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PROJECT PERFORMANCE ASSESSMENT REPORT

UGANDA

SEXUALLY TRANSMITTED INFECTIONS PROJECT (CR. 2603-UG)

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Sector, Thematic and Global Evaluation Group
Operations Evaluation Department

Currency Equivalents
Currency Unit = Uganda Shilling (USh)

(as of March 9, 1994)	(as of February 15, 2005)
US$1.00 = 1282.9 Ush	US$1.00 = 1716.0 Ush
1.00 USh = US$0.00078	1.00 USh = US$0.00058

Abbreviations and Acronyms

ACP	AIDS Control Programme
AIC	AIDS Information Centre
AIDS	Acquired Immune Deficiency Syndrome
ANC	Ante-natal clinic
CAS	Country Assistance Strategy
CBO	Community-based organization
CSO	Civil society organization
CSW	Commercial sex workers
DANIDA	Danish International Development Agency
DFID	Department for International Development
DHS	Demographic and Health Survey
DHSP	District Health Services Pilot and Demonstration Project
GPA	Global Programme on AIDS
HIV	Human Immunodeficiency Virus
ICR	Implementation Completion Report
IDA	International Development Association
IEC	Information, Education and Communication
KfW	Kreditanstalt für Wiederaufbau
MAP	Multi-Country AIDS Program
M&E	Monitoring and evaluation
MoFPED	Ministry of Finance, Planning and Economic Development
MoH	Ministry of Health
NGO	Non-governmental organization
NOP	National Operational Plan for HIV/AIDS/STDs
NRM	National Resistance Movement
ODA	Overseas Development Association
OED	Operations Evaluation Department
PAPSCA	Program for Alleviation of Poverty and Social Costs of Adjustment
PCO	Project Coordination Office
PEAP	Poverty Eradication Action Plan
PEPFAR	President's Emergency Program for HIV/AIDS Relief
PLWHA	People living with HIV/AIDS
PPAR	Project Performance Assessment Report
SDR	Special Drawing Rights
SIDA	Swedish International Development Agency
SOMARC	Social Marketing for Change
STD	Sexually transmitted disease
STI	Sexually transmitted infection
STIP	Sexually Transmitted Infections Project
TB	Tuberculosis
UAC	Uganda AIDS Commission
UDHS	Uganda Demographic and Health Survey
UPDF	Uganda People's Defense Forces
USAID	United States Agency for International Development
WHO	World Health Organization

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About this Report

The Operations Evaluation Department assesses the programs and activities of the World Bank for two purposes: first, to ensure the integrity of the Bank's self-evaluation process and to verify that the Bank's work is producing the expected results, and second, to help develop improved directions, policies, and procedures through the dissemination of lessons drawn from experience. As part of this work, OED annually assesses about 25 percent of the Bank's lending operations. In selecting operations for assessment, preference is given to those that are innovative, large, or complex; those that are relevant to upcoming studies or country evaluations; those for which Executive Directors or Bank management have requested assessments; and those that are likely to generate important lessons. The projects, topics, and analytical approaches selected for assessment support larger evaluation studies.

A Project Performance Assessment Report (PPAR) is based on a review of the Implementation Completion Report (a self-evaluation by the responsible Bank department) and fieldwork conducted by OED. To prepare PPARs, OED staff examine project files and other documents, interview operational staff, and in most cases visit the borrowing country for onsite discussions with project staff and beneficiaries. The PPAR thereby seeks to validate and augment the information provided in the ICR, as well as examine issues of special interest to broader OED studies.

Each PPAR is subject to a peer review process and OED management approval. Once cleared internally, the PPAR is reviewed by the responsible Bank department and amended as necessary. The completed PPAR is then sent to the borrower for review; the borrowers' comments are attached to the document that is sent to the Bank's Board of Executive Directors. After an assessment report has been sent to the Board, it is disclosed to the public.

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Relevance of Objectives: The extent to which the project's objectives are consistent with the country's current development priorities and with current Bank country and sectoral assistance strategies and corporate goals (expressed in Poverty Reduction Strategy Papers, Country Assistance Strategies, Sector Strategy Papers, Operational Policies). *Possible ratings:* High, Substantial, Modest, Negligible.

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Efficiency: The extent to which the project achieved, or is expected to achieve, a return higher than the opportunity cost of capital and benefits at least cost compared to alternatives. *Possible ratings:* High, Substantial, Modest, Negligible. This rating is not generally applied to adjustment operations.

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Outcome: The extent to which the project's major relevant objectives were achieved, or are expected to be achieved, efficiently. *Possible ratings:* Highly Satisfactory, Satisfactory, Moderately Satisfactory, Moderately Unsatisfactory, Unsatisfactory, Highly Unsatisfactory.

Bank Performance: The extent to which services provided by the Bank ensured quality at entry and supported implementation through appropriate supervision (including ensuring adequate transition arrangements for regular operation of the project). *Possible ratings:* Highly Satisfactory, Satisfactory, Unsatisfactory, Highly Unsatisfactory.

Borrower Performance: The extent to which the borrower assumed ownership and responsibility to ensure quality of preparation and implementation, and complied with covenants and agreements, towards the achievement of development objectives and sustainability. Possible ratings: Highly Satisfactory, Satisfactory, Unsatisfactory, Highly Unsatisfactory.

Contents

Principal Ratings v

Key Staff Responsible v

Preface vii

Summary ix

1. Background and Context 1

HIV/AIDS Epidemic 2

Uganda's Response 3

World Bank Support for AIDS Control through 1995 5

Donor Support at the Time of Project Design 5

2. Objectives and Design 6

3. Implementation and Costs 10

Implementation Experience 10

Planned Versus Actual Costs and Financing 13

4. Outputs and Outcomes by Objective 14

Objective #1: To prevent sexual transmission of HIV 15

Objective #2: To mitigate the personal impact of AIDS 22

Objective #3: Institutional Development 23

5. Ratings 25

6. Lessons and Challenges 30

References 35

Annex A. Basic Data Sheet 39

Annex B. Persons and Organizations Consulted 41

Annex C. Timeline of events for HIV/AIDS in Uganda 44

Annex D. STI Project Support: Planned vs. Actual by Component/Subcomponent 54

This report was prepared by Denise Vaillancourt, who assessed the project in January 2005. The report was edited by William B. Hurlbut. Pilar Barquero prepared the graphs and tables and provided administrative support.

Annex E. Project Cost and Financing 60

Annex F. Project Outcomes by Objectives and Targets 62

Annex G. Trends in Program Outcomes 65

Boxes

Box 1. National Operational Plan for HIV/AIDS/STDs Prevention, Care and Support for 1994-1998.......... 4
Box 2. Donor Support to HIV/AIDS and Health in the Early 1990s:.......... 6
Box 3. HIV/AIDS Control Project.......... 33

Tables

Table 1. Planned Versus Actual Costs by Component (US$ million equivalent) 14
Table 2. Summary OED Ratings by Objective.......... 25

Figures

Figure 1. Reported AIDS cases by year for the period 1983-2001.......... 3
Figure 2. Share of adults that knows HIV can be avoided by using a condom, 1995, 2000.......... 16
Figure 3. Proportion of young people (15-19 years) who have never had sex 17
Figure 4. Annual sales of socially marketed condoms in Uganda (millions of units) 18
Figure 5. Share of population who used a condom at last sex with a non-regular (non-marital, non-cohabitating partner), 1995, 2000 19
Figure 6. Share of all men and women reporting STD or STD symptoms, who sought treatment or advice (any source).......... 20
Figure 7. HIV Prevalence at ANC sentinel surveillance sites, 15-19 year olds. 21

Principal Ratings

	ICR	*ICR Review**	*PPAR*
Outcome	Satisfactory	Moderately Unsatisfactory	Moderately Unsatisfactory
Sustainability	Likely	Not evaluable	Likely
Institutional Development Impact	High	Substantial	Substantial
Bank Performance	Satisfactory	Unsatisfactory	Satisfactory
Borrower Performance	Satisfactory	Satisfactory	Satisfactory

* The Implementation Completion Report (ICR) is a self-evaluation by the responsible operational division of the Bank.

Key Staff Responsible

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Preface

This is the Project Performance Assessment Report (PPAR) for the Sexually Transmitted Infections Project in Uganda. This project was financed through IDA Credit No. 2603 in the amount of US$50.0 million equivalent (36.3 million SDR) with a planned government contribution of US$7.4 million, projected co-financing by KfW and the Government of Sweden in the respective amounts of US$6.8 million and US$5.0 million, and parallel financing by ODA in the amount of US$4.2 million for a total cost of US$73.4 million. The credit was approved on April 12, 1994, became effective on July 22, 1994, and closed on December 31, 2002 after extensions totaling two years. The credit was 99 percent disbursed.

The findings of this assessment are based on an Operations Evaluation Department (OED) mission to Uganda carried out in January/February 2005. The mission met in Kampala with authorities and staff of the Uganda AIDS Commission; the Ministry of Health; other public sector agencies implementing HIV/AIDS activities; Marie Stopes International, other NGOs contracted under the project and other representatives of civil society; and bilateral and international partners. The mission also visited selected facilities, institutions and community-based projects in the districts of Mukono, Soroti and Ntungamo, interviewing public sector and civil society actors and beneficiaries. Key documentary sources consulted include: (a) World Bank project files; (b) project-related reporting and evaluation; and (c) epidemiological data, studies and research on HIV/AIDS, much of it generated in Uganda.

This PPAR is one of several conducted on the “first generation” of the Bank’s HIV/AIDS projects, as background for a larger OED evaluation of the development effectiveness of World Bank’s assistance for fighting the AIDS epidemic. In light of that purpose, relatively more material has been presented in this “enhanced” PPAR than is the OED standard.

This report draws heavily on the technical reports and inputs of mission members Sebastian O. Baine and Simon Kasasa, both of the Institute of Public Health, Makerere University. The OED team gratefully acknowledges all those who made time for interviews and provided documents and information.

Following standard OED procedures, copies of the draft PPAR were sent to the relevant government officials and agencies for their review and feedback. However, no formal response was received

Summary

The objectives of the Sexually Transmitted Infections Project (STIP) were to: (a) prevent sexual transmission of HIV; (b) mitigate the personal impact of AIDS; and (c) support institutional development to manage HIV prevention and AIDS. The project was placed under the responsibility of the AIDS Control Program (ACP) of the Ministry of Health (MoH) and designed to support Uganda's new (1993) decentralization policy, giving health districts the responsibility for preparing, overseeing and monitoring the implementation of HIV/AIDS annual action plans, in collaboration with public sector and civil society actors. Project implementation was constrained by the lack of Government counterpart financing, weak procurement capacity, and, in the early years of implementation, weak management capacity at the district level and delays in financial flows to the districts.

The first AIDS cases were identified in Uganda in 1982. At the time of project design in 1993 HIV prevalence in Uganda was estimated at 15 percent of adults, up from about 9 percent in the late 1980s, with higher levels in urban areas; and cumulative AIDS cases were estimated to be on the order of 163,000. In 1985 Government established a National Committee for the Prevention of AIDS. When the National Resistance Movement came to power in 1986 under the leadership of Yoweri Museveni, a new momentum in the fight against AIDS in Uganda emerged, characterized by strong political leadership and official candor in discussing the problem and its potential impact, both nationally and internationally. The ACP was established that same year to monitor and contain the response; and civil society was active in responding to the crisis.

Prior to the STIP, the First Health Project (Credit 1934-UG), approved in FY88, also supported HIV/AIDS activities. In 1990 the World Bank launched an assessment of Uganda's AIDS epidemic and its social and economic consequences with a view to intensifying its dialogue and support. In 1993 a National Operational Plan for HIV/AIDS/STDs was approved that emphasized prevention, care and support, and surveillance. It received the support of multiple bilateral and international partners. The STIP (FY94) was conceived to complement such support.

Prevention. The project's intention to set realistic prevention targets in the first year of implementation, on the basis of solid baseline data, was never realized. The STIP has contributed to improvements in knowledge on how to prevent HIV transmission and to the adoption of safer behavior among the general population. Over the project life the share of 15-19 year olds who have never had sex increased and indicators on condom knowledge, availability and use showed positive trends. The share of women and men reporting the use of condoms during last sex with a non-regular partner increased during 1995-2000 from 20 to 38 percent for women and from 36 to 59 percent for men, with the greatest gains among rural residents. However, levels of condom use are still low. The project invested in behavior change interventions aimed at some high-risk groups identified during project design, but they were inadequate relative to the need, coverage was limited, and there was no systematic tracking of outcomes within these groups. While the project may have stimulated increased knowledge and awareness of sexually transmitted diseases (STD) and did invest in treatment and counseling services, there is no evidence of significant improvements in care-seeking behavior or in actions to inform and protect partners of those suffering with STDs. Declines in HIV prevalence in the 1990s are often cited as the measure of the success of Uganda's HIV/AIDS program, but these declines are attributable in part to significant AIDS mortality during the early 1990s. There are, however, indications that decline in HIV incidence (rate of new infections) was also a factor. HIV prevalence rates among pregnant women aged 15-19

(a group with low mortality in which HIV prevalence is a good proxy for incidence) declined in the early 1990s and, during the life of the project, gradually leveled off.

Mitigation. Project assistance expanded and supported community-based care and social support for people living with HIV/AIDS and their families. However, data were never collected to measure the impact of this assistance. Procurement of drugs for opportunistic infections and training of service providers in palliative care have modestly improved these services. However, low availability of qualified health personnel in peripheral health facilities and sporadic availability of drugs compromised the potential impact of this support. Expansion of support for tuberculosis control in selected districts did not result in an increase in the treatment success rate.

Institutional Development. The STIP significantly strengthened the capacity of districts to undertake strategic planning and management of activities supporting the fight against HIV/AIDS and to manage resources. The project strengthened the capacity of the ACP/MoH to manage and oversee HIV/AIDS activities carried out by a multiplicity of public and civil society actors. The project succeeded in further expanding national capacity for HIV/AIDS program implementation by encouraging and supporting the involvement of experienced non-governmental organizations (NGOs) and community-based organizations (CBOs) in the planning and implementation of key activities. A total of 935 NGOs/CBOs carried out one or more subprojects covering all districts in Uganda. However, research on the cost-effectiveness of HIV/AIDS interventions and monitoring and evaluation were not carried out as planned.

Ratings. The outcome of the STIP is rated moderately unsatisfactory overall, based on moderately unsatisfactory outcomes of the prevention and mitigation objectives, and a satisfactory outcome of the institutional development objective. Institutional development is rated as substantial; and sustainability is rated as likely. The Bank's performance and the Borrower's performance were satisfactory.

Lessons

- Political commitment is a strong catalyst for mounting a broad-based national response to the HIV/AIDS epidemic. It also influences program content. In this case, sensitive to the convictions of religious groups and other facets of civil society, the promotion of condoms and support to marginalized high-risk groups received only modest support from the government and their potential was not fully realized.
- Even if it is provided for in project design, monitoring and evaluation will not be carried out if the incentives are not right. The setting of appropriate targets requires (a) knowledge of the right measures of success; and (b) baseline data.
- Failure to implement research on the cost-effectiveness of various interventions is a missed opportunity to learn from experience and to enhance program impacts.
- Reliable provision of relevant supplies (such as condoms and drugs for the treatment of STDs, tuberculosis and opportunistic infections) is critical to the successful implementation of HIV/AIDS programs.

Nils Fostvedt
Acting Director-General
Operations Evaluation

1. Background and Context

1.1 This section provides a brief overview of national political events, development challenges, key landmarks in the HIV/AIDS epidemic and in Uganda's response, and the support of the World Bank and other donors to this effort. More detail is found in Annex C which presents a timeline of events.

1.2 As of 2003 Uganda had a population of about 25.3 million, growing at an annual rate of 2.7 percent (World Bank World Development Indicators 2005), of which more than one third was living below the poverty line (MoFPED 2005). Uganda's human development indicators have lagged behind its good economic performance in the 1990s, a remaining consequence of political and economic turmoil of the 1970s and early 1980s. Recent efforts in the education sector have increased net primary enrollment to 86 percent of which 49.4 percent are girls. Despite health system reform and investment, infant and child mortality rates remain high at 88 and 150 per 1000 (MoFPED 2005), respectively. Maternal mortality fell only slightly from 523 to 504 per 100,000 live births, and fertility has remained high at 6.9 children. Life expectancy at birth is low at 42 years, having declined from an estimated level of 49 years in the late 1980s and early 1990s (Armstrong 1995). Poor health status is attributable to the prevalence of communicable, preventable disease, low access to clean water and sanitation services, poverty and inequalities (across income, place of residence and gender) in access to information and services. There has been little improvement in children's nutritional status since 1995.[1]

1.3 After independence in 1962 and throughout the 1960s Uganda showed great potential as one of the strongest economies in Sub-Saharan Africa. However, its performance was set back considerably during the subsequent periods of military rule (1971-79) and civil war (1980-1985). In 1987 the new National Resistance Movement (NRM) government under the leadership of President Yoweri Kaguta Museveni launched a recovery program to restore financial stability, create conditions for rapid and sustained growth, and develop human capital. It also embarked on policy and institutional reform to deregulate the economy, eliminate direct state involvement in all but essential public services, and improve institutional efficiency. These efforts put Uganda on a path of recovery, but progress was slow through the early 1990s.

1.4 In 1996 Museveni was elected as Head of State in the first Presidential election under the new Constitution ratified in 1995. This new government sought to enhance the poverty focus of national development objectives and policies. To this end it set out to maximize growth, increase domestic resource mobilization, improve public sector management (through decentralization,[2] civil service reform, and efficient allocation and use of resources), promote private sector development, and protect the environment. Substantial progress in social and economic development has been made in the 1990s, including: economic growth averaging 6.5 percent per

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1. According to MoH 2003 statistics, 38.8 percent of children were stunted in 1995; and the 2000 level of 38 percent reveals virtually no change.

2. Decentralization law ratified in 1993.

year since 1992, improvements in quality and access of basic social services, and a notable fall in income poverty. However, income poverty has recently risen from 34 percent in 2000 to 38 percent in 2003, inequality has increased,[3] and conflict persists in the north. Government's most recent Poverty Eradication Action Plan (PEAP 2004/5 – 2007/8) cites four core challenges: the restoration of security and improving regional equity; sustainable growth in the incomes of the poor; human development; and using public resources transparently and efficiently to eradicate poverty.

1.5 The existence of formal civil society associations (CSOs) dates back to colonial rule, during which time they were established to promote economic and social interests of various groups and to resist colonial oppression and exploitation.[4] Colonial-era CSOs also included welfare and charitable organizations such as national branches of the Red Cross Society, the Salvation Army, and other European-based organizations. However, during the dictatorships of Idi Amin and Milton Obote (1966-86), associational life in Uganda was severely repressed.

1.6 The establishment of the NRM Government in 1986 enabled a revival and rapid growth of CSOs. As of 2002 there were over 2000 registered NGOs in Uganda, and many more (unregistered) CBOs and other informal groups. NGOs and CBOs represent a broad and diverse range of constituencies, motivations, roles and mandates, encompassing: promotion of group interests, service delivery, advocacy, community development, culture and religion, networking and information dissemination. They are increasingly consulted in policy formulation and in monitoring public expenditure at the district level, but need to further develop capacities in these areas. Additionally, they are heavily concentrated in and around Kampala.

HIV/AIDS Epidemic

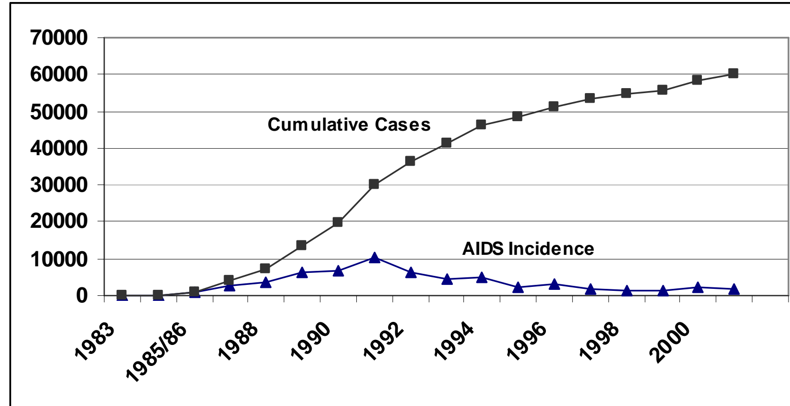
1.7 **AIDS Cases and Mortality.** The first AIDS cases were identified in Uganda in 1982 in Rakai district on the shores of Lake Victoria. By 2001 a total accumulation of 60,173 AIDS cases had been reported. The number of reported AIDS cases peaked in 1991 and declined thereafter (Figure 1).[5] While reported AIDS cases provide indication of trends over time, they do not provide an accurate picture of the actual number of AIDS cases in Uganda, estimated to be considerably higher. It is also important to note that AIDS cases represent HIV infections that occurred in the previous decade.

3. The Gini coefficient rose from 0.35 in 1997/98 to 0.43 in 2003. (Source: Ministry of Finance, Planning and Economic Development 2005).

4. This section drawn from Thue and others, July 2002.

5. While 38,500 cumulative AIDS cases had been officially reported as of December 1992, it was estimated that this figure represented a significant underreporting of the situation and that a more accurate estimate for 1992 would be on the order of 163,000 (Armstrong 1995).

Figure 1. Reported AIDS cases by year for the period 1983-2001



Source: Ministry of Health 2003a

1.8 According to MoH estimates, as of 2001 there have been a total of 947,552 AIDS deaths since the beginning of the epidemic. AIDS has had a significant impact on adult mortality, taking the lives of the most productive segment of Uganda's population, and on life expectancy, which has declined from 49 in 1993 to 42 today. In the absence of the HIV/AIDS epidemic, life expectancy was projected to increase to about 55.5 years by 2013 (Armstrong 1995).

1.9 **HIV Prevalence and Incidence.**[6] At the time of project design HIV prevalence in Uganda was estimated to have increased from about 9 percent of adults in the late 1980s to about 15 percent by 1993, with higher levels of infection in urban areas. However, the momentum of the epidemic in rural areas was of concern.[7] Women were thought to be infected at an earlier age than men, based on average ages of women and men with AIDS (28 and 32 years old, respectively). Furthermore, in 1993, women were 1.3 times more likely to be infected by men, based on estimated HIV prevalence rates among women and men of 15.8 percent and 13.7 percent, respectively. While sexual transmission was known to be the primary mode of infection, perinatal transmission was also acknowledged to be a risk factor.

Uganda's Response[8]

1.10 The timeline in Annex C highlights the main decisions and actions taken by the Government of Uganda to address the HIV/AIDS epidemic. The year the NRM took power (1986), President Museveni spoke openly and frequently about the epidemic. He encouraged all nationals to be aware and practice safe behavior, particularly to practice abstinence and fidelity. However, he initially took a stance against promoting the use of condoms (UAC 2004b). In May 1986, the Minister of Health announced to the World Health Assembly in Geneva that there was AIDS in

6. Data on this section drawn from Armstrong 1995.

7. For example, in one predominantly rural district (Rakai) in southwest Uganda, the incidence of new infections between 1989 and 1990 was found to be over 3 percent (Armstrong 1995).

8. This section is limited to Government's reponse up until 1994. Its efforts during project implementation (1995-2002) are discussed in Chapters 3 and 4, and ongoing efforts are highlighted in Chapter 6.

Uganda and appealed to the international community for their support. With the establishment of the AIDS Control Programme (ACP) within MoH later that year, information, education and communication (IEC) activities, surveillance, blood safety and prevention of infection in health facilities were launched. The support and involvement of other national partners, including international and indigenous NGOs and other sectors (notably Ministry of Defense) were mobilized. In 1991 the President relaxed his stance against the use of condoms and endorsed a policy of "silent promotion" of condoms. That year social marketing of condoms was launched,[9] but many religious organizations and leaders in Uganda remained opposed to the promotion of condoms.[10]

Box 1. National Operational Plan for HIV/AIDS/STDs Prevention, Care and Support for 1994-1998

Objective:

- to prevent HIV infection and to mitigate the adverse health and socio-economic impact of the HIV/AIDS epidemic.

