



UGANDA RED CROSS SOCIETY HIV/AIDS & TB STRATEGY 2008-2010



The HIV/AIDS & TB Strategy of 2008-2010 focuses on:

- HIV/TB prevention
- Care for PLWHIV/TB
- Support to Orphans & Vulnerable Children
- Fight HIV/TB stigma and discrimination

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2008

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Foreword

This HIV and AIDS/TB Strategy 2008-2010 adds value to existing URCS HIV response by streamlining programming and implementation. Secondly the Strategy 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. URCS is therefore targeting to promote behavior change especially among the high risk groups that include, persons living in internally displaced peoples' camps, fishing communities, discordant couples and persons in stable relationships.

URCS will also tackle other components of HIV programming on the basis of where the national society has a comparative advantage; a niche to do better and benefit most. As a humanitarian, community based and volunteer run organization, URCS will continue to rely on its army of volunteers to deliver HIV/TB prevention and home based care services to PLHIV and those with TB. URCS will also continue its fight against HIV stigma and discrimination as well as pursuing economic empowerment of the most vulnerable among the PLHIV and OVC.

Allow me to congratulate URCS upon its recognition of the threat of TB and thereby incorporating in its programming a response to TB especially in a unique setting-that of prisons. This new programming is another manifestation of URCS' resolve to compliment rather than compete with the government of Uganda's programs. The Ministry of Health presently requires HIV programming to undertake an HIV/TB collaborative approach which recognizes the reciprocate danger of TB and HIV to persons with either of the two sicknesses. URCS' intervention is timely and will contribute to filling an existing service gap of follow up of ex-prisoners that have TB and who return to the community yet they have not completed their TB drug dose.

As earlier indicated, the formulation of this HIV and AIDS/TB Strategy is a milestone in URCS' HIV response which dates far back to 1987. URCS' HIV response has been supported by and sustained with financial and non-financial resources from various donors and partners among who include Danish Red Cross, Irish Aid, Netherlands Red Cross, Norwegian Red Cross, Hope for African Children, Uganda Government Ministries of Health and Gender, the IFRC, ICRC, JCRC, TASO, AIC and Uganda Cares. Once again I recognize the efforts of our volunteers for keeping URCS' HIV (and indeed other) programs running. As URCS we look forward to a continued support from all our partners and donors.

The HIV epidemic is affecting all of us-young and old, men and women; it therefore requires the contribution of us all to scale down its onslaught. This Strategy represents a commitment by URCS to make its contribution to scaling down that HIV onslaught. The Strategy 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 Strategy 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.



Tom Buruku
Chairman URCS

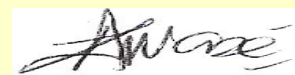
Preface

This is URCS's first HIV/AIDS/TB Strategy. This Strategy is a clear testimony that URCS is not just developing a document but expressing a commitment to do more and to do better. The Strategy 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. As we launch this Strategy we also congratulate ourselves in the growth of our service menu which has now widened to include TB integration into HIV and AIDS programming.

URCS's HIV and AIDS intervention and indeed the development of this Strategy 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 Red Cross, Irish Aid, Netherlands Red Cross, Norwegian Red Cross, Hope for African Children, Ministries of Health and Gender, the IFRC, ICRC, JCRC, TASO, AIC and Uganda Cares, for their kind financial and technical support to us. It is our hope that we will get even more support from the same and other donors to enable us implement this Strategy.

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 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 Strategy.

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

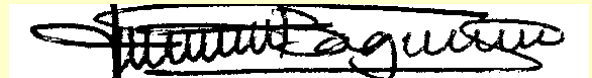


Alice Uwase Anukur
Secretary General URCS

Acknowledgement

Uganda Red Cross Society (URCS) is grateful to all those who participated in the formulation of this HIV and AIDS/TB Strategy 2008-2010. We are thankful of the efforts, time, ideas and experiences of participants that were freely given in the course the strategy 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 Strategy.

We would like to thank the Consultant Mr. Christopher Muhoozi and his team that led the Strategy development process which included consultations with staff, partners and beneficiaries as well as facilitating the Strategy validation workshop.



*Dr. Bildard Baguma
Head of Department, Health and Care*

Acronyms

AIC	-	AIDS Information Center
AIDS	-	Acquired Immune Deficiency Syndrome
ARCHI	-	African Red Cross and Red Crescent Health Initiative
ART	-	Anti-Retroviral Therapy
BDC	-	Blood Donor Club
BDR	-	Blood Donor Recruitment
BFC	-	Branch Field Coordinator
BGB	-	Branch Governing Board
BYC	-	Branch Youth Council
CAO	-	Chief Administrative Officer
CB-DOTS	-	Community Based-Directly Observed Therapy
CBFA	-	Community Based First Aid
CGB	-	Central Governing Board
CSF	-	Civil Society Fund
DHO	-	District Health Officer
DOTS	-	Directly Observed Therapy
GFAMT	-	Global Fund to Fight AIDS, Malaria and Tuberculosis
GoU	-	Government of Uganda
HCP	-	Health and Care Program
HCT	-	HIV Counseling and Testing
HIV	-	Human Immune Deficiency Virus
IDPs	-	Internally Displaced Persons
ICRC	-	International Committee of Red Cross and Red Crescent Societies
IEC	-	Information Education and Communication
IFRC	-	International Federation of Red Cross/Crescent
JCRC	-	Joint Clinical Research Centre
M&E	-	Monitoring and Evaluation
MoH	-	Ministry of Health
MoU	-	Memorandum of Understanding
MTCT	-	Mother-to-Child Transmission
NAFOPHANU	-	National Forum of PLHA Networks in Uganda
NSP	-	National Strategic Plan (for HIV and AIDS)
NYC	-	National Youth council
PLHIV	-	People living with HIV
PMTCT	-	Prevention of Mother to Child Transmission (of HIV)
PTCs	-	Positive Living Clubs
SP	-	Strategic Plan
TASO	-	The AIDS Support Organization
TB	-	Tuberculosis
UAC	-	Uganda AIDS Commission
UNAIDS	-	United Nations Joint Program on AIDS
UNGASS	-	United Nations General Assembly Special Session
URCS	-	Uganda Red Cross Society
VCT	-	Voluntary Counseling and Testing

Executive summary

Introduction and background

This HIV and AIDS/TB Strategy will guide programming of HIV and AIDS/TB control and mitigation activities in the Health and Care department for the period 2008 to 2010. This Strategy has been aligned to the URCS Strategic Plan 2007-2010, the Global Alliance and the National HIV/AIDS Strategic Plan 2007/8–2011/12. The Strategy targets to reach 15 branches up from 10 that are currently targeted. This implies a 50% increase in targeting; thus, 4875 PLHIV/TB will be targeted –up from 3250 and 1650 OVC-up from 1100. The Strategy financing is estimated to cost up to 23,431,235,000 Uganda shillings for the three years.

Rationale for Developing the Strategy

Up until now, the national Society lacked a strategic direction in as far as HIV/TB programming is concerned in a written form. There has not been a compressive study to inform general programming and planning, the few studies that have done are narrow and project based instead, hence limiting possibilities of generating routine program data, designing a harmonized M&E plan, scaled up partnerships, uniform approaches and resource mobilization.

The implication has been that there is a lot of time spent on reporting under different project based formats without standard indicators, coverage in the targeted areas has also been limited; resources for HIV have remained low compared to the need; among others. Similarly proposal development /resource mobilization processes are not straight forward since there is no specific mother document on HIV to refer to

Given the above undesirable situation the program needed to conduct a SWOT and design a program strategy to guide future programming of HIV activities in the Health and Care department for the period 2008 to 2010. The Strategy spells out Monitoring and Evaluation framework to guide implementers in assessing progress towards achievement of Program Objectives in line with URCS Strategic Plan 2007-2010, country HIV strategic plan 2007/11, HIV global alliance strategy 2007-2010, Federation strategy 2010.

Strategy formulation process

The Consultant adopted a participatory methodology to achieve the assignment objectives. The process of developing the Strategy involved stakeholders at both branch and headquarter levels. The process also involved desk review of key documents whose contribution was twofold; (i) to provide input into research instruments or tools and to provide secondary data.

The consultation process covered six branches namely, Kampala South, Soroti, Kitgum, Arua, Luweero and Mbarara¹. All except Mbarara branch were chosen because they are implementing HIV and AIDS program activities. Individuals and groups met were purposively selected on the basis of their role in the URCS and more specifically the Health and Care Program. The

¹ The process in Mbarara was limited to meetings with district and prisons officials, since the branch is not implementing any HIV and AIDS program activity. The branch was randomly sampled out of those whose coverage area include a regional prison

participants in the consultation process included officials at URCS headquarters, partners of URCS at national and branch levels, Branch Field Officers, Members of Branch Governing Boards, Sub-branch Governing Board members, Volunteers and Beneficiaries under the HIV and AIDS programs currently running in their areas. Others were stakeholders from UAC, JCRC, NOFAPHANU, MoH, District officials and the Prisons.

Highlights of the HIV/AIDS/TB Strategy 2008-2010

Goal

URCS contributes to the overriding international (through the Global HIV Alliance) and national (through the Uganda National Strategic Plan for HIV/AIDS) goals. Thus the goal, purpose and objectives are formulated to realize this contribution. The goal is:

To upscale the role of communities in reducing vulnerability to HIV infection and its impact

Purpose

The URCS HIV and AIDS/TB Strategy purpose relays what the latter is actually accountable for, what should result from the successful implementation of its program deliverables/outputs. Thus the purpose is:

To reduce susceptibility to HIV infection and vulnerability to its impact in targeted communities over a three year period

In order for URCS to achieve the purpose stated above and thus contribute to its goal it will implement the following objectives:

1. To contribute to a 40% reduction in the spread of HIV and TB by promoting behavior change among targeted communities, over a three year period
2. To improve the quality of life of PLHIV in targeted communities through economic empowerment, care and psychosocial services at individual and household level
3. To strengthen selected communities in URCS branches to reduce HIV stigma and discrimination
4. To strengthen the capacity of URCS to effectively and efficiently deliver services as per the objectives of this HIV/AIDS/TB Strategy

Strategies

Objective 1: To contribute to a 40% reduction in the spread of HIV and TB by promoting behavior change among targeted communities over a three year period

Strategy 1: Peer education and community mobilization

Strategy 2: IEC for targeted vulnerable groups (fishing communities, people in stable relationships, discordant couples, internally displaced persons and other refugees, prisoners and out of school youth) to address sexual transmission of HIV, faithfulness, PMTCT and HCT/TB detection and treatment

Strategy 3: Skills for personal protection, including condom use

Strategy 4: Support formation and strengthening of existing blood donor clubs to create a pool of repeat donors and ensure safe blood thereby reducing the possibility of transmitting HIV through contaminated blood

Objective 2: To improve the quality of life of PLHIV in targeted communities across 15 URCS branches, through economic empowerment, care and psychosocial services at individual and household level

Strategy 1: Providing treatment and care (home or community based and through health institutions) for PLHIV and networks

Strategy 2: Developing community support groups

Strategy 3: Assisting children and orphans (OVC) made vulnerable by HIV

Strategy 4: Enhancing the socio-economic well being of 50% of the registered households that are affected by HIV/AIDS by the year 2010

Objective 3: Strengthen targeted communities to reduce HIV stigma and discrimination

Strategy 1: Developing community support groups and networks of PLHIV, and partnerships with PLHIV organizations

Strategy 2: Ensuring that all 50 URCS branches have developed and are implementing HIV workplace policy and programs (respectively) for all staff, volunteers and their families

Objective 4: To strengthen the capacity of URCS (Health and Care Department) to effectively and efficiently deliver services as per the objectives of this HIV/AIDS/TB Strategy

Strategy 1: Re-orient URCS implementing staff to current HIV and AIDS/TB programming

Strategy 2: Strengthening program cycle management

Strategy 3: Widening partnerships and expanding resource mobilization

Strategy Implementation and management

The Strategy will be implemented by URCS with support from IFRC Secretariat, the GoU, partner national societies and other donors. The Strategy will be implemented in 15 branches except for the TB in prisons output that will be piloted in two branches that have a region prison in their coverage area. After three years of piloting and subject to the outcome of the post pilot review, the TB in prisons component will be rolled out to cover three more branches bringing the total number covered to five.

