

SAP' HIV/AIDS PROGRAM FOR SLUM DWELLERS IN UGANDA

world *aids*
campaign



sap
PROJECT

Background

It now 20 years ever since HIV manifested its self in Uganda. The efforts to combat HIV have been made and Uganda managed to realize the drop in prevalence from 18% in 1992 to 6.4% in 2004. Unfortunately, according to the United Nations Development Programme (UNDP) in 2007 the prevalence has steady increased from 6.4 to 7.2%¹. Although Uganda had been hailed for the fight and success it registered against HIV/Aids by reducing the prevalence from 18% t0 6.4%, there is now a cause of alarm as the prevalence begins to rise shockingly. In Kampala the statistics reveal that the prevalence is 8.5%, the highest as compared to other regions of the country².

Policy analysts have noted that the HIV/AIDS pandemic dynamics have brought a shift in the paradigm. As such this will eventually influence the change the mode of combating HIV. The Abstinence, be faithful to your partner and use of condoms (ABC) strategy has began to be insignificant apparently. The key risk factors are multiple concurrent sexual partnerships amongst the youths and adults, discordance and non-disclosure among couples, lack of condom use, transactional sex, cross-generational sex, intact foreskin among men and relaxed sexual behaviors due to antiretroviral treatment (ART). SAP intends to contribute in re-aligning the focus among all risk groups especially the married people whose HIV prevalence is rising and rendering B (Be faithful almost insignificant).

¹ UNDP in Uganda 2009

² The state of the Ugandan population report 2008

Justification:

Over the past 15 years, HIV/AIDS prevention campaigns have been based on the premise that young, single people were the most risk groups. It has over time, now come out that people living in formal marriage are also at risk. Occasionally, Uganda has spent most HIV resources to promoting the ABC model. However, new studies indicate that 43 per cent of infections occurring among those who had multiple sex partners besides their regular partners.³ This indicator has shown that there has been a shift in dynamics of the HIV/AIDS epidermis. These changes have sounded a wake up call from us to change our intervention by targeting the actual groups and rejuvenate the ABC strategy. A call for behavioral change amongst all groups is presumed to bring change in the rising HIV/AIDS prevalence rates in Uganda. *New Vision news paper dated 1st December 2007*

Messages on abstinence and condom use in will continue to act as preventive measures to HIV/AIDS. Sexual abstinence and cross-generational sex programmes are well supported largely by donor initiatives, and the gap remains in addressing issues in monogamous stable marriages and discordant couple relationships, where condoms may not be very practical, and are most times not used. Messages on abstinence and condom use in particular do not, however, have any practical promise for married couples

Goal

To reduce the high prevalence of HIV/AIDS amongst all categories the people living in the slum areas in Uganda.

Purposes:
1) Youths and adult communities educated in behavioral change practices for the prevention of HIV/AIDS.
2) Local capacities strengthened to mitigate the psychosocial impact of HIV/AIDS in the slum areas
3) Prevention of sexual transmission of HIV/AIDS and promote access to HCT services among the youth and adults
4) Capacities of CBOs/FBOs and community groups improved to develop and implement sustainable HIV/AIDS interventions in the slum areas.

³ Daily Monitor, June 6, 2009

5) Palliative care to all infected and affected people living in the slum areas.

Program beneficiaries

Direct Beneficiaries: SAP targets to initially reach 1 million people of the people staying in the slum areas. The program will then scale up to directly reach all slum dwellers.

- All Youths
- All adults living in the slum areas
- Children affected and infected by HIV/AIDS
- Social support groups.
- Those in serious relationships, formally and informally married couples.

