIV/AIDS policy include:

- None discrimination in employment related to HIV status eg career opportunities
- Principles of equality and equity must be adhered to
- Continuation of employment regardless of HIV status
- Confidentiality
- Responsibility
- Inclusion and human dignity
- Healthy and safe work environment
- Gender equality as the basis of interventions for prevention and coping
- VCT and non screening for employment or recruitment or promotion
- Recognition of the importance of social dialogue, consultation with employees and their representatives in developing and implementing policy
- Recognition of the need for programs of prevention, care and support as the basis for addressing the epidemic in the work place
- Accessing employees to ART(free where possible)

The Commitment of the LG should be demonstrated by the commitments of both financial and human resources to develop, implement and sustain the program. FPO should be established and their roles clearly outlined. The policy must be translated into practice.

4.2 Integrating Workplace HIV/AIDS Program in LG plans

A workplace HIV/AIDS program outlines how all the different elements within the policy will be translated into practice at the workplace. Key elements of an HIV/AIDS workplace program include:

- An impact assessment of HIV and AIDS on the organization
- HIV/AIDS awareness programs
- Voluntary HIV testing and counseling programs
- HIV/AIDS education and training
- Condom availability and distribution
- Encouraging health treatment for STDs
- Universal infection control procedures including post exposure prophylaxis
- Creating an open and accepting environment
- Treatment of opportunistic infections for all PLHA staff
- Counseling and other forms of psycho-social support for affected stakeholders and their families
- ART and referral of patients/clients for further management
- Management, evaluation and review of the program.

The ULGA Workplace Program shall focus on the following:

4.2.1 Coordination and Management

LG shall ensure:

- existence of an HIV/AIDS Focal Point Person, (FPO) with clearly defined roles and duties
- establishment of the HIV/AIDS Task Forces and Partnership Committees at the District, (DAT), Municipal, Sub County, (SAT) Town Council, Parish and Village levels etc for implementation and coordination of programs.
- provision of regular progress reports to Executive Committees and Top Management
- that pledge by LG on commitment to demonstrate its role in fight against HIV/AIDS is made and implemented
- commitment on conducting annual review of implementation of the policy and the changing needs as per epidemic
- carrying out of impact assessments as need be so as to inform strategic planning, and establish cost of the epidemic on LG resources
- constant review of employee benefits, and a skills succession plan as part of HR Development
- regular review and monitoring of the policy/program
- data collection and analysis to monitor trends
- communication of any information on amendments, etc to workers.

4.2.2 Awareness Raising and Prevention

LG shall ensure:

- Awareness raising through ongoing continuous, regularly updated information dissemination, and education about HIV/AIDS, basic facts on transmission,

prevalence rates, national/international policies, employment rights and current, treatment, care and support options.

- Distribution of media materials eg. brochures, leaflets etc. to all staff members and their families. Dissemination materials shall be adapted/translated as appropriate to reflect diversity in terms of staff position, culture, religion etc
- Peer education within areas of work by trained educators
- Drivers should be provided with a minimum First Aid Kit
- Involvement of PLWHA in the design and provision of awareness raising as a means of combating stigma
- Involvement of cultural and religious leaders in fighting stigma and raising awareness on HIV/AIDS. LGs shall regulate activities of traditional healers in the management and treatment of HIV/AIDS

4.2.3 Healthy and Safe Work Environment

LG shall ensure:

- Access to barrier methods which provides protection against infection. Eg free access to male and female condoms, and updated information on storage, use and disposal.
- Provision of first aid kits with protective gear in case of accidents eg gloves, syringes and needles, and helmets for motorcycle riders.
- Post exposure prophylaxis (PEP) for staff exposed to the risk of HIV infection, through accident or sexual assault, whether in the workplace or elsewhere.
- Provision of counseling and reasonable paid time off for staff following occupational or other exposure.
- STI management
- Encouragement of healthy lifestyles eg. dietary information

4.2.4 Equal Treatment and Anti-Discrimination Measures

LG shall ensure:

- Nurturing of positive attitudes within the workplace through training and awareness-raising
- That pre-employment medical tests should not include an HIV/AIDS test.
- That indirect screening questions in verbal or written form are not included in interviews.
- That an individuals HIV status does not affect recruitment choices and/or promotion prospects and/or other work opportunities, such as transfers, training and travel (unless there are clear health grounds for doing so).
- That discrimination and/or harassment of staff on the grounds of their HIV status will be treated as a disciplinary matter and the relevant part of the existing personnel policy will be amended accordingly.
- On Disclosure; a person should be encouraged to inform his/her supervisor about his/her HIV/AIDS status when no longer able to perform assigned duties, or where he/she so desires
- On Benefits: An HIV/AIDS person is entitled to equal benefits with the uninfected employee

4.2.5 Care and Support

Medical care and associated costs

- The benefits shall include access to ARV treatment, as well as the costs of treating opportunistic infections
- Local governments shall provide health packages that can prolong/improve lives of PHA
- The workplace management in collaboration with ULGA and AMICAALL shall review their health policies to ensure that all critical/terminal illnesses are adequately covered in order to uphold the principle of equity and non-discrimination and avoid a situation whereby people with HIV/AIDS become subject to resentment and increased stigma on the grounds of 'favoritism' within the health policy.

