Baseline Assessment – Uganda

Scaling up Programs to Reduce Human Rights-Related Barriers to HIV, TB and Malaria Services

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The Global Fund

Disclaimer

Towards the operationalization of Strategic Objective 3(a) of the Global Fund Strategy, *Investing to End Epidemics*, 2017-2022, this paper was commissioned by the Global Fund to Fight AIDS, TB and Malaria and presents, as a working draft for reflection and discussion with country stakeholders and technical partners, findings of research relevant to reducing human rights-related barriers to HIV and TB services and implementing a comprehensive programmatic response to such barriers. The views expressed in the paper do not necessarily reflect the views of the Global Fund.

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Acronym List

AGHA	Action Group for Health Human Rights and HIV/AIDS
AMICAALL	Alliance of Mayors and Municipal Leaders on HIV/AIDS in Africa
ART	Antiretroviral therapy
CBHTC	Community-based HIV testing and care
CBO	Community-based organizations
CCM	Country Coordinating Mechanism
CHAU	Community Health Alliance Uganda
DHO	District health officer
DOTS	Directly observed therapy, short course
FGD	Focus group discussion
FHI 360	Family Health International 360
HIV/AIDS	Human immunodeficiency virus/acquired immune deficiency syndrome
HRAPF	Human Rights Awareness and Promotion Forum
IDI	Infectious Disease Institute
ILO	International Labour Organization
KII	Key Informant Interview
MARPI	Most at Risk Population Initiative
MDR-TB	Multi-drug resistant tuberculosis
MNL	MARPs Network
MoH	Ministry of Health
NACWOLA	National Community of Women Living with HIV/AIDS
NAFOPHANU	National Forum of PLHA Networks in Uganda
NTLP	National Tuberculosis and Leprosy Programme
OST	Opioid substitution therapy
PEPFAR	President's Emergency Plan for AIDS Relief
PITCH	Partnership to Inspire, Transform and Connect the HIV response
PLHIV	People living with HIV
PMTCT	Prevention of mother to child transmission
RHITES	Regional Health Integration to Enhance Services
STI	Sexually transmitted infection
TASO	The AIDS Support Organization
TB	Tuberculosis
UAC	Uganda AIDS Commission
UGANET	Uganda Network on Law, Ethics and HIV/AIDS
UHRC	Uganda Human Rights Commission

UHRN	Uganda Harm Reduction Network
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
WHO	World Health Organization
VHTs	Village Health Teams
WONETHA	Women's Organization Network for Human Rights Advocacy

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Executive Summary

Introduction

Since the adoption of its strategy, *Investing to End Epidemics, 2017-2022*, the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund) has joined with country stakeholders, technical partners and other donors in a major effort to expand investment in programs to remove human-rights related barriers in national responses to HIV, TB and malaria[1]. It has done so because it recognizes that these programs are an essential means by which to increase the effectiveness of Global Fund grants. The programs increase uptake of and retention in health services and help to ensure that health services reach those most affected by the three diseases.

Though it is providing support to all grantees to remove human rights barriers to health services, the Global Fund is providing intensive support over the next five years to 20 countries to enable them to put in place comprehensive programs aimed at significantly reducing these barriers[2]. Based on criteria involving needs, opportunities, capacities and partnerships in country, Uganda has been selected as one of the countries to receive intensive support. This baseline assessment is the first component of the package of support to Uganda and is intended to provide the country with the data and analysis necessary to identify, apply for, and implement comprehensive programs to remove barriers to HIV, TB and malaria services. This assessment: (a) establishes a baseline of human rights-related barriers to HIV, TB and malaria services and existing programs to remove them; (b) sets out a costed, comprehensive program aimed at reducing these barriers; and (c) recommends next steps in putting this comprehensive program in place.

The comprehensive programs proposed are based on the key program areas identified by Governments, UNAIDS and the Global Fund and others as effective in removing human rights-related barriers to HIV services, and on a set of TB and malaria program areas identified as effective in removing human rights-related barriers to TB and malaria services and developed in consultation with TB and malaria experts. These are described in detail in the Global Fund Technical Briefs on these subjects[3] and are set out in the respective program sections below.

Methodology

In October 2017, a literature review of formal and informal literature on the HIV, TB and malaria responses in Uganda was conducted, followed by an in-country assessment. This assessment involved a total of 31 face-to-face and four phone interviews carried out with 44 key informants, and 14 focus group discussions. The respondents included 52 key and vulnerable population members, eight health facility workers and two community health workers. The respondents also included national level senior government officials, including: two from the

[1] *The Global Fund Strategy 2017-2022: Investing to End Epidemics*. GF/B35/02
[2] *Ibid*, Key Performance Indicator 9.
[3] References to Technical Briefs

Ministry of Health AIDS Control Program (MoH/ACP) two from the MoH National TB and Leprosy Program (MoH/NTLP), one from the Uganda AIDS Commission (UAC); and four district health officers. Meetings were also held with the senior management team at MoH, as well as a range of government officials. A standard assessment protocol, developed to be used across the twenty country assessments and standard tools for the key informant interviews and focus groups discussions were used. An Inception Workshop was held with key stakeholders at the beginning of the data collection process to inform them of the assessment process and consult with them on focus areas and key informants. This meeting was also used to fill any gaps in the literature review. Following the fieldwork, a national multi-stakeholder meeting will be held to discuss and validate the findings and consider a longer-term plan for a comprehensive response to the removal of human rights-related barriers to HIV, TB and malaria.

Summary of baseline findings: HIV

Key and vulnerable populations

As recognized by the Government of Uganda in the National HIV and AIDS Strategic Plan (NSP) 2015/16-2019/20, key populations most affected by HIV in Uganda include: people living with HIV, sex workers, fisher folk, long distance truck drivers, uniformed services personnel, boda boda taxi drivers, and other key populations[4]. Groups considered especially vulnerable to HIV in the NSP include adolescent girls and young women, migrant and mobile populations, HIV-discordant couples, pregnant women and people who inject drugs[5].

Barriers to HIV services

The most significant human rights-related barriers identified by key and vulnerable populations and the people who work with them were the following:

a) Stigma and discrimination, based on HIV positive status, or status as a member of a key population. Stigmatizing attitudes and discriminatory practices toward key populations due to moral judgements about their economic activity (sex work) or illegal practices (injecting illicit drugs) are common in the community and at health facilities.
b) Gender inequalities and power dynamics create vulnerabilities for women and adolescent girls, particularly in the context of intimate relationships. Related to this is the incidence of gender-based violence (GBV) in Uganda, which both increases the vulnerability of women to HIV infection and acts as a barrier to seeking and accessing health services.

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[4] As recognized by the Government of Uganda in the National HIV and AIDS Strategic Plan (NSP) 2015/16-2019/20, key populations most affected by HIV in Uganda include: people living with HIV, sex workers, long distance truck drivers, men having sex with men, fisher folk, uniformed services personnel. Among emerging key populations, the NSP lists prisoners, miners, plantation workers, boda boda taxi drivers, brick-layers and salt-extractors.

[5] UAC (2015). National HIV/AIDS Strategic Plan: 2015/2016 – 2019/2020

c) Laws that hinder key population access to HIV services – including laws that criminalize sex work and same-sex sexual relationships and are often associated with police arrests forcing some key population groups to go into hiding. This makes it difficult to estimate the population sizes, and hence there is limited knowledge of the HIV care cascade among key population groups. This can lead to insufficient programming and poor access to quality HIV services.

d) Health facility-level barriers including poor quality services to some key population groups; frequent commodity stock-outs; discriminatory practices or stigmatizing attitudes of the health workers and other patients; and inconvenient opening times.

The ways that these barriers impact key and vulnerable populations are set out in detail in the findings section of this report.

Programs to address human rights-related barriers to HIV services – from existing programs to comprehensive programs

This section summarizes the existing or recent programs that have been implemented in Uganda to remove human rights-related barriers to services and provides a summary of the proposed elements of a comprehensive program[6], based on the seven program areas (PA) set out in the Global Fund *HIV, Human Rights and Gender Equality Technical Brief*.[7]

The seven program areas are:

PA 1: Reducing stigma and discrimination related to HIV

PA 2: Training health care workers on human rights and ethics related to HIV

PA 3: Sensitizing lawmakers and law enforcement agents

PA 4: Legal literacy ("know your rights")

PA 5: HIV-related legal services

PA 6: Monitoring and reforming laws, regulations and policies related to HIV

PA 7: Reducing discrimination against women and girls in the context of HIV

Currently, several non-government and community-based organizations, as well as government entities, are working to some extent to address human rights-related barriers to HIV. However, the programs they implement do not fully cover each Program Area and lack the resources to be implemented at scale. Part of the assessment process involved examining the outcomes and evidence for effectiveness of these existing interventions in order to determine which ones would be appropriate to take to scale.

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[6] Programs to remove human rights-related barriers to services are defined to be *comprehensive* when the *right programs* are implemented *for the right people* in *the right combination* at the *right level of investment* to remove human rights-related barriers and increase access to HIV, TB and malaria services.
[7] Technical *Brief HIV, Human Rights and Gender Equality,* Global Fund to Fight AIDS, TB and Malaria (April 2017)

Summary of existing/recent programs and elements of a comprehensive program

PA 1: Reducing stigma and discrimination related to HIV

Current and recent initiatives to reduce HIV-related stigma and discrimination have included: (1) Training for a variety of populations to increase awareness on stigma and discrimination and promote a safe and healthy environment for people living with HIV and other key and vulnerable populations; (2) local initiatives building capacity of CSOs working with key populations to reach their members and provide counseling, linkage to health facilities and follow up on service uptake; (3) expanding community mobilization, workplace mobilization and awareness creation about effects of stigma and discrimination against key populations or people living with HIV; (4) group-based support for people living with HIV and key populations to overcome stigma and discrimination; (5) advocacy and awareness raising through Crane surveys, PLHIV Stigma Index surveys, community dialogue meetings; and (6) mobilizing key populations, including people living with HIV, through CSOs to provide counseling against stigma.

It is proposed that some of these interventions continue with refinements for some activities and at greater scale for others, as follows:

- Support advocacy and assistance for the finalization of the Uganda AIDS Commission National HIV Anti-stigma and discrimination policy and its associated guidelines, including its expansion to cover stigma based on key population status alone, beyond positive HIV status.
- Integrate training on reducing stigma, discrimination and violence related to HIV into curricula at professional schools for key duty-bearers (i.e. teachers, doctors, nurses, social workers, lawyers, judges) by integrating modules on stigma reduction in the existing curricula. Continue in-service trainings and community leader/stakeholder trainings.
- Integrate training on gender equality and sexuality diversity in professional schools for duty bearers (i.e. doctors, nurses, lawyers, judges, law enforcement agents). Continue in-service trainings and community leader/stakeholder trainings.
- Increase frequency of mass media campaigns, both audio and visual, to reduce stigma and discrimination based on HIV status, social status based on work, as well as to address gender equality issues.
- Support stigma-reduction programmes that use cultural and religious media delivered through large, public events, combined with advocacy and engagement led by key populations. This should be supported and scaled-up throughout the country.
- Repeat the national *PLHIV Stigma Index* and Crane Surveys on a 2-3 year basis to provide updated data for assessing impact of programs to remove human rights barriers to HIV services and ensure funds for follow-up based on findings.
- Establish a national-level monitoring system to capture stigma, discrimination and rights violations experienced by people living with HIV, key populations and people with TB and support redress.

- Support advocacy for expansion of MARPI clinics across the country, or replication of MARPI clinic model of services to sex workers and their clients and other key populations and support the inclusion of human rights training and orientation of those providing such services.

PA 2: Training healthcare workers on human rights and ethics related to HIV

Current and recent initiatives throughout the country to train healthcare providers on human rights and medical ethics have included: (1) mapping and sensitizing health service providers on the human rights of the key populations to support the provision of safer and more efficient services for young members of key populations, including training in identification and response to gender-based violence; and (2) mapping and sensitizing health service providers on human and sexual rights of minorities, as well as encouraging health workers to use the Patient's Charter.

It is proposed that these interventions be strengthened as follows:

- Scale up the in-service training of health workers, health managers as well as other people working in health facilities (e.g. laboratory technicians, receptionists, data clerks) using a harmonized training curriculum to more health facilities.
- Integrate a course in the existing curricula for doctors, nurses and health managers on medical ethics and human rights obligations, by integrating existing curricula with modules on reducing stigma and discrimination related to HIV and TB.
- Support routine assessments (i.e. every 1-2 years) of knowledge, attitudes and practices of health workers towards people living with HIV and/or TB and other key populations to support health facility administrators to identify and address any issues. Healthcare setting-based surveys should be done among providers and exit interviews with key population clients throughout the country with the help of proper guidelines, and follow-up undertaken based on results.

PA 3: Sensitizing lawmakers and law enforcement agents

Current and recent initiatives to sensitize lawmakers and law enforcement agents have included trainings and orientation programs to promote HIV prevention and appropriate policing practices and to sensitize police, law-makers, and other public officials and community influencers about the rights and services for people living with HIV and key and vulnerable populations.

It is proposed that these interventions be expanded as follows:

- Integrate HIV sensitization, stigma and discrimination-reduction and human rights sensitization into curricula at police academies.
- Support in-service trainings for police, judiciary, and prison staff after careful assessment based on need and impact of training.
- Support routine assessments of law enforcement agents' knowledge, attitudes and behaviors towards people living with HIV and/or with TB and other key populations, as

well as addressing gender-based violence, and support police administrators to identify and address any issues.

- Support key population networks to engage with law enforcement to prevent harmful policing practices, such as arresting sex workers and peer educators for carrying condoms and incarcerating people who inject drugs on criminal drug charges instead of referring to harm reduction programs.
- Expand the training for prison personnel to other prisons in the country regarding the prevention, health care needs and human rights of detainees living with or at risk of HIV and TB infection; and key population members.
- Train members of the local council in the rights-based approach to HIV, health and justice, and in sensitizing their communities so they may support the messages conveyed in the legal literacy campaigns.

PA 4: Legal literacy ("know your rights")

Current and recent initiatives to expand legal literacy among people living with HIV and key populations have included: (1) community outreach and campaigns to provide vulnerable communities with HIV information and services related to their legal rights; and (2) training paralegals to sensitize communities about human rights including the right to health, and provide legal aid and support.

It is proposed that current efforts be expanded throughout the country and additional efforts including people living with HIV and/or TB and key populations be added as follows:

- Expand provision of legal advice, awareness raising and "know your rights", including patient's rights, campaigns among key populations and/or in health care facilities to each district, including through deploying cadres of peer human rights educators.
- Support legal literacy and patient's rights education through conducting awareness campaigns and workshops among people living with HIV and/or with TB and other key populations in each district towards mobilizing around health rights and needs. New materials should also be developed and disseminated on patients' rights for women and adolescent girls in maternal and child health (MCH) and prevention of vertical transmission (PVT) clinics.
- Support further mentoring and capacity-building of community service organizations working with people living with HIV and key populations to continue to involve them in HIV service programming and monitoring of health service provision.

PA 5: HIV-related legal services

Current and recent initiatives to provide HIV-related legal services have included: (1) mobile clinics for legal aid to provide people living with HIV and vulnerable communities legal services related to HIV; (2) paralegal capacity-building and mentorship, as well as training of peer educators; (3) training future lawyers and academics on the legal environment relevant to HIV; (4) national efforts to combat discrimination and promote a more successful national response

to HIV; and (5) *pro-bono* legal assistance to key populations and marginalized groups, to counter discrimination in communities and the workplace.

The following activities are suggested:

- Current efforts should be continued and expanded throughout the country. The paralegal officers system should also be expanded to all districts hardest hit by HIV and TB and all prisons in the country.
- Expand legal support, in the form of a pool of lawyers willing and able to work with marginalized populations, and provide supervision and support to paralegals. In this way, all CSOs working with people living with HIV and other key populations have access to affordable or *pro bono* lawyers for casework, legal defense and strategic litigation, where necessary. This could be done through support of a training of a pool of lawyers willing and able to work with marginalized populations and located and/or available to supervise and back up the paralegals in each district. Sensitization of the key populations to use the available free services should also be supported.
- Assessment of access to rights/legal information and to justice for people living with or vulnerable to HIV should be done as part of *PLHIV Stigma Index* surveys and the Crane surveys for sex workers, people who inject drugs and other key populations.

PA 6: Monitoring and reforming laws, regulations and policies related to HIV

Current and recent initiatives to monitor and reform laws, policies, and regulations related to HIV have included: (1) petitions and advocacy against policies, laws, regulations, or guidelines related to key populations that are perceived as punitive or not supportive of access to health services, (2) tracking and supporting the implementation of supportive policies and regulations, (3) formation of leadership hubs for increased involvement in HIV policies, (4) mobilizing community leaders and young people to advocate for HIV policies, and (5) capacity-building of CSOs and grass-roots network of member organizations for policy advocacy for HIV services to implement advocacy activities.

The following activities are suggested:

- Support local networks of people living with HIV and of other key and vulnerable populations to monitor the impact of problematic laws (civil and penal codes) that impede HIV services, as well as any changes in policy and law and advocate for supportive laws and policies as needed. Advocacy efforts can be informed by data from the PLHIV Stigma Index and Crane surveys.
- The Ministry of Health should be supported to establish an office on gender and human rights in health that, among other things, would promote protective laws and policies and their implementation, as well as the reform or updating of problematic laws, practices and policies. In addition, this office would support other key aspects of the comprehensive response, such as the national monitoring and redressal system for stigma, discrimination and rights violations, and the routine assessments of attitudes of healthcare workers in the contexts of HIV and TB.

- Support and increase the capacity of CSOs and networks led by key and vulnerable populations to identify and advocate for protective laws and policies to increase equitable access to quality HIV services for key populations, participate in governance structures that influence health systems and services, and advocate for greater government funding to increase quality of counseling availability of HIV and TB services by well-trained professionals in prison health facilities.

PA 7: Reducing discrimination against women and girls in the context of HIV

Current and recent initiatives to reduce discrimination against women in the context of HIV have included: (1) community awareness campaigns to facilitate open communication around women's sexual and reproductive health, sexuality, stigma reduction and changing harmful gender norms; (2) training for advocacy leaders to support advocacy efforts, create a platform for sharing, and empower women by providing information on HIV, rights and relevant laws; (3) and gender-based violence (GBV) prevention and mitigation through comprehensive integration of multi-disciplinary GBV reduction efforts in targeted districts.

It is proposed that these interventions be continued on a larger scale and refined and added to as follows:

- Support networks of women living with HIV, female sex workers, and women who use drugs to advocate and organize against mistreatment and illegal practices by police and health care providers.
- Support advocacy and engagement with relevant government stakeholders towards the adoption of the Sexual Reproductive Health/elimination of Mother-To-Child Transmission of HIV (SRH/eMTCT) guidelines for women living with HIV that have been developed by NGOs and development partners.
- Expand community-based advocacy and mobilization of people living with HIV to reduce gender-based violence and support redress for survivors of violence using a human rights-based approach. This should include strengthening community structures through training of local council members, village health teams and the police family protection unit to effectively use a human rights approach to GBV and women's inequality more generally.
- Expand current efforts on GBV mitigation and prevention programming to all districts, especially the SASA! Program that has proven effective in reducing GBV and HIV risk behaviors among adolescent girls and young women. Women living with HIV, including young women and adolescent girls, should be involved in the implementation of the activities as peer educators.
- Implement community and school-level campaigns and dialogues to promote gender equality, shift harmful gender norms and reduce gender-based violence and show the relationship between these and vulnerability to HIV and retention in treatment and clinical care.
- Integrate training on gender and sexuality diversity in pre-service and in-service trainings for duty bearers (i.e. doctors, nurses, lawyers, judges, law enforcement agents,

etc.). These efforts can be combined with the training efforts mentioned in PA 1, PA2 and PA3 above.

Investments and proposed comprehensive program costs, 2016 - HIV

In 2016, a total of around 511, 443 USD was invested in Uganda to reduce human rights-related barriers to HIV services. Major funders and allocated amounts for reduction of human rights barriers to HIV services in 2016 were as follows:

Funding source	2016 allocation
AmplifyChange	USD 37,597
UNAIDS	USD 17,915
PEPFAR	USD 258,108
Irish Aid	USD 19,457
GFATM	USD 178,366
Total	**USD 511,443**

Although several funders stated that they were unable to provide exact figures for the amounts allocated to each program area, the assessment team estimated the likely split among program areas by acquiring expenditure data from the funded organizations and matching these to activities under each program area. This gave the following split of funding across program areas to remove human rights-related barriers to services:

HIV Human Rights Program Area	2016
PA 1: Reducing stigma and discrimination related to HIV	USD 262,525
PA 2: Training health care workers on human rights and ethics related to HIV	USD 88,242
PA 3: Sensitizing law-makers and law enforcement agents	USD 8,277
PA 4: Legal literacy (“know your rights”)	USD 10,390
PA 5: HIV-related legal services	USD 0
PA 6: Monitoring and reforming laws, regulations and policies relating to HIV	USD 3,408
PA 7: Reducing discrimination against women and girls in the context of HIV	USD 0
PA 8: Other interventions	USD 138, 602

Total	**USD 511, 443**

The estimated costing for the 5-year comprehensive program is set out in the following table *(to be updated):*

HIV Human Rights Program Area	**Total**
PA 1: Reducing stigma and discrimination related to HIV	USD 2,381,842
PA 2: Training health care workers on human rights and ethics related to HIV	USD 1,150,403
PA 3: Sensitizing law-makers and law enforcement agents	USD 1,294,022
PA 4: Legal literacy ("know your rights")	USD 681,397
PA 5: HIV-related legal services^	USD 1,059,034
PA 6: Monitoring and reforming laws, regulations and policies relating to HIV	USD 553,733
PA 7: Reducing discrimination against women girls in the context of HIV	USD 4,342,787
Program management (22,07%)	USD 2,529,932
M&E (1,21%)	USD 138,705
Research (2,96%)	USD 339,311
Total	USD **14,471,166**

Summary of baseline findings: TB

Key and vulnerable populations

The Government of Uganda recognized the following populations as most vulnerable to TB in in the National TB and Leprosy Program (NTLP) National Strategic Plan (NSP) 2015/16 to 2019/20: prisoners, police officers, internally displaced persons, residents of crowded urban and peri-urban slums and people living with HIV. During the baseline assessment, key informants suggested other populations that are vulnerable to TB, including heath workers, sex workers, people who inject drugs, miners and prison workers.

Barriers to TB services

Based on the research conducted for this assessment, the most significant human rights-related barriers identified by key and vulnerable populations and the people who work with them were the following:

a) Punitive laws, policies, and practices that could attract police harassment and discrimination from the public
b) Stigma and discrimination
c) Health facility-level barriers
d) TB-related barriers in prisons

The ways that these barriers impact key and vulnerable populations are set out in detail in the findings section of this report.

Programs to address barriers to TB services – from existing programs to comprehensive programs

There were only a few programs identified that address human rights-related barriers to TB services in Uganda. Most of the key informants that were interviewed, including government officials, had little understanding of human rights-related barriers to TB services. For those who did recognize human rights-related barriers, they did not perceive these barriers to have a significant effect on the delivery of TB services in the country. This in and of itself is a barrier to reducing human rights-related barriers to TB services.

