



Civil Society Contribution to HIV&AIDS Response in Uganda, 2009

STUDY REPORT

CIVIL SOCIETY CONTRIBUTION TO HIV & AIDS
RESPONSE IN UGANDA, 2009

STUDY REPORT

Acronyms

AIC	AIDS Information Centre
ART	Anti-retroviral Therapy
ASO	AIDS Support Organization
BCC	Behavior Change Communication
BCP	Basic Care Programme
CBO	Community-Based Organization
CHAIN	Community Health and Information Network
CICC	CS's Inter-Constituency Co-ordination Committee
CRS	Catholic Relief Services
CSF	Civil Society Fund
CS	Civil Society
CSOs	Civil Society Organisations
CSWs	Commercial Sex Workers
DAC	District AIDS Committee
DAT	District HIV and AIDS Taskforce
DHO	District Health Officer
DP	Development Partners
FBO	Faith-Based Organisation
GoU	Government of Uganda
HBC	Home-Based Care
HC	Health Centre
HCT	HIV Counseling and Testing
ICOB1	Integrated Community Based Initiative
ICW	International Community of Women Living with HIV & AIDS
IDI	Infectious Diseases Institute
IEC	Information, Education and Communication
IGAs	Income Generating Activities
JCRC:	Joint Clinical Research Center
KIBANET	Kibale District Network of People Living with HIV & AIDS.
KNASO	Kabarole Network of AIDS Service Organisations
LG	Local Government
MARPs	Most at Risk Populations
MBADNASO	Mbarara District Network of AIDS Service Organisations
MoH	Ministry of Health
NMS	National Medical Stores
NSP	National Strategic Plan
OIs	Opportunistic Infections
OVC	Orphans and Other Vulnerable Children
PACE	Programme for Accessible Health, Communication and Education
PC	Partnership Committee
PEs	Peer Educators
PET	Peace, Education and Trust Uganda
PHA	Person Living with HI&AIDS
PMTCT	Prevention of Mother to Child Transmission
RANNET	Rwenzori Association of NGOs and Networks.
RUDINET	Rukungiri District Network of People Living with HIV & AIDS.
RUGADA	Rukungiri Gender and Development Association
RUPAD	Rural People Action in Development
STIs	Sexually Transmitted Infections
TASO	The AIDS Support Organisation
TSO	Technical Support Organisation
UNASO	Uganda Network of AIDS Service Organizations
UPE	Universal Primary Education
UPMB	Uganda Protestant Medical Bureau
URCS	Uganda Red Cross Society
URDT	Uganda Rural Development and Training Program
USE	Universal Secondary Education
USG	United States Government
VCT	Voluntary Counseling and Testing

Foreword

I am pleased to share with you this report which documented the contribution of civil society organisations to the national HIV and AIDS response in the country in 2009.

This report which captures CSO contribution to the main thematic areas of the National HIV and AIDS Strategic Plan - prevention, care and treatment, social support, systems strengthening, and advocacy and policy engagement - is a clear manifestation that the civil society has not grown tired of devoting persistent efforts to counteract the effects and impact of HIV and AIDS in Uganda.

I take this opportunity to thank external development partners and the Civil Society Fund, who contributed the resources on which the civil society organisations largely relied to make the reported contribution to the national HIV and AIDS response.

I would also like to thank the Government of Uganda for creating the necessary environment and the legal and policy framework for all of us to participate in the national HIV and AIDS response under the Multi-sectoral approach.

Despite the above commendable contribution, the report also reveals that civil society faced a number of challenges during the year, and several recommendations to address the challenges have been fronted. What remains critical for all of us is to persistently continue to devise innovative approaches and strategies that are cost effective in mitigating the impact of HIV and AIDS epidemic.

My hope is that this report will be a source of valuable information for all stakeholders including decision makers, development partners, academia, and the general public to further appreciate the contribution of civil society and to see how more partnerships can be developed for a more effective response to HIV and AIDS in this country.

I applaud the Uganda Network of AIDS Service Organisations (UNASO) which commissioned the documentation of this report on behalf of the Civil Society Inter-Constituency Coordination Committee (CICC), and all study participants who willingly provided the information that has culminated into this report.

I would also like to thank Civil Society Fund for providing the financial resources that facilitated the documentation process and the publication of this report.



Rev. Sam Ruteikara
Chairperson, CICC

Acknowledgements

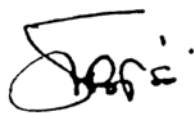
On behalf of the Uganda Network of AIDS Service Organisations (UNASO) I take this opportunity to thank the Civil Society's Inter Constituency Co-ordination Committee (CICC) that spear headed the process of documenting this report.

I also extend my sincere gratitude to all the study participants and staff of various civil society organisations (CSOs) both at national, district and lower levels, particularly the 70 CSOs from Central, West Nile, Northern, Eastern, Southern Western and Western Uganda who willingly provided the information that culminated into this report.

My sincere special thanks go to the consultants for the commendable job done by gathering information from all over the country and compiling this report.

The report clearly shows that civil society organisations largely relied on external development partners and the Civil Society Fund, to make the reported contribution to the national HIV and AIDS response. I take this opportunity to thank all AIDS Development Partners for this support and to ask them for continued support for the future.

I wish also to thank the Government of Uganda and the Local Governments in the various districts for creating a conducive environment allowing CSOs to operate freely and for providing the policy and legal guidance to them as they undertook various interventions to respond to HIV and AIDS in this country.



Dr. Mugisa John Bitanihirwe MD, MPH.
CHAIRPERSON, UNASO Board of Directors

Table of Contents

Acronyms	ii
Acknowledgements.....	iii
List of Tables.....	vi
List of Figures.....	vi
Executive Summary.....	vii
1.0 INTRODUCTION.....	1
1.1 Introduction.....	1
1.2 Background.....	1
1.3 Objectives of the Assignment.....	1
1.4 Methods and Approach to the Approach.....	1
1.4.1 Overall approach.....	1
1.4.2 Study coverage and areas.....	2
1.4.3 Study participants	3
1.4.4 Data collection techniques.....	3
1.4.5 The process of data collection.....	3
2.0 PROFILES OF CIVIL SOCIETY CONTRIBUTING TO THE NATIONAL RESPONSE	5
2.1 Introduction.....	5
2.2 Type of Organisation.....	5
2.3 Geographical Area of Operation.....	5
2.4 Target Population Served.....	6
2.5 Models of Service Delivery.....	7
2.6 Implemented Interventions.....	7
3.0 CONTRIBUTION OF THE CIVIL SOCIETY TO HIV & AIDS IN UGANDA 2009.....	8
3.1 Introduction.....	8
3.2 Prevention.....	8
3.2.1 Information, education and communication (IEC).....	9
3.2.2 Condom education & distribution.....	10
3.2.3 HIV counselling and testing (HCT).....	10
3.2.4 Prevention of mother to child transmission (PMTCT).....	11
3.3 Care and Treatment	11
3.3.1 Basic care kits.....	11
3.3.2 Management of opportunistic infections (OIs) and provision of ARVs.....	12
3.3.3 Home-based care and palliative care.....	13
3.3.4 Paediatric HIV & AIDS care.....	14
3.3.5 Laboratory and referral services.....	14
3.4 Social Support.....	14
3.4.1 Psychosocial support.....	15
3.4.2 Formal and vocational education.....	15
3.4.3 Income generating activities (IGAs).....	16
3.5 Systems Strengthening.....	17
3.6 Advocacy and Policy Engagement.....	18
4.0 BEST PRACTICES, LESSONS AND INNOVATIONS	20
4.1 Introduction.....	20
4.2 Best Practices.....	20
4.2.1 Involvement of PHAs in the delivery of social services.....	20
4.2.2 Using starter kit.....	20
4.2.3 Undertaking supplementary interventions.....	21
4.3 Lessons.....	21
4.4 Innovations.....	21

5.0	RESOURCE ACCESS BY CIVIL SOCIETY AND A SWOT ANALYSIS.....	23
5.1	Introduction.....	23
5.2	Resources Access.....	23
5.2.1	Civil Society Fund (CSF)	23
5.2.2	Other sources of financial resources.....	24
5.2.3	Human resources.....	26
5.2.4	Infrastructural and logistical.....	26
5.3	A SWOT Analysis.....	27
6.0	CHALLENGES FACED BY CIVIL SOCIETY.....	28
6.1	Introduction.....	28
6.2	General Challenges.....	28
6.2.1	Co-ordination.....	28
6.2.2	Financial access and continuity of service provision.....	29
6.2.3	Capacity to deliver services.....	30
6.2.4	Urban versus rural concentration.....	30
6.3	Thematic Area Specific Challenges.....	31
6.3.1	Prevention.....	31
6.3.2	Care and treatment	33
6.3.3	Social Support.....	35
7.0	CONCLUSION AND RECOMMENDATIONS.....	37
7.1	Introduction.....	37
7.2	Conclusion.....	37
7.3	Recommendations.....	37
7.3.1	General and cross-cutting.....	37
7.3.2	Specific Recommendations.....	39
	References.....	41
	Appendix 1: Matrix of sample CS agencies covered by district and interventions.....	42
	Appendix 2: List of People Interviewed.....	56
List of Tables		
	Table 1: Distribution of sampled districts.....	2
	Table 2: HIV Prevention component in NSP 2007/8-2011/12.....	8
	Table 3: HIV care and Treatment component in NSP 2007/8-2011/12.....	12
	Table 4: HIV support/mitigation component in NSP 2007/8-2011/12.....	15
	Table 5: Partners contributing to the CSF.....	23
	Table 6: Recipients of CSF between 2007 and 2009.....	24
	Table 7: Sample sources of CS financial resources.....	25
	Table 8: SWOT Analysis of CS involved in the national response.....	27
List of Figures		
	Figure 1: Type of civil society actors.....	5
	Figure 2: Geographical area of operation.....	5
	Figure 3: CS actors and level of operation (%).....	5
	Figure 4: Distribution of agencies involved in the national HIV & AIDS response in Uganda.....	6
	Figure 5: Implemented interventions by CS in 2009 (%).....	7
	Figure 6: Sample of SC actors in E. Uganda and their interventions (%).....	7
	Figure 7: Range of prevention services by CS actors.....	8
	Figure 8: Care and treatment services provided by CS in 2009.....	12
	Figure 9: Nature of social support by CS.....	15

Executive Summary

1.0 Introduction and Methodology

This study on documentation of civil society (CS) contribution to the national HIV & AIDS response for the year 2009 was commissioned by UNASO on behalf of CICC and undertaken between March and May 2010. A predominantly qualitative methodology was utilized to undertake this study. A total of 70 CS agencies in Central, West Nile, Northern, Eastern, South Western and Western Uganda were covered. Data were collected through a desk review, key informant interviews, written submissions and focus group discussions.

Key Findings

2.0 Profiles of CS

A range of CS actors contributed to the national response including national NGOs, international NGOs, FBOs, CBOs and CS networks. A relatively big number (40%) of CS actors operated at national level followed by those that operated in two (2) or more districts. About a fifth of the CS actors visited operated in one (1) district and a tenth operated in selected sub-counties. National and district NGOs operated in specific sub-counties of one or more than districts. Overall, CS actors were found unevenly spread in the country with the whole of Karamoja sub-region having very few CS actors compared to the rest of the regions. In terms of interventions as per the four thematic areas of the NSP 2007/08 – 2011/12, the findings revealed that over a half of the CS actors (50%) were involved in prevention, followed by those involved in providing social support, care and treatment to PHA, and lastly systems strengthening.

3.0 Contribution of the CS in National Response

3.1 Prevention

Information, Education and Communication (IEC), condom promotion and distribution, HCT, promotion of abstinence and faithfulness, and PMTCT were key areas where CS made a remarkable contribution during 2009. CS actors participated in a range of service provision aimed at the realization of the “ABC” strategy. A review of all district directories of HIV & AIDS service providers for the year 2008/9 showed that CS predominantly implemented majority of the prevention interventions in the respective districts compared to other players.

3.2 Care and Treatment

CS contribution in care and treatment was in the area of provision of services such as basic kits, ART, management of opportunistic infections, HCT, laboratory service, provision of HBC, and referral. However, most CS could not engage in care and treatment due to lack of infrastructure, technical, and managerial capacity needed to provide HIV & AIDS treatment.

3.3 Social Support

Data from the field and secondary sources reviewed point to predominance of CS in contributing to the realisation of the NSP objectives under this thematic area compared to the public sector. CS actors have been involved in the provision of psychosocial support, formal education, vocational training support to orphans, vulnerable and other vulnerable children (OVC), and supporting income generating activities (IGAs) to affected households and psychosocial support.

3.4 Systems Strengthening

Study findings show that some CS actors including UNASO contributed to systems strengthening or capacity-building of small CS actors as well as that of government facilities. This involved support to human resource and infrastructural development, research, as well as M&E systems of partner organisations. Some CS agencies helped to build capacity of health units through trainings. At a wider level, CS has been at the forefront of strengthening systems in endeavour to promote quality service delivery such as HCT through skills building in HIV counseling and testing.

3.5 Advocacy and Policy Engagement

CS in Uganda is considered instrumental in advocating for the various HIV & AIDS issues. For instance, issues like rights of PHAs have mainly been championed by networks and coalitions such as HEPS Uganda, NAFOPHANU, ICW, and NGOs like HAG, TASO etc.

4.0 Best Practices

The study findings revealed that CSOs rely more on the use of PHAs experiences to reach out to other members in the community, which is a best practice. In particular, some CS agencies have trained community-based peer educators (CBPEs) who follow up their colleagues in the community. Other best practices include provision of a starter-kit, which is a component of the evidence-based Basic Care Program (BCP) and undertaking of supplementary interventions.

5.0 Resource Access by CS

CS agencies largely accessed resources from external agencies in 2009, and from Civil Society Fund (CSF). Records obtained from CSF Secretariat revealed that to-date, over UG.SH 50/= billions have been disbursed to CS in Uganda. On a limited scale, though, some CS agencies have levied user-fee, collected membership fees and training fees. Several CS agencies revealed that in 2009, they only operated with a budget of 30-50% of the total required budget. Insufficient financial resources as a hindrance to implementation of planned activities were more common among small CS agencies that relied on single source of funds. Other resources that CS had included human resources such as counsellors and social workers, equipment such as computers and other office accessories like internet, telephone for communication, motor vehicles and motorcycles as well as bicycles to facilitate movement, office and premises. However, for several small CS agencies such resources were in limited quantities.

6.0 Challenges Faced by CS

i. Lack of effective co-ordination

All informants were unanimous on the issue of poor or lack of co-ordination of CS. CS is so diverse with varied mandates and each actor largely pursuing own and at times competing or rivaling interests. CS players tend to provide similar services to the same community or beneficiaries at the same time due to ineffective or lack of a co-ordination mechanism for the interventions. Key informants argued that not much in terms of co-ordination has been done by Development Partners (DP) and UNASO to promote effective co-ordination.

ii. Financial access and continuity of service provision

There are many CS operating in the country, all competing for funds from a few funding agencies. Although CSF was established to access funds to CS participating in national HIV & AIDS response, and whereas much has been done in terms of disbursement, numerous challenges remain. Most of small CS operating at the grassroots (i.e., community-based organizations) hardly meet the conditions for eligibility and qualification for CSF, while big national NGOs access huge amounts of resources from CSF, their geographical areas of operation and range of services provided, notwithstanding. For instance, nine (9) big NNGOs received almost 50% (i.e., UG.SHS 27.06/= billion) between 2007 and 2009, while the rest of CS that contribute to the response including 80 local governments shared the remaining 50%.

iii. Capacity to deliver services

Most CSOs appear to lack the capacity to provide comprehensive care and treatment packages for the PHAs. On the other hand, the referral system used by several CS agencies can be described as not fully effective in assisting the PHAs access services. When the PHAs are referred, the referring agency does not have mechanism for follow-up to ensure that the PHAs are given the necessary treatment.

iv. Prevention

The commonly cited challenges faced by CS agencies engaged in prevention was the cost associated with IEC; cost of communication, insufficient funding to produce materials, fatigue from messages and illiteracy. CS experience two major challenges, namely; stock-outs of IEC materials due to irregular production and distribution by the partner agencies.

During 2009, provision of HCT was mostly affected by inadequate personnel and sporadic supply of HIV testing kits. Further, lack of funds to facilitate health workers from government facilities to implement VCT outreaches posed a major challenge, which affected implementation of HCT activities.

Irregularity in supply of condoms was cited by several study participants as a major challenge. A number of the actors do not procure the condoms themselves, but rather distribute those procured by other actors such as the district health departments, which at times run out of stocks. With regard to PMTCT, the uptake is still constrained by stigma. The major challenges that faced CS actors involved in PMTCT in 2009 and which continues unabated is also the poor laboratory coverage across the country.

v. Care and treatment

Periodic shortage of testing kits and laboratory reagents was reported in all the CS providing laboratory services due to a combination of factors including irregular supplies, termination of funding and overwhelming demand for screening services for multiple health conditions. Misuse of some products in the basic care kits by the beneficiaries seems to be another challenge in the provision of basic care kits. Provision of basic care kits was further affected by stigma. On the other hand, provision of ART services is affected by the inadequate supplies and stock-outs of ARVs and septrine.

Implementation of HBC interventions by CS during 2009 was largely challenged by lack of personnel and logistics. Majority of CS actors engaged in HBC rely on services of volunteers, but sustaining such volunteers posed a big challenge. CS agencies especially those operating in northern Uganda revealed that they started having challenges with HBC when people started going out of the IDP camps.

iii. Social Support

For several agencies, the sponsorship support for OVC was not continuous due to uncertainty in funding. With regard to vocational education training, the major challenge faced by implementers of such interventions was the cost of tools. With regard to supporting IGAs, the needs of beneficiaries are immediate, and hence the supported IGAs do not enable the affected to meet such instant needs.

7.0 Recommendations

Co-ordination of CS

- DPs supporting CS need to work with UNASO to make co-ordination functional and effective.
- DPs need to stress and oblige CS agencies as a condition for funding to publish their strategic plans, programs and annual plans
- UNASO assisted by UAC should at least once in two years produce a detailed inventory of CS involved in the response.
- There is a need to re-think the whole concept of co-ordination at district level and effectively support district networks to play this role, and support the whole area of monitoring and evaluation (M&E).
- As a measure towards effective co-ordination, this annual exercise need to be turned into a two-year exercise and, among others, conducted to input into the Country UNGASS Reporting.

Resource access

- There is need to revisit the funding conditions of accessing resources especially from the CSF by small CS. A portion of funds with CSF could be “ring-fenced” for small CS.
- UNASO and other CS agencies involved in advocacy and lobbying need to work together to present a concerted effort and lobby government to provide partial funding to CS activities.
- UNASO need to be supported by DPs and even government to build and strengthen the capacity of CS especially small agencies to mobilize and utilize resources.

