



Uganda Civil Society Priorities Charter

An Advocacy Roadmap for the Global Fund to fight AIDS, Tuberculosis and Malaria
New Funding Model

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#1 Priority – Community & Health Systems Strengthening

Top Priority – Direct active engagement, participation, empowerment and ownership of communities

There are limited platforms for meaningful participation at community level, leading to gaps in service provision. Civil society is best placed to support community led initiatives such as the Uganda Community Scorecard, CRC, people's parliament, health literacy campaigns and client satisfaction surveys at the health units. Most-at-risk populations must be at the center of this priority, particularly the LGBTI community, young people, sex workers and women. This should be implemented in border districts, followed by islands, landing sites, and the trans-Africa highway. This activity should be a three year programme, aligning with the Global Fund New Funding Model. Those with comparative advantage to implement this activity are community-based organizations (CBOs) who work on HIV, women's networks, boda boda associations, farmers, young people's associations, village health teams (VHTs), and people living with HIV. A key component of this activity will be TB integration into HIV/AIDS coordinating structures, particular focusing on integrating TB into HIV planning, support, monitoring and evaluation, implementation and budget allocations.

#2 Priority – Behaviour Change

Top Priority – Address social and cultural drivers of risky behaviour

In Uganda, civil society has identified that behavioural norms are rooted in social and cultural traditions which are related to elevated risk for HIV and TB. In order to change this, civil society can engage with cultural and religious leaders as a conduit to deliver key behaviour change messages to address the traditions and practices that propagate risky health behaviour, especially among key affected populations. Family units should be strategically targeted, along with community groups and cultural and religious leaders. The Eastern region of Uganda should be prioritized first, followed by the Western region, then the Central region and then the North. Implementation should align with the Global Fund New Funding Model, and should be led by people living with HIV (PLHIV) along with human rights groups, FBOs, CBOs and CSOs. Civil society will also prioritize TB information to be integrated into comprehensive HIV prevention packages throughout this activity.

Secondary Priority – Produce a stronger evidence base for behaviour change programming

There has been inadequate documentation to inform targeted behaviour change interventions based on evidence. Civil society has comparative advantage to conduct research on existing documented best practice, with the objective to identify the requisite psychosocial skills that are critical to translating knowledge into practice. The target population should be in and out of school youth aged 10-24. The need to identify best practice for this age group is linked to the gender disparity in infection burden; women aged 20-24 are 2.5 times more likely to be HIV positive than their male peers (Uganda AIDS Commission, 2014). Urban and semi-urban areas should be prioritized for this assessment and it should be a three year programme to align with the Global Fund New Funding Model. Those best placed to implement include youth networks, in partnership with other organizations that work with young people. To ensure TB integration, civil society proposes that TB awareness raising activities also be documented in terms of best practice so that this evidence base is also available.

#3 Priority – Key Populations

Top Priority – Access to comprehensive HIV/TB/SRHR services

The concept of "comprehensive services" for key populations (KPs) is defined by civil society as prevention, care, treatment and support. Currently, stigma and discrimination against KPs is a human rights barrier to accessing services, which is coupled with a hindering legal and policy environment. Civil society proposes the following interventions: creation of an advocacy plan on integration KP issues in the National Health Policy; building the capacity of KPs; conceptualization and implementation of guidelines on KP health issues (combining TB/ HIV services and materials); awareness campaigns; building community networks; human rights training for law enforcement and media. Targeted groups should be healthcare providers, peer educators, police, KPs (MSM, sex workers, IDUs and fisher folk), media and civil society. Areas for prioritization include landing sites, islands (Buvuma and Kalangala), Victoria Lake and Albert shores, slums, transit and border towns, health facilities, entertainment centers, schools, religious facilities and government offices. This should be rolled out from 2015-2017 and be led by KP networks, community-led organizations, CSOs, religious institutions and educational institutions, in partnership with local government, politicians and parliamentarians and law enforcement bodies.