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, branches chosen for the implementation of this Strategy, 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. Thus it is of strategic importance that implementation of this strategy should be integrated into the above mentioned Health & Care Departmental programs. 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 (is in conformity) with existing programming for HIV which

requires a basic package for PLWHIV including safe water, improved sanitation and malaria prevention.

The implementation will utilize an existing structure of URCS which stretch from the community level through the branches to the national society head quarters. Using the other computer draw an implementation structure starting with the home care facilitators, coaches, project management committees, project officers and branch field coordinators, regional health and care program officers, HCP headquarters staff, Deputy Secretary General, Secretary General; technical support is from the Federation

Monthly, quarterly and annual monitoring reports will be filed by implementing branches through the regional HCP officers and a consolidated one compiled by the HCP at the headquarters.

M&E tools will be designed and reviewed periodically. Tools to be used by community based volunteers will be designed jointly with them, while branch level tools will be designed jointly with branch and headquarter staff. The URCS M&E Department will ensure that the tools and indicators measured are aligned to the Uganda HIV/AIDS National Strategic Plan, the ARCHI 2010 and in conformity with the Global Alliance targets.

Six months before the end of the Strategy and external evaluation shall be conducted to determine the performance of URCS as per the strategy objectives.

Sustainability

Sustainability of resources-the financial resources will involve a strategy of keeping looking for resources; writing proposals, documenting the successes achieved and sharing them with the public which further strengthens the good image of the national society thus making it easier to reach potential donors who want to start or continue contributing to a good cause. For instance, a good communication strategy to publicize URCS' contribution to safe blood in the country would potentially attract funding to strengthen this strategy output.

Working with partners will help sustain activities that were implemented in such partnerships; when URCS's program intervention ends, the partner(s) continue with the implementation. Among the partners is government-local government level

The strategy period is three years, a period too short to realize meaningful impact and outcomes in target communities. A five year period is proposed as reasonable enough to enable significant progress and improvement in beneficiaries' quality of life. It is therefore suggested that the successor strategy should run for five years instead three. With such programming, individual targeting programs like OVC educational support, agricultural support and small loans can be augmented with community projects which in the long run benefit other vulnerable not reached by the project. Such community projects include rehabilitation and/or construction of safe water points, schools, health units and indoor residual spraying for mosquitoes.

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1.0 Introduction

1.1 Background

Uganda Red Cross Society (URCS) is one of the oldest humanitarian organizations in Uganda. URCS was established by Act of Parliament in 1964, although it existed previously as a branch of the British Red Cross since 1939. In 1965, URCS became a member of the International Federation of the Red Cross and Crescent Societies (ICRC). URCS has 50 Branch Offices across the country.

HIV/AIDS is one of the six program components of URCS' Health and Care Department (HCP). The others are first aid/road safety; water and sanitation; immunization and malaria control, reproductive health and blood donor recruitment. URCS started HIV programming in 1987 with a strong leaning on prevention, a programming approach that did not change until the year 2000. From 2000 to date URCS HIV programs were scaled up to include HIV home care, OVC support and of late TB integration in HIV programming. The URCS HIV/AIDS program has been running under three broad areas of:

1. Improved prevention and reduced spread of HIV
2. Improved wellbeing of PLHIV
3. Improved well being of orphans and vulnerable children (OVC) affected by HIV

1.2 Rationale for the strategy

Until this Strategy was formulated, the national society (URCS) lacked strategic document in as far as HIV/TB programming is concerned. The implication was a lot of time spent on reporting under different project based formats without standard indicators, coverage in the targeted areas was also limited. Similarly proposal development and resource mobilization processes were not straight forward since there was no specific mother document on HIV for reference and guidance. The HCP became reactive instead of proactive in its approach to HIV programming.

The specific objectives guiding the strategy development process were:

1. Conduct a rapid situational analysis in sampled implementing branches
2. Document the strengths, limitations, successes, failures, achievements, (SWOT) and make recommendations
3. Determine which elements of the projects to continue, modify, expand, replicate or discontinue to avoid similar/same mistakes
4. Develop an M&E frame work with baseline data , midterm and final phase targets/milestones at district and sub county levels
5. Develop a Comprehensive 3 year HIV/AIDS/TB Strategic plan 2008-2010 through a participatory process

1.3 Strategy formulation process

The Consultant adopted a participatory methodology to achieve the assignment objectives. The process of developing the Strategy involved stakeholders at both branch and headquarter levels. The process also involved desk review of key documents whose contribution was twofold; (i) to provide input into research instruments or tools and to provide secondary data.

The consultation process covered six branches namely, Kampala South, Soroti, Kitgum, Arua, Luweero and Mbarara². All except Mbarara branch were chosen because they are implementing HIV and AIDS program activities. Individuals and groups met were purposively selected on the basis of their role in the URCS and more specifically the Health and Care Department. The participants in the consultation process included officials at URCS headquarters, partners of URCS at national and branch levels, Branch Field Officers, Members of Branch Governing Boards, Sub-branch Governing Board members, Volunteers and Beneficiaries under the HIV and AIDS programs currently running in their areas. Others were stakeholders from UAC, JCRC, NOFAPHANU, MoH, District officials and the Prisons.

Data collected were analyzed and after a synthesis process, a Draft Strategy document was produced. The Draft Strategy was a basis for discussion in a workshop that involved URCS staff and stakeholders. The workshop debated and suggested areas of improvement in the Draft. A final Strategy document was prepared after the workshop and after incorporating comments of stakeholders who did not participate in the workshop.

Participation by involvement was a key characteristic of the Strategy development process. A consultative workshop was held to present the Draft HIV Strategy and gather additional views to strengthen the same. The workshop brought together URCS staff from different branches and regional officers, as well as head quarter based staff.

1.4 Structure of the strategy

The HIV and AIDS/TB Strategy 2008-210 is aligned to the Uganda NSP (2007-2012) and the Global Alliance Strategy on HIV and AIDS. The Strategy also rhymes with the objectives of the ARCH1 2010 and URCS Strategic Plan 2007-2010.

The URCS HIV and AIDS/TB Strategy has four objectives, three of which reflect the widely accepted key strategic areas for targeting HIV. The three areas include prevention (objective 1), economic support, care and psychosocial support (objective 2), and systems strengthening (objective 4). The fourth objective, although cutting across the first two objectives (1&2), has been made a stand alone, strategically to elevate its importance and underline URCS' recognition of this importance. The fourth (third in write-up) objective targets to reduce HIV stigma and discrimination among the targeted communities.

2.0 Situation analysis

2.1 HIV and AIDS Situation in Uganda

Almost three decades since HIV/AIDS was first reported in Uganda, this epidemic continues to ravage the country. Uganda has a total population of 29 million people; 6.4% of its adult population (15-49) and 0.7% of the children are HIV positive (UAC, 2007). This however is a big leap from the early years of the HIV epidemic (e.g., in 1992) when adult prevalence was reported at 18%. Recent studies show that the number PLHIV in need of ART continues to grow each year for example; 129,000 in 2007 and projected to 238,000 in 2012 –far outstripping the existing capacity to respond (UAC, 2007). The huge increases in population (3.2% per annum in 2006)

² The process in Mbarara was limited to meetings with district and prisons officials, since the branch is not implementing any HIV and AIDS program activity. The branch was randomly sampled out of those whose coverage area include a regional prison

coupled with a high number of new infections are making it extremely difficult for Uganda to stay ahead of the epidemic.

The magnitude of the epidemic has geographic, socio-demographic and economic heterogeneity; women, urban residents especially people residing in Kampala-the capital city of Uganda; central and mid-northern regions are most disproportionately affected. Available evidence shows that the population group most severely affected is no longer that of the young unmarried individuals but older and married or formerly married individuals. Prevalence for women is generally higher than for men at ages 15-49, though at ages 40-44, the male rate is marginally higher than the female rate. At ages 50-59, the pattern reverses and prevalence is slightly higher among men than women. HIV prevalence peaks among women aged 30-34 years and men aged 40-44 years, a shift of five to ten years from the early 1990s, (UAC, 2007).

The socioeconomic picture of the HIV spread shows that urban residents have a significantly higher rate of HIV infection (10.1 percent) than rural residents (6.7 percent) (UAC, August, 2006). This is true for both sexes, though the urban-rural difference is much stronger for women than for men. Prevalence among urban women is 13 percent compared with 7 percent for rural women, and prevalence among urban men is 7 percent compared with 5 percent for rural men. Women and girls are the most affected, yet least served. Women account for 55-60% of cumulative AIDS cases. Women are often unable to negotiate safer sex due to lower status, economic dependence and fear of violence. Moreover, women bear the brunt of caring for sick family members and are more likely to be rejected, expelled from the family home and denied treatment, care and basic human rights.

Available data shows the most vulnerable population groups and which have a high than average risk of HIV infection as, commercial sex workers (CSWs) especially in Kampala City; fishing communities-mainly around the shores of Lake Victoria in central Uganda and Lake George in western Uganda; internally displaced people (IDPs) in northern Uganda; uniformed services³; and people with disability (PWDs).

2.2 Drivers of the epidemic

Sexual transmission accounts for a worrying 76% of new HIV infections (Uganda National Sero-Behavior Survey, 2004/5)⁴. The high rate of HIV transmission through sexual contact is partly attributed to inconsistent and incorrect use of condoms, despite sensitization and awareness raising activities on condom use. Other drivers of HIV spread (sexual transmission) include casual sex, multiple sex partners, extramarital sex, and STI treatment seeking behavior. This picture of the current dynamics of the epidemic in Uganda indicates a relationship between sexual behavior and HIV spread; that more people (and relatively wealthier people, living in urban areas, and married) are engaging in risky sexual behavior. Among other implications, this revelation

³ The current National Strategic Plan (NSP) for HIV and AIDS defines uniformed services as the military community which includes regular forces (infantry, air force and marines, police), spouses and children of uniformed men and women, auxiliary forces (home guards, militias, LDUs), civilian communities surrounding areas of operation and encampments. Conspicuously missing in this definition are persons employed in the prison services

⁴ HIV infection is highest in marital sex (42%), commercial sex workers (21%) and casual sex (14%). Mother to child transmission stands at 22%; while medical injections account for 1% of HIV infection

underpins prevention responses, specifically calling for more effective and individualized approaches targeting behavior change in adult sexual relations.

In the context of the workplace and work related (environmental) causes, the nature of certain jobs inadvertently increases the vulnerability and susceptibility of the workers to contract, or spread the virus amongst their spouses and sexual partners. This is especially true for persons whose jobs involve lots of traveling, spending days away from their regular partners. The chances of an individual worker catching HIV are likely to increase if s/he has money, restricted access to prevention messages, yet operating in the conditions just described above.

2.3 Impact of the epidemic

HIV and AIDS contribute to very high morbidity and mortality rates in Uganda. The cumulative number of AIDS deaths stands at 900,000. 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. The 2002 Population Census found 1,763,300 orphaned children aged 1-17 years in the country. Life expectancy at birth is decreasing, due at least in part to AIDS; current life expectancy considering the impact of AIDS is estimated to be 48/50 years; without AIDS, the projected life span in Uganda would be 55/56 years.

No family has been left untouched. When parents are infected and affected, the girl children often have take up the burden of illness care, leading to a high drop out from school. Early marriages, discrimination, property grabbing and disinheritance are all more common for children in HIV-affected families. There is a growing burden of orphans to be cared for, but the culture of extended family support and fostering by the elderly is being overstretched, so much so that adolescents are sometimes becoming heads of families or being lost to life on the street.

HIV and AIDS also lead to important impacts on human rights including discrimination, stigmatization and other violations. Gender-based human rights violations and HIV-related discrimination aggravate the situation of women and girls, who constitute the majority those currently being infected with HIV.

