Learning by Doing: Uganda’s AIDS Control Project Empowers Local Managers

by Joseph J. Valadez and Peter Nsubuga

Surveillance systems in Uganda detect that HIV prevalence declined from 21.1 percent in 1991 to 6.4 percent in 2001. The most common explanations for this decrease are that the population mobilized itself with the consequence that more people were faithful to their partners, or abstained from sexual contact, and used condoms during sexual intercourse (Low-Beer et al 2003). Although one might debate which of these behavior changes contributed most to the apparent reduction in HIV prevalence, no one would claim that Uganda can now become complacent about its HIV/AIDS programs. Quite the contrary. National HIV/AIDS Committees continue to have the responsibility for both covering their populations with the highest quality prevention, care, support, and treatment programs possible, and to improve them constantly.

While this mandate is clear, the process that managers can use to continually enhance programs is not well understood. What contributes to this challenge is that program quality can vary substantially from one area of a nation to another. Diverse geographical, cultural or logistical conditions contribute to this variation. Also, some areas may have had HIV/AIDS programs for several years, while in other areas programs are recently established. Due to these substantial differences, local managers should be in a better position to make decisions about how to make tactical changes to their programs than administrators stationed in a national capital. The people who are responsible on a daily basis for providing services are in the best position to analyze the challenges in their areas and to decide on the tactical changes.

What is Community Learning?

During 2003 the Global HIV/AIDS Monitoring and Evaluation Support Team (GAMET)—a unit of the World Bank’s Global HIV/AIDS Program—launched its Community Learning activities to equip local managers with tools to rapidly assess their program interventions and identify priority areas for improvement. GAMET offered training in tools that are suitable to be used at the local level by service providers, re-
quire a small amount of time to collect data, and produce information that is reliable and easy to interpret. GAMET promotes a “Learning By Doing” approach to program management. Such an approach is particularly needed to improve HIV/AIDS programs due to the immense variation in conditions that exits in a nation. By empowering local managers to guide their own programs, the assumption is that solutions can be tailored to specific local conditions.

Central to the Community Learning tool kit is a method called Lot Quality Assurance Sampling. LQAS is an old method, having been developed in the 1920s (Dodge and Romig 1944) as an industrial quality control method to assess industrial batch production (Reinke 1988, Valadez 1986 and 1991, Valadez et al 2002 and 2003 Robertson et al 1997). During the mid-1980s it was adapted to manage public health programs in developing countries.

The Ugandan experience

During September 2003 the Ugandan AIDS Control Project (UACP) on behalf of the Uganda AIDS Commission (UAC), with support from GAMET, was implemented to assess the current status of its programs. By September 30 districts were identified for assistance. For the initial assessment, UACP identified 19 of these districts to participate.

By mid-October all the District HIV/AIDS Committees (DHACs) had been contacted and agreed to participate. They recruited Civil Society Organizations in each county who identified at least 2 people to be trained in LQAS. The DHACs used the national census to identify villages targeted for HIV/AIDS program support. The UACP developed a set of six short questionnaires to collect information useful to program management, and translated them into six local languages. The six questionnaires were developed to survey small samples of: orphans, mothers of infants, youths, sexually active men and women, and people living with HIV/AIDS. The surveys were intended to provide information for key categories of HIV/AIDS Programs including: Prevention of Mother to Child Transmission, Voluntary Testing and Counseling, Home-Care, Prevention, Behavior Change, Care and Support of people affected and or infected with HIV.

The data collection in most cases took 5-days. A few locations required an additional day due to problems of rain and difficult roads. After that, the teams returned to the training venue in Mukono District to hand tabulate their data. One week later they presented preliminary findings to their own DHACs in their home districts. Soon after, the UACP organized three more workshops. The “Learning by Doing” approach was being successful and teams were becoming increasingly empowered to use Community Learning approaches.