This section summarizes the few existing programs identified that aimed to remove human rights-related barriers to TB services and the proposed elements of a comprehensive program, based on the ten program areas (PAs) set out in the Global Fund Technical Brief *Tuberculosis, Gender and Human Rights*.[8]

The ten program areas are:

PA 1: Reducing stigma and discrimination

PA 2: Reducing gender-related barriers to TB services

PA 3: TB-related legal services

PA 4: Monitoring and reforming policies, regulations and laws that impede TB services

PA 5: Know your TB-related rights

PA 6: Sensitization of law-makers, judicial officials and law enforcement agents

PA 7: Training of health care workers on human rights and ethics related to TB

PA 8: Ensuring confidentiality and privacy

[8] Technical Brief *Tuberculosis, Gender and Human Rights,* Global Fund to Fight AIDS, TB and Malaria (April 2017)

PA 9: Mobilizing and empowering patient and community groups

PA 10: Programs in prisons and other closed settings

Summary of elements of a comprehensive program

Key stakeholders suggested that several activities in the comprehensive plan should be developed and implemented jointly by the HIV and TB sectors, and that these activities should be cost-shared. Key activities are summarized below.

PA 1: Reducing stigma and discrimination

No past or existing programs to address stigma and discrimination related to TB in Uganda were identified.

Elements of a comprehensive response in this area would include:

- Integrate TB-related stigma concerns into National Anti-Stigma and Discrimination Policy. Expand content to include TB-related stigma and develop TB-specific guidelines, including workplace guidelines
- Integrate TB-related stigma, discrimination and human rights concerns into the stigma and discrimination-reduction curricula mentioned above under PA 1 for HIV.
- Develop and conduct national TB Stigma research to collect more information on effects of stigma and discrimination on TB services in Uganda. The study should have a module for health facility-based health workers.
- Support community level structures, such as CSOs/CBOs, to implement stigma reduction campaigns. Train village health teams (VHTs) and community health education workers (CHEWs) to sensitize the communities about TB (i.e. what causes TB, how it is transmitted, and whether it can be cured, etc.) and the causes/effects of TB-related stigma and discrimination.
- Increase frequency of mass media campaigns, both audio and visual, to reduce stigma and discrimination based on HIV and TB status, increase awareness on laws and policies protecting the rights of people living with HIV and/or with TB, and reduce fear of infection and subsequent avoidance behavior.
- Support stigma-reduction programmes to use religious and cultural media delivered through large, public events, combined with advocacy and engagement led by key and vulnerable populations, including ex-TB patients.
- Expand desk guide for diagnosis and management of TB in children to include guidelines on stigma reduction counselling for families and children.

PA 2: Reducing gender-related barriers to TB services

There were no formal programs reported through the fieldwork to remove gender-related barriers to TB services.

Elements of a comprehensive program in this area would include:

- Develop, implement and evaluate strategies to reduce gender-related barriers to TB services in Uganda. This would include conducting a gender analysis of the current setup for provision of services and extending existing peer-led approaches that use gender-specific interpersonal communication to encourage access and utilization of TB services. This could also include advocacy for financial or other assistance to support women's care roles while they are away from home obtaining TB treatment.
- Advocate with MOH to reorganize the delivery of TB and HIV services to ensure that services are sensitive to gender issues to maximize health outcomes. For women, this would include establishing gender-sensitive TB and HIV diagnostic and treatment services. For men, this would include identifying a set of entry points into broader work being done to improve men's health seeking behaviors and integrating awareness of TB symptoms and treatment into these. For example, including information to support men to overcome the vulnerabilities of women and girls to TB and to reduce stigma and discrimination based on TB.

PA 3: TB-related legal services

There were no legal services specifically in place for people living with or vulnerable to TB. However, both Human Rights Awareness and Promotion Form (HRAPF) and Uganda Network on Law, Ethics and HIV/AIDS (UGANET) paralegal officers and legal aid services serve marginalized populations and can be utilized by people with TB.

Elements of the proposed comprehensive program in this area include:

- Develop a system to provide legal services to TB patients for legal issues relating to their TB status. This would include training and support to peer paralegals currently working with people living with HIV and other key populations to provide TB-related legal advice at the community level for people living with or vulnerable to TB, among key populations and/or in health facilities, as well as support to sufficient lawyers to supervise these paralegals and provide legal representation where needed.
- Expand the number of paralegals linked with CBOs and NGOs working to support people living with HIV and TB. Train new paralegals on issues specific to people with TB, as well as people living with HIV.

PA 4: Monitoring and reforming policies, regulations and laws that impede TB services

There are no laws or policies in Uganda that directly impede access or utilization of TB services. However, due to high co-infections of TB and HIV, some laws and policies that impede access or utilization of HIV services may indirectly impede access to TB services. Further, regulations about isolation of suspected TB cases in enclosed settings, such as prisons, exist. UGANET has also provided support to prisoners in 13 Prison Units since 2014, where they sensitized prison staff and helped to improve practices that were limiting the right to health services for prisoners.

The following elements of the proposed comprehensive program should be considered.

- Conduct an assessment of the impact on vulnerability to TB and uptake of TB services of current policies and laws regarding isolation and compulsory treatment (in the community, prisons, schools) as well as sentencing laws and policies that lead to overcrowding of prisons and substandard conditions
- Support to CSOs and networks to conduct joint advocacy and lobbying for TB infection control and regulatory reform based on findings from the assessment of current policies and laws noted above.

PA 5: Legal literacy or Know your TB-related rights
There were no formal programs identified that aimed to increase awareness of TB-related rights

Elements of the comprehensive program in this area would include:

- Empower the current community structures, such as VHTs, CHEWs, local council, religious and cultural leaders, to include legal literacy and patient's rights education related to TB in their communications and train some people affected by TB as peer educators to empower communities with information on patient rights, knowledge of TB transmission and remission and stigma reduction.
- Support TB peer educators to train members of the local councils and VHTs in providing information on "know your rights" related to TB.
- Empower local CSOs/CBOs especially those working with people living with HIV and key populations with TB-related legal literacy and patient rights, in addition to reduction of TB-related stigma.

PA 6: Sensitization of lawmakers, judicial officials and law enforcement agents

Training on human rights, TB and stigma for judges across sub-Saharan Africa has been implemented previously to improve judges' knowledge and awareness about health and human rights and inform the decisions they make in cases where these issues are relevant. While none of the key informants interviewed reported improper or stigmatizing treatment from lawmakers, judicial officials or law enforcement agents specific to their TB status, such training may be helpful in the Uganda context, particularly in terms of ensuring the right to health of prisoners with TB.

Elements of the comprehensive program in this area would include:

- Support in-service training for law enforcement officers, judiciary, prison staff, and policy makers, by: updating existing training curricula on HIV for police and law students to include TB, focusing on aspects that promote supportive, accepting, and responsive services for those vulnerable to or affected by TB; funding and implementing in-service trainings for police, members of judiciary, and prison staff on HIV and TB policies, key populations, responsible and supportive policing in the context of HIV and TB and reduction of illegal police practices; and expanding the training for prison

personnel regarding the prevention, health care needs and human rights of detainees living with or at risk of HIV and TB infection.

PA 7: Training of health care workers on human rights and ethics related to TB

Current and recent initiatives identified were focused on training health workers on medical ethics in relation to TB.

Elements of the comprehensive program in this area would include:

- Integrate TB-related human rights and medical ethics concerns into training curriculum for health workers, health managers, as well as other people working in health facilities (e.g. laboratory technicians, receptionists, data clerks).
- Support routine assessments of health workers' knowledge, attitudes and behaviors towards people living with HIV and people with TB and support health administrators to identify and address any issues.
- Support in-service training of health-workers and health managers in hard hit areas on human rights and medical ethics relevant to HIV and TB services.
- Train health facility managers to implement routine surveys of health care worker attitudes about people with TB to inform training needs and policy changes at the facility-level.

PA 8: Ensuring confidentiality and privacy

Confidentiality and privacy are important for preventing stigma and discrimination among people with TB and people living with HIV. However, no programs were identified that focused specifically on these topics.

Elements of the comprehensive program in this area would include:

- Conduct a service provision assessment at a range of health facilities throughout the country of the modalities of TB and HIV service delivery to determine whether procedural changes are needed to minimize the identification of people with TB and people living with HIV that would amount to disclosure of confidential information.

PA 9: Mobilizing and empowering patient and community groups

No programs were identified that aimed to empower patient and community groups in relation to TB.

Elements of the proposed comprehensive program in this area would include:

- Support the formation of networks of people affected by TB and CSOs/CBOs that support them to advocate for human and patient rights related to TB, issues around gender inequality that increase vulnerability to TB, and rights to protective work places. CBO stakeholder meetings would explore creating/supporting networks and expanding CBO engagement in TB-related human rights work.

- Train CBO(s) on TB-related advocacy issues and support them to conduct community sensitization about types of support available to people with TB through the CBO(s) and advocate for the rights of people with TB, including the need for the development of work place policies on TB management and infection control, and patient compensation.
- Support effective advocacy, communication and social mobilization to improve engagement of communities, including ex-TB patients and elderly TB patients, to improve case finding and combat stigma and discrimination.
- In Karamoja, engage and support cultural leaders, herbalists and religious leaders through sensitization and trainings, as part of an outreach model to the communities and as a way to reduce stigma and discrimination and disputes related to TB.

PA 10: Programs in prisons and other closed settings

The current programs and initiatives identified in prisons and other closed settings included: (a) a peer educator model, (b) outreach services by nearby health facilities, and (c) legal aid services for people with TB and people living with HIV.

Elements of the comprehensive program in this area would include:

- Support CBOs/CSOs working on prisoners' rights to increase advocacy and interventions for prisoners related to TB, such as nutrition for people living with HIV and/or TB
- Support a national-level assessment of human rights-related vulnerabilities and barriers that are relevant to TB and HIV to fully elucidate the situation in prisons. This assessment should examine protection from dangerous and substandard living conditions leading to TB and HIV, including lack of adequate nutrition, sanitation and access to HIV and TB prevention and treatment services; protection from discrimination and violence, including sexual violence; and protection from discriminatory and arbitrary isolation based on health status.
- Support advocacy for increased investments in improved TB service delivery in the prisons through improving the prison conditions that are risk factors for TB acquisition or transmission and improving health facility structures and practices, and also through expanded integrated outreach models.

Investments and proposed comprehensive program costs 2016 - TB

In 2016 a total of around 37,400 USD was invested in Uganda to reduce human rights-related barriers to TB services. The GFATM was the only funder in 2016. The total amount was split across three program areas, as depicted in the following table:

TB Human Rights Program Area	2016
PA 1: Reducing stigma and discrimination	USD 0

PA 2: Reducing gender-related barriers to TB services	USD 4,800
PA 3: TB-related legal services	USD 0
PA 4: Monitoring and reforming laws, regulations and policies relating to TB services	USD 0
PA 5: Knowing your TB-related rights	USD 0
PA 6: Sensitization of law-makers, judicial officials and law enforcement agents	USD 4,600
PA 7: Training of health care workers on human rights and medical ethics related to TB	USD 28,000
PA 8: Ensuring confidentiality and privacy	USD 0
PA 9: Mobilizing and empowering patient and community groups	USD 0
PA 10: Programs in prisons and other closed settings	USD 0
Total	**USD 37,400**

The estimated costing for the 5-year comprehensive program is set out in the following table *(to be updated):*

TB Human Rights Program Area	**Total**
PA 1: Reducing stigma and discrimination	USD 1,372,559
PA 2: Reducing gender-related barriers to TB services	USD 480,202
PA 3: TB-related legal services	USD 620,532
PA 4: Monitoring and reforming laws, regulations and policies relating to TB services	USD 297,979
PA 5: Knowing your TB-related rights	USD 619,929
PA 6: Sensitization of law-makers, judicial officials and law enforcement agents	USD 446,918
PA 7: Training of health care workers on human rights and medical ethics related to TB	USD 515,957
PA 8: Ensuring confidentiality and privacy	USD 54,018

PA 9: Mobilizing and empowering patient and community groups	USD 1,776,966
PA 10: Programs in prisons and other closed settings	USD 134,037
Program management (22,07%)	USD 1,394,625
M&E (1,21%)	USD 76,461
Research (2,96%)	USD 187,045
Total	USD **7,977,229**

Summary Baseline Findings: Malaria

Vulnerable and underserved populations

The National Malaria Reduction Strategic Plan indicates that children under five and pregnant women are the most vulnerable to malaria, while noting that the entire population of Uganda is at risk. In the interviews conducted as part of the baseline assessment, however, several other vulnerable populations were identified in addition, including: refugees, the mobile population in Karamoja (notably due to nomadic life and civil instability), people living with HIV, older persons and prisoners.

Barriers to malaria services

In discussions with key informants, including focus groups with communities, it became evident the barriers below affect access to primary healthcare generally, and the malaria response, as a critical part of primary healthcare:

a) While there is no stigma associated with having malaria, stigma and discrimination based on age, ethnicity, socio-economic status, health status including real
b) or perceived HIV positive status, and other grounds limits access to primary healthcare generally, and to malaria services specifically, by vulnerable and underserved populations. This stigma can be internalized or experienced within the community and/or from healthcare providers.
c) Gender inequality, including decision-making power at household level, occupational exposure, higher burden of household chores, and gendered preferences in care-seeking behavior
d) The voices and concerns of some affected populations, including prisoners, refugees, and mobile populations in Karamoja, are not heard and accounted for in programme decision-making, and these populations may not be well informed about services.
e) Broader barriers to access to health services, including inadequate access to information resulting from low literacy rates, limited coverage of services in hard-to-reach areas such

as dry and mountainous parts of Karamoja, and high poverty levels in some parts of the country.

Programs to Address Human Rights-Related Barriers to Malaria Services

The five program areas are:

PA 1: Reducing gender-related barriers and harmful gender norms

PA 2: Promoting meaningful participation of affected populations in program decision-making and implementation

PA 3: Strengthening of community systems for participation in malaria programs

PA 4: Improving services in prison and pretrial detention.

PA 5: Improving access to services for refugees and others affected by emergencies

The few programs addressing some aspect of human rights-related barriers to accessing basic services, of which malaria is a crucial part, are identified are listed in the following sections.

PA 1: Reducing gender-related discrimination and harmful gender norms

Current and recent initiatives in Uganda to reduce harmful gender norms included: (1) community awareness campaigns to facilitate open communication around decision-making about health at household level and health-related seeking behavior; and (2) and gender-based violence (GBV) prevention and mitigation through comprehensive integration of multi-disciplinary GBV reduction efforts in targeted districts. While the latter efforts are not specifically linked to the malaria responses, prevention and response to GBV are important for gender empowerment and hence affect health-seeking decision making, and as such, represent an important health sector response.

Elements of the comprehensive program in this area would include:

- Conduct operational research to explore gender and health dynamics as relevant to malaria and develop a gender analysis framework.
- Based on the results from the gender assessment/operational research, strengthen the capacity of key malaria stakeholders, managers, and data analysts to understand, prioritize, and use gender-related information in efforts against malaria and to mainstream gender issues at all levels of malaria program design, implementation, and evaluation.
- Involve young men and women meaningfully in promoting malaria prevention and control, and in broader advocacy and education around the gender-related vulnerabilities to malaria through participatory approaches such as peer education initiatives.
- Support or expand efforts such as SASA! aimed at empowerment of both men and women at the community level, especially targeting decision-making at household level about health care and health-seeking behavior. Develop and implement educational sessions on human and gender-related barriers to malaria services alongside those on malaria

symptoms and care, with messages targeted at different groups including mothers, pregnant women, men, fathers, male and female adolescents, and schoolchildren. These sessions could focus not only on early recognition of malaria, but could also encourage prevention, more equitable household decision-making and the sharing of caregiving activities. (costed under PA 7 for HIV as malaria would only be a small component of the main intervention).

PA 2: Promoting meaningful participation of affected populations

Current programs or initiatives include community level dialogues and engagement of the VHTs and health unit management committees.

Elements of the comprehensive program in this area would include:

- Create a system for mapping, identifying, and engaging hard-to-reach, minority and socially disadvantaged populations that are vulnerable to malaria, especially on the islands and mountainous areas of Karamoja. Sensitize and engage the local religious or cultural structures within these areas to promote community-level dialogues and integration of feedback into service delivery.
- Support the implementation of a community scorecard assessment of quality at the health facility-level for malaria services.
- Develop and implement educational sessions/SBCC on human and gender-related barriers to primary healthcare, including malaria services alongside those on malaria symptoms and care, with messages targeted at different groups including mothers, pregnant women, men, fathers, adolescent girls and boys, and schoolchildren. These sessions could focus not only on early recognition of malaria, but could also encourage prevention and more equitable household decision-making, as noted under PA 2.

PA 3: Strengthening community systems for participation in malaria programs

Current programs or initiatives included management and capacity building of local CSOs/CBOs and VHT system.

Elements of the comprehensive program in this area would include:

- Strengthening VHT system through trainings, supportive supervisions, and provide funds for facilitation and village level activities, regarding promotion of access to non-discriminatory care, patients' rights, rights/legal literacy
- Strengthening the capacity of health unit management committees and local CBOs and supporting them to hold community-level dialogues on vulnerability to and access to prevention, diagnosis and treatment of malaria, including human rights and gender-related barriers.

PA 4: Malaria programs in prisons and pre-trial detention

There were no programs noted by key informants for those in closed settings (including both prisoners and pre-trial detainees).

Elements of the comprehensive program in this area would include:

- Support advocacy or other efforts to ensure that malaria services in prison are overseen and given technical support by health ministries
- Develop and implement prevention and case management services for both men and women in prison
- Support advocacy for improved malaria service programming and delivery in prisons and other closed settings
- Support advocacy for training and targeted measures to ensure that malaria prevention and control supplies are rolled out in prisons.

PA 5: Improving access to services for underserved populations, including for refugees and others affected by emergencies

Poverty, social and geographic exclusion, harmful gender norms and financial barriers are just some of the many health determinants that disproportionally affect people's wellbeing, bringing severe hardship and ill health to underserved and marginalized groups. People living in fragile settings or affected by conflicts, such as refugees and internally displaced people often experience deprivation of basic healthcare services, linked to discrimination or lack of security. Research has found that marginalized populations can be particularly vulnerable to malaria and face barriers to accessing health services, including those for malaria.

Guiding principles of The Uganda Malaria Reduction Strategic Plan include equity and non-discrimination, as well as universal coverage for all populations, including vulnerable populations such as children under the age of five, pregnant women, people living with HIV, internally displaced populations and refugees.

Current programs or initiatives included behavior change communication, with messages through radios and community-level dissemination by the VHTs; and HIV and malaria integrated services at the health facilities. The messages promote the availability of malaria services without discrimination at the health facility level.

Some recommendations include:

- In the framework of High Burden to High Impact action planning and response, further assess people's ability to access and utilize healthcare services, ensure that no one is left behind, irrespective of who and where they are, and consider the root causes of health inequity across different contexts, populations and groups of individuals.
- Develop guidelines for integrated service delivery that includes non-discriminatory equitable access
- Integrated service delivery with a patient-centered approach

While programs to improve access to malaria services for refugees and others affected by emergencies are recommended in the Global Fund Technical Brief, those conducting this assessment were not able to conduct any interviews in refugee settings in Uganda nor meet with refugee experts. Therefore, this assessment has no specific recommendations for programs to address malaria services in refugee settings. It is hoped that the multi-stakeholder meeting will represent an opportunity to address this limitation.

Comprehensive program costs - malaria

Programs to remove human rights-related barriers to primary healthcare services, and specifically to malaria services, can and should be integrated in the overall planning and delivery of effective responses. The estimated costs outlined below could be reduced significantly through effective human rights-based approaches to the malaria vector control and case management, as wells as specific preventative interventions. However, it is recognized that appropriate funding and staffing are needed for the National Malaria Control Program, including securing expertise geared at ensuring equity in addition to traditional technical expertise, to reorient program delivery to reach those most underserved, and ensure Universal Health Coverage.

The estimated costing for the 5-year comprehensive program is set out in the following table:

Malaria Human Rights Program Area	
PA 1: Reducing gender-related barriers and harmful gender norms	USD 481.776
PA 2: Promoting meaningful participation of affected populations in program decision-making and implementation	USD 596,503
PA 3: Strengthening of community systems for participation in malaria programs	USD 1,213,710
PA 4: Improving services in prison and pre-trial detention	USD 2,251,598
PA 5: Improving access to services for refugees and others affected by emergencies	USD 113, 791
Program management	USD 1,027,883
M&E	USD 56,354
Research	USD 137,858
Total	**USD 5,879,474**

Priorities for scaling up towards comprehensive programs to reduce barriers to HIV, TB and malaria services

The full description of programs and activities proposed in the comprehensive response are summarized in Annex 1 for HIV, and Annex 2 for TB and Annex 3 for malaria. In terms of priorities for scaling up comprehensive programs to address human rights-related barriers, HIV and TB are discussed first, followed by malaria below.

HIV and TB

Given the nature of human rights-related barriers to HIV and TB services in Uganda, it is recommended that the early focus be on activities to update and finalize the National Anti-stigma and Discrimination Policy, develop curricula and implement training on stigma and discrimination reduction and human rights for health care workers and law enforcement. The launch of the Anti-stigma and Discrimination policy should be followed by mass media campaigns, capacity-building of community-level structures and CSOs in campaigning against and monitoring stigma and discrimination; and the sensitization and involvement of religious and cultural leaders. In addition, the Government of Uganda should set up human rights and gender focal points in MoH AIDS/STD Control program and MoH National TB and Leprosy Program. The development/updating of advocacy and legal literacy tools and subsequent training for advocacy groups should also be prioritized, to ensure that networks, CSOs and patient advocacy groups are able to actively support the comprehensive response throughout its implementation. The peer human rights educators and peer paralegal system and the training of local council members to address human rights violations and harmful gender norms should be expanded countrywide.

Following the completion of these initial activities, the next stage in the response would focus on training-of-trainers and training of instructors/professors, followed by the rollout of routine training/re-training of key duty-bearers (i.e. health workers, police, prison staff, teachers, lawyers, judges, etc.) both pre-service and in-service. Linked with the scale-up of training activities, mid-term efforts should focus on developing and implementing appropriate monitoring tools for the various duty-bearers (i.e. health workers, police, prison staff, teachers, lawyers, judges, etc.) with a feedback loop for institutional administrators to ensure appropriate action and support following the trainings. In addition, this phase of the response would also include outreach and engagement with *pro bono* lawyers and paralegals to support clients utilizing the new monitoring mechanism or the rapid response unit. The PLHIV Stigma Index and TB stigma research should be implemented in year 2. Additional funding support to people living with HIV and people living with TB networks to conduct follow-on advocacy and awareness raising activities in the final year of the comprehensive response.

Malaria

There should be an effort to assess further gender-related and other equity barriers to malaria services, using tools such as the Malaria Matchbox – building on what is known about gender-related barriers to health services generally in Uganda -- followed by the use of this information to improve patient-centered approaches to malaria services and related care in the context of the

High Burden to High Impact initiative, aimed at supporting targeted responses to re-ignite the pace of progress in the global malaria fight. Concurrently, the collection of community feedback on malaria services and service programming should be conducted, including in refugee settings. The Ministry of Health and NGOs should adopt and roll out community scorecard events in a representative sample of health facilities to collect feedback and also conduct consultations with VHTs and community leaders to collect information on cultural barriers, gender issues, community level specific barriers to adoption of preventive strategies against malaria.

Next Steps

It is intended that the findings of this baseline assessment be used by the Government, civil society, other stakeholders, technical partners and donors in Uganda to develop a five-year, comprehensive program to remove human rights-related barriers to HIV, TB and malaria services. Data from the baseline assessment will be used as a baseline for subsequent reviews at mid-term and end-term during the period of the Global Fund strategy to assess the impact of scaled up programs in reducing human rights-related barriers to services.