The debilitating effects of AIDS at the workplace come in the form of loss of skilled workers, absenteeism (related to HIV/AIDS morbidity and mortality), conflicts at workplaces that result from stigmatization and discrimination of PLHIV. Other costs of HIV and AIDS for organizations include depression and low staff morale associated with emotional grief; rising bill on medical expenditure, recruitment and training; which in combination leave organizations struggling with increasing overheads and declining output. This in turn limits the organizations' ability to deliver effectively on their mandates, targets and deadlines.

Increasing the burden of HIV; Tuberculosis-HIV co-infection

There has been a resurgence of tuberculosis, and 60-65% of confirmed TB cases are also HIV infected. Mycobacterium tuberculosis infects a third of the world's population. Uganda is said to be the world's 22 high-burden countries with TB. The country has an estimated annual risk of infection of 3%-equivalent to 150-165 new smear positive TB cases per 100,000 per year. Uganda is

TB Status for Mbarara main prison (as on November 26 2007)

- Total lock 715M; 79F, 15 children
- HIV+ 94M; 9F
- TB cases; 17M; 00F
- TB with HIV 5M
- PLHIV on septrin; 65M; 6F
- PLHIV on ART; 29M; 3F

yet to meet the global detection and treatment success targets of 70% and 85%, respectively.

The interaction of TB and HIV is increasing the burden of both diseases. It is widely acknowledged that HIV presents a massive challenge to the control of TB, while TB is the one of the common causes of morbidity and the leading cause of mortality in PLHIV (MoH, 2006). An estimated 30% of all deaths among PLHIV are attributed to TB (MoH, 2006). In Mbarara district, data from the District TB focal person's office shows that in the month of September 2007, out of 325 persons that had TB, only 233 were tested for HIV and 178 (76%) of those tested positive for HIV.

2.4 Uganda's HIV/AIDS/TB Intervention

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. In the case of specific TB response, in 2006, the GoU (MoH) launched policy 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. However existing funding and consequently interventions have tended to alienate TB instead preferring to focus on HIV and other diseases like malaria.

2.5 URCS' HIV/AIDS Response

URCS' HIV response dates back to 1987 when the national society was implementing programs of HIV prevention and blood safety, a programming approach that did not change until the year 2000 when care, HIV stigma and discrimination and socioeconomic support were added to the programming menu.

As a member of the Red Cross movement URCS subscribes to the views of the Red Cross and Red Crescent Societies, the Global Alliance and the ARCHI 2010. The main aim of the Red Cross and Red Crescent Global Alliance is to scale up the international Federation's efforts in support of national HIV and AIDS program to reduce vulnerability to HIV and AIDS impact, through three programmatic outputs namely, preventing further HIV infection; expanding AIDS care, treatment and support; and reducing AIDS stigma and discrimination.

"URCS has done well on IEC; the first pamphlet I read 20 years ago and which opened my eyes and decided to go for an HIV test and live positively thereafter was a URCS pamphlet"-Male Key informant, NPHAPANU [Nov. 2007]

In the last three years, the national society estimates that it reaches 3 million people annually with HIV prevention messages; has achieved approximately 65% stigma reduction in targeted communities, while 20% of the targeted clients enrolled for ART. Available data at URCS shows that the national society was able to achieve approximately 80% ART treatment adherence among its PLHIV. In terms of socioeconomic support, 25% of the adult clients benefited from a revolving fund for basic self support. Currently the HIV & AIDS program is active in 10 branches taking care of 3250 PLHIV and 1100 OVC, as summarized in table 1.

Table 1: URCS HIV and AIDS Program Implementing Branches⁵

Partner	Implementing branches	PLHIV supported	OVC supported
Netherlands Red Cross	Kampala East, Luweero, Kitgum	1,400	300
Norwegian Red Cross	Kampala South, Katakwi/Soroti	600	-
Development assistance for refugee hosting areas (DAR)	Hoima, Masindi, Arua, Nebbi	800	800
Irish Aid	Arua, Apac	450	-
ICRC –TB under discussion	Mbarara regional prison	-	-
TOTAL		3,250	1100

Over the years, URCS has accumulated experience in managing HIV program activities, an experience that is visible not only at the national level (planning, advocacy and resource mobilization) but also at branch level (coordination, planning, and implementation including community mobilization and M&E). The strength of URCS in HIV programming is also reflected in its strong community base consisting of at least 150,000 members and community volunteers. This strong community base enabled the scale of up OVC activities which was largely due to working with caregivers. Recent approaches in tackling HIV and AIDS have emphasized the active involvement of the community for a successful and meaningful program implementation. 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.

URCS' HIV programming has been devoid of a clear intervention on TB. TB prevention has been embedded, with no specific targets to achieve and indicators to measure. Nevertheless, URCS recognizes the big burden of TB to PLHIV and the threat of HIV to persons with TB. URCS' resolve to make a contribution constitutes a response to the National Policy Guidelines for TB/HIV collaborative activities in Uganda (2006) which lists NGOs as partners in the fight against TB and HIV. The National Policy Guidelines observe that expanding collaborative activities beyond the health sector through involvement of the community is crucially important. During the consultation process for this Strategy, one focal person for TB revealed that his district was finding it challenging to manage TB at the community level, because of the lack of active volunteers.



Some of the Orphans & Vulnerable Children (OVC) receiving scholastic materials from URCS volunteers

Control of TB has been under the community based TB care (CBTC) with direct observed therapy (DOTS). DOTS was rolled out to all districts by the Ministry of Health (MoH), although its

⁵ Most of URCS Branches are composed of several districts. Thus Kitgum branch has Kitgum and Pader districts, Soroti has Amuria as well, Apac has Oyam and Arua has Maracha-Terego. These have been pointed out to show coverage by district as well.

effectiveness at the community level (cell, parish and sub county), is weak. Under DOTS a community health worker (CHW) links the formal health system to communities in their respective sub counties. The CHW conducts community mobilization, facilitates communities through their leaders to select community volunteers (CVs) and trains those selected. The CHW supervises the CVs and replenish their TB drugs fortnightly. The CVs are responsible for referring the TB patients to the health centre for appropriate follow-up sputum testing.

URCS which boasts of a 150,000 membership countrywide, has a niche in taking part in collaborative activities by relying on its pool of community based volunteers, some of who are already volunteering as community volunteers under CB-DOTS. Indeed home based care groups that URCS has under its existing HIV and AIDS program can be involved in identifying people with symptoms and signs of TB, referring them to health facilities for diagnosis and treatment and ensuring directly observed treatment.

Along with community based interventions, URCS drawing from its experience of working with prisoners under its tracing program, but also in cognizance of the vulnerability of persons in such places of confinement to TB and HIV, has planned to extend this TB-HIV collaborative intervention to prisons. In congregate settings like prisons, IDP camps, schools, military and police barracks, there is a high risk of getting infected with TB.

The URCS prisons intervention is borne of the realization of a gap in the TB service provision in prisons, which poses a threat to the community that ex-prisoners return to. Available evidence shows that whereas there is a fairly effective TB detection and treatment system within the prisons, there is no follow up mechanism for ex-prisoners who have not yet completed their TB treatment, to ensure compliance and adherence. At discharge, such prisoners with TB are given a referral letter to the nearest health centre in their home community to introduce them but also enable them to continue with their treatment. The prisons health staff do not have any follow up mechanism beyond this point. They cannot tell whether the referral letter was delivered or not; and whether their former patient continued with treatment or healed. What is more worrying is that it is almost impossible to tell whether such ex-convicts continue with the treatment. Considering that such a letter is more or less confidential, the community is ignorant of the health threat that such a person poses, for them to be provoked into action. The consultation process for this strategy revealed that the community and community leaders are largely ignorant of TB-its prevention and management-which undermines their ability to participate and support TB prevention and management programs.

Inside the prisons, the living conditions for those prisoners living with HIV and TB make them susceptible to the impact of the two sicknesses. Poor nutrition potentially makes prisoners on ART and/or TB drugs less like to adhere, while non-isolation (reportedly due to lack of space) of prisoners diagnosed with TB from the rest of the prisoners is a health risk to those without the disease.

2.6 SWOT of URCS HIV/AIDS Response

Table 2: SWOT of the current URCS HIV and ADS Program

SWOT	WHICH IMPLIES	ACTION NEEDED
STRENGTHS		
<ul style="list-style-type: none"> • A nationwide volunteer network • A rich experience in ensuring donation of safe blood • Availability of blood donor clubs • A home based care system which has a referral component • Ability to reach far and wide; URCS reaches conflict and remote/hard to reach areas 	<ul style="list-style-type: none"> • A strong community mobilization structure and easy reach and access to all beneficiaries in the country especially the youth who constitute the majority of the volunteers • Blood donor clubs ensure a safe source of blood which prevents HIV • Potential for strengthening community structures that respond to HIV prevention, care and treatment • Able to benefit those deprived because of remoteness and conflict 	<ul style="list-style-type: none"> • Developing stronger volunteer motivation strategies • Initiate and support existing blood donor clubs to have a pool of repeat donors • Use the blood donor clubs to reach young people with HIV prevention messages • Communicating the role of donation of safe blood in the prevention of HIV • Developing models/strategies for initiating a wider community role in prevention of HIV, care and treatment for PLHIV • URCS should exploit this comparative advantage and benefit those in need but leaving in remote areas far from service points like the fishing villages and IDP camps
WEAKNESSES		
<ul style="list-style-type: none"> • Weak targeting in the prevention of HIV among the high risk groups • Some volunteers not fully trained in the provision of care and treatment especially for TB • General gap in control the spread and in treatment of TB infection in communities • General weakness in the flow of information and in the communication of performance- M&E tools are not integrated 	<ul style="list-style-type: none"> • Failure to influence the high risk groups' social behaviors in the fight against HIV infection • Stigma is still a problem in the communities; • weak adherence and creation of drug resistance TB infection • In ability to improve approaches towards HIV prevention, care and treatment and social support 	<ul style="list-style-type: none"> • Improve strategies for targeting high risk groups in the prevention of further spread of HIV • Involve all categories in the HIV prevention campaigns so as to reduce stigma and discrimination • Strengthen the community systems and structures to improve TB case detection and treatment; e.g., train volunteers in monitoring and follow up of patients particularly those on TB treatment • Establish benchmarks and targets for performance management.
OPPORTUNITIES		
<ul style="list-style-type: none"> • Positive public attitude towards the activities of the national Society • External recognition of the efforts of the national Society • Existing MoU with MoH, JCRC and general goodwill from the government at the central and local government levels 	<ul style="list-style-type: none"> • Positive response to the national Society activities e.g. for blood donation, volunteer recruitment and charity campaigns • Information sharing and better coordination thus increased efficiency 	<ul style="list-style-type: none"> • Introduce communication strategy aimed at giving the public more information about the activities and the impact of the national society activities

SWOT	WHICH IMPLIES	ACTION NEEDED
THREATS		
<ul style="list-style-type: none"> • High volunteer turn over-'defection' of volunteers to other NGOs that offer better incentives • Dwindling funding opportunities • Challenges in determining achievements and impact • Lack of transport facilitation for referred persons • Inability of partner service providers to provide adequate services to referred persons, especially those living in remote and hard to reach areas, including areas affected by conflict 	<ul style="list-style-type: none"> • In the long term there is likely to be erosion of the core strength of the national Society – "volunteers" • Competition with other NGOs for the dwindling funds • Failure to source more funds for projects and programs • Constrained access to care and treatment for HIV related OIs. The poor are the main victims; results include faster development of full blown AIDS and increase in number of bed ridden cases, increased mortality related to AIDS, increased non adherence and drug resistant cases both among ARV taking persons and those on anti TB drugs 	<ul style="list-style-type: none"> • strengthen the volunteer recruitment and retention program activities • establish strong linkages with other implementers so as to minimize competition • identify the national Society niche achievements and capitalize on these • renegotiation of MoUs to ensure a stronger and better service to those that need it

2.7 Lessons Learnt and Recommendations

Clearly there is a lot that is being done on prevention and indeed other intervention areas for HIV. What is not clear for URCS is the effectiveness of what is being done. Moreover, URCS' response needs to contribute to achieving the national objectives and targets set in the NSP and indeed the objectives of the Global Alliance, to affirm its solidarity with the Red Cross movement and membership of the Federation. The UNAIDS (March 2007) recognizes that in the past prevention efforts have mainly focused on the general populations and thus paying little attention to the subgroups that are at much higher risk of infection. Under the prevention activities, aspects of prevention of mother to child transmission, to blood safety, promoting abstinence, behavior change and condom use are all encouraged.