Targeted direct program beneficiaries

Category	Female	Male	Total
0-6 years	30,000	30,000	60,000
6-13 years	40,000	40000	80000
15-24years	150,000	130,000	280,000
18-30 years	150,000	130000	280000
Above 30	150,000	150000	300000
TOTAL	445,000	420,000	1,000,000

Project Intervention Area

Specific Program Area
1. Information education and behavior change communication
2. HIV counseling and testing
3 Distribution of condoms
4 Training counselors and peer educators in slums
5. Spear head School programmes on HIV/AIDS
6. Palliative care
7 Promotion of the IPT-G therapy for groups

SAP Approach

- 1) **Youths and adult communities educated in behavioral change practices for the prevention of HIV/AIDS.**

In pursuance of this output, the following activities will be implemented:

- Develop and disseminate Behavior Change Communication (BCC) messages targeting slum dwellers (youths and adults) through various media
- Facilitate HIV/AIDS educative seminars, drama competitions and sports tournaments for teachers in various schools and other educational institutions
- Train HIV/AIDS peer educators in schools and slums

Approach:

SAP will identify local, competent CBOs/FBOs and groups involved in HIV/AIDS education that will be able to mobilize and conduct HIV/AIDS seminars for slum dwellers in the different slums. Various groups will be trained in categories named. These CBOs/FBOs and groups will also train HIV/AIDS educators within the slum areas who will continue to provide the same kind of training to other slum dwellers and youths in the community after the program has phased out.

The media (mass, print and folk) will be used in the dissemination of HIV/AIDS information for even a wider audience than the slum community. Relevant Behavior Change Communication (BCC) messages will be sourced from various places and repackaged to address the needs of the school communities. Local FM radio stations will be approached and airtime purchased in order to air HIV/AIDS programs. Discussions regarding HIV/AIDS in the homes and community will be held by various groups. Music and drama competitions with HIV/AIDS themes will be organized and coordinated by the selected CBOs/FBOs for the different schools or slum institutions. Awards will be given to the best performing as will be decided by competent adjudicators. Sporting activities

are another avenue that will be used in the delivering and sharing of HIV/AIDS information especially for the youths and adult community. HIV/AIDS peer educators will be trained (two per slum) that will pass on HIV/AIDS information to their peers. One of the peer educators will be an adult while the other one will be a child.

2 Local capacities strengthened to mitigate the psychosocial impact of HIV/AIDS in the slum areas.

Below are the activities which will be implemented in order to achieve this output:

- Facilitate training of psychosocial adult, youth and children counselors for both adults and children
- Facilitate interpersonal therapy for groups (IPT-G)

Approach:

Studies have shown that HIV/AIDS does not only affect one physically but also results in emotional and psychological stress both for the person infected with the virus and their immediate family. This is partly due to the length of time that one suffers with the disease, the stigma that is attached to it, and also, the subsequent economic drain to the family. For the people and their family members that develop AIDS related illnesses, they will be referred to the nearest health units for medical treatment. However for the emotional/psychosocial needs, SAP will facilitate training of psychosocial counselors from among the schools and slum communities for adults, youths and children. These will provide ongoing psychosocial support to the infected and affected teachers and their families. In each of the slums in the target parish, at least two counselors will be trained. These will include adult counselors and child counselors. Schools will be facilitated to carry out counseling of teachers and children. The adult counselors will form groups of

youths and adults in the slums or slum schools, both those who are HIV+ and those who are not (or who don't know yet). These groups will meet once a week for max 2 hours. In a group confidentiality is important, so that is the first issue the counselor will have to work at. The Inter Personal Therapy for Groups (IPT-G) model was tried in Masaka and Rakai districts with people who have clinical depression caused by the effects of HIV/AIDS (among other causes) as identified by John Hopkins University⁴. *SEE IPTG TOOLS IN APPENDIX*

3 Prevention of sexual transmission of HIV/AIDS and promote access to HCT services among the youth and adults.

To achieve this output, the following activities will be pursued:

- Identify and facilitate existing HCT service providers in the target areas to scale up their services.
- Support establishment of new HCT outreach centers in the target areas

Approach:

Facilities for HCT by either government or AIDS Information Center (AIC), a local NGO, do exist in most of the districts in Uganda where this program will be implemented. These facilities or centers however are not easily accessible by many people because in most places, they are stationed within the major towns and are few in number. Despite Uganda's record in pioneering HCT, counseling capacity and services

⁴ “WV has been partnering with John Hopkins University and Columbia University to pilot a treatment for adults diagnosed as clinically depressed using a culturally appropriate tool. Through this group therapy, the results have shown a more than 90% curative effectiveness rate. See article in Journal of American Medical Association (JAMA), Group Interpersonal Psychotherapy for Depression in Rural Uganda – A Randomized Controlled Trial, Vol. 289, No. 23, June 18, 2003. SAP will work with World vision to spear head this in the slums of Uganda.

are still underdeveloped in the health care system. SAP will therefore link up with the existing HCT service providers and support establishment of new HCT outreach centers in the target communities. The new HCT outreach centers will then be facilitated to provide HCT services to the school communities. The selected CBOs/FBOs in these communities will raise awareness about the importance and availability of the HCT services and in ensuring their use.