1. Introduction

1.1 Overview of Global Fund efforts to support the removal of human rights-related barriers to health services

This report comprises the baseline assessment conducted in Uganda to support scaling up of programs to remove human rights-related barriers to HIV, TB, and malaria services. Since the adoption of its strategy, *Investing to End Epidemics,* 2017-2022, the Global Fund has joined with country stakeholders, technical partners and other donors in a major effort to expand investment in programs in national responses to HIV, TB and malaria. This effort is grounded in Strategic Objective 3 which commits the Global Fund to: "*introduce and scale up programs that remove human rights barriers to accessing HIV, TB and malaria service";* and, to *"scale-up programs to support women and girls, including programs to advance sexual and reproductive health and rights and investing to reduce health inequities, including gender-related disparities*."[9]

The Global Fund recognizes that programs to remove human rights-related barriers are an essential means by which to increase the effectiveness of Global Fund grants as they help to ensure that health services reach those most affected by the three diseases. The Global Fund is working closely with countries, UNAIDS, WHO, UNDP, Stop TB, PEPFAR and other bilateral agencies and donors to operationalize this Strategic Objective.

1.2 Background and Rationale for the Baseline Assessment in Uganda

Though the Global Fund will support all recipient countries to scale up programs to remove barriers to health services, it is providing intensive support in 20 countries in the context of Global Fund Key Performance Indicator (KPI) 9 – «Reduce human rights barriers to services: # of countries with comprehensive programs aimed at reducing human rights barriers to services in operation". This KPI measures "the extent to which comprehensive programs are established to reduce human rights barriers to access with a focus on 15-20 priority countries".[10] Based on criteria that include needs, opportunities, capacities and partnerships in country, the Global Fund selected Uganda as one of the countries for intensive support to scale up programs to reduce barriers to services. This baseline assessment, focusing on HIV, TB and malaria, is the first component of the package of support Uganda will receive.

[9] *The Global Fund Strategy 2017-2022: Investing to End Epidemics*. GF/B35/02

[10] 2017-2022 Strategic Key Performance Indicator Framework, The Global Fund 35th Board Meeting, GF/B35/07a - Revision 1, April 2016

1.3 Purpose, Objectives and Expected Outcomes of the Assessment

The objectives of the assessment in Uganda were to: (a) establish a baseline of human rights-related barriers to HIV, TB and malaria services and existing programs to remove them; (b) set out a costed, comprehensive program aimed at reducing these barriers; and (c) recommend next steps in putting this comprehensive program in place.

The programs recognized by UNAIDS, Stop TB and other technical partners as effective in removing human rights-related barriers to HIV and TB services are: (a) stigma and discrimination reduction; (b) training for health care providers on human rights and medical ethics; (c) sensitization of law-makers and law enforcement agents; (d) reducing discrimination against women in the context of HIV and TB; (e) legal literacy ("know your rights"); (f) legal services; and (g) monitoring and reforming laws, regulations and policies relating to HIV and TB. Three additional program areas are included for TB: (h) ensuring confidentiality and privacy related to TB diagnosis; (i) mobilizing and empowering TB patient and community groups; and (j) establishing programs in prisons and other closed settings.[11]

The programs recognized as effective in removing human rights-related barriers to malaria services are: (a) reducing gender-related barriers and harmful gender norms; (b) promoting meaningful participation of communities; (c) strengthening of community systems for participation in malaria programs; (d) improving services in prison and pretrial detention; (e) improving non-discriminatory patient-centered services for underserved populations, including refugees.

The findings of this baseline assessment will be used by the Uganda Government, the Global Fund, civil society organizations, technical partners and other donors to develop a five-year plan by which to fund and implement a comprehensive set of these programs to remove human rights-related barriers to services in Uganda. Its data will also be used as the baseline against which will be measured the impact of the interventions put in place in subsequent reviews at mid-term and end-term during the current Global Fund Strategy period.

2. Methodology

2.1 Conceptual Framework

The conceptual framework for the baseline assessments is the following: (a) Depending on the country and local contexts, there exist human rights-related barriers to the full access to, uptake of and retention on HIV, TB and malaria services. (b) These human rights-related barriers are experienced by certain key and vulnerable populations who are most vulnerable to and affected by HIV, TB and malaria. (c) There are human rights-related program areas comprising several interventions and activities that are effective in removing these barriers. (d) If these interventions and activities are funded, implemented and taken to sufficient scale in country,

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[11] See *Key Programmes to Reduce Stigma and Discrimination and Increase Access to Justice in National HIV Responses*, Guidance Note, UNAIDS/JC2339E (English original, May 2012); ISBN: 978-92-9173-962-2. See also Technical *Briefs HIV, Human Rights and Gender Equality* Global Fund to Fight AIDS, TB and Malaria (April 2017); *Tuberculosis, Gender and Human Rights* Global Fund to Fight AIDS, TB and Malaria (April 2017)

they will remove, or at least significantly reduce, these barriers. (e) The removal of these barriers will increase access to, uptake of and retention in health services and thereby make the health services more effective in addressing the epidemics of HIV, TB and the malaria. (f) These programs to remove barriers also protect and enhance Global Fund investments, strengthen health systems and strengthen community systems.

Under this conceptual framework, the assessment in Uganda has identified:

a) Human rights-related barriers to HIV, TB and malaria services
b) Key and vulnerable populations most affected by these barriers
c) Existing programs to address these barriers; and
d) A comprehensive set of programs to address these barriers most effectively.

Human rights-related barriers to HIV, TB and malaria services were grouped under the following general categories: stigma and discrimination; punitive laws, policies, and practices; gender inequality and gender-based violence; and, poverty and economic and social inequality. Key populations have been defined as follows by the Global Fund:

a) Epidemiologically, the group faces increased risk, vulnerability and/or burden with respect to at least one of the two diseases – due to a combination of biological, socioeconomic and structural factors;
b) Access to relevant services is significantly lower for the group than for the rest of the population – meaning that dedicated efforts and strategic investments are required to expand coverage, equity and accessibility for such a group; and
c) The group faces frequent human rights violations, systematic disenfranchisement, social and economic marginalization and/or criminalization – which increase vulnerability and risk and reduces access to essential services.[12]

Vulnerable populations are people who do not fit into the definition of key populations, but nevertheless are more vulnerable to HIV, TB and/or malaria and their impact.[13]

The design, outcomes and costs of existing programs to reduce these barriers were analyzed, and a set of activities and interventions have been identified to make up a comprehensive response at scale to address human rights-related barriers experienced by key and vulnerable populations in Uganda.

2.2 Steps in the assessment process

a) *Desk Review* - A comprehensive search to assess human rights-related barriers to HIV, TB and malaria services in Uganda, key and vulnerable populations affected by these barriers and programs to address them was conducted using PubMed, Embase, and Web of Science to identify peer-reviewed literature. Thirty-eight relevant articles were identified for HIV, thirteen were identified for TB and six for malaria. The publications section of local NGOs and CBOs

[12] The Global Fund to Fight AIDS, Tuberculosis and Malaria. *Key Populations Action Plan 2014-17*. Geneva
[13] Greenall M, Kunii O, Thomson K, Bangert R and Nathan O (2017). Reaching vulnerable populations: lessons from the Global Fund to Fight AIDS, Tuberculosis and Malaria. *Bulletin of the World Health Organization* 2017;95:159-161.

working in Uganda in the HIV, TB and malaria sector were also searched for relevant publications. In addition, documents relevant to legal and policy environment in Uganda were reviewed in the context of HIV, TB and malaria. Emails seeking additional information on programs were sent to several non-government organizations (NGOs) working on HIV, TB and/or malaria in Uganda to achieve a greater understanding of issues faced by their clients. Lastly, four phone interviews were conducted with key stakeholders at USAID Uganda, USAID/Freedom House Project, UNAIDS, and at Stop TB Program.

b) *Preparation for in-country work* **-** From the Desk Review, a list of key informants and types of focus groups was developed to guide data collection in country. The key informants included government officials (central and district level), civil society organizations, UNAIDS, UNHCR, and PEPFAR- or GF-supported NGOs implementing HIV/TB or malaria services. Instruments developed for these forms of data collection were adapted to the circumstances of Uganda. Researchers were trained in the use of these instruments and were assigned tasks. Approval to conduct the baseline assessment was granted by the Makerere University School of Public Health Higher Degrees, Research and Ethics Committees and the Uganda National Council of Science and Technology (UNCST).

c) *In country work* - An inception meeting introduced the project to national stakeholders, explained the role of the baseline assessment and data collection procedures, and summarized the findings of the Desk Review. This was followed by key informant interviews and focus group discussions with members of key and affected populations in Karamoja sub-region and in Central, Eastern, Mid-Northern and Southwestern Uganda. A total of 31 face-to-face interviews were carried out with 41 key informants; and 52 key and vulnerable population members participated in 7 focus groups.

d) *Data collection* **-** Data were collected on the following areas:
   - Human rights-related barriers to HIV, TB, and malaria services
   - Key and vulnerable populations most affected by these barriers
   - Programs carried out presently or in the recent past that have been found through evaluation or through agreement by many key informants to be effective in reducing these barriers
   - Stated needs regarding comprehensive programs to address the most significant barriers for all groups most affected by these barriers
   - Funding of all such programs (for 2016 financial year); and
   - Costing of effective[14] programs carried out presently or in the past.

e) *Data analysis* **-** The in-country data were analyzed to explore agreement with or divergence from the Desk Review findings and to add data on barriers and affected populations missing from the Desk Review. This information, together with data on funding in 2016, was used to develop the Baseline Data Summary. Data on effective projects and on stated needs were combined to suggest the comprehensive programs to reduce human rights barriers to HIV, TB and malaria services in Uganda.

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[14] Effectiveness is determined either by evaluation or by broad agreement among key informants that a program is/was effective.

f) *Finalization and next steps* –Upon finalization, this assessment was provided to the Global Fund Secretariat for use as background in preparation of an in-country multi-stakeholder meeting to consider its findings and discuss how best to scale up programs to reduce human rights barriers to HIV, TB and malaria services in Uganda.

2.3 Costing methodology

Three sets of costing processes were undertaken for this assessment:

First, all donors and funders who have financed any activities in the program areas for HIV, TB or malaria were asked to supply details of the amount of funding provided and the program areas for which funding was provided; and, if possible, to state the type of activities and reach or coverage of funded activities. This approach was largely successful in overall terms for HIV in that most donors were able to state what program areas the funds were directed to but did not provide details of the funded activities or their reach. For TB and malaria, no cost data was possible to obtain given the limited existing programs that were identified, as well as the limited number of interviews conducted in the frame of this rapid assessment.

Second, specific implementers were approached, and information was gathered on costs involved in carrying out specific interventions. This process followed the Retrospective Costing Guidelines (available from Global Fund on request). The expenditure lists and donors for HIV, TB and malaria are summarized in Annex 4. Individual costing sheets for services provided by each of the organizations were prepared.

Third, a Prospective Costing of the comprehensive program was carried out. The results of this process are provided in Annex 5. For each type of intervention, an intervention-level cost was assembled.

These costs were used to construct calculation tables (see HIV, TB and malaria calculation tables in Annex 5). In these calculations, the number of services to be provided and people to be reached/trained were multiplied by the intervention-level cost to provide an annual cost for each activity. Annual costs are required because some activities only take place every few years, such as the *PLHIV Stigma Index*, and others require capacity-building or other activities in the first year that are not needed in later years. Comment boxes to the right of each activity in these calculation tables show where the data came from to construct the calculation. These calculation tables were used to provide overall Program Area and Activity sub-activity budgets (tabs labeled 'HIV Budget', 'TB Budget' and 'Malaria Budget' in Annex 5), for each of five years as well as a five-year total. These are the budgets that are used to construct the five-year totals provided at the end of the HIV and TB sections of this report.

Limitations

The costing component of the baseline assessment was a rapid investment analysis, therefore it should not be viewed as a full-fledged resource need estimation. The retrospective costing has informed the estimation of intervention-level costs, hence the limited data collected through the baseline assessment inherently affected the prospective costing.

The baseline assessment encountered certain limitations in the costing component both as pertaining to HIV, TB and malaria programs aimed at removing human rights-related barriers:

- Certain key stakeholders were not able to take part in the data collection due to competing priorities. As a result, an important viewpoint on human rights barriers and on the effectiveness of current efforts to address them may be missing from the analysis. Stakeholders that could not participate also included a number of bilateral partners and, as a result, the description of current efforts to address and remove barriers may not include what these entities are currently funding or undertaking directly.

More specific limitations and challenges to the collection of financial data included:

- It appeared that a number or organizations felt that the information requested was too sensitive to share even though it was indicated in the invitation messages that the data would be consolidated and anonymized at the implementer level.
- Some organizations appeared to take the position that the benefit of completing the exercise was not worth the level of effort required, given other pressures on them.
- Most funders and intermediaries appeared to be unable to disaggregate their investments in combination prevention interventions to the level where funding for programmes addressing human rights barriers could be identified.
- Finally, as the analysis has noted there is a large gap in current and comprehensive quantitative data on a number of the human rights barriers identified by the assessment. As a result, there may be an over-reliance on individual or anecdotal accounts or perspectives which may not, in some cases, be an accurate reflection of an overall, country-wide trend.

The prospective costing of the comprehensive response to removing human rights-related barriers will inform the development of the five-year strategic plan and will therefore likely to change throughout the country-owned participatory plan development process.

Further costing considerations are described in detail in Annex 6.

3. Baseline findings: HIV

3.1 Overview of epidemiological context and key and vulnerable populations

In 2017, the number of people living with HIV in Uganda was estimated by UNAIDS to be roughly 1,300,000, making the adult prevalence (ages 15-49) 5.9%.[15] Women in the same age group account for a larger HIV prevalence than men in Uganda, women having a prevalence of 7.3%, men having a prevalence of 4.5%. For young men and women, the prevalence is nearly tripled for young women, at 2.9%, compared to the prevalence for young men at 1.0%.[15]

Estimates indicate that the mid-Northern region, which was severely conflict-affected in the past, has a prevalence of more than double that of the mid-Eastern region of Uganda, at 12.2%.

[15] UNAIDS. (2017). Uganda Fact Sheets. http://www.unaids.org/en/regionscountries/countries/uganda

Due to underreporting, it is thought that these numbers are likely an underestimation of the real prevalence in this formerly conflict-affected area of Uganda.[16] In response, a number of CSOs have established offices in the mid-Northern region to provide HIV prevention, care and treatment services, alongside other support services (e.g. to address GBV).

According to the National HIV/AIDS Strategic Plan: 2015/2016 – 2019/2020[17]:

"HIV prevalence is especially higher in key populations particularly sex workers (35-37%) fisher folk (22-29%), long distance truck drivers (25%), uniformed services personnel (18.2%) men who have sex with men (13.7%) and *boda-boda* taxi men (7.5%)"

Groups considered especially vulnerable to HIV in the National Strategic Plan included migrant and mobile populations, HIV-discordant couples, and people who inject drug, people with disabilities and adolescent girls and young women:

"Young women who experienced intimate partner violence were 50% more likely to have acquired HIV than women who had not experienced violence. In Uganda, 3% of adolescent girls 15-19 years live with HIV and prevalence doubles (7.1%) by the time they are 24 years."

The baseline assessment report focuses on the key and vulnerable populations specifically indicated by the Uganda AIDS Commission (UAC) in the National Strategic Plan.

Areas such as Rakai, located in the central part of the country, and other areas where there are high levels of migrants, fisherman, and sex workers, also see high prevalence of HIV.[18] Alcohol consumption and sex work are greater in fishing villages around Lake Victoria than other areas, fueling HIV transmission and leading to a high HIV prevalence in these villages. [19] Kasensero fishing village, known for Uganda's first documented case of HIV, has a reported prevalence of 44.3%, with an especially high prevalence for female bar workers, at 74.5%.[20]

The United Nations has indicated that Ugandans with disabilities may be at increased risk of HIV infection due to limited availability of HIV prevention, treatment, and testing information available to disabled persons.[21] Physical accessibility for people with disabilities and the ability

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[16] Malamba SS, Muyinda H, Spittal PM, Ekwaru JP, Kiwanuka N, Ogwang MD, Odong P, Kitandwe PK, Katamba A, Jongbloed K, Sewankambo NK, Kinyanda E, Blair A, Schechter MT. (2016). The Cango Lyec Project – Healing the Elephant: HIV related vulnerabilities of post-conflict affected populations aged 13-49 years living in three Mid-Northern Uganda districts. BMC Infectious Disease 16(1), 690.

[17] UAC (2015). National HIV/AIDS Strategic Plan: 2015/2016 – 2019/2020

[18] Kuhanen J. (2010). Sexualised space, sexual networking &emergence of AIDS in Rakai, Uganda. *Health & Place* 16(2), 226-235.

[19] Sileo KM, Kintu M, Chanes-Mora P, Kiene SM. (2016). Such Behaviors Are Not in My Home Village, I Got Them Here: A Qualitative Study of the Influence of Contextual Factors on Alcohol and HIV Risk Behaviors in a Fishing Community on Lake Victoria, Uganda. *AIDS and Behavior* 20(3), 537-540.

[20] Lubega M, Nakyaanjo N, Nansubuga S, Hiire E, Kigozi G, Nakigozi G, Lutalo T, Nalugoda F, Serwadda D, Gray R, Wawer M, Kennedy C, Reynolds SJ. (2015). Understanding the socio-structural context of high HIV transmission in kasensero fishing community, South Western Uganda. *BMC Public Health* 15, 1033.

[21] Abimanyi-Ochom J, Mannan H, Groce NE, McVeigh J. (2017). HIV/AIDS knowledge, attitudes and behavior of persons with and without disabilities from the Uganda Demographic and Health Survey 2011: Differential access to HIV/AIDS information and services. *PLoS One* 12(4).

to communicate with healthcare workers are common barriers to treatment for disabled people living with HIV.[22]

Sex work and same-sex sexual relationships are criminalized in Uganda, which, among other things, can put those engaging in those activities at risk of arrest. Sex workers and men who have sex with men also report being subjected to illegal police practices, such as arbitrary arrest, extortion and violence at the hands of the police.[23] It has been estimated that sex workers are 13.5 times more likely to be HIV infected than women in the general population,[24] with an estimated prevalence at 33%.[25]

People who inject drugs, are recognized in the National HIV and AIDS Strategic Plans (NSPs) as a key population. With a reported prevalence of 16.7%,[26] people who inject drugs face a high vulnerability to HIV globally, and this vulnerability stems in part from the fact that taking drugs is criminalzed and often results in severe marginalization in communities.[27]

3.2 Overview of the policy, political and social context relevant to human rights-related barriers to HIV services

3.2.1 Laws, policies and practices

Uganda is a signatory to several human rights-related international covenants, including the *Universal Declaration of Human Rights*, the *International Covenant on Economic, Social and Cultural Rights* and *the International Covenant on Civil and Political Rights*. Additionally, Uganda is a signatory to international conventions including the *Convention on the Elimination of all Forms of Racial Discrimination*, the *Convention on the Rights of the Child*, and the *Convention on the Elimination of all Forms of Discrimination against Women*.

At the continental level, Uganda is a signatory to significant charters and protocols, such as the *African Charter on Human and People's Rights*, the *Optional Protocol on the African Charter on Human and People's Rights*, and the *OAU Charter on the Rights and Welfare of the African Child*

National legislation has also been implemented to protect human rights for Ugandans, starting with the *Constitution of the Republic of Uganda (1995*). Chapter 4, Article 20, protects fundamental and other human rights and freedoms, and Article 21 of the same chapter declares

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[22] Nampewo Z. (2017). Young women with disabilities and access to HIV/AIDS interventions in Uganda. *Reproductive Health Matters* 15(50), 121-127
[23] Goldenberg SM, Muzaaya G, Akello M, Nguyen P, Birungi J, Shannon K. (2016). War-Related Abduction and History of Incarceration Linked to High Burden of HIV Among Female Sex Workers in Conflict-Affected Northern Uganda. *Journal of Acquired Immune Deficiency Syndrome* 73(1), 109-16.
[24] UNAIDS. (2016). Uganda Fact Sheets. http://www.unaids.org/en/regionscountries/countries/uganda
[25] Hladik W, Baughman AL, Serwadda D, Tappero JW, Kwezi R, Nakato ND, Barker J. (2017). Burden and characteristics of HIV infection among female sex workers in Kampala, Uganda – a respondent-driven sampling survey. *BMC Public Health* 17(1), 565.
[26] Avert. (2017). HIV and AIDS in Uganda. https://www.avert.org/professionals/hiv-around-world/sub-saharan-africa/uganda
[27] Avert. (2017). People who inject drugs, HIV and AIDS. https://www.avert.org/professionals/hiv-social-issues/key-affected-populations/people-inject-drugs

all people equal under the law, and prohibits discrimination on the basis of sex, race, color, ethnic origin, tribe, birth, creed, religion, social or economic standing, political opinion or disability. In Articles 22 and 24, the protection of the right to life and respect for human dignity and protection from inhuman treatment are stated respectively. Articles 32 through 36 affirm the protections for affirmative action in favor of marginalized groups; equal opportunity; equal treatment and opportunities for women, children, and people with disabilities in political, economic, and social activities; as well as the protection of the rights of minorities generally[28][29].

Other acts and laws are also in place in order to protect human rights in Uganda, including the *Equal Opportunities Act (2007)*, which established the Equal Opportunities Commission, providing legal grounds for members of key and vulnerable populations to receive justice from discrimination; the *Children's Act (1997)* which provides for the protection of children in homes with HIV, tuberculosis, or malaria, including the duty of the parent to fulfill the child's rights, and the rights of the child to stay with their parents; and the *Employment Act (2006)* which prohibits discrimination based on HIV status. The *Domestic Violence Act (2010)* is a widely known legal act in Uganda, which criminalizes gender-based violence (GBV), a human rights violation associated with the heightened risk of HIV acquisition among women. Since this act, gender-based violence has become the most reported crime in the country. A National Gender Based Violence policy specifies certain requirements from the Ugandan Police Force that includes providing security for victims, timely apprehension of perpetrators and a budget to accomplish this, sensitization of communities on gender-based violence, a toll-free hotline for rapid response to GBV cases, and strengthening of law enforcement procedures[29][30].

Some of Uganda's policies also cover issues of human rights as it relates specifically to health and to HIV. For example, the *National Health Policies of Uganda (2000, 2010)* aim to ensure a quality standard of health, address sexual and reproductive health and rights, and legal aspects, citing HIV, tuberculosis, and malaria as areas of concern. The *Second National Health Policy* reflects the significant changes that have occurred over the decade, citing the increased burden of HIV as a reason for a more current health policy. A *National HIV and AIDS Policy* was adopted in 2011 with the aims to ensure proper management of the national HIV response, reduce vulnerability, promote equal access to services, minimize socioeconomic consequences, and address gender-based concerns.

With respect to HIV and equality in the workplace, the *National Policy on HIV/AIDS and the World of Work (2007)* provides the principles and framework for mounting an optimum response to HIV/AIDS in the Ugandan world of work. It forms the basis for the development of workplace policy guidelines that address the more specific HIV issues relevant to the workplace. The policy applies to all employees and workers, including applicants for work, within the public and private sectors. It also applies to all aspects of work, both formal and informal. Under its provisions, employees with HIV/AIDS cannot be discriminated against in terms of allocation of

[28] Republic of Uganda. (1995). Constitution of the Republic of Uganda.
[29] Mukasa S, Gathumbi A. (2008). HIV/AIDS, Human Rights, and Legal Services in Uganda: A Country Assessment. Public Health Program Law and Health Initiative, Open Society Initiative for East Africa.
[30] CEDOVIP. A call on Uganda Police Force to curb Gender Based Violence in Uganda through law enforcement.

employee benefits. Employees with HIV/AIDS should be treated like any other employee with a comparable life-threatening illness with regards to accessing all the employee benefits. A charter was disseminated to health facilities across the country, the *Client Charter (2012-2015),* to address the right to quality healthcare irrespective of political affiliation, disability, race, age, sex, social status, economic status, disease, ethnicity, nationality, or other such grounds when receiving care. In addition, after the withdrawal of the *Anti-Homosexuality Act* of 2014, the Ministry of Health (MOH) issued a directive to all health providers regarding non-discriminatory services to key population clients. Other relevant policies include the *Anti-Retroviral Treatment (ART) Policy for Uganda (2003*), and the Policy for *Reduction of Mother-to-Child HIV Transmission (2003)*[29,31,32].