Counseling services

- Management shall create an open and accepting environment for counseling affected and infected at work
- Management shall ensure provision of an effective and suitable counseling service to accompany the treatment

4.2.6 Medical Care and Associated Costs

- The benefits shall include but will not be limited to access to ARV treatment, as well as the costs of treating opportunistic infections
- LG shall enlist the services of professional medical personnel in the administration of ARVs, and provide information to staff on possible access points for ARVs within the different program and operational areas.
- Proper sensitization and education about the use of, and dangers of misuse of the drugs shall be provided. Employees shall take full responsibility for ensuring adherence to medical direction

4.2.7 Counseling Services

- LGs shall encourage voluntary confidential counseling and testing
- Counseling shall include, pre and post-test counseling to equip recipients with problem solving tips and skills
- Staff shall be given the option to choose where to access counseling services, within the workplace management or other counseling service providers. The LG shall provide information to all staff on where HIV-related advice, counseling and referral could be found outside the work environment.
- LG shall identify a suitable staff member from whom staff can seek confidential advice, counseling and referral on HIV-related matters. Adequate time and training shall be provided to that individual to enable her/him to fulfill these functions adequately.

4.2.8 Creating an open and accepting environment

- Extended sick leave and/or compassionate leave: existing provisions shall be reviewed and revised as necessary to take account of the situation of staff infected and/or affected by HIV/AIDS.
- Shall include flexible working hours and time off for counseling and medical appointments, part-time and return to work arrangements.
- HIV/AIDS Status shall not, under any circumstances, be used as a basis for termination of employment. Staff with HIV-related illness shall be enabled to continue in employment so long as they are fit for available, appropriate work.
- In case of termination of employment due to extended illness, staff with HIV/AIDS shall be accorded similar benefits and conditions to termination due to other serious illness.

4.2.9 Confidentiality

- All employees shall have a right to confidentiality on their medical information.
- A staff member's HIV status shall always be treated as confidential
- An employee who divulges information about the HIV status of a staff member, without that member's consent, shall be subject to disciplinary action. The relevant part of the disciplinary procedures under the existing personnel policy shall be amended accordingly.
- Access to benefits shall not be pegged to declaration of one's status.
- Management shall assist staff, who feel so, to disclose his/her status in the presence of a counselor or a doctor. The information shall be kept confidential.

4.3. Implementation of the Program

a) **HIV/AIDS Task Force Committees:** The DATS and DACS right up to the lower level shall be established

b) Shared Responsibility:

Responsibility for implementation of the different elements of the program will be shared across the staff, and the community including CBOs, NGOs

c) Training/Capacity Building

- Staff shall be trained in the implementation of the program.
- Training on the general needs of people living with HIV/AIDS and their caregivers shall be carried out.
- Information and training shall be provided to all irrespective of gender, race, nature of employment and sexual orientation. Such information and training shall be integrated into existing education and human resources policies and program as well as occupational safety and ant-discrimination strategies.
- Staff training on HIV/AIDS shall take place during paid working hours and attendance by all staff including senior staff shall be treated as part of work obligations.

d) Resource Mobilization

- Management shall be encouraged to develop resource mobilization plans and activities eg identify opportunities for volunteers to off set costs, e.g.: introduction of a volunteer/trainee of internship program as back-up support and delegation
- Management shall hold donor conferences with development partners with a view to mobilize resources.
- Management shall ensure that the HIV/AIDS strategic plan is integrated into the DDP and that there is an annual budget line for HIV/AIDS activities.

e) Monitoring and Review

- Management shall establish a monitoring and evaluation mechanism of the program based on agreed indicators by the three ones of the UAC ie One National Monitoring and Evaluation Framework
- There shall be a bi-annual review of implementation to address attainment of goals and objectives.

4.4 Getting Started

LGs must seek to benefit from additional funding from Government and other agencies for example the global fund, President Bush Initiative etc.

1) Consultations with local government workers and key stakeholders to build consensus based on local state of the epidemic
2) Establish a task force-committee to carry out situational analysis, on LG capacity and Finances, etc; Local Governments to provide technical support.
3) Conduct a Situation and Impact Analysis of HIV/AIDS in the locality
4) Assess the impact of HIV/AIDS on the functioning of the LG
5) Identify some preliminary priority areas eg. Policy
6) Approval of policy framework by established committee and management
7) The Task Force Committee undertakes further research and develops program goals and specific objectives, place for activities and a budget for identified/approved activities
8) Integration of program into existing organization and personnel policies (health policy, grievance, harassment, equal opportunities, etc) and revision of these policies to bring them in line with HIV workplace program.
9) Establishment of monitoring indicators and systems
10) Implementation of awareness-raising and prevention components of the program commences (at least at the level of resource planning, training and budgeting)
11) Commence implementation of other parts of the program
12) Review and revision of program as appropriate
13) Adoption by Local Government Councils

5.0 HIV/AIDS Workplace program and policy at ULGA

ULGA's Policy at the Secretariat is as above in most of the areas identified. However, ULGA has ensured the following:

- availability of condoms in the bathrooms and toilets
- appointed one staff member to be the focal person on HIV/AIDS activities
- attends HIV/AIDS related fora and programs
- Is the secretariat for the self coordinating entity, (SCE) of the decentralized response to HIV/AIDS
- participates actively in HIV/AIDs national partnership committee meetings

5.1 Conclusion

Uganda has taken bold steps in the fight against HIV/AIDs, led by His Excellency the President. The Local Governments have supported the struggle in various ways but this has been isolated and oftentimes unreported on. The significant contribution of ULGA is to coordinate the efforts of the Local Governments and to help invigorate their interventions. Accelerating the decentralized response to HIV/AIDs is timely and is the logical step to ensure a sustainable response for HIV/AIDs prevention at the grassroots. ULGA's commitment is to lead by example in the struggle.

Annex 1

DISTRICT COORDINATION