Capacity to deliver

- CS should explore forming partnerships and to instituting collaborative arrangements so that CS agencies are mutually supportive of one another instead of exhibiting competition.
- CS should establish strong links with the local government in the areas of their operations to benefit from the infrastructure established by government institutions.

Prevention

- Less expensive but interactive mediums of disseminating information should be sought and used. In particular, more emphasis should be placed on the use of drama and music on top of the traditional IEC materials.
- Where IEC materials are used, it is necessary to develop the materials that can be reproduced locally using the available ICT facilities.
- Increase and sustain the involvement of PHAs in HIV prevention campaigns.

Care and Treatment

- CSOs should work with government and other partners to ensure constant/continuous availability of care and treatment facilities.
- Invest in development of effective referral systems. This calls for close collaboration among different CSOs involved in care and treatment.

Social Support

- Social support interventions should be enriched beyond the existing interventions.
- There is need to have a comprehensive capacity-building for CSOs engaged in livelihood activities so that they can extend the same training to the beneficiaries.

Systems Strengthening

- Investments in systems strengthening need to be given enough priority in HIV programming for a host of CS agencies.
- There is need to develop and forge partnerships between the bigger CSOs and CBOs to increase the capacity of small organisations.
- There is need to facilitate effective integration of CSO work in the district administration. This would also require harmonizing planning calendars for both district local governments and the CSOs in different districts.

1.0 INTRODUCTION

1.1 Introduction

Uganda Network of AIDS Service Organisations (UNASO) on behalf of the Civil Society's Inter-Constituency Coordination Committee (CICC) commissioned this Assignment aimed at *"Documenting Civil Society Contribution to HIV & AIDS Response in Uganda, 2009"*. The Assignment was carried out between March and May 2010 in all the regions, but covering selected districts.

1.2 Background

UNASO formed in 1996, is an umbrella organization that exists to coordinate and represent AIDS Service Organizations (ASOs) e.g., non-governmental organizations (NGOs), community-based organizations (CBOs), faith-based organizations (FBOs) etc., in Uganda so that prevention, quality care and support services are available to all. The program activities of UNASO are guided by the Uganda National Strategic Plan (NSP)—2007/08 -2011/12) whose mission is to "ensure HIV & AIDS prevention, quality care and support services through coordination and strengthening of civil Society HIV & AIDS service organizations (ASOs) in Uganda". To-date, UNASO has a membership of over 1,000 out of the estimated 2,500 organizations that are engaged in HIV & AIDS response (UNASO, 2008). Thus, Civil Society (CS) in Uganda is a very diverse community including the entire "public space" between the state and the private citizens. The CS (which includes private sector, NGOs, FBOs and CBOs), among other things, complements the public sector through; direct service delivery; supporting capacity building activities; advocacy, communication/voicing needs of society; promoting rights of people with respect to HIV & AIDS; and mobilization for HIV & AIDS activities.

Civil society (CS) in Uganda is variously engaged in the national response to HIV & AIDS, Tuberculosis (TB) and Malaria. However, because of their diversity, there was need for coordination and harmonization that would ensure effective and efficient contribution. As a result, the Partnership Committee (PC) in 2006 endorsed the desire by the civil society engaged in HIV & AIDS response to establish CICC outside the PC to deliberate and articulate their views and positions on matters relating to different aspects of HIV & AIDS, TB and Malaria. The documentation of the various contribution by the entire CS to national response during 2009 in the context of HIV & AIDS became of critical importance and, hence the purpose of this assignment.

1.3 Objectives of the Assignment

The main objective of this study was to collect information on the contribution of the CS to the HIV & AIDS national response. The documentation was intended to generate suggestions regarding the most appropriate measures to be taken in order to improve the contribution of CS to HIV & AIDS response in Uganda. Specifically the study sought to achieve the following objectives:

- To document the contribution of the CS as per NSP thematic areas (prevention, care and treatment, social support, service delivery, institutional/systems strengthening including coordination of the response among the CS, advocacy and policy engagement)
- To document best practices, lessons learnt and innovations.
- To identify sources of funds to the civil society and challenges in accessing funds
- To make recommendations to improve effectiveness and efficiency² of the CS in contributing to the national response.

1.4 Methods and Approach to the Approach

1.4.1 Overall approach

A qualitative methodology was utilized in assessing and establishing the contribution of CS in Uganda to the national HIV & AIDS response. Qualitative methods using purposive selection of CS representatives

2 Efficiency will be limited to establishing in general terms how the resources received by the civil society are used.

instead of quantitative methods were preferred due to the diverse nature of CS, differing interests and mandates. This was meant to ensure that a wide spectrum of CS was captured. Only in a few instances were collected primary data quantified, while the rest were collected from secondary sources.

1.4.2 Study coverage and areas

The study covered international and national NGOs, FBOs, CBOs, the private sector and associations of people living with HIV & AIDS (PHAs) with district specific and national operations. A sample of the national level NGOs was targeted to capture not only achievements in direct service delivery, but also their contribution in policy and decision-making at national level. For primary data collection, a sample of CS was selected from the six operationally defined major regions in the country. These included Central, West Nile, Northern, Eastern, South Western and Western Uganda.

In each of the regions, three districts were covered for in-depth interviews—making a total of 18 districts spread all over the country. In each district, at least three to four CS representatives were purposively selected; one dealing in prevention, the other involved in care and treatment, and then social support. Very few organizations were found involved in systems strengthening/capacity-building. The distribution of the civil society representatives was cognizant of the old and newly created districts. See Table 1.

Table 1: Distribution of sampled districts

District	Civil Society	District	Civil Society
Apac	Acenworo Child & Family Programme WACANE	Masindi	JCRC -Build Africa Masindi District NGO forum Family Sprit Children Centre
Lira	Medical Teams International LIDFOPHANU AIDS Orphans Education Care Foundation	Nebbi	AFARD Uganda Red Cross Society Nyapea Safe Motherhood and Child Care Association Caritas
Adjumani	YAASA Agency for Co-operation in Research and Development (ACORD) Straight Talk Foundation – Adjumani	Arua	Nacwola Arua Indigiosus Resource Development Agency West Nile Youth Organization on Health Education Caritas
Gulu	Comboni Samaritans of Gulu Health Alert – Uganda Dyere-tek Agency for Co-operation in Research and Development (ACORD)	Mukono	Kismba Moslem Mission Good Spirit Support Action Centre URCS Asiika Obulamu People Living with HIV & AIDS
Mbarara	TASO Mayanja Memorial Foundation Integrated Community-Based Interventions (ICOBi) Agency for Co-operation in Research and Development (ACORD)	Jinja	The AIDS Intervention Program AIDS Orphan Education Trust Child Fund AIDS Information Center
Rukungiri	RUDINET TASO RUGADA JCRC Nyakibare	Kapchorwa	Kapchorwa Integrated Community Mobilisation Program Kapchorwa Forum for PHAs Kapchorwa Civil Society Organization Alliance Reproductive Health Uganda
Kisoro	Mutolere Public Health Program, Mutolore Hospital Virunga Allied For Dynamic and Health Society KOINONIA Ministries PET	Soroti	Soroti Rural Development Agency TASO Teso Islamic Development Action Centre Community Care Services
Kabarole	MEETING POINT RANET- JCRC- Kabarole Fort Portal Diocese-HIV and AIDS Project Unit	Kampala	ACORD GOAL Uganda Action Group for Health, Human Rights and HIV & AIDS (AGHA) Uganda URCS PACE HCU
Kibale	IDI- Kibale Branch KIBANET RUPADA		
Luwero	ICOBi VEDCO React Out Mbuya AMREF		

In each selected district, the Research Team worked with the District Networks of AIDS Support Organizations and the district HIV & AIDS Focal Persons (FPs) to identify a sample of legally registered ASOs. Deliberate efforts were made to balance the selection of CS representative in different districts. Secondly, district networks were visited to obtain an in-depth assessment on CS contribution with regard to response to HIV & AIDS, documentation of best practices, lessons learnt and innovations. All this was approached with respect to the thematic coverage in accordance to the NSP 2007/08-2011/12.

1.4.3 Study participants

Study participants were selected at national and district levels. At the national level, study participants were drawn from UNASO, CICC, Uganda AIDS Commission (UAC), representatives of international NGOs, other CSOs, and representatives of AIDS DPs. At district level, study participants comprised the district HIV & AIDS FPs, DHOs, District AIDS Committees and Taskforce, the executive committees of the district networks of AIDS Service Organizations, staff and target groups/beneficiaries of CS.

1.4.4 Data collection techniques

Qualitative methods of data collection were applied in executing this assignment. These included a desk review, key informant interviews (KIIs), written submissions, group and focus group discussions (FGDs).

i. Desk review

Key documents on existing HIV & AIDS policies and guidelines were reviewed by the consultant. This, among others, enabled an appreciation of the sector environment in which CS in the country as well as globally, CS operations, geographical coverage and funding source and levels.

ii. In-depth and key informant interviews

Using unstructured interview guides, data was collected from the management of selected CS representatives and key informants (KIs) at national and district level familiar with the CS sector as well as those representing the international NGOs. These shared their views on the challenges, good practices of the CS working in the area of HIV & AIDS; lessons learnt, and contributed to generation of recommendations on improving civil society work

iii. Written submissions

Efforts were made to reach a big number of CS actors at the national level and where appointments could not be secured; issues were e-mailed to designated officers. A few of these national level actors responded to the issues on CS contribution that were raised to them.

iv Group/FGDs

Group interviews or FGDs were conducted with target groups of selected CS representatives. Data were collected on actual benefits accruing to target populations from the interventions/activities implemented by the CS in responding to HIV & AIDS as well as the limitations.

1.4.5 The process of data collection

The process of data collection was implemented under three major phases; (i) a desk review, (ii) field visits to districts, and (iii) consultations at national level

Phase 1

During Phase 1, the Consultant reviewed key existing HIV & AIDS policies and guidelines such as the NSP 2007/08-2011/12 to provide a basis for the documentation of CS contribution to the response and map the various areas of intervention i.e. thematic and geographic. Some literature was also accessed on websites of some of the organizations.

Phase 2

Phase 2 involved field visits to conduct in-depth interviews at district level and below. Group discussions were conducted during this phase with selected beneficiaries of CS interventions. See Appendix 2 for the list of study participants.

Phase 3

District level consultations were followed by national level consultations-i.e., with stakeholders and actors at the national level. This phase involved face to face interviews and electronic responses. See Appendix 2.

Phase 4:

This entailed holding of a Validation Workshop where representatives of CS converged in Kampala at Hotel Africana on July 8, 2010 to validate the study findings. Comments, views and opinions of all the participants were incorporated into this study report.

1.4.6 Data Management

The information generated was analyzed using Content and Thematic Approaches. A review of all transcripts to delineate aspects directly relevant to the study objective was done. An Analysis Grid was prepared for all the interviews/discussions conducted using the key quotations, insights, and explanations delineated from the transcripts.

1.5 Challenges Encountered

CS is so diverse, scattered/fragmented, with diverse interests and mandates. As a result, to scientifically derive a representative sample and hence quantify the contribution made by CS in a given year would pose daunting challenges. To overcome this challenge, a purposive and outward looking approach was adopted to enable generation of views, observations and opinions on the contribution of CS.

The other challenge encountered in this study was that of demarcating actual CS contribution during 2009 from that of 2008, for this is a yearly exercise. Selected CS representatives were found to have been implementing similar activities over several years, and were still implementing similar interventions. It could be better if documentation of CS contribution to the national response is turned into a two-year exercise, and, among others, it should be aimed at contributing the UNGASS Reporting. Instead of compiling a CS UNGASS Report, documentation of CS response in a two year period could be adopted.

It was almost a nightmare getting appointments with representatives of some of the selected CS actors at the national level allegedly due to having hectic schedules. A few responded by e-mail, while a big number did not respond even after sending constant reminders.

1.6 Organisation of the Report

The rest of this Report is organised under Six major Sections—2.0 to 7.0. Section 2.0 presents the profiles of CS contributing to the national response based on studied agencies. Section 3.0 is a presentation of CS contribution to national HIV & AIDS response along the four main thematic areas in the NSP 2007/08-2011/12; prevention, care and treatment, social support and institutional strengthening. Section 4.0 focuses on best practices, lessons and innovations by CS, while Section 5.0 is on resource access and analysis of CS strengths, weaknesses, opportunities and threats. In Section 6.0, the various challenges faced by CS especially during 2009 are discussed, while 7.0 presents the conclusions and possible recommendations arising out of the study findings.

2.0 PROFILES OF CIVIL SOCIETY CONTRIBUTING TO THE NATIONAL RESPONSE

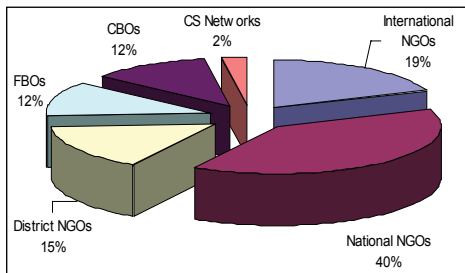
2.1 Introduction

In this Section a profile of the sample of CS captured in this study that contributed to the national HIV & AIDS response is presented; the type of the CS, geographical coverage, target population served, models of service delivery and the interventions implemented.

2.2 Type of Organisation

A range of CS actors contributed to the national HIV & AIDS response during 2009. These included national NGOs, international NGOs, FBOs, CBOs and CS networks.

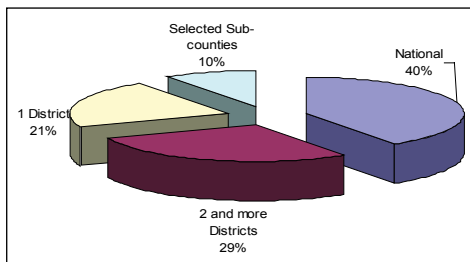
Figure 1: Type of civil society actors



Of these, 40% were national NGOs, followed by international NGOs and then district-based NGOs. FBOs and CBOs similarly contributed to the national response. CS networks were also operational in some of the districts that were visited. The findings, however, need to be understood and appreciated in the context that this study did not cover all the districts in the country, but merely a sample of selected districts spread all over the country. This notwithstanding, the sample provides a picture on what was the actual situation during 2009.

2.3 Geographical Area of Operation

Figure 2: Geographical area of operation



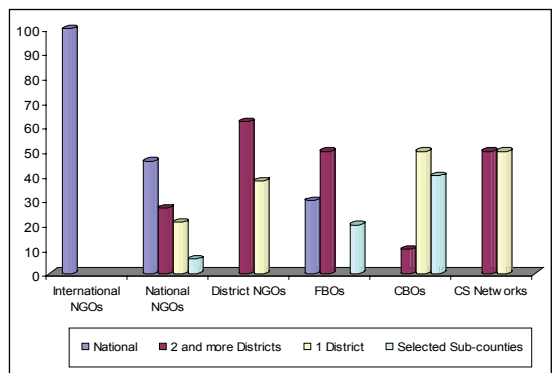
CS actors operate at all levels; ranging from national to sub-county. A relatively big number (40%) of SC actors operate at national level followed by those that operate in two (2) or more districts. As shown in Figure 2, about a fifth of the CS actors visited operated in one (1) district and a tenth operated in selected sub-counties. In terms of coverage, the important determinants for geographical coverage and scope of services were mainly the amount of resources available to the CS and the political environment. Big NGOs (TASO and AIC) tend to operate at a national level and, therefore, covering almost

all districts at a regional level. National and district NGOs have tended to operate in specific sub-counties of one or more than districts. The role of CBOs was rather difficult to estimate. For resource accessibility purposes, CBOs tended to exaggerate coverage and scope of their services, whereas the situation on ground would be totally different. Though, it is also true that most CS tended to concentrate within and around the municipalities.

Figure 3: CS actors and level of operation (%)

In terms of coverage, international NGOs cover the national level while national NGOs apart from operating at national level, extended specific services to selected districts and sub-counties.

Overall, apart from the presence of government facilities and hence interventions that seem to be spread country over, quality and quantity notwithstanding, the rest of the actors are unevenly spread in the country.



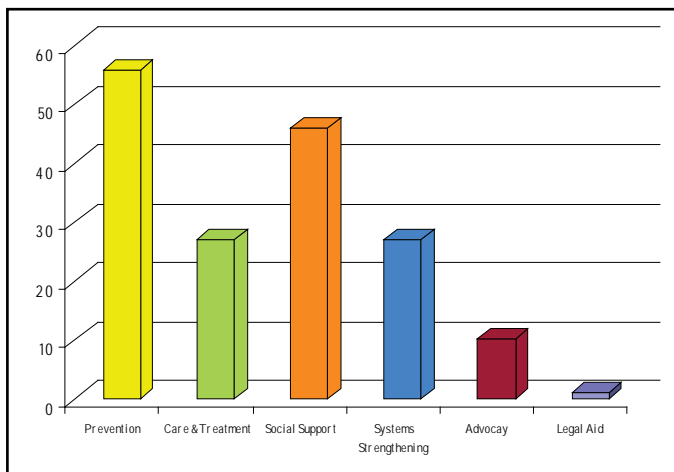
2.5 Models of Service Delivery

The study findings reveal that the dominant mode of service delivery was community-based. Most of the community-based services were prevention and social support. A few CS actors used facility/clinic-based mode especially for care and treatment.

2.6 Implemented Interventions

Overall, the findings reveal that over a half of the CS actors were involved in prevention activities or interventions. These were followed by those involved in providing social support to sections of society that have been impacted on by HIV & AIDS such as orphans and other vulnerable children (OVC), care and treatment to PHAs and then systems strengthening. As Figure 5 shows, very few CS actors contributed to advocacy and legal aid services.

Figure 5: Implemented interventions by CS in 2009 (%)



Regional specific cases covered by this study serve a good illustration of the above finding. For instance, in Eastern Uganda where 16 CS actors were studied, the major contribution to the HIV & AIDS response was in the area of HIV prevention. In a descending order, of the 16 CS that were sampled in the Eastern region, the picture that evolved is shown in Figure 6.

Figure 6: Sample of SC actors in E. Uganda and their interventions (%)



High concentration of CS in HIV & AIDS prevention can be attributed to the fact that, unlike the HIV & AIDS care and treatment component and systems strengthening, information, education and communication (IEC) or awareness campaigns and counseling do not require heavy investment in health infrastructure, technical staff and laboratories.

3.0 CONTRIBUTION OF THE CIVIL SOCIETY TO HIV & AIDS IN UGANDA 2009

3.1 Introduction

The contribution of the CS to the national HIV & AIDS response in 2009 is presented under the respective thematic areas of the NSP 2007/08 – 2011/12 for HIV & AIDS activities. The four thematic areas include prevention, care and treatment, social support and systems strengthening. This Section presents the contribution attributable to CS in the above thematic areas of the NSP.

