NAFOPHANU
The National Forum of PLHA Networks in Uganda
The Quarterly Newsletter
Uganda AIDS Commission
Civil Society Fund
Volume 1 : Issue 3
June - December, 2009

COPING WITH HIV/AIDS IN ARMED FORCES

NAFOPHANU visit to the Fourth Division Post Test Club in May 2009 in Gulu District.

By Stella Kentutsi

In the recent past, armed forces have been considered as one of the categories of the Most At Risk Populations (MARPS). This is because of the nature of their work that involves deployment/movement from one area to another and more often than not, leaving their families behind. In the process, a number of officers have acquired HIV/AIDS. In a bid to forestall and mitigate the impact of HIV transmissions and infections, NAFOPHANU, on inception in 2003, organized to have Uganda Peoples Defence Forces (UPDF) included in its networks/forums and thus, treated as a special district of armed forces and represented at the Board of Directors level.

Despite the formation of the UPDF district forum, there has been no clear leadership structure at various levels such as division and Headquarters which made the Armed Forces constituency lack proper representation at the national level. The UPDF were recipients of the Stephen Lewis Fund from NAFOPHANU, but due to lack of streamlined leadership with no clear systems and structures, the livelihood support project could not benefit the PLHIV in the UPDF as targeted.

Consequently, discussions were held in 2008 between the Forum and leaders of UPDF. One such meeting was held on December 5, 2008 to streamline and strategically position UPDF in particular and armed forces generally in the national HIV/AIDS response. The meeting agreed on ensuring better quality of life for UPDF members who are living positively and those of the surrounding communities. This was to be done through building the institution's capacity and framework for supporting members of UPDF and the surrounding communities in coping with HIV/AIDS infection and effects, and promoting behavioral change, acceptance and positive living. An interim committee of the UPDF, guided by NAFOPHANU was put in place.

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Editorial

Welcome to NAFOPHANU third edition newsletter

The year 2009 has been another fruitful period for NAFOPHANU and very crucial in the sense that we have been able to enhance our activities as well as our relevancy at the district level through the aid of Civil Society Fund (CSF).

The main activity has focused on scaling up the capacities of PLHIV district leadership to increase coordinated PLHIV network formulation and registration. Forty PLHIV forums have been empowered financially to efficiently and effectively reach out to their target groups in this case the networks. Other beneficiaries of the CSF are the national networks. These have been boosted with funds to be able to reach a wider coverage of cohorts such as women, youth, men, children, and religious leaders among others.

Through Partnership Committee (PC), NAFOPHANU has also carried out coordination meetings to enable PLHIV forums plan, re-strategize where possible and also elect their representatives to key national HIV policy committees. In addition, PC has also funded a research into men's involvement into the national HIV response and NAFOPHANU will soon disseminate a comprehensive report in that regard.

The role of UNAIDS cannot also be over emphasized. The ongoing campaigns to see to it that the current HIV Prevention and Control Bill is not passed in parliament in its current form has been jointly done with UNAIDS. Regional consultations (on how the general public perceives the Bill) were rolled out and a report is in place.

Soon, UNAIDS will fund a media campaign to further concretize the need to address very pertinent clauses in the Bill that may dwindle the current achievements gained so far in the HIV national response. Other close partners since the year begun include; HEPS-Uganda and Great Lakes Initiatives on HIV/AIDS (GLIA), among others. Also significant to note is our ability to streamline HIV/AIDS in the Armed/Uniform Forces- Army, Police and Prisons. We now have in existence a PLHIV forum for the 18 UPDF divisions, well coordinated with committed leadership.

However, the main challenge faced in the HIV constituency today is the ARVs crisis/Stock outs, leave alone their side effectives, counterfeit and resistance/ drug failure. This newsletter brings out different interventions on ART, HIV Prevention and Control Bill, nutrition, among other HIV related issues.

Enjoy your reading,
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Designed and Printed - Artfield Graphics

COPING WITH HIV/AIDS IN UNIFORMED FORCES

Monitoring visit to Armed Brigade Masaka in May 2009

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Basing on the above background, members agreed to do everything possible to streamline leadership at divisional and national level. To this end, visits to UPDF divisions to reorganize and establish PLHIV networks/Post test clubs became paramount as a starting point for a strong and empowered forum. With support from the Partnership Fund of Uganda AIDS Commission, the exercise was embarked on. The joint UPDF-NAFOPHANU exercise started on May 1, 2009 with Kabamba and Mbarara and was concluded on July 2, 2009 with Military Police and Chieftaincy of Military Intelligence (CMI). In all, 18 divisions and independent units were visited. They included; Kabamba, Mubende, Kakiri, Mbarara, Masaka, Nakasongola, Masindi, Gulu, Pader, Moroto, Mbale, Magamaga, Jinja, Presidential Guard Brigade (PGB), Airforce, Military Police, CMI and Bombo General Army Headquarters. In each of the visits, focus group discussions were held with a selected team of officers irrespective of status. This involved sharing of what was actually on the ground, that is activities, challenges, ARV status for officers who are living with HIV, election of committee members and forging a way forward. The mini-situational analysis laid foundation for the action planning exercise that the members had to work on and was later shared in the general meeting at Bombo on 16 July 2009.

The officers recommended a number of strategies for increased involvement of all stakeholders but largely starting at division/ independent unit level. these included; establishment of ART centres in all divisions/ units, decentralise service delivery for units/ divisions that have branches, capacity building in various skills e.g. life planning skills, peer counselling, positive prevention, I.G.As identification, initiation and management, among others.

Having concluded the exercise, a general meeting for the Post-test clubs networks' leaders was organized at Bombo on July 16, 2009 to share the field findings, lay foundation for a sustainable district forum and elect the district forum leadership and BOD member. It was attended by all newly elected/confirmed leaders, UPDF Directory of HIV/AIDS services, NAFOPHANU and Uganda AIDS Commission (UAC).

Representing UAC, Owek. Joyce Namulondo Kadowe gave the background to the HIV/AIDS response in Uganda, successes, challenges and highlighted the role of people living with HIV/ AIDS in the struggle against the pandemic. She observed that PLHIV are no longer seen as recipients but are equal partners in national response-are key actors in controlling epidemic. GIPA principle thrives on PLHIV who are front liners in advocating for MIPA vs. GIPA as well as ensuring implementation of prevention with positives as stipulated in the National Strategic Plan (NSP), She urged NAFOPHANU to ensure functional district networks, access to Civil Society Fund (CSF) and ensure capacity building of district networks including those in UPDF. On the side of the UPDF Directorate of HIV/AIDS services, Lt. Col. Mr. Stephen Kusasira say uniformed officers are currently enjoying an unenviable position in HIV intervention: happily consorting with fishermen, truck drivers, commercial sex workers under the unholy matrimony of MARPS [Most at Risk Populations] which marriage must be broken using the post test clubs leadership and multiple stakeholders.