Secondary Priority – Sensitization, advocacy and awareness training for policy makers and service providers

To ensure access to quality and comprehensive KP friendly services, civil society will prioritize sensitization and training for health care workers and for policy makers to understand the health needs of KPs, including the need for TB to be integrated into HIV services in a one-stop center. Civil society used data from the Young Key Populations Priorities Charter (CHAU, ICW EA, UNYPA, CYSRA & MSU, as part of the Link Up project in Uganda: 2014) to show that HIV prevalence is 13.2% among MSM, 35.7% among sex workers, 16.7% among IDUs and 9.3% among fisher folk. Civil society proposes training for policy makers and service providers on KP issues, particularly those facing MSM/LGBTI communities, sex workers, fisher folk, IDUs, truckers, uniformed personnel and young women living with HIV. Ntungamo, Kaliro, Kapchorwa, Sironko should be prioritized, since service uptake is low; HIV counselling and testing (HCT) is below 40% (Uganda AIDS Commission 2014). This activity should be implemented from 2015-2017 in line with the Global Fund New Funding Model, implemented by CSO coalitions who have experience working on amending laws which criminalize key populations.

#4 Priority – Condom Promotion

Top Priority – Increase accessibility of both male and female condoms

According to the Uganda AIDS Accountability Scorecard (UNASO, 2014), access to both female and male condoms is not adequate in either communities or health centers, which is related to low usage rates; 9.7% of women and 14.7% of men used a condom the last time they had sex (Uganda AIDS Commission, 2014). Civil society has comparative advantage to advocate for increased funding for procuring free condoms and to use community systems to improve condom distribution. Priority populations are sex workers, boda boda drivers, fisher folk, sexual minorities, discordant couples, truck drivers and PLHIV. This should be implemented in the island regions, trading centers along highways, urban centers, hotels, bars and lodges. This activity should commence immediately, scaling up to reach communities for STI prevention and family planning. Strong implementers include district-based CBOs, NGOs and CSOs, hoteliers, boda boda associations, youth clubs, women's groups, men's groups and refugee groups. To integrate TB in an impactful way, civil society proposes combining messages on TB screening on condom wrappers and dispensing containers.

Secondary Priority – Comprehensive condom knowledge

Civil society has identified that there are many misconceptions about condoms in Uganda, paired with low knowledge. This is particularly true among Ugandan youth, with the percentage of young women and men aged 15-24 who correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission at only 38.9% (Uganda AIDS Commission, 2014). This intervention should strategically target young people with messages about comprehensive sexual reproductive health awareness. Youth aged 15-24 should be prioritized, especially young married people, in and out of school youth and boda boda drivers. Civil society will focus campaigns on condom awareness in schools, market places, and other areas where urban youth are concentrated. These youth campaigns should commence in 2015, to align with National targets. Organizations with comparative advantage to implement this activity are those who are currently working with young people and the Ministry of Health. Messaging campaigns should also include information on sexual reproductive health and rights awareness as well as TB screening and treatment.

#5 Priority – PMTCT

Top Priority – Addressing the policy and legal environment, and human rights violations

Human rights barriers to accessing prevention of mother-to-child transmission (PMTCT) services are a top priority for civil society to address. Civil society site data showing that male involvement in PMTCT is low, with only 19.7% of pregnant women's male partners testing for HIV in the last 12 months (Uganda AIDS Commission, 2014). This may be related to harmful laws and policies which criminalize or punish young women in age disparate relationships. Comparative advantage lies with civil society to conduct advocacy around revising guidelines of care, advocating for HIV and TB infrastructure and equipment, carrying out community empowerment, empowering religious leaders and developing linkages between religious institutions and health facilities so as to promote PMTCT, including men's involvement. Policy makers, religious leaders, peer groups, communities and service providers should be targeted for this intervention, particularly within the Ministry of Health, Uganda Law Reform, Parliament and the Uganda Human Rights Commission. This should be implemented from January 2015 – December 2019, led by CSOs who have demonstrated capacity in this area, in partnership with others such as the Foundation for Human Rights Initiative and the Uganda National NGO Forum.