3.2 Prevention

The goal of NSP under prevention is to reduce the incidence of HIV & AIDS by 40% by the year 2012. The realisation of this goal is to be made possible by achieving five objectives on prevention in the NSP for which CS made a contribution in 2009. See Table 2.

Table 2: HIV Prevention component in NSP 2007/8-2011/12

Thematic area	Goal	Objectives
Prevention	The incidence of HIV and AIDS is reduced by 40% by the year 2012	The prevention of sexual transmission of HIV and AIDS is accelerated, targeting vulnerable and high-risk groups
		The HIV transmission from mother to child is prevented
		Blood transfusion safety, universal precautions and PEP are ensured
		Sexually transmitted infections are controlled
		New HIV intervention technologies and approaches proven to be effective, are implemented

The study findings reveal that CS actors participated in a range of service provision aimed at the realisation of the “ABC” strategy—“abstinence, be faithful and use condom, which is an integral component of Uganda’s prevention strategy. Similarly, a review of all district directories of HIV & AIDS service providers for the year 2008/9 showed that CS predominantly implemented majority of the prevention interventions in the respective districts. For instance, CS actors engaged in all aspects of prevention ranging from general passing of information education and communication (IEC), organizing and mobilizing communities for voluntary HIV counselling and testing (HCT/VCT) including couples, making available HIV testing kits, condom education & distribution, mobilizing women and their spouses for prevention of mother to child transmission (PMTCT), providing Mama kits and safe delivery kits to expectant mothers, to promoting abstinence & faithfulness practices. All stakeholders interacted with recognize that NGOs/FBOs/CBOs and the private sector especially the media were and had continued to be significant actors in the championing of Uganda’s prevention campaign using the ABC+ model.

More specifically, as shown in Figure 7, field data obtained from studied CS actors revealed that condom promotion and distribution, IEC, HIV counselling and testing (HCT), promotion of abstinence and faithfulness, prevention of mother to child transmission (PMTCT), couple counselling and testing were key areas where CS made a remarkable contribution in the national response during 2009

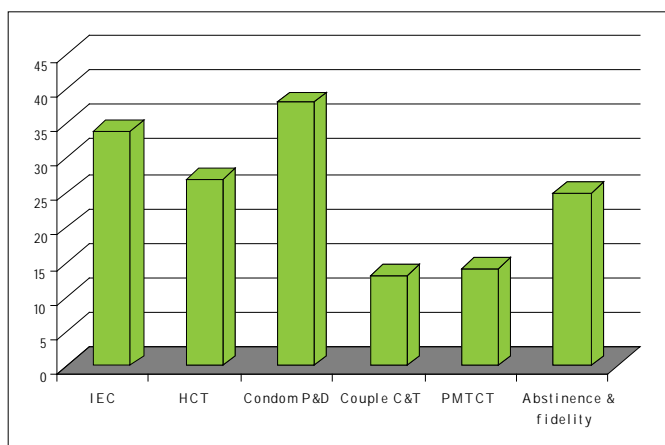


Figure 7: Range of prevention services by CS actors

3.2.1 Information, education and communication (IEC)

Among the contributions, CS actors are credited for during 2009 was its instrumental role in the creation and raising awareness among the people on the various basic facts about HIV & AIDS through IEC. At both national and lower levels, it was revealed that CS actors within 2009 were at the forefront of making available IEC materials, organizing and conducting/facilitating radio talk show programmes as well as drama to disseminate information on prevention of infection with HIV.

We have agencies like MTI which organizes drama shows in the communities, pays for radio talk shows, and produce IEC materials to educate our people on prevention of HIV (District HIV & AIDS FP, Lira District).

Findings of our prevention programme intensely implemented in Lamogi shows that awareness about HIV & AIDS is about 80% in a population of 50,000 people (KI, Dyere-tek, Gulu District).

We have raised students' awareness about the dangers of HIV & AIDS; we distribute Straight Talk Newsletters twice a month to 12 Secondary and 55 Primary schools in Adjumani (KI, Straight Talk Foundation, Adjumani District).

The sources of IEC material for most CS actors have been either big NGOs such as TASO, AIC, PACE, Straight Talk and Ministry of Health (MoH). According to CS and stakeholders interviewed, the IEC messages had resulted in behavioural change manifested in the; 1) increased demand and/or utilization of health services and preventive items (HCT services, HIV/OIs treatment services, condoms, basic care kits); 2) a decrease in the number of STI cases reported at various health centres (HCs), 3) increase in HIV & AIDS related knowledge, particularly knowledge on transmission, drivers, prevention & treatment, and; 4) increase in the demand for IEC materials, an indicator of information diffusion.

Findings reveal that some CS agencies set up a vibrant community peer education system. It is through this structure that NGOs/FBOs/CBOs mobilized community members to attend HIV & AIDS education and awareness events, distributed and erected posters and other IEC materials to continuously sensitise to people about HIV & AIDS. Similar structures were established in schools involving both teachers and students.

We reached a total of 2,811 people with HIV & AIDS messages through community dialogue, 26,840 students through school debates held on a quarterly basis (Key Informant, MTI, Lira District).

Awareness was similarly raised through use of testimonies from people living with HIV & AIDS (PHAs). On various events during 2009, NGOs/FBOs/CBOs worked with PHAs to give testimonies about their HIV status and experience living with HIV & AIDS as part of efforts to stimulate people to embrace the prevention campaign.

We have been working with PHAs to promote awareness, for example on World AIDS Day, we made an HIV+ student to be the guest of honour, we have also secured permission from PHAs admitted in hospitals to take youths especially those in school so that they talk to them about the realities of infection with HIV (Key Informant, YAASA, Adjumani).

Data obtained from secondary sources that were accessed corroborate the above findings. For instance, Uganda Red Cross Society (URCS) had by end of 2009 organized and staged 45 educative films on HIV & AIDS and various life skills camps. Through the films, it was projected that a total of 4,905 people were reached with HIV & AIDS messages while another 1,236 Youth reached through the life skills camps (URCS Health Annual Report 2009). On the other hand, FBOs such as Uganda Protestant Medical Bureau (UPMB) were at the forefront of developing IEC materials and memory aids for use during counselling sessions, posters, flipcharts and illustrated booklets. The materials were utilised in all UPMB's network of 270 hospitals, health centres and training institutions countrywide (UPMB Annual Report 2009). PACE another

CS agency produced and sponsored radio spots on BCC, which were aired 44,562 times and spearheaded a nationwide campaign against cross-generational sex to reduce vulnerability of girls between 15-24 years to HIV infection. Finally, PACE designed and spearheaded a fidelity program code named GO RED aimed at enforcing faithfulness among couples. It was reported that PACE's interventions in HIV & AIDS averted 4,776 cases of HIV infection in 2009, this was an improvement from 2008 where 4,227 were averted.

3.2.2 Condom education & distribution

Promotion, distribution and education on condom use were largely undertaken by CS throughout 2009. CS set and sustained condom distribution channels within the communities besides the health centres. Throughout 2009, NGOs/CBOs continued to work with individuals and their staff to make access to condoms for those in need possible.

We gave out 74 cartons of condoms containing 20 boxes of 120 pieces each...we have over 33 condom distributors within the district. We also make available condoms at all events we organize within the communities (Key Informant, YAASA, Adjumani).

In 2009, we distributed an equivalent of two cartons of condoms...some were utilised at the workplace; we have mainstreamed HIV & AIDS in all our programmes so even when we go to visit farmers groups, we carry with us condoms (Key Informant, ACORD, Gulu District).

Figures obtained from CS operating at national level revealed the tremendous role played by CS in 2009 in the area of condom distribution. For instance, Uganda Red Cross Society (URCS) had by end of 2009 distributed 2,560,000 pieces of condoms through their 26 distribution outlets (URCS Health Annual Report 2009). Other CS agencies such as PACE distributed 17,488,992 pieces of condoms in 2009 through social marketing up from 10,354,567 pieces in 2008, and about 98,000 female condoms to commercial sex workers (CSWs).

Some CS agencies in Eastern region targeted particular special risk groups with condoms. For instance, in Mukono, Kisimba Moslem Mission (KMM) was targeting boda-boda cyclists as a risk group. The major strategy for condom promotion and distribution has been creating multiple condom distribution outlets at health facilities, strategic locations, as well as through private outlets. There are proxy indicators that reflect a positive change in condom use. First, is the observed increase in demand for condoms in both public and private outlets.

Here at AIC, we usually distribute 1000 small boxes a month and we always run out of stock due to high demand. As a result of using condoms there has been a decrease in the number of STI infections recorded per month, un-wanted pregnancy, and in lateral HIV infection among discordant couples (KI, AIC Jinja).

After the HIV & AIDS candlelight sensitization event held at Kiyindi landing site in April 2009, we registered 7 people who requested us to always reserve some condoms so that they don't miss using condom. Even the number of boda-boda cyclists suffering from STI has dropped from 10 to 4 cases a month (Kisimba Moslem Mission Buyikwe District).

3.2.3 HIV counselling and testing (HCT)

During 2009, HCT/VCT was undertaken by the CS through some of its actors such as AIDS Information Centre (AIC), The AIDS Support Organisations (TASO), Integrated Community Based Initiative (ICOB) etc. In 2008, AIC through its branches provided HCT services to a total of 337,523 clients; an increase of 26% from 2007 (AIC Annual Report 2008). Similarly, other CS actors such as TASO and ICOBI are recognised as biggest providers of home-based HIV counselling and testing (HBHCT) services, which involves moving door-to-door providing HCT services. PACE another CS actor successfully implemented a MARPS program; reaching 2,500 CSWs and 15,000 uniformed servicemen with HCT and family planning services (FP) services.

Further, findings reveal a significant role played by CS in the mobilization and provision of HCT/VCT. Mobilization and facilitation of VCT outreaches was made possible by civil society actors. Apparently, whereas government through its various health centres (HCs) has the personnel to provide HCT/VCT

services, they lack the logistics to conduct VCT outreaches; wherever outreaches have been conducted, it was with facilitation by CS actors. Some actors like Dyere-tek, MTI, etc. do not stop at providing facilitation (money), they also make available staff to complement the health workers as well as HIV test kits and reagents.

The IEC we give has brought some changes, for example, in 2009 alone, uptake of VCT rose to over 2000 people mostly youth, this was a rise up from less than 1000 the year before...(KI, Acenlworo Child & Family Programme, Apac District).

Late last year TASO came into our district and they are the only ones with the capacity to provide door-to-door counselling and testing for HIV...they identify the HIV+ people and refer them to the health centres (Forum of PHAs, Apac District).

The channels commonly used by CS were found to include community sensitization meetings/gatherings, drama, radio, community peer educators, church, youth clubs, moving aides such as T-shirts, posters and brochures, as well as newsletters from Straight Talk. With regard to service products used in reducing risk of infection i.e. condoms, the popular channels used by the civil society for distribution are the peer educators, lodges & hotels, community sensitization meetings/gatherings and workplaces.

Due to the technical and logistical investment involved, most small CS have concentrated on community mobilization, counseling and referring the intending people to the existing sites managed by the few big CS or the government for actual testing. Therefore, one of the most important achievements has been the mobilization of the hard-to-reach communities to access HCT services in 'referral' centres. For instance, in Mukono, URCS branch mobilized communities in Kiyindi landing site and referred them to the referral hospital and other facilities within Mukono district.

Regional specific cases provide differing situations. For instance, of all the CS agencies covered in the Eastern region, only two CS were providing complete HCT services, at the static and outreach levels; AIC (Jinja and Iganga) and AIDS Orphan Education Trust [TAIP] operating in Bugembe Town Council, Jinja, and Kamuli. For the static HCT carried out at AIC Jinja-offices (static services), client had to pay UG.SH 2500 and 5000 for HCT and CD4 respectively. Beyond a mere provision of HCT services, AIC-Jinja extended technical support to the public facilities in form of testing kits, training laboratory technician in AIC testing algorithm, providing support supervision and monitoring, facilitating community outreaches, and providing a monthly reporting to the beneficiary districts. In order to induce demand for HCT services, AIC also created a network of Village Health Teams and counselors who mobilize and refer potential clients. Lastly, AIC has continued to establish and support "know your sero-status" clubs.

The overall outcome of the combined effort by the CS has been increased demand for HCT services. 'We register a high turn for HCT manifested in the regular shortage of reagents' (Reproductive Health Uganda – Kapchorwa). By last year AIDS Orphan Education Trust had tested 1384 people. Secondly, there has been a reduction in stigma.

3.2.4 Prevention of mother to child transmission (PMTCT)

Given that most CS lacked a full range of antenatal services, the contribution of CS in PMTCT during 2009 was largely limited to mobilization and referring expectant mothers to facilities especially government ones where PMTCT services could be accessed. Health officials met in this study reported a decrease in vertical transmission, as well as an increase in demand for PMTCT services partly as a result of mobilization and making referrals by CS. Despite the efforts in PMTCT, it remains the 3rd leading source of HIV infections (24%) in the country. Uptake is still low, it is below 50% (UAC/UNAIDS 2010).

3.3 Care and Treatment

The goal of the National NSP 2007/08-2011/12 for care and treatment is to mitigate the health effects of HIV & AIDS as well as improve the quality of people living with the disease. During the year 2009, several CS actors contributed to the national response in endeavor to realize the five objectives under the goal for

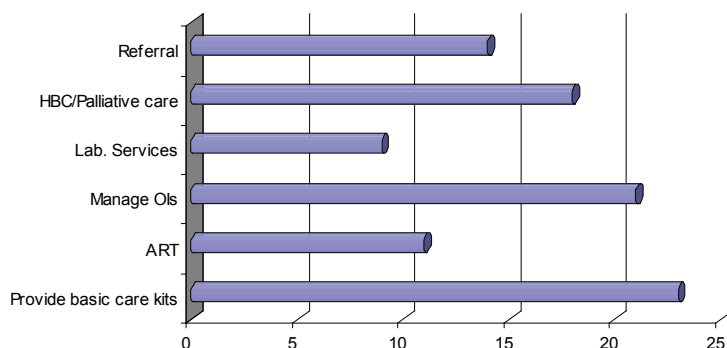
care and treatment. The objectives as shown in Table 3 include, among others, to increase equitable access to anti-retroviral therapy (ART), provision of home-based care (HBC) and improved referral systems with other health facilities. It has to be noted at the onset that care and treatment services are largely provided by government through its health facilities in the country.

Table 3: HIV care and Treatment component in NSP 2007/8-2011/12

Thematic area	Goal	Objectives
Care and Treatment	The health effects of HIV and AIDS are mitigated, improving the quality of life of people living with the disease	Equitable access to ART increased
		Access to prevention and treatment of opportunistic infections including TB and non ART care is increased
		HIV counseling and testing scaled up to facilitate universal access
		Prevention is integrated into care and treatment services
		The provision of home based care and improved referral systems with other health facilities are supported and expanded

Overall, unlike the dominant CS contribution to prevention in the national response during 2009, its contribution to care and treatment was rather minimal given the few agencies involved in provision of services such as basic kits, ART, management of opportunistic infections, HCT, Laboratory service, provision of HBC, and referral. The type of care and treatment provided by CS actors as revealed in this study is shown Figure 8.

Figure 8: Care and treatment services provided by CS in 2009



3.3.1 Basic care kits

A Review of all district directories of HIV & AIDS service providers for the year 2008/9 revealed that majority of actors from the CS limited themselves to providing basic care kits to PHAs, which is an integral part component of the Basic Care Program (BCP). The significant

reductions in morbidity and mortality among PHAs are attributed to programmes spearheaded by CS such as the BCP. Through this program, service providers countrywide were supported by Program for Accessible Health, Communication and Education (PACE) to provide basic care kits to PHAs and to adopt the desired behaviours among PHAs. Cumulatively, PACE distributed 236,758 basic care starter kits through its partner sites countrywide (PACE, 2009).

Most CS could not engage in care and treatment due to lack of infrastructure, technical, and managerial capacity needed to provide HIV & AIDS treatment. Various components of care and treatment require certain technical expertise, infrastructure or facilities, which most CS actors do not have.

3.3.2 Management of opportunistic infections (OIs) and provision of ARVs

The other key function played by CS in care and treatment is referral of PHAs for management of OIs and access to ARVs. Aspects relating to treatment and provision of ARVs i.e. prescription of drugs such as ARVs is a preserve for designated government and a few CS actors such as TASO that have the required expertise and personnel. Such organizations e.g., TASO not only provided direct treatment for OIs but also ARVs. Currently TASO cumulatively serves over 7,000 PHAs with ARVs. TASO has since provided ART to over

23,000 people (including 1,000 children). With regard to general care, over 200,000 PHAs and their family members have so far been aided by TASO in relation to care and support (*TASO website*).

A review of directories shows numerous SC agencies providing care and treatment of PHAs. Although, individually they serve small numbers and covering small areas, together, they are making a significant contribution to the response. For instance, Reachout Mbuya is currently providing holistic health care to over 2,400 clients in Mbuya Parish (*Reachout website*). By end of 2009, Mildmay Uganda had 18,862 PHAs (23% of whom children) in its care programme, of whom 8,739 were on ART (*Mildmay Report 2009*).

In majority of districts visited, the district local government staff interacted with acknowledged that NGOs and FBOs were significant actors in the provision of drugs to supplement district stocks.

Agencies like AIC, MTI, and programmes like NUMAT contribute about 30% of all the drugs (i.e. septrin and ARVs) we use in our health facilities to treat PHAs...in 2009 MTI supported 3 health sub-districts out of the 5 in Lira with drugs...(District HIV & AIDS Focal Person, Lira District).

Apparently, district local governments rely on CS actors to provide buffers of drugs in instances of delays from the National Medical Stores (NMS). Generally, have continued to play a central role in advocating for greater treatment access to the level of procuring and providing health facilities which run-out of supplies with buffers to cushion them until their drugs are delivered.

3.3.3 Home-based care and palliative care

Government participation in HBC has remained insignificant, leaving the provision of HBC entirely in the hands of CS. With HIV & AIDS, HBC is labour-intensive and costly requiring the implementation of activities that include; community mobilization; recruitment, training, motivation of CHW; provision of logistical support (transport); support supervision; inter-agency networking and partnership; implementation of regular home-visits for palliative treatment and adherence support; and recommending referrals where necessary. CS (i.e., NGOs/FBOs) has invested heavily in personnel who provide counselling including adherence counselling to PHAs within the comfort of their homes. CS actors are better placed unlike district local governments to set up community structures for provision of HBC. For instance, Comboni Samaritans of Gulu have recruited and trained 130 Adherence Follow-up Caregivers charged with monitoring and supporting PHAs resident within their localities.

