



Uganda Red Cross Society HIV/ OVC & TB strategic plan



2011 - 2015

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Foreword

This HIV/OVC & TB Strategic plan 2011-2015 adds value to previous strategy 2008-2010 by streamlining programming focus from 3 to 5 years and scaling up the scope of the URCS response in the fight against HIV and TB, and against child neglect. Secondly the Strategic plan has been informed by and responds to existing data which among others shows that sexual transmission of HIV is the biggest cause of HIV in Uganda in recent times and that PLHIV & child discrimination remains a key hindrance in the care and support continuum for OVC and PLHIV & TB.

URCS is therefore targeting to promote behaviour change and support especially among the high risk groups that include, persons living with HIV, fishing communities, un circumcised men, people that are not tested for HIV, discordant couples, persons in stable relationships, people involved in drug/substance abuse, high way truck drivers, commercial sex workers, orphans and vulnerable children, prisoners and other marginalized groups affected by HIV. As earlier indicated, the formulation of anew HIV/OVC & TB Strategic plan is another milestone in URCS' HIV response which dates far back to 1987. URCS' HIV, OVC and TB response has been supported by and sustained with financial and non-financial resources from various donors and partners that include sister national societies, UN agencies, Embassies, local and international funding mechanisms.

The HIV, OVC, TB and drug/substance abuse challenges are affecting all of us-young and old, men and women; it therefore requires the contribution of us all to scale down their onslaught. This Strategic plan represents a commitment by URCS to make its contribution to scaling down such an onslaught. The Strategic plan also constitutes a plan of action as well as grand proposal to our partners in particular donors to support URCS to actualize the stated intentions-in the name of planned outputs. It is through such a concerted effort that URCS can be effective in sustaining its HIV response.

Let this Strategic plan be a tool not only to mobilize financial and human resources but also a blue print for us to make a meaningful contribution to improving the lives of the most vulnerable and disadvantaged of our society and whose condition predisposes them to catching HIV and makes them susceptible to its impact.



Michael Richard Nataka
Secretary General



Preface

This is URCS's second HIV/OVC & TB Strategic plan. This Strategic plan is a clear testimony that URCS is not just developing a document but expressing another commitment to do more and to do better. The Strategic plan is another milestone in the journey that URCS started way back in 1987 with a response that focused primarily on prevention of HIV. This response has gradually and steadily grown to include the care, anti stigma and discrimination and socioeconomic support components for both PLHIV and OVC. As we launch this new Strategic plan we also congratulate ourselves in the growth of our service menu which has now widened to include TB and drug/substance abuse.

URCS's HIV and AIDS intervention and indeed the development of this Strategic plan have largely depended on the good will of donors who have generously committed funds to ensure the success of our programs. URCS is grateful to Danish RC, Netherlands RC, Belgium RC, British RC, Swedish RC, ICRC, IFRC, Ministries of Health and Gender, UNFPA, JCRC, TASO, AIC and Uganda Cares, for their kind financial and technical support extended to URCS. It is our hope that we will get even more support from the same and other donors to enable us implement this Strategic plan.

URCS is a humanitarian and community based organization, run mainly by community based volunteers. I salute the contribution and selfless actions of our volunteers that have spurred the achievements of the Society's HIV, OVC response. URCS' achievements are the achievements of our volunteers, because without them we are but a shadow of ourselves. I urge the volunteers and indeed those persons with an intention of volunteering to join efforts with us to successfully implement this Strategic plan.

URCS is committed to the promise of fighting the HIV & TB and supporting OVC, a commitment now put in writing within the pages of this Strategic plan. It is our duty as URCS to bring this promise to fruition by successfully implementing this Strategic plan. I call upon all of us to work tirelessly to realize the targets we have set ourselves in this Strategic plan.



A handwritten signature in black ink, appearing to read 'Bildard Baguma'. The signature is stylized and written in a cursive-like font.

Dr Bildard Baguma
Under Secretary General Programs

Acknowledgement

Uganda Red Cross Society (URCS) is grateful to all those who participated in the formulation of this HIV/OVC & TB Strategic plan 2011-2015. We are thankful of the efforts, time, ideas and experiences of participants that were freely given in the course the Strategic plan formulation process. We especially recognize our staff both at national and branch levels, members of the Branch Governing Boards, our partners, our volunteers and beneficiaries for their immense contribution to the successful formulation of this Strategic plan.

We would like to thank the Consultant Mr. Christopher Muhoozi and his team that led the Strategic plan development process which included consultations with staff, volunteers, partners and beneficiaries.

Special thanks go to partners such as Uganda AIDS Commission, Ministry of Health, Ministry of Gender, Ministry of Education, WHO, UNAIDS, UNFPA, TASO, Belgium RC, Netherlands RC, Danish RC, Swedish RC, Irish Aid, British RC, American RC, IFRC, ICRC, Japanes RC, among others; whose technical and financial support made this document a reality.



Sarah Musisi
Director, Health and Care

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List of Acronyms



AIC	: AIDS Information Center
AIDS	: Acquired Immune Deficiency Syndrome
BC	: Behavioural Change
CB-DOTS	: Community Directly Observed Treatment
CICC	: Civil Society Inter Constituency Committee
CSF	: Civil Society Fund
CSW	: Commercial Sex Workers
DHO	: District Health Officers
DSA	: Drug and Substance Abuse
GoU	: Government of Uganda
HCT	: Health Counselling and Testing
HIV	: Human Immuno deficiency Virus
IDI	: Infectious Disease Institute
IEC	: Information, Education and Communication
IFRC	: International Federation of Red Cross and Red Crescent
MARPS :	Most at Risk Populations
MOGLSD	: Ministry of Gender, labour and Social Development
MoH	: Ministry of Health
MTCT	: Mother to Child Transmission
NSP	: National Strategic Plan
NTLP	: National TB and Leprosy Programme
OVC	: Orphans and Vulnerable Children
PLHIV	: People Living with HIV and AIDS
TASO	: The AIDS Support Organisation
TB	: Tuberculosis
UAC	: Uganda AIDS Commission
UNAIDS	: The United Nations Joint Action on AIDS
UNASO	: Uganda Network of AIDS Service Organisations
UNGASS	: United Nations Special Session on HIV and AIDS
UNICEF	: United Nations International Children's Emergency Fund
URCS	: Uganda Red Cross Society
WHO	: World Health Organisation



URCS HIV/OVC&TB STRATEGIC PLAN 2011 - 2015

Chapter 1

Introduction

1.0 INTRODUCTION

The HIV/AIDS epidemic is continuing to expand, touching all corners of the world and impacting on the lives of countless individuals and communities. It continues to destroy the social fabrics of the Ugandan community (NSP, 2007/8-2011/120) and to cripple the Ugandan economy. The HIV infection and AIDS disease has impacted on all sectors of the economy; it is now a generalised epidemic (UAC, 2010).

In a population of about 30 million people (UBOS, 2009), the HIV prevalence is estimated at 6.4% among adults and 0.7% among children (UAC, 2009). Approximately 1.1 million people in Uganda are infected with HIV (MOH, 2010) and an estimated 110,694 new infections occurred countrywide in 2008 and approximately 61,306 people died to AIDS related illness in the same year (MoH, 2009), close to 132,000 new infections were experienced in 2009 (UAC, 2010).

The changing trends of the epidemic and the impact which it has caused to the Ugandan communities has tickled people's minds and has led to innovations and inventions of addressing it; the multi-sectoral approach being one of them. Through this approach, different stakeholders share ideas and combine efforts to address the problem. Uganda Red Cross society is one of the partners that has had a long time record and experience of addressing HIV and AIDS & TB in the country. It has addressed HIV/AIDS and TB in settings including but not limited to; the country border areas, the fishing communities, the prisons, populations in displaced settings, populations in post conflict settings, rural and urban, just to name but a few of the intervention areas.

In the light of addressing its HIV interventions more strategically, URCS adopted the strategic planning processes. The society developed its first HIV/AIDS/OVC & TB strategic plan in 2007. This guided the HIV interventions of the society till 2010.

This new HIV/AIDS/OVC and TB Strategic Plan of the URCS has been developed to guide all processes and functions of the society towards achieving its set strategic objectives for the period 2011-2015. Through this axiom of planning, the society has prepared effectively for the future, identified problems and pointed the way to solutions. This strategic plan has taken a systematic, thorough look at the current situation and thinking about the implications for the future, has brought issues to light and will help the society to do first things first. In other words, it provides a rationale for assigning priorities of HIV/AIDS interventions for the society.

This plan will further the HIV/AIDS & TB mandate to yet another level and will re-position the society to address the epidemic more meaningfully and impact-fully.

1.1 The URCS HIV/AIDS/OVC and TB Programme

The Uganda Red Cross Society (URCS) is one of the oldest humanitarian organizations in Uganda recognised by Act of Parliament in 1964. The organisation has many directorates and among them is the Health and care which the HIV/AIDS and TB programme is part.

HIV and AIDS programmes have been implemented since 1987. These programmes were started with emphasis on HIV prevention till the year 2000 from when to-date, these programs have been scaled up to include HIV home care, OVC support and of late TB integration. The URCS HIV and AIDS strategic plan (2007-2010) has been guiding URCS programming with support from partners under four broad outcomes;

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- Increased prevention to reduce the spread of HIV
- Improved psychological, social and physical wellbeing of PLWHIV
- Improved well being of Orphans & Vulnerable Children
- Systems strengthening for URCS and community HIV support groups.

1.2 Purpose for the Strategic Planning Process

The primary purpose of the HIV/AIDS/TB strategic plan is to develop a comprehensive 'road map' setting the direction and pace at which the HIV/AIDS/TB activities within the Uganda Red Cross Society will be implemented in a focused and coordinated manner. The plan addresses the changing trends of the HIV/AIDS epidemic by providing a balanced and integrated multi-model approach to HIV related issues.

1.2.1 The process of the Strategic Plan Development

The development of this strategic plan involved a review of related documents, as well as consultations with different stakeholders; assessment of the situation internal and external to the URCS with regard to the HIV/AIDS TB problem, interventions and policies. The analysis also presents the national policy framework on HIV/AIDS TB in Uganda, key partner policies & strategies, recent changes in HIV epidemic and implications on new strategic directions for URCS interventions, external challenges and opportunities. This analysis also includes a review of stakeholders and opportunities and challenges of existing partnerships. It presents the strengths and weaknesses of URCS generally but more specifically of the concerned departments in implementation of the old strategy as well as opportunities and threats encountered. The analysis was conducted through; review of literature, key informants interviews and focus group discussions involving the organisation staff and key partners at all levels.

1.3. Rationale for developing the URCS HIV/AIDS/OVC and TB Strategic Plan 2011-2015

Several document reviews were conducted to justify the need for a new strategic framework for HIV and AIDS programming of the URCS. These included the review of the former HIV and AIDS strategic plan 2008-2010, the review of the NSP 2007/8-2011/12 and the review of the URCS 2008-2010, among others.

1.3.1. Review of the URCS HIV and TB Strategy 2008/2010

Despite the fact that the review process of the above document found out that the URCS HIV priorities are still relevant to the national priorities as spelt out in the NSP 2008/12 with reference to the thematic areas of prevention, care, social support and systems strengthening; sadly, the goal and objectives were not aligned to the NSP; The strategic goal was not well aligned to the NSP goal; notably, URCS's goal was to increase the role of communities in HIV susceptibility reduction yet the national goal is about universal access. The review also established that URCS turned most of the NSP thematic goals into its objectives, and this raised questions on mandate to attain certain objectives, measurability and timeframe provided for the objectives. The review also found that gaps in the M&E framework for the HIV and TB strategy especially on the logic flow. There were no indicators set at all objective level.

Although URCS has progressed well in the implementation of the said strategy several gaps in implementing TB programmes were prominent. This was attributed to the fact that, TB activities had originally been expecting support from the Ministry of Health which unfortunately hit a dead rock. It also established that URCS has had some human resource capacity gaps and this could in future affect the performance of some HIV/AIDS interventions.

1.3.2. Review of the NSP, 2007/8-2011/12

The NSP 2007/8-2011/12 was also reviewed to ascertain the relevance of the document that was being developed. It was noted that the specific objectives needed further tuning but since the current National HIV&AIDS Strategic Plan (2007/8 – 2011/12) will soon be reviewed with the view to identify critical implementation gaps and barriers.

1.3.3. URCS 2011-2015 Strategic Plan

Based on the recommendations of the Mid-Term Review of the URCS Strategic Plan, 2007-2010 carried out in 2009, the development of the new Strategic Plan 2011-2015 was recommended. Subsequently the 2011-2015 URCS Strategic Plan was developed with a new direction for the society's activities. The plan defines the strategic focus for the society for the next five years. It is therefore only logical that the HIV/AIDS and TB strategic plan be re-aligned to reflect the changing realities.