According to the MoH (Ministry of Health) communication strategy for prevention of mother to child transmission of HIV (PMTCT) for 2002-2005, approximately 25% of the women attending antenatal care do not accept HCT services and refusal to take a test is largely attributed to lack of community support and involvement by male partners. Today it is mandatory for mothers to be tested. This helps to prevent mother to child transmission. Therefore, there is need to sensitize, educate and encourage women in the slum areas not to shun going to hospitals in fear of being tested.

SAP will facilitate training of psychosocial counselors from among the schools and slum communities for adults, youths and children. These will provide ongoing psychosocial support to the infected and affected teachers and their families. In each of the slums in the target parish, at least two counselors will be trained. These will include adult counselors and child counselors. Schools will be facilitated to carry out counseling of teachers and children. The adult counselors will form groups of youths and adults in the slums or slum schools, both those who are HIV+ and those who are not (or who don't know yet). These groups will meet once a week for max 2 hours. In a group confidentiality is important, so that is the first issue the counselor will have to work at. The Inter Personal Therapy for

Groups (IPT-G) model was tried in Masaka and Rakai districts with people who have clinical depression caused by the effects of HIV/AIDS (among other causes) as identified by John Hopkins University⁵. *SEE IPTG TOOLS IN APPENDIX.*

4 Capacities of CBOs/FBOs and community groups improved to develop and implement sustainable HIV/AIDS interventions in the slum areas.

To achieve this output, the following activities will be pursued:

- In liaison with reputable training institutions, carry out a training needs assessment and develop training curriculum for the various partners and groups
- Conduct training for the various partners and groups

Trainings will be organized in unison with the slum support groups and leaders to train all groups in HIV/AIDS programming. Opinion leaders and Teachers from the slum communities will be targeted to conduct these trainings in local languages.

5 Palliative care to all infected and affected people living in the slum areas.

What is Palliative care (PC)?

SAP has taken the definition of the World Health Organization (WHO), to define PC for slum dwellers..

⁵ “WV has been partnering with John Hopkins University and Columbia University to pilot a treatment for adults diagnosed as clinically depressed using a culturally appropriate tool. Through this group therapy, the results have shown a more than 90% curative effectiveness rate. See article in Journal of American Medical Association (JAMA), Group Interpersonal Psychotherapy for Depression in Rural Uganda – A Randomized Controlled Trial, Vol. 289, No. 23, June 18, 2003.

PC is an approach which improves the quality of life of patients and their families facing life-threatening illness, through the prevention, assessment and treatment of pain and other physical, psychosocial and spiritual problems.

Palliative care at Slum Aid Project:

- Provides relief from pain and other distressing symptoms;
- Affirms life and regards dying as a normal process;
- Intends neither to hasten nor postpone death;
- Integrates the psychological and spiritual aspects of patient care;
- Offers a support system to help patients live as actively as possible until death;
- Offers a support system to help the family cope during the patient's illness and in their own bereavement;
- Uses a team approach to address the needs of patients and their families, including bereavement counselling, if indicated;
- Will enhance quality of life, and may also positively influence the course of illness;

SAP Believes Palliative Care is Important

Palliative care is an essential component of a comprehensive package of care for people living with HIV/AIDS because of the variety of symptoms they can experience - such as pain, diarrhea, cough, shortness of breath, nausea, weakness, fatigue, fever, and confusion. Palliative care is an important means of relieving symptoms that result in undue suffering and frequent visits to the hospital or clinic. Lack of palliative care results in untreated symptoms that hamper an individual's ability to continue his or her activities of daily life. At the community level, lack of palliative care places an unnecessary burden on hospital or clinic resources.