We have a system of community caregivers...each caregiver is responsible for a certain number of PHAs in his/her area, so s/he monitors them including making sure they have taken their drugs, secures basic care kits for them, and makes personal reports to us on a regular basis (Key Informant, Comboni Samaritans, Gulu District).

We had 16 volunteers in 2009 who were providing counselling to PHAs in their homes and making referrals to health centres and hospitals (Key Informant, WACANE, Apac District).

The increased uptake for care and treatment services including ART at the Government health facilities is based on the foundation largely built by the civil society. Throughout 2009, they were the forerunners of the principle of "living positively with AIDS". It is mostly NGOs and FBOs who have identified, trained and attached "expert clients"/network support agencies to health facilities with AIDS clinics. The "expert clients"/network support agencies encourage people to test for HIV, disclose and live positively. The ability of these "expert clients" to stand-out courageously in the face of discrimination, stigma and human rights violations has promoted disclosure and resulted into increased uptake for HIV & AIDS care and treatment services.

Our intervention has led to high disclosure and because we encourage HIV+ people to take their drugs, adherence to ARVs has improved...(Key Informant, LIDFOPHANU, Lira District).

The CS is also recognized for the role it played in initiating and sustaining networks of PHAs in the various communities. All stakeholders interacted with acknowledged that sustenance of the various PHA networks

has been the sole responsibility of CS agencies such as the Agency for Co-operation in Research and Development (ACORD), Acenlworu Child & Family Programme and NAFOPHANU. Further, findings reveal that nutritional support for PHAs, and in particular women enrolled on the PMTCT programme was largely undertaken by the CS throughout 2009. Agencies like Health Alert and ACIDI-VOCA were at the forefront of providing infant formula milk (NAN), cows' milk and corn-Soya blend as well as cooking oil respectively.

We provide mama kits, cows milk and NAN milk for nine months to all babies of women enrolled on the PMTCT programme...we supported 1000 women and because of our intervention, in 2009 we managed to save majority; only 32 babies turned out HIV+ at the end of the 9 months (Key Informant, Health Alert, Gulu District).

As part of HBC, by end of 2009, PACE had procured and distributed 236,000 basic care kits, which included 2 ITNs, a water purifying solution, a safe water vessel, a filter cloth, positive living guides and condoms.

With regard to palliative care in Uganda, the reputable center for providing palliative care and trainer for care service providers is a member of the CS i.e., Hospice Africa Uganda. Hospice Africa Uganda is the largest and pioneer providers of palliative care to PHAs and cancer patients in the country (Hospice Annual Report 2009). Currently, Hospice Africa Uganda provides palliative care services through three main centres; Kampala for central, Mbarara for Western and Hoima for Mid-west.

3.3.4 Paediatric HIV & AIDS care

Skills in provision of paediatric HIV & AIDS care and treatment are mostly among personnel in the civil society. All stakeholders recognize that NGOs such as Baylor College of Medicine Children' Foundation-Uganda are the largest providers of paediatric HIV & AIDS services in the country. Baylor-Uganda alone is providing care and treatment to close to 13,000 HIV infected children i.e., in Uganda there is an estimated 120,000 children living with HIV & AIDS (Baylor-Uganda Annual Report 2009).

Baylor-Uganda is also involved in the provision of nutritional support; with support from Canadian Feed the Children, it provides its children with food rations comprising of milk, soya sauce and soya flour. It also provided a monthly ration comprising maize flour, rice, beans and sugar to 50 households (Baylor-Uganda Annual Report 2009).

3.3.5 Laboratory and referral services

Only few CS actors countrywide provide laboratory services or have laboratory infrastructure. The scope and flexibility of services provided by CS is determined by the level of technical capacity. For instance, while some district CS actors visited e.g., AIDS Orphan Education Trust (AOET) and Kisamba Moslem Mission in Eastern Uganda provided rapid HIV test and screening, they lacked CD4 machines. Instead, it is AIC-Jinja that provided comprehensive laboratory tests for HIV, OIs, CD4, CD8, TB, and STI. AIC, which is a major CS actor provided technical services to most of the LG facilities in the country where it is present. Thus, given the complexity and technicalities involved, CS providing laboratory services worked in partnership with other agencies providing similar services. For instance, in Mukono, Kisimba Muslim Mission (KMM) worked jointly with TASO and St Francis to carry out HIV and TB test, as much AIC worked closely with the public and community health teams.

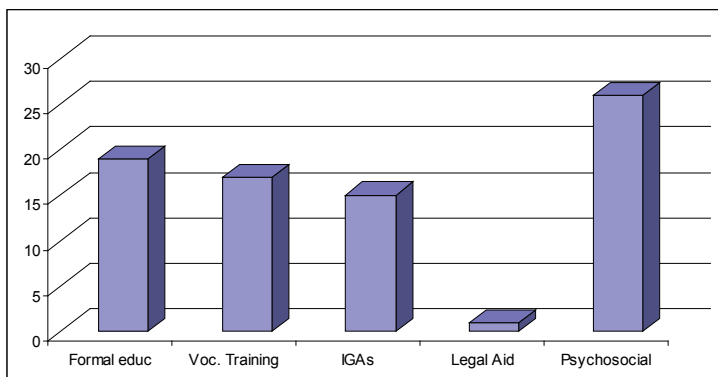
3.4 Social Support

Social support to families and individuals afflicted and affected by HIV & AIDS remains a daunting challenge to all public and non-public actors involved in implementing activities that address the socio-economic impacts created by HIV & AIDS. In the current NSP, government's goal is to mitigate the social, cultural and economic effects of HIV& AIDS at individual household and community levels. Four objectives through which this goal has to be attained are provided in the NSP. Data from the field and secondary sources reviewed point to predominance of CS in contributing to the realisation of the NSP objectives under this thematic area compared to the public sector. See Table 4.

Table 4: HIV support/mitigation component in NSP 2007/8-2011/12

Thematic area	Goal	Objectives
Social Support	The social, cultural and economic effects of HIV and AIDS are mitigated at individual household and community levels	Sustained and practical formal and informal education; and vocational and life skills development for OVC, PHAs and other disadvantaged groups promoted and supported
		Sustainable livelihoods and economic empowerment of affected communities and households facilitated
		Access to basic social services for PHAs ensured
		Legal and appropriate social and community safety nets benefiting PHAs, OVC and other disadvantaged groups, ensured

CS actors as shown in Figure 10 have been involved in the provision of psychosocial support, formal education, vocational training support to OVC, and supporting income generating activities (IGAs) to affected households and psychosocial support.

Figure 9: Nature of social support by CS

Provision of social support to mitigate the socio-cultural and economic effects of HIV & AIDS was largely by civil society. All stakeholders interacted with recognize that with the weakening of the extended family structure, NGOs/FBOs/CBOs have stepped in to fill the gap.

3.4.1 Psychosocial support

Various CS actors played an instrumental role in supporting the formation of community and family support groups that offer psychosocial support to individuals and families affected by HIV & AIDS. At a local level, it is recognised that districts lack funds to mobilize and sustain activities of associations of PHAs and other family support groups that played a significant role in the response against HIV & AIDS due to their capacity to foster disclosure of HIV status. Key informants from local governments acknowledged that during 2009, they witnessed more disclosure of HIV status due to activities of the family support groups.

We have been supported by Bible Society of Uganda to make open testimonies which has helped people to come out...in 2006 there were 714 members of the PHA forum but to-date there are 4,872 members in the forum who have disclosed...(Key Informant, Forum of PHAs, Apac District).

Some CSOs have established children centres where they bring OVC together on specific days and give them food, toys to play with to make them feel loved as other children in the society (LC KI, Luwero).

3.4.2 Formal and vocational education

CS actors have helped the OVC in obtaining education in two ways, namely by; i) putting up primary and technical school for OVC and meeting the entire maintenance costs, ii) providing education sponsorship for secondary and tertiary going-cohort. At both national and lower levels, it is recognized that CS in 2009 played a big role in providing sponsorship to OVC and particularly AIDS orphans for both formal and vocational

education training. The sponsorship covered scholastic materials such as books, pens, school uniforms, sanitary towels for the adolescent girls, medical care, school fees and start-up kits and/or capital.

We have since 2003 supported 56 AIDS orphans in Lira...some of them are now in secondary school around S1-S3. We give them a complete package including school fees, all scholastic materials, sanitary towels and we link them to health centres for medical care (KI, AIDS Orphans Education Care Foundation, Lira District).

In 2009 alone, we sponsored 20 OVC for training in carpentry and tailoring...we gave each one of them materials for start-up worth UGX 50,000/= and many of them are doing well... (Key Informant, WACANE, Apac District).

We are supporting many OVC from families affected by HIV & AIDS, we give them a complete sponsorship... there are some who have now reached the university (KI, Comboni Samaritans, Gulu District).

Sponsorship to OVC helped in increasing the rate of retention in school for children coming from AIDS affected families. It has to be noted that although GoU provides free education for all in government primary schools and lately secondary schools under the Universal Primary Education (UPE) and Universal Secondary Education (USE) respectively, pupils and students are required to meet all the other education related costs which are untenable for many OVC. The sponsorship also provided an opportunity to reach these young people with information on the basic facts about HIV & AIDS. The sponsored OVC were visited routinely and it was in such meetings that information about HIV & AIDS was passed.

Box 1: Examples of CS social support contribution from selected organisations

- CHAIN extended support to 80 OVC; paying school fees for secondary and extending supplementary funds to those in UPE schools.
- The Kisamba Moslem Mission constructed one Primary School in Buikwe and provides education to 480 students. The CS had 2 Vocational Schools, one in Buikwe (with 75 students) and another on Kyanja Island (with 180 students).
- Good Spirit Support Action Centre (GOSSACE) constructed one primary school in Ntenjeru Sub-county, and supported 295 students.
- Community Care Service (Teso) has a Primary School with more than 400 pupils, but also sponsored OVC for vocational training off-campus.
- Between 2007 and 2009, Teso Islamic Development Organisation (TIDO) extended technical support to 9 Vocational Schools in Amuria district, in return to train 135 OVC. On graduation, the OVC were equipped with start-up kits. The technical assistance extended to the 9 Vocational schools included; infrastructure, tutor's allowances, and meals for orphans.
- In 2009 TASO-Soroti sponsored 264 students; 164 and 100 in primary and secondary schools respectively. In addition, 12 students were placed in vocational institutions in the different parts of Uganda.
- In 2009, for instance, Soroti Rural Development Agency (SORUDA) supported 8 girls for a tailoring course.

3.4.3 Income generating activities (IGAs)

During the year 2009, provision of economic empowerment through skills training and IGAs was largely undertaken by CS actors. Thus, the role of CS in supporting livelihood activities was registered in the areas of: agricultural production, revolving micro-credit, and providing start-up kits. In all districts visited, CS was quickly pointed out by all informants as the main provider or supporter of the initiatives to empower households affected by HIV & AIDS. They mobilized affected households to form self-help groups through which they provided them with goats, chicken, turkeys, piglets and vegetable seeds to boost their household income levels.

We gave 6 chicken each to a total of 200 AIDS orphans...they have since sold off the offspring and some have used the proceeds to upgrade to goats (KI, WACANE, Apac District).

In Soroti Rural Development Agency we provided revolving capital for micro-enterprises (UG. SH 150,000/=), and cassava stem to the PHAs in 2009 (KI, SRDA)

Community Care Service provided start-up kits, seed money, goat revolving scheme, bee keeping. As a result, widows' household benefited from improved household income, milk production and nutrition, and affordability of education services (KI, TASO)

Some of them (SC) are involved in activities which help to improve the psychosocial and the economic well being of PHAs by providing them with IGAs such as pineapple growing and livestock keeping. Others are in nutrition support like URCS. (LG KI, Luwero)

The civil society also made a contribution in infrastructural development of communities through the social support interventions to HIV & AIDS. Some civil society actors provide indirect support to AIDS orphans and OVC through construction of schools, teachers' houses, latrines, buying school uniforms and equipping teachers with basic information about HIV & AIDS which they, in-turn, passed on to the pupils and students.

3.5 Systems Strengthening

Discussions with key informants in selected districts coupled with the review of available literature revealed that some CS actors including UNASO contributed to systems strengthening or capacity-building of small CS actors as well as that of government facilities. This involved support to human resource and infrastructural development, research, as well as M&E systems of partner organisations. According to the key informants met in this study, UNASO organized approximately four different training programmes between 2009 and 2010 for District AIDS Support Organisations on such areas as financial management and, proposal writing. According to the CS participants, while the level of knowledge gained in financial management was satisfactory, that of project proposal writing was rather insufficient.

District ASOs have executive committee whose members are appointed from the member CS within the district, and the ASO is hosted by one of the existing NGOs. The district ASO is mandated with several functions that include; coordinating, sharing information, identifying priority problems for discussion and on-ward forwarding to UNASO, organizing annual general meeting (AGM), facilitating partnership among CS and the local government (LG). Therefore, once the district ASO Executive has acquired knowledge and skills, it is supposed to share such with member CS. However, owing to the problem of funding and absorption capacity of the executive members, the role of the district ASO has been reduced to organizing AGM except in a few cases such as that of SONASO in Soroti.

We mentor them in resource mobilisation; specifically in proposal writing. We are encouraging them to spread out in all parts of the district so that we do not have a very high concentration of CSOs in one area while others areas are underserved. We also help CSOs to develop their internal systems with in their organisations like organisation structures and financial guidelines. Earlier on, we were trying to develop an idea of peer monitoring visits... I also receive information from UNASO, print it out and distribute it among members (SONASO Chairperson)

Of the 16 CS actors that were sampled in the Eastern region, two were implementing peer capacity building programs, namely, Kapchorwa Civil Society Alliance (KACSOA) and The AIDS Intervention Programme (TAIP) in Jinja. Despite their cardinal aim to strengthen the capacity of fellow CS, some CS lacked sufficient amount of financial resources, technical knowledge, and logistics to effectively do so. Beyond the CS capacity building process, there has been a symbiotic relationship between the CS and the DHO in the area of coordination, logistical support, funding, and sharing information.

Whenever we experience transport problems we resort to Sebei Diocese for a vehicle. We meet the costs of the fuel cost...They also depend on for IEC materials, for instance; video, the screens and the generator; we also share crucial information (DHO-Kapchorwa).

It was found out that some CS agencies occasionally invite district officials to officiate at the functions. Government also extends financial and human resources to Private Not-for-Profit hospitals in order to subsidize their operating costs (Mukono). Some CS agencies have helped to build capacity of health units to better provide health services in the district through trainings. They also have sufficient logistical and transport means to reach places in the periphery. Some have supported health units and communities in form of testing kits, mosquito nets, drugs for OIs etc.

At a wider level, CS has been at the forefront of strengthening systems in endeavour to promote quality service delivery such as HCT through skills building in HIV counselling and testing. For instance, all stakeholders both at national and lower levels acknowledged that CS actors such as AIC, Mildmay Uganda, TASO have actively been involved in Strengthening HIV Counsellor Training in Uganda (SCOT) and are the largest trainers of HIV counsellors and laboratory personnel. For instance, in 2008, AIC trained a total of 1,541 people in HIV counselling and testing (AIC Annual Report 2008) while SCOT facilitated³ training of 93 ToTs and 705 facility service providers in HIV/ART counselling during 2009 (SCOT Annual Report 2009). In the case of TASO, it has cumulatively trained over 1,500 Community AIDS Support Agents (CASA)⁴ in counselling for adherence to ART and 15,000 people in HIV & AIDS management both locally and internationally (TASO website).

Financial resources to almost all CS agencies implementing HIV & AIDS interventions in Uganda is made available by other CS, bi-lateral and multi-lateral funding agencies such as USAID, UNICEF, Irish Aid, DFID, GTZ Feed the Children and other numerous international NGOs.

With regard to infrastructural development for HIV & AIDS service provision, it was revealed that CS throughout 2009 contributed tremendously to development of model service centres. Mildmay was recognised in particular for its significant contribution towards development of model centres of expertise in HIV & AIDS care. Other CS agencies such as PACE provided capacity-building sessions for Ministry of Health condom distributors

ICW supported women living with HIV & AIDS from rural community setting in various parts of Uganda to acquire skills in conducting action research and documenting status of service delivery to PHAs at health centres within their communities i.e. availability of drugs, sharing of drugs, quality of care, attitude of health workers among others.

3.6 Advocacy and Policy Engagement

Like any other sub-Saharan countries, the CS in Uganda is considered instrumental in advocating for the various HIV & AIDS issues. For instance, issues like rights of PHAs have mainly been championed by networks and coalitions such as HEPS Uganda, NAFOPHANU, ICW, and NGOs like HAG, TASO, UNASO etc. Through its vision of **"A world without AIDS"**, TASO continues to be one of the leading advocates for both the affected and infected from the local communities through national to international conventions (TASO website). CS has played a big role in attracting, maintaining and sustaining goodwill at all societal levels towards the fight against HIV & AIDS through its advocacy and lobbying activities.

There are several examples of CS's work in policy advocacy and policy engagement that were enumerated by various participants in the course of this study. For instance, with regard to HIV & AIDS at the workplace,

3 SCOT provided financial and technical support (2008-09 Annual Report)

4 CASA are a group of HIV positive people who counsel and sensitize their peers on the importance of ART adherence.

CS in Uganda was at the forefront of championing this campaign. Agencies such as Oxfam, ACORD, Concern Worldwide and Standard Chartered Bank made internal mainstreaming of HIV & AIDS at the workplace a reality. As a result of this, there are various organizations including government institutions that have developed and implemented HIV & AIDS workplace AIDS policies.

Discussions with key informants of International Community of Women Living with HIV & AIDS (ICW) succinctly bring to the fore some of positive aspects of advocacy by the CS actors.

ICW successfully lobbied MoH and other partners advocating for availability and regular supply of ARVs to government health centres in various parts of the country (Eastern and Central). There were several complaints in 2009 by women living with HIV & AIDS that they were being turned away at their ART sites due to lack of ARVs. But after ICW's intervention, supplies of ARVs and other drugs for OIs were made available.

ICW highlighted the critical drug (ARVs) shortage in Uganda during the national dialogue with government. Government policy makers, planners and AIDS development partners were given the facts on ground regarding access and availability of ARVs. This has contributed to the recent moves by National Medical Stores (NMS) to ensure consistent availability of drugs at all government health centres. – supply is being improved

ICW produced a "Patient's Bill of Rights" for women living with HIV & AIDS. This is a list of things to be observed and done with a woman or a baby born to a woman living with HIV & AIDS. This bill of rights has been displayed in various health centres in the country and it is helping HIV+ women know their SRH rights.

ICW together with partners played a key role in helping the public to understand the implications of the AIDS Bill which was being passed by Parliament of Uganda. This done thru advocacy, engagement with the media, MPs

ICW advocated for female condoms which have been brought back on the market in Uganda.