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Chapter 2

Situation Analysis

2.1 Current HIV/AIDS/OVC, and TB situation in Uganda

The current HIV and AIDS/TB situation is looked at in terms of the HIV and AIDS prevalence and trends, drivers of HIV and AIDS and TB as well as the impact of HIV and AIDS and TB.

2.1.1 HIV/AIDS Prevalence and Trends

Based on the last Uganda HIV and AIDS Sero-behavioral Survey, 2004/2005, the country's HIV and AIDS prevalence rate is estimated at 6.4% for adults and 0.7 % for children¹ indicating that over 1.1 million people are infected with HIV and AIDS. According to the UAC (2007), this figure is likely to reach 1.3 million by 2012 posing significant challenges to the country particularly for designing, implementing and supporting an appropriate response to the disease. Other epidemiological studies² indicate that although HIV prevalence declined from a peak of 18% in 1992, it has stagnated between 6.1 and 6.5 % in some antenatal care sites. Studies have attributed this to complacency on the part of the people and sometimes failure by the actors to address this complacency.

However, there are significant variations across gender and region. With regard to gender, studies have indicated that HIV and AIDS prevalence is higher among women than men. The trend continues with age until it reaches a peak of 30-34 (12%) for women and 35-44 (9%) for men and then reverses at ages 50-59³. As observed in other studies, (Uganda UNGASS, March 2010; MOH, 2009), since the onset of the epidemic in Uganda in the early 1980s, the prevalence has remained high in major urban areas compared to rural areas and villages (see Figure 1). The analysis of the social, biological and behavioral factors associated with HIV (Biraro S., Shafer L.A., Kleinschmidt I., et al., 2009) shows that at a prevalence of 10%, urban residents have a significantly higher risk of HIV infection than rural residents (6%).

According to the Uganda HIV & AIDS Sero-Behavioural Survey, (2004/2005), the HIV and AIDS epidemic is heterogeneous with significant intra-regional variations. Central, Kampala, and North Central all have rates of infection above 8% while West Nile and North East regions have the lowest prevalence rates at 2% and 4% respectively⁴. Trends in antenatal HIV sero-prevalence also indicate a rather challenging picture of HIV



1 Government of Uganda, UNGASS Progress Report, (March, 2010) for the period January 2008-December, 2009.

2 Wabwire-Mangeni (2008) cited in UNGASS Progress report Jan, 2008- Dec. 2009

3 ibid

4 ibid

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infection. According to UNGASS report (March, 2010), of the pregnant women (739,656) who attended antenatal care at health facilities between July 2007 and June 2008, 6% (39,328) tested HIV positive. Between July 2008 and June 2009, out of 1,079,214 pregnant women who attended antenatal care in health facilities, 5.92% (57,301) tested HIV positive⁵. This increases the probability of MTCT of HIV.

2.1.2 Prevalence of TB

From the discussions conducted with key actors in TB prevention, care and treatment, it was revealed that TB cases are on the increase. These claims were indeed corroborated by the review of the recent studies that have been undertaken, which also indicate that TB cases are on the increase in the different parts of the country. Uganda is one of the world's 22 high burden countries with TB. The WHO Global Tuberculosis Control Report (2008), Uganda registered the lowest TB cure rate in the world at just 32%. This is attributed to low adherence levels and late detections of TB infections among those infected. This is also below the global and national targets of detecting 70 percent of infectious cases and successfully treating 85 percent of them.

In Uganda, the interaction of TB and HIV is increasing the burden of both diseases. It is well established that HIV is the biggest risk factor for the development of active TB among individuals infected with TB. By 2004, an estimated 50% of TB patients were also co-infected with HIV⁶. There is evidence that the trend is not about to change. It is estimated that at least 60% of the TB patients in the country are co-infected with HIV yet by 2006 only one quarter of TB patients were tested for HIV⁷.

It was also noted that TB is more common among the prisoners and armed forces where access to TB services is very limited. TB interventions also seem to have failed to focus on addressing TB as a disease among these groups. Recommendations point towards establishing and scaling up TB interventions for the most affected communities including the prisons and the armed forces.

2.1.3 Drug and Substance Abuse

Worldwide, substance and drug abuse problem is becoming a global challenge, affecting almost all sections of the society. According to WHO the global trends in substance use show that, there are many countries which are adopting the problem. For instance the harmful use of alcohol results in 2.5 million deaths each year; and of these are 320,000 young people between the ages of 15 and 29 years resulting in 9% of all deaths in that age group. Several reports indicated the strong linkage and high prevalence rate of HIV infection among this population.

In Africa, this situation has worsened for the last two decades. In 2004/05, Africa contributed 26% of the global cannabis herb production second to America (UNODC, 2006). In 2006, South Africa and Malawi ranked third and fourth after the USA and Mexico in cannabis herb seizure. This data suggests that overall substance use continued to rise in Africa (UNODC, 2009). This therefore calls for various interventions including harm reduction and humanitarian approaches that would reduce on substance consumption and its related consequences.

In Uganda, the WHO Global Status Report on Alcohol released in 2004 showed that in Uganda, 19.47 liters of pure alcohol are consumed per capita each year. With this statistics, Uganda ranked number 1 out of 189 WHO member states in level of alcohol consumption (YEAH, 2007). The problem of substance use in Uganda is not limited to alcohol only. In a baseline study by UYDEL on DSA in Rubaga

⁵ Government of Uganda, UNGASS Progress Report (March, 2010) for the period January 2008-December, 2009.

⁶ MoH-NACP, 2003, cited in National Policy Guidelines for TB/HIV Collaborative activities in Uganda, 2006.

⁷ Special Report, Monitor April, 3, 2011.

division-Kampala district (2003), it was observed that 48% of the respondents used marijuana, those who used cigarettes constituted 43%, Khat 47%, heroin 11%, inhalants 19%, stimulants and cocaine constituted only 6%.

It is on record that Uganda and East Africa in general are used as transit routes to most of the drug traffickers on their route to Asia, Europe and USA. The common substances / drugs in Uganda include alcohol, Marijuana, Khat, inhalants such as petrol and heroin.

Uganda has a projected estimated population of 34.6 million people. Currently there are no figures on the number of people abusing substances and drugs in Uganda. However, extrapolated statistics indicate that a total number of 388,092 people abuse drugs (NWHIC). Available data from Police, NGOs and Health centers, also suggest an increase in use of drugs and substances in Uganda. Drugs and substances are mostly abused by youths in slum areas and mostly as a result of peer pressure. In these slum areas there is much idleness among the youths due to unemployment thus resorting to abusing drugs and other substances.

According to reports (Kigozi, 2000), 30% of the cases admitted in Butabika mental hospitals are drug and alcohol related. This report is further supported by the rapid situational assessment that was conducted by Uganda Red Cross Society on the knowledge, attitude behavior and practices on drug/substance abuse among youths in Nakawa. The rapid assessment found that out of 10 mental cases admitted in Butabika referral hospital 5 are diagnosed for abusing drugs and other substances.

.According to the rapid assessment conducted by URCS (Nov 2010- Jan-2011) Social cultural factors which include rights of passage, cultural acceptability which form the integral part of every day life looks at taking alcohol as a normative behaviour. These cultural beliefs are common among these slum areas of Nakawa division which have promoted the substance/drug abuse problem.

Weak laws on liquor and other substances which include the liquor (Enguli) Act Cap 93 which limits production and distribution of illicit brew has not been enforced. Therefore slum areas continue being brewing centers for such illicit liquor where deaths have been reported as a result of taking this illicit liquor.

Most criminals held at various police stations indicate that those aspects got involved in the criminal act due to influence of some drugs (police report of 2008, 2,542 cases reported). Many road traffic accidents that have led to multiple deaths are largely as a result of drivers driving under influence of drugs.

In addition, drug/substance abuse is cited as one of the key drivers of HIV transmission as identified in the strategic plan by Uganda AIDS Commission 2007/2011. This therefore implies that with drug abuse, most people will continue contracting HIV and hence continued increase on the already worsened disease burden in the country with its social and economic consequences

2.1.4 Children Living with HIV&AIDS and HIV/AIDS OVCs'

Despite the progress registered over the last decades to reduce the spread of HIV, more than 1.5 million of the country's over 30 million people are living with HIV, and approximately 1.8 million children have lost at least one parent to AIDS-related causes⁸. The last sero-behavioral survey established that

⁸ United Nations Joint AIDS Programme, 2005, 'Uganda' [http://www.unaids.org/EN/Geographical+Area/by region/sub-saharan+Africa, Asp](http://www.unaids.org/EN/Geographical+Area/by+region/sub-saharan+Africa,Asp), Date read: 29 April 2005

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young people aged 15 - 24 represent over half of all new infections⁹. Of the 50,000 CLWHA who need treatment, only 10,000 currently access ART and 20,000 children are infected every year. As many Ugandans die due to HIV and AIDS, unprecedented numbers of children left behind place enormous strain on extended families and communities. The country has the highest proportion of children orphaned by HIV&AIDS worldwide.¹⁰

2.2 Drivers of HIV and AIDS and TB

Understanding HIV and TB drivers is very critical in the design of interventions that work to prevent the two diseases. According to the most recent study conducted to analyse the HIV modes of transmission and prevention¹¹, Wabwire-Mangeni categorise the drivers of HIV transmission as individual risk factors and contextual or community, societal and structural level factors.

According to the UAC (NSP, 2007/08-2011/12), understanding the drivers of the epidemic is a critical strategy consideration in combating the epidemic. Some of the drivers of the epidemic noted include individual behaviours influencing risk of sexual transmission, discordance with partner, occupations associated with greater risk of transmission, economic factors (such as poverty) linked with sexual risk, socio-cultural other factors influencing relationship risks, gender factors, biological/medical factors, geographical and nutritional factors. Studies indicate that sexual transmission accounts for 76% of new HIV infections in Uganda¹². Discussions with the stakeholders indicate that beyond the above mentioned factors, complacency attributable to increase in care and treatment services could also be a key driver to HIV and AIDS.

2.3 Impact of HIV/AIDS and TB

The impact of HIV and AIDS is manifested in loss of life, poverty, escalating problem of street children, child headed households as the family structure and attendant informal social safety nets give way to economic desolation visited upon the population by the debilitating effects of HIV and AIDS. Besides the general breakdown in families, more so where there are discordant couples, the epidemic has had negative effects on the business community in the urban areas¹³. The cyclic nature of the effects of the HIV&AIDS pandemic therefore cut across; from the individual to the household, the community, the workplace and , almost crippling all these aspects of society.

HIV and AIDS also contribute to very high morbidity and mortality rates in Uganda. The cumulative number of AIDS deaths stood at 900,000 by 2007¹⁴. HIV is responsible for up to 20% of all deaths, and is the leading cause of death in the 15-49 year old age group. AIDS is also the fourth leading cause of under-5 mortality. Studies¹⁵ indicate that over 76,400 deaths due to HIV and AIDS occurred in 2005 alone but this reduced to approximately 61, 306 deaths due to AIDS in 2008¹⁶.

9 Ministry of Health & ORC Macro, 2006, Uganda HIV/AIDS sero-behavioral survey 2004-2005. Calverton, Maryland, USA: Ministry of Health (Uganda) and ORC Macro

10 UAC, 2006, Accelerating HIV prevention in Uganda. The road towards Universal Access. Drivers of HIV/AIDS epidemic and effectiveness of prevention/intervention in Uganda: Synthesis Report; Kampala: Uganda AIDS Commission'

11 *ibid*

12 *ibid*.

13 A situational analysis study of HIV and AIDS in urban areas in Uganda by AMICAALL Uganda

14 URCS, 2008, HIV and AIDS/TB strategic plan, 2008-2010.

15 *ibid*.

16 UNGASS Report, March 2010.

2.4 Uganda's HIV/AIDS/TB Interventions/Response

Uganda's national policies, strategies and technical guidelines for key HIV services particularly bi-medical prevention services of PMTCT, HCT, condom promotion, blood safety, STI treatment, and medical infection control, post HIV exposure prophylaxis and HIV education in schools are available, evidence-based and regularly updated. Condom procurement and distribution statistics show a progressive increase from 28.3 million in 1999 to 130.7 million condoms procured and distributed in 2007 (UAC, 2009). The proportion of adults who have ever tested and received their results increased from 4% in 2000 to over 21% in 2006 and, the number of women receiving PMTCT services increased from virtually none in 2001 to over 26,484 out of a total of 91,000 women in need of PMTCT services (ibid). The number of AIDS patients accessing ARVs increased only marginally from 34.4% in 2005 to 35.7% in 2007, because the number of people in need of ARVs increased from 194,000 to over 312,000 over the same period.