PLHIV are no longer seen as recipients but equal partners in national response

He adds that the HIV/AIDS program started 1987 and UPDF recognizes HIV/AIDS as one of the security threats. The program transformed overtime from just a component of public health to a fully fledged directorate, implications of which are; resource allocation – both human and monetary and increased expectations from both the leadership and target population while serving the two service arms [Lands and Air force]. The programme scope targets prevention, HIV Counselling and Testing (HCT-both static and mobile) and treatment, care and support. The other cross cutting programme components include Policy issues, PMTCT, SGBV, M&E, Lab support, I.E.C material development, School programs and operational research. There are 12 accredited centres with 5700 people on ART, individual testing -20491 tested in 2008, couple testing, children testing (873 tested in 2008), routine counselling and testing and PMTC testing with 363 in 2008 alone. Lab equipment has been acquired and personnel trained in a number of skills.

Despite the achievements, the programme has challenges such as implementers are elastic with high turnover without specific deployment to the Directorate, commercialization of interventions, incomplete task shifting, non contextualized I.E.C materials. Other challenges include; 'stupid' confidentiality policies, population mobility- clients and service providers, high training costs, limited lab monitoring, and M&E issues such as different reporting areas with diverse requirements/ indicators some of which are unrealistic, obsession with numbers from support partners, unfair attribution of outputs and personnel, and computerization of all data being limited.

The Guest of Honour, Major-General Katumba Wamala, Chief of Land Forces, appreciated the work by all stakeholders and pledged support to the now organized networks.

The interim district forum executive was confirmed to lead all post test clubs and Captain Cassette Wamundu elected BOD member representing Armed Forces (UPDF).

Plans underway are to incorporate Uganda Police and Prisons in struggle to prevent more infections and promoting access to treatment .The strategies with contacts are already in place.

The author is the Programme Manager,
NAFOPHANU

Women Drama Group performing at Positive Prevention workshop in Rukungiri in July 2009

Criminalizing HIV transmission targets women most

BY Flavia Kyomukama

How can we criminalize HIV transmission when we haven't fulfilled our own obligations in the family, community and government? Where is the Penal code in all this? How about the Domestic Relations Bill and Sexual Offences Bill? How much investments have we put into livelihoods to contain HV transmission?

All the above questions beg for answers. However, HIV/AIDS in a culture like ours has really doomed us Africans. In a country like Uganda where:

- Only 12% Ugandans have actually tested for HIV and actually received their results,
- Only 17% of the people living with HIV know their HIV status.
- 60% of couples are discordant.
- In the year 2007/8 only, 80 million condoms were procured,
- Where Prevention of Mother to Child Transmission (PMTCT) coverage is only 42%. ,
- The government does not allocate any specific resources to HIV but rely on foreign donation and sympathy.
- Some international NGOs have all registered locally to also take part of the available resources which may have otherwise benefited the local organizations.
- A country Where Joint Clinical Research Council has pulled out of some centres and cannot enroll any new person with HIV for ART unless their CD4 is 150mm or below.
- Annual new HIV infection is 132,000 and 25% of these are newly born.

And, where only 30 % of global investment has gone to agriculture in the last decade plus increased sale of public propriety with impunity with no accountability to the people. This has further complicated the already complex situation.

Therefore, criminalizing HIV transmission has the following consequences especially on women. Firstly, women are the ones that interface with health centres more regularly and likely to be tested for HIV and therefore discover their HIV status first. The HIV Bill in the offing indicates women will be asked to inform their spouses and if they do not within a stipulated time then the doctor or counsellor will inform the husband. What is likely to happen in such a situation? I hope we are thinking on the same plane. If yes – the woman is likely to be sent out of the home if she is seen as source of HIV infection and therefore denied a livelihood even if she has been in the family and contributed, for say, over 20 years to the family development. So , wont this prescription endanger society? Aftermath of HIV screening, many times a man may send the woman away, she is packed off with her children or if she leaves the children then the children may get less attention from the new mother and consequently get abused by relatives and employees in the household. The abuse can range from child labour, dropping out of school, incest, defilement and rape. For the case of a girl child, she may be forced to find love elsewhere and will land in the hands of other scavengers in form of men, get married early, have unwanted pregnancies and the unfortunate cycle continues. This will be a key source of new infections.

Another scenario likely to pop up is children suing mothers for HIV infection, children may murder mothers. Children born with HIV frequently hear of messages like, when you have sex with one infected, you are likely to get re-infected so their thinking is that since one who is HIV negative will not infect me, I will go in for that one. For this young boy or girl, it's a means of prevention, isn't it? And isn't that what our medical personnel preach to us. The next day when an HIV negative girl or boy gets infected, then they will sue the other partner. In their defense if they referred to the information received from the health centres about being re-infected by fellow HIV colleagues, would not they have a case?

The other issue is the ABC plan. If one is told to keep free from HIV he/she must Abstain, Be faithful and or use a Condom. Take a case scenario where one practices ABC at 28, he/she gets a partner and marries. Then two years later one partner finds has HIV. What would his or her reaction? That my partner I live with was the one who infected me! The recipe we prescribe for the young people must be richer than ABC yet most young people receive that message plainly.

We must ensure that people have ample livelihood to pay for their children to remain in school, to afford travelling to the ART centres, to afford to understand condom use and related negotiation- this is especially difficult for girls/females. We must ensure that we have PMTCT that reaches all the sub counties. The Domestic Relations Bill (DRB) that seeks to protect the rights of woman and men in the family

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VCT tent the entry point for treatment at Mildmay Uganda

Mildmay: Restoring life to its fullness

By Rosemary Mbabazi

Africa is home to 80 percent of PLHIV (People Living with HIV), according to the 2007 UNAIDS updates. And over the past two-and-half decades, the pandemic has continued to ravage communities and infringe on the freedom of those living with it from fulfilling lives. However as we wait for scientists on trials for an HIV/AIDS vaccine as a long lasting solution to this pandemic, Mildmay Uganda has been privileged to be apart of those dedicated to contribute towards addressing this challenge.

Mildmay Uganda lives up to its mission; "a world where everyone with HIV/AIDS can have life in its fullness".

We do this by offering clinical and holistic care to both children and adults living with HIV/AIDS as well as training of healthcare workers in that field. HIV/AIDS is no longer a stranger in our midst with a record of over 31, 000 clients treated since the centre opened its doors to the public in 1998.

Last year as Mildmay celebrated our 10th anniversary, it was a time to not only jubilate but also to ponder on the long yet significant journey that started as a simple invitation by the Ugandan government through the Uganda AIDS Commission to develop a care programme for people living with HIV/AIDS.

In 1993, Mildmay International was entrusted with the task, which led to the opening of The Mildmay Centre located at Lweza on the Kampala –Entebbe road as part of Mildmay International HIV/AIDS programmes overseas.

Mildmay International operates in other African countries that include Kenya, Tanzania, Zimbabwe and Rwanda. Today, Mildmay Uganda continues to grow as one of the country's leading centres for specialised HIV/ AIDS care, treatment and training for both children and adults.

The centre has not only restored health through its services but has given a ray of hope to hundreds of people living with HIV/AIDS with over 14,000 patients, 66 percent of them on Anti-Retroviral Therapy (ART). This has been possible through the adult out-patients clinic that operates four days a week.

The lives of children living with HIV/AIDS have also been transformed by accessing free care and treatment including paediatric Anti-Retroviral-Therapy through Out-patients care, Noah's Ark (children receive supervised care on site as they wait to see a doctor) and In-patient care for intensive treatment of acute problems.