Components:

- *Prevention* of sexual transmission (IEC, provision of condoms, early diagnosis/treatment of sexually transmitted diseases - STDs) and of transmission in health care settings (safe blood and safety precautions to prevent infections)
- *Care and support for persons living with HIV/AIDS (PLWHA)* focusing on home-based care w/ appropriate support from health care facilities and for those affected
- *Surveillance*: to monitor HIV transmission, STDs and related drug resistance and TB

Strategic Features:

- Expansion of activities to be nationwide in coverage and multisectoral in scope
- Decentralization of the planning and management of activities to the district level and of implementation to the sub-county and village/community levels
- Community mobilization to encourage resource mobilization and action at the local level in prevention and mitigation
- Intensification of partnerships with NGOs in line with their comparative advantages, especially their ability to interface with communities

1.11 In 1992 the Uganda AIDS Commission (UAC) was established under the Office of the President to respond to an emerging consensus for a multisectoral approach in addressing the epidemic. Also in 1992, the ACP was merged with the Sexually Transmitted Disease (STD) program.[11] In 1993 a National Operational Plan for HIV/AIDS/STDs Prevention, Care and Support for 1994-98 was developed through a widely participatory process and adopted (Box 1). In 1994 a number of other Ministries established AIDS control units.[12] However, HIV/AIDS efforts were not yet decentralized; and governmental and non-governmental efforts were uncoordinated and sprinkled across many organizations and projects.

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9. Social marketing of condoms remained very modest prior to the support provided by the STIP. In 1993 under 2 million condoms were socially marketed in Uganda by a condom social marketing NGO (SOMARC) with USAID Support.

10. During his visit to Uganda in 1993, Pope John Paul II stated that "…self control and chastity are the only sure ways to end the tragedy of AIDS" (Catholic World News 2004).

11. STD Program activities at the time were weak and limited in scope and coverage. They did not include counseling or provision of condoms.

12. Ministries of Agriculture, Gender, Education, Internal Affairs, Justice, Finance, Public Service and Local Government (UAC 2001).

World Bank Support for AIDS Control through 1995

1.12 *Country Assistance Strategy.* The primary objective of the Bank's strategy for Uganda in the 1990s was to reduce poverty through efforts to: maximize labor-intensive economic growth, strengthen economic and social infrastructure, support human resource development, enhance the provision of public services, and measure effectively changes in poverty over time (World Bank 1995). Among the highest priorities of this strategy were improvements in health and education. Support to health sector development emphasized primary and preventive care, decentralization, and HIV/AIDS (see para. 1.13). While lending for health and HIV/AIDS was initially conceived under one project design in the early 1990s, it was decided to split them into two separate operations to accelerate the availability of financing for HIV/AIDS, which was considered urgent.[13]

1.13 *Non-Lending Support.* In 1990 a World Bank mission visited Uganda to assess the nature and momentum of the AIDS epidemic and its social and economic consequences with a view to intensifying its dialogue and support.[14] Additionally, in 1993 a social sector strategy was published, highlighting again AIDS as a major threat to Uganda's development objectives.[15]

1.14 *Lending.* The World Bank provided early lending and non-lending support to Uganda in its fight against HIV/AIDS. The First Health project (approved by the Board in June 1988, declared effective in January 1989, and closed in March 1996 after seven years of implementation) financed awareness raising, AIDS prevention messages, and the development of a program for counseling and patient management for people infected with HIV. The Program for Alleviation of Poverty and the Social Costs of Adjustment (PAPSCA) (1990-1995) financed a component to support widows and orphans in Rakai, Masaka and Gulu districts. The experience of this project, the first Bank operation which supported substantial involvement of NGOs in social service delivery, pointed to the important role of NGOs in the implementation and facilitation of social support.[16]

Donor Support at the Time of Project Design

1.15 Numerous international donors were active in AIDS control in Uganda in the early 1990s (Box 2). In addition, the European Union, DANIDA, SIDA, Italy, KfW, Austria, the UK, and the African Development Bank were providing health sector financing. Direct support to HIV/AIDS efforts provided by WHO/GPA was running out in the mid-1990s. Despite other assistance provided by USAID, UNDP and

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13. A health and HIV/AIDS operation was initially identified as the Community Health and AIDS Project (CHAP) in the early 1990s, but later split into (a) the STIP; and (b) the District Health Services Pilot and Demonstration Project (DHSP), approved on February 7, 1995..

14. Armstrong 1995.

15. World Bank 1993.

16. Operations Evaluation Department 1997.

UNICEF, critical gaps persisted, especially in areas of provision of condoms and drugs for treatment of STDs.

Box 2. Donor Support to HIV/AIDS and Health in the Early 1990s:

Agency	Areas of Intervention
WHO/GPA:	One of the main financial supporters of the ACP, primarily in areas of IEC, epidemiological surveillance, blood safety, laboratory strengthening, patient care and STD control, program management assistance; support to UAC Secretariat.
WHO	HIV vaccine trials to be launched
UNDP	Support for UAC Secretariat; support of small, community-based projects (AIDS education and counseling, orphan support, and care of PLWHA)
UNICEF	Support to MoH and Ministry of Education to support the Health Education Network, prevention of HIV infection among youth, especially young women; support to UAC Secretariat,
USAID	Support to 10 districts to reduce HIV transmission and fertility (IEC, VCT, STD diagnosis, but no substantial condom and STD drugs provision); support to UAC Secretariat, support to primary health care.
EU	Support to national blood bank, and strengthening of health service delivery in 8 districts
DANIDA (Denmark)	Financial and technical assistance for essential drugs provision, including support to Central Medical Stores
SIDA (Sweden)	Substantial support to STI program through GPA, UNICEF and World Bank (cofinancing of first Health Project [US$6.5 million] and support for preparation of District Health Services Project).
Italy and KfW	Support of National TB and Leprosy program in 22 districts; commodity support for STD services
Austria	Co-financier of First Health Project: US$10.4 million
UK	Support to health service delivery
AfDB	Construction/rehabilitation of rural health infrastructure

Source: World Bank 1993 and 1994.

2. Objectives and Design

2.1 The Sexually Transmitted Infections Project was financed through an IDA credit of US$50.0 million equivalent[17], approved on April 12, 1994, and a planned government contribution of US$7.4 million. The time between start of preparation and credit effectiveness was 13 months.[18] Cofinancing by KfW and SIDA in the respective amounts of US$ 6.8 million and US$ 5.0 million and parallel financing by ODA in the amount of US$4.2 million brought the total estimated project cost to US$73.4 million.[19] This first free-standing HIV/AIDS/STD project in Uganda became effective on July 22, 1994.

2.2 **Objectives and Targets.** In support of Uganda's National Operational Plan (Box 1), the project objectives were to: (a) prevent sexual transmission of HIV; (b) mitigate the personal impact of AIDS; and (c) support institutional development to manage HIV prevention and AIDS. Key program targets provisionally set during

17. All US$ amounts represent the US$ equivalent of SDRs or other currencies.

18. The project was prepared as a standalone operation in June 1993, appraised in November 1993, negotiated in February 1994, approved on April 12, 1994, and declared effective on July 22, 1994, a year ahead of the District Health operation, which became effective on July 17, 1995.

19. Over and above cofinancing and parallel financing, WHO and USAID agreed to provide technical assistance and training to support project efforts.

project design (all of them associated with the prevention objective), were: the ability of 50 percent of the target population[20] to cite at least two acceptable ways of protecting themselves from HIV; a 50 percent increase in reported condom use among this population; a 20 percent decrease in sex with non-regular partners; and an increase of appropriate STD case management to 70 percent of those seeking care. Project design documents noted that activity and impact targets were provisional and would be updated and rendered more realistic during the first year of the project, during which time baseline information on all indicators would be collected and analyzed.

2.3 **Components.** Project components were articulated around the project's three objectives, briefly presented below (with estimated costs at appraisal). A more detailed inventory of planned inputs is presented in Annex D.

2.4 *Prevention of sexual transmission of HIV* (US$37.7 million or 51 percent of total project cost). This component was conceived to support (a) ***the promotion of safer sexual behavior*** through the design and implementation of countrywide awareness programs disseminated through public and private radio stations, newspapers, drama, films and shows, educative documentaries, as well as through the strengthening of district capacity with investments in training and in audiovisual and other logistical equipment. The content of these messages would be coherent with national IEC strategy, which promoted a range of safer behaviors (abstinence, fidelity, use of condoms during high-risk sex, early and appropriate use of STD services).[21] Promotional activities were targeted to (i) the general population, with a special effort to reach and involve the less-informed rural communities through community mobilization activities; and (ii) specific high-risk sites and target populations[22] through contracts with experienced NGOs and CBOs; (b) ***the provision of condoms and the promotion of their utilization*** through the procurement of 425 million condoms.[23] Some condoms were to be distributed to populations free of charge through public health facilities, NGOs and CBOs (for low income, high-risk groups) and other public agencies (for military, police and prisons). Others were to be socially marketed through contracts with specialized agencies for this purpose; (c) ***the promotion of STD care seeking behavior*** (incorporated into above-mentioned IEC activities); and (d) ***the provision of effective STD care*** through the financing of STD drugs and training of health care providers.

2.5 *Mitigation of the personal impact of AIDS* (US$24.2 million or 33 percent of total project cost). This subcomponent was designed to support: (a) ***provision of support for community and home-based health care and social support for people living with HIV/AIDS (PLWHA)***. Services provided to AIDS patients were to be incorporated into district health plans, and carried out by experienced NGOs and

20. Adults 15-49 years of age.

21. Interviews with numerous actors in the ACP and MoH 1994.

22. Target groups cited in project design documents included: adolescent girls, professional sex workers, truck drivers, military, police, migrant workers, slum dwellers, among others (not specified).

23. During the first year of the project this estimate was revised downward to 200 million, following a more in-depth assessment of needs carried out by the ACP with technical assistance.

CBOs. They would include: drugs for opportunistic infections, supplies for AIDS care, training of counselors and delivery of counseling services and social support; (b) ***provision of drugs against opportunistic infections and staff training*** to improve response to the medical, emotional and social needs of the patient; (c) ***provision of clinical and protective supplies*** needed for delivery of STD, tuberculosis and maternal and child health and family planning (MCH/FP) services to prevent transmission of HIV in health-care settings; and (d) ***diagnosis and case management of tuberculosis***, with an emphasis on the provision of an adequate supply of drugs to enable prompt treatment of TB cases, upgrading of the reference laboratory and supply of diagnostic equipment.

2.6 *Institutional development* (US$11.5 million or 16 percent of total project cost). Consistent with national decentralization policy,[24] support under this component aimed at: (a) ***strengthening district capacity to plan, manage, monitor and implement HIV/AIDS activities*** through the provision of technical assistance, technical and managerial training (on-the-job and fellowships), materials, equipment and other resources and supplies for local-level coordination, supervision and resource management; (b) ***strengthening of national capacity*** to enable the ACP to provide training, technical oversight and support to guide district-level program implementation and to strengthen the STD Reference Center at Mulago Hospital (national referral hospital), through the financing of technical assistance, training, materials, equipment, logistics and other related recurrent costs; (c) ***supporting NGO/CBO initiatives to develop and try out new approaches to prevention targeted at special populations*** (especially out-of-school youth, rural women, commercial sex workers [CSW] and their clients); (d) ***strengthening of HIV, STD and TB surveillance, especially at the district level*** through the design of forms, and the financing of local training, office supplies, testing kits, local consulting services and vehicle running costs. At the time of project design, there were no plans to increase the number of ANC sentinel surveillance sites to improve coverage. Emphasis was instead placed on improving the accuracy and reliability of existing sites, which were considered to be strategically located; (e) ***operational research*** to assess and improve the effectiveness of interventions supported by the project; (f) ***monitoring and evaluation*** of project interventions, including: the establishment of baseline data on key indicators and, on this basis, the setting of realistic targets, the tracking and analysis of indicators at the district level; epidemiological surveillance of HIV, STDs, and TB; behavioral surveillance through special surveys; operational research to assess/improve the effectiveness of interventions; routine supervisory visits and reports to IDA; periodic reviews, especially an in-depth mid-term review and a final evaluation at completion; and the use of data and results in planning and decision-making; and (g) ***project coordination and management*** (salaries, technical assistance, equipment, material, logistical support and other running costs).

24. A Decentralization Bill was passed by Parliament in 1993, which transferred control of most Government services from central ministries to district governments, including significant changes in the allocation and management of public resources and in the distribution of roles and responsibilities between central and district-level government. (World Bank 1994 b [DHSP SAR])

2.7 **Implementation Arrangements.** No new institutions were created under this project. It was placed under the auspices of the MoH, with the Permanent Secretary named as Project Director in charge of coordination and implementation. The option of assigning responsibility for project management to the UAC Secretariat was considered. However, MoH was believed to have stronger capacity, especially in light of experience gained under the First Health Project. The AIDS Control Program (ACP) within MoH was responsible for the technical aspects of the project, including the provision of technical support to the districts. An intersectoral Project Steering Committee, including representation of the UAC and other national and international partners, was established as an advisory body to the implementing parties.[25]

2.8 In support of Uganda's decentralization policy and to achieve greater involvement and coverage at the local level, the bulk of project activities was envisaged to be implemented through district-level organizations, community groups and NGOs. A particularly innovative feature of project design was the disbursement of project funds under the Special Account to districts to support the implementation of HIV/AIDS plans that integrate activities of government and civil society actors (NGOs/CBOs). The District Medical Officer (DMO), supported by the District Health Team (DHT), had primary responsibility for the planning, coordination and oversight of project activities and implementing agencies, through a process of participatory design, planning, supervision and reporting. In line with the vision of the NOP, the project design provided for a phased approach to district support and implementation, with 8 districts supported in the first year, an additional 14 in the second year, and all districts supported by the third year. The National Medical Store was assigned responsibility for procurement of commodities, for which a detailed procurement plan had been available at the time of approval. The finalization of a project implementation manual was a condition of effectiveness.

2.9 *Involvement of NGOs/CBOs.* In support of national policies on decentralization and fuller utilization of the non-governmental sector, also reflected in health sector policy[26], the project envisaged the involvement of NGOs and CBOs in project implementation. The intention was to utilize more fully and to expand civil society's strong links with communities and demonstrated skills and experience in the provision of care, counseling and support to those afflicted and affected. At the district level, NGO involvement was to be defined in district work plans and a Memorandum of Understanding (MoU) between the NGOs/CBOs and the districts would frame the terms of the collaboration, defining the roles and obligations of each party, as well as the outputs expected. It was envisaged as well that at the central level MoH would contract out project implementation tasks to NGOs, also to be

25. This committee included representatives from the MoH (Director of Medical Services, Commissioner for Health Planning, Commissioner for Health Promotion, Commissioner for CDC/AIDS, Commissioner for Curative Services, ACP Manager, Director of National Medical Stores), Ministry of Local Government, Ministry of Finance and Economic Planning, UAC Secretariat, Ministry of Information, NGO community, UNICEF, WHO, USAID, and the STIP Coordinator (World Bank 1994a).

26. Government's "White Paper on Health Policy," approved by the Cabinet in November 1993, encouraged the full exploitation of the comparative advantages of the public and private sectors and assigned districts a primary role in the planning, management, oversight and implementation of health sector activity.

defined and managed by MoU. The purchase and social marketing of condoms is a case in point.

2.10 *Project Coordination* was the responsibility of a Project Coordinating Office (PCO), headed by a Coordinator, and composed of a small staff including experts in evaluation, accounting/financial management and procurement and auxiliary personnel.[27] The PCO was attached to the Office of the PS (Project Director) and it was envisaged that the Project Coordinator would work in close cooperation with the Program Manager of the ACP. The main role of the PCO was to facilitate and coordinate project implementation and to ensure fulfillment of the administrative and fiduciary requirements of IDA.

2.11 **Risks.** The main risks identified during project design were: a continued, rapid increase in HIV infection that may overwhelm program efforts; inadequate experience and capacity of health services to implement STD screening and prevention; weak condom promotion because of Government's continued (albeit declining) sensitivity; inadequate capacity of the ACP to coordinate and oversee project efforts; and the difficulty of achieving behavior changes. Actions to mitigate these risks included: ensuring that program efforts were inclusive, cost-effective and accelerated; intensified capacity building through training, supervision and technical assistance; the contracting out of social marketing of condoms to the non-governmental sector. Furthermore, it was anticipated that the widespread and compelling consequences of the epidemic would be an important factor in accelerating behavior change.

3. Implementation and Costs

Implementation Experience

3.1 The project was approved by the Board on April 12, 1994 and declared effective on July 22, 1994, as originally planned. The project was implemented over a period of eight years and five months (including three extensions[28]) and closed on December 31, 2002 (two years after the original closing date). All activities and

27. Fiduciary expertise was drawn from the project implementation unit of the First Health Project, which was in its last years of implementation; it was envisaged that key fiduciary staff from this unit would be absorbed into the new PCU as needed, once the Health project was closed.

28. In 2000 the closing date was extended to December 31, 2001 to enable completion of outstanding district activities, ongoing procurement, and to allow a smoother transition to new funding (including new Bank operation and support from other external partners). In 2001 the credit was extended a second time to June 30, 2002 to compensate for delays in the procurement and installation of sound broadcasting equipment. In early 2002 an additional six-month extension (to December 31, 2002) was approved to allow additional time for completion of works and services associated with the sound broadcasting contract. A subsequent request from Government to extend the closing date for a fourth time (to complete works and services under the sound broadcasting contract) (to June 30, 2003) was denied. Seventy five percent of works and services were completed on this contract at that point in time.

contracts except one (the establishment of a national sound broadcasting system[29]) were completed a full year before the project's final closing date.

3.2 **Counterpart Financing and Legal Covenants.** Early in project implementation the budgeting of Government's counterpart obligations was inadequate. While counterpart budgeting did improve over the first few years of the project, the timely release of these funds remained problematic. In addition, the arrears accumulated in the early years due to non-release of funds were never fully paid by the time of project closure.[30] In 1998 IDA agreed to reduce Government's counterpart obligations from 10 percent to 5 percent of total project cost. Government's failure to meet its counterpart obligations was a problem generic to virtually all projects in the Bank's portfolio for Uganda. This issue was not resolved during the project period and continued to compromise the pace of implementation. The Government did fulfill all other essential convenants in the Development Credit Agreement.

3.3 **Slow procurement** and the untimely and inequitable distribution of major commodities (drugs for the treatment of STDs, opportunistic infections, and tuberculosis, and condoms) to decentralized implementing entities constituted major constraints to the smooth and efficient implementation of the project. A number of elements were put into place during project design to facilitate procurement, including: tapping of procurement expertise developed/utilized under the First Health Project, the preparation of a procurement plan, and the review and approval during negotiations of sample tender documents for drugs, diagnostics and condoms. However, (a) the forecasting of needs was inaccurate, in some cases, and not carried out, in others, (b) the procurement cycle took considerably longer to complete than anticipated; (c) and capacities for procurement and distribution of commodities were very weak.[31]

3.4 As a consequence, commodities arrived late, a number of drugs that were used in combination were procured in separate lots and often were not delivered and available in health facilities at the same time, and procurements for the replenishment of commodities were not carried out sufficiently in advance to avoid gaps in their availability. This delayed training in the provision of services. Many MoH staff interviewed at central and district levels noted that supply gaps undermined the quality and reliability of services, with utilization rates rising and falling with the availability (or non-availability) of essential commodities. This problem was mitigated by other donors, who undertook emergency procurement on a number of occasions (DIFID, WHO and USAID, in particular, were cited by many interviewed). While the STIP built procurement capacity through technical guidance provided by

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29. This activity was not included in the original project design. It had been initiated under the First Health Project, but not completed. The Bank and Government agreed to complete this activity under the STIP given its relevance to the development objectives.

30. Respondents have indicated that Government still intends to make money available to pay outstanding bills.

31. Interviews with MoH staff, including some former staff of the PCO, highlighted the fact that prior to STIP virtually all major procurement of commodities for HIV/AIDS/STD Program activities were carried out by the international partners (WHO and USAID were cited in particular). Thus the STIP constituted the first major financial support to HIV/AIDS for which MoH would be responsible for massive procurement of commodities.

the Bank, training, and applied experience, capacity weaknesses persisted in the areas of forecasting of needs, procurement planning, coordination and execution. The capacity to distribute commodities to health districts and, in turn, to local-level facilities and services also remained problematic.

3.5 **Financial Management.** Periodic audits have confirmed that overall the Government respected the exigencies of financial management and accounting required by IDA. However, the innovative, decentralized nature of the project design, most particularly disbursement of project funds to districts caused complications and delays as central and district capacity was slowly built through experience. Major bottlenecks to the smooth flow of funds to districts included: an initial delay in district authorization to incur expenditures, the weak capacity and inexperience of districts[32], the districts' delays in submitting financial accounting reports, on which basis they would receive a follow-on tranche of financial support, turnover of district accounting staff, the (initial) small size of the Special Account, and the closure in 1999 of the commercial Bank holding the Special Account.[33]

3.6 These constraints were addressed by technical assistance[34] to improve financial flows and capacity, supportive supervision and training to districts in financial management and accounting, a doubling of the amount of the Special Account (from US$1.5 million to US$3.0 million), and the reopening of the Special Account in another commercial Bank.[35] However, persistent delays in the cycle of financial reporting and provision of the subsequent financing tranche, combined with a chronic turnover in trained district health accountants, slowed district plan implementation and pointed to the need for continued capacity building.

3.7 **Role of Civil Society Organizations.** NGOs and CBOs were actively involved in the planning and implementation of activities included in district annual work plans. In line with their experience and comparative advantages, they carried out a range of prevention and care and support activities. In addition, in recognition of their status as district-level implementing agencies, they were systematically included in training events and routinely supervised and supported by technical missions carried out by central- and district-level teams. At the central level NGOs were also enlisted to participate in the project, given their experience in working with specific population groups and the coherence of their activities with project objectives.[36]

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32. This was the first major support to HIV/AIDS that provided direct support to districts under which districts themselves would be responsible for the management and accounting of financial resources.

33. The closing of Greenland Bank, which held the project's Special account, also considerably stalled procurement, causing the expiration of special commitments, letters of credit and performance guarantees.

34. SIDA provided a full-time technical assistant to the PCO to support capacity building of district-level accountants in financial management and accounting. All districts visited and central level staff expressed profound appreciation for his dedication and availability, which culminated in improved district capacity.

35. Stanbic Bank.

36. For examples: TASO, AIDS Information Centre (AIC), Slum-AID Project, Kampala Women Welfare Association (KAWWA), Uganda National Association for the Deaf (UNAD), Uganda National Association for Nurses and Midwives (UNANM), Uganda Network on Law, Ethics and HIV (UGANET), Youth Active Club.

3.8 The selection process for district-level NGOs was different from that of national, centrally-based NGOs. The former were invited by district health teams to join the planning and implementation of annual district plans, covering a range of prevention, care and support, and capacity building activities. They were solicited on the basis of: their location and target groups (with a view to improving coverage and equity); implementation experience and capacity[37]; the nature and sustainability of their activities; their technical capacity; and their transparency. Activities were incorporated into the district health plans and were financed through the districts on a quarterly basis. On the other hand, national NGOs submitted technical proposals, which were reviewed by a technical committee formed by ACP. For approved subprojects a MoU was cosigned with the MoH and laid out the activities to be funded, duration and amount of funding. Both national and district-level NGOs submitted financial and technical reports, were routinely monitored and supervised, and participated in periodic reviews of project activities. However, NGO/CBO activities were not evaluated and there was no requirement for financial or in-kind contribution by these organizations.

3.9 **Risks.** Two risks anticipated during project design did come to pass. First, the capacity of health staff was indeed inadequate for effectively delivering STD services, despite intensified training efforts undertaken to mitigate this risk. Second, while behavior change did occur, it was, as predicted, difficult to elicit and it did lag behind higher levels of knowledge. The false sense of complacency, prompted by availability of antiretroviral (ARV) drugs and by declines in prevalence, may have contributed to this phenomenon. An unanticipated risk was the constrained flow of funds to district, attributable in part to project design and in part to the lack of experience of districts in the context of a new policy of decentralization. This risk was mitigated by slight modifications in the project disbursements and intensified capacity building in financial and strategic management.