All the above achievements in HIV and AIDS response are attributable to a wide range of policies, strategies and plans in place to address HIV and AIDS. Some of these policies, strategies and plans include the HIV Prevention strategy outline in the country's Health sector Strategic Plan 2006-2010, the National HIV/AIDS strategic plan, 2007/08-2011/2012, National Performance Measurement and Management Plan, 2007 for the NSP, 2007/08-2011/2012, National Policy Guidelines for TB/HIV Collaborative Activities 2006, Uganda National Policy Guidelines for HIV Counselling and Testing, 2005, The National Health Policy among others.

To achieve universal access targets for HIV/AIDS prevention, care, treatment and social support by 2012 the current NSP focuses the national response on four thematic areas, which reflect its goals; prevention; care and treatment; social support; and systems strengthening.

However, there are no clear guidelines and policies for IEC, mass media, behavioural interventions, targeted services for MARPS and programs addressing environmental interventions for HIV transmissions such as sexual and gender based violence, livelihood support for PHAs among others¹⁷.

2.5 Current efforts to address TB in Uganda

The Government of Uganda through the ministry of health established the National TB and Leprosy Program (NTLP) in 1990¹⁸. The department was purposely established to carry out a vigorous campaign to combat TB and Leprosy in the country. NTLP Campaigns to change community negative attitude and stigmatization of TB and leprosy patients and also helping the sick to get and adhere to treatment have been ongoing using different strategies to contain the situation. Communities in Uganda believe that TB and Leprosy are diseases that are contracted as a result of curses and are not curable. To improve on detection rate further, the ministry of health through NTLP posted district TB and Leprosy supervisors to all districts of Uganda so as to take services nearer to the people. To date every district in Uganda has a medical officer attached to specifically implement the programmes at community level and encourage people to go for medical checkup and sputum screening for tuberculosis¹⁹.

Early detection remains the best way to minimize the spread of both TB and Leprosy because once detected and put on treatment, the spread is minimized and the patient's immunity remains strong to counter other infections. As a result the CB-DOTS strategy was launched in 1995 because it was found

¹⁷ UAC, 2009.

¹⁸ Mallimbo, 2009, <http://mallimbo.wordpress.com/2009/08/23/>.

¹⁹ Ibid

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that many patients with TB were not following the treatment. So far the strategy seems to be yielding positive results.

In 2006, the Government of Uganda through the Ministry of Health launched National Policy Guidelines for TB/HIV Collaborative Activities, to guide TB-HIV collaborative activities with a goal to decrease the burden of TB and HIV in Uganda through improved TB and HIV/AIDS collaborative interventions. The policy promotes an enhanced collaboration between TB and HIV programs in the provision of a continuum of quality care at service delivery level for people with or at risk of TB and PLHIV.

Although, as revealed above, there are efforts increase treatment and prevention, Uganda remains one of the most hit countries in the world. The country faces an uphill task to control the disease with about 102,000 cases reported every year contributing to an already high burden of disease.

2.6 URCS Response to HIV/AIDS/OVC and TB

The Uganda Red Cross society has over 23 years experience of HIV/AIDS and TB programming. The strength of URCS in HIV programming is also reflected in its strong community base consisting of members and community volunteers that are part and parcel of the Village health teams. This strong community base enables the scale of up HIV care and prevention which is largely due to working with the PLHIV and their caregivers. Community based volunteers are crucial for effective community mobilization for behavior change, for condom education and distribution for anti malaria campaigns, for treatment literacy, for home based care, for education on PMTCT and for TB detection and adherence. URCS' planned HIV/TB program activities will rely on its strong community base to boost their efficiency and effectiveness. In execution of the HIV programs, URCS has built international, national, district and sub county level partnerships with among others PNS, IFRC, ICRC, WHO, UNCICEF, UNFPA, Ministry of Health (Malaria, TB, HIV/AIDS, Immunization), Ministry of Gender, Labor and Social Development (for OVC), Uganda AIDS Commission. MACIS, Stop TB Partnership committee, associations of PLWHIV, Civil Society Inter Agency Coordination Committee (CICC) and UNASO.

The HIV/AIDS and TB programs among other programs in URCS have core technical staff at National, Regional and district levels with the ability and expertise to run comprehensive HIV/AIDS and TB programs in line with the current international, national and community priorities.

URCS is visible and audible at community level with functional structures especially the community HIV post test support groups at sub county level in each of the implementing sub counties with a minimum membership of thirty people. These structures are linked with the village health teams at village and parish levels in terms of community mobilization and referral for health. These have been instrumental in comprehensive HIV & TB prevention, care and support mechanisms of the program.

Uganda Red Cross Society has had commendable achievements in areas of HIV prevention, care for PLHIV and OVC support. The prevention interventions of URCS reached over the last three years have reached over 4,200,000 in the targeted districts of Luweero, Kitgum, Kampala, Pader, Apac, Oyam, Arua, Maracha, Kalangala, Mukono, Rakai, Busia, Amuria, Katakwi, Kamuli, and Iganga; as compared to 3,000,000 people that were being reached in 10 districts at the begging of the 2008-2010 strategic plan .

In terms of care for PLHIV; a total of 4200 PLHIV have been reached with home based care services; 51% of these have been supported with income generating activities; 49% of the total have been assisted to enroll on ART and treatment adherence through home visits is at an average of 90 to 95%. In terms of support to orphans and other vulnerable; a total of 2600 OVC have been reached with care and support

services; while HIV/AIDS stigma and discrimination have reduced to appropriately 20% with higher scores in the rural setting. However, it should be noted that in the ending strategic plan, URCS did not succeed in attracting fund for enriched TB programming; instead TB was merely mainstreamed especially in HIV prevention sessions and adherence support to PLHIV and TB. It's expected that in future resource mobilization efforts such TB programming gaps (case detection, adherence to People living with TB with HIV, Prevention of TB) will be addressed. The above are commendable achievements in that at the beginning of the current URCS HIV strategic plan 2008-2010; URCS was reaching 3250 PLHIV, 25% of PLHIV were being supported with IGAs, 1100 OVC were being reached with support services and stigma had reduced to 35% respectively.

The URCS program and the national response at large is facing challenges ranging from inadequate resources for effective response; stock outs of commodities related to HIV, lack of adequate ART, PMTCT and treatment programs to cater for the needs; inadequate innovations to counteract the HIV dynamics, inadequate packaging for to address HIV/AIDS in a comprehensive manner (URCS currently does not provide actual VCT or treatment of PLHIV which are critical in HIV/AIDS Care and support aspects) among other challenges that have hindered wider impact despite impressive gains that have been registered in the current strategic plan.

Despite the challenges; the niche for the Society with regard to HIV/AIDS prevention, care and support still lies in its constituency. As noted in some studies, the current HIV & AIDS programs in are strongly skewed in favor of the urban residents and those in the easy to reach areas. Uganda Red Cross Society has a comparative advantage in its ability to penetrate and work among marginalized people in need of humanitarian assistance, in conflict areas, areas of extreme poverty, civil strife and disaster, where nobody else takes a lead. The URCS can also easily work with the hard to penetrate sections of the population such as the army.



2.7. Current URCS response to Drug/Substance Abuse

In terms of harm reduction (drug and substance abuse) the experience so far is promising with many clients or potential drug and substance abusers coming up to share with URCS their challenges and how they became victims of the wrong practices. It is therefore expected that URCS will play a big role Harm reduction interventions are concerned given the positive results so far and the good will that the public has, given the fact that drug and substance abuse are stigmatizing practices.



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Chapter 3

SWOT Analysis of URCS

Please see PEST analysis below. The stakeholder's analysis requires longer processes

Understanding the institutional strengths, weaknesses, opportunities and threats is very critical for the achievement of the strategic interventions. During the situational analysis, the capacity of URCS was assessed to determine the areas of competency and weaknesses that can be addressed for proper programming and strategic interventions especially in the area of HIV/AIDS and TB.

3.1. SWOT Analysis of URCS

Strengths	How to maintain the strengths	Weaknesses	Strategies to address the weaknesses	Opportunities	Strategies to harness the Opportunities	Threats	What can be done to counter the threats
Wide experience in implementing HIV and AIDS interventions	-Enhance support to HIV and AIDS interventions	-Inadequate partnerships	-Encourage local partnerships for health	Community trust and acceptance of URCS by the community and other stakeholders	-Encourage continuous involvement of community members in the URCS HIV and AIDS programs	Donor fatigue	-Encourage and enhance diversification of sources of funding for HIV and AIDS.
Competent staff	-Devise a strategy for retaining the staff and strategies for continuous skills enhancement of staff to match with the changing trends -Need for continuous skills enhancement of the staff to meet the changing HIV trends	-Inadequate resources to implement HIV and AIDS and TB interventions	Devise strategies for mobilising resources	-Existence of a strong force of volunteers with professional expertise	Encourage and ensure comprehensive training of the volunteers to gain the relevant expertise in HIV and AIDS Develop a strategy for recruiting more volunteers and remunerating their services	- Some sections of the population see it as a foreign organisation	Repackage URCS to be more marketable among the local people

SWOT Analysis of URCS

Strengths	How to maintain the strengths	Weaknesses	Strategies to address the weaknesses	Opportunities	Strategies to harness the Opportunities	Threats	What can be done to counter the threats
Wide coverage	Strengthen the existing branches and encourage the opening up of more branches	Few or inadequate staff to implement HIV and AIDS interventions	Devise strategies to attract more competent staff in all the branches of the society	Positioned to reach most vulnerable communities countrywide	Attracting multi-lateral and multi-dimensional support	Changes in government strategy and priorities for HIV and AIDS.	Continuously review and align the strategy to fit into the government changing priorities
Existence of willing partners including MoH and other partners in the area of HIV and AIDS.	Continue to strengthen the partnerships and bring new partners on board through MOUs.	Some interventions are overstretched due to wide coverage of the society	Develop clear guidelines for implementation of interventions with very realistic timelines		-	Competition for funds or resources from other agencies implementing similar interventions	Advocacy and lobbying for harmonisation of interventions with other agencies implementing similar interventions.
		Limited follow up for HIV/AIDS/TB leaving many people with no services	Encourage and strengthen follow-up services for PHAs receiving services from the society			Community complacency on issues of HIV and AIDS	Continuous sensitisation and awareness creation

3.2 PEST analysis for the URCS HIV/AIDS & TB Program

A set of micro and macro environment factors affecting the URCS HIV/AIDS and TB program Politically, Economically, Socially and Technologically were also analysed as follows;

<p>Political/Legal</p> <ul style="list-style-type: none"> ▪ URCS is the only humanitarian organisation in the country with a niche of addressing HIV programs in emergency settings ▪ The existing HIV/AIDS work place policy of the organisation ▪ The political stability in most post conflict areas enabling HIV programming and implementation ▪ The mergers and strong partnerships built between the URCS HIV & TB program and the government entities causing continuity of HIV services among the subjects 	<p>Economic</p> <ul style="list-style-type: none"> ▪ The high inflation rate in the country affecting the uptake of HIV nutritional and other complementary services ▪ The high exchange rate of the foreign currency causing high cost of living across borders even for the HIV infected people and high costs for the imported ARVs and other HIV commodities ▪ The high taxes on goods and services as levied by the Uganda Revenue authority.
<p>Social</p> <ul style="list-style-type: none"> ▪ URCS is a socially accepted organisation, the community believes in its HIV interventions, strategies and the general HIV service package ▪ The Ugandan population is predominantly young people yet they are the most affected by the HIV epidemic ▪ The general spread of its HIV services across the whole country, reaching all people at all levels ▪ Ugandan populations are becoming complacent to HIV information and services causing a stagnated prevalence rate ▪ The high income distribution gaps where the rich are richer and the poor are growing poorer 	<p>Technological</p> <ul style="list-style-type: none"> ▪ There is commendable technological advancement in HIV service delivery and programming ▪ The country is investing in HIV research for prevention, treatment and vaccine development ▪ Existing systems strengthening for health ▪ Extended reach of technology for HIV services to most population including mobile HIV testing services and CD4 count machines ▪ Government effort in supporting investments in HIV industry as evidenced by the quality chemicals factory for HIV treatment ▪ The high energy use and costs involved in running health programs in the country ▪ The impact of the improved information technology for HIV and AIDS.



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Chapter 4

Issues Emerging from Literature and Consultations

4.1 Changing HIV patterns and trends

Literature indicates that there are changing HIV and AIDS patterns and trends. Recent data show that there has been a shift in the epidemic from spreading mainly in casual relationships to also seeing a large proportion of new infections among people in long-term stable relationships. This is accompanied by deterioration in behavioural indicators especially an increase in multiple concurrent partnerships. The mode of transmission study showed that of all new HIV infections in adults (15-49 years) in 2008, 43% were among people in discordant monogamous relationships in the past 12 months while 46% were among persons reporting multiple partnerships and their partners.