4.0 BEST PRACTICES, LESSONS AND INNOVATIONS

4.1 Introduction

This study attempted to document the best practices, lessons and innovations by the CS actors to HIV & AIDS in Uganda during 2009. This documentation is based on what several participants reached by this study considered to have been the best practices, lessons and innovations.

4.2 Best Practices.

According to UNAIDS Best Practice—Responses That Work and Lessons Learned; available at <http://www.aids.md/information/best-practices/what-best-practices-are>, a “best practice” is defined as any undertaking that has contributed in one way or another to progress in the field of HIV & AIDS work or shed new light on relevant issues. UNAIDS further argues that best practices refer not only to the most successful practices that demonstrate new techniques that can be adapted or built on, but also the ones that help identify certain weaknesses, so that they can eventually be avoided or more easily overcome

4.2.1 Involvement of PHAs in the delivery of social services

The study findings revealed that the CSOs rely more on the use of PHAs experiences to reach out to other members in the community. In most cases, PHAs are trained and equipped with counselling skills to reach out to other PHAs in the community. In particular, some CSO have trained community based peer educators (CBPEs) who follow up their colleagues in the community. During these follow-up visits, it was mentioned that PHAs counsel their fellow PHAs and encourage them to adhere to treatment. It was found that the PEs also share their experiences with other members of the community and help them to disclose. The involvement of PEs was perceived to be the best practice because their participation encourages other community members to access the services. This was corroborated by the discussions with the district HIV & AIDS FPs who revealed that CSOs are better placed to deliver the HIV related services because they are able to tap into the PHAs experiences and use such to reach out to other members of the community.

These organizations have tried to bring PHAs together and they share experiences and they have provided humanitarian support and material support and counseling support (DAC Members, Kabarole district)

As a result of the involvement of the PHAs in the implementation of HIV & AIDS services in the community, more other community members have been able to disclose their HIV status:

In our villages we usually find people who are so fearful asking us how we started medication, the challenges we are facing and then explain everything to them. Then they become very active and also get on board (FGD Participant, FGD Rukungiri district).

For me I am a community counsellor and I move around in the community, encouraging my fellow PHAs to live positively. But because I have been very open about my status, other people have been coming to me to ask some questions. In fact I have helped some to open up and disclose their status (FGD participant, FGD Kabarole district)

We are now involved as community volunteers to help others on issues of adherence and make sure that people follow their treatment very well. We are also involved in mobilization of the clients; and make sure that we encourage people to come for clinic days at the center and also encourage them to visit health centres. We do this by visiting the PHAs in their homes and making sure that they come for clinic days (FGD Participants, Kibale District)

These findings indicate that the involvement of PHAs has helped in addressing the problems of stigma that is usually attached to HIV & AIDS.

4.2.2 Using starter kit

With support from development partners such as the United States Government (USG), some CS actors such as PACE implemented HIV services in 2009 including care and support for PHAs through the Basic Care

Program (BCP). The evidence based BCP aims to help reduce morbidity and mortality caused by OIs in PHAs and to reduce HIV transmission to unborn children and sexual partners through prevention with positives interventions (PWP). Through IEC and training of health workers and PEs, many of them “expert clients”, the BCP promotes use of co-trimoxazole prophylaxis (CTX), safe water systems (SWS), and family planning and PMTCT services. Items provided to PHAs in the BCP Starter Kit include four (4) bottles of purifying solution - Waterguard, two (2) long lasting insecticide treated bed nets (LLINs), a filter cloth, a guidebook on positive living, and sixty (60) condoms.

BCP program maximizes utilization of the existing infrastructure and human resource in the partner sites, organizes an integrated package of the basic care kits, using local manufacturers for some of the commodities, extending holistic products to the clients while reducing the handling costs. Refresher trainings, supportive supervision and home visits are arranged as and when needed. The BCP is relevant since it fills a critical gap and improves the quality of life of individuals and families affected by HIV & AIDS. For instance, malaria is the number one cause of morbidity and mortality, which is controlled by adherence to the program by PHAs beneficiaries of the kit. Implementation of the BCP and particularly provision of a comprehensive care kit to PHAs has proven a valuable intervention in reducing morbidity and mortality caused by OIs among PHAs. The BCP strategy/concept can be replicated in other areas with HIV and malaria. Rollout of the concept only requires adequate funding and partnering with existing structures and networks providing care and support to PLHIV.

4.2.3 Undertaking supplementary interventions

In some communities, services such as ART were combined with health education talks and home visits for support of the PHAs. This was revealed to be the most important arrangement that has helped in the delivery of HIV & AIDS services. For example, in Rukungiri district, TASO combines clinic-based services with home-based care follow-up visits. It was revealed that such follow-up visits help in monitoring the patients’ adherence to treatment and also provide psychosocial support through counselling.

4.3 Lessons

CS does not have a lot of resources, but is able to make a noticeable contribution to the national response. The lesson learnt here is that even with modest resources, but if well utilised and in a more transparent manner, noticeable impact can be created.

The study findings revealed that where CS actors have involved the beneficiaries of interventions e.g., PHAs in delivery of services, service delivery has been quite effective. The study findings indicate that when the PHAs share their experiences with others, people easily identify with them in the community than if the services were delivered by other people whose sero-status is not known. Involvement of PHAs in the delivery of HIV & AIDS related services contributes greatly in reducing stigma. Stigma is a barrier to seeking HIV & AIDS related services, and one of the ways of minimising it is to involve PHAs in the wide range spectrum of AIDS service provisioning.

The study findings also revealed that PHAs usually have a host of problems which come almost at the same time. For example, PHAs may need proper nutrition but also treatment, care and psychosocial support. Therefore when the PHAs are given ARVs, it is not enough. It is important that such treatment should be accompanied with access to proper nutrition, proper hygiene and other good health behaviours. Therefore, CSOs that combine these interventions were found to be more helpful to the PHAs than those that just give one of the critical services.

4.4 Innovations

To avoid duplication of resources and services, many CS actors are working with and through the existing structures of government. This means that some CS agencies use the existing structures already established by the government, which contributes to efficiency in the operations of CS. In many districts, CS actors are using government health workers, and also providing services such as HCT through the government health centers/hospitals. In some districts such as Rukungiri, there is a data base of all CS players in the district.

This data base aims at increasing coordination among the different CSOs. In other districts e.g., Mbarara, CSOs partner with the local government in the delivery of HIV & AIDS services.

We partner with these organisations to deliver HIV and AIDS services in the district. For example, some use of established health centers for HCT, counselling support (LC Chairperson, DAT Chairperson, Mbarara district)

Many CS actors are trying new ways of partnering with fellow CS agencies in delivering services. In some districts, CS actors have formed their own networks that try to bring them together. For example, in Mbarara there is MBADINASO, in Kabarole there is KNASO, while in Kibale there is KIBANET. These networks sometimes help to strengthen information sharing among the CS for service delivery.

Some organizations have devised strategies that would help them reach out to the hard to reach areas with HIV & AIDS related services. For example, in Kibale and Mbarara districts, Infectious Diseases Institute (IDI) and Mayanja Memorial Foundation facilitate and undertake community camping. This is where the CSO staff camp in a particular area for about a week providing services similar to those provided at the health facility/agency. This is usually done in the hard to reach areas, where services are not easily accessed by the community members. For example, in Kibale, IDI targets people who live around Lake Albert. This was reported to have helped to bring services closer to the people.

5 At the time of writing this Report, 1 USD = UG.SH 2,240

5.0 RESOURCE ACCESS BY CIVIL SOCIETY AND A SWOT ANALYSIS

5.1 Introduction

The contribution of CS in the national AIDS response can be more appreciated by examining their resource access and analysis of their strengths, weaknesses, opportunities and threats.

5.2 Resources Access

For CS to contribute to the national response, a range of resources is needed. These include financial, human, logistical and equipment, and or infrastructural.

5.2.1 Civil Society Fund (CSF)

In the last 2-3 years some CSOs contributing the national response have succeeded in obtaining funds from the CSF. The funds are disbursed by CSF to recipients to help in implementation of activities in prevention, care and treatment, support to orphans and other vulnerable children (OVC). A substantial amount is allocated to programme management and administration. Analysis of HIV & AIDS spending thematic area reveals that during Financial Year 2009/09, out of the total amount of UG. SHS⁵ 25,493,997,273/=, almost a quarter i.e. 5,203,905,736/= was spent on program management and administration. As shown in Table 5, various partners have contributed a substantial amount of resources to the CSF.

Table 5: Partners contributing to the CSF

Bilateral Partners contribution to the Civil Society Fund (CSF)		
DFID	7,193,976,400	7,523,460,000
DANIDA	5,901,853,598	17,452,579,930
US Government /USAID	6,902,933,262	16,934,539,982
IRISHAID	5,739,526,100	22,335,519,519
ITALIAN COOP		152,347,500
Interest on Income	36,356,858	66,780,125
Sub-total Bilateral CSF	25,774,646,218	64,465,227,056

Source: GOU UNGASS Report, January 2008-December 2009

Data obtained from the CSF Secretariat indicate that over UG.SHS 50/= billion has to-date been disbursed and accessed by various CSOs from CSF. These include national NGOs, district/regional focused CSOs/NGOs and a myriad of other small CSOs and CBOs spread countrywide. Of these, nine (9) CSOs also provided technical services to 49 CSOs/CBOs and 88 local governments. It is also important to note that 80 local governments have to-date accessed funding from the SCF. See Table 6.

Table 6: Recipients of CSF between 2007 and 2009

Type of CS	Total No.	Round	Solicit-ation	Type of Intervention/ Projects	Amount
National NGO (NNGO)	9	NNGO	Ongoing Commitment	Predominantly Prevention, followed by care, treatment and support and to a lesser extent capacity strengthening	27,063,232,029/=
NNGO & INGOs	3	PAED AIDS	RFA 08 004	Strengthening Paediatric HIV & AIDS and OVC care	2,593,713,748/=
CSOs	31	HIV 1	RFA 08 001	Predominantly Prevention	10,143,936,475/=
CSOs	54	HIV 2	RFA 08 003	Predominantly Prevention	4,631,503,758/=
CSOs	28	OVC 1	RFA 08 002	Socio-economic protection for OVC	5,194,621,383/=
CSOs	17	OVC 2	RFA 09 002	Socio-economic protection for OVC	3,394,861,442
Technical Service Organisations (TSO)	9	TSO	RFA 09 0003-09 011		2,633,714,218/=
NNGO (Mayanja memorial Hosp. & International NGOs e.g., MildMay, Save the Children)	3	PAED AIDS	RFA 08 004	Children care and support through, among others, strengthening the capacity of service providers	2,593,713,748/=
Local Governments					2,000,000,000/=

Data in the above Table reveals that nine (9) national NGOs have so far received the highest amount of funding from CSF. These include TASO, AIC, Straight Talk Foundation, URCS, PACE, HAU, UGANET, NAFOPHANU and UNASO. These big CSOs operate nationwide except HAU that provides palliative care in three sites of Kampala, Hoima and Mbarara. Apart from operating countrywide, the above NNGOs implement a wider range of interventions including prevention, care and treatment as well as social support compared to other CS players that are predominantly involved in prevention of the epidemic. Overall, it is estimated that about 2000 CS actors contributed to the national response during 2009, but a very small number as shown in Table 5 accessed financial resources from the CSF.

5.2.2 Other sources of financial resources

Although CSF has been a source of financial resources to CS, it only reaches a few CS actors that are contributing to the national response. Majority of CS depend on resources from external sources; international development partners; multi and bi-lateral donors and international NGOs as well as national level funding programs. The international and big national CS actors, by their publicity, credibility and performance, have multiple funding agencies such as the USG (i.e., CDC, USAID, and PEPFAR), SIDA, HCP, GTZ, Irish Aid, and DFID etc. Table 7 gives an example of source of resources by CS.

Table 7: Sample sources of CS financial resources

Name of Civil Society Agency	Sources of Financial Resources
WACANE	World Vision, NUMAT, UAC and membership fees
Acenlworu Child & Family Programme	Save the Children, Civil Society Fund, Communication for Dev't Foundation Uganda (CDFU), and community contributions
YAASA	UNHCR, DFID, EU, ACORD-Adjumani, Civil Society Fund, and membership subscription
Straight Talk Foundation – Adjumani	US Govt
Comboni Samaritans of Gulu	Good Samaritans - Italy, International Refugee Trust –UK, Scottish Catholic International Aid funding, CRS Uganda, IRCU, ISP-Kampala, PACE, Combonians in Uganda, and Italian Cooperation
Health Alert – Uganda	Save the Children –Denmark, Save the Children-Italy, and Civil Society Fund
Dyere-tek	World Vision Uganda, Gulu and Amuru District Local Governments
ACORD	Oxfam Novib, CSF, Unicef , MoWE, WFP
Medical Teams International	Unicef and Greger Foundation
AIDS Orphans Education Care Foundation	Zest for Kids, KNH-German and Children of Grace
LIDFOPHANU	Save the Children- Uganda and NAFOPHANU
ICOB	US Govt

It is therefore clear in the above Table that sources of resources for CS include international NGOs, bi-lateral and multi-lateral agencies, UN agencies and to some lesser extent central and local governments. In general, the source of resources for CS is predominantly CS itself. For, even resources from central government tend to be resources from donors, and government simply channels such resources in a public-private partnership to a CS agency for implementation of activities. For instance, Ministry of Water and Environment (MoWE) passed resources to ACORD to implement a safe water project in Rakai, which is also meant to benefit PHAs and OVC. As discussed ahead, of the above CS agencies only one (1) indicated to have accessed financial resources from the CSF, which was established to access resources to CS.

The other strategy for financial resource mobilization has been user-fee, membership fees and training fees. For instance, TASO usually charges UG. SH 500/= per adult client per visit, while AIC charges UG. SH 2,500 for HIV testing carried in organizational setting, and CD4 is UShs 5000/=. Membership fee is an internal resource mobilization mechanism, but which varied from one CS to another⁶. Finally, some big organizations such as TASO are engaged to train counselors in other organizations, which attract training fees.

Assessment of financial resources and other logistics required to implement planned activities revealed inadequacies in both the amount of funds and other logistics to implement HIV & AIDS activities by the CS. Several CS agencies revealed that in 2009, they only operated with a budget of 30-50% of the total required budget to implement their interventions.

6 TASO had a complex membership structure from individual to corporate membership paying different rates and having different privileges. Other organizations, charged a flat membership fees. For instance, Kisamba Moslem Mission was charging 50,000 per annum and having 33 members. Some CS Network NGOs, for Good Spirit Support Action, had different rates for individuals (20,000), CBOs (50,000), and NGOs (50,000).

We have 30% of what we need...we have the capacity to do much more but we lack resources (Key Informant, Dyere-tek, Gulu District).

In some of the NGOs/FBOs/CBOs, the insufficiency of funds was due to lack of foresight in planning and inability to forecast challenges during implementation.

We did not budget for facilitation of post-test clubs, we had not even planned for family support but we discovered it was inevitable so we had to divert some funds to cater for those unforeseen (Key Informant, MTI, Lira District).

We are experiencing shortage in resources. At present, we have 12,000 active clients and 17,000 cumulative. Each client is assigned a counselor, and each client has to undergo medical sessions (TASO Manager Soroti)

The funding is so little, we cannot meet the needs of the people. Out of the 116 CSO we can cover approximately 30. The funding we get from DANIDA and membership subscription is just 2 million shillings (KACSOA).

Insufficient financial resources as a hindrance to implementation of planned activities are more common among small CS agencies that rely on single sources of funds. CS actors, who reported more than two sources of funds, and preferably international NGOs, reported having sufficient financial resources to implement their interventions. This brings to the fore the need for CS actors to diversify their sources of financial support. One of the effects of limited funding has been over concentration of programme activities within and around municipalities.

I think this because they lack the capacity to work outside the municipality. Most of them lack transport to conduct outreach in distant location. Communication is easier in Soroti County than in other parts of the district. There are very few organisations working in the fishing communities of Lake Kyoga, although I also know that there are Community-based Organisation struggling to make a change out there (KI DH, Soroti).

The other problem is that CS agencies to compete for the same sources of external funding... 'Recently, we almost won a grant from USAID and at the last moment the grant was given to another organisation' (Source undisclosed)

One characteristic of most of the financial resources accessed by SC is that they are provided on a project mode i.e., lasting a specified period of time with a possibility of renewal in some agencies. Thus, most CS actors rely on project funding which has budget ceilings, and hence the need/demand for services outmatches the existing financial capacity.

5.2.3 Human resources

It was revealed that some CSOs employ well qualified staff with specialised skills in HIV& AIDS counselling, resources mobilisation and also people management skills. Most organisations employ counsellors and social workers who directly deal with the community beneficiaries. There are some CS agencies that employ a big number of staff excluding volunteers especially international NGOs. Most of the big CS actors covered by this study acknowledged having adequate numbers of skilled personnel to execute their tasks.

5.2.4 Infrastructural and logistical

Other resources available to CS include computers and other office accessories like internet, telephone for communication, motor vehicles and motorcycles as well as bicycles to facilitate movement, land and office premises as a point of contact, digital cameras and connectivity to electricity. Where there is no connectivity to the national grid, agencies have generators to provide them with electricity.

Except for big NGOs (AIC and TASO) that tend to have own office blocks and means of transport (including motorcycles), most of the CS suffered from limited accommodation and logistical capacity. With regard to transport, nearly all small CS agencies cited lack of enough means of transport i.e. vehicles, motorcycles and bicycles to implement their planned activities.

We have only 5 motorcycles used among 21 members of staff; these are in adequate for us to provide service in the 4 districts where we operate (KI, Health Alert, Gulu District).

We lack transport to do monitoring in all the sub-counties...we have 1 motorcycle and yet we work in 15 sub-counties (KI, LIDFOPHANU, Lira District).

With the exception of big organization the MIS in the form of hardware and management of such was small. On average, CS had 1-3 computers, but often lacking access to office-based internet connection and own website. Internet use was low among district-based CS, thereby excluding themselves from e-funding opportunities.

However, what is important to note is that some of these resources are more available to national and international organisations such as TASO, AIC, ACORD, ICOBI than small-scale and CBOs. It was revealed that it is these organisations that have the capacity to mobilise the necessary resources for project activities. Their staff are highly trained and experienced in proposal writing. By contrast, in some districts such as Kisoro, majority of the CSO were largely small and community-based in nature with limited capacity to mobilise the necessary resources. In most cases, their coverage was limited to either a sub-county or at best a county. This was found to undermine their capacity to mobilise resources and implement projects in the community.

5.3 A SWOT Analysis

In this Sub-section a synthesis of CS strengths, weaknesses, opportunities and threats is presented in tabular form. See Table 8. This Sub-section is meant to augment the presentation of CS contribution presented in detail in the previous sections, which reflects the strengths, and the subsequent Section 6.0, which is a detailed account of challenges faced by CS actors.