Very few organizations are engaged in effective behavioral change as a strategy for reducing the spread of HIV infection. The impact of mass campaigns led to a reduction of infection among the youth however, the public was not prepared for the resultant increase in the level of infection among the older groups specifically those within the family unit. Therefore new approaches which are geared towards specific groups of the population and not necessarily mass campaigns on radios or Television are needed.

Seeing that the national society already has a generally accepted volunteer role and draws a positive response from the public URCS is therefore among the best placed organizations to take on the fight against HIV prevention at the local and community level.

However, the national society has to engage the services of very skilled communication specialists to take on the role of designing messages that would appeal and draw a response from the different categories of people in the communities. The consultation process revealed that effective awareness creates high demand for services, yet in some cases the existing services are inaccessible or inadequate or both. One of the most frequently cited case is the constrained access to CD4 testing services. In Mbarara, TB testing was reported constrained by inadequate testing services. In other cases, there is increased demand for HCT, yet reduced service provision-in Mbarara main prison it was revealed that AIC which provides free HCT services for the prison, had taken four months without offering HCT to the prison. In most other areas visited, lack of mobile HCT services and temporary shortage of testing kits were mentioned as drawbacks HCT uptake.

Poverty continues to undermine the effectiveness of most of the programs which require a community/individual contribution that directly or indirectly requires monetary contribution. Thus poverty related reasons are frequently cited as behind poor feeding which is a leading cause of non adherence to treatment (mainly ART).

"Treatment goes with good nutrition, so when you tell someone that they should feed well; they tell you that they do not have that kind of food and do not have the money to buy it"
Female key informant, St. Francis Acumet
HCIII Oditel SC, Amuria

Unfortunately few donors are available to support individual household targeted income improvement programs like small loans projects. On the other hand management and success of such projects has been minimal most often increasing on the vulnerability of the recipient. This is because recipients of such loans are often the poor and vulnerable and have many pressing needs of basic livelihood support, such that repayment of the loan becomes secondary. With no property worth attaching to recover the loan, many a project abandons such projects with a few switching to grants instead of loans. Either way, cash support to the

poor and most vulnerable needs to be approached cautiously, and should be preceded by wide consultations between the beneficiaries and URCS. Where cash support has been successful, the recipients are organized in groups. The money is received and guaranteed by the group (although in some cases utilized individually) rather than by the individual beneficiary of household.

TB intervention is timely, but may not be linked to tracing, since a government initiated structure namely the DOTS already exists. Where DOTS has collapsed, it can be revamped and strengthened where it is weak. Revamping and strengthening can take different forms including recruiting and training new volunteers, as well as giving refresher training to the existing ones. Working with a government structure is largely crucial for ease of buying into TB care and treatment system, but also ensures sustainability of the intervention.

In terms of follow up, URCS will link up with the respective prison through the regional program officer who will then link up with the respective BFC and then the volunteers, jointly with the local health centre where the ex-prisoner will be introduced by URCS, to enable him/her continue with treatment. To buttress the partnership with the health centre(s), URCS through the BFC and regional HCP has to jointly work with the office of the DHO and the district TB focal person. However, this being a relatively new program area, URCS HIV/AIDS program officers will need training in TB/HIV collaborative issues. This training will also cover volunteers involved in the HIV/TB program activities.

The consultation process revealed that there is a lot of need for socioeconomic support among PLHIV and those affected by HIV. URCS ought to remain within the realm of its purse, but more importantly doing that where the impact is greatest. Community based responses are a relevant option for a community based organization like URCS. The national society ought to continue supporting the rural based PLHIV and those affected by HIV with agricultural related packages, while small loans for the urban based seem feasible to boost their incomes and empower them economically to enable them afford life's basic necessities.

Finally, URCS needs to appreciate the gigantic nature of the HIV/TB problem and realize that it cannot do all. This makes effective prioritization more relevant; thus URCS can only focus on where it has a niche but more importantly where it can create an improvement in the life of the target beneficiaries, given the available resources. It is worthwhile observing that the majority of the categories of those at a greater risk of HIV transmission are persons/communities in areas where URCS has comparative advantage-in terms of its geographical spread across the country, but also its community based nature relying on its pool of volunteers. Thus it is feasible for URCS to target IDPs, fishing communities and those in remote areas. Its community based structure also enables to target persons in stable relationships.

Other lessons cited are:

- Resource mobilization is critical for sustainable and wider impact
- Treatment support groups are key in adherence
- Involve PLHIV in program activities
- Treatment literacy is a precondition to adherence

3.0 HIV and AIDS/TB Strategy 2008-2010

The interventions under the Strategy will be in line with the URCS mission, vision and core values

3.1 Vision

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

3.2 Mission

To improve the quality of life of the most vulnerable people in Uganda as an effective and efficient humanitarian organization

3.3 Principles

The seven principles of the Red Cross Movement are: Humanity, Impartiality, Neutrality, Independence, Voluntary service, Unity and Universality.

3.4 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.

3.5 The HIV and AIDS/TB Strategy 2008-2010

3.5.1 Goal

URCS contributes to the overriding international (through the Global HIV Alliance) and national (through the Uganda National Strategic Plan for HIV/AIDS) goals. Thus the goal, purpose and objectives are formulated to realize this contribution. The goal is:

To upscale the role of communities in reducing vulnerability to HIV infection and its impact

3.5.2 Purpose

The URCS HIV and AIDS/TB Strategy purpose relays what the latter is actually accountable for, what should result from the successful implementation of its program deliverables/outputs. Thus the purpose is:

To reduce susceptibility to HIV infection and vulnerability to its impact in targeted communities over a three year period

3.5.3 Objectives

In order for URCS to achieve the purpose stated above and thus contribute to its goal it will implement the following objectives:

1. To contribute to a 40% reduction in the spread of HIV and TB by promoting behavior change among targeted communities over a three year period
2. To improve the quality of life of PLHIV in targeted communities across 15 URCS branches, through economic empowerment, care and psychosocial services at individual and household level

3. To strengthen selected communities to reduce HIV stigma and discrimination
4. To strengthen the capacity of URCS (Health and Care Department) to effectively and efficiently deliver services as per the objectives of this HIV/AIDS/TB Strategy

3.5.4 Specific Outputs/Strategies

Objective 1: To contribute to a 40% reduction in the spread of HIV and TB by promoting behavior change among targeted communities over a three year period

Strategy 1: Peer education and community mobilization

Activities

- 1.1.1 Train youth [15-25] (both in and out of school) and adult men and women (aged between 30-55) in peer education
- 1.1.2 Conduct peer education sessions
- 1.1.3 Organize and support social events for the out of school youth
- 1.1.4 Hold youth holiday camps

Strategy 2: IEC for targeted vulnerable groups (fishing communities, people in stable relationships, discordant couples, internally displaced persons and other refugees, prisoners and out of school youth) **to address sexual transmission of HIV, faithfulness, PMTCT and HCT/TB detection and treatment**

Activities

- 1.2.1 Prepare electronic Media campaigns
- 1.2.2 Development and distribution of IEC materials

Strategy 3: Skills for personal protection, including condom use

Activities

- 1.3.1 Train Youth multipliers in life skills
- 1.3.2 Follow up youth multipliers
- 1.3.3 Condom promotion and distribution

Strategy 4: Support formation and strengthening of existing blood donor clubs to create a pool of repeat donors and ensure safe blood thereby reducing the possibility of transmitting HIV through contaminated blood

Activities

- 1.4.1 Mobilization of communities to donate blood
- 1.4.2 Formation of blood donor clubs

Description of Implementation and management strategy

The HIV is spread mainly through sexual encounters, transfusion of infected blood and sharing of sharp instruments and at birth from mother to child. Objective one of the Strategy aims to influence behavior change through raising awareness on the different and proven methodologies for preventing further spread of HIV and TB among different community members with emphasis on the high risk groups of the community. The high risk groups being targeted are:

- Fishing communities,
- Internally displaced persons and other refugees
- The married and couples
- Out of school youth and
- Prisoners

Different strategic actions have been posited as effective means of reducing the further spread of the epidemic:

1. Promoting delaying sexual debuts for the young boys and girls using the **LIFE SKILLS and the Peer Education** training approach, which integrates HIV and reproductive health information
2. Voluntary Counseling and Testing (VCT) as well as HCT particularly for discordant couples
3. HIV/AIDS at the work place targeting the older men and women and the population groups who are in both formal and informal employment
4. Reducing multiple and concurrent partnerships for both men and women
5. Promotion (including encouraging correct and consistent use of condoms) and distribution of condoms
6. Promoting safe circumcision for men
7. Prevention of Mother to Child Transmission
8. Ensuring donation of safe blood as a way of preventing infection through transfusion of contaminated blood

TB targeting in prisons will initially focus on 2 out of the 15 implementing branches. The two will be pilot sites for three years. After review of the pilot stage, three more sites will be added to have at least one regional prison targeted. TB targeting in the community will be incorporated into all HIV program activities in all 15 implementing branches.

URCS' role in HCT will be to mobilize the community by giving information on the importance of HCT, its availability, accessibility including the cost if applicable.

Objective 2: To improve the quality of life of PLHIV in targeted communities across 15 URCS branches, through economic empowerment, care and psychosocial services at individual and household level

Strategy1: Providing treatment and care (home or community based and through health institutions) for PLHIV and networks

- 2.1.1 Carry out assessment to determine the most vulnerable
- 2.1.2 Train home care volunteers in integrated HIV/AIDS and TB, Malaria and hygiene promotion; link the trained volunteers to the DOTS to strengthen partnership with the government structure
- 2.1.3 Carry out home and prison visits
- 2.1.4 Follow up treatment adherence for persons with TB at community level, including ex-prisoners still on TB treatment
- 2.1.5 Procure basic house hold kits
- 2.1.6 Refer PLHV/TB for advanced care to health facilities.

Some of the food given out as part of the home care activity to PLWHIV.



Strategy 2: Developing community support groups

- 2.2.1 Form and empower positive living clubs (PTCs) for all persons receiving HBC and Palliative care
- 2.2.2 Coach PLHIV in public speaking
- 2.2.3 Establish community friendly condom distribution points
- 2.3.4 Train family/household members in managing HIV and TB in the household

Strategy 3: Assisting children and orphans (OVC) made vulnerable by HIV

- 2.3.1 Support Memory book training
- 2.3.2 Support Will writing for PLHIV
- 2.3.3 Support Apprenticeship training and equipment for out of school youth
- 2.3.4 Provide Educational support to OVC
- 2.3.5 Promote and support sustained vocational and life skills development for OVC
- 2.3.6 Establish and support children's clubs
- 2.3.7 Provide other basic needs (scholastic materials/school fees, food, and clothing e.t.c) of OVC through the establishment of linkages with donors
- 2.3.8 Train OVC peer counselors

Strategy 4: Enhancing the socio-economic well being of 50% of the registered households that are affected by HIV/AIDS by the year 2010

- 2.4.1 Provide livelihood and food support for the most vulnerable PLHIV/TB
- 2.4.2 Periodically assess to determine the neediest PLHIV/TB
- 2.4.3 Train caregivers of OVC and PLHIV/TB in basic farming skills (food security)
- 2.4.4 Procure seeds, animals and other agricultural inputs for targeted PLHIV/TB
- 2.4.5 Train 50% of PLHIV/TB in managing small scale enterprises
- 2.4.6 Avail to 50% of PLHIV/TB with capital funds or inputs to boost their small scale enterprises

Description of Implementation and management strategy

URCS role's role in improving access to better health care for PLHIV/TB will mainly focus on providing community education as well as referral to existing health providers. On the other hand the role of URCS would include the follow up of all those receiving health care to ensure adherence to treatment as way of preventing relapse of infection. The Society will also ensure that there is a system in place for ensuring that all those under their health care program receive regular psycho-social counseling.