Planned Versus Actual Costs and Financing[38]

3.10 The total project cost was US$70.0 million or 95 percent of the cost estimated at appraisal (US$73.4 million). The costs of each component were in line with original estimates.

37. Central and decentralized staff involved in NGO/CBO contracting emphasized the importance of this criterion in order to avoid the proliferation of new NGOs/CBOs just to access financial resources.

38. This section summarizes planned vs. actual cost data by project component, cost category and source of financing. See Annex E for relevant tables.

Table 1. Planned Versus Actual Costs by Component (US$ million equivalent)

Component	Planned[39]	Actual[40]	Actual as % of Planned
Prevention of Sexual Transmission of HIV	37.7	36.8	98%
Mitigation of the Personal Impact of AIDS	24.2	21.4	88%
Institutional Development	11.5	11.8	102%
Total	**73.4**	70.0	95%

3.11 The IDA credit was 99 percent disbursed, SIDA (cofinancier) provided more funding than initially anticipated (US$5.6 million vs. US$5.0 initially planned) and KfW (cofinancier) provided what was initially planned,[41] as did DFID (parallel financier) (formerly known as ODA). Actual counterpart funds (US$4.5 million) fell short of the original obligation (US$7.4 million). In addition to the financial contributions, of the above agencies, two other important partners in the fight against HIV/AIDS (WHO and USAID) provided technical support to STIP implementation (see Annex E, Table E-2).

3.12 Initial allocations against cost categories of both IDA and SIDA funds[42] were revised to reflect emerging experience and needs, reflected in expenditure patterns. More than double the amount originally allocated to monitoring, research and training was expended against this category in order to respond to the critical need to build capacity at central and district levels in program management and implementation (mostly through training of district managers and service delivery staff, including the widespread training of counselors and home-care providers to meet growing demand for these services). For the same reasons, 30 percent more was spent on technical assistance than originally anticipated. The financing of incremental operating costs was not initially planned for either IDA or SIDA financing, but was ultimately supported by both agencies to compensate for low counterpart financing.

4. Outputs and Outcomes by Objective

4.1 Annex F provides an overview of program outcomes against indicators and targets set by project objective and subobjective. Provisional targets on sexual behaviors, specifying proportionate changes, were set during project design in the absence of baseline data. These targets were never revised when the 1995 DHS data on these indicators became available, as had been planned. A second DHS conducted in 2000 allows for the analysis of trends in some aspects of sexual behavior over the

39. World Bank Staff Appraisal Support, 1994.

40. Sources: Government/PCO financial data, Implementation Completion Report, with slight adjustments for exchange rate fluctuations.

41. After KfW's contribution to the project was fully disbursed, it approved an additional grant equivalent to about US$5.7 million (Euro 5.12 million) to continue support for condom social marketing operations. This is not counted as additional cofinancing to STIP, but, rather, as support to the program, particularly since the financing period transcended the end of the project life.

42. The SIDA Trust Funds were administered by the World Bank and followed World Bank rules for procurement, disbursement and financial management.

life of the project. For all other project indicators, baselines were never established, and end-of-project data were never collected and analyzed.[43] Nevertheless, this evaluation has compiled and analyzed available relevant data in an effort to provide information and insight on outcomes. Annex G presents the highlights of data and trends on project and program outcomes, which underpin the findings presented in this chapter.

4.2 During the period 1995-2001, financial support provided under STIP represented 45 percent of all resources (donor and domestic) allocated to the fight against HIV/AIDS (Ddamulira 2002) (see also Annex E, Table E-5). This chapter assesses outputs and outcomes by objective and relates achievements to specific support provided under the project. For further reference, Annex D provides a detailed overview of planned vs. actual inputs and outputs organized by program objective.

Objective #1: To prevent sexual transmission of HIV

4.3 ***Through investments in a wide array of IEC activities[44] and the procurement, free distribution and social marketing of condoms, the project has likely contributed to improvements in knowledge on how to avoid infection and to the adoption of safer behavior among the general population, and among youth in particular.[45]*** With project support messages to improve knowledge and promote safer sexual behavior were developed and disseminated through the media (television, radio, newspaper) as well as through the translation and wide dissemination of printed material and the organization of local-level drama productions. Using audio visual equipment and film vans purchased with project funds, communities were mobilized to address the epidemic more proactively through the organizations of community discussions, risk assessments, active promotion of safer behavior, school campaigns and other innovative activities. International, national and local NGOs, along with key public sector agencies were supported under the project to continue and to intensify their work on behavior change interventions.

43. Most "end-of-project" data cited in both the Government and the Bank's final evaluation reports were from 1998, the mid-point of the project's implementation period, despite the availability of 2000 UDHS and other relevant data. Nor were 1995 DHS data sufficiently used in these reports for baseline information. Unfortunately, 2000 UDHS data on some aspects of sexual behavior cannot be compared with the 1995 UDHS data because the reference period of certain questions was changed.

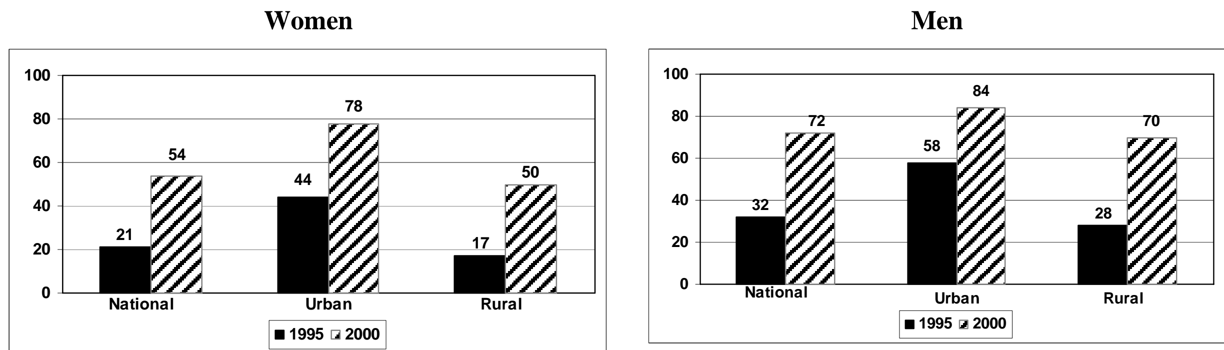
44. In line with national IEC strategy, which was developed with project assistance, a range of information and messages were conceived and delivered to different segments of the population: to provide information and skills needed to prevent the spread of HIV/STDs, to advocate for abstinence until marriage for youth; to promote mutual faithfulness among partners; to promote consistent and correct condom use; to promote early and appropriate STD treatment seeking behavior; to advocate for positive living for PLWHA; to advocate for care and support of the infected and affected; to help districts to better plan and manage IEC activities; to strengthen IEC capacity at national and district levels.

45. This section highlights evolutions in knowledge and behavior, drawing on two Uganda Demographic and Health Surveys (UDHS) carried out, respectively, in 1995 and 2000/01 and on a series of KAPB studies in selected districts. The UDHSs are based on nationally representative samples of women aged 15-49 and men 15-59. Both surveys cover most of the country and have comparable geographic coverage and questionnaires. It also draws on two in-depth analyses of these data, the 1989 UDHS and two GPA surveys carried out in 1989 and 1995 (UAC 2003 and Uganda HIV/AIDS Partnership 2004).

4.4 *General awareness of HIV/AIDS was virtually universal among men and women in 1995 and remained so in 2000.* While this high level of awareness might have been attributable in part to IEC, it is very likely that Ugandans' first-hand experience played a role. Already in 1995, 85 percent of women and 91 percent of men knew someone who was suffering or who had died from AIDS; and levels for 2000 were 90 percent for both men and women.

4.5 ***There was significant improvement in the specific knowledge that condoms can protect against HIV, but a slight deterioration in the knowledge of the risk of multiple sexual partners from 1995-2000.*** Women's unprompted reporting that HIV can be avoided by using a condom more than doubled from 21 percent to 54 percent (with a tripling of knowledge levels recorded among rural women) and so did men's knowledge (from 32 percent to 72 percent), with the most significant increase occurring among rural men (Figure 2). Knowledge that HIV can be avoided by limiting sexual partners declined from 62 to 50 percent among women and from 58 to 46 percent among men, with declines among both urban and rural residents (Annex G, Table G-1). In addition women's knowledge that an HIV-infected person can appear healthy slightly deteriorated from 82 to 77 percent, the decline mostly attributable to rural women. Also, in 2000, 92 percent of women knew that HIV cannot be transmitted by a mosquito, down from a level of 100 percent in 1995. This is an indication of the need to continue IEC efforts even where levels of knowledge are already fairly high in order to maintain and to further boost these levels.

Figure 2. Share of adults that knows HIV can be avoided by using a condom, 1995, 2000

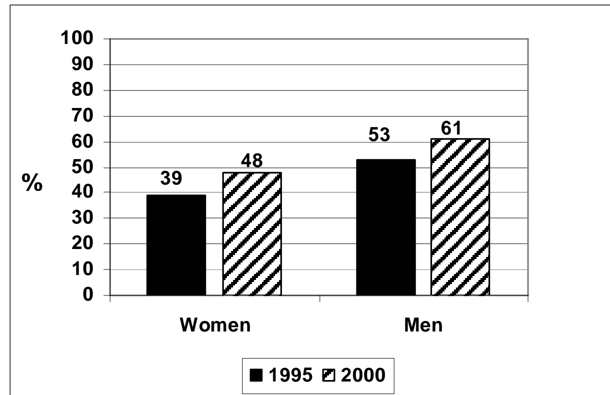


Source: UDHS 1995 and 2000 and UAC et al., 2003

4.6 ***Both the share of 15-19 year olds who have never had sex and the median age at first sex in the 15-24 age group rose during the period 1995- 2000.*** In 2000 48 percent of women and 61 percent of men 15-19 years reported never having sex, up from 1995 levels of 39 and 53 percent, respectively (Figure 3). Also during the life of the project, the median age at first sex for women in the 15-24 age group rose

from 16.7 years to 17.3 years and for men in this age group from 17.6 years to 18.3 years (UAC et al., 2003). Disaggregated data for the 15-19 year age group show even higher median ages at first sex (for both men and women) (Annex G, Figure G.3).

Figure 3. Proportion of young people (15-19 years) who have never had sex



Source: UDHS 1995 and 2000, and Uganda HIV/AIDS Partnership et al., 2004

4.7 Due to differences in the wording of the respective questionnaires[46], DHS data from 1995 and 2000 on women and men having sex with a non-regular partner and on those having sex with two or more partners could not be compared and so trends on these high-risk behaviors are not available.

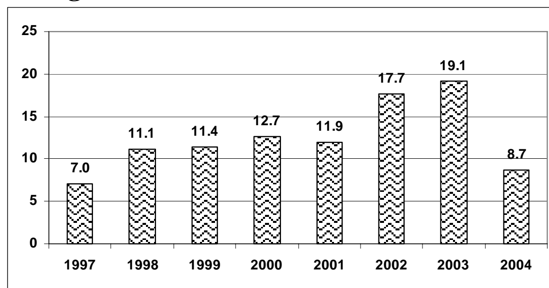
4.8 ***All indicators on condom knowledge, availability and use showed significant, positive trends during the life of the project, possibly reflecting project investments in IEC and social marketing and free distribution of condoms. However, levels of condom use are still low.*** A total of 155 million condoms were purchased under the project (against a revised plan of 200 million), of which some were socially marketed and others were distributed free of charge through the health system, NGOs and community distributors, and other public sector agencies.[47] The total condoms purchased under the project represented about three quarters of all condoms purchased during the life of the project. With KfW cofinancing, Marie Stopes International (MSI) launched a condom social marketing program under the brand name "Lifeguard." The program was established with project assistance in 1996, with sales starting in 1997. Annual sales under this program rose during the life of the project (see Figure 4), but were constrained, nevertheless, by occasional stockouts in condom supplies. During project implementation, the only other condom social marketing entity (SOMARC), which promoted the "Protector" brand of condoms, submitted a proposal to STIP for financing to expand its activities, in complement to financing received from USAID. The project approved such support totaling some US$235,000 over the life of the project. Figure 4 shows the annual sales of "Protector" condoms, but information on the share of these condoms financed by STIP is not available.

46. The 1995 DHS specified a reference period of the previous 6 months, while the 2000 DHS specified a reference period of the previous 12 months.

47. Most notably: Ministry of Defense and Ministry of Interior (Departments of Police and Prisons).

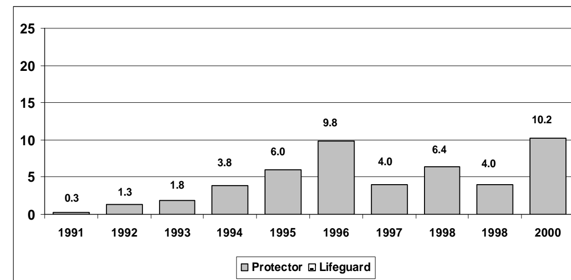
Figure 4. Annual sales of socially marketed condoms in Uganda (millions of units)

Marie Stopes International (MSI) "Lifeguard" brand



Source: MSI Program Statistics 2005.

Social Marketing for Change (SOMARC) "Protector" brand



Source: UAC et al., 2003

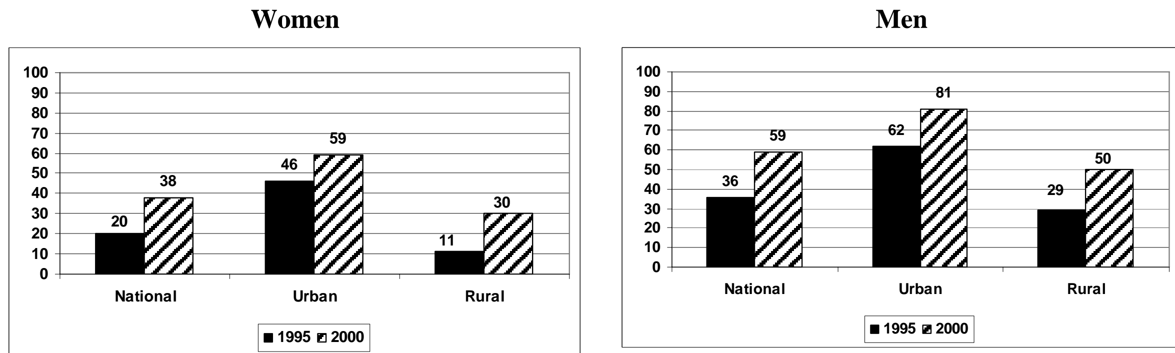
4.9 The share of men and women who had heard of condoms was already high in 1995, having increased dramatically over documented levels in 1989, and increased to even higher levels between 1995 and 2000, especially among women.[48] Knowledge about where to get condoms for both women (from 32 percent to 53 percent) and men (from 60 percent to 77 percent) (Annex G, Figure G.8).[49] Most significantly, the share of women and men reporting use of condoms during high-risk sex (last sex with a non-regular partner) increased from 1995 to 2000, with the most significant increases among rural residents (Figure 5). While these trends are positive (a near doubling of levels for women and an increase of 50 percent for men), current levels are still inadequate for making important headway in reducing new HIV infections, leaving considerable scope for further increasing condom use among those engaged in high-risk behavior. [50]

48. The proportion of women and men who had heard about condoms increased from 76 to 88 percent and from 89 to 97 percent, respectively, with the greatest gains among rural residents (Annex G, Table G-7).

49. This information is corroborated by KAPB surveys which document a rise in knowledge of condom source for men and women combined from 67 to 90 percent in Kampala, from 34 to 72 percent in Jinja, and from 13 to 38 percent in Lira.

50. KAPB surveys show similar trends over the period 1995 – 2001 with increases in condom use during last high-risk sex (with non-regular partner) for Kampala (from 33 to 72 percent), Jinja (from 29 to 67 percent) and Lira (from 17 to 36 percent) (Annex G, Figure G.11).

Figure 5. Share of population who used a condom at last sex with a non-regular (non-marital, non-cohabitating partner), 1995, 2000



Source: UDHS 1995, 2001 and UAC et al., 2003

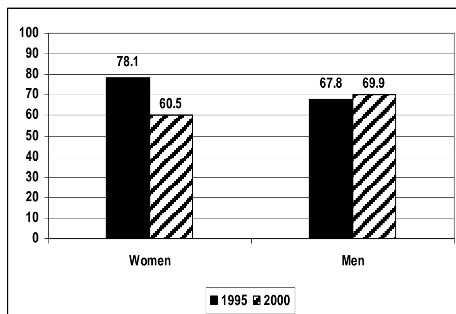
4.10 ***The project supported intensified efforts to conceive and disseminate IEC messages directed at youth both in-school and out-of-school settings, which, combined with social marketing of condoms, contributed to safer behavior patterns, especially among the 15-19 age cohort.*** UDHS data from 1995 and 2000 reveal a significant increase in condom use among those in this age group engaging in high-risk sex. Over one half of young women engaging in sex with a non-regular partner used a condom at last sex in 2000, up from less than one quarter in 1995. Condom use among women 20-24 years of age with a non-regular partner rose slightly. Among young men the most significant positive changes happened within the youngest age cohort (15-19 years) with condom use during sex with a non-regular partner rising from one quarter to over half of those engaging in this behavior (Uganda HIV/AIDS Partnership et al., 2004).

4.11 ***The project invested in behavior change interventions aimed at some high-risk and other target groups identified during project design, but interventions were inadequate relative to the need, coverage was limited, and there was no systematic tracking of outcomes. The absence of data on trends in behaviors and in incidence or even prevalence rates within these different groups makes it impossible to evaluate project impact***. The project financed HIV/AIDS activities carried out by other public sector agencies, most notably: the UAC, Ministries of Defense (UPDF), Internal Affairs (police and prison departments), Local Government, Gender, Labour and Social Development, Education, Justice, Agriculture, Animal Husbandry and Fisheries, and the President's Office (Department of Information). Military, police and prisoners were targeted by Ministry of Defense and Ministry of Interior; and primary and secondary school students received messages through Ministry of Education interventions. NGOs carried out some targeted interventions aimed at adolescent girls, professional sex workers operating in Kampala, drivers, migrant workers and slum dwellers. Groups for which data on HIV prevalence and on knowledge and behaviors would be extremely important to monitor include: the military, police, prisoners, CSW and others who engage in high-risk sex, migrants, transport workers.

4.12 A recent study[51] has shown that most high-risk sites in Kawempe Division in Kampala (specific bars, taverns, shops, video clubs, hotels and brothels where patrons find new sexual partners) were not adequately covered with prevention services, although the need and the demand for these services are significant. Of the 227 sites visited by researchers, only 33 percent had ever had an AIDS prevention program, although 95 percent of managers said that they would be willing to organize an AIDS prevention activity on their premises. Only 11 percent had an AIDS prevention poster displayed and 20 percent had condoms available on the premises at the time of the visit. Managers of 67 percent of these sites reported that condoms were never available, but 61 percent were willing to sell condoms if they were available. In those few sites where condoms are available, 90 percent of male patrons reported using a condom with their most recent partner. This level of use dropped to 70 percent of male patrons at sites where condoms were not available.

4.13 ***There is no evidence of significant improvements in care-seeking behavior or in actions to inform and protect partners of those suffering with STDs.*** The project procured drugs and financed training of health personnel in an effort to improve the quality and availability of STD services. Many respondents reported an observed increase in STD service utilization when drugs were available, and a decline in utilization when they were not.

Figure 6. Share of all men and women reporting STD or STD symptoms, who sought treatment or advice (any source)



Source: UDHS 1995, 2001

4.14 UDHS data reveal deteriorating trends for women and very slight improvements for men on a number of STD indicators. The share of women reporting that they had an STD or STD symptoms in the previous year doubled from 3.5 percent in 1995 to 7.5 percent in 2000, while the share of men declined by half (from 6.3 in 1995 to 3.1 percent in 2000) (Ananex G, Figure G. 12). These self-reports understate STD prevalence, as many STDs are asymptomatic. While there was a decline in the percent of women suffering with STDs who sought treatment or advice (from 78.1 to 60.5 percent), the percent of men seeking treatment or advice did not change significantly (see Figure 6).By the same token only half of women suffering with an STD informed their partners (down from three-quarters in 1995) (Annex G. Figure G.13), with a slight increase in those reporting the use of a condom to protect their partner (from 2.5 to 6.1 percent, Figure G. 14). On the other hand, the share of men informing their partners that they were infected with an STD rose from 57.6 in 1995 to 63.2 in 2000 (Figure G.13), and their use of a condom to protect their partner rose from 4.6 to 15.9 percent of those infected (Figure G.14).

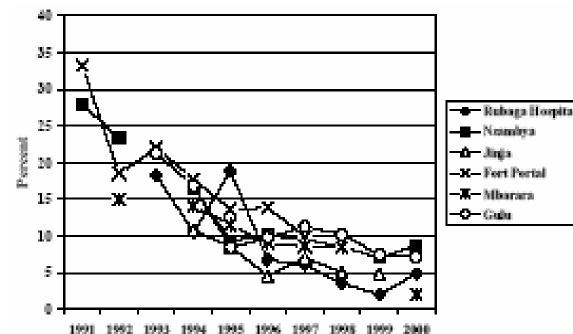
4.15 ***Documented declines in HIV prevalence rates among pregnant women attending ANC clinics are attributable in part to significant AIDS mortality which***

51. Ssengooba et al., 2003.

occurred during the early 1990s.[52] ***There are, however, indications that a decline in HIV incidence (rate of new infections) was also a factor.*** Figure G.15 in Annex G show HIV prevalence among pregnant women rising from the mid-1980s to the early 1990s, peaking around 1992 (in a few selected sites as high as 30 percent), declining in the middle part of the 1990s, and leveling off thereafter.[53] HIV prevalence varies across geographical regions, with higher rates in urban areas, especially Kampala, and along major transport routes. While trends in HIV among antenatal data are considered to be robust and reflective of trends in the country (UAC, Measures, MoH, 2003), ante-natal women at the selected clinics are not necessarily representative of that group nationally or of the general population; and trends in HIV in a mature epidemic, like that in Uganda, do not mirror trends in new infections (incidence). HIV prevalence is not an ideal measure of the dynamics of a mature HIV epidemic.[54]

4.16 Indications that incidence may actually be declining are found in ante-natal sentinel data on the youngest cohorts of women. Because younger women have been sexually active for a considerably shorter period of time and their AIDS mortality would be low, HIV prevalence rates among this group are more reflective of trends in new infections than they would be for all women 15-49. Figure 7 shows notable declines in prevalence rates of ANC women aged 15-19 years in selected sites during the 1990s. They level off in the late 1990s and suggest a slight increase into 2000. These patterns are corroborated by data on incidence collected in the southwestern district of Rakai in the context of a long-term research project. HIV incidence peaked in 1993 (at 8.5 new infections per 1000 population per year), declined for a few years thereafter, and leveled off in 2000-2001 (at 3.5 and 3.7 per 1000, respectively) and rose slightly in 2002 (to 4.7 per 1000). Data on HIV prevalence and incidence rates among specific high-risk groups have not been systematically collected and analyzed to reveal trends. Limited data in Kampala show a significant recent increase in the HIV prevalence rate among CSWs, from 28 to 47 percent in 2000-2003 (ACP/MoH Statistics 2003).

Figure 7. HIV Prevalence at ANC sentinel surveillance sites, 15-19 year olds.



Source: Ministry of Health 2003a

52. AIDS cases peaked in early 1990s; and period between developing full-blown AIDS and death is 9.3 months (World Bank 2004), implying that significant mortality from AIDS occurred in the 1990s.

53. Data on HIV prevalence (percent of the population infected at a given time) among pregnant women using antenatal services has been collected and monitored over the past two decades through a system of sentinel surveillance, started in Kampala in 1989, and gradually expanded to a cumulative total of 6 urban sites in 1989, 13 sites in 1993, 19 sites in 1995 and 20 by end-2001. While the more recently established sites were chosen with a view to encompass rural areas and achieve a more balanced coverage of the country, sites are primarily located in towns and urban areas and not necessarily representative of Uganda's population, which is 80% rural.