Mildmay Uganda uses a multi disciplinary approach to care and treat its clients with all efforts geared towards addressing a total person; physical, psychological, spiritual and social aspects. These include specialist medical and nursing care, counselling, pastoral care, physiotherapy, occupational therapy, an X-ray and

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Making children speak out on Serostatus

By James Lule

An opportunity to speak out about one's challenges is the beginning of opening up that usually brings about change in many things. However, many people may find it difficult. We often ask whether this is the right time to speak or whether this is when we are supposed to act. So, it is of paramount importance that many things are in place before one speaks out or acts. This could be a dilemma facing children too. Children need some assurance to get where to place their trust. The children's future is in our hands and it's upon us to create a friendly environment for them. We need to give a significant and fundamental attitude towards our children because we hold their future. Positive children are often very inquisitive on how they got infected since they are young and innocent in this dynamic life. It's the role of us all to understand the importance of disclosure in children, especially those living and affected with the HIV virus.

The trust our children have in us should not be ignored. It's our responsibility to reconcile with all possible means to freedom and to deal candidly with any situation which eventually will enable our children live a better life.

It is important to understand the pain our children go through. We get enraged when our children's dignity is injured, that kind of rage can only be provoked by the strongest love that must occur when those we love most are hurt or injured in any way. We have sometimes denied our children their rights; some have not gone to school and have not received essential needs in their life. Therefore, it is the obligation for us all to comfort, be understanding, love and keep them safe.

At least the hope of our children should be restored by grandparents as care givers in absence of parents. We need to remind our selves that children are the pillars of society. Understanding children's fears and what they need from the general community internationally is critical.

Let us listen to some of our children's jokes, comments about sex and try to assess the depth of their understanding. How much they know can attribute to direct experience as opposed to family and school sources. You may assume that your children have learnt a lot about HIV/AIDS from media, classes in school and how to take care of themselves, which may not be the case. If children have learnt a lot about HIV/AIDS, it surely has not made them cautious. There are women, men and young people in families and communities who are vulnerable; exposed to HIV and misjudged. May we accept each other so that together we can make a difference, and yes we can!

The writer is KADFO+ Coordinator

Behavioral change emphasized at Candle Light Day

By Lule James

The annual celebrations to mark Candle Light Day were celebrated on May 18, 2009 at Muzinga Park, Entebbe. The function which started at 8:30am was flagged off by the chief guest, the Speaker of Parliament Hon. Edward Kiwanuka Ssekandi who started by lighting a fire. He said that remembering the dead will not change anything but rather it is behavioral change which is key and must be incorporated in all HIV/AIDS interventions. Ssekandi also said more should be done to protect and respect lives of PLHIV.

The Director General Uganda AIDS Commission, Dr. Kiwumulo Apuuli noted with sadness the increase in HIV infections, wondering whether the HIV/ADS messages out there have had any impact in the HIV/AIDS National response. He wondered why people know about HIV but have not changed behaviour. He appealed to members to change their life styles so as to reduce the HIV/AIDS prevalence rates, not to mention avoiding new infections.

In his welcome remarks, the Mayor of Entebbe Steven Kabuye thanked participants for having selected Entebbe to organize this very important occasion as we remember our dear ones who have died of HIV/AIDS. He thanked all those carrying out vaccine studies and those in the struggle to mitigate the virus in Uganda. He encouraged people to go for HIV counselling and testing (HCT) as well as as fighting stigma and discrimination.

Rev. Canon Kisawuzi who led the prayers reminded Ugandans that HIV/AIDS is still a serious problem while sensitization is still minimal. Kisawuzi noted that there must be a change in people's behavior. He urged people living with HIV not to transmit it to others and asked for more support to PLHIV.

Hon. Edward Kiwanuka Sekandi lighting a fire during this year's Candle Light Day Celebrations in Entebbe Municipality

Participants also received information about people living with HIV/AIDS in Wakiso from the District Forum of PLHIV Networks.

Dr. Ponsiano Kalebu from International AIDS Vaccine Initiative (IAVI) said they are working hand in hand with international community to ensure HIV vaccine development. He briefly gave the statistics of HIV/AIDS in Uganda and called upon continued education to young people as this will help reduce the spread of HIV/AIDS and other illnesses. Dr Kalebu said through this, we shall be able to manage the epidemic and reduce morbidity and mortality in Uganda. He called for public awareness, community and families involvement in HIV/AIDS prevention.

Guests were entertained by different support groups which included TASO, SAIL, Baylor College of medicine among others and exhibition of different items and activities was done by partner organizations.

The theme for this year celebrations was; " Together we are the solution." The candle light day was celebrated together with the World vaccine awareness day. In attendance were religious leaders, government officials, officials from Wakiso district among others.

The writer is Coordinator, KADFO+

Criminalizing HIV transmission targets **women most**

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has consistently been opposed in this country. Do we ever put into perspective the aspects that the DRB would sort out if we had a better justice system that ensures equity and equality for men and women? Allow me to keep thinking aloud as you know when thinking there is no order. Our justice system has been weak in protecting woman and children especially in the days of property and land grabbing by relatives and other people. Many women and their children lie on the streets because their greedy uncles and aunts cannot bear to see them enjoy the fruits of their departed parents. If they go to police, police will ask for money before before action is taken. However today, I think no police man can interfere in any property and land wrangles as the President has had to intervene to help. Many women living with HIV have often been stressed to death by court frustrations and prefer to ignore their spouse property in the hands of intolerant in-laws. Even for FIDA, which is supposed to provide legal services, entails costs unaffrdable in the litigation.

Today, issues of sex in Africa and Uganda are rarely discussed in public. Sex issues still remain in the private realm. Can the initiators of the HIV Bill tell us how to go about reporting some husbands and boyfriends who rape us every night? After he paid the bride price, can we say it is rape for a married woman? Oh if I recall aloud again, isn't the Sexual Offences Bill (SOB) which is supposed to regulate this rape and define rape is only gathering dust on the shelves?

The writer is the National coordinator, Global Coalition of Women Against HIV/AIDS in Uganda

Is **Counterfeit Bill** timely for Ugandans?

By Richard Serunkuma

In Uganda, the majority of the population especially PLHIV have difficulty in accessing essential medicines required to treat not only HIV/AIDS but even opportunistic infections such as tuberculosis and malaria.

However, don't you think policy issues such as the Counterfeit Bill may add to the already miserable situation in the Health sector? One in every three people in the world does not have basic medicines they need. For some the cost is too high. For others, the medicines are not available in their local health centres. It has been learnt that reliance on the market alone to supply medicines to develped countries including those most affected by HIV/AIDS is still minimal. It is against this background that Medicine Transparency Alliance (MeTA) in conjunction with the Uganda Coalition for Access to Essential Medicines (UCAEM) organized a five day MeTa Civil Society Capacity Building Workshop in Jinja on April 26th – 30th, 2009. The theme of this workshop was; "Increasing Transparency and Accountability in Medicines Procurement and Supply Management".

Richard (R) receiving a certificate of attendence during a MeTa Civil Society Capacity Building Workshop on April 26th - 30th 2009 in Jinja

Presentations were made by stakeholder bodies such as MoH, JMS, NMS, MeTA, UCAEM, Experience sharing by participants and field visits to selected agencies and health centers formed a vitally extensive learning plan. It was noted that there is great need to educate communities; including policy makers on the meanings of the counterfeit bill before it is passed.