Table 8: SWOT Analysis of CS involved in the national response

Strengths	Weaknesses	Opportunities	Threats
<ul style="list-style-type: none"> • Big CS agencies have technical competencies in programme. • Easier accessibility to international and national funding • Use of community-based approaches and responsive to the needs of the PHA • Strong in the area of HIV & AIDS prevention and social support • Provide capacity building to the districts especially in the area of PMTC • A strong human resource base of community volunteers, both PHA and non-PHAs • Ability to lobby and advocate for resource mobilization. Organised in CS Networks, in form of district ASO 	<ul style="list-style-type: none"> • Dominance of prevention over other response • Urban bias • Limited technical competences for writing competitive proposal • Small and medium CS lacks administrative structures • At times suffers the “founders’ syndrome” • Suspicious of the external environment and unwilling to seek partnership • Inherent inter-rivalry for resources • Limited sharing of information; making co-ordination difficult. • Lack of a sustainability framework 	<ul style="list-style-type: none"> • Availability of government and community • Presence of HIV & AIDS related by-laws • Existence of LG HIV & AIDS structures • Government funding sources (CSF, OVC) • Presence of UNASO to coordinate the ASO activities • Presence of Development Partners • Inherent trust by beneficiaries • Conducive policy environment i.e., potential to exploit PPP 	<ul style="list-style-type: none"> • Donor fatigue, short-term funding, and small membership contributions • Irregular and inadequate funding • Adherence to different planning cycle • CS is marred with local and national politics • Community apathy • Hard-to-reach areas affects the spirit of competition and innovativeness • Rivalry and competition among CS • Overwhelming demand for their services and also issues to do with sustainability

6.0 CHALLENGES FACED BY CIVIL SOCIETY

6.1 Introduction

The agencies visited enumerated various challenges which they faced in implementation of the HIV & AIDS interventions in the areas of prevention, care and treatment, and social support programmes as well as systems strengthening. It has to be noted at the outset that although the focus was meant to be on the challenges faced in 2009 by CS, it was difficult to discern those of 2009 from the ones faced currently. The challenges are categorised into two, namely, (i) general or cross-cutting, and (ii) NSP thematic area specific.

6.2 General Challenges

6.2.1 Co-ordination

In all the discussions held at district and national level, all informants were unanimous on the issue of poor or lack of co-ordination of CS actors involved in the HIV & AIDS response in Uganda. CS is so diverse with varied mandates and each actor largely pursuing own and at times competing or rivaling interests. As a result, whereas co-ordination would on surface be viewed as important, in practice several CS actors question the “added value” of co-ordination. It was the view of everyone interacted with that many CSOs engaged in the response have not been able to harmonise their interventions, which could put to optimal use of available resources. From the findings, and particularly from interactions with the district HIV & AIDS stakeholders, it was revealed that many CS players tend to provide similar services to the same community or beneficiaries at the same time due to ineffective or lack of a co-ordination mechanism for the interventions.

It was argued by district officials that when attempts are made by the district to provide some form of co-ordination by suggesting where services should be directed most or needed, their ultimate allocation is determined by the funding agency of a given CS and not district directives. Not only district official decried lack of co-ordination of CS, but also actors at national level and development partners.

It is true that co-ordination of CS actors is very challenging...to co-ordinate the CS you need authority...you need to give resources the ones you are co-ordinating so that they can pay allegiance to you (KI, National Level).

The civil society is an important constituency in the response against HIV & AIDS but it is not well coordinated; this creates an uncoordinated response and the reason for the duplications in service (KI, DP)

CS is faulted for not being keen on sharing critical information especially regarding resources available to them, which potentially facilitates effective co-ordination. Key informants argued that not much in terms of co-ordination has been done by DPs and UNASO to promote effective co-ordination. However, informants at UNASO revealed that even where District Networks exist and are given support to facilitate sharing of information among CS through quarterly meetings, not much has been realized. Networks have not been able to hold meetings that attract big CS actors except where the hosting CS is a big agency. Further, networks are comprised of volunteers most of whom do not have adequate time to attend to other functions beyond their designated mandates. Volunteers were reported to lack adequate competence and confidence to deal with an array of stakeholders especially local council authorities and other big CS agencies.

We get UG.SH 250,000/= for organizing the quarterly meeting. Some of the (Executive) members come as far as Buyikwe. You can imagine giving UG.SH 5000/= to a person who must have spent UG.SH 10,000 on transport. [An Interjection] Sometimes I have a feeling that that being appointed as MUDINASO Executive was a ploy to make my organizations. I have to use my personal saving to meet the transport costs of coming here. [An interjection]- Absolutely true! (Mukono MUDINASO)

The main limitation is that these meetings are one day's event and attended by very many people, which does not give adequate time for participants to internalize. Then secondly is that many of the CBOs don't play part, especially the women groups, the small PHA groups. We feel there are the people on the ground, what they would say would be very important (Arua District AIDS Network Co-ordinator)

Limited funding means weak support supervision, coordination, information sharing among stakeholders, publicity and advocating of UNASO activities at the local level. Some districts ASO had just hoisted their signposts.

Given the challenges in co-ordination, it was argued by some key informants that often CS actors' interventions tend not to be in tandem with community priorities. Within the circles of development partners, it was suggested that CS needs to steer interventions to focus on community priorities especially prevention of HIV in an innovative way to reduce incidence of infection with HIV. It was, for instance, noted that given the ceiling from all PEPFAR supported health centres, it will be a challenge to get newly infected people get on treatment unless there are instituted deliberate co-ordination measures to harness the little resources available.

CS has not identified its own priority areas of intervention – intervention is guided and determined by donor's interests; hence there is no consultation of the communities who need the service. Many initiatives that have a good potential fail because there is no consultation and involvement of the target communities. There is need to revert to the bottom-up planning. There is need for putting emphasis on participation and consultation of stakeholders at grassroots; people need to be consulted on their priorities (KI, DP)

In the same vein, proposals were mooted that CS should identify unique systems within the community which have authority, respect and invisible power and appeal to get people to respond positively to the fight against HIV & AIDS – like church leaders, influential community leaders, traditional and cultural leaders. But for this to be effective, co-ordination mechanisms must be made functional.

6.2.2 Financial access and continuity of service provision

The major challenge faced by CS especially small agencies is resource access and mobilization given the competition for funds where big CS actors have an upper hand over small CS actors. There are many civil society agencies operating in the country, all competing for funds from a few funding agencies.

We have been submitting proposals whenever we see a call for proposals but we don't get funding (Key Informant, LIDFOPHANU, Lira District).

There is high competition for funds, we face international NGOs in bidding for funds which out-compete us the local NGOs (Key Informant, AIDS Orphans Education Care Foundation, Lira District).

Although CSF was established to access funds to CS participating in national HIV & AIDS response, and whereas much has been done in terms of disbursement of funds as shown earlier, noticeable challenges were shared during this study. Informants noted that there has been skewed distribution of resources by CSF, which has led to inequity of resources in different parts of the country attributed to the failure by most grassroots small agencies or CBOS to access the funds. Most of small CS operating at the grassroots can hardly meet the conditions for eligibility and qualification for CSF. Informants contended that there is seemingly lack of trust; small CS and local NGOs are viewed with suspicion in the wake of rampant corruption in the country. The new trend is for development partners funding agencies including the CSF to channel funds through intermediaries who are mostly international NGOs. It is these intermediaries that are expected to sub-grant to local NGOs and CBOs. The view of affected CS and district personnel is that such a mechanism is too costly as it causes loss of funds in administration which would have been used for implementing interventions. As the findings earlier showed, almost quarter of the total amount spent is on programme management and administration.

Lack of human capacity to prepare and submit good quality proposals was also cited among the challenges some civil society actors especially the local NGOs and CBOs face in resource mobilization. It is noted that most funding agencies have complex formats for proposals; unfamiliar to many local NGOs and CBOs.

Funding agencies put stringent conditionalities in their RFs...they ask for many requirements to fund a proposal which we don't have. Some of the things they ask for can only be found in large NGOs not local NGOs and CBOs, and once you don't attach them they disqualify you... (Key Informant, YAASA, Adjumani District).

Whereas the above partly explains some of the challenges in the external environment, there are more pertinent challenges in the internal CS environment. For instance, weak systems, poor project planning and proposal writing skills were cited as a pertinent barrier to organizations in applying for funding. All this is happening amidst the feeling by some of the small CS actors that Request for Proposals (RFPs) for financial support from international NGOs and CSF are complicated and unfavorable to grassroots CSOs such as CBOs, which makes access to financial resources difficult.

We have limited skills in proposal writing ...funding agencies keep changing their proposal formats, it is almost impossible to get their money...last year nobody here got money from Civil Society Fund (KI, WACANE, Apac District).

The civil society lacks the technical capacity which is a key consideration for the donors before they commit their funds; they need to be sure that their money is not going to be lost, CS have the capacity to provide accountability. Donors are not interested in giving grants to organizations which are not technically prepared (KI, DP).

Echoing almost similar sentiments as above, some of the big NGOs that support small CS actors and CBOs argued that significant amounts of funds received to augment the capacity of CS was being spent on didactic training which is poorly planned, facilitated or resourced.

The amount of financial resources extended to the district ASO by UNASO was considered to be small to meet the mandate of these structures. Secondly, membership contribution has remained small and irregular, because CS agencies weigh the cost over benefits of being a member of the ASO network.

Apparently, the CBOs may not see the purpose of paying the membership fee of 10,000 shillings when we can hardly organize capacity building seminars for them, or linking them to external funders. When we were carrying out the mapping exercise, the most frequent question posed by the CS was- 'How shall we benefit from such exercise?' The only answer we had off our head was that; 'your (organization) name will feature in the (ASO) Directory'. That can as well explain why CS wait and pay membership fee only when there is a call for project proposals (FGD MUDINASO Executive- Mukono District).

6.2.3 Capacity to deliver services

Most CSOs appear to lack the capacity to provide comprehensive care and treatment packages for the PHAs. Where comprehensive packages are provided, it is only to the registered clients. For example, when an organisation provides ARVs, it doesn't provide for mechanisms to ensure that the PHAs receive the necessary food intake for the ARVs. As such there is still a big gap between ART and adherence to ARVs. In other words, some organisations do not have an in-built mechanism for ensuring that the PHAs who are on ARVs adhere to the treatment.

The referral system used by several CS agencies can be described as not fully effective in assisting the PHAs access services. When the PHAs are referred, the referring agency does not have mechanism for follow-up to ensure that the PHAs are given the necessary treatment.

6.2.4 Urban versus rural concentration

Although CSOs have made a noticeable contribution to HIV & AIDS both in rural and urban areas, they tend to concentrate more in urban areas. Discussions with the key informants revealed that there is a significant

concentration of CSOs in urban areas than rural areas for reasons such as access to internet, electricity to run computers among others. As such, most services such as condom distribution, distribution of IEC materials, HCT, PMTCT etc., are more available to the urban dwellers than the rural population. Again, some rural areas are more accessible than others. In some districts, the furthest areas were reportedly largely underserved.

6.3 Thematic Area Specific Challenges

In every thematic area of the NSP (prevention, care and treatment, social support and systems strengthening) where CS made a contribution, several challenges were encountered, which need to be addressed in order to enhance CS contribution to the national response.

6.3.1 Prevention

i. IEC

The commonly cited challenges faced by civil society actors engaged in community sensitization/IEC interventions include cost of communication, insufficient funding to produce materials, fatigue from messages and illiteracy. Apparently, the cost of airtime on radio, especially the prime time, is high; the price ranges between UG. SH 450,000/= and 800,000/= per hour. This inadvertently affects the frequency of radio programmes/talk shows to disseminate information. In addition, civil society actors have limited control on media allocation of time; the most desired prime time has a lot of competition. Effective sensitization requires that an organization has sufficient numbers of IEC materials such as posters, banners, and brochures. However, production of these IEC materials requires a lot of money which many CS do not have. Some CS actors could not translate IECs into local languages due to heavy costs involved. IEC fatigue on the part of the target populations and the low levels of literacy in rural communities constituted yet another challenge for IEC. Study participants noted fatigue in the community with regard to IEC messages:

Apparently people appear to have heard everything there is to know about HIV & AIDS and that they do not want to listen anymore...messages are have become less inspiring as they used to be in the past (KI, Masindi).

CSOs involved in HIV prevention activities mentioned a range of challenges that make it hard to effectively undertake their activities. With regard to IEC, it was revealed that the IEC materials are not only inadequate but are also printed in English, which makes it hard for the community to understand. Majority of the communities' rural people where CSOs operate are largely illiterate. Yet translating the printed materials into the local languages was regarded a costly exercise, which many organizations can hardly afford. As a result of this, it was revealed that the IEC materials have not created the desired impact because of the language barrier. In other words, the IEC materials are not appealing to a large section of the population because they are packaged using the language that many people do not seem to understand.

To address the problem of insufficient funds, CS embarked on writing funding proposals to potential partners in order to increase their funding base and resources available to produce sufficient numbers of IEC in languages understood by majority of people. On the other hand, to spur reading, some NGOs/FBOs/CBOs put motivators such as trendy note books to encourage reading of IEC materials. In some instances during community sensitization meeting when IEC materials such as brochures and leaflets would be handed out, participants would be informed that a prize would be presented to whoever answered correctly questions related to the IECs they had received. With IEC materials, CS experience two major challenges. First, CS experience stock-outs of IEC materials due to irregular production and distribution by the partner agencies (MOH, PACE, TASO, and AIC)

We have taken approximately almost 6 months without receiving any materials from the Headquarter and the supplies from the MOH is small and irregular. For the last one year I have been in this office we received 5-6 posters from the MOH – (AIC Manager Jinja).

ii. HCT

During 2009, provision of HCT was mostly affected by inadequate personnel and sporadic supply of HIV testing kits. According to key informants, presence of few trained health workers was a big constraint to implementation of the SC activities. Apparently, many health centres remain understaffed making it difficult to allocate staff to attend community VCT outreaches. Even in instances where NGOs/FBOs/CBOs had the capacity to mobilise the community for VCT, it could not regularly take place due to lack of staff/health workers i.e. laboratory personnel and counsellors to provide the service.

Further, lack of funds to facilitate health workers from government facilities to implement VCT outreaches posed a major challenge, which affected implementation of HCT activities. Lack of transport and lunch allowances for government health workers implied that VCT services could not be provided as CS would have planned. Some SC are small entities in terms of resources available—lacking appropriate transport e.g., vehicles and hence when an outreach is organized, they have to incur costs of hiring a vehicle to carry the HIV test kits and reagents as well as health workers to provide the service.

The other major challenge faced was insufficient supplies of HIV testing kits and reagents. Whenever good mobilization would be done, many people would turn up for testing but would get frustrated after being sent away due to inadequate HIV test kits. The demand for HCT in 2009 was on many occasions reported to be overwhelming in all places visited, but limited volumes of HIV testing kits and reagents meant that the demand was not met.

It was also revealed that disclosure is still a big challenge in many districts. Even when organizations have invested heavily in sensitization and awareness campaigns, it is still such a big challenge. Men were particularly mentioned to be more discrete in their behaviors. Even when they test, they hide their results from their wives to the extent of taking medicines/ARVs without the knowledge of their wives;

Male involvement in our activities is very slow, which undermines our efforts to reach out to families. In fact, couple counseling is such a big challenge because sometimes men do not turn up for these counseling sessions. It's just the women only (Field Officer/Focal Person, Fort Portal Diocese HIV & AIDS Focal Point).

Men fear to open-up and even can't go to test for HIV. Those who get the courage to test, they never reveal the results to their wives and sometimes they test when it's already late and can not gain from the ARVs that are given to them (FGD Participants, TASO Beneficiaries, Rukungiri District)

iii. Condom promotion and distribution

Irregularity in supply of condoms was cited by several study participants as a major challenge. A number of the actors do not procure the condoms themselves, but rather distribute those procured by other actors such as the district health departments, which at times run out of stocks. Further, the NGOs/CBOs engaged in condom education reported having difficulties with accessing sufficient teaching aides. Effective education on correct use of condoms requires availability of teaching aides like dildos, which are inadequate for all peer educators engaged in condom education.

Other challenges faced in condom promotion and distribution during 2009 by CS included lack of logistics especially transportation of condoms to especially remote rural communities, appropriate space for storage of condoms—with many CS actors operating in small office premises, and then non-branding of free condoms, which was reportedly unappealing. Free condoms especially from district health departments (government) are unbranded. The unbranded condoms have continued to be perceived with suspicion following the engabo bad experience.

Measures were put in place by some CS actors to minimise the impact of these challenges on condom distribution and use. CS sought partnership with various other partners to avoid reliance on only one supplier – the district health department. Among the partners sought included agencies such as ACORD

and Straight Talk Foundation. Other CS made efforts to lobby for funds to go into direct procurement of condoms instead of getting supplies from district health departments.

iv. PMTCT

The commonly cited challenges faced by CS actors engaged in mobilization for PMTCT included lack of adequate numbers of PMTCT nurses, inadequate drugs for PMTCT clients, inadequate nutritional support and low male involvement. Whereas it is policy by government for all women attending antenatal care (ANC) to enrol for PMTCT, this has not been followed by making available personnel, alternative feeding supplements and drugs for breastfeeding mothers. Majority women enrolled on the PMTCT program cannot afford alternative foods and yet the few CS actors engaged in provision of nutritional support have inadequate supplies, they cannot support all clients. Sustaining the provision of some products such as NAN is beyond the reach of most mothers.

In most places visited, study participants acknowledged that uptake of PMTCT is still constrained by stigma. Actors recognise that stigma is still existent in communities; communities still look at HIV testing as a sign of mistrust of partners. Further, there is low male involvement in the program. Apparently, men use their wives as proxy for knowing their HIV status.

The major challenges that faced CS actors involved in PMTCT in 2009 and which continues unabated is also the poor laboratory coverage across the country, especially for early infant diagnosis of HIV. Most service providers have to travel long distances to deliver samples to laboratory that offer DBS. And the mothers have to wait for months to receive the results (Baylor-Uganda Annual Report 2009).

Shortage and/or termination of donor funding has resulted in scaling down mobilization, sensitization, monitoring couple counseling and PMTCT activities. For instance, for AIC, the Health Communication Partnership and USAID funded project for couple counseling was left in the hands of the community-based counselors due to irregular funding. In Kapchorwa the LG sought extra-funding from PREFA⁷ for PMTCT but the funding was soon coming to an end. The funding challenges also affect the available of testing kits and laboratory reagents.