Commercial sex workers, their clients and partners of clients contributed 10% of new infections. Mother to child transmission is estimated (using Spectrum) to have contributed about 20,500 new HIV infections. In all (including incidence through MTCT), 37% of infections (adults and children) are attributable to multiple partnerships, 35% occurred within discordant monogamous couples, 18% were due to mother to child transmission while 9% arose in commercial sex networks. There has also been a shift in concentration of the epidemic from younger to older individuals with the highest prevalence for men being among 35 – 39 year olds (9.9%) while for women it is among 30 – 34 year olds (12.1%) (UNAIDS 2009).

Given that URCS strategy has, previously been weak on some issues such as addressing HIV among people in stable monogamous relations, and based on the changing HIV patterns and trends therefore, it becomes pertinent for any HIV program to respond to the reported situation if the response is to remain relevant and address the problem.

4.2 Changes in Sexual Behaviour

Data from population-based studies indicate a general decline in HIV and AIDS prevalence rates from 18% in 1992 to 6.4% in 2004/2005. These studies also examined the incidence and sexual behaviours of individuals over time. After a review of a series of sources of evidence, Kirby (2008 cited in UAC, 2009), noted that changes in sexual behaviour led to the decline in prevalence of HIV in Uganda in the 1990s. In particular, Kirby reports that there was a reduction in the number of sexual partners and breaking up of sexual networks and then a reduction in transmission due to increased condom use. However, according to Opio et al (2008 cited in UAC 2009), prevalence trends since early 2000 suggest an increase in HIV prevalence and a shift towards more risk taking behaviours particularly an increase in multiple sexual partnerships and non-spousal sex and decrease in condom use in non-spousal sex among men.

This revelation compounds an already precarious situation indicating that HIV and AIDS prevalence is on the increase mainly due to complacency and increased risk taking behaviours as well as low condom use. Interventions ought to also concentrate on HIV prevention and also aim at abating the risky sexual behaviours.

4.3 Targeting

Preliminary reviews and consultations indicate that for any program to be successful in HIV and AIDS/ TB interventions there is need to continuously identify and target the most at risk persons. As revealed in the changing patterns and trends of HIV & AIDS infections, it becomes very critical that targeting takes into consideration the new risk groups such as the married couples.

Issues Emerging from Literature and Consultations

Also in terms of targeting, it was established through consultations and reviews that over the last few years, the number of people getting infected with HIV and AIDS outnumbers those who are dying due to the disease implying complacency and low levels of behaviour change. In essence, the new interventions ought to contribute more to the prevention of HIV and AIDS. Targeting should therefore be directed to prevention efforts.

4.4 Drug and Substance Abuse

According to the rapid assessment conducted by URCS (Nov 2010- Jan-2011) Social cultural factors which include rights of passage, cultural acceptability which form the integral part of every day life looks at taking alcohol as a normative behaviour. These cultural beliefs are common among these slum areas of Nakawa division which have promoted the substance/drug abuse problem.

Weak laws on liquor and other substances which include the liquor (Enguli) Act Cap 93 which limits production and distribution of illicit brew has not been enforced. Therefore slum areas continue being brewing centers for such illicit liquor where deaths have been reported as a result of taking this illicit liquor.

Most criminals held at various police stations indicate that those aspects got involved in the criminal act due to influence of some drugs (police report of 2008, 2,542 cases reported). Many road traffic accidents that have led to multiple deaths are largely as a result of drivers driving under influence of drugs.

In addition, drug/substance abuse is cited as one of the key drivers of HIV transmission as identified in the strategic plan by Uganda AIDS Commission 2007/2011. This therefore implies that with drug abuse, most people will continue contracting HIV and hence continued increase on the already worsened disease burden in the country with its social and economic consequences





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Chapter 5

Gaps in HIV and AIDS/TB Interventions

Gaps in HIV and AIDS/TB Interventions

5.0 Gaps in HIV and AIDS/TB Interventions

5.1 Limited focus on TB

The review and discussions with the stakeholders have revealed that interventions targeting the reduction of TB cases are either limited or lacking in many of the districts. Interventions ought to concentrate on TB screening and treatment.

5.2 Coordination and Commitment

HIV and AIDS interventions have not been well coordinated. A number of players appear to pursue disjointed and disintegrated services on their own. Efforts to coordinate these interventions appear to have been hampered by the limited commitment on the actors. Limited commitment to the HIV & AIDS/TB cause was found to be eminent among the local leaders mainly in terms of planning, budgeting and mainstreaming HIV and AIDS in all the sectors at the local level.

5.3 Failure to integrate Nutritional components into HIV/OVC and TB Interventions

HIV & AIDS/TB affected and infected individuals require highly nutritious foods to boost their immunity against opportunistic infections. However, interventions and programs targeting to scale up HIV and AIDS interventions have not succinctly embedded nutrition into their programs. This affects adherence to ARVs and leads to generally low standards of living. Stakeholders recommended for the introduction of IGAs for the PHAs.

5.4 Limited access to HIV/AIDS services for OVC infected and affected by HIV and AIDS/TB

As already observed above, despite significant efforts to scale up care and support for OVC, Uganda continues to face significant challenges in its response to HIV&AIDS in relation to OVC services. A Situational Analysis on OVC (2009) indicated that of an estimated 30 million people, approximately 7.5 million children are considered most vulnerable while 2.3 million of vulnerable children are orphans, 46 percent as a consequence of AIDS. However, services reach only 23 percent of OVC.²⁰ Of the 50,000 CLWHA who need treatment, only 10,000 currently access ART and 20,000 children are infected every year (MGLSD OVC Status Report, 2010). To reverse these trends and increase access and utilization of HIV&AIDS services for children, youth and adults, there is need to scale up prevention, treatment and care services. Interventions ought to be scaled up to support OVC access to HIV and AIDS services

²⁰ Kalibala, S and Elson, L. (2010) Situation Analysis of Vulnerable Children in Uganda; New York: Population Council.



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Chapter 6

HIV/OVC and TB

Strategy 2011-2015:

Strategic Frameworks

HIV/OVC and TB Strategy 2011-2015: Strategic Frameworks

6.0 HIV/OVC and TB Strategy 2011-2015: Strategic Frameworks

6.1. Introduction

In this Chapter, the vision, mission, goal and the strategic objectives of the HIV and AIDS/TB are presented. The interventions under the strategy will be in line with the URCS mission, vision, and core values. Reference was made to the overarching national planning framework i.e., the National HIV and AIDS Strategic Plan, 2007/8-2011/12 and Sectoral Plans and policies. The guiding principles of the URCS were deemed to be still relevant and hence all were largely maintained.

6.2 Vision

An empowered, healthy and self-sustaining community that responds to the needs of its most vulnerable

6.3 Mission

To be a leading humanitarian agency in Uganda in saving lives, supporting livelihoods and promoting human dignity.

6.4 Principles

The seven principles of the Red Cross Movement are:

- Humanity,
- Impartiality,
- Neutrality,
- Independence,
- Voluntary service,
- Unity and,
- Universality.

6.5 Core Values

Based on the seven principles of the Red Cross Movement, the core values are:

- Open-mindedness,
- Responsiveness,
- Integrity/Transparency/Stewardship,
- Responsibility,
- Democracy, and Value for people,
- Equity/Equality and
- Respect for Gender and other forms of diversity and
- Time Management.

6.6 Goal of the URCS HIV/AIDS/OVC and TB Strategic Plan 2011-2015

To reduce the spread of HIV&TB and improve care and support for PLHIV /TB and OVC

6.7 Strategic Aims of HIV/OVC/TB Strategic Plan, 2011-2015

The strategic aims of HIV/OVC and TB Strategy, 2011-2015 were formulated in cognizance of the national objectives articulated in the National HIV and AIDS Strategic Plan, 2007/08-2011/12 and the URCS Strategic Plan, 2011-2015. See Table 2.

Table 2: Strategic Aims for HIV and AIDS/TB Strategic Plan, 2011-2015

Thematic Area	Strategic Aims
1.HIV and AIDS	<ul style="list-style-type: none"> Susceptibility and Vulnerability to HIV and AIDS infection and its impact among the targeted community reduced.
2.TB	<ul style="list-style-type: none"> Access to TB Prevention, Care and Support services in targeted communities increased.
3. OVC	<ul style="list-style-type: none"> All OVC in URCS' targeted community access prevention, care and support services increased.
4. Drug and substance abuse	<ul style="list-style-type: none"> All drug and substance abusers are treated as patients rather than criminals as a weapon to successful re-integration and prevention.

6.8 Strategic Plan Target Groups

Through literature review and discussions with stakeholders, a number of categories of MARPs were identified and should be targeted under this plan. Available data show that HIV risk is spread across a number of groups disaggregated by age, gender, location, occupation, marital status and level of HIV exposure. The risk groups were derived based on where most of the new infections occur, and where an individual has more than one risk behaviour. The HIV is spread mainly through sexual encounters, transfusion of infected blood and sharing of sharp instruments and at birth from mother to child. The high risk groups being targeted, as identified from the literature and discussions with the stakeholders, are also in line with the target group under the HIV and AIDS/TB strategic plan, 2011-2015. These include:

- Individuals reporting multiple partners (MP)
- Sex workers (SW)
- Fishing communities,
- Internally displaced persons and other refugees
- Youth in and out of school
- Prisoners
- Armed forces
- People living at the border posts such as Nebbi, Arua, Yumbe, adjumani, Gulu, Kitgum, Karamoja, Mbale, Bubulo, Tororo, Busia, Kalangala, Rakai, Mbarara, Ntungamo, Kabale, Kisoro, Rukungiri, Bushenyi, Kasese, Bundibujjo, Kabarole, Kibale, Hoima and Masindi.
- Bodaboda riders, taxi drivers, long distance truck drivers.
- People Living with HIV/AIDS and TB

According to the recent mode of transmission study (UAC/UNAIDS 2009), the risk groups were further segregated by age, and HIV is reported to be high among the younger adults of between 25-45 years especially among males. This is the same age group that is mostly in a permanent relationship (married or cohabiting). This strategic plan therefore also seeks to strengthen the interventions of URCS among the married people.

HIV/OVC and TB Strategy 2011-2015: Strategic Frameworks

The categories of OVC to be targeted include:

- Orphans and orphans households
- Children affected by armed conflict.
- Children abused or neglected.
- Children infected and affected by HIV/AIDS or other diseases.
- Children in need of alternative family care.
- Children affected by disability.
- Children in 'hard-to-reach' area
- Children living under the worst forms of labour and those living on the streets.

6.9 Strategic Objectives

Objective 1:
Increase HIV prevention services in the general population and among MARPS in the next 5 years.

Objective 2:
To improve the psychological, physical and socio-economic well being of PLHIV by the end of 2015

Objective 3:
To improve the wellbeing of orphans and vulnerable children in the next 5 years

Objective 4:
To increase TB, and Drug/substance abuse prevention, treatment, and support services in the general population and MARPS (prisoners) in the next 5 years

Objective 5:
To strengthen the HIV programming systems for URCS and the targeted community level support groups in the next 5 years

6.9.1 Description of Strategies

Objective 1: To increase HIV Prevention services in the general population and MARPS in the next 5 years

Strategy 1: Extending Core package of HIV prevention Services to the general population in the URCS program areas with particularly emphasis on MARPS

Activities:

- 1.1.2 Provide HCT either as couple or to more first time testers
- 1.1.3 Integrate prevention messages into HCT
- 1.1.4 Promote correct and consistent use of condoms for the general population & MARPS
- 1.1.5 Promote use of new technologies and approaches (SMC, PMTCT, ART) proven to be effective in the general population and high risky populations
- 1.1.6 Promote referral for HIV/AIDS/TB services, particularly for those testing HIV/TB-positive.

Strategy 2: Increase awareness and promote behavioural change interventions with focused messages on HIV/AIDS/TB in the general population and targeting MARPS.

Activities:

- 1.2.1. Conduct sensitisation and awareness campaigns on HIV/AIDS and TB
- 1.2.2. Sensitise the communities on HIV prevention methods
- 1.2.3. Sensitise the communities on TB prevention methods

- 1.2.4 Review and update IEC/BCC materials tailored to reach the general population and MARPS and promote other complimentary HIV prevention services
- 1.2.5 Expand peer education/networks/social groups in all URCS branches
- 1.2.6 Expand life skills and peer network based HIV education program for in school youths
- 1.2.7 Expand peer network/ life skills training and youth friendly SRH services for out of schools
- 1.2.7 Expand community friendly condom distribution for the general population/MARPs
- 1.2.8 Ensure access to condoms among the risky groups
- 1.2.9 Conduct Condom promotion Campaigns using a dynamic mix of channels (mass media, fetes etc)

Objective 2: To improve the psychological, physical and socio-economic wellbeing of PLHIV in the next 5 years

Strategy 1: Increase and expand uptake of HIV/AIDS / TB treatment, care and support services and strengthen their referral system

Activities:

- 2.1.1. Capacity building of community resource persons on care and support
- 2.1.2. Support and expand the provision of HBC
- 2.1.3. Increase provision of complimentary support including nutrition for PHA and TB patients
- 2.1.4. Increase provision of quality psycho social support services to PHAs
- 2.1.5. Provide minimum package of services for Prevention with PLHIV (Risk Reduction Counseling, disclosure of HIV sero-status to partners)
- 2.1.6. Promote male involvement in HIV/AIDS/TB treatment, care and support services
- 2.1.7. Build and implement networks for referral

Strategy 2: Integrate TB screening, Infection control and Treatment into HIV care

Activities:

- 2.2.1. Promote management of TB/HIV Co-infected persons
- 2.2.2. Support laboratory HIV diagnosis and treatment
- 2.2.3. Support referral of HIV infected person's treatment and support.
- 2.2.4. Promote male involvements in TB-HIV care and treatment

Strategy 3: Scale up the provision of economic and social support for individuals and families affected by HIV/AIDS.