The Strategic and National Plans in Uganda are also significant in discussing the Ugandan legal context. The *National HIV and AIDS Strategic Plan* (NSP) 2015-2016 to 2019-2020 promotes a scale-up of HIV prevention and intervention, advocating for the reduced vulnerability of certain populations to HIV, and increased access and quality of treatment. This includes principles of shared responsibility and non-discrimination, as well as human rights and gender-focused approaches to programming. The Ministry of Health and the Uganda AIDS Commission (UAC) formed a technical working group on most at risk populations' (MARPs) access to health services and response to HIV. The group developed the *MARPs Priority Action Plan 2014,* which was signed into action in 2015. This is aimed at targeting the MARPs communities, minimizing stigma, eliminating discrimination in HIV services delivery and also ensuring high quality HIV/AIDS services (UAC 2015 National HIV and AIDS Priority Action Plan 2015/2016-2017-2018, Uganda AIDS Commission, Republic of Uganda)[33].

Whereas, the country has made significant strides in implementing these laws, policies and strategic action plans, there are still gaps in the implementation process due to limited resources or conflicts in the provisions of different laws. With regard to the *HIV and AIDS Prevention and Control Act 2014*[34] which is generally protective – encouraging early HIV testing and ensuring availability of HIV services at primary health care points, it contains articles that criminalize the willful or intentional transmission of HIV and consequently requires pregnant women to undergo mandatory HIV testing. The criminalization of intentional transmission, according to the law, would result in a conviction of up to ten years, and a fine of UGX4.8 million (USD$1317). There is concern that this component of the law may place women, even women who have been the victims of sexual assault, at risk of punishment if they do not undergo testing for HIV before giving birth.[35] In the same bill, however, confidentiality of status is maintained between the person being tested and the healthcare provider, making involuntary disclosure by a healthcare worker a criminal offense. There are exceptions to this rule, such as

[31] The Republic of Uganda Ministry of Health. (2010). Second National Health Policy: Promoting People's Health to Enhance Socio-economic Development.
[32] Uganda AIDS Commission (2011): Uganda National HIV and AIDS Policy-Final.
[33] The Republic of Uganda. The Uganda Malaria Reduction Strategic Plan 2014-2020.
[34] MOH (2014). HIV and AIDS Prevention and Control Act 2014
[35] Library of Congress. (2014). Global Legal Monitoring: Uganda: New Law Criminalizes HIV/AIDS Transmission, Requires Pregnant Women to Undergo HIV Testing.

the allowance of a medical practitioner to release the results of an HIV test to someone in close contact to the person living with HIV.[36] Additionally, the bill calls for the criminalization of any misleading information on prevention and treatment of HIV. Concern was expressed that the law does not sufficiently define its terms and may lead to arbitrary consideration of what is misleading and what is not, resulting in arbitrary prosecutions.[37] In the focus group discussions and key informant interviews, it was noted that this law is yet to be enforced against the HIV positive sex workers.

Concern was expressed about other laws and policies that, if misinterpreted, could foster discrimination from the public, health care workers and/or the police:

- The *Non-Governmental Organizations Law* (NGO Law) [38] came into national law in 2016 and enables the Government to regulate NGOs, requiring them to register with an NGO Bureau and apply for permits to operate. It also restricts NGOs from working in districts without approval from the district's Monitoring Committee and without entering into a memorandum of understanding (MOU) with local governments in the the locales where they operate. This law prohibits NGOS from engaging in activities that are deemed prejudicial to the security and laws of Uganda. Thus, NGOs that work with key populations that engage in activities that are criminalized (gender and sexual minorities, sex workers and people who use drugs) may encounter difficulty in registering and may be subject to penalties for the HIV-related work that they do with these populations.
- The *Penal Code Act*, Cap 120 on sex work and same-sex relationships[39] criminalizes sex work and same-sex relationships.
- The *Narcotic Drugs and Psychotropic Substances Control Act (NDPSA) 2015*[40] criminalizes all forms of narcotics and psychotropic substances and does not provide for harm reduction and harm reduction strategies.
- The *National Policy Guidelines for PEP for HIV, Hepatitis B and C (2007)*[41] provides direction for implementation of PEP to victims of sexual offences, health workers, barbershop attendants, and police officers. The policy does not recognize any key populations as groups possibly in need of PEP and does not offer or suggest particular programming considerations to serve these groups.
- *Medical and Dental Practitioners: Code of Professional Ethics (2013)* (based on *Medical and Dental Practitioners Act of 1998*)[42] sets the code of professional conduct, including a provision that requires medical practitioners to ensure patient confidentiality and privacy.

[36] Library of Congress. (2014). Global Legal Monitoring: Uganda: New Law Criminalizes HIV/AIDS Transmission, Requires Pregnant Women to Undergo HIV Testing.
[37] Human Rights Watch. (2010). Uganda AIDS Policy: from exemplary to inefficient.
[38] The Non-Governmental Organizations Law (NGO Law)
[39] Penal Code Act, Cap 120
[40] MOH (2015). Narcotic Drugs and Psychotropic Substances Control Act (NDPSA) 2015
[41] MOH (2007). National Policy Guidelines for PEP for HIV, Hepatitis B and C (2007)
[42] MOH (2013). Medical and Dental Practitioners: Code of Professional Ethics (2013) (Based on Medical and Dental Practioners Act of 1998) .

The code allows the practitioner to disclose patient information where such disclosure would *"protect the public or advance greater good of the community"*.

Focus group discussions elucidated some of the ways in which these laws may be influencing access to HIV prevention, care and treatment services. For example, limited availability of lubricants at health facilities was reported, as well as a lack of opioid substitution therapy (OST) available for harm reduction. Participants in the focus groups linked the lack of these prevention services to government policies. In addition, the police have used some of these laws to close health facilities that predominantly provided healthcare services to key populations, such as the Walter Reed clinic in Kayunga,

Throughout the discussions with key informants and focus groups, arbitrary arrests, harassment, extortion and violence at the hands of the police were noted as a main barrier to health services for members of key populations who engaged in activities that were criminalized. For example, female sex workers described a spectrum of harassment and violence at the hands of police and shared numerous stories of police demanding money from them, forcing them to have sex to avoid arrest, and engaging in verbal harassment, among other abuses.

Some efforts at community outreach (e.g. HIV testing and STI screening) for key populations have been affected by laws that criminalize the activities of these populations. The focus discussions with gender and sexual minorities and people who inject drugs reported instances where police waited outside outreach services to arrest them after they had taken up the HIV prevention and treatment services. Some key population members reported fearing this result and thus stay away from these services. One peer-leader of a key population network noted:

> *Towards the end of 2016, we held an outreach in Ntungamo town after alerting the police about key population friendly services. We were later shocked that they followed up and arrested 16 men who have sex with men. We had to bail them out. Many others now fear the outreaches, as there is no protection from police arrests.*

The peer leaders attributed the police arrests to pressure from high-ranking police officials who have not been sensitized on HIV-related needs of key populations.

Criminalization of sex work in Uganda has been associated with increased vulnerability of sex workers to sexual violence, which in turn increases risk of contracting sexually transmitted infections , including HIV.[43] Discussions with participants in the focus group with sex workers concurred with the findings from the literature. Arrests reported by focus group participants included arrests for possession of condoms. Key informants stated that practice by the police led to more unprotected sex, as sex workers may not carry condoms for fear of being arrested. Managers of sex workers may also stop providing condoms because of this arrest practice.

Lastly, sex worker focus group participants reported that when they report crimes to the police, such as violence against them, the claims are often not investigated, they receive threats of violence from the police officers and sometimes experience violence at the hands of police officers themselves. These experiences dissuade many sex works from seeking justice and has

[43] Twinomugisha BK (2012). Beyond “Malaya” or “prostitute”: Interrogating sexual and reproductive health rights of young female sex workers in the context of HIV/AIDS in Uganda. HURIPEC Working Paper No.37 (25)

eroded trust in civil society organizations that try to help them access health care service delivery, overcome stigma and protect their rights.

3.2.2 Political environment

The Constitution of Uganda, established in 1995, recognizes an executive, legislative, and judicial branch of government. For the legal environment, Uganda has a number of institutions that provide legal and justice services, from the administration of justice to the Uganda Law Reform Commission as well as the Uganda Human Rights Commission.

The Supreme Court is the highest court in Uganda, with the Final court established in 1995 as the Court of Appeal, followed hierarchically by the Constitutional Court in questions of constitutional issues, the High Court for civil and criminal cases, and finally the Magistrate Court, which handles most of civil and criminal cases in Uganda.[44]

3.3 Human rights barriers to access, uptake and retention in HIV services

The major human rights-related barriers identified in the desk review and confirmed in discussions with key stakeholders and members of key populations, included:

a) Stigma and discrimination based on HIV status alone and/or stigma and discrimination based on membership in a key population. These are experienced in the community and at health facilities (i.e. inefficient and discriminatory practices in healthcare facilities, which are heightened for members of key and vulnerable populations);

b) Gender inequality, including gender-based violence, lack of decision-making power, and the gender issues affecting the transmission of HIV and other aspects of the epidemic;

c) Punitive or outdated laws, policies and practices that, among other things, hinder key population access to HIV services;

d) Health facility-level barriers including poor quality services for some key population groups; frequent commodity stock-outs; discriminatory practices or stigmatizing attitudes of health care workers and other patients; and inconvenient opening times.

3.4 Stigma and discrimination

3.4.1 Stigma and discrimination related to HIV status

Early in the epidemic's history within the country, stigmatizing attitudes were common and legitimized in the media and general population, typically identifying the disease as a punishment for immoral behavior. Other common narratives detailed HIV as disgusting, and a

[44] Hauser Global Law School Program, GlobaLex, Mahoro B, Matte L. (2016). UPDATE: Uganda's Legal System and Legal Sector

dividing force between the general population and people living with HIV. Due to these common and long-lived perceptions surrounding the disease, stigma and discrimination have become some of the foremost barriers to testing, treatment, and care for HIV.[45]

Assumptions about people living with HIV as promiscuous have created an environment in which 70% of respondents to one 2012 study on stigmatization in Gulu were afraid to access healthcare or voluntary testing for fear of being labeled as sexually promiscuous or immoral.[46] Fear of infection is another reason for stigma and discrimination in Ugandan society. In the 2016 DHS survey 26.3% of women stated that they would not buy fresh vegetables from a shopkeeper who had HIV. This discriminating attitude was particularly high in Karamoja sub-region, at 58%.[47]

In general, people living with HIV noted stigma from many levels of society, including familial rejection, workplace stigma, healthcare discrimination and stigma, self-stigma, and community stigma. Common concerns for people living with HIV, especially in more impoverished areas, were fears of losing jobs, friends, and family.[48]

Youth living with HIV in Uganda have noted that the stigma of having HIV has made it difficult for them to come to terms with their illness, and limits their willingness to take up antiretroviral therapy (ART) or any other form of care. Within the home and the healthcare facility, youth living with HIV have reported harsh reprimands and beatings for not taking doses of antiretroviral treatment.[49] Further, a lack of familial and social support, as well as discrimination from peers, reduce motivation to undergo treatment. Within health facilities, youth living with HIV have reported coerced sterilization, discrimination, and breaches of confidentiality.[50]

In focus group discussions held in Karamoja sub-region, both male and female people living with HIV reported stigmatizing gossip, verbal insults and threats, and social rejection by community members and some family members. Stigma and discrimination were reported to have negatively affected their quality of life and adherence to ARVs, as many try to hide their status. Health workers were reported to breach confidentiality by telling others about their patients' HIV status or openly calling for people living with HIV across the health facility isles. Key informants reported heightened self-stigma among the adolescents living with HIV who limit their social interactions with other adolescents for fear that they would be humiliated or rejected.

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[45] Kitara DL, Aloyo J. (2012). HIV/AIDS stigmatization, the reason for poor access to HIV counseling and testing (HCT) among the youths in Gulu (Uganda). *African Journal of Infectious Disease* 6(1), 12-20.
[46] Kitara DL, Aloyo J. (2012). HIV/AIDS stigmatization, the reason for poor access to HIV counseling and testing (HCT) among the youths in Gulu (Uganda). *African Journal of Infectious Disease* 6(1), 12-20.
[47] Uganda Bureau of Statistics (UBOS) and ICF. 2018. *Uganda Demographic and Health Survey 2016.* Kampala, Uganda and Rockville, Maryland, USA: UBOS and ICF.
[48] Too W, Watson M, Harding R, Seymour J. (2015). Living with AIDS in Uganda: a qualitative study of patients' and families' experiences following referral to hospice. *BMC Palliative Care* 14, 67.
[49] Bernays S, Paparini S, Seeley J, Rhodes T. (2017). "Not Taking it Will Just be Like a Sin": Young People Living with HIV and the Stigmatization of Less-Than-Perfect Adherence to Antiretroviral Therapy. *Medical Anthropology* 36(5), 485-499.
[50] UNESCO. Brighter Life for All: Advocacy Strategy for Adolescent and Young People Living with HIV in Uganda.

According to interviews and focus groups, community-level stigma and discrimination against people living with HIV is based on the limited understanding of, as well as misconceptions about, HIV. As noted in the Uganda National Demographic and Health Surveys 2016, discriminatory attitudes are common among individuals who did not attend secondary schools. Those who have not attained secondary school education unfortunately form 65% of the country's population.

Sub-Saharan Africa, as a region, as well as Uganda, report consistently high levels of stigma and discrimination towards key populations.[51] Stigma and discrimination towards gender and sexual minorities is common, with some individuals experiencing heavy violence, verbal, and physical abuse by family members, community members, health care workers and police.[52] The high levels of stigma make members of key populations feel uncomfortable attending healthcare facilities, and 72.9% of respondents in one study felt that they could not tell healthcare workers their sexual practices and related illnesses. Cases describe healthcare workers asking offensive questions, gossiping, and openly discriminating against gender and sexual minorities. Beyond the stigma by healthcare workers, some members of key population groups did not want to be seen at the clinic for fear of inadvertent disclosure of their sexual orientation.[53] Heterosexual men who become infected with HIV also suffer related stigmatization, as an HIV diagnosis is believed to imply a loss of one's masculinity. This fear negatively influences some men's likelihood of seeking testing and treatment.[54]

Female sex workers in Uganda also face stigma-related barriers to their HIV services. Many sex workers have a limited knowledge and awareness of the disease as well as the services available, and the idea of seeking treatment is associated with a fear of breach of confidentiality and discrimination from healthcare workers. In addition, due to the odd hours sex workers are available to seek treatment, many are unable to attend regular clinic hours.[55] Focus group discussions with sex workers also noted a negative effect of stigma on adherence to ART, especially among the HIV positive sex workers who live in brothels. Many of them fear disclosing their HIV status to their peers and are forced to hide taking their medications. Due to lack of social support and stigmatizing attitudes from fellow sex workers, some abandon their HIV treatment.

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[51] King R, Barker J, Nakayiwa S, Katuntu D, Lubwama G, Bagenda D, Lane T, Opio A, Hladik W. (2013). Men at risk; a qualitative study on HIV risk, gender identity and violence among men who have sex with men who report high risk behavior in Kampala, Uganda. *PLoS One* 8(12).
[52] King R, Barker J, Nakayiwa S, Katuntu D, Lubwama G, Bagenda D, Lane T, Opio A, Hladik W. (2013). Men at risk; a qualitative study on HIV risk, gender identity and violence among men who have sex with men who report high risk behavior in Kampala, Uganda. *PLoS One* 8(12).
[53] Wanyenze RK, Musinguzi G, Matovu JK, Kiguli J, Nuwaha F, Mujisha G, Musinguzi J, Arinaitwe J, Wagner GJ. (2016). If You Tell People That You Had Sex with a Fellow Man, It Is Hard to Be Helped and Treated: Barriers and Opportunities for Increasing Access to HIV Services among Men Who Have Sex with Men in Uganda. *PLoS One* 11(1).
[54] Wyrod R. (2011). Masculinity and the persistence of AIDS stigma. *Culture, Health, and Sexuality* 13(4), 443-456.
[55] Wanyenze RK, Musinguzi G, Kiguli J, Nuwaha D, Mujisha G. (2017). When they know that you are a sex worker, you will be the last person to be treated: perceptions and experiences of female sex workers in accessing HIV services in Uganda. *BMC International Health and Human Rights* 17(11), 1-11.

For people who use drugs in Uganda, stigmatization is common across all levels of society, and because use of drugs is criminalized, many people who use drugs fear to seek testing and treatment for HIV or TB, as this could lead to prosecution, detention or drug rehabilitation.[56]

Focus group discussions with key population members from various regions covered by the study reported widespread stigma and discrimination in their families, communities and at health facilities. Sex workers reported that health workers question their morality; while other key populations reported health workers' negative attitudes toward their sexual orientation. People who inject drugs reported being isolated and attended to last at the health facilities because they are often considered 'dirty' or 'thieves'. None of the sex workers, people who inject drugs or other key populations interviewed reported failure to access healthcare completely, but many reported health workers refusing to attend to them, referring them to another health worker or health facility or delaying service to them. This kind of discrediting treatment has caused some key population members to avoid health facilities. Sex workers also reported psychological abuse by the health workers. Focus group discussion members unanimously agreed:

> *"Health workers abuse us; they look at us badly. There are many instances when health workers ask us to quit sex work, and yet jobs are very hard to find."*

In our discussions with health workers, it was noted that many of the health workers do not regard their attitudes and practices as stigmatizing or discriminating. They do not understand the impact of the actions and consequences of the key population members' access to and utilization of HIV services.

3.4.2 Stigma and discrimination against people with disabilities

Healthcare facility-level barriers place constraints on people with disabilities accessing HIV testing, treatment and care. Some people with disabilities have reported being denied healthcare from health workers due to communication problems and other social and physical barriers. Additionally, healthcare workers may also place lower priority on quality care for people with disabilities, especially when there are limited HIV services and medications. Assumptions by health workers that people with disabilities are not sexually active also result in a lower likelihood of being tested in the first place.[57] Delays in testing are common for people with disabilities living with HIV, and once diagnosed, access to treatment was limited as a result of lack of disability-friendly services, stigmatization by health workers, physical inaccessibility of healthcare facilities, and lack of disability-focused skills by providers.[58]

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[56] Uganda Harm Reduction Network. (2016). Drug Use Situation in Uganda. http://www.ugandaharmreduction.org/index.php?option=com_content&view=article&id=159&catid=78&Itemid=530

[57] Abimanyi-Ochom J, Mannan H, Groce NE, McVeigh J. (2017). HIV/AIDS knowledge, attitudes and behavior of persons with and without disabilities from the Uganda Demographic and Health Survey 2011: Differential access to HIV/AIDS information and services. *PLoS One* 12(4).

[58] Tun W, Okal J, Schenk K, Esantsi S, Mutale F, Kyeremaa RK, Ngirabakunzi E, Asiah H, McClain-Nhlapo C, Moono G. (2016). Limited accessibility to HIV services for persons with disabilities living with HIV in Ghana, Uganda and Zambia. *Journal of the International AIDS Society* 19(Suppl 4), 208-229.

3.5 Gender inequality and discrimination against women

Worldwide, gender inequality and sexual violence place women at specific risk of becoming infected with HIV. Harmful gender norms and inequality limit women's human rights in health and agency, and especially in the case of HIV.[59] Coerced and forced sex, which is associated with a lack of condom use, for example, is a common result of low relationship control. Societal norms around gender increase risk and limit health-seeking practices for both men and women.[60] [61]

The Uganda *Population HIV Impact Assessment Survey 2016/17* estimates that adult women in Uganda between the ages of 15 and 49 face an overall HIV prevalence of 7.5%, while men of the same age have a prevalence of 4.3%.[62] However, men often have a higher death rate, which is likely due to harmful gender norms that cause men to delay presentation for treatment.[63]

In a 2016 demographic survey in Uganda, it was reported that only 22% of married women independently held decision-making power over their health, including in cases of sexual autonomy and safe sex negotiation.[64] Lack of bodily autonomy can result in greater risk of HIV infection, involving the inability to negotiate condom use, rape, sex as a marital obligation, and gendered positions of power in household decision-making.[65]

Gender-specific stigmas related to HIV, like assumptions of promiscuity and immorality, prevent many women from getting tested for fear of violence from their sexual partners if diagnosed.[66] Sexual violence and abuse puts many Ugandan women at risk of HIV infection and impedes access to HIV testing, treatment, and care.[67]

Whereas incidence of gender-based violence appears to have lessened since the enactment of the Domestic Violence Act of 2010, nearly one in four married women in a national survey in 2016 reported intimate partner physical violence, while 17% reported intimate partner sexual violence within the past 12 months.[68]

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[59] Nampewo Z. (2017). Young women with disabilities and access to HIV/AIDS interventions in Uganda. *Reproductive Health Matters* 15(50), 121-127

[60] Mathur S, Higgins JA, Thummalachetty N, Rasmussen M, Kelley L, Nakyanjo N, Nalugoda F, Santelli JS. (2016). Fatherhood, marriage and HIV risk among young men in rural Uganda. *Culture, Health and Sexuality* 18(5), 538-552.

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[62] Uganda Population HIV Impact Assessment Survey 2016/17 Preliminary Result Fact Sheet.

[63] Kanters, S., Nansubuga, M., Mwehire, D., Odiit, M., Kasirye, M., Musoke, W., Druyts, E., Yaya, S., Funk, A., Ford, N., & Mills, E. J. 2013. Increased mortality among HIV-positive men on antiretroviral therapy: survival differences between sexes explained by late initiation in Uganda. HIV/AIDS – Research and Palliative Care, 5, 111-119.

[64] Nampewo Z. (2017). Young women with disabilities and access to HIV/AIDS interventions in Uganda. *Reproductive Health Matters* 15(50), 121-127

[65] Human Rights Watch. (2003). Just Die Quietly: Domestic Violence and Women's Vulnerability to HIV in Uganda. https://www.hrw.org/report/2003/08/13/just-die-quietly/domestic-violence-and-womens-vulnerability-hiv-uganda

[66] Watts C, Seeley J. (2014). Addressing gender inequality and intimate partner violence as critical barriers to an effective HIV response in sub-Saharan Africa. *Journal of the International AIDS Society* 17.

[67] Goldenberg SM, Muzaaya G, Akello M, Nguyen P, Birungi J, Shannon K. (2016). War-Related Abduction and History of Incarceration Linked to High Burden of HIV Among Female Sex Workers in Conflict-Affected Northern Uganda. *Journal of Acquired Immune Deficiency Syndrome* 73(1), 109-16.

[68] Uganda Bureau of Statistics (UBOS) and ICF. (2018). *Uganda Demographic and Health Survey 2016*. Kampala, Uganda and Rockville, Maryland, USA: UBOS and ICF

Female sex workers living with HIV face violence and discrimination, both as a sex worker and for some, as a woman living with HIV.[69] Sex workers who inject drugs in Uganda face intersecting stigmas: in addition to discrimination relating to their drug use, they experience gender-based violence related to their work that increases their risk of acquiring HIV.[70] Young sex workers were reportedly prone to physical and sexual violence and exploitation at the hands of their clients who did not want to use condoms, the police and their intimate partners[71]. Sex workers are often unable to report the gender-based violence perpetuated by their clients, the police and intimate partners to the police, as in most cases the violence is deemed "deserved".