The term "counterfeit" under the bill is so broad that it includes generic medicines! Yet, counterfeit should mean "deliberate and fraudulently, with the intent to deceive, produce in any manner, counterfeit trademark goods and pirated copyright goods including counterfeit medicines."

In fact passing the bill with its overly broad definition would have far reaching consequences. It would in effect ban the local manufacturing, exportation and importation of generic versions of medicines patented in Uganda; including the ARVs currently being manufactured by Quality Chemicals Uganda Limited.

Now that it is set for its second reading in parliament; it may be passed and enacted into law, amidst concerns and gaps. And therefore all stakeholders ought to act now. If passed, the bill may hamper access to generic medicines on which most Ugandans and PLHIV in particular depend on. One of the biggest lessons learnt was the difference between Generic and Branded medicines which in the current bill are both portrayed as counterfeits. 35 participants were drawn from various CSOs such as UNCHO, POMU, NACWOLA and NAFOPHANU in Uganda. It was learnt that:

- Branded medicine is the actual medicine that was manufactured by the innovator / originator while a Generic medicine is "a copy of the originator/innovator medicine containing exact active ingredients.

Other equally important issues to note include:

- Generics are substantially cheaper than Brands as there are no costs related to research and development (of the medicine).
- The term Counterfeit can apply to both branded and generic medicines or any other products
- 90% of the medicines we in poor countries like Uganda use are generics; and they work!
- Counterfeit medicines/products may be with the correct or the wrong ingredients, poor quality ingredients, without active or insufficient ingredients; or with fake packaging

Last December, HAI Africa Pharmacist Ms Christa Cepuch, said that Kenyan parliament passed its counterfeits bill into law and the President assent to it. However, she highlights the need for the civil society to act faster focusing on collaborative action with various stakeholders; information sharing using briefings, fact sheets and web postings calling for international input; engagement with MPs; textual drafting in collaboration with the clerk to the parliamentary health committee; and constant media contact.

And therefore CSOs in Uganda should enhance poor people's access to affordable and quality essential medicines by improving transparency and accountability within the marketplace.

In conclusion, significant and regular improvements, consultations and policy reviews should be carried out to save the many lives of Ugandans who cannot even access the 'so called' counterfeit essential medicines.

The writer is POMU National Coordinator.


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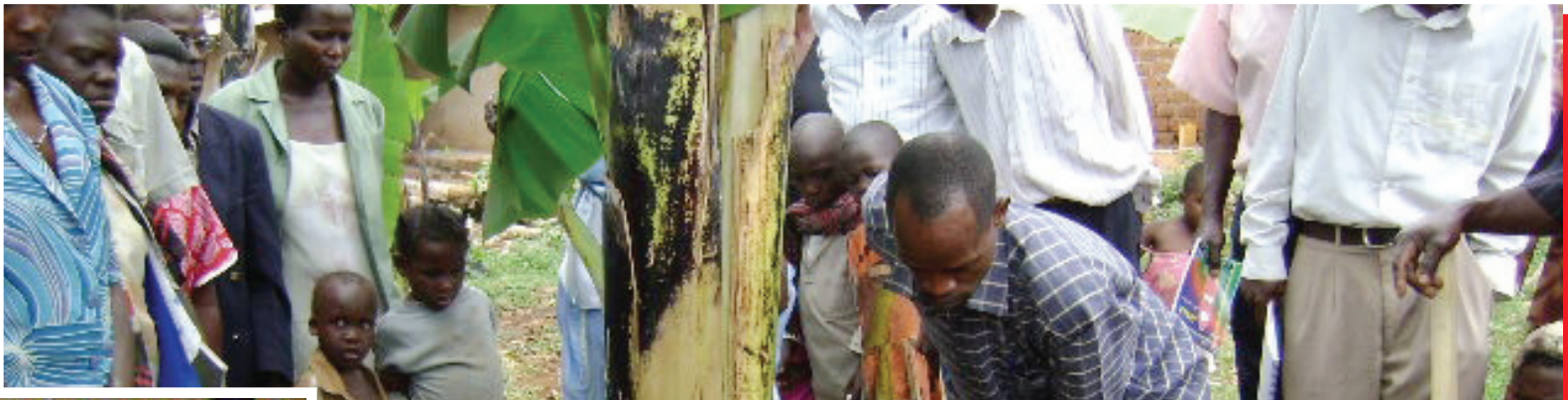

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1. *HIV Bill consultative meeting convenied by Uganda Law Reform Commission that took place on 5th- 6th Oct. 2009 at Lake View Resort Mbarara*
2. *President Yoweri Kaguta Museveni acknowledging best practices of Kinawataka Women Initiatives (Benedicta Nanyonga) at the Presidential Promotion Awards organised by Uganda Export Promotion Board in Oct. 2009 at Imperial Royale Hotel*
3. *Practical session during training of PLHIV Network members on 24th -28th Aug. 2009 in Mityana*
4. *James Samuel Kibanga, National Coordinator NAFOPHANU addressing participants at the National Coordination meeting in September at Forest Cottages in Kampala*
5. *Canon Gideon Byamugisha, Convener, (M)with other religious leaders at the Global Race to SAVE Lives Conference on 25th Aug. 2009 at Colline Hotel Mukono*
6. *Civil Society Organisations matching at this year's Candle Light Day in Entebbe Municipality*

How good nutrition improves lives of PLHIV

By Tumukunde Christopher Baingana

Good nutrition cannot cure AIDS or prevent HIV infection, but it can help to maintain and improve the nutritional status of a person with HIV/AIDS and delay the progression from HIV to AIDS and opportunistic infections. It can therefore improve the quality of life of people living with HIV/AIDS. Nutritional care and support are important from the early stages of infection to prevent the development of nutritional deficiencies. A healthy and balanced diet will help to maintain body weight and fitness. Eating well helps to maintain and improve the performance of the immune system- the body's protection against infection- and therefore helps a person to stay healthy.

Many of the conditions associated with HIV/AIDS affect food intake, digestion and absorption, while others influence the functions of the body. Many of the symptoms of these conditions (e.g. diarrhea, weight loss, sore mouth and throat, nausea or vomiting) are manageable with appropriate nutrition. Good nutrition will complement and reinforce the effect of any medication taken.

When nutritional needs are not met, recovery from an illness will take longer. During this period, the family will have the burden of caring for the sick person, paying for health care and absorbing the loss of earnings while the sick person is unable to work. In addition, nutrition can help to extend the period when the person with HIV/AIDS is well and working.

Healthy and balanced nutrition should be one of the goals of counselling and care for people at all stages of HIV infection

Recommended foods to eat for PLHIV

1. Eat staple foods with every meal

These foods are relatively cheap and supply not only energy and protein but also small amounts of vitamins and minerals. Staples include cereals and starchy fruits such as plantains, maize and corn.

2. Eat legumes if possible everyday.

These foods provide a person with the proteins needed to develop and repair the body and also to build up strong muscles. They include beans, peas, groundnuts and soybeans.

3. Eat animal and milk products.

Food from animal and fish products should be eaten as often as possible. These include all forms of meat, poultry, eggs, dairy products. If insects, such as grasshoppers and white ants are part of your diet, they also provide good nutrients.