How it is done

SAP Will help Slum Dwellers to decide who provides PC. These are basically

- *Health workers* : Health workers can provide basic medical and psychological support including necessary drugs to control pain and other symptoms that occur as a result of HIV related disease.
- *Family and community caregivers* : when patients choose to be at home, caregivers can be trained by health workers to effectively provide the prescribed medications and other physical and psychological support that may be needed. Friends, relatives and others in the community can be trained to ensure that the patient is comfortable. Medical attention from health facility workers (home visits to support the patient and to assist the caregiver) should be available as needed. Families and friends should be provided support even after the death of the patient. Bereavement counselling is an opportunity to support the loss of affected loved ones and to consider future plans.

Other issues to consider when deciding where palliative care can be provided

- In low HIV seroprevalence countries palliative care may be a routine part of hospital and clinic care.
- In countries with a high burden of HIV infection, palliative care should be part of a comprehensive care and support package, which can be provided in hospitals and clinics or at home by caregivers and relatives. In many settings, HIV infected people prefer to receive care at home. The provision of palliative care can be augmented significantly by the involvement of family and community caregivers. A mix of psychosocial support, traditional or local remedies, and medicines can be combined to provide palliative care that surpasses that found in many overcrowded or poorly staffed hospitals.
- Wherever palliative care is provided, factors to be assessed include affordability and the presence of community care and support services.
- Developing guidelines and training for palliative care should be specifically included in national guidelines for the clinical management of HIV/AIDS.
- Training on the provision of palliative care should be incorporated into the curriculum for all health care providers.

- Guidelines for home care services should include basic management of palliative care by family members and community volunteers.
- Training courses for family members and community volunteers can be organised and provided by health care workers at the community level.

In all of the above, symptomatic care and pain control using the full analgesic ladder should be incorporated.

APPENDIX

IPTG TOOLS

One of the purposes is: Local capacities strengthened to mitigate the psychosocial impact of HIV/AIDS in workplaces. (Activities to achieve this are:

- (a) Facilitate training of psychosocial teacher and children counselors for both adults and children.
- b) Facilitate Interpersonal Therapy for Groups (IPTG).

N.B

1. Schools and teachers being unique as compared to other communities and peasants have different attitudes, knowledge, responses to issues and view points, and different operations among others. So due to these differences suggestions are made in the ways to run the IPTG component in this project, and change some questions in tools/instruments to suit the school settings and teachers. E.g recommendations have been made to run the IPTG treatment for 16 meetings. This means one meeting per week, 4 meetings in one month, and 16 meetings in 4 months. This is a challenge with teachers because the terms in schools run for only 3 months, then schools break off for holidays. During holidays some teachers go for further trainings, visit relatives, go for other kinds of work, or to their homes or villages. There are also some days that meetings may be postponed due to major events or occasions hence making the 3 months tricky. So to solve this challenge a suggestion is made to compress these meetings to 3 months that is have two meetings in some weeks either at the beginning or towards the end, then once in some weeks. Because without a thoughtful plan it will mean skipping treatment for sometime which will not enable us achieve our goals. Further more if depression patients stayed for some time and may missed other important activities or events in their lives that can later worsen the depression or make them not fill helped in the IPT groups.

2. For the case of primary schools the number of teachers is between 6 & 13. This means there are possibilities of not getting a depressed teacher in a school or near by schools. There are also few secondary schools in some sub-counties meaning there are chances of getting few depressed teachers. So to bring about 8-10 teachers in different sexes who are depressed; together for treatment may mean making teachers travel a long distance to join the rest for the therapies. Also the facilitators may have to move to long distances to facilitate the groups due to this. Another factor is this project is being piloted in a wide area so there needs to be facilitation in terms of transportation to the IPTG group facilitators who are teachers and members of CBOs this means this may need a budget yet it would not be advisable to give money to teachers since these are there communities. There is also an important question incase the teachers are not given facilitation will they be able to move long distances to attend IPTG, how about the teachers who will be leaders or facilitators? All this is food for thought.

3. Another unique aspect is that since all the teachers are educated the therapy will be done in English and this makes any educated person to follow and be able to learn new issues, ideas and concerns that arise without many interpretations compared to local languages such as Luganda.