Steering programs by making tactical change

Once the county teams analyzed their data, the information was aggregated to display the condition of the program within each of the districts that participated in the LQAS assessment. The LQAS assessment sampled villages some of which were targeted for HIV/AIDS programs and others that were not targeted. This stratification permitted comparisons. However, Figure 1 only displays mothers living in villages targeted by their district for HIV/AIDS programs. The figure is known as a radar-chart. The districts are arranged as though they were on the face of a compass. At the top of the figure are districts in the center of the country. Moving clockwise one finds districts to the East, Southeast, South, Southwest, West, Northwest, and North of Uganda. The figure is very revealing. Firstly, the black line shows that large proportions of women throughout Uganda report
they visited a clinic at least once during their pregnancy for Antenatal Care (ANC). This result suggests that women do have access to health facilities. However, the blue line, which depicts the proportion of women delivering babies in health facilities, varies considerably from one part of the country to another. In the center and eastern districts larger percentages of women deliver in health facilities. But as one moves towards the west, smaller proportions of women report they delivered their babies in health facilities. Notice how the line for the western and northern districts attenuates, moving closer to the center of the radar chart. A result such as this one suggest that managers in the western and northern portions of the country need to understand the barriers constraining women to deliver in facilities. Possibly, community outreach programs by clinically trained providers would increase the proportion of woman delivering with someone trained to provide an antiretroviral as well as emergency obstetric care if needed. This is another case in which local managers need to consult systematically with women in their areas to better understand the barrier that make HIV testing less acceptable to them.

A final example concerns people living with HIV/AIDS (PLWHA) (Figure 3). The data are aggregated at a national level. The LQAS data show that 78.3 percent of PLWA were ill during the last month and 94.5 percent of those who were ill sought medical care. This is an very positive evidence that treatment component of the Home Care program is functioning as PLWHA are counseled to see medical support whenever they are ill. Despite this positive sign the data also reveal portions of the program that need improvement. The data show that 41 percent of PLWHA are sexually active. However, as the figure reveals only 51 percent of men and 48 percent of women always used a condom. Twenty-four percent of men and 22 percent of women reported they never used a condom. These data show that not only are some PLWHA placing others at risk but they are also exposing themselves to re-infection.

Understanding problems

Another component of Community Learning is a diagnostic phase in which the UACP and the districts try to understand underlying reasons for the problems they detect. Let us consider the above-mentioned result, namely, that pregnant women are not taking an HIV test despite their knowledge of MTCT and counseling during ANC. The Uganda AIDS Control Project selected 9 districts throughout the country in which to carry out focus group discussions of mothers. As of this writing 5 districts had been visited—information from all visits indicate similar conclusions. Firstly, mothers seldom agree during one ANC visit alone to take a test. Several were required. This meant that more effective promotion of regular ANC visit alone to take a test. Several were required. This meant that more effective promotion of regular ANC visits was needed. Secondly, women reported that they needed social support. They were very concerned that if they were HIV positive they would have to disclose their status to their husbands. This, they feared, would result in them losing their marriage. They worry primarily for their unborn child; should the mother be cast adrift, then the child’s health and quality of life would be placed in jeopardy. Mothers recommended that husbands
be included in ANC counseling so that they participate in both counseling and testing simultaneously with the women. This finding is being studied in more detail in the districts and discussed locally. A similar finding resulted from interviews of PLWHA. They revealed that they did not use a condom so as not to disclose to their partners they were HIV+. With a regular partner they said it was not possible to use condoms unless they revealed their status. The next phase will be a strategic thinking workshop in which the district teams will come together and share their interpretations of the results.

A success story?

It may be tempting to look at Uganda as a success story; however, it may be a disservice to us all to do this. At this stage of the epidemic no one really knows what the propitious program model is that results in a decline in HIV prevalence. If we did, it would be replicated globally. The point of this article is that for now we define a success story as one in which managers are empowered to scrutinize their programs and courageously make tactical changes in an attempt to address their own conditions. The more managers are empowered to do just this, the greater the likelihood that we will be able to gather a set of lessons that can be built upon. Lessons are derived from local people working together to solve their own problems while being provided with the support they need. If local managers can do this, we consider the program to be on the road to success.

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References