3.6 Health Facility-Level Barriers

Health facility-level barriers exist for many people living with HIV, where studies note inadequate linkages and referral systems among service providers.[72] A gap in integration of services for TB and HIV is also a reported issue, resulting in low screening for both diseases. However, these problems are likely due to low staff numbers at most clinics, and the heavy overworking of most healthcare providers.[73] Greater adherence to treatment has been linked to integrating the health facility and technical lab so as minimize the time between testing and receiving results, thereby increasing a patient's likelihood to commit to ART.[74]

For female sex workers, health facilities provide barriers to sufficient HIV testing and treatment. Inconvenient hours of operation, low quality of services, lack of confidentiality, and discrimination, denial, and delay of services discourages the health seeking behavior of female sex workers who are living with HIV.[75]

Lack of key population-friendly HIV services in public health facilities is associated with limited access and utilization of the available HIV services especially among the key populations who cannot afford to travel far away to attend a health facility with key population-friendly services. Discussions with sex workers and men who have sex with men and their representatives noted some of health facility level practices that bar them from access and utilization of the available HIV services.

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[69] Hladik W, Baughman AL, Serwadda D, Tappero JW, Kwezi R, Nakato ND, Barker J. (2017). Burden and characteristics of HIV infection among female sex workers in Kampala, Uganda – a respondent-driven sampling survey. *BMC Public Health* 17(1), 565.
[70] UNAIDS. (2013). Global Report: UNAIDS report on the global AIDS epidemic 2013.
[71] George A, Sabarwal S, Martin P. Violence in contract work among female sex workers in Andhra Pradesh, India. J Infect Dis 2011;204:S1235-40
[72] Siu GE, Kennedy CE, Bakeera-Kitaka S. (2016). Young people with HIV attending a transition clinic in Kampala, Uganda: An explanatory study of social context, illness trajectories, and pathways to HIV testing and treatment. *Children and Youth Services Review* 65, 9-16.
[73] Bajunirwe F, Tumwebaze F, Abongomera G, Akakimpa D, Kityo C, Mugyenyi PN. (2016). Identification of gaps for implementation science in the HIV prevention, care and treatment cascade; a qualitative study in 19 districts in Uganda. *BMC Research Notes* 9(217).
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[75] Wanyenze RK, Musinguzi G, Kiguli J, Nuwaha D, Mujisha G. (2017). When they know that you are a sex worker, you will be the last person to be treated: perceptions and experiences of female sex workers in accessing HIV services in Uganda. *BMC International Health and Human Rights* 17(11), 1-11.

In focus group discussions, pregnant sex workers living with HIV who have not declared their key population status are often chased away from health facilities when they fail to turn up with a male partner. They also described situations where health workers from some health facilities refer them to specialized facilities with key population-friendly services. Unfortunately, due to financial constraints, some referred members of key populations are unable to reach these specialized clinics, especially if they are far.

Whereas, most of the sex workers interviewed noted that they can access HIV services, there were a few accounts of HIV positive sex workers being turned away from services. For example, one participant described being denied PMTCT services since she did not turn up with a male partner. Due to fear of discrimination, she did not disclose her sex worker status to health workers. This example highlights that while emphasizing male partner testing and access to services, providers should be sensitive to the circumstances of female sex workers and other populations that may not be able to present such partners. Another participant shared how a health worker at a facility with key population-friendly services revealed her HIV status to her sex worker colleagues, resulting in her being forced to flee to another brothel due to discrimination by fellow sex workers who learned of her HIV status. The situation ultimately disrupted her ability to take medications regularly, as she began missing pills to avoid her new colleagues discovering her HIV status.

Two focus group participants reported changing their dosing times for ARVs due to fear of inadvertently disclosing their HIV status, while many described failure to adhere to dosing times due to poor feeding. The participants described a young sex worker who gave up on taking ARVs in 2016 due to lack of food availability and later died.

Due to fear of stigma and the criminalization of their behavior, many members of key population groups are reluctant to self-identify and hence fail to receive necessary, appropriate and quality health services. Sex workers living with HIV often fail to receive appropriate counseling due to failure to identify as sex workers and often struggle with dual stigma - HIV-related stigma and sex work-related stigma. The key informants from key populations noted that some sex workers who required professional counseling have less opportunity to overcome stigma and many give up on their medications. Similarly, one gender and sexual minority participant noted:

> *It is hard for MSM most times; if you show the health worker the anal bruises she will call her colleagues to come and see – you become a specimen. Some will start preaching to you.*

HIV service provision should go beyond the numbers of people reached and focus on the quality of services and activities. It is important to consider, for example, who the people are behind the numbers, their experiences in gaining access to services, their satisfaction with such services, how nutrition affects adherence to HIV or TB drugs, and how other rights considerations (e.g. access to employment) shape their uptake and adherence. Periodic assessment of these issues will be important for understanding the lived experiences of these populations and how they might be impacting uptake of services.

3.7 Programs to address barriers to HIV services – from existing programs to comprehensive programs

Overview

The following section describes the existing or recent programs in Uganda to remove human rights-related barriers to services under each key program area, as well as the comprehensive programs that, if put in place, would remove such barriers to services (see also Annex 1 for a chart summarizing the comprehensive programs). As will be seen, there are many non-governmental and community-based organizations, as well as governmental entities, working to address human rights-related barriers to HIV. However, the activities they are implementing are often implemented on a small scale or for a limited time, impeding their ability to yield sustainable change. Uganda has institutions, protective laws and a civil society that can all be strengthened and engaged to significantly reduce human rights-related barriers to HIV. However, such an effort will require increased and sustained direct investment in interventions and activities that provide important human rights-related knowledge and skills to officials, health care workers, police and to the populations of those affected by HIV and that change harmful attitudes and practices.

Sources and uses of funds for interventions to address HIV barriers

The funding for HIV programming in Uganda comes from PEPFAR, Global Fund, Irish AID and the UN family, among others. Some of the funds are allocated to reducing human rights-related barriers to HIV services. The US Government, through PEPFAR, funds HIV-related prevention, care and treatment activities for sex workers, people who inject drugs and other key populations. The Global Fund, through a prime award to The AIDS Support Organization (TASO), supports HIV-related programming for people who inject drugs, sex workers, and other key populations. Some CBOs receive additional funding support from other bilateral donors or foundations including the Elton John Foundation and the Clinton Initiative.

Gaps, challenges, and opportunities

Uganda has contributed less to the funding of programs aimed at reducing barriers to HIV services with most of the funding coming from the few donors mentioned above. Whereas, in July 2014, the government passed a law establishing the AIDS Trust Fund to mobilize domestic resources for the national HIV and AIDS response [76], to date its implementation is still awaiting approval by parliament.

Whereas, the key funding agencies for HIV services in Uganda have a high-level of engagement and a forum through the Uganda AIDS Commission aimed at minimizing any redundancies in funding, as noted by a KII, there are some indications that HIV services for key populations are not rationally allocated. For example, there appears to be overlap or duplication in programming of activities. As noted by several KIIs, the overlap of HIV services delivery

[76] Uganda AIDS Commission (2016) 'The Uganda HIV and AIDS Country Progress Report July 2015-June 2016'

activities is mainly in regional towns including Kampala, Mbarara, Mbale, and Gulu, but there is limited coverage of HIV services in other districts.

Another challenge to appropriately allocating funding for key population programs and services is the lack of data estimating the size of these populations in Uganda. However, funding for such studies was included in the current Global Fund grant and this gap will be subsequently addressed.

There have been many pilot projects aimed at reducing stigma and discrimination experienced by key populations, including those living with HIV, improving access and utilization of high quality HIV services, and improving the capacity of the CSOs to support key and vulnerable populations. However, only a few of these have been evaluated and taken to scale. Training sessions of the health workers and the police that are reportedly effective in reducing stigma and discrimination, improving skills of health workers and reducing illegal arrests are yet to be integrated fully into pre- and in-services trainings throughout the country. Other models, such as moonlight clinics, community drop-in centers, community linkage facilitators and peer-to-peer outreach, are being implemented by several CSOs. Although there are some effective and promising interventions, they may be threatened by the departure of external funders.

There is an opportunity to implement the strategies identified in the Most-at-Risk Populations (*MARPs) Action Plan 2014* by the Government. Further, the revised health management information system (HMIS) tools developed by the Ministry of Health will allow the capture of data specific to key populations. These tools will likely improve the amount and quality of data available about key population groups at the health facility-level and hence inform better programming and service delivery for these groups.

PA 1: Reducing stigma and discrimination related to HIV

The table below provides an overview of current programmatic efforts on stigma and discrimination reduction as well as recommendations for scale-up. The content of the table is then further elaborated upon.

Reducing stigma and discrimination related to HIV					
Program	***Description***				***Limitations***
Stigma-reduction training	Training for a variety of populations to increase awareness on stigma and discrimination and promote a safe and healthy environment for people living with HIV and other key and vulnerable populations.				Not evaluated for its impact, although anecdotal evidence suggests positive effects on stigma reduction
Implementer	***Population targeted***	***# trained***	***Region(s)***	***Timeframe***	***Recommended scale-up***
Uganda Harm Reduction Network	Police, health workers	120 police officers; 30 health workers	Kampala, Gulu, Mbale and Mbarara	2016-2018	Scale up the training and form community support agents or people living with HIV support groups in every community. Harmonize or standardize the training curricula across the institutions. Extension to key population status related stigma should be integrated to support key population groups members.
PEPFAR/ USAID/ "Regional Health Integration of Services" projects	Health workers; community linkage facilitators; key population focal persons; project staff	Data not available	18 districts	2017-2022	
PEPFAR/CDC/TASO	as above	Data not available	3 districts	2017-2022	
PEPFAR/CDC/Baylor-SNAPS	as above	135 health workers; 110 key population focal persons in 2016	4 districts	2017-2022	
PEPFAR/CDC/ Mildmay Uganda	as above	Data not available	3 districts	2017-2022	
PEPFAR/CDC/IDI-Kampala region	as above	Data not available	3 districts	2017-2022	
NAFOPHANU	Community support agents/ peer leaders for people living with HIV;	Data not available	Country-wide	Since 2006	

	community health workers; village health teams					
Community Health Alliance Uganda (CHAU)	Community level support groups/ peer leaders for people living with HIV	Data not available		40 districts	Since 2012	
National Community of Women Living with HIV/AIDS (NACWOLA)	People living with HIV; community support agents; community health workers; village health teams	Data not available		Country-wide	Memory book developed in 2005; has been modified over time	
The AIDS Support Organization (TASO)	Counselors and health workers	Data not available		Country-wide	Since 2006	
Program	***Description***					***Limitations***
Capacity-building of CSOs working with key populations	Local initiatives building capacity of CSOs working with key populations. These CSOs reach out to their members and provide counseling, link their members to health facilities and follow up on service uptake. They also introduced an HIV scorecard for service delivery at the health facility level. This scorecard captures some aspects of discrimination by health workers and provides a pathway for meaningful participation of LGBTI and sex workers to reduce gaps in health service provision. CSOs advocate for improve service delivery and change in policies.					Most of these activities have been in pilot phase and concentrated in Kampala.
Implementer	***Population targeted***	***# trained***	***Clients reached***	***Region(s)***	***Timeframe***	***Recommended scale-up***
PEPFAR/ CDC Local Capacity Initiative (LCI)	Key populations	18 CSOs involved in pilot study	Data not available	Kampala city and	2016-2018	Capacity building should be extended to CSOs in other districts.

				surrounding districts		
Community Health Alliance Uganda (CHAU)	People living with HIV and key populations	15 CSOs	Data not available	Data not available	2016-2020	
MARPs Network/ Strengthening Uganda Civil Society Engagement for Targeted HIV/AIDS National Responses for Key (Affected) Populations	Key populations	10 CSOs	Data not available	38 districts	2011-2014	
Program	***Description***					***Limitations***
Expanding community mobilization, workplace mobilization and awareness creation about effects of stigma and discrimination against key populations or people living with HIV	Interventions through community-level structures, faith-based organizations or networks and workplace settings to create awareness about the impact of stigma and to campaign against stigmatization and discrimination of people living with HIV and other key populations.					No evaluation done to assess implementation of the mobilization activities agreed upon.
Implementer	***Population targeted***	***Clients reached***	***Region(s)***	***Timeframe***		***Recommended scale-up***
CHAU	Religious leaders; local leaders; village	*48 community dialogue meetings*	*Central & Northern*	*2014-2015*		Scale-up community-level dialogues on stigma and discrimination, its forms and harms;

	health teams (VHT)s				Scale-up the dialogues with religious leaders to talk about stigma and discrimination, as well as HIV prevention and treatment services for MARPs after church/mosque sessions; Encourage the extension of the sensitization to the religious leaders to lower community levels of stigma and discrimination
MARPs Network/ "Engaging faith-based organizations (FBOs): a quest to reach out to MARPs in Uganda project."	Members of Interreligious Council of Uganda and other church leaders	Data not available	All religious leaders represented	2014/2015	
Program	***Description***				***Limitations***
Group-based support for people living with HIV and other key populations to overcome stigma and discrimination	Group-based interventions and programs typically support people living with HIV and other key populations by providing a safe space for people to come together, discuss challenges, including stigma and discrimination, seek support and build community. These interventions range from unstructured sessions on a drop-in basis to structured sessions.				Difficult to assess effectiveness, lack of structure and similar competencies across organizations and CSOs, driven by motivation and good facilitation
Implementer	***Population targeted***	***Clients reached***	***Region(s)***	***Timeframe***	***Recommended scale-up***
The Hunger Project UK	Women living with HIV	Data not available	Data not available	Data not available	Ensure that these efforts benefit from the engagement of peer human rights educators to build literacy and mobilize around necessary rights.
CHAU	Young people living with HIV	160-200	Central and Northern	2014-2015	
NAFOPHANU	Community support agents	Data not available	Country-wide	Since 2006	
Program	***Description***				***Limitations***

Advocacy and awareness raising	Use of a combination of public events, relevant cultural mediums and advocacy to raise awareness about stigma and discrimination faced by key population communities and how these heighten their risks of HIV acquisition. These programs also involve creating platforms for information sharing and community dialogues.				Limited in scale and many shut down by police arrests
Implementer	***Population targeted***	***Clients reached***	***Region(s)***	***Timeframe***	***Recommended scale-up***
JSI/ USAID/ Government of Uganda	People living with HIV, people with disabilities	Data not available	Data not available	Data not available	Increase frequency of mass media campaigns to reduce stigma and discrimination Support and scale-up of stigma reduction programs that use cultural and religious media delivered through large, public events, combined with advocacy and engagement led by key and vulnerable populations.
CHAU	People living with HIV, communities	Data not available	40 districts	2006-2009	
PEPFAR/ CDC regional projects	Key populations	Over 120,000	9 districts*	2012-2016	
PEPFAR/ USAID/ STAR South West and STAR East Central	Key populations	Over 120,000	10 districts*	2012-2017	
PEPFAR/ USAID/ Regional Health Integration of Services (RHITES) Projects	Key populations	Data not available	12 districts	2012-2017; 2016-2021	
Program	***Description***				***Limitations***
Mobilize key populations, including PLHIV, through CSOs to provide counseling against stigma	Reaching out to key populations through CSOs working on key population issues to sensitize them about their right to health, provide counseling, and address stigma and discrimination reduction with families.				Limited knowledge of the population sizes and the coverage of the HIV services is not known
Implementer	***Population targeted***	***Clients reached***	***Region(s)***	***Timeframe***	***Recommended scale-up***

MARPs Network/ "Strengthening engagement and involvement of People living with disabilities and MARPs in Global Fund's new funding model processes"	"MARPs" and other key populations	Data not available	62 districts*	2013/2014	Invest in strengthening the CSOs organizational, management, and policy/ advocacy capacities around stigma reduction. This will enable their active engagement addressing stigma in communities s.
MARPs Network/ "Nothing for us without us – tailoring and coordinating behavioral, biomedical, and structural interventions for key populations in Uganda"	"MARPs" and other key populations	1,100	Kampala city and surrounding districts (Wakiso and Mukono)	2014/2015	
MARPs Network/ "Synergy Model Project (SMP)"	"MARPs" and other key populations	700 gender and sexual minorities	Kampala and surrounding districts	2012/2013	
MARPs Network/ "Promote uptake of HIV and AIDS services among key affected populations in Uganda"	Sex workers, men who have sex with men, transgender persons	10,251 sex workers; 3,227 gender and sexual minorities	41 districts	2016-2017	

Program	***Description***	***Limitations***
Peer-to-peer education and outreach	Provides information, HIV risk-reduction counseling, and referrals; provides information on HIV-related human rights; discusses stigma and discrimination (including self-stigma); promotes access to services; distributes condoms and lubricants. The degree to which stigma and discrimination reduction is central to the peer education program varies by implementer/CSO.	Insufficient attention to psychological/emotional concerns; limited reach, capacity of peers, and health facilities willing to participate. Potential lack of motivation and incentives

					for peer educators is a concern.
Implementer	***Population targeted***	***Clients reached***	***Region(s)***	***Timeframe***	***Recommended scale-up***
Several Lady Mermaid Bureau	Sex workers	Over 2,000	Central Uganda		Scale up human rights peer education and outreach models through investing in capacity building of key population-led CSOs Support the CSOs in compensating human rights peer educators for their work.
OGERA	Gender and sexual minorities	Over 500	Central Uganda		
Spectrum Uganda	Gender and sexual minorities	Over 500	Country-wide		
WONETHA	Sex workers	Over 2,000	Central Uganda		
UHRN	People who inject drugs	Over 1,000	Country-wide		
Program	***Description***				***Limitations***
The community linkage facilitator or key population focal person at health facility model	Provides information, drugs, traces loss to follow-up, follows up referrals to ensure linkage; discusses stigma and discrimination (including self-stigma); promotes access to services; distributes condoms, lubricants. This model also includes Drop-in Centres for information and drugs in the communities and CSO offices and key population hot spots.				Sustainability of this model is dependent on donor funding. Facilitators or focal persons are often paid trained professionals.
Implementer	***Population targeted***	***Clients reached***	***Region(s)***	***Timeframe***	***Recommended scale-up***
PEPFAR/ USAID/ "Regional Health Integration of Services" projects	People living with HIV and other key populations	Data not available	Health facilities with at least 500 patients on ART in 64 districts	2017-2022	Strengthen the human rights aspect of the model to enable community-based monitoring and feedback on stigma and discrimination at health care facities. Scale up this community

					monitoring to all health facilities offering HIV services
PEPFAR/CDC/TASO	as above	Data not available	6 districts	2017-2022	
PEPFAR/CDC/IDI-Kampala region	as above	Data not available	3 districts	2017-2022	
PEPFAR/ CDC Local Capacity Initiative (LCI)	Gender and sexual minorities and sex workers,	18 CSOs involved in pilot study	Data not available	Kampala city and surrounding districts	

*All MARPs network initiatives have reached 62 districts total since 2014.

Current Programs

Overview

Stigma and discrimination are widely recognized as key barriers to the access of HIV care in Uganda. As a result, almost all the organizations working with key and vulnerable populations include some component of programming that is aimed at reducing stigma and discrimination. The most common approaches used were: stigma-reduction training for key duty-bearers; capacity-building on stigma reduction of CSOs working with key and vulnerable populations; expanding community mobilization around stigma reduction; workplace mobilization; awareness creation about the effects of stigma and discrimination against people living with hIV and other key populations; advocacy and awareness raising about stigma and discrimiation among sex workers, men who have sex with men, people who inject drugs and transgender people; group-based support for people living with HIV and other key populations to overcome stigma and discrimination; mobilizing key populations or people living with HIV through CSOs to provide counseling against stigma; peer education; and having a community linkage facilitator or key populations focal person at health facilities.

Stigma-reduction training

Efforts to improve understanding of stigma and its harmful consequences for people living with HIV and to reduce continuing irrational fears of infection, and moral judgments through participatory training methods have been underway in Uganda since 1987 when The AIDS Support Organization (TASO) was formed. In 1988, TASO opened a training centre where HIV counselors and staff of Governmental and non-governmental organizations are trained. The training includes stigma reduction training. Several other organizations have supported, or are supporting, stigma-reduction training among health workers, managers and regulators, and other individuals interacting with people living with HIV. The USAID/Health Communications Partnership Project (2007-2012) developed several toolkits, including stigma reduction toolkits, for training. Currently, several other organizations, including NAFOPHANU, Mildmay Uganda, and tertiary institutions, train health workers, CSO staff and peer educators in stigma reduction.

Several organizations that support HIV service delivery at health facility-level and in the communities also include in their activities the training of their staff, and to a lesser extent, the health workers at health facilities, about stigmatizing attitudes. Such organizations and programs include PEPFAR supported programs. (See also below program area on training of health care workers on human rights and medical ethics.)

In the past five years, Global Fund and PEPFAR-supported programs have also included gender and sexuality diversity training for implementing partner staff and some health workers at some health facilities. Gender and Sexuality Diversity training by the PEPFAR/Local Capacity Initiative Project (2016-2018) so far has been attended by over 50 facility-based health workers in six health facilities in Kampala, Mukono and Wakiso.

Limitations/Challenges

There is a need to integrate training on stigma and human rights within pre-service training institutions for key duty bearers (i.e. nurses, doctors, social workers, lawyers, judges, police,) to make the trainings more sustainable over time. Currently, trainings are in-service, and it is often difficult to reach all police or health workers in a facility, for example. In addition, regular re-assignment of staff in government health facilities and police stations requires regular re-training of staff.

Some of the key population members noted the limited capacity of some trained HIV counselors in handling both HIV stigma and key population status-related stigma. There is a need to integrate key population status-related stigma reduction training and the HIV status stigma reduction to address the needs of key populations, other than people living with HIV.

The HIV Anti-Stigma policy that would otherwise be informative in developing a harmonized training curriculum is still in draft form.

Capacity building on reduction of stigma and discrimination of CSOs working with key populations

Several programs and NGOs have worked with local CSOs supporting key populations to strengthen their capacity in handling stigma and discrimination-related issues and in mobilizing communities for HIV services. Organizations such as CHAU, UGANET, MNL, THETA and MARPI have supported training and mentorship of several small CSOs and people living with HIV networks. Between 2016 and 2018, a PEPFAR-funded local capacity initiatives project provided capacity-building for 15 CSOs working with key populations in Kampala, Mukono and Wakiso. The key informants from these CSOs reported improved capacity to interact with communities' law enforcement agents and health workers to discuss issues of stigma and discrimination. Some of the CSO members are part of the Global Fund CCM, district AIDS Committees and MARPs committees formed by Uganda AIDS Commission (UAC).

Further, CHAU and partners are currently implementing a "Partnership to Inspire, Transform and Connect the HIV response (PITCH)" project (2016-2020). One of PITCH's main component is aimed at strengthening local organizations' capacity to advocate, generate evidence and develop robust policy solutions for upholding the rights to HIV and other sexual and reproductive health services for men who have sex with men, sex workers, transgender people, people who use drugs and adolescent girls and young women.

Similarly, PATH and Initiatives Inc. was awarded a 5-year USAID/Advocacy for Better Health project in 2014-2019 and has built capacity of the 20 local CSOs across 35 districts to advocate to decision-makers at both the local and national levels for better health services and hold them accountable for their promises. The capacity is aimed at the CSOs to advocate to government to implement activities to reduce stigma and discrimination including sensitizing the wider community and health workers.

Under the Strengthening Uganda Civil Society Engagement for Targeted HIV/AIDS National Responses for Key (Affected) Populations (2011-2014), MNL supported the capacity-building activities and development of tools to enable grass-root advocacy by 10 CSOs.

Finally, over the past five years, well-established CSOs working to support people living with HIV and networks such as NAFOPHANU and NACWOLA have collaborated with other NGOs such as UGANET and TASO to strengthen the capacity of their grass-root networks and peer educators to fight stigma and discrimination through community sensitization, engagement of local and religious leaders and supporting PLHIV discriminated against due to their HIV status to receive justice or redress.