6.3.2 Care and treatment

i. Laboratory Services

Periodic shortage of testing kits and laboratory reagents was reported in all the CS providing laboratory services. This was mainly due a combination of factors that included; irregular supplies, termination of funding and overwhelming demand for screening services for multiple health conditions. Comprehensive laboratory services are usually offered in Hospital and HC IV, which are also few countrywide.

ii. Inadequacy of supplies and misuse: basic kits and management of OIs

Misuse of some products in the basic care kits by the beneficiaries seems to be one of the major challenges faced by CS involved in the provision of basic care kits. The study findings indicate that the provision of basic care kits to PHAs, is limited by the poverty among the communities. As a result of poverty, some PHAs who receive the kits have ended up selling them and yet it is very expensive to replace:

Because of poverty some of the kits we give to the PHAs are actually sold off. For example, some people sell off the jerrycans they get, others sell off the ITNs and you can't easily control that unless you empower the communities economically (Ag. Regional Manager, JCRC, Kabarole district)

7 PREFA in full is Protect Families Against AIDS

Provision of basic care kits was further affected by stigma associated with waterguard and the water vessels as some beneficiaries did not want to be identified as being PHAs especially those who had not yet disclosed their HIV status publicly. Cases of PHAs who would plead to leave the water vessel at the program implementing agency's offices were recorded but through continuous sensitization and counselling, this problem was minimised.

The challenges are not only on acceptance and use but also inadequacy. Lack of adequate numbers of kits was also commonly cited by CS actors. The kits were provided by very few agencies, and in particular PACE, which in turn had a budget within which to operate. In some places, less than half the number PHAs received the kits. Inadequacy of kits was exacerbated by duplication of services; many PHAs would register with more than one provider in order to get more kits.

All CS's HIV & AIDS programs are run on a project mode; interventions are only sustained as long as the funding is available. For some months during 2009, some agencies did not have drugs for the management of OIs. Duplication of treatment was also reported among the challenges faced during 2009. Apparently, some PHAs on treatment for OIs enrolled at one site would also seek to enrol with another site in order to obtain improved services. Provision of ART services is affected by the inadequate supplies and stock-outs of ARVs and seprine. In several districts visited, discussions with key informants and community members revealed that some health workers are not well facilitated in the care and treatment of OIs;

Some of the nurses at some of the health centers do not know if they have facilities to diagnose and treat OIs. Sometimes the treatment is purely on guesswork (FGD Participant, FGD Kabarole district)

iii. Adherence

Satisfactory adherence levels (taking 95% of the prescribed pills) are supposed to register clinical and immunological improvement within 6 months of taking antiretroviral therapy, manifested in increase in CD4+ T cell (CD4) and reduced viral load. However, such prospects were being undermined by structural factors that are well beyond the control of CS themselves. Occasional lack of transport money resulted in missed pharmacy refill appointment for some clients, resulting in informal drug-sharing practices, and sub-optimal adherence to ARVs.

CS managing clinics tend to experience shortage of drugs for OIs due to limited funding. The amount of credit-line (drugs in kind) extended to CS by the MOH is small. For instance, Kisimba Moslem Mission was receiving drugs from MOH worth UG.SH 300,000 on a quarterly basis. But also AOET-Jinja that previously enjoyed funding from IRCU had scaled down treatment and HBC activities after the termination of IRCU funding during the last quarter of 2008. Big agencies such as AIC were not exceptional to the problem of irregular funding for drug procurement.

iv. HBC

Implementation of HBC interventions by CS during 2009 was largely challenged by lack of personnel and logistics. Majority of CS actors engaged in HBC rely on services of volunteers, but sustaining such volunteers posed a big challenge. It was reported that the volunteers expected remuneration and where it was not given, many became inactive. In addition, organizations lack sufficient logistics in the form of transport to conduct HBC. CS agencies especially those operating in northern Uganda revealed that they started having challenges with HBC when people started going out of the IDP camps.

When the program was starting people were in camps but they have moved back to their communities; there is only one motorcycle to do follow-up of all clients which is very challenging for us (Key Informant, HealthAlert, Gulu District).

The other challenges faced are stigma, denial and abandonment of bedridden HIV+ patients. In some communities, some patients are abandoned by their relatives and community people when they are bedridden. But actors have provided family counselling and somehow the practice of abandoning sick PHAs has reduced. Some PHAs change locations without informing their community caregivers who would make it difficult for them to be followed-up and monitored for adherence among others.

In 2009 we lost 25 males and 50 females to follow-up, they moved without any notice to the community care givers...some have gone to Sudan, others have even died in the process. When they feel healthy enough, they move and you cannot trace them (KI, Comboni Samaritans, Gulu District).

With the exception of those districts that are being served by big NGOs such as TASO and AIC, HBC geographical coverage still remains limited due to large investment required. It involves training counselors/CORPS/home-care givers; motivating health teams (allowance, bicycles, protective wear); and providing support supervision. Further, as already noted, government has invested limited resources in HBC activities, reflected in the under-facilitation of the HIV & AIDS committees previously instituted at the district and sub-county level.

These committees (DAC/SAC, DAT/SAT) are supposed to carry out community sensitization, home-visiting, distribution of IEC materials, and condom distribution. Because of lack of funding, these committees are increasingly becoming redundant and dysfunctional. (Jinja HIV & AIDS Focal Person)

v. Referral

Although referrals were reportedly common among CS, there were concerns from the CS with regard to feedback. Organizations that offer referral services rarely receive feedback after a person has been referred to another organization for a service. This makes it hard to measure the impact and understand the extent to which such services could have helped the PHAs. Besides, the referral system has been affected by the fact that most CS agencies providing care and treatment only offer the service to those who are registered. This makes it hard for those who have been referred from other agencies to benefit from the services provided by the receiving agency. For such a referral system to work well, it needs a clear networking mechanism that facilitates sharing of information. Low staffing, funding, laboratory services, logistical support, and distance etc., all conspire to undermine the purpose of referral services. This is exacerbated by non-compliance of the referral process as recommended by MoH; with referral team paying little attention to the referral forms, poor coordination of referral process between CS, the patient, and referral facility.

6.3.3 Social Support

i. Formal and vocational education

For several agencies, the sponsorship support for OVC was not continuous; OVC were only assured of sponsorship when the funds would be available. Some CS actors received funds for one year which meant that they could only keep the OVC in school for only one year. Further, the funding made available would in many instances be limited.

With regard to vocational education training, the major challenge faced by implementers of such interventions was the cost of tools. It is a requirement that OVC sponsored for vocational education are provided with start-up kits/tools but the cost of tools is high. In addition, community attitude towards vocational studies was reportedly negative, which impact on the interest of the OVC in the program. It was reported that community largely perceives vocational education as a trade for failures.

ii. Provision economic empowerment intervention

Economic empowerment interventions which involve provision of IGAs are mostly targeted to the most vulnerable including PHAs and families of OVC. In all instances small IGAs are supported such as providing a goat, piglet, and in some rare instances, a heifer etc., to a family. In majority cases the needs of beneficiaries are immediate, and hence the supported IGAs do not enable the affected meet such instant needs. Reports in communities of some IGAs that did not live to the expectations of beneficiaries were common i.e., in situations where animals died due to lack of capital to access veterinary services or were simply sold off to meet urgent family or individual needs.

The other reported challenge faced by agencies in implementation of economic empowerment intervention is lack of skills and knowledge on the part of the beneficiaries or declining health on the part of PHAs to provide care to animals such as goats and pigs.

iii. Managing unqualified community expectations

The biggest challenge faced by the CSOs providing social support for the HIV affected households and communities is managing people's expectations. It was revealed that people expect a lot from the CSOs due to high levels of poverty in the community. This is also coupled with an overwhelming demand for the services provided by CS.

7.0 CONCLUSION AND RECOMMENDATIONS

7.1 Introduction

This Section presents the conclusion and recommendations arising from the study findings. The recommendations are made in light of the challenges that have been identified in this study.

7.2 Conclusion

The study findings have revealed that in line with the NSP 2007/08-2011/12, CS in 2009 made noticeable contribution in the four thematic areas of the NSP, namely, prevention, care and treatment, social support and institutional strengthening. CS in Uganda is, however, diverse, fragmented and pursuing various interests and mandates, which makes its contribution towards the national response difficult to quantify. This notwithstanding, all stakeholders in the national response recognize and acknowledge the contribution of CS in all the thematic areas of the NSP. There is no doubt that CS has largely augmented or complimented government efforts in addressing the epidemic, and in some instances, it has implemented interventions that government has not supported as enshrined in the various objectives of the NSP thematic areas.

In the area of prevention, CS is credited for mounting intensive campaigns aimed at stemming the spread of HIV within the framework of the “ABC” strategy, which is an integral component of the Uganda HIV prevention strategy. Evidence from CS agencies covered by this study has revealed a number of HIV cases that have been averted due to their interventions. Indeed, there is no doubt that CS has dominated the prevention space compared to the public sector. The small CS such as CBOs and associations or networks of PHAs are implementing HIV & AIDS related interventions (e.g., prevention campaigns and providing some form of psychosocial support) in hard-to-reach areas. On the other hand, some of the big CS agencies have been able to make a contribution in care and treatment of PHAs, providing some social support to PHAs and their families, and also contributing to institutional strengthening of government facilities and other small CS agencies. The evidence available also indicates that CS agencies have adopted new approaches that have made it possible to make such a noticeable contribution in the national response.

Although the contribution of CS to the national response in 2009 was recognized and acknowledged, there were and still are pertinent challenges that constrain CS work. The issue of access to adequate and predictable resources keeps on cropping up amongst all stakeholders. This is exacerbated by lack or ineffective co-ordination mechanism among CS agencies and inadequate monitoring that contribute to inefficient utilization of available resources. Further, the latent competition of available resources by CS makes small CBOs who are “frontline soldiers” in the fight against the epidemic quite disadvantaged since they lack technical capacity to write fundable proposals or systems in place that development partners/donors require as conditionality. Nevertheless, all these challenges need to be appreciated in the context of an ever increasing number of actual and potential beneficiaries of HIV & AIDS services amidst uncertain and dwindling resources.

7.3 Recommendations

The study recommendations are categorized into two, namely, general and cross-cutting, and recommendations as per the NSP thematic areas.

7.3.1 *General and cross-cutting*

i. **Co-ordination of CS**

The study findings have indicated that all stakeholders were unanimous on the issue of lack or ineffective co-ordination of CS contributing the national response. The effect of poor or lack of co-ordination is clear including inefficient utilization of available resources as it leads to duplication of services and hence resource wastage. It is therefore recommended:

- Various development partners supporting the CS involved in the national response need to work with UNASO to make co-ordination functional and effective. For this to happen, all CS agencies contributing to the response need to be made aware of the “value added” if well co-ordinated.
- DPs need to stress and oblige CS agencies as a condition for funding to publish their strategic plans, programs and annual plans so that it becomes easier to know what each is implementing with the fraternity of CS
- In relation with the above, UNASO assisted by UAC should at least once in two years produce a detailed inventory of CS involved in the response. The detailed inventory could indicate the name of the CS, district/region of operation, intervention area and target population.
- Of urgency, there is a need to re-think the whole concept of co-ordination at district level and effectively support district networks so that they can effectively coordinate the CS within the area of their jurisdiction. The study findings revealed that co-ordination at district level was simply limited to holding quarterly meetings.

ii. Resource access

Competition of resources between small and big CS from same source e.g., CSF puts small CS agencies at a big disadvantage. It is also clear that the biggest proportion of funding for CS comes from external agencies especially development partners, and hardly any from government. Against this, the following are the recommendations:

- There is need to revisit the funding mechanism and conditions of accessing resources especially from the CSF by small CS. The application requirements by CSF and CS developed systems as a condition to qualify for CSF need to be revisited for small CS. A portion of funds with CSF could be “ring-fenced” for small CS such as CBOs, while instituting easy accountability procedures and measures.
- UNASO and other CS agencies involved in advocacy and lobbying need to work together to present a concerted effort and lobby government to provide partial funding to CS activities contributing to the national response.
- UNASO need to be supported by DPs and even government to build and strengthen the capacity of CS especially small agencies to mobilize and utilize resources. This could be through imparting funding proposal writing skills, planning, monitoring and accountability so that “value for money” can be obtained.
- As a measure towards effective co-ordination, this annual exercise need to be turned into a two-year exercise and, among others, conducted to input into the Country UNGASS Reporting instead of CS compiling own UNGASS Report.

iii. Capacity to deliver

A number of factors constrain the capacity of CS to deliver HIV & AIDS related services. Some of these factors include lack of co-operation or partnerships among CS, which also breeds rivalry and uncalled for competition. Although areas of capacity building can be supported, this would entail a process that take can take a while. For the immediate, it is recommended that:

- CS should explore forming partnerships and to instituting collaborative arrangements so that CS agencies are mutually supportive of one another instead of exhibiting competition.
- Secondly, CS should establish strong links with the local government in the areas of their operations to benefit from the infrastructure established by government institutions.
- There is need for capacity-building in resource mobilization and sustainability for local NGOs and small CBOs.
- There is need for CS to form a consortium so that they can do advocacy and lobbying together, which can increase funding prospects

7.3.2 Specific Recommendations

i. Prevention

Study findings indicate that a large part of prevention is implemented through the production and distribution of IEC materials. However, sometimes these are expensive to produce and distribute. The biggest challenge, however, was that innovative models of interventions with the greatest impact on prevention are still eluding the national response. It is therefore recommended that:

- Less expensive but interactive mediums of disseminating information should be sought and used. In particular, more emphasis should be placed on the use of drama and music on top of the traditional IEC materials. This is because edutainment appears to have a greater impact on prevention.
- Where IEC materials are used, it is necessary to develop the materials that can be reproduced locally using the available ICT facilities. It is important that CSOs take initiatives of developing simple IEC material that can be readily photocopied and distributed.
- Increase the involvement of PHAs in HIV prevention campaigns.
- There is need to invest in piloting new ways of HIV prevention, not simply copying from the others.

Care and Treatment

The study findings indicate that CSOs involved in care and treatment reported regular stock-outs and irregular supplies of ARVs, and other facilities needed for care and treatment. Therefore, it is recommended that:

- CSOs work with government and other partners to ensure constant/continuous availability of care and treatment facilities.
- Invest in development of effective referral systems so that people who fail to receive services at particular points can be referred to other service centers. In areas where the referral system was found to exist, the beneficiaries were able to access services at various service points. However, this also calls for close collaboration among different CSOs involved in care and treatment.

Social Support

Support to communities and individuals infected and affected by HIV and AIDS were found to be benefiting more from the interventions of CSOs involved in social support. It was also revealed that majority of these CSOs were still struggling to manage the expectations of the community members. In some districts, it was revealed that CSOs are overwhelmed by the community demands to the extent that meeting one of the needs doesn't seem to significantly alter the status quo. Based on these and other significant challenges, it is recommended that:

- Social support interventions should be enriched beyond the existing interventions. Apparently, CSO interventions cover a few aspects such as IGAs, school fees but on a short-term basis. This would also enable the CS in managing community expectations requires concerted efforts from all actors
- It was also revealed that eligibility criteria for the OVC and PHAs served by CSOs involved in social support are insufficiently shared. There is need to publicize further the work of CS in various parts of the country and within communities to coordinate and share information and ways of working.
- There is a need to have a comprehensive capacity building for CSO engaged in livelihood activities so that they can extend the same training to the beneficiary. Specifically, training in business plan, management, marketing and production are urgently required. Such training should also target specialized change agents to facilitate entrepreneurial and production training

Systems Strengthening

From the study findings, a lot of CS agencies' work is evident in prevention, care and treatment and social support. However, little has been done in systems strengthening. This is partly the reason for the lack of sustainability of interventions/changes. As such, work of CS agencies is largely limited in coverage, clientele, and time-bound. It is therefore recommended that:

- Investments in systems strengthening be given enough priority in HIV programming for a host of CS agencies.

- Invest in building capacity for resource generation, programming, monitoring and evaluation.
- There is a need to develop and forge partnerships between the bigger CSOs and CBOs to increase the capacity of small CBOs not only to deliver services but also to account and manage funds.
- There is need also to facilitate effective integration of CSO work in the district administration. This would also require harmonizing planning calendars for both district local government and the CSOs in different districts.

REFERENCES

1. GOU (2009), *“UNGASS Country Progress Report Uganda, January 2008-December 2009”*. Kampala, Uganda
2. GOU/UAC (2007), *“The National HIV & AIDS Strategic Framework, 2007/08-2011/12”*. Kampala, Uganda.
3. Uganda AIDS Commission (June 2009), *“National HIV & AIDS Stakeholders & Services Mapping”*, Kampala, Uganda.
4. Civil Society Fund (2007-2010), *“Summaries of Financial Disbursements”*. Kampala, Uganda

APPENDICES

Appendix 1: Matrix of sample CS agencies covered by district and interventions

District & CS visited	Interventions engaged in by thematic area				Systems Strengthening
	Prevention	Care & Treatment	Social Support		
Apac District WACANE Acenlwo Child & Family Programme	-IEC -Organize & mobilize for HCT including couple counselling & testing -Promote PMTCT -Prevention with positives	-HBC for mothers on PMTCT programme; provides nutritional support	-OVC sponsorship; formal and vocational education -Economic empowerment through IGAS		
Adjumani District YAASA	-IEC -Organize & mobilize for VCT including couple counselling & testing -Condom education & distribution -Promote PMTCT				
ACORD - Adjumani Straight Talk Foundation – Adjumani	-Facilitate VCT -IEC -Prevention with positives -IEC -Condom promotion & distribution -Promote abstinence & faithfulness	-Promote adherence & positive living	-Promotion of PHAs' rights -Economic empowerment through IGAS		

<p>Gulu District</p> <p>Comboni Samaritans of Gulu</p>	<p>-IEC in schools with sponsored OVC</p>	<p>-Provision of basic care kits -Treatment of OIs -HBC for adherence -Monitor ART adherence</p>	<p>-OVC sponsorship; formal & vocational education -Food & non-food items -Spiritual formation & counselling</p>	
<p>Health Alert – Uganda</p>		<p>-Counselling for PMTCT -HBC -Provide Mama kit to mothers on PMTCT -Promote disclosure -Referral for management of OIs</p>		
<p>Dyere-tek</p>	<p>-IEC -Organize & mobilize for VCT -Provide HIV testing kits -Condom education & distribution -Mobilize for PMTCT -Provide safe delivery kits -Promote abstinence & faithfulness</p>		<p>-OVC sponsorship; formal education -Economic empowerment through IGAs -Psychosocial support</p>	
<p>ACORD – Gulu</p>	<p>-IEC -Condom promotion & distribution -Promote abstinence & faithfulness</p>			<p>-Training of PHA network in Gulu in proposal writing -Facilitating activities of PHA network in Gulu</p>

Lira District Medical Teams International AIDS Orphans Education Care Foundation LIDFOPHANU	-IEC -HCT at existing HCs -Condom promotion & distribution -Support PMTCT thru education & provision of drugs	-Provision of drugs for women enrolled on PMTCT program i.e. Nevirapine, Septrin, & ARVs -Collect Dry Blood Spots (DBS) for infants born to women on PMTCT	-OVC sponsorship; formal education -Provide medical care to OVC -Child counselling -Economic empowerment through IGAS	
		-HBC -Follow-up of women on PMTCT in health facilities -Referral for management of OIs, ART, DBS		

District	CSOs visited	Prevention	Care and Treatment	Social Support	Systems strengthening
Mbarara District	TASO Mbarara		-Provision of basic care kits with ITNs, water vessels, and water guard -Confirmatory tests -CD4 Count -Management and Treatment of OIs especially TB, Malaria and STIs -ART services including providing ARVs. -Provision of HBC through home visits		

District	CSOs visited	Prevention	Care and Treatment	Social Support	Systems strengthening
	Mayanja Memorial Foundation	<ul style="list-style-type: none"> -IEC for the youths -Condom promotion for the most at risk groups -HCT -PMTCT targeting pregnant mothers. -Couple counseling and testing for those who are courting and those who are married -Abstinence and faithfulness campaigns targeting the youths -Peer to peer education for couples -Outreach activities 			
	ICOBI			<ul style="list-style-type: none"> -Paying school fees for OVC -Provide Sanitary towels for girls -Apprenticeship training in carpentry, saloon, mechanics, welding/fabrication, tailoring -Referral for special needs education -Household support to 3 households per parish -Psychosocial support and counseling -Child protection programs 	
	ACORD				<ul style="list-style-type: none"> -Child rights awareness in schools -Capacity building for civil society organizations -Trainings in specific areas like M&E. -Giving grants to organized CSOs -Promotion of rights of PHAs through awareness creation and capacity building for PHAs.