Activities:

- 2.3.1. Provide IGAs to affected households
- 2.3.2. Scale up access to social economic support to PHAs.
- 2.3.3. Scale up access to livelihood support to OVC households
- 2.3.4. Support community dialogues to address social-cultural and gender norms
- 2.3.5. Promote social and legal intervention for violence against women and girls due to HIV (status disclosure, discordance or sero differences)
- 2.3.6. Conduct community dialogues on HIV/AIDS related discriminations

Objective 3: To improve the well being of Orphans and vulnerable children (OVCs) in the next 5 years

Strategy 1: Ensure the provision of apprenticeship skills and education among OVCs

Activities:

- 3.1.1. Identify OVC in need of apprenticeships skills
- 3.1.2. Train OVC in apprenticeships
- 3.1.3. Provide start up kits for OVC trained in apprenticeships

HIV/OVC and TB Strategy 2011-2015: Strategic Frameworks

Strategy 2: Ensure the provision of quality HBC and psychosocial support to OVC infected and affected by HIV and AIDS/TB

Activities:

- 3.2.1. Provide quality counselling services
- 3.2.2. Conduct drama and sports gala
- 3.2.3. Home visits to OVC families
- 3.2.4. Facilitate will writing
- 3.2.5. Facilitate memory book writing
- 3.2.6. Provide nursing care
- 3.2.7. Strengthen community –based referral system and monitor referrals between OVC caregivers and service providers
- 3.2.8. Adherence support

Objective 4: To increase TB and Drug/Substance abuse prevention and treatment support services in the general population and for MARPS in the next 5 years

Strategy 1: Increase uptake to TB Interventions in the general population and among MARPs

Activities:

- 4.1.1. Train home care volunteers in integrated HIV/AIDS and TB
- 4.1.2. Train family and household members on managing TB in the household.
- 4.1.3. Link the trained volunteers to the DOTS to strengthen partnership with the government structure
- 4.1.4. Carry out home and prison visits
- 4.1.5. Follow up treatment adherence for persons with TB at community level, including ex-prisoners still on TB treatment
- 4.1.6. Procure basic house hold kits
- 4.1.7. Refer TB Patients for advanced care to health facilities

Strategy 2: Integrate TB screening, Infection control and Treatment into HIV care

Activities:

- 4.2.1 Support community efforts for TB diagnosis and awareness
- 4.2.2 Support referral of TB infected persons for HIV screening and support.

Strategy 3: Increase uptake of DSA Prevention and Harm Reduction Intervention among highly risky groups

- 4.3.1 Provide sensitization on DSA prevention
- 4.3.2. Promote peer education and community dialogue on dangers of DSA

Objective 5: To strengthen the HIV programming systems for URCS and for the general population / MARPs in the next 5 years

Strategy 1: Promote awareness on HIV and TB stigma and discrimination in the general population

Activities:

- 5.1.1 Mobilise the communities for anti-HIV & AIDS/TB stigma campaigns
- 5.1.2 Produce and distribute IEC materials on stigma and discrimination
- 5.1.3 Conduct anti- stigma and discrimination community dialogue meetings
- 5.1.4 Local media
- 5.1.5 Conduct door to door anti stigma campaigns
- 5.1.6 Develop tool kit for reducing HIV stigma and discrimination

Strategy 2: Widening partnerships and Resource Mobilization

Activities:

- 5.2.1 Sign MOU
- 5.2.2 Sharing reports
- 5.2.3 Conduct and implement Joint activities with other agencies involved in HIV and AIDS/TB.
- 5.2.4 Mobilize resources for intensified HIV programming
- 5.2.5 Conduct Stakeholders meeting

Strategy 3: Enhance URCS human resource capacity in HIV /OVC and TB programming

- 5.3.1 Conduct training and orientation sessions for URCS human resource
- 5.3.2 Recruitment of more skilled workers on HIV programming
- 5.3.3 Streamline communication systems
- 5.3.4 Recruit and train HBC facilitators
- 5.3.5 Facilitate HBC facilitators

Strategy 4: Standardize HIV/OVC & TB programming operating procedures

Activities:

- 5.4.1 Strengthen and operationalise the M+E system across all HIV and TB implementing branches
- 5.4.2 Scale up and operationalise the HIV/AIDS and TB work place policy across the entire work population of the URCS
- 5.4.3 Develop operating manuals
- 5.4.4 Institutional assistance for improved HIV and AIDS & TB strategy implementation

Strategy 5: Address harmful Socio-cultural and gender norms that increase vulnerability to HIV

Activities

- 5.5.1 Conduct community dialogues to address factors that impede behaviour change and up-take of HIV prevention services
- 5.5.2 Support community leaders to mobilize communities to change cultural norms and practices that perpetuate spread of HIV
- 5.5.3 Support community dialogues to address socio-cultural and gender norms
- 5.5.4 Promote social and legal interventions for violence against women and girls due to HIV
- 5.5.5 Advocate for and support effective implementation of policies and laws addressing SGBV and structural drivers of HIV

Strategy 5: Promote HIV Work Place Policy

Activities

- 5.6.1. Roll down Work Place Policy within the URCS work population
- 5.6.2. Conduct HIV Work Place sessions for all the branches, regions and hqtr staff
- 5.6.3 Advocate for adequate treatment support to staff and active volunteers



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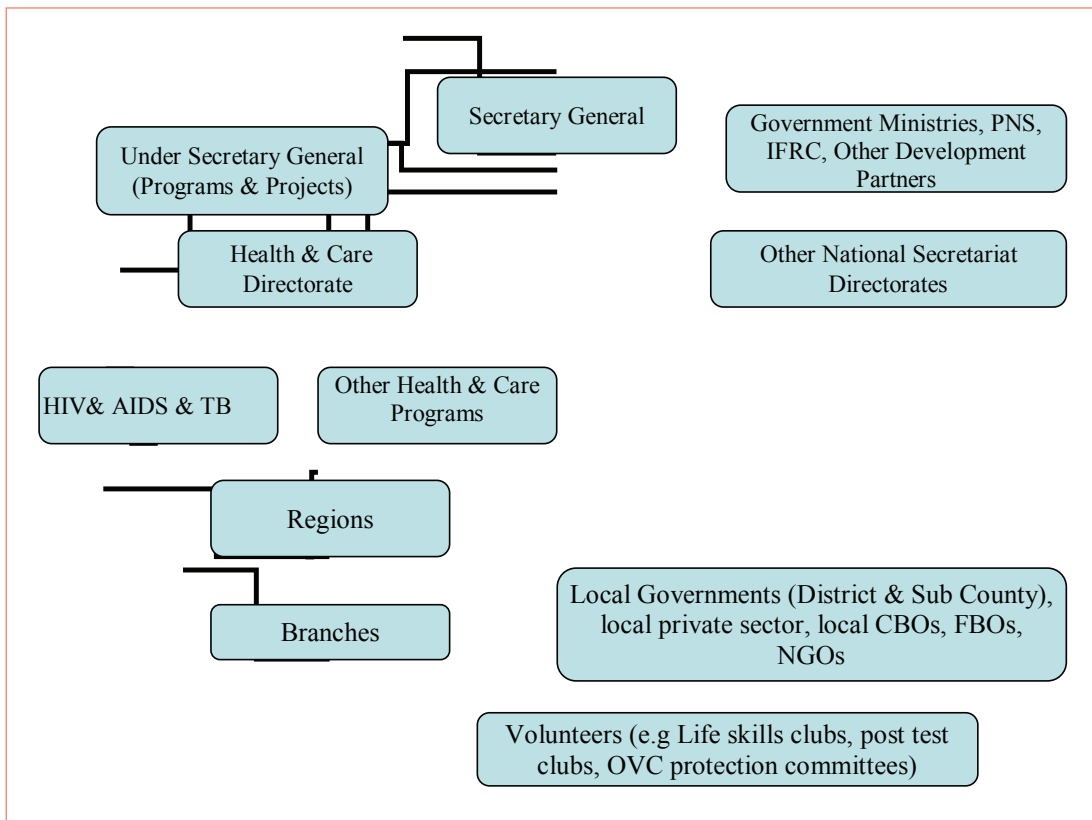
Chapter 7

Implementation and Coordination Arrangements

7.1 Implementation Management

The URCS secretariat will be responsible for technical support, setting standards, guidelines, supervision, quality assurance, monitoring and evaluation. While coordination of HIV/AIDS/TB interventions lies within the national URCS secretariat, actual implementation of activities takes place within the different branches. Within this institutional framework, the role of local government, line ministries, development partners including partner national societies (PNS) and IFRC, academic and research institutions, private sector and civil society will be pronounced. Figure 2 below is a graphic representation of the implementation and coordination arrangements for the HIV and AIDS/TB Strategic Plan, 2011-2015.

Figure 1: Implementation and Coordination Mechanisms



7.1.1 URCS Secretariat-Office of the USGs

The URCS national secretariat specifically the office of the USGs will provide the overall direction and guidance to the implementation of the HIV and AIDS/TB Strategic Plan, 2011-2015 in consultation with the Secretary General who is the overall Executive Director. The URCS Department of Health and more specifically the HIV/AIDS & TB Program will be in charge of the day-to-day activities of the implementation of the plan. The HIV/AIDS & TB Program works along with other programs within the Health and Care Department and in turn, planning and implementation of the HIV/AIDS & TB activities shall be in close consultation and coordination with other URCS Departments like Disaster Management, Dissemination, Youth and Volunteer Management and Community Development. In the same way

Implementation and coordination arrangements

the HIV/AIDS & TB Plan shall be implemented in close consultation and coordination with URCS service departments including, Resource Mobilization, Organizational Development, Human Resource, Finance, Community Development, Logistics and Audit.

Beyond the National Secretariat, the strategic plan will be implemented through URCS regional centres and branches across the country. Implementation of the Strategy in each selected branch should cover all the outputs, instead of scattering individual outputs across several branches and whose impact will be less significant. To ensure a greater impact and continuity, branches chosen for the implementation of this strategy, should be those that were already involved in the implementation of the HIV/AIDS Strategic Plan, 2008/2010. It is also important that branches involved should be those that are already implementing (or earmarked to implement) other health and care program components including, water and sanitation, malaria control, and reproductive health. In a similar way, implementation at branch level should focus on targeting a beneficiary community with a “package of programs” instead of small and isolated programs that inadequately address the needs of the targeted beneficiaries. This suggested approach resonates with existing programming for HIV which requires a basic package for PLHIV including safe water, improved sanitation and malaria prevention.

The implementation of the Strategy, will utilize an existing structure of URCS which stretches from the community level through the branches to the national society headquarters. At the community level, the structure is composed of a body of volunteers including, home care facilitators, youth links, blood donor groups (BDR) and women groups.

7.1.2 Government Ministries and Development Partners

URCS enjoys the goodwill and support from her development partners in the areas of financial support; technical support and input into planning, policy and implementation processes; and advocacy to government and their peer institutions. The HIV and AIDS/TB Strategic Plan, 2011-2015 will be implemented with the assistance from IFRC Secretariat, the GoU, partner national societies (PNS) and corporate organizations that form the business private sector and other donors. In line with the overall Strategic Plan of URCS 2011-2015, the office of the DSG will coordinate resource mobilization efforts to realize necessary technical and financial support to actualize the objectives of this HIV/AIDS & TB Plan. Implementation of the strategic plan will require commitment to promoting cross-sectoral linkages. Priority line Ministries currently with activities related to HIV /OVC and TB include: Ministries of Health; Education and Sports; Local Government; Justice and Constitutional Affairs; Internal Affairs; Defence; Agriculture; Animal Industry and Fisheries; Housing and Urban Development; and, Finance, Planning and Economic Development. Efforts will be made to ensure effective coordination with all these sectors.

7.1.3 Civil Society Organizations

These include national and international NGOs, FBOs, CBOs, religious and cultural institutions that are providing HIV /OVC and TB related services either in partnership with government or directly with funds from development partners or the private sector. URCS shall work closely with public and private sector agencies, communities and other stakeholders by providing and sharing capacities through training, resource mobilization, provision of tools to identify the needy, monitoring and evaluation.