Limitations/Challenges

The key informants noted limited coverage of CSO and networks capacity trainings and mentorship, and some cited limited funding to scale-up capacity building programs. Further, the ability to maintain the developed capacity of these CSOs is affected by high staff turnover.

Expanding community mobilization, workplace mobilization, and awareness creation about the effects of stigma and discrimination against key populations or people living with HIV

Several NGOs and programs have supported interventions through community-level structures and workplace settings to create awareness about the impact of stigma and to campaign against stigmatization and discrimination of people living with HIV and other key populations. Such interventions include community dialogues or meetings, workplace-based HIV policies, engagement of peer educators and community linkage facilitators, and engagement of the religious and cultural leaders.

Since the development of the National Policy on HIV/AIDS and the World of Work 2003[77] that prohibits discrimination at work based on HIV status, several work places have developed local policies to conform to this national policy. This has helped to reduce discrimination at work places. There have been several projects supporting work place policies in Uganda. Currently, one such project is the USAID/Uganda HIV/AIDS and health Initiatives in the Workplaces Activity (HIWA), a 5-year program (2016 – 2021) implemented in 33 districts by several implementing partners. The overall goal of the activity is to improve the health of the members of the Uganda People Defense Forces (UPDF), private security guards Uganda Wild Authority staff, and staff in selected hotels affiliated with the Uganda Hotel Owners Association (UHOA).

There have been notable efforts to engage religious and cultural leaders on issues affecting key and vulnerable populations and to more systematically enlist their support to address stigma and discrimination; and opportunities exist to expand these efforts, as well as to involve these leaders in promoting general awareness about HIV. In 2014 and 2015, CHAU reached out to religious leaders and village health teams (VHTs) in 48 communities in Central and Northern Uganda through community dialogue meetings. Similarly, the cultural institutions in the Kings and Cultural Leaders' Forum, a forum that brings about 14 cultural institutions together, are playing a significant role in reducing HIV-related stigma. They are using different platforms to reach out to specific age groups in their kingdoms.

[77] Ministry of Gender, Labour and Social Development. 2003. Uganda National Policy on HIV/AIDS and the World of Work

Several NGOs and CSOs, including NAFOPHANU, CHAU, and NACWOLA, have used community dialogue meetings and mass media extensively in conducting anti-stigma campaigns in the different regions of the country. NACHWOLA has community volunteers (individuals living with HIV/AIDS) who offer free counseling services to people living with HIV as one of the ways to fight stigmatization. Some of these volunteers also visit schools to discuss HIV issues and effects of stigma. They have district and sub-county HIV/AIDS Committees where they train people living with HIV members to support others.

The *PLHIV Stigma Index* surveys provide information for advocacy and empower people living with HIV in communities to advocate for their rights using this information. In Uganda, there have been only one national *PLHIV Stigma Index* by NAFOPHANU with support from UNAIDS and other partners[78]. UNAIDS also has supported a regional level *PLHIV Stigma Index* survey in Karamoja region[79]. WONETHA reported to have also conducted a *PLHIV Stigma Index* survey among sex workers living with HIV in 2017[80]. In all these studies, it was clear that self-stigma is still an issue where it was 25.7% in Karamoja and 38.5% among sex workers; but there was a decrease from the 50% reported in the national survey index survey conducted in 2013.

Limitations/Challenges

Key informants noted that the reach and frequency of community-level mobilization activities has been limited by funding.

Whereas, it was intended that the *PLHIV Stigma Index* be repeated every 2 years, this has not happened over the past five years. Further, data on stigma, discrimination and other rights violations is not being collected routinely from people living with HIV, which makes it difficult to assess the impact of the stigma and discrimination reduction efforts that have been implemented over the last 5 years. Investments in routine data collection efforts and follow-up to these efforts, like conducting the *PLHIV Stigma Index* every 2 years, are needed to support national goals to achieve the 90-90-90 targets by 2022 and to determine if investments in stigma reduction are paying off. Outside of the Index, there is currently no mechanism to capture experiences of stigma and discrimination and facilitate redress.

Advocacy and awareness raising about sex workers, men who have sex with men, people who inject drugs and transgender people

Several community dialogues have been conducted by CSOs supporting other key populations across the country. Uganda Harm Reduction Network has held several community dialogues and group meetings with local leaders, health workers, and law enforcement officers in Kampala, Mukono and Wakiso. They reached 100 community members, health workers and police officers in 2017. In 2017, WONETHA held 17 dialogues with 41 local council leaders, 20 lodge managers, 16 lawyers, 66 police and 668 sex workers about the stigmatizing attitudes, discrimination and rights of the latter in Kampala district. The meetings reported to have

[78] NAFOPHANU (2013). The PLHIV Stigma Index, Country Assessment, Uganda NAFOPHANU. Kampala: Uganda
[79] NAFOPHANU (2017). PLHIV Stigma Index Baseline Survey conducted in Karamoja, Uganda NAPHOFANU. Kampala: Uganda
[80] WONETHA (2017). PLHIV Stigma Index Survey among HIV positive sex workers, Uganda WONETHA. Kampala: Uganda

brought about an improved interaction between people who inject drugs, sex workers and the community leaders and police.

Further, in 2014-2015, MNL reached out to religious leaders through "Engaging faith-based organizations (FBOs): a quest to reach out to MARPs in Uganda project." With support from the Global Fund, ICWEA held dialogues with religious leaders from 18 districts in 2015, where they reached 262 leaders. Further, key informants from TASO and Mildmay also reported reaching religious leaders through dialogues and sensitization meetings about key population status-related stigma.

Under the *Strengthening Uganda Civil Society Engagement for Targeted HIV/AIDS National Responses for Key (Affected) Populations (2011-2014)*, MNL supported the capacity building activities and development of tools to enable grass-root advocacy by 10 CSOs.

The Crane surveys in 2013 among sex workers and men who have sex with men provided valuable information about access to and utilization of HIV services.

Limitations/Challenges

The reach of advocacy and creation of awareness activities about gender and sexual diversity and stigma and discrimination against people living with HIV, sex workers, and other key populations is still limited in communities, among religious and local political leaders, health workers and law enforcement. Further, the activities so far implemented have not been evaluated to assess acceptability and effectiveness among different key populations.

Group-based support for people living with HIV and key populations to overcome stigma and discrimination

Group-based interventions and programmes have been a key component of the HIV response, with local NGOs and key population-focused CSOs and networks supported to provide such services. Several NGOs, networks and service programs or implementing partners (such as UGANET, CHAU, NAFOPHANU, NACWOLA, TASO, IDI, Mildmay Uganda) have community-level peer educators and networks of people living with HIV that provide group support to each other. Such groups include the community support agents, family support groups, mentor mothers or Saving Mothers Giving Life or peer mothers, and Young people living with HIV. For sex workers, men who have sex with men and people who inject drugs, the CSOs that are focused on these key populations provide group-based support. The Drop-in Centers (DiCs) at the CSO offices provide safe space for these groups to access HIV services with minimal stigma. Donor funded organizations, such as Uganda Harm Reduction Network (UHRN) and MARPI, have developed networks of key populations that support each other.

Whereas, the impact of this group-based support regarding stigma and discrimination has not been evaluated, the focus group discussions provided anecdotal evidence of its positive effects on access to HIV services and stigma reduction among the people living with HIV and other key populations. This conforms to findings in available literature where support groups have been found to be successful in combating the multidimensional effects of stigma and discrimination.

Limitations/Challenges

The lack of sufficient structure within many of the current support groups makes it difficult to assess the importance and impact of their work on people living with HIV. Different organizations and CSOs have different structures of these groups and with slightly different roles and competencies. The functionality of these groups is also determined by differing levels of facilitation and motivation. Whereas, some support groups are engaged in some income generating activities, many are not. Integration of economic and income-generation skill development, educational programs, transitional economic and housing support in support models for people living with HIV have been shown to be more effective in battling stigma[81].

Mobilizing key populations, including people living with HIV, through CSOs to provide counselling against stigma

Since 2010, PEPFAR-supported programs have included some activities focused on information, prevention, and referrals for reducing HIV transmission among key populations, including female sex workers, men who have sex with men, and people who inject drugs. They operate through CSOs to implement such activities as peer-to-peer outreaches, home-based care by peers, creation of HIV awareness, condom promotion and distribution, drop-in-centers for treatment distribution, and community linkage facilitators or key population focal persons at the health facilities. Global Fund-supported programs also operate similar models.

Several sex workers, men who have sex with men and people who inject drugs have been reached through CSOs and networks to sensitize them about their right to health, provide counselling, and address stigma and discrimination reduction within families. Other projects that the MARPs Network (MNL) has coordinated through the member CSOs to reach the key population members include: "Nothing for us without us – tailoring and coordinating behavioral, biomedical, and structural interventions for key populations in Uganda (2014-2015)" that reached 1,100 members of key populations, and "Promote uptake of HIV and AIDS services among key affected populations in Uganda 2016-2017" that reached 10,251 sex workers and 3,227 men who have sex with men.

Limitations/Challenges

Due to limited knowledge of the population sizes, the coverage of the HIV services is not known.

Peer educator model

One of the most common interventions with key populations in Uganda has been the peer to peer education and outreach model. Key population members and CSOs are at the center of this intervention model. This model includes the peer leaders used by CSOs focusing on sex workers, men who have sex with men or people who inject drugs; expert patient intervention used by TASO; the community support agents or family support groups set up or supported by UGANET, NAFOPHANU, NACWOLA and Positive Men Union (POMU), and lay counselors set up by some health facilities. They generally carry out one-on-one and group activities, offer an array of useful information including internal stigma reduction counseling, legal literacy, and

[81] Poudel V et al. (2015). Women living with HIV/AIDS (WLHA), battling stigma, discrimination and denial and the role of support groups as a coping strategy: a review of literature.

actively promote access and utilization of HIV services. This model is also being used in some of the prisons that were visited during this assessment.

As noted in focus groups, the peer educators of sex workers, men who have sex with men and people who inject drugs also do home or work place visits to their members to discusses stigma and discrimination (including self-stigma); promote access to services; distributes condoms and lubricants; and provide adherence counseling to ARVs. In some cases, they ask their members about the treatment they received at the facility, and where relevant and possible, they follow-up and discuss the feedback with the health workers.

The role of peer leaders cannot be overestimated as almost all the HIV services programs, including the PEPFAR and Global Fund supported programs for sex workers, men who have sex with men or people who inject drugs, are using this model. These peer leaders are members of CBOs and partner with NGOs and health facilities to do outreach and provide lists of health facilities offering key population friendly services, and in some cases accompany their members to the services. In prisons, the peer leaders ensure adherence to ARVs and TB treatments, promptly report poor health of their members to health workers, mobilize for HIV is testing and TB screening whenever health workers visit the prison facilities.

A variant of the peer model is the peer mothers' model, which has been in place in the PEPFAR/CDC funded Mildmay Uganda project in central Uganda and TASO, among others and is also being supported by UGANET. In addition to counselling women when they visit the health facilities, they do home visits to provide ART adherence counselling, psychosocial support and stigma reduction counselling among HIV positive pregnant women and new mothers.

In 2016/2017, AMICAALL trained and equipped 140 peer educators and facilitated them to conduct peer education and community mobilization for HIV/AIDS services through addressing internalized HIV-related stigma among the adolescents and urban area youth. These efforts included helping youth involved in sex work and injection drug use to overcome community level stigma in order to access HIV services. The 140 peer educators trained reached out to 40,320 members of these key populations, and young people and adolescents with messages about HIV and AIDS.

Limitations/Challenges

The coverage of the functional peer education and outreach model for people living with HIV is still limited, especially in communities with low HIV prevalence due to long distances that peers would have to walk to visit their members. Similarly, long distances have limited the activities of peers of sex workers, men who have sex with men and people who inject drugs.

Further, interventions primarily based on peer education may have limited reach – for example, because of stigma, the focus groups noted that older and more affluent men who have sex with men, and older people who inject drugs prefer to stay underground or anonymous and are thus not effectively reached through face-to-face peer meetings.

The focus group discussions and key informant interviews noted limited capacity of some of the peers to support stigma reduction, while the small number of health facilities that are willing to work with the peers to support these key populations has limited the effectiveness of the peer models for sex workers, men who have sex with men and people who inject drugs. Further, another shortcoming of the peer-peer model is its dependence on the dedication and morale of peer educators, which may not be guaranteed all the time due to poor motivation, and lack of incentives.

The community linkage facilitator, or key population focal person, at health facility model

Many health facilities offering ART services have community linkage facilitators and/or people living with HIV focal persons at the health facility who track people living with HIV for psychosocial support and counselling for stigma reduction or who receive people living with HIV at the health facility. The linkage facilitators include some peer educators and other trained professionals including village health teams (VHTs). In 2018, all PEPFAR supported ART sites with at least 500 ART patients were to have at least one community linkage facilitator or focal person. For sex workers, men who have sex with men and people who inject drugs, the community model is built on the interdependent relationship between their small member organizations and service supply organizations (NGOs, programs and Government health units). Most organizations built on the basis of their peer network not only mobilize key populations for HIV testing but also refer them to established health units, facilities or programs for care. Other than health services, key populations are also referred/linked to organizations providing services including legal, financial and skills training services.

In addition, some donor-funded organizations are implementing some form of a community treatment-distribution model. The community treatment distribution models were started by TASO several years ago; while other organizations, such as MARPI and PEPFAR/CDC/ IDI projects, are operating drop-in-centers at the CSO offices and key population hot spots to deliver ARVs to HIV positive sex workers, men who have sex with men and people who inject drugs.

In 2015, TASO reported 70% of its ART clients receiving their monthly ARVs refills through community treatment-distribution points run mainly by the trained counselors and the community support agents (CASAs)

Research participants referenced drop-ins as an important resource for key populations, particularly female sex workers and men who have sex with men. These centers provide information, psychosocial support, and free services, including HIV testing and counseling, and STI treatment. They also serve as stigma-free “safe space” for key populations, thus responding to both human rights and psychosocial needs. The research participants underscored the usefulness of these centers in availing services to men who have sex with men, people who inject drugs and sex workers since they are safe spaces and reduce on distances to health facilities. These centers also provide counseling to the members of key populations to manage internalized stigma and community-level stigma. They also encourage their clients to attend with family members and work colleagues (mainly for sex workers) for stigma reduction counseling.

Many health facilities offering ART services have community linkage facilitators and/or people living with HIV focal persons at the health facility who track people living with HIV for psychosocial support and counselling for stigma reduction or who receive people living with HIV at the health facility. Commonly, these focal persons are people living with HIV who have been trained as lay counselors. Few are professional counselors and physicians. In 2018, all PEPFAR supported ART sites with at least 500 ART patients were to have at least a community linkage facilitator or focal person.

Limitations/Challenges

The models of linkage facilitators face similar challenges to the peer education and outreach models. They both need an established incentive structure and formal recognition and support by the Ministry of Health.

Recommendations to reach comprehensive programming

The following recommendations are made to move towards comprehensive programming for the reduction of stigma and discrimination:

- The Uganda AIDS Commission should finalize the National HIV Anti-stigma and Discrimination Policy and the associated guidelines. This policy and the guidelines should be expanded to cover stigma based on key population status alone, beyond positive HIV status.
- Integrate training on reducing stigma, discrimination and violence related to HIV in professional schools for duty bearers (i.e. teachers, doctors, nurses, social workers, lawyers, judges, etc.) by integrating modules on stigma reduction in the existing curricula. Continue in-service trainings and community leader/stakeholder trainings.
- Integrate training on gender equality and sexuality diversity in professional schools for duty bearers (i.e. doctors, nurses, lawyers, judges, law enforcement agents, etc.). Continue in-service trainings and community leader/stakeholder trainings.
- Increase frequency of mass media campaigns, both audio and visual, to reduce stigma and discrimination based on HIV status, social status based on work, as well as to address gender equality issues.
- Support and scale up throughout the country stigma-reduction programs that use cultural and religious media delivered through large, public events, combined with advocacy and engagement led by key populations.
- Repeat the national *PLHIV Stigma Index* and Crane Surveys on a 2-3 year basis to provide updated data for assessing impact of programs to remove stigma and discrimination and ensure funds for follow-up based on findings.
- Establish a national-level monitoring system to capture stigma, discrimination and other rights violations experienced by people living with HIV, key populations and people with TB and support redress.
- Support advocacy for expansion of MARPI clinics across the country, or replication of MARPI clinic model of services to sex workers and their clients and other key

populations, and support the inclusion of human rights training and orientation of those providing such services.

PA 2: Training health care workers on human rights and ethics related to HIV

The table below provides an overview of recent and current programmatic efforts on training health care workers on human rights and medical ethics as well as recommendations for scale-up. The content of the table is then further elaborated upon.

Training health care workers on human rights and ethics related to HIV						
Program	***Description***					***Limitations***
Training and sensitization workshops for healthcare workers	Mapping and sensitizing health service providers to provide safer and more efficient services for young people who use drugs, men who have sex with men, sex workers, and transgender workers. Training in identification and responding to gender-based violence and other community mobilization trainings. Project activities for sensitizing the health workers and training them on the human rights of the key populations.					Human rights trainings in HIV context are not mandatory or institutionalized and reach is limited.
Implementer	***Population targeted***	***# trained***	***Clients reached***	***Region(s)***	***Timeframe***	***Recommended scale-up***
Uganda Harm Reduction Network/ "Don't push" campaign	Health service providers, law enforcement agents	Data not available	Data not available	Data not available	2015	Develop and integrate updated curricula on HIV/TB related human rights and medical ethics into pre-service and in-service training of health workers and clinic staff who deal with PLHIV and other key and vulnerable populations To assess impact of training, support routine assessments of healthcare workers knowledge, attitudes, and practices with regard to stigma, discrimination, supportive care, confidentiality and informed consent concerning PLHIV and other key and vulnerable populations.
MARPs Network/ "Promote uptake of HIV and AIDS services among Key Affected Populations in Uganda"	Police officers and health workers	Data not available	Data not available	24 districts	2017	
UGANET/ "Strengthening systems addressing legal barriers in responding to GBV in the context of HIV"	Police officers and health workers	Data not available	Data not available	27 districts	2016	
VINACEF Uganda	Health workers	Data not available	Data not available	Kampala city	2016	

MARPs Network	Health workers	Data not available	Data not available	Data not available	2013	
PEPFAR/ CDC Local Capacity Initiative	Health workers	50 health workers, six health facilities	Data not available	Kampala city and surrounding districts of Mukono and Wakiso	2016-2018	
USAID/ Strengthening TB and HIV/AIDS Responses projects, The Regional Health Integration of Services	Health workers	Data not available	Data not available	Data not available	2009-2017, 2017-2022	
Program	***Description***					***Limitations***
Legal and human rights awareness campaigns for sensitization of public officials and health providers	Mapping and sensitizing health service providers on human and sexual rights of minorities, as well as encouraging health workers to use Patient's Charter.					Trainings are not mandatory or institutionalized and reach is limited.
Implementer	***Population targeted***	***# trained***	***Clients reached***	***Region(s)***	***Timeframe***	***Recommended scale-up*** (See recommendations above)
HRAF	Health providers	121 health workers	Data not available	Data not available	2016	

Current Programs

Overview

Stigmatizing attitudes and discriminatory practices in health care settings act as a major barrier to access, utilization and retention in care for clients vulnerable to or living with HIV. Thus, most of the current trainings and creation of awareness activities are aimed at reducing stigma and discrimination in health care settings that are related HIV status and/or key population status. Nonetheless, these trainings and sensitization activities have been limited to certain regional towns and to relatively small cohorts of staff.

Training and sensitization workshops for healthcare workers

Since 1990, health workers have been trained in HIV service delivery following the MoH Clinical Guidelines and HIV Counseling and Testing Guidelines, and with regard to the medical ethics of service delivery. These trainings have been institutionalized in the training institutions for the health workers. The training of health workers, managers and regulators in human rights related to HIV and key and vulnerable populations has, however, been done by NGOs; notably human rights-based NGOs such as UGANET, HRAPF, AGHA among others. For sex workers, people who inject drugs, and other key populations, trainings and sensitization of health workers have also been done by NGOs focusing on most at risk populations, including MARPI, that have an extensive training program. The people living with HIV networks, such as NAFOPHANU and NACWOLA and community linkage facilitators, regularly interface with health workers to discuss stigmatizing attitudes and discriminatory practices.

Other donor-funded programs, such as MARPI and CHAU, have organized several trainings and workshops for health workers, security officers and other service providers to make them aware of the harmful consequences both in terms of health and wellbeing, of stigma, discrimination and punitive approaches on people living with HIV, sex workers, men who have sex with men and people who inject drugs. Creating separate corners in health facilities and ending arbitrary arrests of female sex workers and men who have sex with men are some of the issues being raised in these fora.

In 2017, UGANET trained 451 health workers while the PEPFAR/CDC Local Capacity Initiative project (2016-2018) by THETA, Action Group for Health, Human Rights and HIV/AIDS (AGHA) and MNL trained at least 50 health workers in Gender and Sexuality Diversity and the human rights approach to HIV services for sex workers and men who have sex with men. UHRN trained 60 health workers in 2017, and Spectrum Uganda, an organization led by men who have sex with men, has trained 284 health workers from 10 districts over the past 4 years. Similarly, Lady Mermaid Bureau, a sex worker led organization, trained 70 health workers in 2017.

Limitations/Challenges

Only few health workers have been trained in human rights in the context of HIV services, especially with regard to the rights and needs of key populations. None of the trainings on human rights in the context of HIV are mandatory as part of in-service training. Further, these trainings are yet to be institutionalized. It was noted that the same health workers are often

trained by different NGOs hence replicating trainings that would otherwise be spread to reach more health workers.

Legal and human rights awareness campaigns for sensitization of public officials and health providers

The trainings about Gender and Sexuality Diversity and human rights have also been extended to health managers such as district health officers and other members of the district health team. It was reported that at least 30 district health team members have been oriented or sensitized on issues of key populations, and they have a district focal person in charge of key population (sex workers, men who have sex with men and people who inject drugs). Further, in 2017, with support from the Ministry of Health, UNFPA and PEPFAR-funded programs, seven districts developed MARPs SRH/HIV strategic, operational and M&E plans (including Kampala, Wakiso, Hoima, Fort Portal, Mbarara, Gulu, Mbale).

Limitations/Challenges

Similar challenges as noted for the health workers.

Routine monitoring of key population client satisfaction to encourage key population friendly health facilities

Different NGOs have supported the use of the Community Score Card in some health facilities across the country. The Community Score Card engages providers of services (duty bearers/health workers/ district health team members and service users in assessing service issues and enables them to dialogue and develop appropriate action plans to improve healthcare service delivery. Potentially it is an important form of community-based monitoring of and feedback to health services. In 2014 and 2015, NAFOPHANU supported Community Score Card assessments for HIV services and meetings in three districts in Eastern and Western Uganda, respectively. The Local Capacity Initiative project (2016-2018) started Community Score Card assessments of HIV services for sex workers and men who have sex with men in six health facilities in Kampala, Mukono and Wakiso districts.

Limitations/Challenges

The Community Score Card implementation is still at a limited scale.

Recommendations to reach comprehensive programming

- Update curricula on human rights and medical ethics related to HIV and TB and scale up in-service training of health workers, health managers as well as other people working in health facilities (e.g. laboratory technicians, receptionists, data clerks) using a harmonized training curriculum.
- Integrate into pre-service training a course on HIV/TB-related medical ethics and human rights for doctors, nurses, health managers and other staff (e.g. front desk staff, lab technicians, cleaners)

- Support routine assessments (i.e. every 1-2 years) of knowledge, attitudes and practices of health workers and staff towards people living with HIV and/or TB and other key populations to support health facility administrators to identify and address any issues. Healthcare setting-based surveys should be done among providers and exit interviews with key population clients throughout the country with the help of proper guidelines executed for this, with built-in provisions for expected follow-up regarding results.
- Scale up and roll out the Community Score Card and other forms of community-based monitoring to support routine monitoring/feedback in health facilities by people living with HIV and other key and vulnerable populations.