Secondary Priority – Improve retention of mothers in care and reduce loss to follow-up

Retention in care is necessary for service provision at every level in the PMTCT cascade. Loss to follow-up is clear, since HCT for pregnant women in Uganda is high, at 93%, but testing for infants is much lower, with the percentage of infants born to HIV-positive women receiving an HIV test within 2 months of birth at only 41.9% (Uganda AIDS Commission, 2014). Civil society has a vital role to play in supporting community structures, improving systems strengthening for PMTCT, and strengthening male involvement. Provision of IEC materials on HIV and TB will also be key for HIV/TB integration around PMTCT. Pregnant mothers, service providers, peer groups and policy makers should be targeted, particularly in Gulu, Kitgum, Pader, Lamwo, Amuru, Nwoya, Kalangala, Ntungamo, Kapchorwa, Bududa and Kaliro. This should be implemented from 2014-2017 to align with the Global Fund New Funding Model and should be led by community groups, CSOs, FBOs and CSOs, in close partnership with the district.

#6 Priority – Treatment Care & Support

Top Priority – Promotion of home-based care

Evidence shows that strengthening the linkages between health facilities and the community improved adherence and retention in care. Further, this may contribute towards promotion of disclosure and reduction in stigma. A connected system also reached more people, especially youth and children, and increased awareness about TB and HIV. Specifically, civil society proposes the promotion of home-based HIV counseling and testing (HCT), directly observed treatment, short-course (DOTS), adherence support, nutrition, awareness and linkages/referrals. For efficiency purposes, civil society will build the capacity of existing structure such as PLHIV networks and VHTs to implement these activities. Civil society will train VHTs in HIV/TB and nutrition, advocate for facilities to do home-based care transport, ensure constant supply of drugs, testing kits and supplies and conduct home-based HCT and TB screening. The key populations to target for this intervention are people living with HIV and their households. The priority area for implementation should be Central Uganda, particularly in Luwero and Mityana where HCT coverage is below 50% (Uganda AIDS Commission 2014, as cited in MSH Report, 2013 LQAS IN 66 Districts). A pilot of this activity should begin in 2015/2016 in line with the mid-term review of the National Strategic Plan for HIV & AIDS (2011/2012 – 2014-2015). Community-based organizations, particularly NGOs, are best placed to implement, but should work in close partnership with health facilities. This activity is integral for HIV/TB integration in Uganda, in order to improve contact tracing for TB, home-based screening for HIV and TB, DOTS and awareness for HIV/TB.

Secondary Priority – Nutrition

Adherence to medicines for both HIV and TB are closely linked with access to a nutritious diet. The treatment cascade in Uganda highlights that there is a gap in keeping people on treatment who need it. For instance, civil society points out that the percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy is 83% (UAC, 2014). This means that after one year 17% of people who were on treatment the previous are lost from the system. Further, this priority is increasingly significant in supporting those who are living with both HIV and TB, to continue momentum around treatment uptake; anti-retroviral treatment (ART) uptake among TB-HIV co-infected patients rose from 54% in 2012 to 60% by June 2013. Civil society has a key role to play in identifying partners to work with on maintaining sufficient food stocks for people taking HIV and TB treatment, including maize, millets, and soya beans. For sustainability purposes, civil society also proposes sensitization of people who are on treatment to the importance of nutrition in their lives. Populations which should be prioritized for this activity include infants, adolescents and youth, adults, people with disabilities, people affected by leprosy, incarcerated people (and their children) and other most-at-risk populations. While this is a needed intervention for all regions in Uganda, civil society will strategically target households, health centers, community groups and associations, prisons and places of worship to reach the populations most-at-risk and to maximize impact and efficiency. This should be a five year project, aligning with the next Ugandan National Strategic Plan for HIV & AIDS (2015-2020). Civil society should work to provide linkages between the government, private sector and community for this activity.

#7 Priority – Male Circumcision

Top Priority – Increase awareness about voluntary medical male circumcision

There is a need to improve knowledge of the benefits of voluntary medical male circumcision (VMMC) in Uganda. The coverage of male circumcision in Uganda is only 26.4% (Uganda AIDS Commission, 2014, as cited in 2011 AIDS Indicator Survey), indicating to civil society that they should prioritize addressing the myths and misconceptions around VMMC which may be linked to low rates of uptake. Primarily, civil society has identified the need to influence the opinions of gate keepers in the community, such as traditional and religious leaders. Civil society has the unique capacity to develop simple VMMC messages in local languages and to establish community level information centers and clubs, and conduct community level meetings around VMMC. Married men and women should be especially prioritized for awareness creation, followed by young boys, traditional leaders, opinion leaders, CSOs and religious leaders. This activity should be rolled in areas of need according to the Uganda AIDS Accountability Scorecard (UNASO, 2014), which are Northern Uganda, followed by Kamwenge and South Western Uganda, then North Eastern Uganda. This programme should start in 2015/2016 and end in 2019/2020 in line with Uganda's new National Strategic Plan on HIV and AIDS. Organizations with comparative advantage to implement include AIDS Service Organizations, cultural institutions, media houses, safe male circumcision champions, VHTs and people living with HIV. Civil society also identifies an opportunity for TB education to be integrated into VMMC and for referrals for TB service points to occur.