The main reason for the provision of social support in the form of income generating activities

is to ensure that families affected by HIV are able to sustain themselves over time.

More particularly the families should be encouraged to save for the future of the children as well to improve the household welfare. Several processes and activities are involved in the initiation and implementation of an income generating component.



Positive Living Club members in Kampala East making hand crafts as an income generating activity.

Among the processes included are:

- Community consultation processes to define the criteria for identifying the beneficiaries, as well as the modalities for managing and supervising the income generating activities
- Identification and validation of beneficiaries.
- Decisions on the type of income generating component to initiate whether it should be a "group or individual household approach"
- What type of assistance should be provided– whether it should be a revolving loan or grant in the form of cash or capital inputs
- Agricultural support will involve seed support among the inputs given. The seeds should be tailored to the nutrition needs of the household as well as ensuring food security.
- What type of micro-enterprises will be supported and over what period of time
- Aspects of monitoring and supervision to minimize misuse of funds/capital as well as to capture lessons/good practices as well as document case studies
- Routine skills training of the beneficiaries so as to ensure proper management of the micro-enterprises.
- The training should incorporate packages on record keeping and savings approaches for both the literate and the illiterate.

The national Society Headquarters will retain the role of establishing linkages with national/regional level actors whereas the branches/volunteer network can where possible establish linkages in and between community systems (FBOs, NGOs and CBOs, private clinics) for the purpose of ensuring that access to HIV/AIDS health care and psycho-social counseling is improved.

Objective 3: Strengthen targeted communities to reduce HIV stigma and discrimination

Strategy 1: Developing community support groups and networks of PLHIV, and partnerships with PLHIV organizations

- 3.1.1 Conduct anti stigma advocacy sessions
- 3.1.2 Mobilize communities for anti HIV stigma campaigns
- 3.1.3 Link support groups with national association of PLHIV networks
- 3.1.4 Produce and distribute anti AIDS related stigma and discrimination IEC materials; this includes documenting and recommending for action on cases of discrimination

Strategy 2: Ensuring that all 50 URCS branches have developed and are implementing HIV workplace policy and programs (respectively) for all staff, volunteers and their families

- 3.2.1 Conduct regular HIV information sessions for staff and volunteers
- 3.2.2 Workplace peer education & awareness sessions
- 3.2.3 Procure and distribute IEC materials and condoms
- 3.2.4 Provide staff and volunteers and their families with HIV related medical and other support
- 3.2.5 Monitor the implementation of HIV and AIDS work place program across all branches

Objective 4: To strengthen the capacity of URCS to effectively and efficiently deliver services as per the objectives of this HIV/AIDS/TB Strategy

Strategy 1: Re-orient URCS implementing staff to current HIV and AIDS/TB programming

- 4.1.1 Train branch staff in HIV/TB program management including managing HIV workplace policy and program
- 4.1.2 Recruit, train and orient (existing) volunteers in HIV/TB program implementation aspects
- 4.1.3 Undertake regular communication of achievement in and between departments as well among the general public

Strategy 2: Strengthening program cycle management

- 4.2.1 Equip all 15 branches implementing activities of the HIV/TB Strategy with office and secretarial hardware to enable them effectively monitor and report as per the Strategy outputs
- 4.2.2 Develop and disseminate M & E tools
- 4.2.3 Carry out monitoring and support supervision with other stake holders
- 4.2.4 Support intra and inter country study trips for staff

Strategy 3: Widening partnerships and expanding resource mobilization

- 4.3.1 Organize Partnership meetings / forums
- 4.3.2 Prepare proposals for funding

Description of management and implementation strategies

- 1 Focus on community capacity building using the community development approaches to improve community capacity to contribute to the program not only as beneficiaries but also as partners at all levels of the cycle.
- 2 Focus on community based volunteers as the main resources for program implementation. The volunteer network shall be broadened and engaged more actively in the implementation process. Continued recruitment and training of volunteers to replace those who drop out
- 3 Partnership and networking with different stakeholders at all levels, including the public sector, the civil society networks and well as the corporate sector. This will involve information sharing, joint micro-planning as well as sharing human and other resources in actual implementation of activities

4.0 Implementation and management framework

4.1 Strategy implementation, monitoring and evaluation

The Strategy will be implemented by URCS with support from IFRC Secretariat, the GoU, partner national societies and other donors. The Strategy will be implemented in 15 branches except for the TB in prisons output that will be piloted in two branches that have a region prison in their coverage area. After three years of piloting and subject to the outcome of the post pilot review, the TB in prisons component will be rolled out to cover three more branches bringing the total number covered to five.

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, branches chosen for the implementation of this Strategy, 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. Thus it is of strategic importance that implementation of this Strategy should be integrated into the above mentioned HCP program components. 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 (is in conformity) with existing programming for HIV which requires a basic package for PLHIV including safe water, improved sanitation and malaria prevention.

The implementation will utilize an existing structure of URCS which stretch from the community level through the branches to the national society head quarters. Using the other computer draw an implementation structure starting with the home care facilitators, coaches, project management committees, project officers and branch field coordinators, regional health and care program officers, HCP headquarters staff-then the Secretary General; technical support is from the Federation

Monthly, quarterly and annual monitoring reports will be filed by implementing branches through the regional HCP officers and a consolidated one compiled by the HCP at the headquarters, (the monitoring plan is attached in annex II)

M&E tools will be designed and reviewed periodically. Tools to be used by community based volunteers will be designed jointly with them, while branch level tools will be designed jointly with branch and headquarter staff. The URCS M&E Department will ensure that the tools and indicators measured are aligned to the Uganda NSP, the ARCHI 2010 and in conformity with the Global Alliance targets.

Six months before the end of the Strategy and external evaluation shall be conducted to determine the performance of URCS as per the strategy objectives.

4.2 Phase out and Sustainability

Sustainability of resources-the financial resources will involve a strategy of keeping looking for resources; writing proposals, documenting the successes achieved and sharing them with the public which further strengthens the good image of the national society thus making it easier to reach potential donors who want to start or continue contributing to a good cause. For instance, a good communication strategy to publicize URCS' contribution to safe blood and behavior change in the country would potentially attract funding to strengthen this strategy output.

Working with partners will help sustain activities that were implemented in such partnerships; when URCS's program intervention ends, the partner(s) continue with the implementation. Among the partners is government-local government level

The strategy period is three years, a period too short to realize meaningful impact and outcomes in target communities. A period of five years is proposed as reasonable enough to enable significant progress and improvement in beneficiaries' quality of life. It is therefore suggested that the successor strategy should run for five years instead three. With such programming, individual targeting programs like OVC educational support, provision of mosquito nets, provision of water treatment chemicals, agricultural support and small loans can be augmented with community projects which in the long run benefit other vulnerable who are not reached by the project. Such community projects include rehabilitation and/or construction of safe water points, schools, health units and indoor residual spraying for mosquitoes

Annex 1: HIV and AIDS/TB Strategy Matrix

Objectives and Strategies	Key Activities/ Interventions	Verifiable Indicators	Expected outcomes	Timeframe
GOAL: To upscale the role of communities in reducing vulnerability to HIV infection and its impact				
PURPOSE: To reduce susceptibility to HIV infection and vulnerability to its impact in targeted communities over a three year period				
Objective 1: To contribute to a 40% reduction in the spread of HIV and TB by promoting behavior change among targeted communities in 15 URCS branches, over a three year period				
Strategy 1: Peer education and community mobilization	Train youth [15-25] (both in and out of school) and adult men and women (aged between 30-55) in peer education	<ul style="list-style-type: none"> Number of youth (both in and out of school), adult men and women attending peer education training sessions 	Reduction in HIV/TB spread related to behavior change among the targeted groups as reflected in: <ul style="list-style-type: none"> Proportion of young boys and girls delaying sexual debuts Increased uptake of VCT as well as HCT particularly for discordant couples Reduction multiple and concurrent partnerships for both men and women Increased correct and consistent use of condoms Safer circumcision for men More adoption of PMTCT Increase in blood donor clubs Percentage reduction in HIV+ cases among blood donors 	Three years
	Conduct peer education sessions	<ul style="list-style-type: none"> Number of peer education sessions held in each implementing branch Proportion of the targeted groups (fishing communities, people in stable relationships, discordant couples, internally displaced persons and other refugees, prisoners and out of school youth) attending/participating in peer education sessions 		
	Organize and support social events for the out of school youth	<ul style="list-style-type: none"> Number of out of school youths participating in social events 		
	Hold youth holiday camps	<ul style="list-style-type: none"> Number of holiday camps held annually 		
Strategy 2: IEC for targeted vulnerable groups (fishing communities, people in stable relationships, discordant couples, internally displaced persons and other refugees, prisoners and out of school youth) to address sexual transmission of HIV, faithfulness, PMTCT and HCT/TB detection and treatment	Prepare electronic Media campaigns	<ul style="list-style-type: none"> Number of media campaigns conducted Number of branches participating Proportion of the targeted risk groups reached 		
	Development and distribution of IEC materials	<ul style="list-style-type: none"> Number and nature of IEC materials produced and distributed Number of branches participating Proportion of the targeted risk groups reached 		
Strategy 3: Skills for personal protection, including condom use	Train Youth multipliers in life skills	<ul style="list-style-type: none"> Number of youths (male & female) trained 		
	Follow up youth multipliers	<ul style="list-style-type: none"> Proportion of the trained youths followed up 		
	Condom promotion and distribution	<ul style="list-style-type: none"> Number of condoms distributed per branch per month 		
Strategy 4: Support formation and strengthening of existing blood donor clubs to create a pool of repeat donors and ensure safe blood thereby reducing the possibility of transmitting HIV through contaminated blood	Mobilization of communities to donate blood	<ul style="list-style-type: none"> Number of blood donor mobilization sessions held per participating branch per month 		
	Formation and follow up of blood donor clubs for blood safety	<ul style="list-style-type: none"> Number of blood donor clubs formed and followed up 		
Objective 2: To improve the quality of life of PLHIV in targeted communities through economic empowerment, care and psychosocial services at individual and household level				
Strategy 1: Providing treatment and care (home or community based and through health institutions) for PLHIV and networks	Carry out assessment to determine the most vulnerable	<ul style="list-style-type: none"> Assessment exercise report for the vulnerable 	Economically empowered individuals and households among targeted groups and	First quarter, 2008
	Train home care volunteers in integrated HIV/AIDS and TB, Malaria	<ul style="list-style-type: none"> Number of home care facilitators trained in integrated HIV/AIDS and TB, Malaria and 		2 nd and 3 rd quarters 2008