PA 3: Sensitizing lawmakers and law enforcement agents

The table below provides an overview of current programmatic efforts on sensitizing lawmakers and law enforcement agents as well as recommendations for scale-up. The content of the table is then further elaborated upon.

Sensitizing of law-makers and law enforcement agents					
Program	***Description***				***Limitations***
Trainings and orientation programs	Mapping and sensitizing police and other community leaders and authoritative figures to support, not retard, access to HIV services for young people who use drugs, men who have sex with men, sex workers, and transgender people. Providing sensitizing info on human rights and legal aspects of health for key populations. For police officers, this might include training to stop and respond to gender-based violence				Weak monitoring and follow-up of program activities and participants that have ledto challengesin sustaining the program impact.
Implementer	***Population targeted***	***# trained***	***Region(s)***	***Timeframe***	***Recommended scale-up***
Uganda Harm Reduction Network/ "Don't punish" campaign	Law enforcement agents, communities, policy makers	Data not available	Data not available	2015	Develop curricul on supportive and rights-based approaches to law enforcement an policy development, so as to support access of PLHIV and other key and vulnerable populations to health servicse and to reduce illegal police practices that hinder HIV efforts. Thi curricua should be integrated into pre-service training of Police Academies, with the support and engagment of the Ministry of Health. Support in-service training for law enforcement and policy makers on HIV and TB services for key populations using the updated curricula. Support routine assessments of knowledge, behaviors, and attitudes towards people living with HIV or TB among law enforcement officers. Support key population networks to engage with law enforcement to prevent harmful practices.
MARPS Network	Law enforcement and law makers/ parliamentarians	Data not available	Data not available	2013	
USAID/ Freedom House	Judges at sentencing level	Data not available	Data not available	2014-2019	
PEPFAR/ CDC Local Capacity Initiative (LCI) 2016-2018	Policy-makers and public officials	100 public servants	Kampala, Wakiso, Mukono	2016-2018	
VINACEF Uganda	Policy-makers, community gatekeepers, and community influencers	Data not available	Data not available	2017	
UGANET	Police officers, prosecutors	429 police officers, 42 prosecutors in 2016; 360 police officers, 41 prosecutors in 2017	All regions	2016-2017	

					Expand training for prison personal on health and human rights of key populations.

Current Programs

Overview

There have been significant efforts to sensitize law enforcement agents, lawmakers, lawyers and magistrates on public health approaches to law practices and law enforcement practices. The ongoing trainings and orientation programs are aimed at ensuring that illegal police practices and punitive approaches that retard HIV prevention and treatment efforts are reduced. Further, several orientations and trainings have focused on gender and sexuality orientation and lifestyle choices to ensure that the right to health and HIV services of sex workers and other key populations is not constrained by fear of arbitrary arrests and detention, violence, extortion, and harassment by law enforcement agents. Similar to trainings and orientation of health workers, there are only a few enforcement agents, lawyers and magistrates that have been trained, especially about the needs of key populations.

Trainings and orientation programs

Key informants from USAID/Freedom House Project (2012-2018) reported various engagements with lawyers, magistrates and police officers on a public health approach to law and law enforcement practices. UGANET, HRAPF, AGHA and MARPI, among others, reported trainings and sensitization workshops for lawyers, magistrates and police officers on a human rights-based approach to law and law enforcement practices. Similarly, several police officers have been sensitized by CSOs supporting key populations.

In 2017, UGANET trained 41 prosecutors, 360 police officers and 120 community champions on how to address the needs of people living with HIV and GBV survivors, without stigmatizing or discriminating against them based on their sexual orientation. MARPI trained over 2,300 police officers over the past three years to address issues of stigmatizing behavior and discriminatory practices toward sex workers and people who inject drugs. In 2017, UHRN reported training 40 police officers in Mukono and Kampala, while WONETHA trained 66 police officers in Kampala.

In 2014, the UGANET received a grant from the AIDS and Rights Alliance for Southern Africa (ARASA) to implement a project aimed at addressing gaps in access to HIV and TB services in prisons and strengthen access to justice for prisoners in the Kampala Extra region. As part of this project, UGANET trained the prison staff regarding the prevention, health care needs and human rights of detainees living with or at risk of HIV infection.

Limitations/Challenges

A major challenge in sustaining the impact of sensitization trainings relates to the constant transfers of police at both management level and field-deployment level. It was noted by key informants that the follow-up mechanisms or monitoring of police activities in the field are very weak and need to be strengthened. The project on sensitizing the prison staff is limited to only 13 prisons in the country.

Recommendations to reach comprehensive programming

- Update and integrate sensitization on HIV-related stigma and discrimination and harmful police practices into curricula at police academies.
- Support in-service trainings for police, judiciary, and prison staff after assessment based on need and impact of training.
- Support routine assessments of law enforcement agents' knowledge, attitudes and behaviors towards people living with HIV/TB and/ and other key and vulnerable populations and support police administrators to identify and address any issues.
- Support key population networks to engage with law enforcement to have supportive joint activities and to prevent harmful policing practices, such as arresting sex workers and peer educators for carrying condoms and incarcerating people who inject drugs on criminal drug charges instead of referring to harm reduction programs.
- Expand the training for prison personnel regarding the prevention, health care needs and human rights of detainees living with or at risk of HIV and TB infection; and key population members to other prisons in the country
- Support CBOs and networks of PLHIV and other key and vulnerable populations to sensitize and engage members of local councils to support the reduction of discrimination, stigma and GBV at local levels.

PA 4: Legal literacy ("know your rights")

The table below provides an overview of current programmatic efforts on legal literacy as well as recommendations for scale-up. The content of the table is then further elaborated upon.

Legal Literacy ("know your rights")						
Program	***Description***					***Limitations***
Capacity-building of clinics to provide legal information	Community outreach and campaigns to provide vulnerable communities with HIV information and services related to their legal rights.					Limited in scale due to funding constraints
Implementer	***Population targeted***		***Clients reached***	***Region(s)***	***Timeframe***	***Recommended scale-up***
UGANET – Access to Justice	Paralegals		Data not available	All regions	ongoing	Continue and expand current efforts
HRAPF/ Access to Health for All	Paralegals		Data not available	Kampala, Kasese, Mbarara, Gulu, Mbale, Kabarole	ongoing	
Program	***Description***					***Limitations***
Awareness raising efforts by key population paralegals	Support to paralegals carrying out legal and human rights awareness and influencing community dialogue on rights.					Limited legal literacy in the general community, and especially among key populations
Implementer	***Population targeted***	***# trained***	***Clients reached***	***Region(s)***	***Timeframe***	***Recommended scale-up***
UGANET	key populations, key population peer leaders/ educators, people living with HIV	Not identified	1,600 people living with HIV	all regions	2017	Continue and expand current efforts Conduct awareness campaigns and workshops among key populations Engage religious and cultural leaders in human rights approach to healthcare and encourage them to disseminate this message Expand model of paralegals in the prison system
UGANET	Prisoners and prison staff	Not identified	Not identified	Central Uganda	2014	
HRAPF	key populations, key population peer leaders/ educators, people living with HIV	72 paralegals trained for sexual minority issues, 30 trained for HIV/AIDS cases	1005 sexual minorities and 991 people living with HIV	all regions	2016	

Current Programs

Overview

The rights of people living with HIV are well documented in various policies and guidelines. However, the data from the *PLHIV Stigma Index* survey in 2013 showed that only 41% of people living with HIV know their HIV-related rights. Since then, networks of people living with HIV and NGOs have implemented various activities to sensitize people living with and vulnerable to HIV. The right-to-health of the most at-risk populations are enshrined in the Constitution. The MARPS-led CSOs are reaching out to their members to sensitize them about their rights. Nonetheless, the effective sensitization of people living with HIV and other key and vulnerable populations is still low, notably due to the limited capacity in strategic and effective communication of the peer educators from networks of people living with HIV and some of the CSOs led by most at-risk populations. The high levels of stigma in some communities have also affected outreach for both the people living with HIV and most at risk populations. Further, the outreach to the most at-risk populations, particularly sex workers and men who have sex with men, is greatly limited by lack of safe spaces.

Capacity building of clinics/CSOs to provide rights and legal information

The *Patients' Charter 2014* that spells out patients' rights, roles and responsibilities has been distributed to several health facilities in Uganda. Health workers in these health facilities have been sensitized about this charter. The charter is supposed to be displayed and information shared with the patients including people living with HIV and other key population clients.

The key population-led CSOs have been trained by human rights-focused NGOs, such as UGANET and HRAPF, to improve their capacity in providing legal information to their members. Most key population-led CSOs have at least one of their staff or volunteers trained as a paralegal officer. In addition to training the CSO staff or volunteer, UGANET and HRAPF have also trained several community members as paralegal officers. Most of these are the peer educators for people living with HIV and other key populations.

Key informants noted that mobile legal aid clinics are rare due to associated costs. Two of the leading organizations providing *pro bono* legal services, UGANET and HRAPF, rely on community volunteers or "paralegal" officers who act as mobilisers, educators and focal points for receiving cases. They refer cases, as necessary, to the appropriate institutions or to regional-based UGANET or HRAPF lawyers, and sometimes act on behalf of the victims e.g. as fit persons or witnesses or reporters of crime. These volunteers have helped to ease the challenge of physical outreach for many legal aid service providers and their knowledge of local contexts, contacts and networks is invaluable in making legal aid provision sustainable.

Limitations/Challenges

Legal literacy efforts to date have been limited in scale and mobile clinics are rarely used. However, with the revival of the local council (LC) system that provides for community level

courts, the community paralegals should be linked to this system to improve their functionality in handling human rights violation cases.

Legal literacy efforts to date have been limited in scale, but there is a common recognition among research participants that there is a need to increase awareness among people living with HIV and other key and vulnerable populations regarding their rights and existing protections against discrimination, including the Patient Charter.

Awareness-raising by peer paralegals among key populations

As described before, peer education programs have been an important vehicle for legal literacy and promoting knowledge of rights.

The ARASA-supported project in 2014 implemented by UGANET among prisoners in Kampala Extra region also trained prisoners on HIV and human rights, as well as to work as paralegals. The trained prisoners provided support to their peers, which included making referrals for TB screening and other health services. As an outcome, the prisoners were empowered about their rights and were able demand them when they met the magistrates. UGANET and HRAPF have also trained community volunteers or paralegal officers, including peer educators of people living with HIV. These play a key role in providing legal information to the people living with HIV. Both UGANET and HRAPF also do legal aid outreaches to sensitize communities. In 2017, UGANET reported 200 legal aid awareness sessions with marginalized communities, including 1,600 people living with HIV. HRAPF conducted the awareness sessions in Mpigi, Luwero, Kiboga and Mityana districts where they were able to reach 991 people living with HIV.

Limitations/Challenges

There is limited coverage of legal literacy in the general community. In particular, the focus group discussion with people who inject drugs showed that they did not understand their rights well. Key informants noted that more is needed to increase awareness among people living with HIV and other key populations regarding their rights and existing protections against discrimination, including also their roles and responsibilities as defined in the *Patient Charter*.

Recommendations to reach comprehensive programming

- Expand awareness-raising and “know your rights” campaigns to each district among PLHIV and other key and vulnerable populations and/or in health care facilities. Support legal literacy and patient’s rights education through conducting awareness campaigns and workshops among people living with HIV and/or with TB and other key and vulnerable populations in each state/district towards mobilizing around health rights and needs.
- Expand recruitment, training, remuneration and deployment of peer paralegals to provide legal advice and mobilization specific to the needs of key and vulnerable populations.

- Expand capacity of community service organizations working with people living with HIV and other key and vulnerable populations on human rights and patients right literacy to better be able to support their constituenceis in these matters.

PA 5: HIV-related legal services

The table below provides an overview of current programmatic efforts on HIV-related legal services as well as recommendations for scale-up. The content of the table is then further elaborated upon.

HIV-related legal services

Program	*Description*	*Limitations*
Capacity-building of clinics to provide legal information	Mobile clinics for legal aid to provide vulnerable communities with legal services related to HIV. Paralegal capacity-building and mentorship, training of peer educators. Training future lawyers and academics on the legal environment relevant to HIV, as well as the national efforts to combat discrimination and promote a more successful national response.	Professional legal aid is provided in rare cases, and laws surrounding HIV are unclear

Implementer	*Population targeted*	*Clients reached*	*Region(s)*	*Timeframe*	*Recommended scale-up*
UGANET – Access to Justice	Paralegals	Data not available	Data not available	2012	Train and support peer paralegals to provide legal advice to key and vulnerable populations, including in communities and at health facilities, where possible Assess access to justice among key populations
IDLO/ UNAIDS	Law students, professors, and legal academics	Data not available	Data not available	Data not available	

Program	*Description*	*Limitations*
***Pro-bono* legal assistance to marginalized groups**	Providing legal aid to key populations, including people living with HIV, to counter discrimination in communities and the workplace. They provide legal aid to sexual minorities and HIV-positive women on different challenges, including family rejection, evictions, assault, arrests, stigma and discrimination, property and custody disputes, denial of access to medicine, domestic violence. Providing legal aid to prisoners while advocating for health service delivery in prisons.	Lack of confidence in the judiciary system among key populations

Implementer	*Population targeted*	*# trained*	*Clients reached*	*Region(s)*	*Timeframe*	*Recommended scale-up*
HRAPF	People living with HIV and other key populations	N/A	365 gender and sexual minority cases, 19 other key	Data not available	2012-2016	Expand current practices including expansion of paralegals in the prison system Expand legal support to CSOs working with key populations,

			population cases			including providing *pro bono* services
UGANET – Access to justice	Paralegals	N/A	Data not available	Data not available	2012-	
UGANET/ "Legal aid and health advocacy program to Uganda Prisons"	Prisoners	N/A	13 health facilities in prisons	Data not available	2014	

Current programs

Overview

Both Government and NGOs have established initiatives to promote access to legal services and redress for cases of HIV-related discrimination and human rights abuses. Government has a system of free legal aid for the poor. However, the system has not realized its full potential as noted by some key informants in the study. Barriers include factors relating to awareness, acceptability and safe spaces to report and receive justice. Internalized stigma, limited knowledge of their rights, distrust in the system, and delays in follow-up and resolution of complaints due to the poorly resourced government system has discouraged many people living with HIV from seeking access to justice for HIV-related discrimination and human rights abuses. For sex workers, transgender persons and men who have sex with men, free legal aid for access to justice against violence and discrimination in accessing and utilizing HIV services is only provided by a few NGOs.

Capacity building of clinics to provide legal assistance

UGANET and HRAPF use standardized tool kits to train the CSO staff and community volunteers as paralegal officers. Where necessary, the paralegals refer cases to the legal offices at the regional level or district level.

Limitations/Challenges

The HIV and AIDS Prevention and Control Bill 2017 is still under discussion, so the laws surrounding HIV specifically are still somewhat unclear.

Pro-bono legal assistance to marginalized groups

The primary government institutions for handling key population-related human rights abuses are the Family Protection Unit of the Uganda Police Service and the Uganda Human Rights Commission.

UGANET and HRAPF have some lawyers at regional level who periodically travel to districts to handle cases. In 2017, UGANET was able to provide 1000 people living with HIV with free legal support. HRAPF provided free legal aid to at least 120 sexual minorities and drug cases that included sex workers and men who have sex with men. UGANET operates a toll-free phone line that clients can use to get legal advice and appropriate referrals.

The key population peer leaders and paralegals reported several cases of arrests in which they had to negotiate for release free of charge or on police bond.

Since 2014, UGANET has worked in 13 Prison Units to reach inmates living with HIV and TB where they advocated for their health rights. UGANET's lawyers have also provided direct legal support to some prisoners whose notices of appeal were never filed.

Limitations/Challenges

A common barrier to access to justice that was cited by one of the key informants is lack of confidence in the justice delivery system. Some fear starting legal battles with the police, while

others fear disclosure and/or stigmatization related to coming forward with a case. It is also possible that the delays in follow-up and resolution of complaints discouraged some individuals from filing complaints.

Recommendations to reach comprehensive programming

- Continue and expand current efforts throughout the country, in particular, expand the recruitment, training, remuneration and supervision of the peer paralegal officers system to all districts and to all prisons in the country.
- Expand the pool of lawyers willing and able to work with marginalized populations, and provide supervision and support to paralegals so that all CSOs working with people living with HIV and other key and vulnerable populations have access to affordable or *pro bono* lawyers for casework, legal defense and strategic litigation, where necessary. This could be done through support of a training of a pool of lawyers willing and able to work with marginalized populations and located and/or available to supervise and back up the paralegals in each district.
- Support sensitization of key and vulnerable populations to use the available paralegal and other forms of legals services.
- Assess access to and uptake of legal literacy/services for people living with or vulnerable to HIV as part of *PLHIV Stigma Index* surveys and the Crane surveys for sex workers, men who have sex with men and people who inject drugs.

PA 6: Monitoring and reforming laws, regulations and policies related to HIV

The table below provides an overview of current programmatic efforts on monitoring and reforming laws, regulations and policies related to HIV as well as recommendations for scale-up. The content of the table is then further elaborated upon.

<table>
<tr><td colspan="7">Monitoring and reforming laws, regulations, and policies related to HIV</td></tr>
<tr><td>Program</td><td colspan="5">Description</td><td>Limitations</td></tr>
<tr><td>Petitions and advocacy concerning reform of policies, laws, regulations, guidelines</td><td colspan="5">Petitioning government lawmakers concerning the offense of willful and intentional transmission or attempted transmission of HIV, and the Anti-Homosexuality Act 2014.</td><td>The hearing and finalization of these petitions are often slow, and their effects on desirable change is limited due to few champions of human rights within government agencies</td></tr>
<tr><td>Implementer</td><td colspan="2">Population targeted</td><td>Clients reached</td><td>Region(s)</td><td>Timeframe</td><td>Recommended scale-up</td></tr>
<tr><td>UGANET/ WONETHA</td><td colspan="2">Sex workers</td><td>Data not available</td><td>Kampala and other parts of the country</td><td>Data not available</td><td rowspan="2">Continue monitoring of impact on access to services of particular laws and policies and advocacy for reform, as needed</td></tr>
<tr><td>HRAPF</td><td colspan="2">Not identified</td><td>Data not available</td><td>Data not available</td><td>Data not available</td></tr>
<tr><td>Program</td><td colspan="5">Description</td><td>Limitations</td></tr>
<tr><td>Tracking the implementation of the protective policies and regulations</td><td colspan="5">Documenting shortfalls and advocating for greater implementation of protective policies and regulations for HIV key and vulnerable populations</td><td>There are only a few NGOs tracking the implementation of protective policies and regulations.</td></tr>
<tr><td>Implementer</td><td>Population targeted</td><td># trained</td><td>Clients reached</td><td>Region(s)</td><td>Timeframe</td><td>Recommended scale-up</td></tr>
<tr><td>HRAPF</td><td>Not identified</td><td>N/A</td><td>Data not available</td><td>Data not available</td><td>2015-2017</td><td>Adopt SRH/eMTCT guidelines for WLHIV
Assess access to justice for people living with HIV</td></tr>
</table>

						Increase government funding for HIV and TB services Establish an office on gender and human rights as part of MoH ACP
MNL					2014-2016	
Program	***Description***					***Limitations***
Formation of leadership hubs for increased involvement in HIV policy	An initiative pilot study to form leadership hubs to increase nurses' involvement in HIV policy, reduce stigma, and increase safety mechanisms.					
Implementer	***Population targeted***	***# trained***	***Clients reached***	***Region(s)***	***Timeframe***	***Recommended scale-up***
Edwards 2016, quasi-experimental study	Healthcare providers	12 hubs in 4 countries	Data not available	Data not available	2016	
Program	***Description***					***Limitations***
Mobilizing community youth leaders and young people to advocate for HIV policy	Creating inclusion and movement by local authorities in the national response to HIV so that community leaders and young people can make policy change. Training future lawyers and academics on the relevant legal environment to HIV as well as the national response to combat discrimination and promote a successful national response.					Limited coverage due to limited resources
Implementer	***Population targeted***	***# trained***	***Clients reached***	***Region(s)***	***Timeframe***	***Recommended scale-up***
Uganda Harm Reduction Initiative	Young people who use drugs	Data not available	Data not available	Data not available	2016-2018	Invest in reaching out to the youth at the community level

IDLO/ UNAIDS	Law students, professors, and legal academics	Data not available	Data not available	Data not available	Data not available	and build their capacity to advocate for better HIV services
Program	***Description***					***Limitations***
Capacity building of CSOs and grass-roots groups for policy advocacy for HIV services	Capacity building of CSOs and grass-roots network of member organizations for policy advocacy for HIV services; and actual implementation of advocacy activities					Lack of sustainability due to limited funding and high rate of staff or member turnovers
Implementer	***Population targeted***	***# trained***	***Clients reached***	***Region(s)***	***Timeframe***	***Recommended scale-up***
THETA, MNL and AGHA	Transgender, sex worker and men who have sex with men led CSOs	15 CSOs	15 CSOs	Kampala, Mukono and Wakiso	2016-2018	Invest in capacity building of CSOs in policy advocacy Government should adopt and scale up the community scorecard methodology for HIV services
MNL (Networking model and capacity building)	Grass-root members organizations of most at risk populations	93 orgs 4 regional TWGs	93 orgs 4 regional TWGs	16 districts (in all 4 regions of Uganda)	2011-2014	

Current Programs

Overview

Current initiatives in this area include court petitions against problematic laws, policies and regulations; hosting public hearings on law reform affecting key and vulnerable populations; collection of information on human rights abuses related to HIV; an audit or review of laws affecting LGBTI communities; and some work on laws relating to intellectual property and generic medicines availability. Programs have also including the capacity-building of local community leaders, youth and MARPS-led groups to analyze the gaps in implementation of protective policies and to advocate for policy reforms and improved HIV service delivery; community efforts to hold health workers and managers accountable have documented valuable lessons. However, government monitoring and acceptability of the implementation gaps has been slow, notably because of limited resources to address such gaps, in the face of many competing health priorities.

Further, advocating for some groups, such as sex workers and men who have sex with men, was noted by KIs as difficult, especially the development of an advocacy tool kit through a participatory manner, in the face of fears that this would be misconstrued as a form of "promoting anti-policy practices".

Petitions and advocacy against problematic policies, laws, regulations or guidelines

Two organizations, UGANET and HRAPF, have worked with several other organizations to review bills, acts, policies and laws, and to challenge some in courts of law. HRPAF and UHRN reviewed and disseminated comments on the *Narcotic Drugs and Psychotropic Substances (Control) Act 2015* in October 2016. Similarly, they reviewed many other laws and acts. UGANET, in conjunction with key population CSOs, challenged the *Anti-Homosexuality Act 2014* as well as the clause in the *HIV Prevention and Control Act 2014* that creates the offense of willful and intentional transmission or attempted transmission of HIV.

This provision in the *HIV Prevention and Control Act 2014* may not only discourage sex workers accessing HIV testing services but also discourage HIV positive pregnant women from accessing HIV services for fear of being prosecuted. In a qualitative study done by ICWEA Uganda Chapter in 2016, some HIV positive women who were in HIV care and fell pregnant reported fearing to face health workers to explain what happened. Some of them feared they had done something against the law. With support from UNAIDS, UGANET in partnership with ICWEA Uganda Chapter, implemented a community level project (2014-2015) in four districts in Uganda targeting sexual and reproductive health services and eMTCT for women living with HIV. They have developed SRH/eMTCT guidelines for women living withHIV. During the project period, UGANET together with ICWEA, engaged with 43 women parliamentarians and parliamentary forum representatives who added their voices to championing SRH, eMTCT and human rights through various forums, legislation and mobilizing a critical mass of women parliamentarians that would facilitate the process of amending sections of the *HIV Prevention and Control Act 2014*.