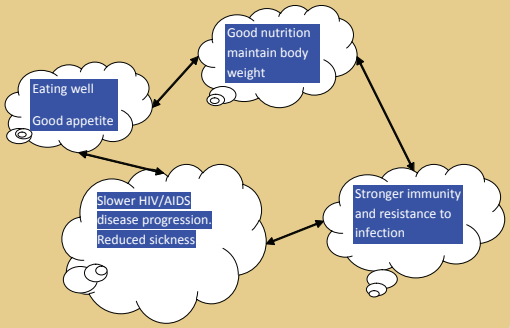
4. Eat vegetables and fruits every day.

These provide vitamins and minerals that keep the body functioning and the immune system strong. These foods are important to PLHIV to fight infection. These include green leafy vegetables, tomatoes, cabbage, orange, guavas, mangoes, passion fruit, pineapples etc.

5. Use fats and oils as well as sugar and sugary foods.

These are good sources of energy and can help one gain body weight which can be particularly important to PLHIV. Fats and oils include butter, lard, margarine, cooking oil etc. They are also found in avocados, oilseeds, fatty meat and fish. Sugars and sugary foods include honey, jam, table sugar, cakes and biscuits. They should be eaten in addition to other foods.

RELATIONSHIP BETWEEN GOOD NUTRITION AND HIV/AIDS



6. Drink plenty of clean water and safe water.

Water is important for life and is necessary every day. If water is from unprotected well or river the water should be boiled for at least ten minutes and stored in a clean container. Avoid taking tea or coffee with a meal as this reduces the absorption of iron from the food.

Alcoholic drinks remove water from the body and should be consumed only in limited amounts. They can also interfere with the absorption of medicines.

The writer is the POMU Administrator

Mildmay: Restoring life to its fullness

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ultrasound facility, help with social-welfare issues, nutritional advice and a comprehensive children's programme.

In efforts to decongest the centre due to the increased demand of free voluntary, counselling and testing services (VCT) as well as free treatment, Mildmay also scaled up its access for the newly registered and very sick patients to access treatment at the centre.

While those that are stable, and either receiving Prophylactic Cotrimoxazole or on stabilized ART, are being referred to the community HIV/AIDS care programmes where they are attended to.

In order to expand its geographic coverage and extend access to care to more PLWHA, Mildmay Uganda (MU) opened its first satellite clinic in Naggalama (Mukono district) in September 2005.

Mildmay (MU) Uganda has since expanded this support to 8 other satellite clinics in 5 districts. Working in partnership with MOH, MU provides technical support, equipment and supplies to these clinics.Mildmay Uganda has also empowered health professionals, and caregivers from different sections of society such as the prison service, the army among others through trainings with more than 1,000 participants from Uganda and across sub Sahara Africa receiving training in HIV/AIDS related care and management each year.

Mildmay Uganda Strategic Business Plan for the period 2009-2014 specifically highlights and emPLHIVises Mildmay Uganda's strategies and plans to strengthen its Paediatric HIV and OVC services within the context of a family-centred approach.

The plan is built upon Mildmay Uganda's mission and vision and contributes to the achievement of goals of the National HIV & AIDS Strategic Plan (NHSP) 2007/8-2011/12 and The National Priority Action Plan for the National Response to HIV and AIDS 2009/10–2010/11, which directs and sets priorities in the implementation of the NHSP. The plan also supports the realization of targets for Orphans and other Vulnerable Children Policy (NOP) as set by the Ministry of Gender, Labour and Social Development and other plans that support the goal of universal access to ART and care for people living with HIV & AIDS.

The planned interventions will also contribute to the achievement of other International goals such as the Millennium Development Goals (MDGs)

We appreciate all those that have given us the opportunity to serve them and encourage those that do not know their HIV status to come and test free of charge at Mildmay Uganda. As you all know VCT is a major or probably the only entry point to access HIV care and treatment.

Let us take this opportunity to inform you that Mildmay Centre and Mildmay Paediatric Care Centre (commonly known as Jajja's home) emerged to form Mildmay Uganda.

(The writer is Advocacy and Public Relations Manager of Mildmay Uganda)

Fighting stigma at Work places

By Sam Mugisha

Stigma and discrimination have no place in the efforts geared toward fighting HIV at least among the Uganda Red Cross Society staff. Aware of the consequences that range from socio-economic and political nature, there is need to fight the vice for the better health of HIV positive work force within the Red Cross movement..

In the fight against stigma and discrimination, we need to consider our contributions to the community, family, and loved ones.

We should know the cause-effect relation of fear. You can live longer, do more and better when you access counselling and treatment services. In an effort to fight HIVIAIDS, there is need to take reasoned action such as; attitude adjustments - how one perceives one's behavior towards HIV/AIDS , subjective norms considerations - what are the opinions of friends, parents and significant people regarding the value of your actions.

Stigma and discrimination cause –effect relationship. Remember to go for counselling and take an HIV test because this can be the starting point to change your lifestyle so that you can do more and better in regard to the fight against HIV/AIDS scourge.

Musambo fund

We are happy to inform you that, for the staff and volunteers of URCS, a fund has been set up by IFRC to support the PLHIV. This is the Masambo fund for PLHIV. Masambo Fund came into existence as a result of the death of 200 HIV/AIDS volunteers of the Zimbabwe Red Society. This was a great loss to the national society in terms of manpower. Therefore, following this scenario, the IFRC sought for means to minimize this problem in subsequent years and it came up with masambo fund. IFRC took up this commitment and canvassed funds to facilitate the treatment of HIV positive staffs and volunteers. Initially, it catered for the treatment component only but following some advocacy from RCRC+, it has been revised to cater for ARVs and basic medical monitoring, General Health Care, Nutritional support, "Make the case"(other support that has no scientific evidence to enable one take treatment /ART effectively. URCS positive staff and volunteers can now apply for this fund so that they can access treatment for HIV. Confidentiality in regard to this matter has been given greater attention. If you do not want your HIV status to be known by "other" people, then so shall it be. More funds are at the federation level that ought to be acquired to serve this purpose. Mid last year, a group of dedicated PLWHIV within the Red Cross movement met in Geneva and formed Red Cross and Red Crescent Positive network (RCRC+) within the movement with special commitment to fight stigma and discrimination. Terms of references were developed for RCRC+ and they were adapted by the HIV governance group. Below are the Terms of Reference for RCRC.

RCRC positive members:

Are champions and watchdogs of the Masambo Fund to ensure access to all RCRC+ who need it;

Are the voice and expression of GIPA within the Federation

Are members of a supportive network that identifies issues, exchanges ideas, strategies and sentiments

Advocate for safe and sustainable working conditions; economic, social and political

Are committed to reducing stigma and discrimination. Ensure the continuation and commitment of the RCRC+ vision and work plan when leaders change

Monitor and provide feedback on the HIV Global Alliance strategies and activities

Act as cultural mediators between formal RCRC structures and less formal communities

In their terms of reference (as above) which the HIV governance group adopted at 88th session, among others was the idea that RCRC+ shall be the champions of Masambo fund within the Red Cross Movement.

The author is a volunteer at Uganda Red Cross Society

Trends on ARVs: Benefit

By Amori Gabriel

In the United States and Europe, it is recommended that CD4 cell counts and viral load be routinely measured every three to four months to monitor the efficacy of antiretroviral therapy (ART) in people with HIV.The expectation is that frequent measurements will detect treatment failure due to resistant virus and allow rapid change to another ART regimen — several of which can usually be constructed out of the numerous antiretrovirals available in those parts of the world. According to the recent European guidelines, the arrival of several new drugs, some from completely new classes of antiretroviral agent, the goal for treatment should be an undetectable viral load below 50 copies/ml in all patients, including those with heavy treatment experience.