Rukungiri	RUDINET				<ul style="list-style-type: none"> -Provision of scholastic materials (uniforms) for OVC -Tuition fees for post-primary students -PHAs training in IGAs -Home based care -Community prevention messages through MDD -Vocational training for OVC -Training of PHAs on human rights protection and awareness 	<ul style="list-style-type: none"> -Organizing Trainings for the other CSOs -Partnerships with other CSOs -Care and treatment -Prevention through peer educators. -Social support to OVC -Home visits for palliative care
	TASO					
	RUGADA	<ul style="list-style-type: none"> -IEC for the young people (10-24 years) -HCT -Condom promotion distribution -Abstinence and faithfulness campaigns 				
	JCRC Nyakibare			<ul style="list-style-type: none"> -Provision of basic care kits -ART -Management of OIs -HCT done in partnership with public health centers 		
Kisoro district	Mutolere Public Health Program, Mutolere Hospital			<ul style="list-style-type: none"> -Provision of positive living kits under the auspice of mini-TASO, Kisoro center -Referral for CD4 count to Kabale hospital. -Laboratory services -ART -Management and treatment of OIs -HCT 		

			<ul style="list-style-type: none"> -Provision of basic care kits on behalf of partners like PACE -ART services including management of adherence to ART services including ARVs, septrine -HCT on particular occasions like World AIDS day -Management of OIs -CD4 Count services -Laboratory services 			<ul style="list-style-type: none"> -Provide trainings for health workers in public health facilities in different areas like comprehensive HIV and AIDS care. -Provided a CD4 count machine -Constant supply of RAVs and Septrines to 10 public health centers and hospitals -Construction of Health facilities like waiting sheds/rooms
JCRC-Kabarole	Fort Portal Diocese-HIV and AIDS Project Unit	<ul style="list-style-type: none"> -IEC Materials - HCT services on Sundays after church - Couple counseling and testing - PMTCT especially counseling courting partners and those who intend to get married. -Awareness programs on radio. 				
Kibale	IDI- Kibale Branch					
	KIBANET	<ul style="list-style-type: none"> -IEC -Condom promotion and distribution -Counseling and referral for HCT to Kibale Hospital. -Promotion of ABC strategy in schools -HIV and AIDS awareness campaigns 				

	RUPADA				<p>-Pay school fees for 15 pupils including giving them uniforms, rent for them hostels and offer scholastic materials</p> <p>-Run a vocational training center for carpentry and tailoring with about 30 OVC benefitting</p> <p>-Provide seedlings to communities e.g. rice varieties, banana from Kawanda</p> <p>-Partner with RUPAD HCIII to provide free medical services to PHAs</p> <p>-Partner with police, probation office and RDC's office to protect the rights of PHAs.</p>				<p>Train resident parish mobilizers in IGAs and HIV & AIDS</p> <p>-Train rural development extension workers to reach HIV social support to farmers</p> <p>-PHA IGA trainings</p> <p>Resource mobilization through case studies, capacity building-training VHTs and DAK</p>
Luwero	ICOB	-They distribute IEC material, condoms/sensitization, Couple testing and counseling			Do home visits and provide psycho-social support to PHAs				
	VEDCO	They distribute IEC materials			They mobilize PTCs, Sensitization on nutrition and general health. Provide transport to PTC members to go for care and treatment and referral services, mobilize for group formation				
	React Out Mbuya	-Provide HCT services			Adherence support, OVC study clubs, PHA group formation, provide plant materials to PHAs, they support vocational training				
	AMREF	-Community sensitization, HCT-couple counseling, condom promotion and distribution, IEC material development and distribution, PMTCT out reaches			Provide lab services, home based HIV monitoring. ARVs/OIs management. In-patient PHA admissions, distribute BCP, referral services				
Masindi	JCRC	HCT services			Provide ARVs, septrine, lab services CD4 count, distribute BCPS				

District /CSO	Prevention	Care & Treatment	Social Support	System Strengthening
Soroti				
Soroti Rural Development Agency (SORUDA)	IEC HCT mobilization Condom distribution Couple counseling Abstinence		Sponsor school drop out for tailory training Livelihood support in form of micro-credit and cassava stems Bio-diversity conservation	
The AIDS Support Organisation	IEC HCT – mobilization Condom distribution Couple counseling PMTCT Family Planning Abstinence	Provision of basic care kits ART OIs HCT Laboratory services HBC Referral	Formal education for OVC Informal education for OVC (apprenticeship) Link up PHA to other agencies for livelihood activities Provide scholastic materials and fees to OVC Will-making sensitisation	Provide training to other agencies Target groups Carrying out research
Teso Islamic Development Organisation (TIDO)	IEC HCT – mobilize thru CORPS Condom distribution Couple counseling PMTCT –referral Abstinence		Technical skills and & start up tools Encourage PHA to access social services	
Community Care Services	HCT in partnership AIC Abstinence thru sensitization		Own a primary school have trained over 300 OVC Facilitate acquisition of technical skills Micro-loan for goat rearing and bee keeping	

Mukono District				
Kisimba Muslim Mission (KMM)	IEC Condom distribution Abstinence	Management of OI Test HIV test & work together with TASO & St Francis Test for OI and provide treatment Laboratory services for HIV & OI HBC through 16 CHW, 2 at island & 14 on land Refer complicated cases	Own a primary with 480 OVs Vocational training, own 2 Technical Schools one in Mukono & Island (Kyanja) Legal rights are facilitated thru child rights and training parents in parenting	
Good Sprit Support Action Centre (GOSSACE)	Condom distribution Abstinence		Formal education thru tuition support (40 student) and in Higher Institution (6) Own a primary with capacity of 295 OVC	CS Network activity is restricted to organizing AGM
Asiika Obulamu PH A Group	IEC Condom distribution Abstinence			
URCS	IEC HCT – refer Condom distribution Abstinence		Only when there is a need for disaster response Only when there is a need for FA	
Kapchorwa				
Kapchorwa Integrated community Mobilisation program (KICOMPE)	IEC Condom distribution Abstinence		Implement child rights and anti-abuse talks in (Tegere PS) schools Train in child right	
Kapchorwa Forum for Persons Living with HIV/ AIDS (KAFOPHA)			Legal rights, especially OVC and inheritance	
Mobilising PHA to access NAADS				

Kapchorwa Civil Society Organization Alliance (KACSOA)				CS capacity building and institutional strengthening Advocacy and lobbying for equal access to social and economic opportunities Information sharing Coordination of CS through ASO forum
Reproductive Health Uganda Kapchorwa	IEC Condom distribution Couple counseling PMTCT –referral Abstinence	Management of OI Refer complicated cases		
JINJA				
The AIDS Intervention Programme (TAIP)				Capacity building of the local churches thru provision of production skills to select church representatives 'Good Samaritan' who in turn pass on the skills to PHA families to meet basic needs (income, food, life-skill) Training include; IGA skills, HBC, life-skills, OVC, Advocacy etc
AIDS Orphans Education Trust (AOET)	IEC HCT - carry out HIV & OIs testing thru static and community outreach approaches Couple counseling Abstinence	Provision of basic care kits HCT Laboratory services HBC Referral		

Child fund	IEC- produce T-Shirts HCT - refer people to AIC sites Condom promotion Abstinence	HBC for only making a follow up on OVC	Attach youth school drop out to local artisans and provide start up kits Support caregivers with IGA in order to meet school requirements for OVC Promulgate child laws Support creation of IGA (piggery and poultry) Promote succession planning	
AIC	IEC HCT – done at AIC and public facilities Condom distribution Couple counseling at testing centres Train counselors in PMTCT but refer the clients Do abstinence thru youth corner, couple clubs	Distribute the basic care kits to PHA Carry out tests for OI and refer them for treatment HCT – provide technical staff to public facility, & CSO in HCT, established health team for HCT services, and you're your sero- status club Laboratory services for HIV & OI HBC - through counselors who give out basic kits Refer complicated cases		Co-ordinate the CS through AGM Pass on communication

Appendix 2: List of People Interviewed**Appendix 2.1: Northern Region**

No.	Name	Designation	District
1.	Dr. Mathew Emer	DHO	Apac
2.	Mr. Marino Mark Oyar	District PMTCT, HCT & ART Coordinator	Apac
3.	Mr. Patrick Olira	Deputy CAO, HIV & AIDS Focal Person	Apac
4.	Mr. Francis Okello Bandeko	Chairperson, Forum of PHAs	Apac
5.	Mr. Martin Ebuu Odwong	Program Coordinator, WACANE	Apac
6.	Mr. Lawrence Olobo	Program Officer, Acenlworu Child and Family Programme	Apac
7.	Mr. James Addu Idraku	Project Director, YAASA	Adjumani
8.	Ms. Gloria Konyio Latigo	Counsellor, Straight Talk Foundation	Adjumani
9.	Ms. Gloria Letio	Project Officer, ACORD	Adjumani
10.	Mr. Noel Waigo Dralobu	Coordinator, APLWAA	Adjumani
11.	Ms. Maria Mesiku	Vice Chairperson, APLWAA	Adjumani
12.	Mr. Walter December Anwar	Ag. Programme Coordinator, HealthAlert	Gulu
13.	Ms. Jacinta Akwero	Team Leader, ACORD	Gulu
14.	Ms. Florence Aol Okech	Executive Director, Comboni Samaritans	Gulu
15.	Mr. Gabriel Ocaya	Coordinator, Dyere-tek	Gulu
16.	Mr. Okello Jasper	Deputy Director Operations, Medical Teams International	Lira
17.	Ms. Diana Ogwal	Director, AIDS Orphans Education Care foundation	Lira
18.	Ms. Linda Otim Olet	Counsellor, LIDFOPHANU	Lira
19.	Mr. Ben Okao	District HIV & AIDS Focal Person	Lira
Designation		Organisation	
Field officer in charge of community health		AFARD(Agency for Accelerated Regional Development)	Nebbi
Coordinator		West Nile Youth Organisation on Health Education	Arua
Person in Charge of Gender and HIV & AIDS Programme		Caritas	Arua
Chairperson and Counselor		Nyapea Safe Motherhood and Child Care Association	Nebbi
Regional Cordinator			
(Ms Atibuni) 0772440602		NACWOLA	Arua
Branch Cordinator 0773206604/ 0776312139		Uganda Red Cross Society	Nebbi
Cordinator and Programme manager		Arua Indigious Resource Development Agency	Arua
Programme Officer			
(Rev Ayelango Jovan)0774047261		Caritas	Nebbi
Programme Cordinator			
(Moses Abdul) 0772198706		ADINGON(Arua District NGO Network)	Arua
HIV & AIDS Focal Person			Nebbi

Appendix 2.2: Western Region

District	CSOs visited	CSO Thematic Area	Name of Officer Interviewed	Position of the Officer Interviewed
Mbarara District	TASO Mbarara	Care and Treatment	Mr. Abel Asiimwe	Center Manager
	Mayanja Memorial Foundation	Prevention		Program Manager
	ICOB	Social Support	Mwesiga Mark	Social Worker, Supervisor
	ACORD	Systems strengthening	Mr. John Najuna	HIV and AIDS Focal Person for ACCORD
One FGD was conducted with the beneficiaries of ICOB				
Rukungiri	RUDINET	Social Support	Mr. Rwabwogo Dickens	Programs Coordinator
	TASO	Systems strengthening	Mr. Godwin Gumisiriza	Center Manager
	RUGADA	Prevention	Mr. Robert Tukamuhebwa	Programs Manager
	JCRC Nyakibare	Care and Treatment	Dr. Luyimbazi	Coordinator, HIV Project
One FGD was conducted with beneficiaries of TASO-Rukungiri				
Kisoro district	Mutolere Public Health Program, Mutolere Hospital	Care and Treatment	Sister Kato	Coordinator for Public Health Program
	Virunga Allied For Dynamic and Health Society	Prevention	Mr. Abel Bizimana	Executive Director in charge of Training
	KOINONIA Ministries	Social Support		Coordinator
	PET	Systems Strengthening	Rev. Dr. Ephraim Mbabazi	Executive Director
One FGD was conducted with the beneficiaries of VIRUNGA ALLIED FOR DYNAMIC AND HEALTH SOCIETY.				
Kabarole District	MEETING POINT	Social Support	Mr. Steven Birungi Atengyi	Social Worker
	RANET-	Systems Strengthening	Mr. Gerald Twebaze	Coordinator
	JCRC- Kabarole	Care and Treatment	Dr. Senkwale Beda	Ag. Head Regional Center Manager
	Fort Portal Diocese	Prevention	Ms. Jakline Kamarunga	
One FGD was conducted with the beneficiaries of RANET				

Kibale	IDI- Kibale Branch	Systems Strengthening	Mr. Silver Katsigaire	Trainer
	KIBANET	Prevention	Ms Marion Tweheyo	Coordinator, KIBANET
	RUPADA	Social Support	Mr. Robert Kyamanywa	Executive Director
	URDT	Care and Treatment	Ms. Kafuko Betty	Assistant, Gender and HIV & AIDS Officer also doubles as M&E.
One FGD was conducted with the beneficiaries of URDT.				
District	Name of the Officer Interviewed		Title of Officer Interviewed	
Mbarara	Dr. Amooti Kaguna		DHO	
	Mr. Umar Masereka		District HIV & AIDS focal Person	
	Mr. Tubugyenda		CAO	
	Mr. William Kayombo		District Community Development Officer	
The team also interviewed the Members of the District Committee for UNASO				
Rukungiri			Deputy- DHO	
	Mr. Francis Ndazarwe		District HIV & AIDS Focal Person	
	Ms Peace Tumushabe Mr. De-Paul Mbonigaba		Two members of DAC- District Population Officer & District Planner.	
	Mr. Henry Ndyabahika		Member DAT Committee District Speaker	
The district did not have the UNASO Committee				
Kisoro District	Mr. Musimenta Boaz		District HIV and AIDS focal person	
	Dr. Assay Ndizihiwe		DHO	
	Hon. Philemon Mateke		LCV Chairperson, (Interview was disrupted by the meeting)	
	Mr. Beinenama Francis		District Planner, Member DAC Committee	
	Ms Sarah Kigongo		Office of District Community Development, DAC	
The study team also talked to members of the District UNASO Committee.				
Kabarole			DHO	
	Mr. Mpuuga Hosea		District HIV & AIDS Focal Person	
	Mr. Moses Ikagobya		LCV Vice-Chairperson, Kabarole, DAT Member	
	Ms. Aminah Kaija		Secretary for Works and Infrastructure, DAT Member	
	Mrs. Linda Katuramu		Secretary for Community Dev. And Gender, DAT Member.	
	Mr. David Mweru		UNASO Committee Member, Kabarole	
	Mr. Andrew Katuramu Mugisha		UNASO Committee Member, Kabarole	

	Mr. Tadeo Balisanga	District Community Development Officer, DAC member
	Dr. Taddeo Assimwe	Veterinary Officer-in Charge of Production, DAC Member
	Mr. Robert Bataringaya	Senior District Planner, DAC Member, Kabarole
	Ms. Stella Kabanyoro	District Education Officer, DAC
Kibale		
	Mr. George William Bizibu	Vice-Chairperson, LCV, Kibale, DAT member.
	Dr. Dan Kyamanywa	DHO/District HIV & AIDS Focal Person, Kibale.
	Mr. John Kyaboona	District Education Officer, DAC Member.
	Mr. Balaba Dunstan	CAO, DAC Chairperson .
Masindi	Kakongolo Beatrice 0776569562	District HIV focal person

Appendix 2.3: Central Region

Luwero	Kalyesubula Edward	District HIV focal person
Luwero	Muhingane Emanuel (0773848285)	Assisstant Adminstrator, ICOBI
Luwero	Ester Opaka	SRH/ AMREF, HIV & AIDS Officer,
Luwero	Nsonga Joseph(0776597757)	React Out Mbuya , Clinic Supervisor,
	Byamukama Ronald (07828808156)	VEDCO, Programme Cordinator,
Mukono	Wandera Vincent (0772304991)	Director, GOSSACE

Appendix 2.4: Eastern Region

Jinja	Loy Twesigye	AIC, Branch Manager
Jinja	Florence	Focal Person
Kapchorwa	Rodgers Martin	Ag. DHO
Soroti	Ochen	SONASO
Soroti	Amodi Martin	FPO
Soroti	Anyumero Beatrice	Secretary for Health Services

Appendix 2.5: National level

Name	Organization	Remark
Mugisa John	AMMICALL/UNASO	
Bhrama Namanya	UNASO	
Stephen Alege	UNASO	
Lillian Mworeko	ICW	
Florence Buluba	ICW	
Hope Birungi	ICW	
Regina Namata Kamoga	CHAIN	Written submission
Mercedes Oviedo deMock	GTZ	
Henry Ssemwanga	PACE	
Peter Buyungo	PACE	
Julius Lukwago	PACE	
Sarah Mwebaze	PACE	
Sandra Kiapi	AGHA	Written submission
Dennis Nduhura	ACORD	