54. Prevalence rates reflect the proportion of a population currently infected (encompassing old and new infections). Prevalence can decline as a result of increased mortality as well as decreased infection rates and should thus be interpreted with caution.

Objective #2: To mitigate the personal impact of AIDS

4.17 ***Project assistance expanded and supported community-based care and social support for people living with HIV/AIDS (PLWHA) and their families. However, data were never collected to measure the impact of this assistance***. The project financed contracts between the health districts and various NGOs/CBOs to implement home and community care of AIDS patients. Based on available statistics it is estimated that some 700 NGOs/CBOs (or three quarters of all 935 NGOs/CBOs supported under the project) carried such activities, covering most, if not all districts. These organizations received financial support and benefited from commodities (drugs for opportunistic infections, supplies for AIDS care) and training (in care and counseling). A few NGO/CBO subprojects supported income generation activities for PLWHA and their families in a few communities. However, these were conceived and implemented in the absence of qualified expertise in micro-finance and ultimately failed. NGO/CBOs visited during the evaluation mission were noted to be providing critical services in promoting and supporting the wellbeing of PLWHA, including counseling psychological support, networking, promotion of community involvement and understanding, and providing an interface between those living with HIV/AIDS and relevant care and support available locally, through both public and private sectors. However, in the absence of data on coverage and impact of the activities, no conclusions can be drawn about their effectiveness. In 2000 roughly about 30 percent of PLWHA were estimated to be receiving some kind of social support (World Bank 2000).

4.18 ***Project procurement of drugs for opportunistic infections and training of service providers in palliative care have modestly improved health service availability for PLWHA. However, low skills and low availability of health personnel in peripheral health facilities[55], combined with sporadic availability of drugs[56], undermined the potential impact of this support.*** Training of health workers in front-line public health facilities, the provision of drugs for opportunistic infections and other commodities, and the production of referral and technical guidelines for NGOs/CBOs, have helped strengthen public sector and community-based services and the interface between the two.

4.19 ***Project support in expanding Directly Observed Treatment Short Course (DOTS) for tuberculosis in selected districts might have contributed to improvements in TB treatment success.*** The project provided drugs, equipment, training, supervision and technical support to the National Tuberculosis/Leprosy Program to support the expansion of TB treatment in Uganda. WHO supplemented this assistance with technical support to develop a national TB control strategy, and USAID supported DOTS in selected districts. Shortages of drugs for TB treatment warranted on occasion emergency procurement by other donors. The DOTS treatment success rate was 62 percent in 1998 and 60 percent in 2002, showing no significant change (Annex G, Figure G.16). Data was not available to permit the

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55. Uganda's health system faces a severe shortage of doctors, nursing staff and nursing aids, which is compounded by their inequitable distribution across the country (World Bank 2004).

56. Deficiencies in the procurement and distribution of drugs are described in Chapter 3 (paras. 3.3-3.4).

evaluation of progress against the TB program indicator established during project design: the proportion of those infected with TB receiving DOTS.

Objective #3: Institutional Development

4.20 ***The STIP significantly strengthened the capacity of districts to undertake strategic planning and management of activities supporting the fight against HIV/AIDS and to mobilize, receive, utilize and account for financial resources.*** In essence, the decentralization of HIV/AIDS program was achieved with this project. Districts received capacity building support through intensive training[57] (designed and delivered by ACP and PCO) covering a range of technical/service delivery skills, as well as management (including strategic management and management of resources). This training was supplemented by intensified on-the-job support and assistance, especially in the first few years of the project, to prepare, implement and monitor HIV/AIDS plans of action and to account for funds received and utilized. Districts were also provided with office and logistical equipment to enable them to carry out their newly decentralized functions. With project assistance, districts now have the capacity and experience to plan, coordinate, implement, contract out and supervise activities supporting the fight against HIV/AIDS. By the end of the project all districts routinely prepared and monitored the implementation of annual HIV/AIDS plans with the involvement of local actors and stakeholders. There is still a wide variance in district performance. While implementation rates and routine monitoring and reporting are satisfactory, by the time of the project's closing date, districts still had not evaluated effectiveness of plans, thus undermining opportunities for improving their performance.

4.21 ***The project strengthened the capacity of the ACP/MoH to carry out strategic management and oversight of HIV/AIDS activities carried out by a multiplicity of actors.*** The ACP/MoH also received technical, financial and logistical support to strengthen capacity in strategic management of the program. The project financed 39 research studies (itemized in Annex D) and provided support to ongoing surveillance activities (HIV, STDs and TB) as well as to the undertaking of second generation surveillance (surveys on knowledge, attitudes, practices and behavior). The project also supported the costs of a small PCO, including salaries, office equipment, logistical support and operating costs. Backstopped by the PCO and strengthened by fellowships in relevant fields of specialization[58], the ACP was successful in taking concrete steps towards a multisectoral approach through its technical and financial support to and collaboration with public sector agencies which designed and implemented HIV/AIDS interventions targeted at key groups, most

57. In addition to intensive training in-country, the project financed 19 long-term training fellowships, focusing on health promotion, health education, sexual and adolescent education, public health, epidemiology and clinical care for HIV/AIDS. These fellowships were awarded to 4 district staff, 3 staff from Ministry of Defense, and 12 from central-level Ministry of Health, mostly staff of the AIDS Control Program. In addition 23 short-term training fellowships were also completed with project financing, covering essentially the same above-mentioned disciplines. Of these 23 fellowships, 4 were awarded to district staff, 7 to Ministry of Defense staff, and the remaining 12 to MoH staff, many of whom worked in the ACP. Interviews with a number of fellowship recipients confirmed the relevance and utilization of this training.

58. Ibid.

notably: Ministry of Defense (military personnel, their dependents and affected communities)[59], Ministry of Interior (police[60] and prisons[61]) and Ministry of Education (school-based programs).

4.22 ***The project succeeded in further expanding national capacity for HIV/AIDS program implementation by encouraging and supporting the involvement of experienced NGOs and CBOs in the planning and implementation of key activities***. A total of 935 NGOs/CBOs carried out one or more subprojects financed under the STI project, covering all 45 districts in Uganda[62], representing about half of all NGOs/CBOs (some 1918) estimated to be carrying out HIV/AIDS activities.[63] Of all NGOs/CBOs participating in the project, project data were available on only 237 (or 25 percent).[64] While this subset of 237 may not be representative of the total of 935, it did cover 44 of Uganda's 45 districts. Available data on this subset show that 60 percent were locally-based, 27 percent were national and 13 percent were international. The majority of them intervened at the district (52 percent) or subdistrict (23 percent) levels, with the remaining intervening at the regional (more than one district) or national levels (10 and 14 percent, respectively). The involvement of these NGOs/CBOs in key components of the HIV/AIDS program is as follows: prevention (90 percent), mitigation (74 percent), capacity building (20 percent), advocacy (12 percent) and research or information generation (3.4 percent). The total amount of project funds spent on NGO/CBO activities is not available, because the financial reports of the districts were not systematically quantified and aggregated by the PCO, and the PCO files on district plan implementation and expenditures were incomplete.[65] Nor did the remaining PCO files contain complete

59 The UPDF benefited from project support to continue and expand activities they had initiated from 1990-94 with support under the First Health project and other financing sources. Activities were organized around the three objectives of the project: (a) prevention of sexual transmission (sensitization, peer education, promotion of condom use, distribution of condoms, use of film, drama, printed media to transmit messages); (b) mitigation of personal impact of AIDS (training in and drugs for improved management of OIs and STD care, training of counselors) and (c) capacity building (training in service delivery, patient management and other related disciplines including specialization fellowships, and operational research). The target group of these interventions included soldiers, their spouses and children, and communities living in and around military bases.

60 STIP support to the police force also covered the three project objectives: (a) prevention (awareness raising, advocacy, promotion of safe behaviors, condom distribution and promotion, management of STIs); (b) mitigation (provision of services to PLWHA, including counseling services, social support, recreational activities, treatment of OIs, and related training and drugs); and (c) capacity building for improved management of HIV/AIDS/STI program efforts (office and laboratory supplies, training in planning, management, surveillance, operational research, monitoring)

61 STIP support to prisons amounted to about US$350,000 and supported: (a) prevention (awareness creation, condom distribution); (b) mitigation (palliative care, counseling); and (c) capacity building (training, improvement of management capacity, monitoring and evaluation).

62. Currently Uganda is divided into 56 administrative districts, but during STIP implementation there were a total number of 45 districts in the country.

63. Source: African Medical and Research Foundation (AMREF) 2001.

64. The total number and names of NGO/CBOs which participated in STIP were obtained from Government's final evaluation report (MoH 2003). Other variables were obtained from an inventory of NGO/CBOs and activities focused on HIV/AIDS in Uganda (AMREF 2001), and project files in MoH archives. The 237 NGOs/CBOs analyzed had data on at least four main variables (collected on costs, target populations, technical and geographical areas of intervention).

65. Financial accounting records, including monies allocated to NGOs/CBOs, were routinely prepared by the districts and submitted to the PCO, on which basis they would receive subsequent tranches of financing. The three

information on the activities and costs of international and national NGOs receiving project support through contractual arrangements with ACP/MoH.

4.23 At the central level key components of the HIV/AIDS program were contracted out to capable NGOs in line with their comparative advantages. A case in point is the setting up and support of social marketing capacity through a contractual arrangement with Marie Stopes International. During the course of the project management of MSI/Uganda was handed over from international to national staff. At the district level, NGOs/CBOs were involved in the preparation of consolidated annual HIV/AIDS action plans for the district and their role in implementing segments of this plan was discussed and agreed during this process. Both NGOs/CBOs contracted at the central level and those collaborating through district plans benefited from training, technical support, supervision, guidelines, drugs, commodities and other supplies and support provided under the project.

5. Ratings

5.1 **Outcome.** The outcome of the Sexually Transmitted Infections Project is rated moderately unsatisfactory overall, based on moderately unsatisfactory outcomes of the prevention and mitigation objectives, and a satisfactory outcome of the institutional development objective.

Table 2. Summary OED Ratings by Objective

Project Objectives	Relevance	Efficacy	Efficiency	Outcome
To Prevent sexual transmission of HIV	High	Modest	Modest	Moderately Unsatisfactory
To mitigate the personal impact of AIDS	High	Modest	Modest	Moderately Unsatisfactory
To support institutional development to manage HIV prevention and AIDS care	High	Substantial	Substantial	Satisfactory

Note: See inside cover of this report for definitions of relevance, efficacy, efficiency and outcome

5.2 The **relevance** of project objectives is *high* overall. The human development pillar of Uganda's Poverty Eradication Action Plan (PEAP) (2004/5 – 2007/8)[66] calls for continued emphasis on the fight against HIV/AIDS, noting that prevalence is still unacceptably high, and specifying three key priorities which are coherent with each of the project objectives: to reduce HIV prevalence[67], to mitigate the impact of

districts visited showed evidence of adequate financial reporting. However, the mission was unable to estimate total project expenditure on NGOs/CBOs because (1) not all districts were visited; (b) PCO files were very incomplete with regard to district reports; (c) there was no special disbursement category for NGO/CBO support; and (d) PCO financial staff were unable to provide this data.

66. Uganda's PEAP is composed of five pillars for supporting poverty reduction: (1) economic management; (2) enhancing production, competitiveness and incomes; (3) security, conflict resolution and disaster management; (4) governance; and (5) human development.

67. What is meant by this objective is to reduce the spread of new infection. For reasons explained earlier, decreased prevalence is not an appropriate objective. Furthermore, the increased availability of ARVs can be expected to prevent HIV prevalence from falling, as those already infected would live longer.

HIV/AIDS, and to strengthen national capacity to coordinate and manage the multisectoral response. The Bank's Country Assistance Strategy (World Bank December 2000) was conceived to support Uganda's poverty alleviation strategy. It includes direct support to Uganda's fight against HIV/AIDS through a follow-on HIV/AIDS operation (Uganda HIV/AIDS Control Project), which supports these same three objectives. The design of this project is also highly responsive to governance objectives articulated in the PEAP and supported as well in the CAS, most notably: support to the decentralization of essential services; enhancement of public sector accountability; and the strengthening of partnerships with the non-governmental sector both to enhance participation and to expand limited public sector capacity.

5.3 Overall the **efficacy** of prevention objectives was *modest.* Activities financed under the project have more than likely contributed to improvements in knowledge and increased use of condoms during sex with a non-regular partner, but current levels are still low by international standards. Condom knowledge and use increased significantly, but from a very low level and is not nearly as high as necessary to thwart the epidemic. The provisional targets of percent increase over 1994 levels were not meaningful as they were set in the absence of baseline data. Rapidly declining prevalence among pregnant women is not a good indicator of program success as it is a function of AIDS mortality and HIV infection rates. The pattern of declining HIV prevalence among the youngest cohorts and lower rates than for older groups is an indication of lower incidence in that group. However, declines have tapered off since 1999 and show signs of slight increase in subsequent years. The efficacy of STI interventions in achieving reductions in new HIV infections is negligible, first because utilization of these services did not substantially increase over the life of the project, and, second, because research results are mixed on the extent to which STI services have an impact on HIV infection rates.[68]

5.4 The efficacy of the project in meeting the mitigation objective was also *modest.* While the project did succeed in expanding home- and community-based care and support in almost all districts and in expanding of public sector services for AIDS and TB patients, the quality and availability of these services were compromised by sporadic gaps in essential drugs supplies and low skills of service providers. The institutional development objective was *substantial* in its efficacy. Technical and managerial capacity was strengthened both at the district and central levels; and capacity for program implementation was further expanded through the encouragement and support of partnerships with NGOs and CBOs through contractual and collaborative arrangements. NGO and CBO capacity was further strengthened by allowing them full access to other types of project support: training, technical assistance, supervision, commodities, supplies.

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68. In 1995 the results of a randomized controlled trial in Mwanza, Tanzania, found that treatment of symptomatic STDs reduces the incidence of HIV by more than 40 percent. However, in the following year, community-based trial of mass treatment of STDs in the population in Rakai district found that STD treatment reduces the incidence of STDs, but not HIV. These conflicting results launched a discussion of conditions under which reduction in conventional STDs will lower HIV incidence, which is still ongoing.

5.5 The prevention objective was achieved with *modest* **efficiency**. It was efficient in exploiting a wide array of messages and channels and used a wide range of NGOs/CBOs and some other (non-health) public sector agencies to carry out activities. Efficiency gains were achieved because (a) the employment of existing civil society and non-health public sector capacity is a considerably lower cost alternative to the creation of new health sector capacity; (b) civil society and other (non-health) sectors have the comparative advantage to work with specific target groups, which would translate into greater efficiency than what the health sector could achieve with these groups. Furthermore, this approach provides for a more efficient use of limited health sector capacity. However, two factors undermined efficiency: (a) inadequate targeting of high-risk and other priority groups, specified in the project design; and (b) sporadic gaps in key commodities, which compromised condom availability and STD services quality and availability. The efficiency of the project with respect to its mitigation objective is also rated as *modest,* due to occasional shortages of drugs shortages as well as qualified service providers to receive and apply training. It was successful in mobilizing and supporting some 700 NGOs/CBOs to expand mitigation services at the community level and interface with health services. Despite difficulties in financial flows and financial management at the outset, the efficiency with which district and central level capacity was built and utilized was *substantial* in that it was consistent with the country's decentralization objective. Furthermore, capacity was built through a combination of inputs which were complementary and reinforcing of one another: formal training, on-the-job training, technical assistance, supervision, monitoring, and learning through experience. Efficiency was further reinforced with adjustments to capacity building interventions, depending on experience and identified needs. However, the project did not sufficiently support research to assess and improve the cost-effectiveness of prevention, mitigation and capacity strengthening interventions.

5.6 **Institutional Development.** The institutional development impact of this project is rated as *substantial*. It supported: the decentralization of the fight against HIV/AIDS; multisectoral interventions conceived and led by other key (non-health) public sector agencies; and partnerships with civil society. All of these approaches combined served to mobilize existing and latent capacity and to use it in line with the comparative advantages of the multiple actors thus fostering a more efficient use of resources. Both through training and logistical support, the ACP refined its capacity to provide technical oversight and support of HIV/AIDS activities being implemented throughout the country. Capacities were developed and reinforced in a number of relevant disciplines, including: condom coordination and distribution, IEC, epidemiological surveillance and research. Districts as well were strengthened to take on the HIV/AIDS challenge in a newly decentralized environment, and are now capable of conceiving and strategically managing annual action plans that encompass a multiplicity of actors and activities, and of mobilizing and managing resources to this end. Mechanisms for partnerships with NGOs/CBOs have harnessed latent national capacity for contributing to the fight. The UAC has the mandate for overall coordination and strategic management of HIV/AIDS activities to encourage more strongly a multisectoral approach. This does not take away the significance of the role of MoH (central and decentralized levels) in terms of its technical leadership, as

well as in light of the growing importance of the care and treatment component, given availability of ARVs.

5.7 **Sustainability.** Overall the sustainability of investments made under this project is rated as *likely.* The high levels of HIV prevalence and the peak of AIDS cases in the early 1990s exposed virtually the entire population to the first-hand knowledge of the disease and its consequences. Social support was further mobilized under the strong leadership and pro-activity of the Head of State. Considerably strengthened capacity for management and implementation of the fight against HIV/AIDS and success in the mobilization of donor resources in the late 1990s and into the present also bode well for sustaining activities. Given the strong conviction of Uganda's leadership and the experience and involvement of many facets of government and civil society it is unlikely that political and financial support will deteriorate in the medium term. However, continued emphasis on prevention in a new era of ARV availability, and intensified emphasis on condom promotion in the face of pressures from religious groups (both domestic and international) constitute important challenges to the equilibrium and efficiency of program interventions.

5.8 Four challenges must be met to ensure continued sustainability. *First,* the technical resilience of the program must adhere to public health principles and best practices and withstand pressures by different interest groups: to abandon condom promotion in favor of abstinence and fidelity, instead of promoting all three; to relax prevention efforts out of a false sense of complacency due to declining prevalence; and to avoid targeting of high-risk groups because of stigma attached to these groups and difficulties in reaching them. *Second,* the forecasting, procurement, management and distribution of key commodities (drugs, condoms, reagents) will need to be strengthened in order to secure sustainability of program activities. *Third,* the total costs of the program should be assessed so as to ensure their adequate coverage in the medium term in light of (a) the inclusion of ARVs in the continuum of services; and (b) an expected transition of external donor assistance from program to budget assistance. *Finally*, the availability of donor resources in the long term needs to be assessed along with government capacity to assume the costs of the program.

5.9 **Bank Performance.** The Bank's performance during preparation was *satisfactory*. The project was strongly owned by Government and the Bank responded to Government's request for urgent financing in light of the end of WHO/GPA financing and of the continued momentum of the epidemic. Drawing on dedicated sector work and an intensified dialogue with Government on the epidemic and its consequences, the Bank was quick to respond. The project was consistent with national policy and priorities for health and HIV/AIDS and with the CAS. Its development objectives were relevant and remain so today. Project design was consistent with governance policies and objectives favoring decentralization of service delivery, and partnerships with civil society. Also during preparation, the Bank made an effort to support Government in mobilizing and coordinating technical and financial assistance to the HIV/AIDS effort, which culminated in considerable cofinancing and parallel financing, and other arrangements for coordination and collaboration among donors. Some respondents noted that district capacity for program management and implementation was underestimated during preparation,

but strong and constant technical support and assistance provided on-the-job, especially during the first two years, combined with massive training efforts, addressed in part this concern.

5.10 Bank support during supervision was *satisfactory*. The Bank was supportive and proactive in the identification and resolution of implementation problems. Key actors and implementers interviewed noted that supervision was regular, collaborative, pedagogical and productive. As was the case during preparation, there was a concerted effort to involve other partners in the supervision process in an effort to coordinate and consolidate external advice and assistance. The Bank's team was flexible in introducing amendments and refinements to the project design and implementation arrangements to accelerate implementation and improve capacity. It was able to address successfully financial flow issues. It also provided advice and guidance on the application of procurement rules and procedures and informal training. However, it was noted that the Bank was oftentimes slow in reviewing and approving procurement documents. Bank performance is noted to have improved with the decentralization of fiduciary staff (procurement specialist and financial accountant) and technical staff (recruitment of a health specialist) to the Bank's Kampala office.

5.11 While satisfactory overall, there were some aspects of the Bank's performance during supervision that were weak. First, the Bank failed to follow up on the critical first-year activity of establishing baseline data on all indicators and setting realistic targets on the basis of this data. Second, the Bank was not cautious in its utilization of HIV prevalence as a measure of project and program success. This undermined opportunities for evaluating the impact of project and program efforts. Third, it did not promote and support the monitoring and evaluation of NGO/CBO activities. Fourth, the Bank did not insist on the implementation of research on the cost-effectiveness of prevention and mitigation efforts. Fifth, the Bank did not place sufficient emphasis on high-risk groups, both to ensure their adequate coverage and to support the collection and analysis of essential data and trends on prevalence and behaviors.

5.12 **Borrower Performance** was *satisfactory* overall**.** The Government remained committed to this project throughout its duration. Its policy of "quiet promotion" of condoms did not obstruct condom social marketing activities, but neither did it actively encourage or promote such activities. The ACP, backstopped by the PCO, provided the technical oversight and support. The PCO provided commendable support to the project throughout implementation. After a learning curve (procurement and disbursement) the PCO performed well w/ improved disbursement, implementation, and regular reporting. The shortfalls in the Borrower performance were the failure to honor its counterpart obligations, inadequate focus on high-risk groups, and the failure to carry out monitoring and evaluation activities, as envisaged in the project design.

6. Lessons and Challenges

6.1 In 1994, the year STIP was approved, Uganda's response to the HIV/AIDS epidemic already claimed over a decade of experience and was characterized by: strong political leadership; early official candor in discussing the problem and its potential impact, both nationally and internationally; a high level of awareness among the general population; an early response by government both to monitor and to contain the epidemic, extending beyond MoH to include other critical sectors, such as Defense and Education; early social mobilization and civil society response; and an HIV/AIDS/STI policy that appropriately prioritized prevention of sexual transmission; and policies that nurtured and encouraged both a decentralized response and partnerships with civil society.

6.2 The degree of success is less certain. HIV prevalence among pregnant women using ANC services has declined over the last decade. However, it is not certain what share is due to increased AIDS mortality and what share to declines in new infections. Available data indicate that both were factors.[69]

6.3 The STIP built on the experience and strengths of the ACP/MoH. By far the largest source of financing to Uganda's HIV/AIDS efforts in its time, the STIP financed inputs and activities which contributed (along with other national, bilateral and international support) to: a decline in the share of young people (15-19 years) who have ever had sex and an increase in condom use with non-regular partners; the expansion of care and mitigation activities in health facilities and at the community level; and the mobilization and strengthening of national capacity (central, district- and local-level government and civil society) to conceive, manage and implement a viable response.

6.4 The experience gained through STIP points to a number of lessons and challenges for further improving the efficacy and efficiency of Uganda's HIV/AIDS efforts.

Lessons

6.5 ***Political commitment is a strong catalyst for mounting a broad-based national response to the HIV/AIDS epidemic. It also influences program content.*** Sensitive to the convictions of religious groups and other facets of civil society, the promotion of condoms and the support of marginalized high-risk groups received only modest support from government and their potential was not fully realized. Support to the social marketing of condoms was included in the project design as an important way to promote condoms against the backdrop of the government's modest support condoms. These activities did succeed in promoting condom use and in making them widely available and accessible in the country. While condom promotion for those engaging in high risk behavior is part of official strategy[70],

69. Ssengooba et al., 2003.

70. Official prevention strategy encompasses Abstinence for youth, Be faithful for those in unions, and Condoms for those engaged in high-risk sex, plus other complementary interventions, such as STD treatment and counseling, promotion of voluntary HIV testing and counseling, among others, coined "ABC-plus."

interviews, newspaper articles and direct observation by the mission reveal that debates about moral behavior and the juxtaposition of abstinence and fidelity against (rather than in complement to) condom promotion have over-shadowed the public health foundations of official strategy, and caused a less than vigorous attention to condoms.[71] The proliferation of media outlets (FM radio stations and newspapers) in recent years has increased discussion and debate about the HIV/AIDS epidemic and exposed disagreements among different stakeholders about how to address it.