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Objectives and Strategies	Key Activities/ Interventions	Verifiable Indicators	Expected outcomes	Timeframe
	and hygiene promotion; link the trained volunteers to the DOTS to strengthen partnership with the government structure	<ul style="list-style-type: none"> hygiene promotion Proportion of trained home care facilitators linked to DOTS 	communities; and better health attributed to increased access to care and psychosocial services in targeted communities	All 3 years
	Carry out home and prison visits	<ul style="list-style-type: none"> Proportion of PLHIV/TB visited in the targeted community and prisons 		
	Follow up treatment adherence for persons with TB at community level, including ex-prisoners still on TB treatment	<ul style="list-style-type: none"> Number of persons (including ex prisoners) being followed per branch per year 		
	Procure basic household kits	<ul style="list-style-type: none"> Number of basic household kits procured Proportion of PLHIV/TB receiving basic household kits 		
	Refer PLHV/TB for advanced care to health facilities	<ul style="list-style-type: none"> Proportion of registered PLHIV/TB referred to health facilities for advanced care, per year 		
Strategy 2: Developing community support groups	Form and empower positive living clubs for all persons receiving HBC and Palliative care	<ul style="list-style-type: none"> Proportion of persons receiving HBC and palliative care that are members of PTCs 	Continuous w.e.f 2 nd quarter 2008	
	Coach PLHIV in public speaking	<ul style="list-style-type: none"> Proportion of registered PLHIV coached in public speaking 		
	Establish community friendly condom distribution points	<ul style="list-style-type: none"> Number of community friendly condom distribution points established per branch 		
	Train family/household members in managing HIV and TB in the household	<ul style="list-style-type: none"> Proportion of registered households per implementing branch trained in managing HIV and TB at the household level 		
Strategy 3: Assisting children and orphans (OVC) made vulnerable by HIV	Support Memory book training	<ul style="list-style-type: none"> Proportion of registered PLHIV per implementing branch participating in memory book training 		
	Support Will writing for PLHIV	<ul style="list-style-type: none"> Proportion of registered PLHIV per implementing branch participating in Will writing 		
	Support Apprenticeship training and equipment for out of school youth	<ul style="list-style-type: none"> Proportion of registered out of school youth per implementing branch participating in apprenticeships 		
	Provide Educational support to OVC	<ul style="list-style-type: none"> Proportion of registered OVC per implementing branch receiving educational support per year 		
	Promote and support sustained vocational and life skills development for OVC	<ul style="list-style-type: none"> Proportion of registered OVC per implementing branch receiving vocational and life skills training 		
	Establish and support children's clubs	<ul style="list-style-type: none"> Proportion of registered OVC per implementing branch participating in children's clubs 		
	Provide other basic needs (food, and clothing e.t.c) of OVC through the establishment of linkages with donors	<ul style="list-style-type: none"> Proportion of registered OVC per implementing branch receiving basic needs support 		
	Train OVC peer counselors	<ul style="list-style-type: none"> Number of OVC counselors trained per branch 		

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Objectives and Strategies	Key Activities/ Interventions	Verifiable Indicators	Expected outcomes	Timeframe
Strategy 4: Enhancing the socio-economic well being of 50% of the registered households that are affected by HIV/AIDS in 15 URCS branches, by the year 2010	2.4.1 Provide livelihood and food support for the most vulnerable PLHIV/TB	<ul style="list-style-type: none"> Proportion of registered PLHIV/TB per implementing branch receiving livelihood and food support per annum 		Continuous w.e.f 3 rd quarter 2008
	Periodically assess to determine the most needy PLHIV/TB	<ul style="list-style-type: none"> Annual assessment exercises covering all implementing branches 		All three years
	Train caregivers of OVC and PLHIV/TB in basic farming skills (food security)	<ul style="list-style-type: none"> Proportion of registered care givers of OVC and PLHIV/TB receiving training in basic farming skills 		2 nd quarter 2008 and 1 st quarter 2010
	Procure seeds, animals and other agricultural inputs for targeted PLHIV/TB	<ul style="list-style-type: none"> Proportion of targeted PLHIV/TB receiving seed, animals and other agricultural inputs 		3 rd quarter 2008 & 1 st quarter 2010
	Train 50% of PLHIV/TB in managing small scale enterprises	<ul style="list-style-type: none"> 50% of registered PLHIV/TB trained in managing small scale enterprises 		2 nd quarter 2008 and 1 st quarter 2010
	Avail to 30% of PLHIV/TB with capital funds or inputs to boost their small scale enterprises	<ul style="list-style-type: none"> 30% of registered PLHIV/TB provided capital funds or inputs to boost their small scale enterprises 		3 rd quarter 2008 & 1 st quarter 2010
Objective 3: Strengthen communities to reduce HIV stigma and discrimination				
Strategy 1: Developing community support groups and networks of PLHIV, and partnerships with PLHIV organizations	Conduct anti stigma advocacy sessions	<ul style="list-style-type: none"> Number of anti stigma advocacy sessions conducted per branch per annum 	HIV/AIDS related stigma and discrimination reduced in targeted communities due to increased community capacity to fight the same	Continuous w.e.f 2 nd quarter of 2008
	Mobilize communities for anti HIV stigma campaigns	<ul style="list-style-type: none"> Proportion of community members in targeted communities participating in anti stigma campaigns 		
	Link support groups with national association of PLHIV networks	<ul style="list-style-type: none"> Number of PLHIV support groups per branch linked with national association of PLHIV network 		
	Produce and distribute anti AIDS related stigma and discrimination IEC materials	<ul style="list-style-type: none"> Number of anti AIDS related stigma and discrimination IEC materials produced and distributed 		
Strategy 2: Ensuring that all 50 URCS branches have developed and are implementing HIV workplace policy and programs (respectively) for all staff, volunteers and their families	Conduct regular HIV information sessions for staff and volunteers	<ul style="list-style-type: none"> Number of HIV information sessions for staff and volunteers conducted per branch per quarter 		
	Workplace peer education & awareness sessions	<ul style="list-style-type: none"> Number of workplace peer education and awareness sessions held per branch per quarter 		
	Procure and distribute IEC materials and condoms	<ul style="list-style-type: none"> Number of IEC materials procured and distributed Number of condoms procured and distributed 		
	Provide staff and volunteers and their families with HIV related medical and other support	<ul style="list-style-type: none"> Number of branches providing their staff and volunteers and their families with HIV related medical and other support 		
	Monitor the implementation of HIV and AIDS work place programs across all branches	<ul style="list-style-type: none"> Number of branches monitored for their implementation of HIV&AIDS workplace program 		
Objective 4: To strengthen the capacity of URCS (Health and Care Department) to effectively and efficiently deliver services as per the objectives of this HIV/AIDS/TB Strategy				
Strategy 1: Re-orient URCS implementing staff to current HIV and	Train branch staff in HIV/TB program management including managing HIV	<ul style="list-style-type: none"> Number of implementing branches who staff have been trained in HIV/TB program 	Stronger capacity of the Health and Care	3 rd quarter 2008

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Objectives and Strategies	Key Activities/ Interventions	Verifiable Indicators	Expected outcomes	Timeframe
AIDS/TB programming	workplace policy and program	management including managing the HIV workplace policy and program	Department as reflected in greater efficiency and effectiveness in strategy implementation	3 rd quarter 2008
	Recruit, train and orient (existing) volunteers in HIV/TB program implementation aspects	<ul style="list-style-type: none"> Number of volunteers recruited and trained in HIV/TB program implementation aspects Number of existing volunteers trained in HV/TB program implementation aspects 		
	Undertake regular communication of achievement in and between departments as well among the general public	<ul style="list-style-type: none"> Number of regular communication items regarding HIV/TB issued by the Health and Care Department to other URCS departments and the general public 		
Strategy 2: Strengthening program cycle management	Equip all 15 branches implementing activities of the HIV/TB Strategy with office and secretarial hardware to enable them effectively monitor and report as per the Strategy outputs	<ul style="list-style-type: none"> Nature of office and secretarial hardware received by all 15 implementing branches 		1 st quarter 2008
	Develop and disseminate M & E tools	<ul style="list-style-type: none"> Nature of M&E tools developed and disseminated in all 15 branches 		1 st quarter 2008
	Carry out monitoring and support supervision with other stake holders	<ul style="list-style-type: none"> Number of monitoring and support supervision conducted jointly with other stakeholders 		Continuous w.e.f 2 nd quarter 2008
	Support intra and inter country study trips for staff	<ul style="list-style-type: none"> Number of inter and intra country study trips for staff supported 		Biannual for three years
Strategy 3: Widening partnerships and expanding resource mobilization	Organize Partnership meetings / forums	<ul style="list-style-type: none"> Number of partnership meetings/forums held per annum 		Annual for three years
	Prepare proposals for funding	<ul style="list-style-type: none"> Number of proposals for funding prepared per annum 		Annual for three years

Annex II: HIV and AIDS/TB Strategy Monitoring Plan

Outputs and Targets	Activities	Indicators	Data Source and means of verification	Frequency of reporting & Responsibility
GOAL: To upscale the role of communities in reducing vulnerability to HIV infection and its impact				
Expected Outcome: reduction in HIV infection and its impact				
Objective 1: To contribute to a 40% reduction in the spread of HIV and TB by promoting behavior change among targeted communities in 15 URCS branches, over a three year period				
Expected result:				
Output 1: Peer education and community mobilization	Train youth [15-25] (both in and out of school) and adult men and women (aged between 30-55) in peer education	<ul style="list-style-type: none"> Number of youth (both in and out of school), adult men and women attending peer education training sessions 	<ul style="list-style-type: none"> Training reports at branch 	Annual; BFC, HIV&AIDS Program Officer Project Officer, HIV Co-ordinator
	Conduct peer education sessions	<ul style="list-style-type: none"> Number of peer education sessions held in each implementing branch Proportion of the targeted groups (fishing communities, people in stable relationships, discordant couples, internally displaced persons ad other refugees, prisoners and out of school youth) attending/participating in peer education sessions 	<ul style="list-style-type: none"> Training reports at branch 	Annual; BFC, HIV&AIDS Program Officer, Project Officer, HIV Co-ordinator
	Organize and support social events for the out of school youth	<ul style="list-style-type: none"> Number of out of school youths participating in social events 	<ul style="list-style-type: none"> Quarterly reports evaluation 	Quarterly; end of three years evaluation BFC, HIV&AIDS Program Officer; HIV Co-ordinator, Consultant/external evaluators
	Hold youth holiday camps	<ul style="list-style-type: none"> Number of holiday camps held annually 	<ul style="list-style-type: none"> Annual reports 	Annually; BFC, HIV&AIDS Program Officer, Project Officer & HIV Co-ordinator
Output 2: IEC for targeted vulnerable groups (fishing communities, people in stable relationships, discordant couples, internally displaced persons ad other refugees, prisoners and out of school youth) to address sexual transmission of HIV, faithfulness, PMTCT and HCT/TB detection and treatment	Prepare electronic Media campaigns	<ul style="list-style-type: none"> Number of media campaigns conducted Number of branches holding campaigns Proportion of the targeted risk groups reached 	<ul style="list-style-type: none"> Annual reports; evaluation 	Annually; end of three years evaluation BFC, HIV&AIDS Program Officer; Consultant/external evaluators
	Development and distribution of IEC materials	<ul style="list-style-type: none"> Number and nature of IEC materials produced and distributed Number of branches participating Proportion of the targeted risk groups reached 	<ul style="list-style-type: none"> Annual reports; evaluation 	Annually; end of three years evaluation BFC, HIV&AIDS Program Officer; Consultant/external evaluators
Output 3: Skills for personal protection, including condom use	Train Youth multipliers in life skills	<ul style="list-style-type: none"> Number of youths (male & female) trained 	<ul style="list-style-type: none"> Training reports at branch 	Annual; BFC, HIV&AIDS Program Officer, Project Officer & HIV Co-ordinator
	Follow up youth multipliers	<ul style="list-style-type: none"> Proportion of the trained youths followed up 	<ul style="list-style-type: none"> Annual reports 	Annual; BFC, HIV&AIDS Program Officer,