Secondary Priority – Partner in providing voluntary medical male circumcision services

In Uganda, civil society has identified that service providers for VMMC are limited, and that there is a need for civil society organizations to partner with government to increase coverage and impact. Civil society has comparative advantage to conduct outreach in the communities, and can also support increased coverage through distributing supplies and equipment needed, as well as by implementing service contracts in partnership with other organizations and the public sector. Key targets for this activity will be government, the Ministry of Health and the district health services, along with CSO networks and VMMC service providers. The areas which are most in need of increased coverage, according to the Uganda AIDS Accountability Scorecard (UNASO, 2014) for VMMC are Northern Uganda (particularly Gulu), South Western Uganda and North Eastern Uganda (particularly Moroto). This programme should start in 2015/2016 and end in 2019/2020 in line with Uganda's new National Strategic Plan on HIV and AIDS. Those who are best placed to implement include AIDS service organizations, the private sector, cultural institutions and professional health associations. Through this partnership, civil society also proposed conducting operations research to identify options for integrating TB screening in VMMC.

Partner Organizations



Action for Community Development (ACODEV)
Action Group for Health Human Rights & HIV/AIDS (AGHA Uganda)
Aids Care and Education & Training (ACET) Uganda
AIDS Healthcare Foundation (AHF)
AIDS Information Centre (AIC)
Arise Uganda
Childrens AIDS Fund (CAF)
CKAF
Community Health Alliance Uganda (CHAU)
Community Health and Information Network (CHAIN)
Country Coordinating Mechanism Secretariat
East Africa National Networks of AIDS Service Organizations
Freedom and Roam Uganda (FARUG)
FXB Uganda
Harnessing Indigenous Potentials in Africa (HIPo-Africa)
Health Global Access Project
ICAW
Ice Breakers Uganda (IBU)
Independent Consultant
Infectious Disease Institute (IDI)
Integrated Community Based Initiatives (ICOBI)
InterAid Uganda
International Community of Women living with HIV & AIDS Eastern Africa (ICW EA)
Joint Clinical Research Centre (JCRC)
Kamwokya Christian Caring Community (KCCC)

KEZ Consult
Kitovu Mobile Ltd
Makerere University School of Public Health (MUSPH)
Marie Stopes Uganda (MSU)
Mildmay Uganda
Mulago Child Center
Namugongo Fund for Special Children (NFSC)
National Community of Women Living with HIV/AIDS in Uganda (NACWOLA)
National Forum of PLHA Networks in Uganda (NAFOPHANU)
National Tuberculosis Leprosy Program, Ministry of Health
Nature Africa
Protecting Families against HIV/AIDS (PREFA)
The African Network for the Prevention and Protection against Child Abuse and Neglect (ANPPCAN)
The AIDS Support Organization (TASO)
The Coalition for Health Promotion and Social Development (HEPS-Uganda)
The International Food Policy Research Institute (IFPRI)
The Uganda Women's Effort to Save Orphans (UWESO)
Uganda AIDS Commission
Uganda Broadcasting Cooperation
Uganda Episcopal Conference - Uganda Catholic Secretariat (UEC-UCS)
Uganda Harm Reduction Network- (UHRN)
Uganda National Health Consumers' Organization (UNHCO)
Uganda Network of AIDS Service Organizations
Uganda Network of Young People Living with HIV/AIDS (UNYPA)
Uganda Network on Law, Ethics and HIV/AIDS (UGANET)
Uganda Stop TB Partnership (USTP)
Uganda Women And Children Organisation (UWCO)
Uganda Youth Positives (UYP)
United Friends Club (UFC)
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