7.1.4 Private Sector Agencies

This includes companies, corporations and other for-profit institutions, foundations, the media and individual donors who, through the private resources available to them, can galvanize financial support to assist in the provision of HIV and AIDS related services. URCS needs to map out a strategy to reach

out and partner with the growing private sector in Uganda to provide some of the resources needed. Private sector agencies can play key roles in fundraising, provision of HIV and AIDS services through sub-contracting, and provision of other services and support such as training to the URCS staff. URCS is expected to work with some types of private sector institutions such as the media, which plays key roles in information dissemination, publicity and advocacy with respect to HIV/OVC and TB.

7.1.5 Academic and Research Agencies

Academic and research institutions shall continue to partner with URCS and implementing URCS branches to improve data collection. There are a variety of local academic institutions such as Universities, UBOS, and a variety of private consulting firms that will be able to provide the technical assistance to the URCS and URCS implementing branches to improve monitoring and evaluations systems.





URCS HIV/OVC&TB STRATEGIC PLAN 2011 - 2015

Chapter 8

HIV /OVC and TB Log Frame

Logical Framework Matrix				
Strategy	Strategic activities/Interventions	Verifiable indicators	Data Source/Means of verification	
GOAL: To reduce the spread of HIV and TB and improve care and support for PLHIV and OVC				
Objective 1: To increase HIV prevention services in the general population and among MARPS in the next 5 years				
Strategy 1: Extend core package of HIV prevention services to the general population and MARPS under the URCS program areas.	1.1.1 Provide HCT either as couples or to more first time testers	Number of people tested and sessions conducted	URCS HCT and referral records	360,000,000=
	1.1.2. Integrate prevention messages into HCT	Number of URCS branches with HCT services integrated with prevention messages		150,000,000=
	1.1.3. Promote correct and consistent use of condoms for the general population and MARPS	Proportion of persons correctly and consistently using condoms		405,000,000=
	1.1.4 Promote use of new technologies and approaches proven to be effective in the general population and for high risky populations – SMC, PMTCT, ART etc	Proportion of people accessing SMC, PMTCT, and ART services		450,000,000=
	1.1.5. Promote referral for HIV/AIDS/TB services	Number of people referred and services they received		150,000,000=
Strategy 2: Increase and promote behavioural change interventions with focused messages on HIV/AIDS/TB prevention for the general population and among MARPS	1.2.1 Conduct sensitisation and awareness campaigns on HIV/AIDS and TB	-Number of sensitisation campaigns conducted. -Proportion of the target population with knowledge on HIV/AIDS.	URCS outreach, sensitization and education programme records	90,000,000=

HIV /OVC and TB Log Frame

Logical Framework Matrix				
Strategy	Strategic activities/Interventions	Verifiable indicators	Data Source/Means of verification	
Strategy 2: Increase and promote behavioural change interventions with focused messages on HIV/AIDS/TB prevention for the general population and among MARPS	1.2.2. Sensitise the communities on HIV prevention	-Number of sensitisation campaigns conducted -Prop of the target population with knowledge on HIV	90,000,000=	URCS outreach, sensitization and education programme records
	1.2.3. Sensitise the communities on TB prevention	- No of sensitisation sessions conducted -Prop of the target population with knowledge on TB	90,000,000=	
	1.2.4. Review and update IEC/BCC materials tailored to reach the general population and MARPS & promote other complimentary HIV prevention services	No. of IEC materials distributed on HIV/AIDS & TB prevention	150,000,000=	
	1.2.5. Expand peer education/networks/social groups in all URCS branches	Number of peer education groups established	144,000,000=	
	1.2.6. Expand life skills and peer networks based HIV education programs for In school youths	Number peer education sessions conducted	630,000,000=	
	1.2.7. Expand peer networks/life skills training and youth friendly SRH services for Out of schools	% age of youth out of school reached	270,000,000=	
	1.2.8. Expand community friendly condom distribution for general population and MARPS	%ge increase in the target population accessing condoms	270,00,000=	
	1.2.9 Conduct Condom promotion campaigns using a dynamic mix of channels among the high risk populations	%ge increase in Budget allocations to the condom purchases	630,000,000=	
	Strategy 2: Increase and promote behavioural change interventions with focused messages on HIV/AIDS/TB prevention for the general population and among MARPS			

Logical Framework Matrix				Data Source/Means of verification
Strategy	Strategic activities/Interventions	Verifiable indicators		
Objective 2: Increase access to improved treatment, care and support for PLHIV and TB in the URCS program areas by 2015				
Strategy 1. Increase and expand uptake of HIV/AIDS and TB treatment, care and support services and strengthen referral system	2.1.1. Capacity Building of community resource persons on care and support	Number of HBC Volunteers trained in integrated HIV/AIDS and TB.	900,000,000=	URCS treatment, care and support records
	2.1.2. Support and expand the provision of HBC	Number of families and HHs reached with HBC	600,000,000=	
	2.1.3. Increase provision of complimentary support including nutrition for PHAs and TB patients	Number of family and household members trained in HIV/AIDS and TB management.	450,000,000=	
	2.1.4. Increase provision of quality psycho social support services to PHAs	Number of people receiving quality PSS	1,050,000,000=	
	2.1.5. Provide minimum package of services for Prevention with PLHIV(PwP)	Proportion of PHAs reached with PwP services	135,000,000=	
	2.1.6. Promote male involvement in HIV/AIDS/TB treatment, care and support services	Proportion of men involved in services	3,750,000=	
	2.1.7. Build and implement networks for referrals	Number of referrals and network meetings conducted	450,000,000=	
Strategy 2. Integrate TB screening, Infection control and Treatment into HIV care	2.2.1. Promote management of TB/HIV Co-infection	Proportion increase in the number of TB cases diagnosed and treated	30,000,000=	URCS treatment, care and support records
	2.2.2. Support laboratory HIV/ TB screening and early detection	Proportion increase in the number of TB cases detected early among communities	3,750,000=	
	2.2.3. Support referral of HIV/TB infected persons for treatment and support	Number of TB infected persons referred for screening, support and vice versa	135,000,000=	
	2.2.4. Promote male involvement in TB-HIV care and treatment	Proportion of men involved in services	1,500,000,000=	



HIV /OVC and TB Log Frame

Logical Framework Matrix				
Strategy	Strategic activities/Interventions	Verifiable indicators	Data Source/Means of verification	
Strategy 3: Scale up the provision of economic and social support for OVC, individuals and families affected by HIV/AIDS and TB	2.3.1. Provide IGAs to affected households	-Proportion of households receiving IGAs		1,350,000,000=
	2.3.2. Scale up access to social economic support to PHAs	-Proportion of PHAs receiving economic support		600,000,000=
	2.3.3. Scale up access to livelihood support to OVC households	-Proportion of OVC households receiving livelihood support		270,000,000=
	2.3.4. Support community dialogues to address social-cultural and gender norms	Number of dialogues supported and people reached		270,000,000=
	2.3.5. Promote social and legal intervention for violence against women and girl due to HIV (status disclosure, discordance or sero difference)	Number of interventions supported		168,500,000=
	2.3.6. Conduct community dialogues on HIV/AIDS related discrimination	Number of dialogues and numbers of people reached		900,000,000=
Objective 3: To improve the well being of orphans and other vulnerable children (OVC) in the next 5 years				
Strategy 1: Ensure the provision of apprenticeship skills among OVC	3.1.1. Identify OVC in need of apprenticeship skills	- Number of OVC identified		37,500,000
	3.1.2. Train OVC in apprenticeships	-Proportion of OVC receiving appren. training and start up kits		1,125,000,000=
	3.1.3. Provide start-up kits for OVC trained in apprenticeships	-Number of OVC receiving start up kits		2,400,000,000=

Logical Framework Matrix				
Strategy	Strategic activities/Interventions	Verifiable indicators	Data Source/Means of verification	
Strategy 2: Ensure the provision of HBC and psychosocial support to OVC infected and affected by HIV and AIDS/TB	3.2.1. Provide quality counselling services	-Proportion of OVC receiving counselling		270,000,000=
	3.2.2. Conduct drama and sports gala	-Number of drama and sports galas conducted		1,200,000,000=
	3.2.3. Home visits to OVC families	-Proportion of OVC families visited		180,000,000=
	3.2.4. Facilitate will writing	-Proportion of the target population facilitated to write wills		540,000,000=
	3.2.5. Facilitate memory book writing	-Proportion of the target population facilitated to write memory books		540,000,000=
	3.2.6. Provide nursing care	Proportion increase in adherence to Treatment		810,000,000=
	3.2.7. Strengthen community-based referral systems and monitor referrals between OVC and caregivers and service providers	Number of referrals made		3,750,000=
	3.2.8. Adherence support	Number of PHAs/TB patients receiving adherence support		162,000,000=

HIV /OVC and TB Log Frame

Logical Framework Matrix			
Strategy	Strategic activities/Interventions	Verifiable indicators	Data Source/Means of verification
Objective 4: To Increase TB and Drug/Substance abuse prevention and treatment support services in the general population and among MARPS in the next 5 years	4.1.1 Train home care volunteers in integrated HIV/AIDS and TB	Number of Home care volunteers trained	TB certificates of completion, training reports and referral reports
	4.1.2 Train family and household members on managing TB in the household.	Number of family/households members trained in management of TB at home	
	4.1.3 Link the trained volunteers to the DOTS to strengthen partnership with the government structure	Number of households with TB patients providing home based management of TB	
	4.1.4 Carry out home and prison visits	Number of home visits conducted and those to the prisons	
	4.1.5 Follow up treatment adherence for persons with TB at community level, including ex-prisoners still on TB treatment	No of follow up visits	
Strategy 1: Increase uptake to TB Interventions	4.1.6 Procure basic house hold kits	Proportion of TB patients completing the TB treatment dosage	1,050,000,00=
	4.1.7. Refer TB Patients for advanced care to health facilities	Number of people referred	3,750,000 =
	4.2.1. Support community TB screening and treatment	Proportion of TB patients screened for TB at community level.	52,500,000 =
Strategy 2: Integrate TB screening, Infection control and Treatment into HIV care	4.2.2. Support referral of TB infected persons for HIV screening and support.	Number of TB patients referred for screening and support	52,500,000 =

Logical Framework Matrix				
Strategy	Strategic activities/Interventions	Verifiable indicators	Data Source/Means of verification	
Strategy 3: Increase uptake of DSA prevention & Harm reduction and interventions	4.3.1. provide sensitisation on DSA prevention	Number DSA cases reached and sessions conducted		540,000,000=
	4.3.2. promote peer –networks and community dialogues on dangers of DSA	Numbers of people reached		540,000,000=
Objective 5: To strengthen the HIV programming systems for URCS and in the general population/MARPPS in the next 5 years				
Strategy 1: Promote awareness on HIV and TB stigma and discrimination in the communities	5.1.1 Mobilise the communities for anti-HIV & AIDS/TB stigma campaigns	Proportion of target community members participating in anti-HIV/AIDS/TB campaigns		540,000,000=
	5.1.2 Produce and distribute IEC materials on stigma and discrimination	Number of IEC materials produced and distributed		375,000,000=
	5.1.3 Conduct anti- stigma and discrimination community dialogue meetings	Number of awareness campaigns conducted		540,000,000=
	5.1.4 Conduct door to door anti stigma campaigns	Number of households visited for door to door campaigns		960,000,000=
	5.1.5 Develop tool kit for reducing HIV stigma and discrimination	A tool kit developed and used in all the URCS branches		540,000,000=
	5.1.6 Roll out the UNAIDS Stigma Index	No of volunteers trained in anti-stigma approaches		187,500,000=

HIV /OVC and TB Log Frame

Logical Framework Matrix				
Strategy	Strategic activities/Interventions	Verifiable indicators	Data Source/Means of verification	
Strategy 2: Widening partnerships and resource mobilization	5.2.1 Sign MOU with stakeholders	Number of Organisations signing MOUs with URCS	URCS HIV/AIDS & TB partnership database URCS HIV/AIDS & TB monetary resources available	
	5.2.2 Sharing Activity reports	Number of activity reports shared	URCS HIV/AIDS & TB technical expertise available at the society	
	5.2.3 Conduct & implement Joint activities with other agencies involved in HIV /AIDS/TB.	Proportion of HIV/AIDS/TB related activities implemented in partnerships with other agencies.		
Strategy 3: Enhance URCS human resource capacity in HIV/OVC and TB programming	5.2.4. Mobilise resources for intensified HIV programming	Proportion of funds raised for HIV programming		
	5.2.5. Conduct stakeholder meeting	Number of stakeholders meetings held		
	5.3.2. Conduct training and orientation sessions for URCS human resource	Number of training sessions conducted Number of URCS staff trained and oriented in HIV/AIDS/TB programming		
	5.3.2. Recruitment of more skilled workers on HIV programming	Number of workers recruited with skills in HIV/AIDS/TB programming		
	5.3.3. Streamline communication systems	Communication systems established		