However, over the past couple of years, one of the hotly debated topics at the major HIV conferences and in the medical literature has been how best to monitor the success or failure of ART in people in developing countries with limited laboratory infrastructure and limited financial resources.

At the core of the debate is the role of viral load monitoring, and it's tempting to try to split the argument into two camps, those who believe that capacity to perform viral load testing is urgently needed to monitor people on ART, and those who think that this isn't absolutely necessary yet, and could potentially be a costly distraction from the roll-out of ART to as many people as possible (as described in the first HATIP this year).

After all, in some settings, the cost of routine monitoring with CD4 and viral load testing (which by itself can range from $15 to $60 per test) exceeds the annual cost of the first-line ART regimen.

But as more ART programmes are beginning to grapple with how to recognise treatment failure and when to switch their own patients to much more expensive second-line regimens, the discussion is becoming more nuanced. Out of expediency, people are reaching their own conclusions about what treatment failure is, what type of monitoring can and cannot be done in their respective settings, and where their HIV programme's priorities for scale-up should lie.

There are a number of ways to monitor a patient's progress on ART, which include clinically, by disease progression and World Health Organisation (WHO) staging; immunologically, generally by following changes in CD4 cell counts over time ; virologically, by measuring changes in plasma HIV-1 RNA levels; or a combination of the former.

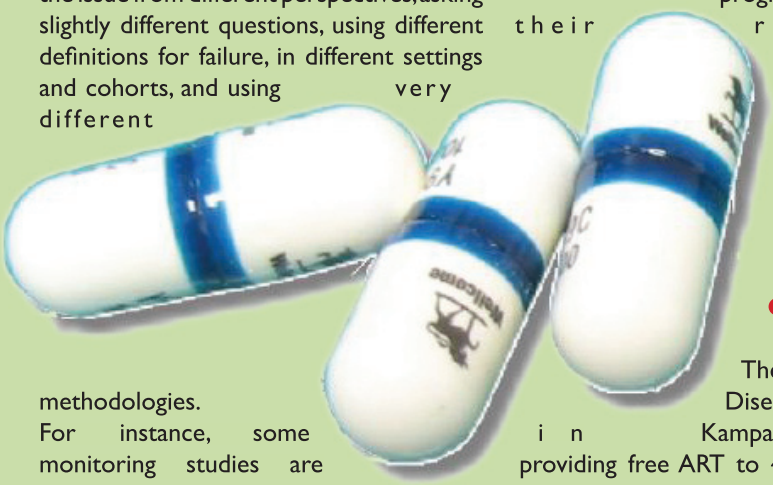
There are differences of opinion about what CD4 and viral load thresholds should be used to define treatment failure, or perhaps more precisely, what degree of treatment failure calls for a switch in ART regimens.

"If the decision is made too early," state WHO's 2006 ART guidelines, "the months or years of potential further survival benefit from any remaining first-line effectiveness is lost; if it is made too late, the effectiveness of second-line therapy may be compromised and the patient is put at additional and appreciable risk of death."

As a result, WHO has staked out a rather conservative position that aims to keep patients on a first-line regimen as long as possible (since switch options are limited) and to make delivery of ART as simple as possible for the poorest of countries. The presumption is that clinical events generally develop subsequent to a rise in viral load and a fall in CD4 cell counts, so the guidelines currently recommend that programmes rely first on clinical assessments as "the primary tool" for monitoring patients on ART, and that, where available, these could be augmented by following trends in CD4 cell counts, which show whether patients are at greater risk of serious clinical events.As for viral load tests, in Towards Universal Access by 2010, WHO calls for "the progressive scaling up of more sophisticated laboratory infrastructure" including the capacity to perform viral loads in regional referral centres and district hospitals. However, WHO believes that, for now, this capacity should first be devoted to diagnosing HIV in infants (where the need is indeed extremely great — and which we plan to discuss in a future issue), but "given the continued cost and complexity of the current technology, viral load monitoring is still not suitable for wide use in the public health management of ART." In countries that have the capacity for viral load available, WHO suggests that a viral load threshold of over 10,000 copies/ml could be considered as a definition of failure. Again, however, the guidelines stress that the use of viral load would likely lead to earlier switches to second-line regimens. WHO recommends that clinical assessments "should take place 2, 4, 8, 12 and 24 weeks after ART begins and should subsequently be performed

s, Resistance & Failure

every six months once the patient has stabilized on therapy." If CD4 cell counts are available, WHO suggests routinely monitoring them every six months, "or more frequently if clinically indicated." But as previously noted, a number of critics think that the WHO guidelines overstate the operational utility of clinical and even CD4 cell count monitoring. It's difficult to draw conclusions from the emerging data that are applicable in every setting. This is because researchers have been approaching the issue from different perspectives, asking slightly different questions, using different definitions for failure, in different settings and cohorts, and using very different methodologies.



For instance, some monitoring studies are measuring clinical endpoints in prospectively randomised cohorts, others are cross-sectional studies comparing whether clinical or immunological outcomes accurately reflect virological failure. Some are essentially case studies focused on the recognition of early failure and its management in a handful of patients, while others are concerned with how programmes will manage the majority of treatment adherence patients who are unlikely to experience clinical progression during the first few years after going on ART. In addition, some critical pieces of the equation are still missing. For instance, what will be the impact of resistance? If patients are switched too late, just how much will high-level drug resistance to components in first line therapy really affect the clinical success of a second-line regimen anchored by boosted protease inhibitors such as Kaletra? The choice of monitoring strategy could depend upon future access to a greater number of antiretrovirals. Will there be more switching options — third or fourth line regimens — or will resource-limited settings be stuck with the two that we have now for the next 10 to 20 years?

In the end, there may not be a single answer because different programmes may want to hedge their bets differently. What works in South Africa may not be the best solution for Malawi.

So in this HATIP, we will try to present unbiased synopses of the major reports on the topic since January in the hope that our readership can use them to help their programmes refine their respective definitions of failure, and improve the outcomes in patients who are currently on ART regimens.

Case study

The Infectious Disease Institute in Kampala has been providing free ART to 4,200 people with HIV since September 2004.

At the IAS meeting in Sydney, Dr Apollo Basenero presented an evaluation of the use of a consensus meeting (attended by doctors, nurses, counselors and PLHIVrmacists who work at the clinic) to consider CD4, clinical and adherence assessments in patients suspected to be failing their first-line regimen (failure is defined according to the WHO guidelines and adherence is measured through self-report and pill count). CD4 testing takes place every six months.

At the consensus meetings, the team decides whether to do a viral load test or employ other interventions like intensive adherence counseling before switching to second line treatment.

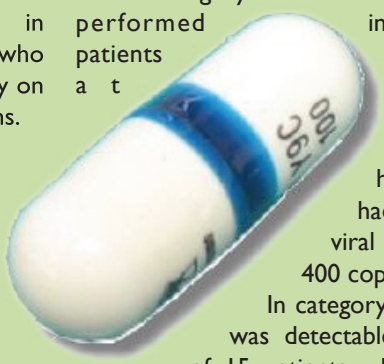
When patients are discussed in these meetings, they are classified into one of three categories:

1. Clearly failing: A switch to second line is recommended for patients with good adherence (>95%) but with proven clinical, immunologic, and if the viral load is present, virological failure.