There is also a suggestion to put this functionality form in landscape so that all the words fit well under the cells or columns and rows.

Suggestions have been written in *Italics*:

FUNCTIONALITY FORM

**MEN
KU BASAJJA**

**ID NUMBER.....
Enamba yoyo Gw' obuza.....**

Activities	Level of difficulties met in Activities					Source / cause of the problem/ difficulty
Eky' okulola oba omulimu	Emitendera gy'obuzibu egiri mu bikolebwa					Awava obuzibu
	No problem sometimes	Little	Moderate	extreme	Not	
	Tewali possible	Butono	Busaamusaamu	Bunge		
	Oluusi					
	Tekisoboka					
A 01 Personal hygiene <i>(How do you compare your cleanness currently to the past)</i>	0	1	2	3	4	
Okwekuuma ng'oli muyonjo						
A 02 Cultivating & rearing animals	0	1	2	3	4	
Okulima emmere n'okulunda ebisoro						
A 02 B <i>Teaching only</i>	0	1	2	3	4	
<i>Kusomesa kwoka</i>						
A 03 Leadership in the family <i>(NB most teachers are single)</i>	0	1	2	3	4	
Obukulembeze mu maka						
A 04 Involvement in manual work	0	1	2	3	4	
Okukola n'emikono						
A 05 Planning for the family	0	1	2	3	4	

Okutekera tekera amaka						
A 06 Involvement in community development work (<i>or school development work</i>) Okwenyigira mu mirimu egy'okukulakulanya ekitundu kyo	0	1	2	3	4	
A 07 Attending village L.C meetings (<i>or attending school meetings</i>) Okwenyigira mu nkiiko	0	1	2	3	4	
A 08 Attending burial ceremonies in village (community) Okwenyigira mu kuziika ku kyalo	0	1	2	3	4	
A 09 Socializing with other people Okutabagana nabantu abalala	0	1	2	3	4	
A 10 Others (specify)..... Ebirara.....	0	1	2	3	4	

Some comments that came out when we tried to pre-test the instruments with the teachers:

A 01 For men: Teachers did not like hygiene question the way it is, some would ask “do you see me dirty especially in Luganda” so they would prefer further explanations. This is why there is a suggestion to frame the question to “*How do you compare your cleanness currently to the past*”

A 17 for Ladies, A 18 about Developmental work within the area (Some of the people who pre-tested the instruments (teachers inclusive) preferred the questions to be rephrased to school community e.g meetings, co-curricular activities among others)

Being school communities there was a suggestion to use both English and Luganda because different tribes of teachers teach in Mpigi schools, and for the case of those who are Baganda (native tribe) in case they did not understand some concepts well in English the Luganda version would be of help.

A 02 for men: there is a suggestion to ask “ do you have any other job/activities a part from teaching then the second question would be asked e.g Have you got difficulties in digging?”

The rest of the tools have been adapted as they are and they are below:

ATTENDANCE FORMS

To be completed each week (*each meeting/sitting*) and reasons for non attendance to be explained

Group facilitator:.....

Village Name (*suggestion for parish or sub-county name due to difficulty in getting recommended number of teachers for treatment within one village*).....

Participant name	ID number	Weeks 1-8 (<i>meeting 1-8</i>)	Other reasons for non attendance

Other notes:

Reasons for absence:

- S= Sick
- SF= Sick family member
- F= Funeral
- W= Work
- O= Other (explain in last column)

To be completed at the pre-group individual meeting.

IPTG GROUP MEETING NOTES

Member ID number_ _ _

Members Name_____ Date _____

Members Village (*parish, Sub-county suggested for discussion*) _____

Member's symptoms (Check all that apply)	Frequency	Duration
_____ Sadness	_____	_____
_____ Lack or loss of interest (Difficulty in thinking or making decisions)	_____	_____
_____ Appetite problems (weight gain or loss)	_____	_____
_____ Sleep problems (too much or too little)	_____	_____
_____ Feelings of guilt or worthlessness	_____	_____
_____ Tiredness or lack of energy	_____	_____
_____ Movements feel slow or fast	_____	_____
_____ Suicidal Member's problem area (trigger)	_____	_____