Logical Framework Matrix			
Strategy	Strategic activities/Interventions	Verifiable indicators	Data Source/Means of verification
Strategy 4: Standardize HIV/OVC & TB programming operating procedures	5.3.4. Recruit and train HBC facilitators	Number of HBC facilitators recruited and trained in all implementing URCS branches	
	5.3.5. Facilitate HBC facilitators	Proportion increase in the facilitation of HBC facilitators	
	5.4.1. Strengthen and operationalise the M&E system across all HIV/OVC and TB implementing branches		The existing and functional monitoring and evaluation system, The HIV/AIDS & TB standard operating procedures (SOPs)
	5.4.2. Scale up and operationalise the HIV/AIDS and TB work policy across the entire URCS work population	Nature of M&E tools developed and disseminated in all 15 branches	
	5.4.3. Develop operating Manuals	Number of URCS branches implementing the HIV/AIDS/TB work place policy	
5.4.4. Institutional assistance for improved HIV/AIDS and TB strategy implementation			
Strategy 5: Address harmful socio-cultural and gender norms that increase vulnerability to HIV in the general population	5.5.1. Conduct community dialogues to address factors that impede behaviour change and uptake of HIV prevention services	Number of dialogues and issues addressed	180,000,000=

HIV /OVC and TB Log Frame

Logical Framework Matrix				
Strategy	Strategic activities/Interventions	Verifiable indicators	Data Source/Means of verification	
Strategy 5: Address harmful socio-cultural and gender norms that increase vulnerability to HIV in the general population	5.5.2. Support community leaders to mobilise communities to change cultural norms & practises that perpetuate spread of HIV	Number of community leaders supported		180,000,000=
	5.5.3. Support community dialogues to address socio cultural and gender norms	Number of dialogues conducted		180,000,000=
	5.5.4. Promote social and legal interventions for violence against women and girls due to HIV	Number of interventions		180,000,000=
	5.5.5. Advocate for and support effective implementation of policies and laws addressing SGBV and structural drivers of HIV	Number of policies and laws supported		270,000,000=
	5.6.1. Roll down Work Place Policy within the URCS work population including HIV information sessions & work place peer networks			92,000,000=
5.6 Promote HIV Work place	5.6.2. Procure and IEC/BCC materials/ condoms and provide staff with HI related medical and other support			240,000,000=
	5.6.3. Monitor and implement HIV and AIDS Work Place Policy			360,000,000=



URCS HIV/OVC&TB STRATEGIC PLAN 2011 - 2015

Chapter 9

Monitoring and Evaluation

9.0. MONITORING AND EVALUATION

9.1 Introduction

Monitoring and Evaluation involves the collection and review of data followed by the incorporation of intermediate results/ lessons learned into the ongoing project planning cycle. The goal of M&E is to collect and use appropriate data at all levels in order to improve services on a continuous basis. A plan for monitoring and evaluating the chosen interventions will be developed by the URCS, and will do so in close collaboration with the recipients of those interventions. The M&E focal point person(s) within the URCS' Implementation Unit and URCS branches all over the country will coordinate the process of monitoring and evaluation. This section presents the guiding conceptual issues to be considered in understanding and developing an M&E framework, levels of stakeholders in M&E implementation, frequency of timing, data sources and methods of data capture, and other key elements in M&E.

9.2. Frequency and Timing of HIV/AIDS strategic plan Monitoring and Evaluation

9.2.1 Regular Monitoring

Monitoring will be done at two levels: the URCS national level; and the branch/sub-national level. Specific tools will be developed during the implementation of the plan to aid the collection of monitoring data at these levels with consultation of the M+E system which is already in existence. At the URCS national level, monitoring will involve mainly checking on inputs utilization. This will comprise monitoring the disbursement of funds to the implementing branches. Other monitoring activities will include periodic meetings with the relevant stakeholders. It is also envisaged that the URCS health and care department will make periodic monitoring missions of branches to ensure conformity and adherence to agreed standards of planning and execution of activities. During these visits, the necessary support will be provided to the implementing branches.

At the branch level, participatory approach will be used for regular monitoring activities. Periodic monthly reports will be submitted to the URCS implementing unit on a quarterly basis or as stated in the M&E Framework. It is anticipated that the report will indicate how far the branch has gone in the implementation of the activities of the plan. The responsibility of monitoring the activities will lie with the branch coordinators.



9.2.2. Mid-Term Review (MTR)

The HIV/AIDS/TB strategic plan should be reviewed half-way its implementation to provide lessons for further implementation and modifications of the plan if necessary. Considerations for the midterm review will be on whether there is substantial progress in the realization of the objectives of the plan. Focus will be on the realization of results (outcomes), and emerging issues in the implementation context. Other considerations will be for the determination of the relevance and appropriateness of coordination and implementation strategies, efficiency and effectiveness in plan implementation. The review should also provided answers as to what needs to be done to effectively and efficiently will look at service uptake, coverage and utilization

9.2.3. Impact Assessment

In assessing impact, focus will be at the extent to which the targets set forth in the M&E framework have been met. Specific measurements will be put on the attainment of the outcomes as defined by the outcome and impact indicators. Issues to be assessed include lessons learned, good practices and sustainability of outcomes attained and replication of interventions.

9.3. Data Management

9.3.1. Data Collection

9.3.2. Key Considerations in Data Collection

Some of the major aspects for good data collection include the following:

1. Knowing the populations of interest e.g. HIV/OVC and TB infected persons, OVC.
2. Outlining the minimal amount of information you will need to collect from the population groups in 1) above
3. Designing an instrument that is not too complicated for the person collecting the data as well as the person responding to the questions
4. Having the administration of the instrument take a reasonable amount of time of the person carrying out the survey and the respondent

9.3.3. Sources of Data

Data for monitoring will be derived from URCS branch records, databases and reports. Activity reports at different levels will provide an important source for monitoring data. Evaluation data for the midterm review and the final impact assessment will be obtained from the databases at the URCS secretariat. Several surveys conducted by URCS and other agencies involved in HIV/AIDS/TB will also aid such assessment.

In linking the M&E framework of the HIV/AIDS Strategic Plan 2011-2015 with that of the URCS Strategic Plan 2011-2015, efforts will be made to ensure that during the process of the annual reviews URCS departments' present reports that are sensitive to the targets and framework of the URCS SP 2011-2015. This therefore requires effective coordination between the URCS secretariat and the various departmental units.

Regarding final evaluation (impact assessment) reporting, it is envisaged that this will be communicated by the URCS secretariat in collaboration with the key development partners and the consulting body.

URCS HIV/OVC&TB STRATEGIC PLAN 2011 - 2015

Annex 1 - Budget

Annex I: Budget

APPROACH	ACTIVITY	BUDGET ITEM / BREAKDOWN	AMOUNT(SHS)
Objective 1: Increase HIV prevention services in the general population and among MARPS in the next 5 years			
1.1 Extend core package of HIV prevention services in general population and for MARPS under the URCS program areas	1.1.1 Provide HCT either as couples or to more first time testers	Transport and Allowances: 15 branches x 12 sessions x 400,000 x 5 yrs	360,000,000 =
	1.1.2. Integrate prevention messages into HCT	Development and distribution expenses: 30,000,000 x 5yrs	150,000,000 =
	1.1.3.Promote correct and consistent use of condoms for the general population and MARPS	Distribution expenses: 15 branches x 36 sessions x 150,000= x 5yrs	405,000,000 =
	1.1.4 Promote use of new technologies and approaches proven to be effective in the general population and for high risky populations – SMC, PMTCT, ART etc	Allowance and transport: 15 branches x 24 sessions x 250,000 x 5 yrs	450,000,000 =
	1.1.5. Promote referral for HIV/AIDS/TB services	Referral Forms : 15 branches x 2,000,000 x 5yrs	150,000,000 =
1.2 Increase awareness and promote behavioral change interventions with focused messages on HIV/AIDS and TB prevention in the general population and among MARPS	1.2.1 Conduct sensitization and awareness campaigns on HIV/AIDS and TB	Refreshments, transport : 120 clubs x 150,000 x 5 yrs	90,000,000 =
	1.2.2. Sensitize the communities on HIV prevention	Refreshments, transport : 120 clubs x 150,000 x 5 yrs	90,000,000 =
	1.2.3. Sensitize the communities on TB prevention	Refreshments, transport : 120 clubs x 150,000 x 5 yrs	90,000,000 =
	1.2.4. Review and update IEC/BCC materials tailored to reach the general population and MARPS & promote other complimentary HIV prevention services	Development and distribution expenses: 30,000,000 x 5yrs	150,000,000 =

Annex 1 - Budget

APPROACH	ACTIVITY	BUDGET ITEM / BREAKDOWN	AMOUNT(SHS)
1.2 Increase awareness and promote behavioral change interventions with focused messages on HIV/AIDS and TB prevention in the general population and among MARPS	1.2.5. Expand peer education/networks/social groups in all URCS branches	Refreshments, transport and drama kits: 120 clubs x 1,200,000 x 5 yrs	144,000,000 =
	1.2.6. Expand life skills and peer networks based HIV education programs for In school youths	Allowances and transport expenses: 15 branches x 24 sessions x 350,000 = x 5yrs	630,000,000 =
	1.2.7. Expand peer networks/life skills training and youth friendly SRH services for Out of schools	Allowance and transport: 15 branches x 24 sessions x 150,000 x 5year	270,000,000 =
	1.2.8. Expand community friendly condom distribution for general population and MARPS	Allowance and transport: 15 branches x 24 sessions x 150,000 = x 5 years	270,00,000 =
	1.2.9 Conduct Condom promotion campaigns using a dynamic mix of channels among the high risk populations	Allowance and transport expenses: 15 branches x 24 visits 350,000 = x 5yrs	630,000,000 =
	SUB TOTAL:		
Objective 2: To improve the psychological, physical and socio-economic wellbeing of PLHIV in the next 5 years			
2.1 Increase and expand uptake to HIV/AIDS and TB treatment, care and support services & strengthen referral systems	2.1.2. Support and expand the provision of HBC	HCFs allowance: 15 branches x 10 x 100,000 x 12 months x 5yrs	900,000,000 =
	2.1.3. Increase provision of complimentary support including nutrition for PHAs and TB patients	Food Supplements: 15 branches x 40,000,000	600,000,000 =
	2.1.4. Increase provision of quality psycho social support services to PHAs	HCFs allowances: 150 HCFs x 50,000 x 12months x 5 yrs	450,000,000 =
	2.1.5. provide minimum package of services for prevention with PLHIV	Procurement and distribution of house hold kits: 6000 kits x 35,000 x 5 years	1,050,000,000 =
	2.1.6. Promote male involvement in HIV/AIDS/TB treatment, care and support services	Allowances: 15 branches x 150,000 x 12 sessions x 5 yrs	135,000,000 =
	2.1.7. Build and implement networks for referrals	Referral Form: 15 branches x 50,000 x 5 years	3,750,000 =

APPROACH	ACTIVITY	BUDGET ITEM / BREAKDOWN	AMOUNT(SHS)	
2.2 Integrate TB screening, infection control and treatment into HIV care	2.2.1. Promote management of TB/HIV co-infected persons	Home Visits: 150 x 12 Visits x 50,000 x 5 years	450,000,000 =	
	2.2.2 Support laboratory HIV diagnosis and treatment	Airtime, transport and allowance: 15 branches x 400,000 x 5 yrs	30,000,000 =	
	2.2.3 Support referral of HIV infected persons treatment and support	Referral Form: 15 branches x 50,000 x 5 years	3,750,000 =	
	2.2.4. Promote male involvement in TB-HIV care and treatment	Allowances: 15 branches x 150,000 x 12 sessions x 5 yrs	135,000,000 =	
	2.3.1. Provide IGAs to affected households	Seed fund: 15 branches x 100 PLHIV X 200,000 X 5 yrs	1,500,000,000 =	
	2.3.2. Scale up access to social economic support to PHAs	Orientation Costs , Allowance and transport expenses: 15 branches x 36 sessions x 500,000 x 5 yrs	1,350,000,000 =	
2.3 Scale up the provision of economic and social support for individuals and families affected by HIV/AIDS and TB	2.3.4. Scale up access to livelihood support to OVC households	Orientation Costs, Allowances, & transport: 15 branches x 2 trainings x 40 OVC x 100,000 = x 5 yrs	600,000,000 =	
	2.3.4. Support community dialogues to address social-cultural and gender norms	Allowances and transport expenses: 15 branches x 24 dialogues x 150,000 x 5yrs	270,000,000 =	
	2.3.5. Promote social and legal intervention for violence against women and girl due to HIV (status disclosure, discordance or sero difference)	Allowances and transport expenses: 15 branches x 24 dialogues x 150,000 x 5yrs	270,000,000 =	
	2.3.6. Conduct community dialogues on HIV/AIDS related discrimination	Refreshments and Allowances: 15 branches x 150,000 x 15 dialogues x 5 yrs	168,500,000 =	
	SUBTOTAL :			