6.6 Targeted interventions for CSW and others with high rates of partner change and low condom use have been undermined because they are difficult to reach and because prostitution is illegal. STIP support of interventions for CSW was limited largely to the work of a couple of NGOs in Kampala. Additionally, there is a great stigma attached to this group. For example, a recent article in the New Vision quotes a local leader in the north telling residents of an internally displaced persons (IDP) camp that it is permissible to beat or even kill prostitutes "…because they are the source of high prevalence in the district." (Source: The New Vision, March 16, 2005) Strong leadership to promote and reward work with high risk groups and to remove legal and social constraints associated with this work would go far in enhancing program impact.

6.7 ***Even if it is provided for in project design, monitoring and evaluation will not be carried out if the incentives are not right. The setting of appropriate targets requires (a) knowledge of the right measures of success; and (b) baseline data.*** Neither the Borrower nor the Bank had in place the proper incentives to establish baseline data, set realistic targets and monitor and evaluate program interventions. Nor did either sufficiently exploit available data (UDHS 1995, 2001) in carrying out their final evaluation of the STIP. The decentralization of HIV/AIDS activities to the district level and the support of partnerships with civil society created new challenges for the monitoring and evaluation of program and project interventions. While districts were given responsibility for the collection and analysis of data on program indicators, they were not given adequate training and support to carry out this new responsibility and it was not a priority. NGOs and CBOs were engaged and monitored on the basis of program inputs and outputs and the outcome of their activities was not evaluated. While surveillance reports do provide data on prevalence of ANC women age 15-19 years (the best available proxy for incidence), Government and the Bank in their monitoring and evaluation of this project associated declining overall prevalence with success.

6.8 ***Failure to implement research on the cost-effectiveness of various interventions is a missed opportunity to learn from experience and to enhance program impacts.*** The project design provided for the undertaking of cost effectiveness research on behavior change interventions, home-based care and other health interventions as a means of improving interventions supported by the project. However, the research actually carried out was less practical and appeared to be supply-driven, rather than driven by the program's priority research needs.

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71. Several respondents pointed out that public messages about condom use have waned in recent years.

6.9 ***Reliable provision of relevant supplies is critical to the successful implementation of HIV/AIDS programs.*** The STIP was ACP/MoH's first opportunity to assume responsibility for the procurement of commodities for Uganda's HIV/AIDS program.[72] Thus, experience and capacity were lacking at the project's outset with regard to forecasting needs, procurement planning, management and execution.[73] Capacity was slowly built through experience and intensive technical support and guidance provided by the Bank. Still, delays in the reception and distribution of essential supplies (drugs, reagents, condoms, other) had a depressing effect on service availability and quality, reliability and availability of condoms for those who use them, and delayed some training activities. Over and above the need still for improved procurement capacity, the forecasting of needs and the timely distribution of commodities to rural facilities still needs strengthening.

Challenges

6.10 A follow-on HIV/AIDS operation, the HIV/AIDS Control Project[74], became effective on May 14, 2001, and is expected to close on December 31, 2006 (see Box 3). This project supports the same three objectives as the STIP, but its components are articulated around implementation agencies. It expands the scope of implementing agencies to all sector ministries (as opposed to selected ones under STIP), continues the support of partnerships with NGOs at the district level for district plan implementation, and allocates funds for community-led initiatives.

6.11 Since the late 1980s the MoH has played a pivotal role in coordinating and supporting a multisectoral approach to the fight against HIV/AIDS. Under the STIP MoH capacity was significantly strengthened at the central and district levels, and expanded through the support of contracts with key public sector and non-governmental entities. The placement of the follow-on project under the UAC, instead of MoH, poses a number of challenges to its successful implementation. First, evaluations of the UAC have noted its tendancy to take on a role of implementation, oftentimes duplicating what other ministries (especially MoH) are better equipped to do and transcending its mandate to coordinate.[75] Second, it has been observed that the MoH has become marginalized as one of many line ministry members of the UAC and with a more limited role than it had in the past.[76] Furthermore, the UAC has not shown itself to be sufficiently strategic or selective in working with key public sector agencies. Third, both external assessments[77] and many respondents have noted that district-level AIDS commissions (local branches of UAC) have assumed from the more experienced health districts the role of HIV/AIDS coordination, and are often chaired by non-health officials with little familiarity or experience with HIV/AIDS

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72. Respondents noted that up until STIP was approved, bilateral and international partners provided commodities in kind to Government, rather than the financing to procure them.

73. Limited procurement capacity had been established under the first health operation and was used under STIP, but this proved to be inadequate for the procurement requirements of this project.

74. Supported under the World Bank Africa Region's Multi-Country AIDS Program (MAP).

75. Putzel 2004 and UNAIDS 2001.

76. Putzel 2004.

77. Putzel 2004 and UNAIDS 2001.

initiatives. These challenges call for intensified efforts to ensure: a continued, prominent role for MoH in the fight against HIV/AIDS, a full utilization of MoH technical capacity and experience, both at central and district levels, strict limitation of UAC's role to one of coordination and not implementation, and selective, prioritized support to those sector ministries with the potential for highest-impact interventions.

6.12 Lessons from STIP implementation have specific relevance to this ongoing project as well as to the imminent design of a follow-on project, as follows:

- There are no indicators or project activities aimed at ensuring access to those with the highest risk behaviors. These are unlikely to be addressed through community-led initiatives. Specification of targets, indicators and activities for reaching marginalized, high-risk groups (especially CSW and IDP[78]) and high-risk sites[79] would be helpful in catalyzing support for such high-impact interventions. Collaboration with local authorities, police and Ministry of Justice in reducing stigma associated with these groups and places would facilitate and improve effectiveness of such support.
- The project has supported strengthening of district capacity for monitoring HIV/AIDS knowledge, practices and coverage at the local level, and for using such data in finetuning their interventions.[80] However, indicators are oriented around the general population and do not include groups with high-risk behavior.
- The project and national AIDS program continue to monitor HIV prevalence in the general population as an indicator of success of prevention. HIV prevalence is a bad proxy for HIV incidence in a mature epidemic. Successful efforts to improve access to anti-retroviral treatment will tend to keep HIV prevalence high by

Box 3. HIV/AIDS Control Project

Total Cost: US$50.0 million, of which IDA ($47.50 million) and Government of Uganda ($2.50 million)

Objectives: To support the goals of Uganda's National Strategic Framework for HIV/AIDS, which aims to: (a) reduce the spread of HIV infection; (b) mitigate the health and socio-economic impact of HIV/AIDS at individual, household and community levels; and (c) strengthen the national capacity to respond to the epidemic. In support of a multi-sectoral response, financing would support activities of all line ministries, civil society and communities.

Components: (a) nationally coordinated initiatives (50 percent of project costs); (b) district initiatives (25 percent); (c) community-led HIV/AIDS initiatives (25 percent).

Institutional home of project: Uganda AIDS Commission

Targets for 2006:
- Reduction from 49 to less than 40 percent the proportion of 15-19 year old boys and girls that are sexually active
- Reduction from 14 to 10 percent the proportion of sexually active people reporting non-regular sexual partners
- Reduction from 15 to 5 percent the rate of reported sexually transmitted (urethritis) infections in men aged 15-49 in the last 12 months
- Reduction by 30 percent in the drop-out rate of orphaned children in primary school
- Increase from 30 to 50 percent in the share of men/women aged 15-49 who report using a condom in their last act of sexual intercourse with a non-regular partner
- Reduction from 9 to below 6 percent in the HIV prevalence rate among women attending prenatal care services.

78. Internally-displaced persons.

79. The mapping, targeting and monitoring of sites of high risk sexual activity is another pragmatic way to target high-impact interventions. Sites of high sexual activity and multiple partners are receptive to prevention messages and condoms, but a recent study of sites in Kampala show that these sites are not adequately covered with such activities and services (Source: USAID and Measure Evaluation 2003).

80. Mukaire et al., June 2004

preventing mortality. Suitable proxies for changes in HIV incidence – such as changes in HIV prevalence among 15-19 year old ANC women, in STD prevalence, in sexual behavior and in condom use – should replace HIV prevalence as key indicators for prevention. It is also advisable to ensure comparability of data collected at different points so that trends can be assessed.[81]

- Especially in light of considerable support for community-led initiatives, more rigorous monitoring and evaluation is warranted with controls to ensure that these initiatives are in keeping with Uganda's priorities and public health knowledge.
- To frame the competitive selection of research sub-projects, the preparation of a research framework highlighting operational knowledge gaps and priorities would ensure the optimal utilization of Uganda's research capacity for enhanced program impact.

81. The reference periods for reporting non-regular sex in the UDHS 1995, 2000 were different, making it impossible to assess trends.

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Annex A. Basic Data Sheet

SEXUALLY TRANSMITTED INFECTIONS PROJECT (CR. 2603-UG)

Key Project Data *(amounts in US$ million)*

	Appraisal estimate	*Actual or current estimate*	*Actual as % of appraisal estimate*
Total project costs	73.40	71.85	99%*
Loan amount	36.30	36.08	99.40
Cancellation		0.21	

* Calculated as % of SDR amounts: Original credit: 36.30 million; actual disbursements: 36.08 million.

Project Dates

	Original	*Actual*
Board approval	04/12/1994	04/12/1994
Effectiveness	07/22/1994	07/22/1994
Closing date	12/31/2000	12/31/2002

Staff Inputs (staff weeks)

	Actual/Latest Estimate	
	N° Staff weeks	*US$('000)*
Identification/Preparation	291.90	285.60
Appraisal/Negotiations	60.00	61.80
Supervision	477.45	569.90
ICR	18.41	84.00
Total	847.76	1,001.30

Mission Data

	Date (month/year)	No. of persons	Specializations represented	Performance rating	
				Development Objective	Implementation Progress
Identification/ Preparation	10/1993	4	1 Sr. Public Health Specialist, 1 Public Health Specialist, 1 Economist 1 Operation Officer		
Appraisal/ Negotiation	11/1993	9	1 Sr. Public Health Specialist 1 Operation Officer, 1 Staff Assistant, 1 AIDS Evaluation Specialist, CED; 3 Health Specialist GPA/WHO; 1 Representative, SIDA, 2 Health Economist		
	2/1994	5	1 Economist, 1 Officer, 2 Health Economist. 1 Procurement Specialist		
Supervision	9/1994	2	1 Operations Officer, 1 Economist	S	S
	3/1995	3	1 Sr. Public Health Specialist 1 Operations Officer, 1 Procurement Specialist	S	S
	10/1995	7	2 Operations Officers, 1 AIDS Spec. (WHO), 1 Task Manager, 1 ODA Representative, 1 USAID, WHO, & UNICEF, 1 Implementation Specialist	S	S
	1/1996	6	1 Operations Officer, 1 AIDS Spec. (WHO), 1 Sr. Economist, 2 Representatives 1 Health Specialist	S	S
	4/1996	4	1 Operations Officer, 1 AIDS Spec. (WHO) 1 Sr. Health Economist, 1 Health Specialist	S	S
	11/1996	6	2 Operations Officers, 1 ODA Representative, 1 Task Team Leader 1 Economist, 1 Disbursement Analyst	S	U
	5/1997	8	3 Economists, 1 Team Leader 1 Communications, 2 Public Health 1 Implementation Specialist	U	U
	11/1997	12	1 Team Leader, 3 Public Health Specialists 4 Economists, 1 Implementation Specialist 1 Procurement Specialist, 1 Sr. Program Officer, 1 STD Advisor	S	S
	5/1998	10	1 Team Leader, 2 Public Health Specialists 1 Program Specialist, 1 Implementation Specialist, 1 Sr. Program Officer 1 Sr. Health Advisor, 1 Sociologist 1 STD Mgt. Specialist, 1 Public Health Specialist	S	S
	10/1998	5	1 Mission Leader, 1 Procurement Specialist 1 Implementation Specialist, 1 Medical Sociologist, 1 Public Health Specialist	S	S
	2/1999	4	3 Public Health Specialist, 1 Health Specialist	S	S
	7/1999	3	1 Lad Specialist, 1 Sr. Health Specialist 1 Health Specialist	S	S
	4/2000	7	1 Mission Leader, 1 Principle Health Specialist, 1 Sr. Procurement Specialist 1 Health Specialist, 1 HIV/AIDS Coordinator, 2 Pharmaceutical Experts	S	S
	10/2000	4	1 Team Leader, 1 Lead Health Specialist 1 Health Specialist, 1 Sr. Procurement Specialist	S	S
	3/2001	2	1 Team Leader, 1 Health Specialist	S	S
	10/2001	4	1 Team Leader, 1 Economist 1 Financial Management Specialist 1 Procurement Specialist	S	S
	3/2002	4	1 Team Leader, 1 Team Member 1 Financial Management Specialist 1 Procurement Specialist	S	S
	12/2002	4	1 Team Leader, 1 Team Member 1 Financial Management Specialist 1 Procurement Specialist	S	S
ICR	1/2003	3	1 Team Leader, 1 Health Specialist 1 Public Health Specialist	S	S

Annex B. Persons and Organizations Consulted

Uganda

Kampala

Uganda AIDS Commission
Dr. David Kihumuro Apuuli, Director General
Dr. Lucy N. Korukiko

Former Staff of STIP/Project Coordination Office
Dr. Peter Nsubuga, Coordinator (current Coordinator of Uganda HIV/AIDS Control [MAP] Project)
David Kaweesa-Kisitu, Monitoring and Evaluation Expert (current member of MAP team)
G. Awo
Enginyu S.S.B. Wanda, Procurement (former Procurement Officer, STIP)
Julius A. Byenkya, Implementation Officer (former Implementation Officer, STIP)
Ekaru, Procurement staff

Ministry of Public Health
Mohammed S. Kezaala, Permanent Secretary
Director of Health Planning
Dr. Francis Runumi Mwesigyl, Commissioner Health Services Planning
Dr. Mwebesa, Assistant Commissioner, Health Services (Quality Assurance)
Elizabeth Madraa, Programme Manager, STD/AIDS Control Programme
Vastha Kibirige, Coordinator Condom Unit, STD/AIDS Control Programme
Saul Onyango, Coordinator Care and Support (including PMTCT), STD/AIDS Control Programme
Dr. Wilford Kirungi, Epidemiologist, STD/AIDS Control Programme
Sam Enginyi, Senior Health Education Officer and IEC Coordinator, STD/AIDS Control Programme

Other Public Sector Agencies/Actors
Dr. Musinguzi Ambrose, UPDF (Military)
Captain Richard Rwanyonga, UPDF (Military)
Dr. Sam Agatre Okuonzi, Secretary General, National Council for Children, Ministry of Gender, Labor and Social Development (former Coordinator of DHSP)
Dr. Barungi Thaddeus Cos, Director Police Medical Services
Mr. Bazirakye Kaguta Didacus, Project Administrator, Police Component, HIV/AIDS/STIP, Uganda Police
Dr. Michael Kyonmya, Director, Prisons Medical Services
Dr. D. Nyabwana, Prisons Medical Services
Mbabazi Frances, Project Field Officer, HIV/AIDS/STIP, Uganda Police
Gertrude Kitone, Field Officer, Slum Aid Project
Dr. Josephine Kasolo, Director, Women’s Crisis Centre
Rogers Kasirye, Director, Uganda Youth Development Link (UYDEL)

Dr. Eugene Kinyanda, Volunteer, UYDEL

Non-Governmental Sector/Civil Society

Christine Namayanja, Program Director, Marie Stokes International (MSI-Uganda)
Charles Goria, Sales Manager, Marie Stokes International (MSI-Uganda)
Edward Zzimbe, Marketing Manager, Marie Stokes International (MSI-Uganda)
Dr. Sam Orach, Uganda Catholic Secretariat
Dr. Hitimana, Executive Director, AIDS Information Centre
Jonathan Mubangizi, Records Officer, AIDS Information Centre
Dr. Benon Biryahwaho, Uganda Virus Research Institute
Romano Ojambo-Ochieng, Project Coordinator, ATGWU-URWU HIV/AIDS Programme

Bilateral and International Partners

Dr. Abdikamal Alisalad, Medical Officer/HIV, World Health Organization
Klas Rasmusson, First Secretary, Embassy of Sweden, Kampala
Robert F. Cunnane, Chief, Health, Education and HIV/AIDS Office, USAID
Dr. Peter Cowley, Chief of Party, The Business PART Project
.

World Bank Office, Kampala

Peter Okwero, Senior Health Specialist

District of Mukono

Public Sector
Dr. Ellys K. Tumushabe, District Director of Health Services
Stephen Muwaga, Financial Officer/Accountant, District Health Team

Non-Governmental Sector
Reuben Mubiru Kaggwa, Program Coordinator, Kyetume Community Based Health Care Program
Ruth Kaweesa, Coordinator, Mukono AIDS Support Association (MASA)
Mr. Nkusi, Former STI Coordinator, Naggalama Hospital

District of Soroti

Public Sector
Dr. Okwana, District Director of Health Services
Amodoi-Martin, Health Educator, District Health Team
Edward O. Egou, Health Inspector, District Health Team
Eunice Acieng-Wange, District Health Team

Non-Governmental Sector
Samuel Omiat Eudu, Project Officer, Severe Water and Sanitation Project
Richard Ochen, Program Manager, Health Need Uganda
Samson Etolu, Program Officer, Health Need Uganda

District of Ntungamo

Dr. William Kalikwisya, District Director of Health Services

Dr. William Kalikwisya, District Director of Health Services
Mr. James Ndyanabo, District Tuberculosis and Leprosy Coordinator
Mr. Francis Twesigye, District Health Educator
Appolo Bwendera, District Focal Person, Reproductive Health Services
Edwig Kyarisiima, Records Clerk

Washington, D.C.

World Bank

Mary Mulusa, Senior Public Health Specialist, Former Task Team Leader

Annex C. Timeline of events for HIV/AIDS in Uganda

Year	Uganda		International Events and Donor Support	World Bank
	National events	HIV/AIDS events and data		
1979	Tanzania invades Uganda, unifying the various anti- IdiAmin forces under the Uganda National Liberation Front and forcing Amin to flee the country; Yusufu Lule installed as president, but is quickly replaced by Godfrey Binaisa. (1) The war with Tanzania is fought in the Kagera region of Tanzania and in the districts of Rakai and Masaka in Uganda, where the first cases of HIV/AIDS in Africa were later identified.			
1980	Milton Obote is elected as President and continues guerilla war and human rights abuses.			World Bank first commits to lending directly for health in its Health Sector Policy Paper.
1981				
1982		"Slim" disease affects 17 fishermen at the Kasensero Landing Site on Lake Victoria, Rakai district. First case of AIDS in Uganda diagnosed. (2)	U.S. Centers for Disease Control formally establishes the term "Acquired Immune Deficiency Syndrome (AIDS). ***(3)***	
1983		Reports emerge of deaths from "wasting disease" in the Ugandan border village of Lukunya. ***(4)***	Start of global surveillance of AIDS cases by World Health Organization (WHO). ***(5)*** U.S. government issues recommendations for preventing HIV transmission through sexual contact and blood transfusions, including: avoiding sexual contact with persons with AIDS; risk groups refraining from donating plasma and/or blood; evaluating blood screening procedures. ***(5)***	
1984			AIDS is tabulated as a "notifiable disease" for the first time in U.S. ***(6)*** Isolation of the human immunodeficiency virus (HIV). ***(3)***	
1985	President Obote is deposed in a military coup and is replaced by Tito Okello. (1)	Government establishes National Committee for the Prevention of AIDS. (7)	First international AIDS Conference in Atlanta, Georgia. Reports that there was an older AIDS	

Year	Uganda		International Events and Donor Support	World Bank
	National events	HIV/AIDS events and data		
			epidemic in Africa that may have originated in monkeys, resulting in blame and "finger-pointing" to Africa as the source of the epidemic. African leaders upset at the insinuation and resistance develops to foreign researchers. ***(4)***	
1986	Jan: National Resistance Movement led by Yoweri Museveni seizes Kampala and ousts President Obote. (1) Lord's Resistance Army (LRA) rebel movement is formed, initially seeking to overthrow the government and set up a fundamentalist Christian regime, but subsequently seeking to establish an independent northern state. (1)	President Museveni embarks on national tour which includes message that avoiding AIDS was a patriotic duty. (5) Government launches STD/HIV/AIDS mass IEC campaign, targeted at both general public and high risk groups. Key messages are on vulnerability for risk and prevention methods. (2) May: Minister of Health announces to the World Health Assembly in Geneva that there is AIDS in Uganda and asks for support from the international community in dealing with it. Some African leaders are unhappy as they think this is spoiling the image of Africa. (2) Sept: Cuban President Fidel Castro informs Museveni that 18 out of 60 Ugandans who had gone for military training in Cuba tested positive for HIV. (2) Oct: MOH, in collaboration with WHO, established AIDS Control Programme (ACP). Focused on prevention, care, surveillance and research. (2, 10)	Early results of clinical test show AZT (zidovudine) slows down attack of HIV. ***(12)***	
1987		The AIDS Support Organization (TASO) founded by 16 volunteers as a community organization. (5) AIDS control program established in Ministry of Defense to control the spread of HIV in the military. (10) Uganda Red Cross begins HIV/AIDS control activities by working alongside rock musician, Philly Lutaaya, the first famous Ugandan to go public about his HIV status.	WHO-Global Program on AIDS (GPA) established and calls for establishing national AIDS programs to prevent further transmission. ***(3, 13)*** WHO-GPA provides funding for ACP, 1987-1992. (14) World Health Assembly passes "Global Strategy for the Prevention and Control of AIDS" put forth by GPA, which establishes the principles of local, national and international action to prevent and control HIV/AIDS. ***(4)***	First Health Project identified (December). Government negotiates policy framework paper with IMF and World Bank.

Year	Uganda		International Events and Donor Support	World Bank
	National events	HIV/AIDS events and data		
			President Kaunda of Zambia announces his son has died of AIDS. ***(5)***	
1988		First national HIV prevalence survey conducted to assess the extent of the epidemic: found 9% prevalence rate. (5)	World Summit of Ministers of Health meets in London to discuss common AIDS strategy and reaffirms GPA's role in international leadership. (4)	First Africa Region AIDS Strategy issued: *Acquired Immunodeficiency Syndrome (AIDS): The Bank's Agenda for Action in Africa.* Calls for country-level assistance (lending and non-lending). First Health Project appraised (February), negotiated (May) and approved by Board (June 23). Total estimated cost: US$65.5 million. Objectives: (a) to rehabilitate health facilities; (b) to promote health through prevention (including HIV/AIDS interventions); and (c) to improve efficiency and effectiveness of health care delivery. Projected closing: March 31, 1996
1989		ACP develops guidelines for blood transfusion, warning to prescribe blood only when absolutely necessary. (2) First National Knowledge, Attitudes, Beliefs and Practices (KABP) survey conducted.	WHO issues statement about link between HIV/AIDS and TB, both growing epidemics. (15*)* Total donor support for HIV/AIDS interventions in Uganda from 1989-1998 was approximately $180 mil, representing about 70% of total expenditures on HIV/AIDS activities in Uganda.	First Health Project declared effective (January). Program for Alleviation of Poverty and the Social Costs of Adjustment (PAPSCA) appraised (May). Includes a component to support orphans in Rakai, Masaka and Gulu districts.
1990		AIDS Information Centre (AIC) established to provide VCT services. (5) Government appoints national task force to work out modalities for a coordinated, multisectoral approach to AIDS control. (2) AIDS cases reported in almost all districts. (2)	Jonathan Mann resigns as head of WHO-GPA. ***(5)*** Michael Merson replaces Mann. U.S. government approves AZT for treatment of pediatric AIDS. ***(3)*** IDA, WHO and UNDP conduct multi-donor mission to review AIDS situation and work with government task force on developing a multisectoral response. (11)	PAPSCA approved by Board (February) and declared effective (June 29). Total estimated cost: Relevant support: component to support AIDS and war orphans in Rakai, Masaka and Gulu districts through contracts with NGOs Projected closing: September 30, 1994 World Bank sends sector mission to Uganda to assess the AIDS epidemic and its consequences.
1991		President Museveni reverses his earlier stand against promoting condom use and allows them with a policy of silent promotion. (2) Prevalence rate among pregnant women (15-24 years) at 21%. (5)	WHO develops guidelines for the clinical management of HIV infection in adults. ***(16)*** USAID provides technical and financial support to Uganda's fight against HIV/AIDS.	