2. Poor adherence: Those with clinical and/or immunologic failure; but with an adherence of <95%. Adherence counselling is emphasized during every subsequent clinic visit, and a CD4 cell count repeated after three or six months. If still failing, a switch is recommended.

3. Inconclusive: A viral load test is ordered in patients with immunologic failure if they are clinically stable and have good adherence.

Since August 2005 to March 2007, 100 patients with suspected failure have been discussed in the switch meeting: 20 patients were put in category 1; 26 patients in Category 2: and 54 patients were in category 3. Viral loads were performed in as many patients as possibly at the time of switching to confirm how many had detectable viral loads (over 400 copies/ml).



In category 1, viral load was detectable in 15 out of 15 patients who could be tested. In category 2, the adherence intervention appeared to improve CD4 cell counts (by 36-113 cells) in 16 (62 percent); however, the repeat CD4 cell tests suggested that 10 out of 26 (38%) were still failing. These were switched to second line and viral load was detectable in each case at switching.

But only 30 (56%) out of the 54 in category 3 had detectable viral loads, with a median of 93,686 and a range of 2,611 to 694,993 copies/ml, while the viral load was undetectable in 24 (44%).

The data suggest that a consensus meeting with experienced clinical staff may be better able to determine when clinical events and CD4 cell decline constitute true failure.

ARVs have encountered a number of challenges including short term deaths; however they need maximum supervision by health administrators, client's discipline and more above all sustainable supply.

The writer is the National coordinator, UNIRELLA

Why i chose to become a volunteer...

By Anna Mugambi

Anna Mugambi (L), VOS Volunteer attending an Advocacy Rights workshop in August 2009 at Hotel Equatorial

This is a question that I have become accustomed to answering every day as I go in and out of office. My Stay in Kampala for the last four months or so as a Voluntary Services Overseas (VSO) Volunteer has been one experience that has been very informative and I can honestly say that this is not something that I will ever forget in my life.

"We know from experience that the availability of treatment encourages people to declare their HIV status and receive counselling, we also know that the availability of treatment reduces stigma for people living with AIDS." - Dr Paulo Teixeira, former Director of the HIV/AIDS Department: W.H.O.

Coming to Uganda has been a journey of discovery and the fact that as a VSO volunteer I was given the opportunity to work with NAFOPHANU, has afforded me the unique chance to learn from more experienced people than I and to be able to take back home, after 6 months, lessons learnt especially where access of ARVs is concerned.

I came to Uganda when, an island barely an acre in size, languishing somewhere in Lake Victoria was at the centre of a regional row pitting Kenya against Uganda. Both Kenya and Uganda maintain that the small island belongs to either of. As laughable as this is to most of us, we have to be aware that Ugandans and Kenyans are closer than ever. The emotions, I notice were more escalated in Kenya than in Uganda and this to me represents exactly what has made me love Uganda and her people so far.

The laid back attitude that is so common in Uganda belies a strategy that I hope to learn and take back home – a strategy to stand back assess your options and act under the umbrella of caution, experience and wisdom. Uganda is often held up as a model for Africa in the fight against HIV & AIDS. Strong government leadership, broad-based partnerships and effective public education campaigns all contributed to a decline in the number of people living with HIV & AIDS in the 1990s.

One thing though that has stood out for me is the degree of openness that Ugandan PLHIV have about their status. I was in a workshop, just after I had arrived in Kampala, and was with a group of PLHIV who had on T-shirts that had the words "HIV Positive" emblazoned across their chests. This is something that is still quite rare in Kenya, where stigmatization is still a crucial issue. HIV/AIDS has traditionally stigmatized communities and ostracized those affected, but in Uganda attitudes have grown more positive over time. According to some studies, currently, 60 per cent of those infected in Uganda, are on anti-retroviral treatment while the rest of sub-Saharan Africa rotates around 20 per cent.

Unfortunately, I came to Uganda at a time when there seemed to be a shortage of ARVS. The major challenge of many people all over Africa living with HIV/AIDS and people affected by AIDS is the issue of access to treatment and care. It has become very obvious to HIV activists that not only poor nutrition weakens the body's defenses against the virus, hastens progress from HIV to AIDS, but also makes it difficult to take ARVs, which can sometimes increase a patient's appetite. Sufficient food can help reduce some side-effects of ARVs and promote adherence to drug regimens.

In Africa, the global financial recession has forced HIV NGOs to close shop.This affected many people and the most bearing goes to children who are on ARVs. Most of the children, majority of them orphans do not have money to buy ARVs and other related drugs. Uganda recently had drug stock outs, amidst closure of major centres of service providers, leaving many people living with HIV/AIDS stranded.

According to NAFOPHANU Board chairperson, Dr. Stephen Watiti, 1.3 million Ugandans are living with HIV. Out of these, 350,000 are eligible for ARVs because their CD4 count is below 250 cells/mm. Out of these, about only 180,000 (bout 40%), are getting ARVs. This means that most of the people who need the life-saving drugs do not get them.

The news from around the country is not good; in some places where people with access to anti-retroviral treatment are succumbing to the Aids because they do not have food to eat (healthy eating is an essential factor in managing the condition), while in other places PLHIV do not have access to therapy partly because there is high incidence of new infections which has outstripped the financial resources currently available to make ARVs available.

At NAFOPHANU, the Forum has taken it upon itself, not only to sound the alarm about the current situation, but to also lobby Government and other stakeholders to treat the current situation as it is with the seriousness it deserves. What do I want to have achieved after my stay here in NAFOPHANU? Well, I do hope to have made some good friends at the Secretariat, but even more importantly, I would like to have achieved the goal that we have set out to achieve as a group; at the Secretariat: to make NAFOPHANU be at the fore front of HIV/AIDS fight in Uganda.

The writer is a VSO volunteer at NAFOPHANU.

YOUTH CARAVAN PROFILE

Youth Caravan is a youth led and innitiated project which was started on 24th November 2008 with help from Straight Talk Foundation - Uganda. The Youth Caravan is composed of 30 members ranging from the ages of 15 – 24 years, affected and infected with HIV/AIDS from birth, who felt the need to join the world in the struggle to fight against the HIV/AIDS pandemic.

GOAL

Youth Caravan's main goal is to promote behavior change and positive prevention among young people, eliminate stigma and discrimination that is usually associated with young people HIV/AIDS especially within Youth Caravan operational areas.

PURPOSE OF GOAL

There will be reduced rates of re-infections and infections of HIV/AIDS among young people. Increased knowledge about HIV/AIDS in communities.

OBJECTIVE

Mobilize and sensitize communities and paediatric centers towards promotion of positive prevention. Youth Caravan has gone an extra mile to disseminate Behavior Change Communication and Positive Prevention messages through performing arts in:

- HIV/AIDS Pediatric Centers
- Adult HIV treatment Centers
- Secondary Schools
- Youth Conversions.