_____ Grief / death of a loved one

_____ Life change

_____ Disagreement what stage? _____ Renegotiation _____ Impasse _____ Dissolution

_____ Shyness / loneliness

Briefly explain the problem:

Member's goals (list one or two. These may change during the 16 weeks ("*Meetings/sittings*" *Suggested for discussion*))

During treatment leaders are to note weekly clinical status and problem status in this tool

Leader's Name

IPT POST GROUP SESSIONS

Date _____

Member ID Number _____

Member's Name _____ Village (*Parish / Sub-county*) _____

Session Number _____

Week Number (*meeting Number*) _____

Did the member attend this group session? _____ Yes _____ No

Did the member participate with the group today? _____ Yes _____ No

Depression symptoms that the member has this week (*meeting*). (Check to see if symptoms have changed from last week (*meeting*.) Check all that apply.

_____ sadness improved _____ got worse _____ stayed the same _____

_____ lack or loss of interest improved _____ got worse _____ stayed the same _____

_____ lack of or poor concentration improved _____ got worse _____ stayed the same _____

_____ appetite problems improved _____ got worse _____ stayed the same _____
(weight gain or loss)

_____ sleep problems improved _____ got worse _____ stayed the same _____
(too much or too little)

_____ feelings of guilt / worthlessness improved _____ got worse _____ stayed the same _____

_____ tiredness or lack of energy improved _____ got worse _____ stayed the same _____

_____ movements improved _____ got worse _____ stayed the same _____
(feel slow or fast)

_____ suicidal improved _____ got worse _____ stayed the same _____

What happened to the member during the week? Explain why symptoms improved/got worse:

IPT Supervisor Meeting Preparation Form

Date _____

For session Number _____ Week Number _____

Status of Each Group Member

Member's Name	Overall impression	Notes
	<input type="checkbox"/> improved <input type="checkbox"/> got worse <input type="checkbox"/> stayed same	
	<input type="checkbox"/> improved <input type="checkbox"/> got worse <input type="checkbox"/> stayed same	
	<input type="checkbox"/> improved <input type="checkbox"/> got worse <input type="checkbox"/> stayed same	
	<input type="checkbox"/> improved <input type="checkbox"/> got worse <input type="checkbox"/> stayed same	
	<input type="checkbox"/> improved <input type="checkbox"/> got worse <input type="checkbox"/> stayed same	
	<input type="checkbox"/> improved <input type="checkbox"/> got worse <input type="checkbox"/> stayed same	
	<input type="checkbox"/> improved <input type="checkbox"/> got worse <input type="checkbox"/> stayed same	
	<input type="checkbox"/> improved <input type="checkbox"/> got worse <input type="checkbox"/> stayed same	

List 3 problems or issues that you are having with your group that you would like to talk with your supervisor about:

- 1.
- 2.
- 3.

What are some of the personal challenges that you are experiencing?

Leader's Name

IPT GROUP TERMINATION NOTES

Member's Village (*parish/sub-county*) _____

Member ID Number _____

Date of last meeting attended _____

Date of termination discussion _____

Reasons for leaving the group:

.....
.....

At the end of the treatment the Leaders are to complete these forms to summarize the members' symptoms, change and process during the group

Review at treatment

Name of leader _____

Name of village (*parish/sub-county*) _____

Name of group member _____

QUESTIONS

The following are some questions about _____ (name)

During the 16 weeks (**16th meeting/16th sitting**) of group meetings, how much did the depression of _____ change?

____ became worse ____ stayed the same ____ improved

At what session did you begin to notice the change? Session No _____

During the 16 weeks (**16th meeting/16th sitting of the group**) of group meetings, how often did _____ discuss her / his problems with the group?

____ never ____ sometimes ____ almost every week

During the 16 weeks (**16th sitting /16th meeting of group**) of group meetings, how often did _____ use the suggestions of the group?

____ never ____ sometimes ____ all the time

During the 16 weeks (**16th sitting /16th meeting of group**) of group meetings, how often was _____ supportive of other group members?

____ never ____ sometimes ____ all the time

During the 16 weeks (**16th sitting /16th meeting of group**) of group meetings, when _____ disagreement with the group, did he / her tell the group?

____ yes ____ no

If yes, what did he / she say or do? _____