Year	Uganda		International Events and Donor Support	World Bank
	National events	HIV/AIDS events and data		
1992		Government adopts the "Multisectoral Approach to Control of AIDS"(MACA): a policy and strategy document that calls for the involvement of all people to fight the epidemic within their mandates and capacities, at all levels. (2) Uganda AIDS Commission (UAC) established by statute of Parliament under the Office of the President. (2) ARV monotherapy using AZT introduced through clinical trials initiated by the Joint Clinical Research Centre. (17) More than 1,000 organizations reportedly engaged in HIV/AIDS control activities in Uganda. (2) MOH merges STD program into ACP. (18) End-1992: 18.3% national HIV prevalence rate. (2)	WHO sets priority target for prevention: availability of condoms. ***(5)*** First successful use of (dual) combination drug therapy. ***(19)*** Funding for UAC Secretariat provided by UNICEF, UNDP, USAID, WHO and IDA. (11)	Issuance of second AIDS Strategy for Africa Region: *Combating AIDS and Other Sexually Transmitted Diseases in Africa: A Review of the World Bank's Agenda for Action.* Updates include: multisectoral approach, focus on "core transmitter" groups; health sector strengthening; and increasing involvement of NGOs/CBOs.. Mid-Term Review conducted for First Health Project (August 13-16).
1993	Decentralization Bill passed by Parliament. (11)	June: National AIDS Consensus Conference and National AIDS Planning Workshop held with participation of 175 people representing more than 50 ministries and organizations. Leads to National Operational Plan for HIV/AIDS/STDs Prevention, Care and Support for 1994-98 developed to operationalize the MACA. (10) On a pastoral visit to Uganda, Pope John Paul II says that "self-control and chastity are the only sure ways to end the tragedy of AIDS." (20)	Reports of transmission of drug-resistant HIV. ***(5)***	Sexually Transmitted Infections Project (STIP) prepared (June – September) and appraised (November). District Health Services Pilot and Demonstration Project (DHSP) preparation launched (November). Total estimated cost: US$75.1 mmillion Objectives: to test and demonstrate the feasibility of delivering an essential health services package to district populations in order to improve efficiency and equity in health services provision. Projected closing date: December 31, 2002 Publication of World Bank Report No. 10765-UG, "Uganda Social Sector Strategy," which highlights AIDS as a major threat to Uganda's development objectives.
1994		Government ministries begin to establish individual AIDS control units – Agriculture,	AZT is shown to reduce the risk of mother-to-child transmission of HIV by 67.5 percent. ***(21)***	STIP negotiated (February), approved by Board (April 12) and declared effective (July

Year	Uganda		International Events and Donor Support	World Bank
	National events	HIV/AIDS events and data		
		Gender, Education, Internal Affairs, Justice, Finance, Public Service, Local Govt. (10)	Two-drug anti-retroviral regimens found only moderately effective in reducing morbidity, add less than one year of disease-free survival and have no real benefit on length of life. ***(22)*** Financial support approved for STIP : IDA (US$50 million); SIDA (US$5.0 million); KfW (US$6.8 million); ODA (US$4.2 million); government counterpart (US$7.4 million).	22). DHSP appraised (May 28) and negotiated (December).
1995	July: Ratification of new Constitution, which legalizes political parties but maintains the ban on political activity. (1) Allied Democratic Front (ADF) rebel movement formed in western part of Uganda, seeking to establish Islamic state.	Uganda hosts International Conference on AIDS and STDs in Africa. Uganda announces declining prevalence rate. (10) National AIDS Documentation and Information Center established as resource center within UAC. (2) Results of DHS show reduction in percent of young adults who have ever had sex, increase in condom use and decline in percent with a casual partner.	U.S. CDC issues first guidelines on prevention of opportunistic infections (OIs). ***(3)*** Results of a randomized controlled trial in Mwanza, Tanzania, find that treatment of symptomatic STDs reduces the incidence of HIV by more than 40 percent. ***(23)***	*Regional AIDS Strategy for the Sahel* issued, which calls for: (1) country-level support through lending and non-lending activities; and (2) regional advocacy and capacity building. DHSP approved by Board (February 7) and declared effective (July 17). PAPSCAP closed (September 30). Publication of World Bank Discussion Paper No. 298, "Uganda's AIDS Crisis: Its Implications for Development," which assesses the nature and momentum of the epidemic and its social and economic consequences. World Bank Country Assistance Strategy issued. Among the highest priorities of this strategy were improvements in health and education. Support to health sector emphasized primary and preventive care, decentralization and HIV/AIDS.
1996	May: Museveni returns to office in first Presidential election under new Constitution. (24)	Uganda begins vaccine trials. (10) MOH creates National Committee on Access to ARV Therapy, primarily focused on making HAART available. Tasks include developing a policy document for ARV therapy, overseeing development of technical guidelines for ARV therapy, quantifying the logistical needs for implementing the ARV program, monitoring and evaluating the ARV	Joint United Nations Programme on HIV/AIDS (UNAIDS) established with six cosponsors: UNDP, UNESCO, UNFPA, UNICEF, World Bank, WHO). Peter Piot named head. Uganda receives first UNAIDS Country Program Adviser. (10) International AIDS Vaccine Initiative (IAVI) founded, launched to accelerate development of preventive AIDS vaccine in developing countries.	*AIDS Prevention and Mitigation in Sub-Saharan Africa: An Updated World Bank Strategy* issued. Five new areas for Bank attention: generating political commitment; risky behaviors; mobilizing resources, cost-effective measures to mitigate the epidemic. First Health Project closed (March 31).

Year	Uganda		International Events and Donor Support	World Bank
	National events	HIV/AIDS events and data		
		program. (25) Community-based trial of mass treatment of STDs in the population in Rakai, Uganda, finds that STD treatment reduces incidence of STDs but *not* HIV. ***(26)*** These results are diametrically opposite those found in Mwanza, Tanzania, and launch a discussion of conditions under which reduction in conventional STDs will lower HIV incidence.	***(3)*** Short-course AZT is shown effective in preventing mother to child transmission in Africa. ***(27)*** Results from clinical trials show effectiveness of combination therapy using protease inhibitors, ushering in era of HAART. ***(28)*** Viral load becomes central piece of information for decisions on beginning and modifying treatments. ***(29)***	
1997	First Poverty Eradication Action Plan (PEAP) is drafted – commitment to reduce incidence of absolute and relative poverty by 2017. (14) Local Governments Act passed – decentralization of government to ensure good governance and democratic participation. (14)	National Strategic Framework on HIV/AIDS for 1998-2002 developed. (2) Uganda Network of AIDS Service Organizations (UNASO) founded as umbrella organization for local agents with HIV/AIDS activities. (31) Ugandans participate in trial using ARVs (nevirapine) for prevention of MTCT. (5)	U.S. government issues draft guidelines recommending early, aggressive treatment with triple-drug therapy: "Hit hard, hit early." ***(32)*** Annual cost of HAART per patient in Western countries is on the order of $20,000. ***(22)*** Issuance of Uganda's Poverty Eradication Action Plan (PEAP). Includes pillar on increasing the quality of life of the poor, including the fight against HIV/AIDS.	Mid-Term Review of STIP (October). World Bank Country Assistance Strategy prepared (August). HIV/AIDS not raised as a prominent as a development issue, but ongoing support under STIP is noted.
1998		Prevalence rate among pregnant women (15-24 years) found to be 9.7%. (5) Communication Strategy for Prevention and Control of STIs and HIV/AIDS developed. (33) Drug Access Initiative established to lobby for reduced prices for ARV drugs and establishment of infrastructure to allow drugs to be generally accessible, primarily for HAART. (25) Test program set up to distribute ARVs and see how an ARV program could be set up and run in a resource-poor country. (5)	April: Uganda reached completion point for Highly Indebted Poor Countries initiative. U.S. CDC issues guidelines suggesting caution in initiating treatment too early. ***(34)***	Mid-Term Review of DHSP (October).
1999	Long-term development plan, "Vision 2025," developed. (14)	MOH starts voluntary door-to-door HIV testing program using rapid tests. (5)	Nevirapine found to be more affordable and effective in reducing MTCT. ***(5)***	*Intensifying Action Against HIV/AIDS in Africa* issued. Four pillars: advocacy to strengthen political commitment; mobilizing

Year	Uganda		International Events and Donor Support	World Bank
	National events	HIV/AIDS events and data		
	National Health Policy developed. (14) Amnesty Act in effect, offering amnesty to all rebel fighters who surrender, until 2001. (35) Bilateral peace agreement signed with Sudan. (35)	End-1999: 8.3% national HIV prevalence rate (2)		additional resources; support for prevention, care and treatment; and expanding the knowledge base. Advocates a "decentralized, participatory approach." Publication of World Bank Discussion Paper No. 404, "Health Care in Uganda: Selected Issues," (August).
2000	PEAP is revised, resulting in PEAP 2000-03.	HIV/AIDS "mainstreamed" into Poverty Eradication Action Plan. (5) National Strategic Framework for 1998-2002 revised, resulting in NSF for 2000/01-2005, which puts HIV/AIDS into the broader context of national development goals. (10) Oct: JCRC begins importing low-cost generic ARV drugs manufactured by Indian company Cipla. (36)	Millennium Development Goals announced, including reversing the spread of HIV/AIDS, malaria and TB. *(3)* UN Security Council meeting held on the issue of AIDS. UNAIDS Executive Director Peter Piot visits Uganda in recognition of the response of the country to the epidemic. (10) World Bank and IMF approve Uganda's Poverty Reduction Strategy Paper. Four pillars: creating a framework for economic growth and transformation; ensuring good governance and security; increasing quality of life of the poor; increasing ability of poor to raise incomes. During 2000-01, external donors spent $43.7 mil on HIV/AIDS activities in Uganda.	World Bank Country Assistance Strategy prepared (December). Under "increasing the quality of life of the poor" pillar, the Bank's support (under the ongoing HIV/AIDS Control Project) to prevention, mitigation and capacity building is highlighted. Uganda HIV/AIDS Control Project (MAP) prepared (October-November), appraised (December 4) and negotiated (December 12). Total estimated cost: US$50 million Objective is to support national goals to (a) reduce the spread of HIV infection; (b) mitigate the health and socio-economic impact of HIV/AIDS; (c) strengthen national capacity to respond to the epidemic. Projected closing date: December 31, 2006
2001	President Museveni re-elected to second and final term with over 69% of the vote. (35)	Uganda HIV/AIDS Partnership Committee established under UAC to engage wide, cross-sectoral representation. (31) ARV therapy (for combination therapy and PMTCT) integrated into the MOH National Program for Comprehensive HIV/AIDS Care and Support. (33) May: Ugandan Business Council on HIV/AIDS launched with aim of persuading large and small businesses to adopt policies to educate staff and support HIV-positive individuals in the workplace. (36) 2000/01 DHS shows that 8% of women and	Global Fund to Fight AIDS, Tuberculosis and Malaria established. *(5)* UN convenes first ever special General Assembly session on AIDS (UNGASS). *(3)*	Uganda MAP approved by Board (January 18) and declared effective (May 14). First PRSC approved by Board (May 31) and declared effective (November 29). Includes support for improving quality and access of health services.

Year	Uganda		International Events and Donor Support	World Bank
	National events	HIV/AIDS events and data		
		12% of men report being tested for HIV. (2)		
2002	Sudan, Uganda sign agreement to contain Ugandan rebel group, Lord's Resistance Army (LRA), which wants to run Uganda along the lines of the Ten Commandments. (1) May: Thousands of children are kidnapped and countless civilians displaced. (1) October: Army evacuates more than 400,000 civilians caught up in LRA conflict and attacks on villages. (1)	Jan: HIV/AIDS Partnership Committee aims to update and monitor implementation of NSF. (33) M&E Subcommittee formed in the UAC to assist with reviewing progress. (33) Communication Strategy for Prevention and Control of STIs and HIV/AIDS revised. (33) UAC begins development of Overarching AIDS Policy aimed at harmonizing national policy and regulatory framework. (33) End-2002: 6.2% national HIV prevalence rate. (2)	WHO publishes guidelines for providing ARV drugs in resource-poor countries, including list of 12 essential AIDS drugs. ***(5)*** In FY 2002/03, 52% of Uganda's total government budget comes from external donors. (30) Apr: Uganda receives $36.3 mil in first round of funding from GFATM. (36)	PRSC II approved by Board (July 23). Includes support for improving quality and access of health services. DHSP closed (December 31).
2003		Oct: Mid-Term Review of National Strategic Framework leads to Revised National Strategic Framework for 2003/04-2005/06. Sept: 2,500 NGOs working on HIV/AIDS in Uganda. (36)	WHO announces 3x5 initiative with the goal of providing treatment for 3 million people by 2005 in resource-poor countries. ***(3)*** UN Office for Coordination of Human Affairs calls the civil conflict in northern Uganda the "world's biggest, neglected, ignored" humanitarian crisis. (36) U.S. President Bush proposes spending $15 billion in combating AIDS in Africa and Caribbean over the next five years (PEPFAR). ***(1)*** US announces that Uganda will be included in list of countries to receive funding from PEPFAR initiative. (36) Oct: Uganda receives $70.3 mil in third round of funding from GFATM. (36)	PRSC II declared effective (March 12). PRSC III approved (September 9). Includes support for improving quality and access of health services.
2004	Second revision of PEAP being developed for 2004-07. (30) February: LRA rebels kill more than 200 people at a camp for displaced people in the north. December: Government and LRA hold first face-to-face talks to end the	NGO National Guidance and Empowerment Network releases report saying prevalence rate is actually 17% - more than four times the official rate. (5) June: 12 members of Parliament make public their decisions to undergo HIV testing to encourage the public that "it is better to know". (5)	May: International donors threaten to stop aid unless the government channels resources away from defense spending. (5)	PRSC III declared effective (February 11). Mid-Term Review of Uganda MAP (March 16). Publication of World Bank Report No. 29425-UG, "Improving Health Outcomes for the Poor in Uganda: Current Status and Implications for Health Sector Development" (June 30).

Year	Uganda		International Events and Donor Support	World Bank
	National events	HIV/AIDS events and data		
	insurgency, but with no results.			PRSC IV approved by Board (September 2). Includes support for improving quality and access of health services.
2005				PRSC IV declared effective (February 25).

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Annex D. STI Project Support: Planned vs. Actual by Component/Subcomponent

Planned Activities by: Component Subcomponent	*Implemented?*	*Comments*
Part A: Prevention of Sexual Transmission of HIV		
A.1: Promotion of safer sexual behavior		
a. Awareness and mass mobilization addressing (i) sexual behavior change, status of women, protection of children and adolescents against sexual abuse and exploitation by adults; and (ii) symptoms and consequences of STIs and how to prevent transmission.		
TV spots produced and aired *to be contracted out	Yes	Outputs not quantified: Materials for prevention messages were developed and disseminated through various forms of the media and through regular service provision by public health units and NGOs. Liberalization of the media in the early years of the project enabled wider coverage.
Radio spots produced and aired *to be contracted out	Yes	
Newspaper articles published	Yes	
Educational materials developed and distributed	Yes	
Dramatic productions at district level	Yes	
Other local-level events	Yes	
b. Community mobilization (through RC system, local NGOs/CBOs, other local health programs/infrastructure		
# communities actively involved in promoting safer sexual behavior	Yes	Number/type of community interventions not quantified in the aggregate. An IEC stratgegy was prepared and implemented to refocus on behavior change (encouraging abstinence for youth, fidelity for married couples and use of condoms during high-risk sex) and on fighting complacency with current prevalence rates. Provision of audio visual equipment and film vans supported and facilitated outreach activities. District and national IEC capacity built through training, equipment. Testimonies by PLWHA.
Community discussions	Yes	
Consensus meetings to assess the risks	Yes	
Development of action and monitoring of changes	Yes	
Community production of drama, videos	Yes	
Community-based counseling and sales of subsidized condoms	Yes	
School campaigns	Yes	
Other	Yes	Procurement of sound broadcasting system for national radio station was inherited from 1st health project and 75% completed under this operation. IEC consultant supported refinement of strategy for behavior change.
c. Targeted behavioral interventions (through national NGOs with extensive capacity and wide coverage, local NGOs/CBOs with experience in delivering behavioral interventions to high-risk groups) – targeting by high-risk sites and high-risk populations.		
Provision of training to public sector and NGO/CBO staff in communication, social, behavioral and decision-making skills for high-risk populations (among others) and financial support to key sector ministries and NGOs/CBOs to support activities		Outputs not quantified in terms of number of NGOs working with high-risk groups, funding amounts provided to each sector ministry and NGOs/CBOs working with high-risk groups, and coverage of high-risk groups.
Adolescent girls	Partial	To some extent, through NGOs and Ministry of Education
Professional sex workers	Partial	Limited to a few NGO interventions in Kampala
Truck drivers	Partial	To some extent
Military	Yes	Extensive support to sector work program prepared and implemented by Ministry of Defense/UPDF

Police, Prisons	Yes	Extensive support to sector work programs prepared and implemented, respectively, by police and prisons departments of Ministry of Interior
Migrant workers	Partial	To some extent through NGOs/CBOs
Slum dwellers	Partial	To some extent through NGOs/CBOs
Other	Partial/No	Fishing communities supported partially; internally displaced persons not at all.
A.2: Provision of condoms (baseline: low availability, low demand)		
Provision of condoms through:	Partial	STIP procured 154.7 million condoms in total (vs. estimated need of 200 million), 81% of all condoms procured during project life and 77% of estimated needs. Condoms promotion guidelines and condom strategy developed. In 2002 (project's last year) some 80 million condoms were distributed or socially marketed (MoH, MSI). Insufficient focus on high-risk groups.
Public distribution at health centers and clinics	Yes	
Distribution through NGOs and CBOs to low-income, high-risk populations	Yes	Insufficient focus on high-risk groups
Distribution to organized groups such as National Resistance Army, Police and Prisons	Yes	
Social marketing, where subsidized products are marketed through retail channels	Yes	Through the creation and contracting with social marketing NGO (MSI), which increased annual # condoms socially marketed from 7 million in 1997 (first year of operation) to 17.7 million in 2002 (the level for 2003 – post-project—was 19.1 million).
Staff training to forecast and meet demand, design systems to monitor condom availability, assist districts in monitoring high risk groups, particularly high-risk.	Yes	WHO provided training in condom management and logistics, but still need to strengthen capacity further. A condom coordinating unit was established within MoH/ACP to keep track of data and coordinate efforts.
A.3: Provision of care and treatment of STDs		
a. Promotion of care and treatment of STDs		
Health care seeking promotion activities to target those at risk of acquiring STDs (sexual partners of patients w/ STD who have been treated; women who are asymptomatic or consider their mild symptoms to be normal):	Yes	
General promotion of STD seeking behavior	Yes	Incorporated into IEC messages
Capacity building of staff in primary health care facilities	Yes	Low quality of health personnel undermined impact of training on staff capacity to provide services.
b. Provision of effective STD care		
Procurement of drugs for STDs through CMS (in line w/ WHO's criteria/guidelines)	Partial	Delays in initial procurement, occasional stockouts requiring ememgency procurement by other donors (ODA, KfW). Combinations of drugs not always available. STD drugs occasionally used by health services for other purposes. Chronic inability to forecast needs. Utilization varied with drug availability.
In-country training of trainers, health assistants, midwives, TBAs, laboratory technicians for the provision of effective STD care. (Training mainly @ district level w/ TA from ACP and National Reference Center for STD)	Yes	Protocols for STD treatment developed and disseminated through training. Training manuals developed, printed and utilized for inservice and pre-service training of nurses. Supervision guidelines also published and utilized.
Develop the institutional capacity to plan, coordinate and implement the STD program, particularly at the district level.	Yes	Incorporated into district plans.
Part B. Mitigation of the Personal Impact of AIDS		
B.1: Provision of support for community and home-based health care and social support for PLWHA		
Financing of contracts between DHTs, NGOs and CBOs to implement home and community care of patients w/ AIDS to provide the following minimum package of services: • Drugs for OI	Yes	Project files did not permit precise quantification of NGO/CBO projects supporting home and community care. Based on available statistics this evaluation estimates that some 700 NGOs/CBOs (or 75% of all 935 NGOs/CBOs supported under the project) carried out such activities, covering most, if not all districts. Interviews, site visits and