Outputs and Targets	Activities	Indicators	Data Source and means of verification	Frequency of reporting & Responsibility
	Condom promotion and distribution	<ul style="list-style-type: none"> Number of condoms distributed per branch per month 	<ul style="list-style-type: none"> Quarterly reports 	Project Officer, HIV Co-ordinator
Strategy 4: Support formation and strengthening of existing blood donor clubs to create a pool of repeat donors and ensure safe blood thereby reducing the possibility of transmitting HIV through contaminated blood	Mobilization of communities to donate blood	<ul style="list-style-type: none"> Number of blood donor mobilization sessions held per participating branch per month 	<ul style="list-style-type: none"> Quarterly reports 	Quarterly, Regional HCP Officer
	Formation of blood donor clubs	<ul style="list-style-type: none"> Number of blood donor clubs formed and followed up 		
Objective 2: To improve the quality of life of PLHIV in targeted communities across 15 URCS branches, through economic empowerment, care and psychosocial services at individual and household level				
Strategy 1: Providing treatment and care (home or community based and through health institutions) for PLHIV and networks	Carry out assessment to determine the most vulnerable	<ul style="list-style-type: none"> Registration list of the most vulnerable per branch 	Assessment report	only once, at inception; BFC, HCP HQrs
	Train home care volunteers in integrated HIV/AIDS and TB, Malaria and hygiene promotion; link the trained volunteers to the DOTS to strengthen partnership with the government structure	<ul style="list-style-type: none"> Number of home care facilitators trained in integrated HIV/AIDS and TB, Malaria and hygiene promotion Proportion of trained home care facilitators linked to DOTS 	<ul style="list-style-type: none"> Training reports Branch annual reports 	Annually; BFC, HIV&AIDS Program Officer, Project Officer, HIV Co-ordinator
	Carry out home and prison visits	<ul style="list-style-type: none"> Proportion of PLHIV/TB visited in the targeted community and prisons 	<ul style="list-style-type: none"> Branch quarterly reports 	Quarterly; BFC, HIV&AIDS Program Officer, Project Officer, HIV Co-ordinator.
	Follow up treatment adherence for persons with TB at community level, including ex-prisoners still on TB treatment	<ul style="list-style-type: none"> Number of persons (including ex prisoners) being followed per branch 	<ul style="list-style-type: none"> Branch quarterly reports 	Quarterly; BFC, HIV&AIDS Program Officer, Project Officer, HIV Co-ordinator
	Procure basic household kits	<ul style="list-style-type: none"> Number of basic household kits procured Proportion of PLHIV/TB receiving basic household kits 	<ul style="list-style-type: none"> HCP quarterly report Branch quarterly reports 	Quarterly; BFC, HIV&AIDS Program Officer, Project Officer, HIV Co-ordinator.
	Refer PLHV/TB for advanced care to health facilities	<ul style="list-style-type: none"> Proportion of registered PLHIV/TB referred to health facilities for advanced care 	<ul style="list-style-type: none"> Branch quarterly reports 	Quarterly; BFC, HIV&AIDS Program Officer, Project Officer, HIV Co-ordinator.
Strategy 2: Developing community support groups	Form and empower positive living clubs for all persons receiving HBC and Palliative care	<ul style="list-style-type: none"> Proportion of persons receiving HBC and palliative care that are members of PTCs 	<ul style="list-style-type: none"> Branch quarterly reports 	Quarterly; BFC, HIV&AIDS Program Officer, Project Officer, HIV Co-ordinator.
	Coach PLHIV in public speaking	<ul style="list-style-type: none"> Proportion of registered PLHIV coached in public speaking 		
	Establish community friendly condom distribution points	<ul style="list-style-type: none"> Number of community friendly condom distribution points established per branch 		
	Train family/household members in managing HIV and TB in the household	<ul style="list-style-type: none"> Proportion of registered households per implementing branch trained in managing HIV and TB at the household level 		
Strategy 3: Assisting children and orphans (OVC) made	Support Memory book training	<ul style="list-style-type: none"> Proportion of registered PLHIV per implementing branch participating in memory book training 		

Outputs and Targets	Activities	Indicators	Data Source and means of verification	Frequency of reporting & Responsibility
vulnerable by HIV	Support Will writing for PLHIV	<ul style="list-style-type: none"> Proportion of registered PLHIV per implementing branch participating in Will writing 		
	Support Apprenticeship training and equipment for out of school youth	<ul style="list-style-type: none"> Proportion of registered out of school youth per implementing branch participating in apprenticeships 	<ul style="list-style-type: none"> Branch quarterly reports 	Quarterly; BFC, HIV&AIDS Program Officer
	Provide Educational support to OVC	<ul style="list-style-type: none"> Proportion of registered OVC per implementing branch receiving educational support 	<ul style="list-style-type: none"> Branch quarterly reports 	Quarterly; BFC, HIV&AIDS Program Officer
	Promote and support sustained vocational and life skills development for OVC	<ul style="list-style-type: none"> Proportion of registered OVC per implementing branch receiving vocational and life skills training 		
	Establish and support children's clubs	<ul style="list-style-type: none"> Proportion of registered OVC per implementing branch participating in children's clubs 		
	Provide other basic needs (scholastic materials/school fees, food, and clothing e.t.c) of OVC through the establishment of linkages with donors Train OVC peer counselors	<ul style="list-style-type: none"> Proportion of registered OVC per implementing branch receiving basic needs support 		
Strategy 4: Enhancing the socio-economic well being of 50% of the registered households that are affected by HIV/AIDS in 15 URCS branches, by the year 2010	2.4.1 Provide livelihood and food support for the most vulnerable PLHIV/TB	<ul style="list-style-type: none"> Number of OVC counselors trained per branch 	<ul style="list-style-type: none"> Training reports 	Annually; BFC, HIV&AIDS Program Officer
	Periodically assess to determine the most needy PLHIV/TB	<ul style="list-style-type: none"> Proportion of registered PLHIV/TB per implementing branch receiving livelihood and food support per annum 	<ul style="list-style-type: none"> Branch quarterly reports 	Quarterly; BFC, HIV&AIDS Program Officer
	Train caregivers of OVC and PLHIV/TB and PLHIV/TB in basic farming skills (food security)	<ul style="list-style-type: none"> Annual assessment exercises covering all implementing branches 	<ul style="list-style-type: none"> Branch quarterly reports 	Quarterly; BFC, HIV&AIDS Program Officer
	Procure seeds, animals and other agricultural inputs for targeted PLHIV/TB	<ul style="list-style-type: none"> Proportion of registered care givers of OVC and PLHIV/TB receiving training in basic farming skills 	<ul style="list-style-type: none"> Training reports 	Annually; BFC, HIV&AIDS Program Officer
	Train 50% of PLHIV/TB in managing small scale enterprises	<ul style="list-style-type: none"> Proportion of targeted PLHIV/TB receiving seed, animals and other agricultural inputs 	<ul style="list-style-type: none"> Branch quarterly reports 	Quarterly; BFC, HIV&AIDS Program Officer
	Avail to 30% of PLHIV/TB with capital funds or inputs to boost their small scale enterprises	<ul style="list-style-type: none"> 50% of registered PLHIV/TB trained in managing small scale enterprises 	<ul style="list-style-type: none"> Training reports 	Annually; BFC, HIV&AIDS Program Officer
		<ul style="list-style-type: none"> 30% of registered PLHIV/TB provided capital funds or inputs to boost their small scale enterprises 	<ul style="list-style-type: none"> Branch quarterly reports 	Quarterly; BFC, HIV&AIDS Program Officer
Objective 3: Strengthen targeted communities to reduce HIV stigma and discrimination				
Strategy 1: Developing community support groups and networks of PLHIV, and partnerships with PLHIV organizations	Conduct anti stigma advocacy sessions	<ul style="list-style-type: none"> Number of anti stigma advocacy sessions conducted per branch 	<ul style="list-style-type: none"> Branch quarterly reports 	Quarterly; BFC, HIV&AIDS Program Officer
	Mobilize communities for anti HIV stigma campaigns	<ul style="list-style-type: none"> Proportion of community members in targeted communities participating in anti stigma campaigns 		
	Link support groups with national association of PLHIV networks	<ul style="list-style-type: none"> Number of PLHIV support groups per branch linked with national association of PLHIV network 		

Outputs and Targets	Activities	Indicators	Data Source and means of verification	Frequency of reporting & Responsibility
	Produce and distribute anti AIDS related stigma and discrimination IEC materials	<ul style="list-style-type: none"> Number of anti AIDS related stigma and discrimination IEC materials produced and distributed 		
Strategy 2: Ensuring that all 50 URCS branches have developed and are implementing HIV workplace policy and programs (respectively) for all staff, volunteers and their families	Conduct regular HIV information sessions for staff and volunteers	<ul style="list-style-type: none"> Number of HIV information sessions for staff and volunteers conducted per branch per quarter 	<ul style="list-style-type: none"> Branch quarterly reports 	Quarterly; BFC, HIV&AIDS Program Officer
	Workplace peer education & awareness sessions	<ul style="list-style-type: none"> Number of workplace peer education and awareness sessions held per branch per quarter 		
	Procure and distribute IEC materials and condoms	<ul style="list-style-type: none"> Number of IEC materials procured and distributed Number of condoms procured and distributed 		
	Provide staff and volunteers and their families with HIV related medical and other support	<ul style="list-style-type: none"> Number of branches providing their staff and volunteers and their families with HIV related medical and other support 		
	Monitor the implementation of HIV and AIDS work place policies across all branches	<ul style="list-style-type: none"> Number of branches monitored for their implementation of HIV&AIDS workplace program 		
Objective 4: To strengthen the capacity of URCS to effectively and efficiently deliver services as per the objectives of this HIV/AIDS/TB Strategy				
Strategy 1: Re-orient URCS implementing staff to current HIV and AIDS/TB programming	Train branch staff in HIV/TB program management including managing HIV workplace policy and program	<ul style="list-style-type: none"> Number of implementing branches who staff have been trained in HIV/TB program management including managing the HIV workplace policy and program 	<ul style="list-style-type: none"> Training reports 	Annually; BFC, HIV&AIDS Program Officer
	Recruit, train and orient (existing) volunteers in HIV/TB program implementation aspects	<ul style="list-style-type: none"> Number of volunteers recruited and trained in HIV/TB program implementation aspects Number of existing volunteers trained in HIV/TB program implementation aspects 	<ul style="list-style-type: none"> Training reports 	Annually; BFC, HIV&AIDS Program Officer
	Undertake regular communication of achievement in and between departments as well among the general public	<ul style="list-style-type: none"> Number of regular communication items regarding HIV/TB issued by the Health and Care Department to other URCS departments and the general public 	<ul style="list-style-type: none"> Branch quarterly reports 	Quarterly; BFC, HIV&AIDS Program Officer
Strategy 2: Strengthening program cycle management	Equip all 15 branches implementing activities of the HIV/TB Strategy with office and secretarial hardware to enable them effectively monitor and report as per the Strategy outputs	<ul style="list-style-type: none"> Nature of office and secretarial hardware received by all 15 implementing branches 	<ul style="list-style-type: none"> Branch annual reports 	Annually; BFC, HIV&AIDS Program Officer
	Develop and disseminate M & E tools	<ul style="list-style-type: none"> Nature of M&E tools developed and disseminated in all 15 branches 		
	Carry out monitoring and support supervision with other stake holders	<ul style="list-style-type: none"> Number of monitoring and support supervision conducted jointly with other stakeholders 		
	Support intra and inter country study trips for staff	<ul style="list-style-type: none"> Number of inter and intra country study trips for staff supported 		
Strategy 3: Widening partnerships and expanding resource mobilization	Organize Partnership meetings / forums	<ul style="list-style-type: none"> Number of partnership meetings/forums held per annum 		
	Prepare proposals for funding	<ul style="list-style-type: none"> Number of proposals for funding prepared per annum 		