Our messages are communicated through performing arts like

- Drama/Skits
- Local dances
- Songs and Poems
- Puppetry
- Sharing testimonies

Our Main messages are:

- Behaviour change
- Positive prevention

Our target audience is young people both HIV positive or negative, parents, religious leaders etc

PARTNERS

- Straight Talk Foundation (STF)
- Baylor College of Medicine Children's Foundation
- Kanyanya Pioneer HIV/AIDS prevention Center (KPHAPC)
- Gordon Creative Arts (GCA)

We look forward to making more collaborations with other people who are willing to help us morally (mentoring) and above all financially so that we can reach as many people as possible both nationally and internationally

Bugiri **PLHIV** Forum

By Grace Namuyomba

Bugiri PLHIV Forum which started in 2004 is continuing to remain afloat in regard to sensitization about HIV. With support from CSF through NAFOPHANU, Bugiri PLHIV Forum has managed to reach out to the people living with HIV/AIDS in the district. By 2004, the Forum had mapped out 15 groups of PLHIV which have grown in number with time. The district Local Government is very supportive too. It facilitated the first annual general meeting, which took place on August 20, 2004. Today, the forum has a constitution in place and is registered at the district.

Its current coordinating office is at Fast Line Medical Centre, located in the heart of Bugiri town.

Also in 2005, the Forum got funding from Policy Two Project, which helped it disseminate the PLHIV guidelines and in the process, the membership increased. All members of this forum subscribe annually at a reasonable fee.

Grace and Forum members during one of the coordinating meetings in Bugiri

Achievements

1. Some of the achievements include attending PLHIV monthly meetings. In planning and implementation of HIV/AIDS campaigns, the forum is fully represented on the District AIDS Committee (DAC) and District AIDS Taskforce (DAT) respectively.
2. The forum held an Annual General Meeting in 2008, which was facilitated by the district.
3. The forum leadership also chairs the BUNASO network.
4. There are child protection and financial policies in place to offer guidance in management.

Finally, Bugiri PLHIV forum consists of 25 groups/networks that are fully registered with the district.

The contributor is the Vice-Chairperson NAFOPHANU Board

Closing information gap on **HIV/AIDS** in NUDIPU

By Betty Iyamuremye

The National Union of Disabled Persons of Uganda (NUDIPU) recently launched Information, Education and Communication (IEC) materials on disability and HIV/AIDS. The vital materials are under the theme, "Making HIV&AIDS information Accessible to persons with Disability is a pre-requisite in the struggle against HIV/AIDS". The objective of developing the materials follows the realisation of a gap between the People with Disabilities (PWDs) and information on HIV/AIDS and reproductive health.

Hon. Sulaiman Madada, minister of State for Disability and the Elderly, presided over the colourful I.E.C launch held on June 25, 2009 at Africana Hotel in Kampala. Madada applauded NUDIPU for continued support to PWDs, especially for the HIV programme. "HIV is disturbing but it's even worse with people living with disabilities," the minister said. He pledged support and encouraged all stakeholders to stand with PWDs to achieve their goal.

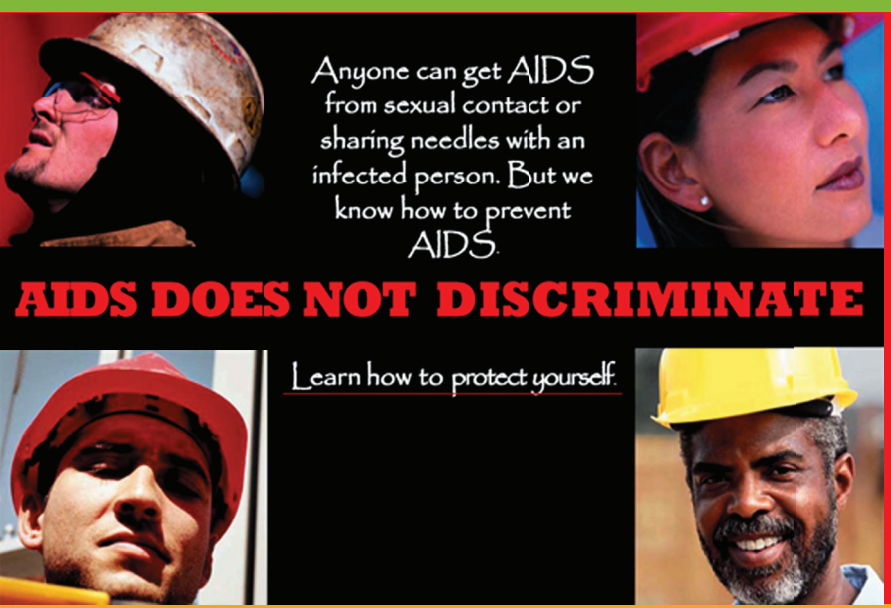
The Executive Director NUDIPU, Micheal Sebuliba emphasized the fact the PWDs are equally susceptible to catching HIV/AIDS. Accordingly, he argued, the issue be integrated in HIV programmes at organizations and national level.

Dr Christopher Oleke, Principle Health Educationist in the Ministry of Health, elaborated on a report on the needs assessment of services that was conducted to develop a mobilization strategy to incorporate issues of disabilities in reproductive health services and in the HIV/AIDS struggle, keeping in mind that PWDs are sexually active.

He remarked that the issue of physical interaction of PWDs with health workers is lacking.

"Many medical officers lack basic information or training in handling people with disabilities, for example they don't know sign languages, there are no special facilities for PWDs," he said, adding "more time should be accorded to PWDs."

Information on HIV prevention, regular counseling and testing, treatment, abstinence and faithfulness are some of the key messages highlighted in the materials launched. Participants on the inauguration included staff from Ministry of health, TASO, CSF, Straight talk, Mild may, Red Cross Uganda and networks of People Living with HIV/AIDS



HIV Events

National and World AIDS Days and Conferences

2009
Philly Lutaaya Day

11-Nov-09 14-Nov-09 12th European AIDS Conference 2009/ EACS Cologne, Germany
30-Nov-3-Dec-SAHARA 2009/ 5th Conference on the Social Aspects of HIV/AIDS Research South Africa
1st December
World AIDS Day

2010
1-Feb-10 4-Feb-10 2nd International Conference on Drug Discovery and Therapy (2nd ICDDT 2010) Dubai, UAE

9-Mar-10 12-Mar-10 14th International Congress for Infectious Diseases (ICID) Miami, Florida, United States

22-May-10 26-May-10 Microbicides 2010 Pennsylvania, United States

06-October-2010 2nd International Conference on Drug Discovery and Therapy San Francisco, California, United

March-10 2010 National STD Prevention Conference
Atlanta, Georgia, United States

9-Mar-10 12-Mar-1014th International Congress for Infectious Diseases (ICID) Miami, Florida, United States

May 19-May-10 22-May-10- 11th Congress of the European Society of Contraception: Culture, Communication, Contraception

22-May-10 26-May-10 Microbicides 2010 Pennsylvania, United States

May
Candle Light Day

Jul 18-Jul-10 23-Jul-10 AIDS 2010/ XVIII International AIDS Conference Vienna, Austria

October
Philly Lutaaya Day

Sep 28 Sep, 1 Oct 10
AIDS Atlanta, Georgia,

1st December
World AIDS Day

For inquiries, additions, or modifications, please contact alliance@microbicide.org, tel. +1-301-587-9690.
Last updated 1 June 2009

NAFOPHANU
The National Forum of PLHA Networks in Uganda
The Quarterly Newsletter

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