• Supplies for AIDS care • Counseling/provision of counselors • Social support.		reports confirmed importance of this activity and reflected more and better activities in districts with strong NGO/CBO presence and capacity. While not specified in the original project design, income generation activities for PLWHA and families were proposed by a few NGOs/CBOs and supported on a pilot basis. Lack of microfinance experience of both NGOs and MoH and failure to contract in such expertise caused these activities to be poorly conceived and not self-sustaining. Training of trainers was intensified to train more counselors in light of great need thus expanding counseling capacity.
B.2: Provision of drugs against OI and staff orientation		
District health facilities (government and non-government) to be supplied w/ drugs for treatment of OI	Partial	Occasional stockouts. Difficulties in monitoring of drug use and drug management and logistics.
Briefing of health care workers @ all levels on concept of a continuum of care and their role in responding to the treatment needs of the individual and also to the emotional and social needs.	Yes	Training and TA to improve case management in health facilities and production of referral and technical guidelines for NGOs and CBOs on home-based care.
B.3: Provision of clinical and protective supplies		
Provision of clinical supplies needed for delivery of care w/emphasis on STD care, TB treatment and MCH/FP activities:	Yes	Exact quantities not available.
• Latex gloves, with priority given to midwives in districts • Sterilizable syringes and needles (to avoid current reuse of disposables) • Provision of disinfectants, mainly sodium hydrochloride solution, to prevent infections in health care facilities	Yes	Exact quantities not available.
Support necessary to maintain a supply of drugs adequate to treat all TB cases promptly (estimated 67,000 new TB cases will be identified and need to be treated over next 5 years)	Partial	Support provided to national TB/Leprosy program in 26 districts (Bank internal reporting), including provision of drugs and diagnostic equipment, training in case management and diagnosis, supervision and expansion of DOTS (expansion to five districts). Shortage of drugs warranted emergency procurement. Supervision missions noted implementation of DOTS to be on track. Combinations of drugs for DOTS not always available. WHO provided support to develop national TB control strategy, including review of the continuum of care and rights of AIDS patients and improvements to the referral system for AIDS management.
Upgrading of national reference laboratory at Mulago Hospital	Yes	
Provision of small supplies such as microscopes, sputum cups, reagents and glassware	Yes	
Part C: Institutional Development		
C.1: District capacity strengthening (in complement to capacity building provided through DHSP project)		
Training for district-level personnel	Yes	Training, supplemented by intensive supervision and technical support, especially during the first two years of district operations to enable districts to assume newly decentralized program functions: planning, coordination, financial management, reporting, monitoring and evaluation. All 45 district health teams benefited from these inputs. Exact numbers of training events, trainees, and supervision visits carried out are not available. Also provided: fellowships for a number of district-level staff to receive master's level training in public health, health education, epidemiology. (See below for

		quantification).
Provision of materials and resources for coordination and supervision	Yes	Provided for and financed in the context of district plan preparation and implementation.
C.2: National capacity strengthening		
Strengthening of ACP, especially STD section; office equipment and supplies, logistics, support to district training and technical supervision activities	Yes	Also provided: fellowships for a number of ACP staff to receive master's level training in public health, health education, epidemiology. (See below for quantification).
Strengthening of STD Reference Center at Mulago Hospital: physical renovation, equipment, supplies, logistics, incremental recurrent costs.	Yes	
Long- and short-term training for central and district-level staff specializations	Yes	*19 long-term training fellowships* were financed, largely focusing on health promotion, health education, sexual and adolescent education, public health, epidemiology and clinical care for HIV/AIDS (4 from districts; 3 from Defense; 12 from central MoH) *23 short-term training fellowships* covering above-mentioned specializations (4 from districts; 7 from Defense; 12 from central MoH) *61 beneficiaries were funded to attend international conferences and seminars* to present scientific papers in most cases. (19 women; 42 men) (4 from districts; 57 from central level)
C.3: Surveillance (district surveillance of STDs and TB to complement reasonably well developed surveillance system and many epidemiological research projects w/ technical and financial support from WHO/GPA and others)		
HIV Surveillance: Training workshops for all staff at sentinel sites (problem solving, orientation of new staff, refresher for existing staff); support for maintenance and strengthening of (already established) quarterly visits of sentinel sites for quality assurance/adherence to standards	Yes	
Support of standardized, comparable and reliable laboratory procedures for HIV testing: refresher training in testing methods and procedures and lab quality assurance methods for Uganda Virus Research Institute and support to Nakasero Blood Bank and AIDS Information Center.	Yes	
STD surveillance: currently 13 PHC using syndromic approach that report STDs to the reference center @ Mulago hospital. Activities envisaged: development of objectives, indicators and standard methods for surveillance and screening; production of training manuals, videos, production and distribution to districts of standard reporting forms	Yes	STD surveillance (particularly syphilis) carried out regularly
TB surveillance: training of staff in district hospitals and PHC in clinical diagnosis and treatment of TB	Yes	Undertaken as a part of training in case management. TB surveillance carried out regularly
General support: design of forms, local training, office supplies, testing kits, local consulting services, vehicle running costs	Yes	
C.4: Operational Research – grants to undertake research to improve interventions supported by the project		
Assessment of models and evaluation of the cost-effectiveness of home-based care (Central level)	No	No research supported on home-based care.
Validation of the syndromic diagnosis of STDs (Central level)	No	
Periodic validation of the STD treatment algorithms and drug regimens (Central level)	Partial	• STD Mass Treatment Study; Rakai Project. Dr. Nelson Sewankambo, Makerere Medical School: 1995/96, 1996/97, 1997/98 (project contribution: support of salary of one staff on major study financed by others) • Quality of STD Case Management in Primary Health Care Facilities in Uganda
Effectiveness of selected behavioral and medical interventions supported by this project (District level)	Partial: Some of these studies are more geared	Behavioral: • Population-Based KABP Surveys (multiple years): Kampala, Junja, Soroti, Lira,

	towards design vs. effectiveness of interventions.	Mpigi, Kotido, Masindi, Mbarara, Pallisa • Time series study of sexual behavior among young people and underlying factors in partner instability. • Case study on AIDS counseling, condom use and change in behavior in Soroti • The effectiveness of IEC radio messages • Teenage sexuality: "compulsory" heterosexuality and AIDS prevention in Ugandan schools • The nature, pattern and correlates of high HIV risk psychological behavioral factors in 2 rural communities of Sentema and Masulita parishes. • The nature, pattern and correlates of high HIV risk behavior among street children attending the UYDEL center in Bakuli Kampala • Determinants of partner referral for STD patients in Uganda Medical: • Study of Efficacy of 2EHRZ/6H3E3 for the treatment of smear positive PTB in HIV infected Ugandans (Mulago Hospital) • Prevalence and predictors of compliance to anti-TB chemotherapy in TB patients in Kampala • A cost-effective analysis study for 2EHRZ/6H3E3 in the treatment of pulmonary TB with HIV-infected Ugandans • Nutritional and hematological indices in patients treated for TB in Mbarara University Teaching Hospital: Associations with HIV infection and outcome of treatment
Follow-up of the National Sero Survey of 1987/88 in selected clusters using the same protocol and sampling frame	No	
Periodic assessment of the surveillance systems and patterns of HIV/STD/AIDS (Central level)	No	
Improvement of database for estimation and projections of infections and AIDS case load.(Central level)	No	
		Unplanned: • Pathophysiology of HIV infection in Ugandan patients • Can ART be offered affordably and cost effectively in Uganda? • Frequency with which psychiatric disorder is associated with a positive HIV serostatus • Economic needs and vulnerability to HIV infection: female adolescents in 4 cities • Viability of HIV in cadavers: implications for teaching medical students • Assessment of HIV related risk behavior and psychological disorder among UTDOA taxi drivers in the old taxi park – Kampala • Culture and sensitivity patterns of Neisseria gonorrhea isolates at Mulago Hospital STD Referral Centre
C.5: Monitoring and evaluation		
Baseline information to be collected on all indicators in 1994 and analyzed annually	No	1995 DHS
Realistic targets to be developed after baseline data has been analyzed.	No	
Surveillance and monitoring of ***behavioral and health outcome data,*** drawing on: • surveillance of HIV, STDs and TB • Special surveys on attitudes and behaviors	Yes	Annual report produced by MoH.

Assessment of project implementation by tracking ***project activity indicators***: • produce progress reports for IDA	Partial	Bi-annual reporting conducted by districts and submitted to ACP which consolidated data into progress reports for IDA
Assessment of ***project effectiveness*** through beneficiary assessments (BAs) at least once during project period. Groups that might be covered: Youth ages 6-20 years old; Individuals w/ STIs; Potential and current condom users and their sexual partners; Pregnant women and their unborn children who receive ANC services; Individuals w/ HIV/AIDS and their families; Individuals w/ TB and their families and colleagues; Health care workers who are trained and who treat HIV, other STIs and TB. Other evaluation studies/special operational research	No	BAs not undertaken.
Tracking ***program impact indicators*** (WHO/GPA prevention and care indicators), mid-term review and final evaluation.	Partial	Mid-term review was carried out in November 1997, and final evaluation report was issued in June 2003, but neither one fully utilized existing data (especially UDHS 1995, 2000) to evaluate impact.
C.6: Innovative NGO activities		
Support of initiatives to develop and try out new approaches, with priority given to NGOs identified and collaborating w/ DHTs and able to develop interventions for prevention of sexual transmission for target populations, especially out-of-school youth, rural women, CSW and their clients.	Partial	NGO/CBO activities included in annual work plans, but most of support was to expand and improve NGO/CBO activities (versus to test new initiatives). There was no special fund (or disbursement category) set up to support innovative activities. Financing was provided through districts, as a part of their plan implementation. NGOs and CBOs operating in districts benefited from training, supervision and commodities provided under the project. A few innovations were tested (e.g., income generation for PLWHA), but there was inadequate attention/tracking of high-risk groups.
C.7: Project management		
Salaries of PCO staff: • Project coordinator/Secretary of Project Steering Committee (appointment) • Professional staff: evaluation, accounting, procurement • Support staff Short-term consultancies on ad hoc basis	Yes	
Provision of 2 vehicles	Yes	
Funds for preparation of a subsequent project	Yes	STIP supported the preparation of the Uganda HIV/AIDS Control Project, which became effective on May 14, 2001.
Project launch workshop	Yes	Held March 1995.
Phasing of implementation (cumulative # districts)		
• Year 1	7	
• Year 2	14	
• Year 3 and thereafter	45	

Sources:
Planned activities: World Bank 1994a.
Activities implemented: Neither the Bank's nor the Government's final evaluation report quantified inputs and outputs delivered with project assistance. This evaluation was unable to compensate fully for this absence of detail. The project files in-country were very deficient in terms of their content and organization. Neither were these fully available in the three districts visited for this evaluation. Similarly, project files were too deficient to permit the analysis of the plans (laid out in Memoranda of Understanding) and actual deliverables of NGOs and CBOs supported under the project. Verification of activities carried out was made by: (i) reviewing actual costs by component and expenditure category; (ii) reviewing available documentation and reports, including those available in the districts visited; (iii) interviewing a range of actors and implementers; and (iv) undertaking field visits.

Annex E. Project Cost and Financing

Table E-1. Planned Versus Actual Project Financing (US$ million equivalent)

Financier	*Planned*[82]	*Actual*
IDA	50.0 (36.30 million SDRs)	48.9[83] (36.08 million SDRs)
SIDA	5.0	5.6[84]
KfW	6.8	6.8[85]
ODA	4.2	4.2[86]
Government	7.4	4.5[87]
Total	**73.4**	**70.0**

Table E-2. Contribution of Cofinanciers and Other Sources of Financial and Technical Support

Partner	*Financial Contribution*	*Area of Support*
SIDA	US$5.6 million (cofinancier)	Provided several resident consultants to support the PCO throughout life of project; regular supervision missions, which were very supportive and productive; PCO consultants developed the financial and management capacity of the PCO and of districts.
DFID	US$4.2 million (parallel financier)	Financing of emergency procurements to close gaps in commodity supplies due to project procurement issues; participation in regular supervision missions; consultant support to improve drugs and medical supplies logistical management; support to procurement logistics.
KfW	US$6.8 million (cofinancier)	Social marketing of condoms; and procurement of drugs and condoms on an emergency basis; regular supervision/support through KfW mission based in Uganda; consultants in procurement planning.
USAID	(no direct financial support)	Provision of resident technical staff as STD Advisor to the project, who regularly supervised project activities; complemented project STD efforts through direct support of STD control interventions in 10 districts and sharing of technical expertise in IEC.
WHO/ UNAIDS	(no direct financial support)	Substantial contribution to project design and implementation (through regular supervision); support to emergency procurement of condoms; provision of consultants to build capacity in management of TB and STDs, epidemiological surveillance and care and support activities.

Table E-3. Planned vs. Actual Use of IDA Credit by Disbursement Category (millions of SDR)

Disbursement Category	*Initial Allocation*	*Final Allocation (by DCA Amendment)*	*Actual*	*Actual as % of Initial Allocation*
(1) Drugs Supplies and Equipment				
(a) under Part A.1 and 2 of Project (promotion of behavior change and targeted behavioral interventions)	3.20	2.05	2.05	64%
(b) other (for services and care)	21.00	18.34	18.34	87%
(2) IEC Materials	4.00	3.11	3.14	79%

82. Source: World Bank Staff Appraisal Report 1994.

83. World Bank Controllers Information System 2005.

84. Ibid.

85. KfW Completion Report, July 2000, and DHSP/STIP/Ministry of Health, Financial Handover Report as of end-2003. The latter report notes that an additional grant worth US$5.7 million (Euro 5.12 million) was secured for condom social marketing operations. Since this was a follow-on grant and much of it was provided for the time period after the initial closing date, it is not reflected as additional cofinancing to this project.

86. DHSP/STIP/Ministry of Health, Financial Handover Report as of end-2003.

87. Ibid.

Disbursement Category	Initial Allocation	Final Allocation (by DCA Amendment)	Actual	Actual as % of Initial Allocation
(3) Vehicles	1.40	1.35	1.35	96%
(4) Monitoring, Research and Training	3.45	8.87	8.92	258%
(5) Technical Assistance and Studies	0.44	0.60	0.59	134%
(6) Unallocated	2.81	0.00	0.00	
(7) Incremental Recurrent Expenditure	0.00	1.76	1.91	Not initially foreseen as IDA-financed expenditure
Reconciliation of Special Account			- 0.22	
Total	**36.30**	**36.08**	**36.08**	**99%**

Source: World Bank Controller's Information System: March 21, 2005.
Note: US$ equivalent of total disbursements (36.08 million SDR) as of March 2005 is US$48.88 million.

Table E-4. Planned vs. Actual Use of Swedish Trust Fund by Disbursement Category (millions of SEK)

Disbursement	Trust Fund 27945			Trust Fund 27946			
Category	Allocation	Actual	Actual as % of allocation	Original Allocation	Revised Allocation	Actual	Actual as % of Revised Allocation
(1) Drugs Supplies and Equipment							
(a) under Part A.1 and 2 of Project	2.0	0.82	41%		9.05	9.41	104%
(b) Other	9.0		0%	2.5	---		0%
(2) IEC Materials	1.0	4.84	484%	14.0	7.50	6.85	91%
(3) Vehicles			---		---		---
(4) Monitoring, Research and Training	2.5	4.19	168%	2.5	7.95	7.77	98%
(5) Technical Assistance and Studies	0.5		0%	1.0	---		0%
(6) Civil Works		1.39	Not initially foreseen as SIDA expenditure		---		---
(7) Operating Expenses		4.33	Not initially foreseen as SIDA expenditure		2.50	2.40	96%
Reconciliation of Special Account		-0.71	--		---	-1.47	---
Total	**15.0**	**14.86**	**99%**	**20.0**	**27.0**	**24.96**	92%

Table E-5. Project Financial Allocations as a Share of Total Financial Allocations for HIV/AIDS, 1994/95 – 2000/01 (US$ millions)

	1994/95	**1995/96**	**1996/97**	**1997/98**	**1998/99**	**1999/00**	**2000/01**
Donors	21.464	28.870	41.210	41.431	27.091	42.284	27.242
of which STIP	*3.150*	*8.755*	*16.898*	*17.554*	*14.762*	*21.172*	*14.445*
Domestic Financing	0.002	0.006	0.005	0.004	0.004	0.003	0.003
Total	21.466	28.876	41.215	41.435	27.095	42.287	27.245
STIP as % of total financing	**15%**	**30%**	**41%**	**42%**	**55%**	**50%**	**53%**

Source: Ddamulira 2002 and Ministry of Ffinance, Planning and Economic Development, approved budget estimates and public investment plan 1991/92 – 2000/01

Annex F. Project Outcomes by Objectives and Targets

Note: Provisional targets on sexual behaviors specifying proportionate changes were set during project design in the absence of baseline data. These targets were never revised when the 1995 DHS data on these indicators became available, as had been planned. A second DHS conducted in 2000 allows for the analysis of trends in sexual behavior over the life of the project. For all other project indicators, baselines were never established and end-of-project data were never collected and analyzed.

Objective sub-objective (or means) Indicator (Source: World Bank 1994a)	***Baseline Data*** (Source: World Bank 1994a and UDHS 1995)	***Target*** (Source: World Bank 1994a)	***Actual Achievement***	***Comments/proxy indicators***
Objective #1: To Prevent sexual transmission of HIV				
Intervention 1a: Promotion of safer sexual behavior				
% of people aged 15-49 to cite at least two acceptable ways of protecting themselves from HIV by the end of the project		50%		
Increase in proportion of people aged 15-49 reporting the use of a condom during the most recent act of sexual intercourse *with a non-regular partner*	Women: 20% Men: 36% Source: 1995 UDHS	20-25% increase over baseline *Provisional target; never revised when 1995 UDHS baseline data became available*	Women: 38% Men: 59% Source: 2000 UDHS	Indicator, as originally stated in project design did not specify "with a non-regular partner", but this specification provides a more appropriate measure, and DHS data are available to show trends.
% decrease in # people aged 15-49 who report having had at least one sex partner other than the regular partner(s) in the last 12 months divided by total number of people aged 15-49 who report having been sexually active in the last 12 months	Women: 12%; men: 30% Source: 1995 UDHS	20% decrease over baseline *Provisional target; never revised when 1995 UDHS baseline data became available*	Women: 14%; men: 28% Source: 2000 UDHS	DHS data available reflect all (married and unmarried) women and men who report sex with a non-regular partner in the past year. Change in this indicator was not substantial for either women or men. The slight increase in this risky behavior among women was found both among urban and rural counterparts. While there was a slight decrease in this risky behavior among men, a notable increase among urban men is noted: from 43 to 49 percent.
Intervention 1b: Provision of condoms				
Indicators				
Condom coverage: # condoms available for distribution *at the central level* during the preceding 12 months divided by total population aged 15-49	Not established.	90-100%	Not available.	While data as specified are not available, a significant increase in the number of socially marketed condoms has been documented, as well as their wide availability throughout the country (over 10,000 points of sale). This, combined with the acquisition and distribution of free condoms by MoH, with the support of NGOs and community-based distributors, has culminated in significant improvements in condom availability and access. See relevant data in other parts of this Annex. Project provided 143.25 million condoms against a total (revised) projection of 200 million (or 72 percent of target). **Mostly achieved.**
Condom coverage: # people *at the peripheral level* estimated to have access to condoms divided by the total population aged 15-49	Not established.	Not specified.	Not available.	

Interventions 1c and 1d: promotion of care-seeking behavior and provision of effective STD care				
% of individuals seeking care: # individuals seeking STD care in health facilities assessed and treated in an appropriate way divided by the total number of individuals seeking STD care in health facilities	Not established.	50%	Not available	While no data were available to assess systematically the adequacy of treatment of those seeking STD care and of advice and support to prevent further transmission of STDs, field visits and interviews indicated that while project investments in training, drugs and other essential inputs may have contributed to modest improvements in the quality of services, issues of human resources quality and availability, inconsistent supply of drugs and use of STD-designated drugs for other purposes all constrained the achievement of this objective. 1995 and 2000 DHS show a decline in proportion of women w/ STDs who sought treatment or advice (from any source): from 78.1% to 60.5% . Levels remained virtually unchanged for their male counterparts (67.8% in 1995; 69.9% in 2000). Between 1995 and 2000 there was a decline in the proportion of women w/ STDs who informed their partners (from 74.0% to 50.7%), while there was an increase in STD-infected men who informed their partners (from 57.6% to 63.2%). Both women and men infected with an STD reported low but increasing rates of condom use to protect their partner from infection: (from 2.5% to 6.1% of women; and from 4.6% to 15.9% of men). **Not achieved.**
% of individuals seeking STD care: # individuals seeking STD care in facilities who received counseling, a condom, advice on partner notification, divided by total number of individuals seeking STD care in health facilities	Not established.	70%	Not available	
% decrease in # pregnant women 15-24 with positive serology for syphilis divided by the total number of pregnant women aged 15-24 attending antenatal clinics whose blood has been screened	Not established	20% decrease from baseline data	Not available	Data were not collected to systematically to permit trends analysis. 1995 and 2000 UDHS data show an increase in the proportion of sexually active women who report having STD or STD symptom in previous 12 months: from 3.5% to 7.5% (self reporting is likely to be significantly underestimated)
% decrease in # reported episodes of urethritis in men aged 15-49 in the last 12 months divided by the total number of men aged 15-49 surveyed	Not established.	20% decrease from baseline data	Not available	Data were not collected to systematically to permit trends analysis. 1995 and 2000 UDHS data show a decrease in the proportion of sexually active men who report having STD or STD symptom in previous 12 months: from 6.3% to 3.1% (self reporting is likely to be significantly underestimated)
% decrease in # pregnant women aged 15-24 testing seropositive for HIV, divided by total number of pregnant women aged 15-24 attending antenatal clinics whose blood has been screened	Not established.	Not specified. % decrease from baseline data	Not available	Significant declines in prevalence among ANC women have been documented in this young age group, with a leveling out of rates since the late 1990s and into the new millennium. (see statistical annex). While prevalence is not an accurate indicator of incidence (rate of new infections), data on younger cohorts of women is more closely related to HIV incidence than is HIV prevalence among older women. See Figures from various ANC sites in this Annex.
Objective #2: To mitigate the personal impact of AIDS				
Intervention 2a: Support for community-based health care and social support				
Total # people attending HIV/AIDS management training		Not specified	Not available.	
# people receiving AIDS-related health services in the community compared to # people in need of such services		Not specified	Not available.	The Uganda AIDS Commission informed the mission during its in-country discussions that, while this data is currently not available, an ongoing exercise to map all HIV/AIDS services and coverage across the country will provide the first set of baseline data of this type against which future support will be planned and measured. In the meantime, project assistance did expand and support community-based care and social support, including the training of massive numbers of community-based care
# people receiving social support services for AIDS-related issues from community compared to # seeking such services		Not specified	Not available.	

# social support service providers in the community by type of social support		Not specified	Not available.	givers and counselors. Some 700 NGOs/CBOs were supported in their efforts to provide home-based/community-based care, while districts provided outreach support through training and interfacing with NGOs/CBOs. Data do not exist to allow a quantification of such support in terms of original indicators: coverage (# beneficiaries as a % of # of those in need) and number of persons trained. Prpoject reports, interviews and site visits provide anecdotal evidence of improvements in the quality and availability of AIDS care, reductions in social stigma, and improvements in the quality of life and life expectancy of AIDS patients. **Achieved**
Intervention 2b: Provision of drugs for opportunistic infection				
# individuals receiving drugs for treatment of opportunistic infections divided by # seeking (or in need of) drugs for OIs		Not specified.	Not available	**Unevaluable.** Counseling training provided to health workers (public and NGO/CBO) is reported to have substantially promoted positive living with HIV/AIDS. Improvements to capacity in the clinical management of AIDS patients is also reported, although the mission was not able to verify this.
Intervention 2c: Provision of TB case management				
# people receiving TB case management compared to # of people w/ TB		Unspecified	Not available	Directly Observed Treatment Short Course (DOTS) for TB was introduced in only 5 districts. Not data available to show the proportion of those on DOTS to those with TB. The detection rate for new smear positive cases has decreased from 61% in 1997 to 52% in 2001 (WHO 2005). The cure rate for new smear positive cases has increased from 40% in 1997 to 63% in 2000, but this rate is still very low compared with those of other SSA countries. **Unevaluable.**
Objective 3: To support institutional development to manage HIV prevention and AIDS care				
Interventions 3a and 3b: • **Strengthening the districts' capacity to plan, coordinate, implement, monitor and evaluate integrated AIDS-related activities** • **Strengthening the national capacity to provide adequate technical support on health issues related to AIDS**				
% of AIDS Control Program components being performed adequately		Unspecified	Not available	Data were not systematically collected to permit trends analysis. This being said, strong indications of strengthened capacity at district and national levels have been documented in Government and Bank reports, and were confirmed during field work associated with this evaluation. Evidence includes: • At district level: regular preparation, implementation, supervision and monitoring of district HIV/AIDS plans, through a participatory process; • At national level: improvements in strategic management by ACP/MoH, backstopped by PCO, including improved and expanded surveillance and operational research; 2nd generation surveillance; improved procurement planning and implementation (with improvements still needed); a concrete move towards a multisectoral approach with support to and involvement of key sector ministries/public agencies; • Within the NGO/CBO sector: the utilization and expansion of civil society capacity through the support and facilitation of contracts/partnerships with civil society and their inclusion in other program activities (planning, supervision, training, etc.).

Annex G. Trends in Program Outcomes

Introductory note: UDHS data for 1995 and 2000 point to numerous trends in knowledge, attitudes, behavior and condom use, which the STIP was trying to affect. Tables G.1 and G.2 group these trends into three categories: (a) those that indicate no change or very small change; (b) those that indicate significant, positive trends in program outcomes; and (c) those that indicate setbacks in program outcomes. These tables clearly show that the main outcomes achieved during the project life were: (a) increases in the practice of abstinence among the young cohorts of Uganda's population; and (b) improvements in condom availability and use during high-risk sex. Graphics on knowledge and behaviors that follow these tables supplement those presented in the main text and provide visual detail of these trends.