Annex III: Budget

APPROACH	ACTIVITY	BUDGET ITEM / BREAKDOWN	AMOUNT(SHS)
OUTPUT 1.0: Further HIV infections prevented			
1.1 Peer education and community mobilization	1.1.1 Train youth, adult men and women in peer education	Training expenses: 15 branches x 2 trainings x 8,500,000= x 3 yrs	765,000,000
	1.1.2 Conduct peer education sessions	Allowance and transport: 15 branches x 24 sessions x 250,000= x 3 yrs	270,000,000
	1.1.3. Organize and support social events for the out of school youth	Sports and drama equipments: 15 branches x 3,500,000=	52,500,000
	1.1.4 Hold youth holiday camps	Camp expenses: 15 branches x 1 camp x 15,000,000= x 3 yrs	675,000,000
1.2 IEC for targeted vulnerable groups	1.2.1 Prepare electronic Media campaigns	Airtime: 15 branches x 3,000,000= x 3yrs	135,000,000
	1.2.2 Development and distribution of IEC materials	Development and distribution expenses: 30,000,000= x 3yrs	90,000,000
1.3 Skills for personal protection, including condom use	1.3.1 Train Youth multipliers in life skills	Training expenses: 15 branches x 14,500,000= x 2 trainings x 3 yrs	1,305,000,000
	1.3.2 Follow up youth multipliers	Allowance and transport expenses: 15 branches x 24 visits 350,000= x 3yrs	378,000,000
	1.3.3 Condom promotion and distribution	Distribution expenses: 15 branches x 36 sessions x 150,000= x 3yrs	243,000,000
1.4 Support formation and strengthening of existing blood donor clubs	1.4.1 Mobilization of communities to donate blood	Allowances and transport expenses: 15 branches x 350,000= x 3yrs	15,750,000
	1.4.2 Formation of blood donor club	Allowances and transport expenses: 15 branches x 350,000= x 3yrs	15,750,000
Sub Total:			3,945,000,000
OUTPUT 2: Expanding HIV treatment, care, and support			
2.1 Providing treatment, support and care (home or community based and through health institutions) for PLHIV and networks	2.1.1 Carry out assessment to determine the most vulnerable	Transport and allowance: 15 branches x 1,000,000= x 3yrs	45,000,000
	2.1.2 Train home care volunteers in integrated HIV/AIDS and TB, malaria and hygiene promotion: link the trained volunteers to the DOTs to strengthen partnership with the government structure	Training expenses: 15 branches x 5 trainings x 21,000,000= x 3 yrs	4,725,000,000
	2.1.3 Carry out home and prison visits including follow up treatment adherence for persons with TB at community level, including ex-prisoners still on Tb treatment	HCFs allowances: 150HCFs x50,000= x 3 yrs	22,500,000
	2.1.4 Procure basic house hold kits	Procurement and distribution of house hold kits: 6000 kits x 35,000=	210,000,000
	2.1.5 Refer PLHV / TB for advanced care to health facilities	Referral forms: 15 branches x 50,000= x 3 yrs	2,250,000
	2.1.6 Conduct community mobilization for and	Transport and allowance expenses: 5 branches x 24 sessions x	63,000,000

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	sensitization about VCT, TB, STIs and PMTCT.	175,000= x 3 yrs	
2.2 Developing community support groups	2.2.1 Form and empower positive living clubs for all persons receiving HBC and palliative care	Refreshments, transport and drama kits: 40 clubs x 1.800,000= x 3 yrs	216,000,000
	2.2.2 Coach PLHIV in public speaking	Airtime, transport and allowance: 15 branches x 400,000= x 3 yrs	18,000,000
	2.2.3 Establish community friendly condom distribution points		
	2.2.4 Train family / household members in managing HIV and TB in the household	Seed fund: 15 branches x 100 PLWHIV X 20,000 X 3 yrs	90,000,000
2.3 Assisting children and orphans (OVC) made vulnerable by HIV	2.3.1 Support Memory book training	Allowance and transport expenses: 15 branches x 36 sessions x 100,000 x 3yrs	162,000,000
	2.3.2 Support Will writing for PLHIV	Training costs: 15 branches x 2 trainings x 20 OVC x 1,000,000= x 3 yrs	1,800,000,000
		Equipment costs: 15 branches x 20 OVC x 800,000 x 3yrs	720,000,000
	2.3.3 Support Apprenticeship training and equipment for out of school youth	Scholastic materials: 18,000 OVC x 200,000	3,600,000,000
	2.3.4 Provide educational support to OVC	Refreshments and sports kits: 15 branches x 2 clubs x 1,500,000 x 3 yrs	135,000,000
	2.3.5 Promote and support sustained vocational and life skills development for OVC	Training expenses: 15 branches x 2 trainings x 21,000,000 x 3 yrs	1,890,000,000
	2.3.6 Establish and support children's clubs		
2.3.7 Provide other basic needs (scholastic materials / school fees, food, and clothing e.t.c.) of OVC through the establishment of linkages wit donors. Train OVC peer counselors			
2.4 Enhancing the socio-economic well being of 50% of the registered households that are affected by HIV/AIDS in 15 URCS branches, by the year 2010	2.4.1 Provide livelihood and food support for the most vulnerable PLHIV / TB	Transport and allowance: 15 branches x 500,000= x 3 yrs	22,500,000
	2.4.2 Periodically assess to determine the most needy PLHIV / TB	Training expenses: 15 branches x 2 trainings x 6,300,000= x 3 yrs	567,000,000
	2.4.3 Train caregivers of OVC and PLHIV / TB in basic farming skills (food security)	Procurement and transportation costs: 6,000 PLHIV x 100,000= x 3 yrs	1,800,000,000
	2.4.4 Procure seeds, animals and other agricultural inputs for targeted PLHIV / TB	Procurement and distribution costs: 6,000 PLHIV x 100,000= x 3 yrs	1,800,000,000
	2.4.5 Train 50% of PLHIV / TB in managing small scale enterprises		
	2.4.6 Avail to 30% of PLHIV / TB with capital funds or inputs to boost their small scale enterprises		
Sub Total			17,888,250,000
OUTPUT 3: Reducing HIV stigma and discrimination			
3.1 Developing community support groups and networks of PLHIV,	3.1.1 conduct anti stigma advocacy sessions		432,000,000
	3.1.2 Mobilize communities for anti HIV stigma campaigns		6,750,000
	3.1.3 Link support groups with national association of PLHIV networks		15,000,000
	3.1.4 Produce and distribute anti AIDS related stigma and discrimination IEC materials		112,500,000

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3.2 Ensuring that HIV in workplace policy and programs for all staff and volunteers are in place in URCS National Societies	3.2.1 Conduct regular HIV information sessions for staff and volunteers	59,400,000
	3.2.2 Workplace peer education & awareness sessions	19,800,000
	3.2.3 Procure and distribute IEC materials and condoms	112,500,000
	3.2.4 Provide staff and volunteers with HIV related medical and other support	32,400,000
	3.2.5 Monitor the implementation of HIV and AIDS work place policy	220,320,000
Sub Total		1,335,390,000
OUTPUT 4: To strengthen the capacity of URCS (Health and Care Department) to effectively and efficiently deliver services as per the objectives of this HIV/AIDS/TB Strategy		
4.1 Re-orient URCS implementing staff to current HIV and AIDS/TB programming	4.1.1 Train branch staff in HIV/TB program management including managing HIV workplace policy and program	33,000,000
	4.1.2 Recruit, train and orient (existing) volunteers in HIV/TB program implementation aspects	9,900,000
	4.1.3 Undertake regular communication of achievement in and between departments as well among the general public	33,000,000
4.2 Strengthening program cycle management	4.2.1 Equip all 15 branches implementing activities of the HIV/TB Strategy with office and secretarial hardware	90,000,000
	4.2.2 Develop and disseminate M & E tools	27,000,000
	4.2.3 Carry out monitoring and support supervision with other stake holders	60,445,000
	4.2.4 Support intra and inter country study trips for staff	15,750,000
4.3 Widening partnerships and expanding resource mobilization	4.3.1 Organize Partnership meetings / forums	15,000,000
	4.3.2 Prepare proposals for funding	4,000,000
Sub Total		262,595,000
Grand Total		23,431,235,000

Annex IV: References

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Annex V: Participants in the Strategy formulation process

Name	Designation & District
Amuria	
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Apolot Dinah	Assistant HIV Focal Person, Amuria Hospital
Akelem Emmanuel	District Planner
Otim Charles	HIV/ AIDS Focal Person
Kababa Dominic	DHO
Eperu Gervase	TB/ Leprosy Focal Person
Acam Bertham	In-Charge St. Francis Acumet HC III
Soroti	
Dr. Oumo John	Medical Coordinator TASO/STI Soroti
Owol Jovanice	In-Charge Uganda Cares Clinic
Kosa Paul	BFC URCS Soroti Branch
	Luwero
Kate Namatovu	Project Officer AMREF (Butuntumura, Kikyusa& Kiboga)
Sewalu Alex	BFC Luwero, URCS Branch Office
Kalyesubula Edward	HIV/AIDS Focal Person
Nabirye Rebecca	Registered Nurse, Assistant In-Charge Butuntumura HC III
Dr. Okware Joseph	DHO Luwero District
Kitgum	
Susan Akol	HIV Project Officer URCS Kitgum Branch
Ogal	Community Development Officer
Akol Susan	Project Officer Kitgum Town Council
Oballim Christopher	Vice Chairperson, BGB
Odipo Martin	Technical Officer Community Services, Northern Uganda Malaria, AIDS & TB Program
Obwono Fielder Obote	Secretary For Health Services
Ojok Thomas	HIV Focal Person
Dr. Charles Okot Lukoya	NPO Disease Control WHO Kitgum Sub-Office
Arua	
Drasi Ronny Mobutu	Field Project Officer, URCS Arua Branch
Jack Kokole Mawa	PHA Network Focal Person
Dr. Anguzu Patrick	District Health Officer
Omua Sam	Acting Coordinator/Manager AIDS Information Centre
Yona Ukoku	BFC URCS Arua Branch
Sr. Abeti Helen	AHAP Coordinator Arua Hospital, Aids Program (AHAP)
Matata Jonathan	Program Manager, NACWOLA Arua
Candia Edward	CDO/ Acting Probation Officer
Ocaatre Ronald	District Health Educator
Onzima Richard	TB/Leprosy Focal Person
Mbarara	
Steven Kabagambe	Regional Program Officer, Health & Care
Namakoye Harriet	Uganda Prison-Mbarara Women Wing
Tom Okullo	Uganda Prison-Ntungamo
Kampala	
Alice Uwase Anukur	Secretary General URCS
Michael Richard Nataka	Deputy Secretary General URCS
Bob Akankwasa	Head of Disaster Management Department URCS

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Bildard Baguma (Dr.)	Head of Health and Care Department URCS
Dan Musoke	Program Officer Monitoring & Evaluation
Prosper Byonanebye	National Program Officer HIV & AIDS/TB
Joram Musinguzi	HIV&AIDS Project Officer, Kampala East
Sarah Musisi	National Program Coordinator HIV & AIDS/TB
Peter Kajula	Head of Planning, Monitoring & Evaluation Department
Catherine Ntabadde	Public Relations Officer
Dr. Madra	Ministry of Health/ACP
Dr. Adatu	Ministry of Health/TB
Joyce Kadowe	Uganda AIDS Commission
Francis Nahamya	AIDS Information Centre
Prossy Namakula	NAPHOPANU
Dr. Nyabwaana	Ministry of Internal Affairs, Prisons Service
Brian Wall	UNAIDS
Dr. Anna Nakanwagi	World Health Organisation
Claire Akun Ntwali	Consultant

**Participants at the URCS HIV and AIDS/TB Strategy Development Workshop
December 18th 2007, Emerald Hotel, Kampala**

Name	Designation	Branch/Organization
Abwang Otim Mike	BFC	Apac
Baguma Bildard	Head of Department	Health & Care, URCS HQrs
Akol Susan	HIV Program Officer	Kitgum
Alex Onzima	Program Officer-OD	Hoima
Barigye G William	BFC	Masindi
Deo Mukii	BFC	Hoima
Emamu John	HIV & AIDS Project Officer	Soroti
Joram Musinguzi	Project Officer, HIV/AIDS	Kampala East
Kabagambe Steven	Regional Program Officer, H&C	Mbarara
Lydia Akello	Regional Program Officer, H&C	Gulu
Masaba Abdu Mulani	Program Officer	Health & Care Dept, URCS HQrs
Mugisha Sam	Volunteer (HIV Workplace)	URCS HQrs
Mukundane Hellen	Regional Program Officer /H& C	Hoima
Musoke Daniel	Program Officer, M& E	URCS HQrs
Nampiima Annet	Project Officer	Kampala South
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Ukoku Yona	BFC	Arua
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Christopher Muhoozi	Lead Consultant	Makerere University
Claire .A .Ntwali	Associate Consultant	Makerere University
Gad Mutaremwa	Rapporteur	Makerere University

Annex VI: Strategy development team

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Volunteers demonstrating how to use a mosquito net.



One Nabitaka Ritah (left) with her family are members of the Kampala South Home Care positive living Club.

Vision

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

Mission

To improve the quality of life of the most vulnerable people in Uganda as an effective & efficient humanitarian organization.



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