Annex 1 - Budget

APPROACH	ACTIVITY	BUDGET ITEM / BREAKDOWN	AMOUNT(SHS)
Objective 3: To improve the well being of Orphans and Vulnerable Children(OVC) in the next 5 years			
3.1 Ensure the provision of apprenticeship skills and education among OVCs	3.1.1. Identify OVC in need of apprenticeship skills	Transport and allowance: 15 branches x 500,000 x 5 yrs	37,500,000
	3.1.2. Train OVC in apprenticeship	Training expenses: 15 branches x 2 trainings x 7,500,000 x 5 yrs	1,125,000,000 =
	3.1.3. Provide start up kits for OVC trained in apprenticeship	Equipment Costs & transportation: 15 branches x 40 OVC x 800,000 x 5 yrs	2,400,000,000 =
	3.2.1. Provide Counseling Services	Refreshments and Allowances: 15 branches x 150,000 x 15 dialogues x 5 yrs	270,000,000 =
	3.2.2. Conduct Drama and Sports gals	Drama /sport Kits, refreshments & allowances: 15 branches x 20 Clubs x 800,000 x 5 yrs	1,200,000,000 =
	3.2.3. Home Visits to OVC families	HCFs Allowances:150 HCFs x 24 Visits x 50,000 x 5 yrs	180,000,000 =
	3.2.4. Facilitate will writings	Refreshments and Allowances: 15 branches x 36 sessions x 200,000 x 5 years	540,000,000 =
	3.2.5. Facilitate Memory Book Writings	Refreshments & Allowances: 15 branches x 36 sessions x 200,000 x 5 years	540,000,000 =
3.2 Ensure the provision of quality HBC and psycho-social support to OVC infected and affected by HIV /AIDS and TB	3.2.6. Provide Nursing Care	Nursing Kits and Allowances: 15 branches x 36 sessions x 300,000 x 5 years	810,000,000 =
	3.2.7. Provide & monitor Referrals	Referral Form: 15 branches x 50,000 x 5 years	3,750,000 =
	3.2.8. Support Adherence	Refreshments & Allowances: 15 branches x 36 sessions x 60,000 x 5 years	162,000,000 =
	SUB TOTAL:		

APPROACH	ACTIVITY	BUDGET ITEM / BREAKDOWN	AMOUNT(SHS)
Objective 4: To increase TB and Drug/Substances Abuse prevention and treatment support services in the general population and among MARPs (prisoners) in the next 5 years	4.1.1. Train home care volunteers in integrated HIV/AIDS and TB	Training expenses: 15 branches x 5 trainings x 25,000,000	1,875,000,000=
	4.1 Increase up take to TB interventions in the general population and among MARPS	4.1.2. Train families and household members on management of TB in the household	Training expenses: 15 branches x 5 trainings x 15,000,000
4.1.3. Link the trained volunteers to the DOTs to strengthen partnership with the government structures		HCFs allowances: 150 HCFs x 12 visits x 50,000= x 5 yrs	90,000,000=
4.1.4. Carry out home and prison visits		HCFs allowances: 150HCFs x 12 visits x 50,000 x 5 yrs	90,000,000=
4.1.5. Follow up treatment adherence for persons with TB at community level including ex-prisoners still on TB treatment		Transport and allowance expenses: 15 branches x 24 sessions x 175,000 x 5 yrs	52,500,000=
4.1 Increase up take to TB interventions in the general population and among MARPS	4.1.6. Procure Basic household Kits	Procurement and distribution of household kits: 6000 kits x 35,000 x 5 years	1,050,000,00=
	4.1.7. Refer TB patients for Advanced care to health facilities	Referral forms: 15 branches x 50,000= x 5 yrs	3,750,000=
4.2 Integrate TB Screening , infection control and treatment into HIV care	4.2.1. Support community efforts to TB diagnosis	Transport and allowance expenses: 15 branches x 24 sessions x 175,000 x 5 yrs	52,500,000=
	4.2.2. Support referrals of TB infected persons for HIV screening and support	Transport and allowance expenses: 15 branches x 24 sessions x 175,000 x 5 yrs	52,500,000=

Annex 1 - Budget

APPROACH	ACTIVITY	BUDGET ITEM / BREAKDOWN	AMOUNT(SHS)
4.3 Increase uptake of DSA prevention and Harm reduction Interventions among highly risky groups	4.3.1 Provide sensitization on DSA prevention	Refreshments & Allowances: 15 branches x 36 sessions x 200,00 x 5 years	540,000,000 =
	4.3.2. Promote peer education and community dialogue on dangers of DSA	Refreshments & Allowances: 15 branches x 36 sessions x 200,00 x 5 years	540,000,000 =
SUB TOTAL:			
Objective 5: To strengthen the HIV programming systems for URCS and in the general population and among MARPs in the next 5 years			
5.1 Promote awareness on HIV and TB Stigma and discrimination in the communities	5.1.1. Mobilize the communities for Anti-HIV/AIDS/ TB stigma campaigns	Refreshments & Allowances: 15 branches x 36 sessions x 200,00 x 5 years	540,000,000 =
	5.1.2. Produce and distribute IEC materials on stigma and discrimination	15 branches x 5,000 copies x 5000	375,000,000 =
	5.1.3. Conduct anti- stigma and discrimination community dialogue meetings	Refreshments & Allowances: 15 branches x 36 sessions x 200,00 x 5 years	540,000,000 =
	5.1.4.Local Media	Radio Talk shows/Radio Spots: 15 branches x 16 shows x 800,000 x 5 years New Supplements/	960,000,000 =
	5.1.5.Conduct door to door anti stigma campaigns	Refreshments & Allowances: 15 branches x 36 sessions x 200,00 x 5 years	540,000,000 =
5.2 Widen partnerships and Resource mobilization	5.1.6.Develop tool kit for reducing HIV stigma and discrimination	15 branches x 100 Manuals x 25,000 x 5 years	187,500,000 =
	5.2.1.Sign MOU		
	5.2.2.Sharing Reports	Refreshments & Allowances:	
	5.2.3. Conduct and implement Joint activities with other agencies involved in HIV and AIDS/TB.		
	5.2.4.Mobilize resources for intensified HIV programming		
5.2.5.Conduct Stakeholders meeting	Refreshments & Allowances:		

APPROACH	ACTIVITY	BUDGET ITEM / BREAKDOWN	AMOUNT(SHS)
5.3 Enhance URCS human resource capacity in HIV/OVC and TB programming	5.3.1. Conduct training and orientation sessions for URCS human resource		
	5.3.2. Recruitment of more skilled workers on HIV programming		
	5.3.3. Streamline communication systems		
	5.3.4. Recruit and train HBC facilitators		
	5.3.5. Facilitate HBC facilitators		
5.4 Standardize HIV/OVC and TB programming operational procedures	5.4.1. Strengthen and operationalise the M&E system across all HIV and TB implementing branches		
	5.4.2. Scale up and operationalise the HIV/AIDS and TB work place policy across the entire work population of the URCS		
	5.4.3. Develop operating manuals		
	5.4.4. Institutional assistance for improved HIV and AIDS & TB strategy implementation		
5.5 Address harmful socio-cultural and gender norms that increase vulnerability to HIV in the general population	5.5.1. Conduct community dialogues to address factors that impede behavior change and uptake of HIV prevention services	Refreshments & Allowances: 15 branches x 12 sessions x 200,000	180,000,000 =
	5.5.2. Support community leaders to mobilize communities to change cultural norms & practices that perpetuate spread of HIV	Refreshments & Allowances: 15 branches x 12 sessions x 200,000 x 5 years	180,000,000 =
	5.5.3. Support community dialogues to address socio cultural and gender norms	Refreshments & Allowances: 15 branches x 12 sessions x 200,000 x 5 years	180,000,000 =

APPROACH	ACTIVITY	BUDGET ITEM / BREAKDOWN	AMOUNT(SHS)
5.5 Address harmful socio-cultural and gender norms that increase vulnerability to HIV in the general population	5.5.4. Promote social and legal interventions for violence against women and girls due to HIV	Refreshments & Allowances: 15 branches x 12 sessions x 200,000 x 5 years	180,000,000 =
	5.5.5. Advocate for and support effective implementation of policies and laws addressing SGBV and structural drivers of HIV	Transport, Refreshments & Allowances: 15 branches x 12 sessions x 300,000	270,000,000 =
	5.5.1. Conduct community dialogues to address factors that impede behavior change and uptake of HIV prevention services	Transport, Refreshments & Allowances: 15 branches x 12 sessions x 300,000	270,000,000 =
	5.5.2. Support community leaders to mobilize communities to change cultural norms & practices that perpetuate spread of HIV	Transport, Refreshments & Allowances: 15 branches x 12 sessions x 300,000	270,000,000 =
	5.6 Promote HIV Work place	5.6.1. Roll down Work Place Policy within the URCS work population including HIV information sessions & work place peer networks	92,000,000 =
	5.6.2. Procure and IEC/BCC materials/ condoms and provide staff with HI related medical and other support	240,000,000 =	
	5.6.3. Monitor and implement HIV and AIDS Work Place Policy	360,000,000 =	
Sub Total			
Grand Total			

URCS HIV/OVC&TB STRATEGIC PLAN 2011 - 2015

Annex II:
Participants – HIV, OVC & TB
Strategic Plan 2011-2015
Development

Annex2 - Participants

Annex II: PARTICIPANTS – HIV,OVC & TB STRATEGIC PLAN 2011-2015 DEV'T

1.	Michael Richard Nataka	Secretary General
2.	Richard Amadro	Under Secretary General-OD & Institutional Devt.
3.	Dr. Bildard Baguma	Under Secretary General-Program and Projects
4.	Sarah Musisi	Director- Health and Care
5.	Joram musinguzi	Branch Manager Kampala East
6.	Catherine Ntabadde	Assistant Director Communication.
7.	Ai Ogata	Japanese Red Cross Society- Delegate
8.	Poul Henric	Country Director- Danish Red Cross
9.	Alex Ssimbwa	Asst. Director- Community Development.
10.	Levi Byaruhange	Asst. Director- Youth, Volunteer Mgt / Membership Recruitment
11.	Moses Mukuru	Program Manager PMER-Health
12.	Peter Buyondo	Program manager PMER-DM
13.	Lawrence Lutaya	Director. Organizational Development
14.	Prosper Byonanebye	Senior Program Manager- HIV, OVC & TB
15.	Okot Paul Bitex	Program Manager CBHC/FA
16.	Dan Musoke	Program Manager- SMRI
17.	Morris Ayikanying	Senior Program Manager CBHC/FA
18.	Consolatta Aywek	Assistant Program Manager- HIV, OVC & TB
19.	Mugisha Sam	HIV Work Place/RCRC+ Focal Point- URCS
Partner Organizations that participated		
20.	Dr. Ssali	AIDS Information Centre.
21.	Dr. Kotino	Infectious Diseases institute.
22.	Dr. Ocaya	The Aids Support Organization
23.	Stella kentusi- ED	NAFHOPHANU
24.	Mr. Bahram	Uganda National Aids Service Organization
25.	Executive Director	Baylor College of Medicine
26.	Dr. Lydia-ED	Uganda Cares
27.	Executive Director	NACWOLA
28.	Dr. Ochan Wilfred	UNFPA
29.	Dr. Benson	MOH
30.	Dr. Apollo	MOH
31.	Dr. Collins	MOH
32.	Dr. Kyambadde	MOH
33.	Mr. Kalyesubula	MOH (TB)
34.	Dr. Adatu Francis	MOH (TB)
35.	Dr. Jennifer Nabalozza	MOH
36.	Dr. Apuuli Kihuumuro-	Uganda AIDS Commission
37.	Dr. Tigawalana	Uganda AIDS Commission
38.	Deputy E.D / Dr. David	Reach Out Mbuya
39.	CDO/KCCA	Nakawa Division
40.	Lydia/OVC Secretariate	Ministry of Gender, Labour and Social Development

URCS Vision

An empowered, healthy and self-sustaining community that responds to the needs of its most vulnerable

URCS Mission

To be a leading humanitarian agency in Uganda in saving lives, supporting livelihoods and promoting human dignity.

URCS Principles

Humanity,
Impartiality,
Neutrality,
Independence,

Voluntary service,
Unity and,
Universality.

URCS Goal

To reduce the spread of HIV&TB and improve care and support for PLHIV /TB and OVC



Plot 551/555 , Rubaga Road
P.O. Box 494, Kampala - Uganda
Tel: +256 - 41-258701/2 | +256-31-260615/6/7
Fax: +256-41 - 258184
Email: sgurcs@redcrossug.org
www.redcrossug.org