Table G.1. Trends in Knowledge and Attitudes among the General Population (15-49 years) from 1995 to 2000 (Source: UDHS 1995, 2001)

No Change/ Very Small Change (< 5%)	*Positive Trends*	*Setbacks*
Knowledge and Attitudes		
Knowledge of AIDS: Virtually universal among men and women in 1995, and again in 2000 (GPA 1989: 97% of men and women knew of AIDS)	***Increase in women's knowledge that HIV can be avoided by using a condom (a):*** 21% to 54% • Urban: 44% to 78% • Rural: 17% to 50%	***Decrease in women's knowledge that HIV can be avoided by limiting sexual partners (a):*** 62% to 50% • Urban: 58% to 47% • Rural: 62% to 50%
Knowledge that AIDS can be avoided: from 86% to 87% among women; from 91% to 95% among men (GPA 1989: 84% of women; 88% of men. However urban bias and wording of questionnaire requires caution in interpretation of trends)	***Increase in men's knowledge that HIV can be avoided by using a condom(a):*** 32% to 72% • Urban: 58% to 84% • Rural: 28% to 70%	***Decrease in men's knowledge that HIV can be avoided by limiting sexual partner(a)s:*** 58% to 46% • Urban: 56% to 48% • Rural: 59% to 45%
Men's knowledge that an HIV-infected person can appear healthy: constant at 88% (GPA 1989: 54%)	***Proportion of women who have heard of condoms:*** 76% to 88% • urban: 92% to 97% • rural: 76% to 86% (UDHS 1989: 33% • urban: 62% • rural: 29%)	
Knowledge of someone suffering or who died from AIDS: 85% to 90% among women; 91% to 90% among men. (GPA 1989: 54% of women; 60% of men)	***Increase in share of men who have heard of condoms:*** 89% to 97% • urban: 97% to 99% • rural: 87% to 97%	

(a) Spontaneous (unprompted) questions

Table G.2. Trends in Behavior among the General Population (15-49 years) from 1995 to 2000 (Sources: UDHS 1989, 1995, 2001)

No Change/Very Small Change (< 5%)	*Positive Trends*	*Setbacks*
Sexual Behavior		

	Increase in median age at first sex in 15-24 age group:
	• women: 16.7 years to 17.3 years
	  ○ 15-19 group: 16.9 to 17.5
	• men: 17.6 years to 18.3 years
	  ○ 15-19 group: 17.8 to 18.5
	  ○
	
	(GPA 1989: 1989 women: 16.5)	

	Increase in share of 15-19 year olds who have never had sex: • Women: 39% to 48% • Men: 53% to 61%	•
Condom Use		
	Increase in share of women who know where to get condoms: 32% to 53% • urban: 59% to 85% • rural: 28% to 47% (UDHS 1989: 22% • urban: 48% • rural: 18%	
	Increase in share of men who know where to get condoms: 60% to 77% • urban: 85% to 96% • rural: 55% to 73%	
	Increase in women's use of a condom at last sex with a non-regular partner: 20% to 38% • urban: 46% to 59% • rural: 11% to 30% • sexually active 15-19 year olds: 20% to 49%	
	Increase in men's use of a condom at last sex with a non-regular partner: 36% to 59% • urban: 62% to 81% • rural: 29% to 50% • sexually active 15-19 year olds: 26% to 52%	
	Increase in ever use of condoms among women: 6% to 15% • urban: 23% to 39% • rural: 3% to 11% • sexually active 15-19 year olds: 8% to 28%	
	Increase in ever use of condoms among men: 16% to 40% • urban: 41% to 74% • rural: 12% to 34% • sexually active 15 to 19 year olds: 21% to 44%	

Knowledge[88]

Figure G.1 Heard of condoms

women men

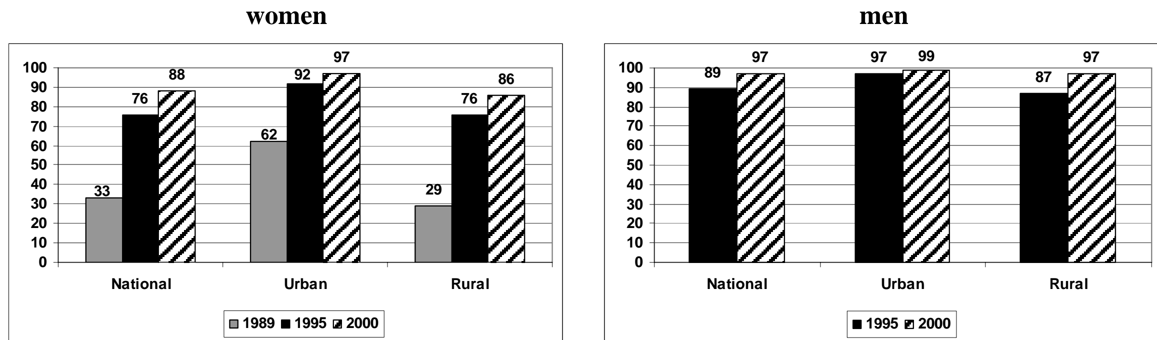
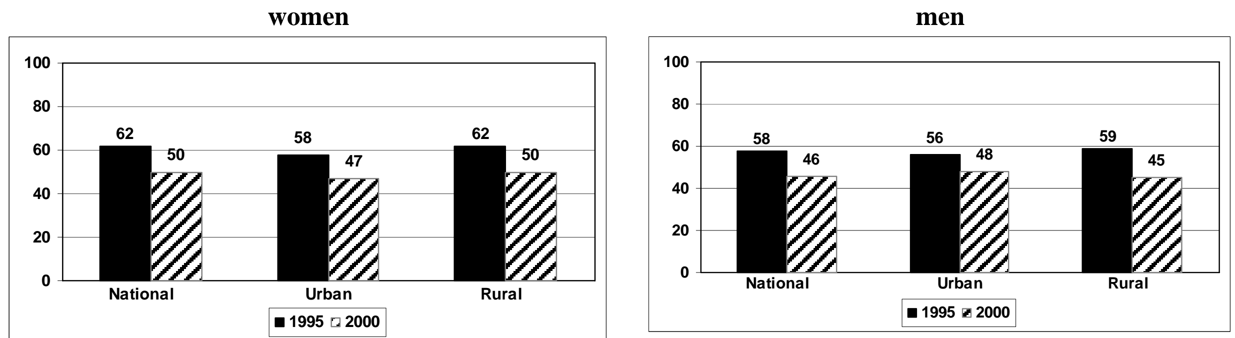


Figure G.2 Knows HIV can be avoided by limiting sexual partners, 1995, 2000 (unprompted reporting)

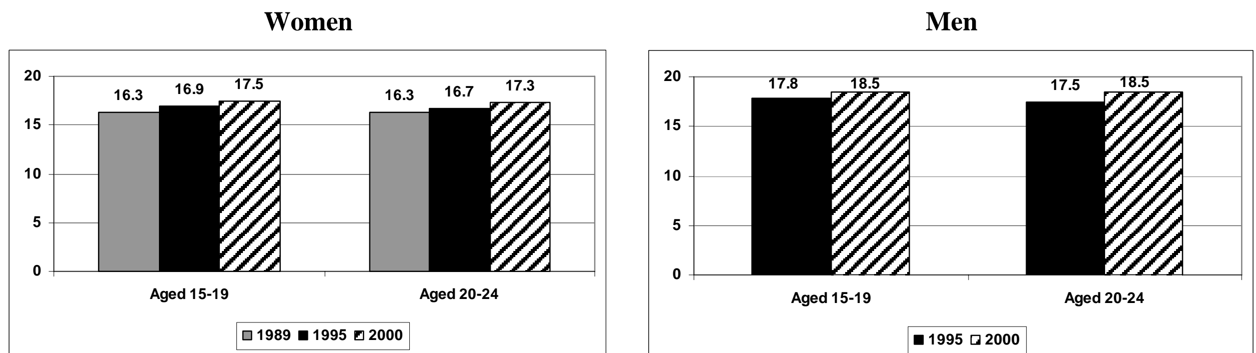
women men



Sexual Behavior[89][90]

Figure G.3 Median age at first sex by age group and gender

Women Men



Source: UDHS 1995, 2000 and UAC et al 2003

88. Sources: UDHS 1989, 1995, 2001 and UAC et al., 2003

89. Ibid.

90. Other relevant data on sexual behavior collected in UDHS 1995 and 2000 could not be exploited for trends analysis because they were not comparable on questions regarding never-married persons having sex, extramarital sex, sex with a non-regular partner and sex with two or more partners. The 1995 UDHS specified a reference period of the previous six months, whereas the 2000 UDHS specified a reference period of the previous 12 months.

Condom Use[91]

Figure G.7 Heard of condoms

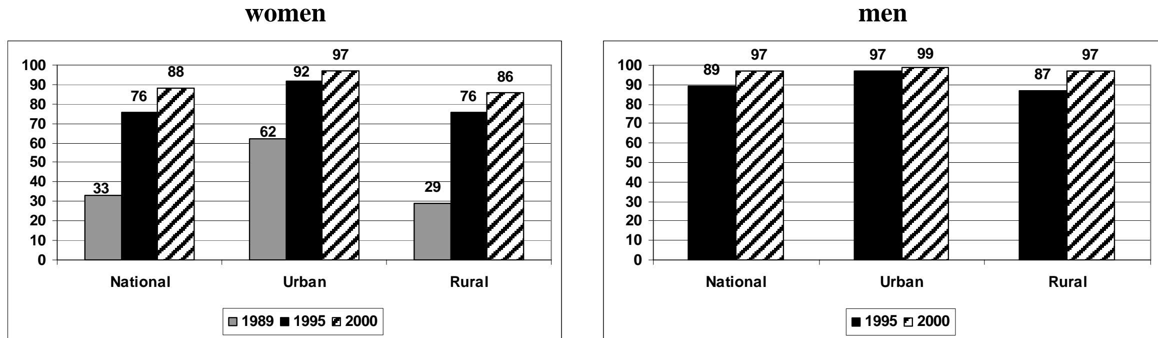


Figure G.8 Knows where to get condoms

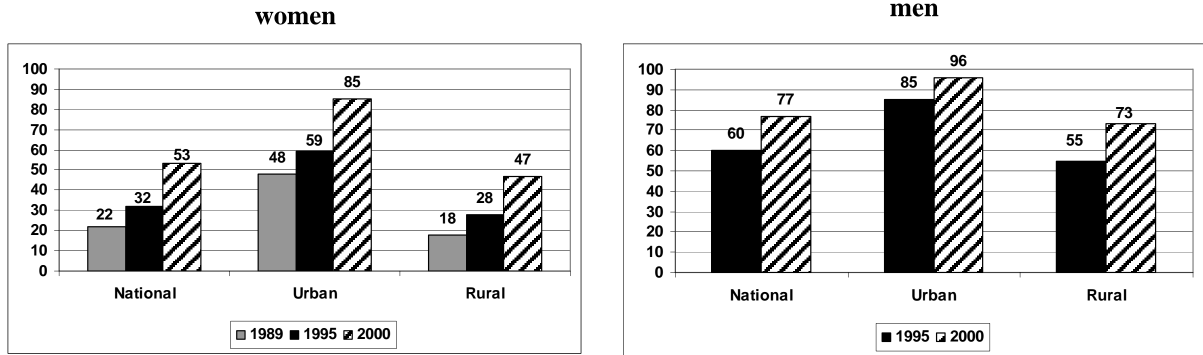
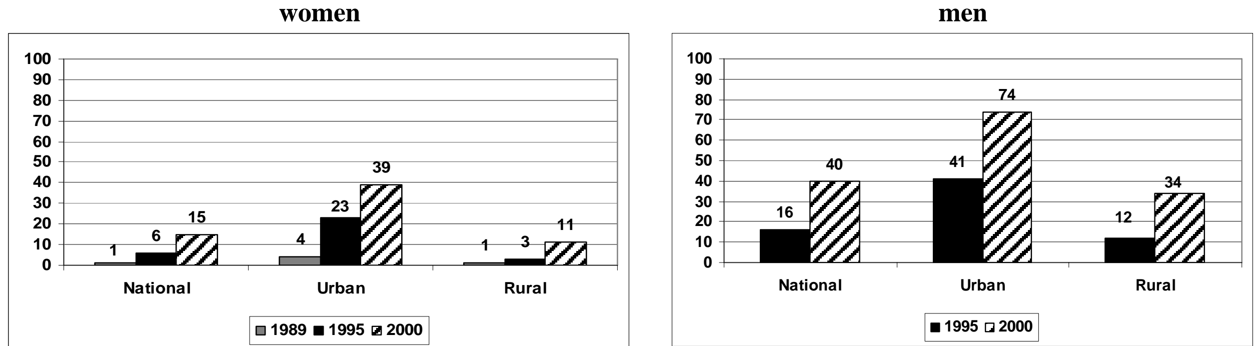


Figure G.9 Ever use of condoms



91. Source: UDHS 1989, 1995, 2001 and UAC et al., 2003

Figure G-10. Share of men and women who know where to get condoms

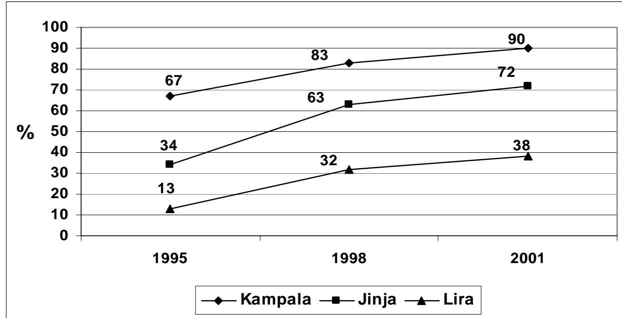
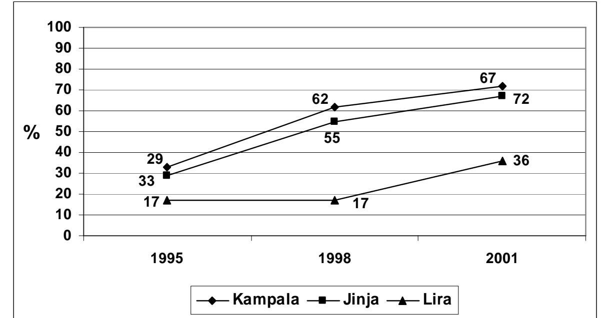
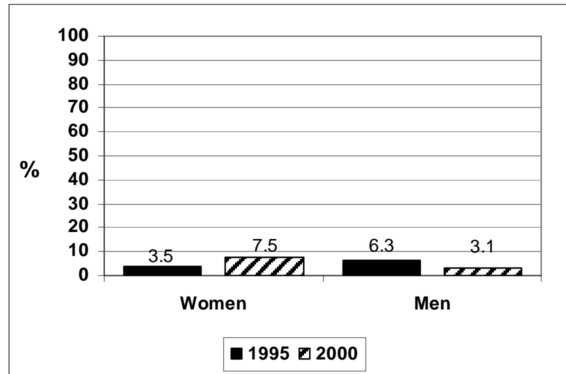


Figure G-11. Used condom at last sex with non-regular partner



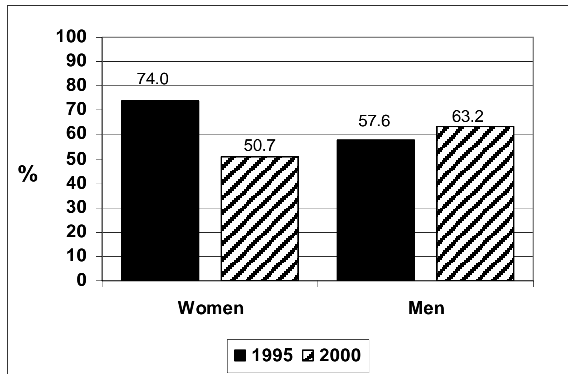
Source: HIV/AIDS surveillance report, June 2002; STD/AIDS Control Programme, Ministry of Health

Figure G.12 Proportion of all sexually active men and women who reported having an STD or STD symptoms



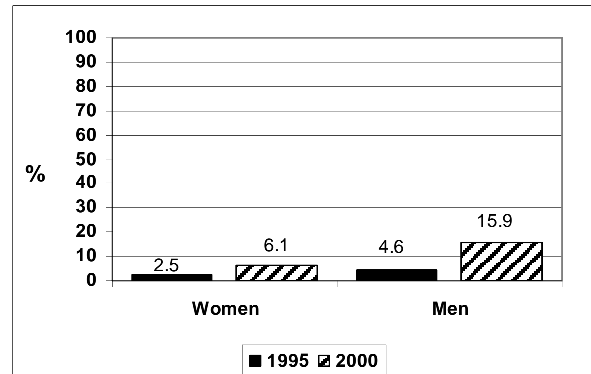
Source: UDHS 1995, 2001

Figure G.13 Proportion of all men and women reporting STD or STD symptoms, who informed their partners



Source: UDHS 1995, 2001

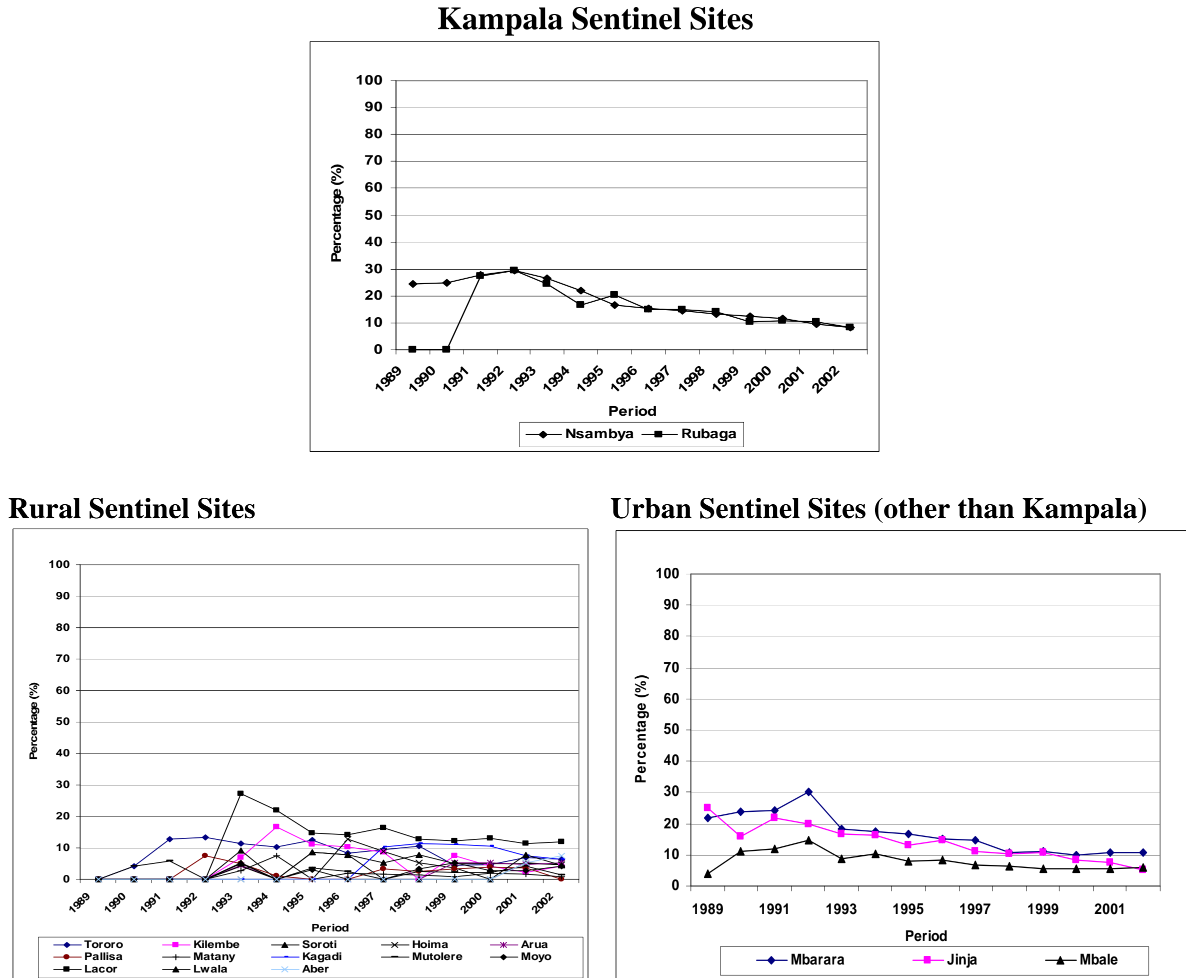
Figure G.14 Proportion of all men and women reporting STD or STD symptoms, who used condoms to protect partners



Source: UDHS 1995, 2001

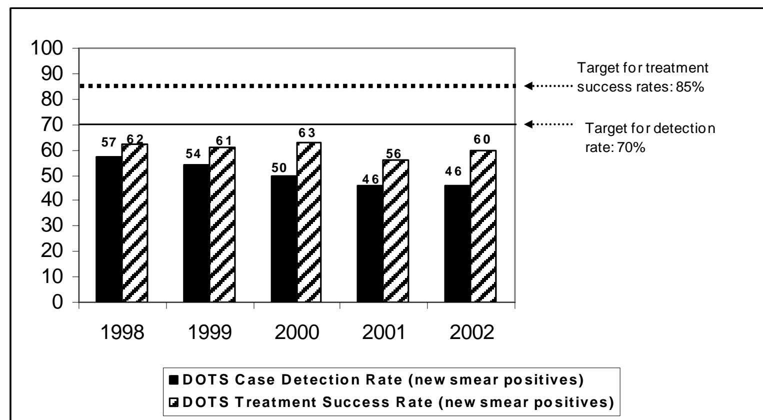
Trends in HIV

Figure G.15 HIV Prevalence Rates Reported by Antenatal Clinics, 1989-2002



Source: Ministry of Health 2003a

Figure G-16. Case detection and Treatment Success Rates



Source: WHO Annual TB reports for 2004, (for 1998-99) and 2005 (for 2000-02)

Table G.3. Incidence rates of HIV/AIDS in cohort in rural Southwest Uganda

Year	*Incidence N(/1000PYAR)*
1990	16(6.7)
1991	22(6.1)
1992	21(5.5)
1993	34(8.5)
1994	23(5.7)
1995	23(5.5)
1996	20(4.7)
1997	20(4.6)
1998	9(1.9)
1999	20(4.3)
2000	16(3.5)
2001	16(3.7)
2002	18(4.7)

PYAR= person years at risk.

Source: HIV-1 incidence and prevalence in rural South-West Uganda:
13 years of follow-up. Medical Research Council Programme on AIDS, Uganda Virus Research Institute.

Table G.4 HIV prevalence rates among ANC women by sentinel site, 1989 - 2001

	Nsambya	Rubaga	Mbarara	Jinja	Tororo	Mbale	Kilembe	Soroti	Hoima	Arua	Pallisa	Matany	Kagadi	Mutolere	Moyo	Lacor	Masindi	Lwala	Nebbi	Aber
1989	24.5	-	21.8	24.9	-	3.8	-	-	-	-	-	-	-	-	-	-	-	-	-	-
1990	25	-	23.8	15.8	4.1	11	-	-	-	-	-	-	-	4.1	-	-	-	-	-	-
1991	27.8	27.4	24.3	22	12.8	12.1	-	-	-	-	-	-	-	5.8	-	-	-	-	-	-
1992	29.5	29.4	30.2	19.8	13.2	14.8	-	-	-	-	7.6	-	-	-	-	-	-	-	-	-
1993	26.6	24.4	18.1	16.7	11.3	8.7	7	9.1	-	4.4	5	2.8	-	4.2	5	27.1	-	5.3	-	-
1994	21.8	16.5	17.3	16.3	10.2	10.2	16.7	-	-	-	1.2	7.6	-	-	-	21.9	-	-	-	-
1995	16.8	20.2	16.6	13.2	12.5	7.8	11.1	8.7	-	-	-	-	-	3.6	3.1	14.7	-	8.7	-	-
1996	15.4	15.1	15	14.8	8.2	8.4	10.4	7.7	12.7	-	-	2	-	2.6	-	14.3	-	7.7	-	-
1997	14.6	14.8	14.5	11	9.5	6.9	8.5	5.3	9	-	3.2	1.6	10.3	-	-	16.3	-	-	-	-
1998	13.4	14.2	10.9	10.5	10.5	6.3	-	7.7	5.4	-	2.6	1.3	11.5	2.5	3.2	12.8	-	-	-	-
1999	12.3	10.5	11.3	10.8	4.5	5.7	7.5	5	3.5	5.2	3.2	0.9	11	2.3	5.2	12.3	-	-	-	-
2000	11.8	10.7	10	8.3	4.7	5.5	4.2	5	-	5.2	3.8	1.9	10.5	2.1	2.7	13.1	-	-	-	-
2001	9.5	10.4	10.6	7.4	7	5.6	2.1	5	5.3	4.8	3.7	1.7	7.4	4.1	2.7	11.3	-	7.9	-	5.3
2002	8.5	8.1	10.8	5	6.3	5.9	4.2	4.6	4.6	5.2	-	0.7	6.4	1.5	4.3	11.9	4.7	4.4	1.3	7.6

Source: HIV/AIDS surveillance report, June 2003, STD/AIDS Control Programme, Ministry of Health.