Limitations/Challenges

A common barrier to acting on the reviews on human rights violations is related to staff transfers at courts of law and at the Uganda Human Rights Commission. In many cases, these transfers have involved moving lawyers who are champions against human rights violations to courts that do not hear human rights violation cases. In other cases, the dispensation of petitions against human rights violations are delayed over long periods. The petition against some sections of *HIV Prevention and Control Act 2014* is still not dispatched to date.

Tracking/encouraging the implementation of protective policies and regulations

The district AIDS committees (DACs) and sub-county AIDS committees (SACs) and the associated networks, such as NAFOPHANU and NACWOLA, track the implementation of protective policies and regulations relating to HIV services. Further, there are projects, such as the CHAU PITCH project (2016-2018) and the PATH Advocacy for Better Health project (2014-2019), that are empowering the communities to demand improved service delivery as provided for in current policies and regulations. Such projects empower communities, including people living with HIV and key populations, to interface with health service managers and decision-makers and NGOs at the district level. In 2017, communities were empowered to protest against ARV stock-outs and poor-quality service delivery by the health workers.

In addition, HRAPF and UGANET provide legal aid to key populations, including people living with HIV, to counter discrimination in communities that are not aware of some policies and regulations and at workplaces that are not implementing some protective policies and regulations. They provide legal aid to sexual minorities and HIV positive women on different aspects including family rejection, evictions, assault, arrests, stigma and discrimination, denial of access to medicine, property and custody disputes and domestic violence.

Limitations/Challenges

Whereas, protective policies exist, they are often poorly implemented due to limited funding and/or lack of awareness about them. Furthermore, monitoring this lack of implementation and advocacy for greater implementation is a long-term process. The government monitoring and acceptability of the implementation gaps has been slow, notably because of limited resources to address such gaps, in rhw face of many competing legal and health priorities.

Capacity building of CSOs and community level networks of member organizations for policy advocacy for HIV services

There have been several activities that built the capacity of CSOs led by most at-risk populations to do policy advocacy and monitor implementation of protective policies i.e. support accountability and demand for quality services. Some of these have been specific to HIV services. The Local Capacity Initiative (LCI) project (2016-2018) funded by PEPFAR/CDC and implemented by THETA, MNL and AGHA built a coalition of 18 CSOs in Kampla, Mukono and Wakiso and strengthened the organizational capacity of the individual CSOs in management systems, strategic planning and policy advocacy for HIV services. Further, the strengthened

CSOs used the Community Scorecard approach to HIV services at six health facilities in three districts in Central Uganda and held dialogues with health workers aimed at achieving recommended protective policies at the health facilities. It was reported to have effectively changed the quality of HIV services at the six health facilities, reduced stigmatizing attitudes and discriminatory practices of the health workers toward sex workers and men who have sex with men. Another project "Strengthening Uganda Civil Society Engagement for Targeted HIV/AIDS National Responses for Key (Affected) Populations" by MNL funded by DANIDA in 2011-2014 also worked on strengthening the capacity of 93 grass-root member organizations of the HIV most at-risk populations to advocate for policy changes, among which the policies for improved delivery of healthcare services included HIV services. The project formed regional technical working groups of most at-risk populations that had dialogues with health managers and decision-makers. These two projects capacitated CSOs led by most at-risk populations and members to participate in national level HIV programming platforms, such as the Global Fund Country Coordinating Mechanism and the national HIV MARPs programming platform supported by the Uganda AIDS Commission as well as that for the Ministry of Health.

Limitations/Challenges

Capacity-building of these CSOs is challenged by high rates of staff turnover, and therefore requires investment for continuous support to these CSOs.

Recommendations to reach comprehensive programming

- Support local networks of people living with HIV and other key and vulnerable populations to monitor the impact of problematic laws (civil and penal codes) that impede HIV services and advocate for change as needed. Advocacy efforts can be supported with data from the PLHIV Stigma Index and Crane surveys.
- Support the Ministry of Health to establish an office on gender and human rights in health. This office should support a process to replace or updateproblematic laws, practices and policies. In addition, this office would support other key aspects of the comprehensive response, such as the national monitoring and redressal system for stigma, discrimination and rights violations, and the routine assessments of attitudes of healthcare workers in the contexts of HIV and TB.
- Support and increase the capacity of CSOs and networks led by most-at-risk-populations to identify and advocate against the legal, policy, and structural barriers that impede equitable access to quality HIV services for key populations, participate in governance structures that influence health systems and services, and advocate for greater government funding to increase quality of counseling availability of HIV and TB services by well-trained professionals in prison health facilities.

PA 7: Reducing discrimination against women and girls in the context of HIV

The table below provides an overview of current programmatic efforts to reduce discrimination against women in the context of HIV, as well as recommendations for scale-up. The content of the table is then further elaborated upon.

Reducing discrimination against women and girls in the context of HIV

Program	***Description***	***Limitations***
Community awareness campaigns	Training volunteers to act as community leaders to maintain vigilance against gender-based violence.	Physical and sexual violence against women and girls is still common in communities. Sex workers may experience violence at the hands of clients, community members and law enforcement officials.

Implementer	***Population targeted***	***Clients reached***	***Region(s)***	***Timeframe***	***Recommended scale-up***
PEPFAR/DREAMS	Young women 15-24 years		10 districts across all regions	2016-2020	
JSI/ USAID/ Government of Uganda – NUMAT	People living with HIV, women and girls	1,327 cases reported since program's start – 308 accessed PrEP	Data not available	2010-2014	Create a platform where women and girls, including among key populations, know their HIV and TB-related rights and can report and advocate against stigma and discrimination in communities and in health services, GBV and illegal police practices.
The Hunger Project UK/ Gender Inequality Campaign	People living with HIV, couples	93,000 women and men have participated	Data not available	Data not available	

Program	***Description***	***Limitations***
Training for advocate leaders	Training volunteers to recognize and respond to cases of violence and refer survivors to medical and legal support, and also to act as community leaders.	There is no special program for prevention of violence for sex workers that is known amongst that population.

Implementer	***Populatio n targeted***	***# trained***	***Clients reached***	***Region(s)***	***Timeframe***	***Recommended scale-up***

JSI/ USAID/ Government of Uganda – NUMAT	People living with HIV, women and girls	Data not available	1,327 cases reported since program's start – 308 accessed PrEP	Data not available	Data not available	Strengthen human rights awareness and legal literacy within community structures resulting in rights-based approach to GBV. Continue and expand GBV prevention programs across the country.
Program	**Description**					**Limitations**
GBV prevention and mitigation	Community mobilization to change social norms and attitudes surrounding gendered power imbalances, GBV, IPV					GBV survivors do not typically report cases to the legal system.
Implementer	***Population targeted***	***# trained***	***Clients reached***	***Region(s)***	***Timeframe***	***Recommended scale-up***
UGANET/ "Strengthening systems addressing legal barriers in responding to GBV in the context of HIV"	Police officers and health workers	Data not available	Data not available	27 districts	2016-	Continue community dialogues, implement school-based, community campaigns, and dialogues on gender equality such as SASA! Expand the Determined, Resilient, Empowered, AIDS-free, Mentored and Safe Women (DREAMS) or similar projects to more districts in the country
CEDOVIP, MIFUMI, Action Aids	Communities and households	N/A	Data not available	13 districts	2016-20120	
PEPFAR/DREAMS	Young women 15-24 years	N/A		10 districts across all regions	2016-2020	

Current Programs

Overview

Several programs have been implemented by Government and NGOs to address gender inequality and gender-based violence as both causes and consequences of HIV infection. Currently, PEP is available at several health facilities across the country, and more recently the PrEP guidelines were finalized, and Government has committed to making PrEP anti-retroviral drugs available for sex workers. The legal and policy environment is well defined with the Domestic Violence Act 2010 criminalizing gender-based violence.

However, reporting of cases of gender-based violence is still low, and some KIs noted the weaknesses of the family protection units of the Uganda police in doing investigations and managing cases from gender perspectives. Further, some KIs noted that sex workers who face violence from their clients are not willing to report such violence to the police who often blame or arrest the sex worker who experienced the violence.

Community awareness campaigns

By early 2000, Uganda had established policies and legislation to advance gender equality with the Ministry of Gender, Labour and Social Development (MGLSD) to provide oversight. Notable among these are: The *National Gender Policy (2007),* the *Domestic Violence Act* (DVA) 2010 and the 2011 Domestic Violence regulations; the *Anti-Female Genital Mutilation Act* of 2010; the *Anti-trafficking in Persons Act* of 2009; and the *Equal Opportunities Commission Act* in 2007. Since the enactment of the *Domestic Violence Act* in 2010, there have been several mass media campaigns. Further, the family protection unit of the Uganda police has been trained in handling domestic and gender-based violence and rights abuses.

Further, there are community-based structures, including as part of the newly reinstated local council system. Cases of gender-based violence are supposed to be reported to or picked up by the community-based local councils and the Family Protection Unit of Uganda Police. Organizations, such as the Center for Domestic Violence Prevention (CEDOVIP), Action Aid Uganda and UGANET, are supporting the country's response to gender equality. They have used the *Start Awareness Support Action (SASA!)* strategy, which is based on efforts of community volunteers. It has shown to be very effective. The SASA! Activist Kit[82] is a tried and tested community mobilization approach for preventing violence against women and HIV. It is designed for catalyzing community-led change of norms and behaviors that perpetuate gender inequality, violence and increased HIV vulnerability for women.

In addition to mass campaigns and communication through religious and cultural leaders, there are several NGOs supporting activities aimed at elimination of gender-based violence.

Other projects, such as the aforementioned PEPFAR/CDC Local capacity initiative (2016-2018), advocated for PrEP for sex workers and led to the development of PrEP guidelines, and government commitment on availing PrEP anti-retroviral drugs toto sex workers.

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[82] Michau L, Chevannes C, Hundle A, Ensor-Sekitoleko D, McMullen K, Moreaux M, Sauvé S. (2008). The SASA! Activist Kit for Preventing Violence Against Women and HIV. Raising Voices, Kampala; 2008.

There are also several programs including the Determined, Resilient, Empowered, AIDS-free Mentored and Safe Women (DREAMS) project that is targeting young women to empower them to reduce on their risks of HIV acquisition and the GBV.

Limitations/Challenges

Despite well laid-out gender-sensitive legal reform, this has not sufficiently made rights and economic transformation real for women and girls. According Uganda Demographic and Health Survey (UDHS) 2016, intimate physical violence and sexual violence and defilements are still common in communities. Further, violence against sex workers by their clients is rarely treated seriously. In focus group discussions, some sex workers reported physical violence and sexual violence perpetrated by their clients and by police officers.

Training for advocacy leaders

Several organizations have trained community volunteers to recognize and respond to cases of violence and refer victims to medical and legal support and also to act as community leaders. UGANET is working with community change agents; while CEDOVIP, MIFUMI and Action Aid Uganda are implementing the *Strengthening Uganda's Response to Gender Equality* (SURGE) project (2016-2020) through community volunteers who have been trained using a *SASA!* strategy.

CEDOVIP has also mobilized religious leaders to promote gender equality and discourage gender-based violence at the community level. CEDOVIP held their first meeting about Domestic Violence Act (DVA) 2010 with the Inter-Religious Council of Uganda in 2010.

Limitations/Challenges

There is no special program for prevention of violence among the sex workers that was known by the study respondents, except the support from their peer educators and the paralegal officers.

Prevention and mitigation of gender-based violence

UGANET and HRAPF are providing legal support to survivors through paralegals and free legal aid services.

Limitations/Challenges

Survivors of gender-based violence often do not disclose violence to formal legal systems. Many prefer, or are culturally forced, to resolve violence within family or with cultural leaders.

Recommendations to reach comprehensive programming

- Support networks of women living with HIV, adolescents living with or vulnerable to HIV, female sex workers, and women who use drugs to know their rights, have access to

legal services, advocate and organize against stigma, discrimination and GBV in communities and in health care settings. (Peer educators and peer paralegals in PA 4 and 5 should include those recruited from and deployed among women and adolescent girls.)

- Support advocacy and engagement with relevant government stakeholders towards the adoption of the Sexual Reproductive Health/elimination of Mother-To-Child Transmission of HIV (SRH/eMTCT) guidelines, as well as patients rights materials, for women living with HIV that have been developed by NGOs and development partners.
- Expand community-based advocacy and mobilization of women living with HIV to reduce gender-based violence and support redress for survivors of violence using a rights-based approach, including access to legal services for survivors. This should include strengthening community structures through training of local council members, village health teams and the police family protection unit to use a rights-based approach to GBV and women's inequality more generally.
- Expand current efforts on GBV prevention and mitigation programming to all districts, especially the SASA! Program that has proven effective in reducing GBV and HIV risk behaviors among adolescent girls and young women. Women living with HIV, including young women and adolescent girls, should be trained and deployed as peer human rights educators to support implementation of the activities.
- Implement community and school-level campaigns and dialogues to promote gender equality, change harmful gender norms and reduce gender-based violence and show the relationship between these and vulnerability to HIV and retention in treatment and clinical care.
- Integrate training on gender and sexuality diversity in pre-service and in-service trainings for duty bearers (i.e. doctors, nurses, lawyers, judges, law enforcement agents, etc.). These efforts can be combined with the training efforts mentioned in PA 1, PA2 and PA3 above.

3.11 Investments to date and costs for comprehensive programs

In 2016, a total of around 511,443 USD was invested in Uganda to reduce human rights-related barriers to HIV services. Major funders and allocated amounts for reduction of human rights barriers to HIV services in 2016 were as follows:

Funding source	**2016 allocation**
AmplifyChange	USD 37,597
UNAIDS	USD 17,915
PEPFAR	USD 258,108
Irish Aid	USD 19,457
GFATM	USD 178,366
Total	**USD 511,443**

Although several funders stated that they were unable to provide exact figures for the amounts allocated to each program area, the assessment team estimated the likely split among program areas by acquiring expenditure data from the funded organizations and matching these to activities under each program area. This gave the following split of funding across program areas to remove human rights-related barriers to services. Further details are included in Annex 4.

HIV Human Rights Program Area	**2016**
PA 1: Reducing stigma and discrimination related to HIV	USD 262,525
PA 2: Training health care workers on human rights and ethics related to HIV	USD 88,242
PA 3: Sensitizing law-makers and law enforcement agents	USD 8,277
PA 4: Legal literacy ("know your rights")	USD 10,390
PA 5: HIV-related legal services	USD 0
PA 6: Monitoring and reforming laws, regulations and policies relating to HIV	USD 3,408
PA 7: Reducing discrimination against women and girls in the context of HIV	USD 0
PA 8: Other interventions	USD 138, 602
Total	**USD 511, 443**

Estimated costs for the recommended interventions for the five-year comprehensive program are shown in the following table *(to be updated)*. Detailed intervention areas and costs are described in Appendix 6.

4.9 Costing for 5-year comprehensive program – HIV

HIV Human Rights Barriers Program Area	Year 1	Year 2	Year 3	Year 4	Year 5	Total
PA 1: Reducing stigma and discrimination related to HIV	547,247	520,930	390,010	631,218	292,437	**2,381,842**
PA 2: Training health care workers on human rights and ethics related to HIV*	164,702	352,033	204,484	224,701	204,484	**1,150,403**
PA 3: Sensitizing law-makers and law enforcement agents*	223,077	348,869	289,665	314,658	117,753	**1,294,022**
PA 4: Legal literacy (“know your rights”)*	62,877	226,823	231,684	95,249	64,763	**681,397**
PA 5: HIV-related legal services*	228,639	112,160	235,498	287,231	195,507	**1,059,034**
PA 6: Monitoring and reforming laws, regulations and policies relating to HIV*	88,578	98,508	116,573	133,502	116,573	**553,733**
PA 7: Reducing discrimination against women and girls in the context of HIV	690,259	1,008,831	930,616	828,025	885,057	**4,342,787**
Program management (22,07%)	442,586.98	588,861.58	529,355.20	554,968.43	414,159.95	**2,529,932**
M&E (1,21%)	24,265.08	32,284.66	29,022.19	30,426.45	22,706.55	138,705
Research (2,96%)	59,359.20	78,977.36	70,996.44	74,431.65	55,546.60	339,311
Total	2,531,590	3,368,278	3,027,902	3,174,409	2,368,987	**14,471,166**

* Some activities within this program area involve both the HIV and TB responses. For these program activities, costs were split 60% for HIV and 40% for TB, based on the suggestion of key stakeholders involved in financing decisions for these grants in Uganda.

Other interventions that are not to be funded with human rights funding

The table below provides an overview of other interventions that are addressing broader right-to-health issues in the context of HIV such as accessibility, acceptability, availability and quality of services. These programs do not fall under the seven human rights program areas, but are critical to the success of a comprehensive response to remove human rights –related barriers to HIV services and continued funding for these programs from funding for health services, not from human rights funding, is recommended. The content of the table is then further elaborated upon.

<table>
<tr><th colspan="6">Other Programs: HIV</th></tr>
<tr><th>Program</th><th colspan="4">Description</th><th>Limitations</th></tr>
<tr><td>Increasing accessibility, acceptability, availability, and quality of services</td><td colspan="4">Capacity-building, technical assistance, resource growth, supervision, financial support, other means of community mobilization, and improving access to screening and testing. Projects may have specific aim of increases health initiatives among police force, security guard, and other community-based staff.</td><td>Limited by funding</td></tr>
<tr><th>Implementer</th><th>Population targeted</th><th>Clients reached</th><th>Region(s)</th><th>Timeframe</th><th>Recommended scale-up</th></tr>
<tr><td>USAID/ MSH/ STAR-E</td><td>People living with HIV, people living with TB</td><td>154 supported health facilities</td><td>12 districts</td><td>Data not available</td><td rowspan="3">Scale up the current activities to cover other districts across the country</td></tr>
<tr><td>Star-E</td><td>General population, people living with TB, people living with HIV</td><td>13 civil society organization</td><td>Data not available</td><td>Data not available</td></tr>
<tr><td>BIPAI/ Baylor Uganda</td><td>Children living with HIV, health care workers</td><td>Kampala and throughout the country</td><td>Data not available</td><td>Data not available</td></tr>
</table>

HIV/Health Initiatives in Workplaces Activity (HIWA)/ USAID	Uganda Police Force, Private security guards, Uganda Wildlife Authority, and staff in conservation areas	Data not available	Kotido and Moroto districts, nation-wide	5-year	
AMICAALL/ “Scaling up HIV Prevention Interventions among Key Populations and other High Risk Populations in Urban and Peri-Urban Areas in Uganda”	Key populations	At least 17,000 key population members	Urban and Peri-urban areas	2013/2015	

4. Baseline Findings: TB

4.1 Overview of Epidemiological Context and Key and Vulnerable Populations

Known as one of the most prevalent and deadly diseases in the world, tuberculosis prevalence has risen globally in the previous two decades, likely due to a challenging and frequent opportunistic co-infection with HIV.[83] Sub-Saharan Africa holds the greatest proportion of new TB cases per population; however, both incidence and mortality rates continue to drop, likely due to the international roll out of DOTS programmes in the previous 20 years. The rise of multi-drug resistant tuberculosis makes treatment more difficult, expensive, and dangerous.

Estimates show that men have higher rates of TB in Uganda than women, and low notification rates among children signify poor case detection in pediatric TB. Outside of HIV-related TB, mortality rates are generally low, at 12 per 100,000. Similarly, multi-drug resistant TB only comprises around 200 cases per year.[84] In 2008, it was noted that Uganda had the lowest TB cure rate in the world, with just 32% of reported TB cases cured.[85] Despite capacity building in Uganda by the Ministry of Health through initiatives like the National TB and Leprosy Programme and AIDS Control Programme, knowledge and practice on TB control, both in healthcare settings and in prisons, is low.[86]

Within Uganda's prison system, which holds approximately 32,500 prisoners across 233 prisons, the prevalence of tuberculosis is triple that of the general population, at an estimated 654 per 100,000. Vulnerability to infection in prisons is exacerbated by overcrowding, poor ventilation and hygiene, irregular and limited diet, indoor confinement and poor access to healthcare and quality medical services.[87] Multidrug-resistant tuberculosis is also a major problem in Ugandan prisons, occurring more frequently among prisoners and prison staff than in the general population.[88]

In Uganda, out of the 40,000 new cases of TB diagnosed each year, approximately three in five are co-infected with HIV.[89] It is estimated by UNAIDS that about 7% of people living with HIV have active TB cases.[90] However, even given these numbers, Uganda struggles with a low case

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[83] Kitara DL, Pirio P, Acullu D, Opira CP. (2015). TB co-infection with HIV/AIDS: a unique radiological presentation at Lacor hospital – a postconflict northern Uganda. *African Journal of Infectious Disease* 9(2), 21-28.
[84] USAID. (2016). Track TB: A Mixed Methods Assessment. Strategies, Partnerships, Leverage Points and Learnings.
[85] Murungi I, Bukare A, Atim S, Boyle A, Dauvergne M. Women of Uganda Network (WOUGNET) (2015). Final Report for the GEKS Uganda National Assessment.
[86] Ministry of Health, Republic of Uganda. Uganda National Guidelines for Tuberculosis Infection Control in Health Care Facilities, Congregate Settings and Households.
[87] Schwitters A, Kaggwa M, Omiel P, Nagadya G, Kisa N, Dalal S. (2014). Tuberculosis incidence and treatment completion among Ugandan prison inmates. *International Journal Lung Disease* 18(7), 781-786.
[88] Schwitters A, Kaggwa M, Omiel P, Nagadya G, Kisa N, Dalal S. (2014). Tuberculosis incidence and treatment completion among Ugandan prison inmates. *International Journal Lung Disease* 18(7), 781-786.
[89] JSI Research and Training Institute. Enhancing health systems and services in a post-conflict setting. Stories from the Northern Uganda Malaria, AIDS, and Tuberculosis Programme (NUMAT).
[90] UNAIDS. (2016). Uganda Fact Sheets. http://www.unaids.org/en/regionscountries/countries/uganda

detection rate of only 51%.[91] Despite the national progress that Uganda has made in the face of TB in the previous decades, there remain human rights-related barriers to TB services.

4.2 Overview of the Policy, Political and Social Context Relevant to Human Rights-Related Barriers to TB Services

4.2.1 Laws, Policies and Practices

As detailed in section on 3.2.1 on page 36, Uganda is a signatory to several human rights-related international instruments that provide protective articles by which to guide the national responses to HIV, TB and malaria. There are important protective national laws as well. However, many of those affected by TB may be living with HIV or come from the same key and populations vulnerable to HIV. Thus, the policy and social context described above as hindering access to HIV services could also hinder access to TB services.

It is important to note that many of the legal barriers affecting people living with HIV also affect people vulnerable to and living with TB as they are often the same or overlapping populations. Although Uganda has protective laws and policies, other aspects of Uganda's legal environment may hinder access to TB services. For example, the *Non-Governmental Organizations Law* (NGO Law) was assented into national law in 2016 and enables the Government to discretionarily restrict the way NGOs operate, requiring them to register with an NGO Bureau and apply for permits to operate. It also restricts NGOs from working in districts without approval from the district's Monitoring Committee and entering a memorandum of understanding (MOU) with local governments where they operate. This law prohibits organizations from engaging in activities that are prejudicial to the security and laws of Uganda. While protective in intent, this law can act as a barrier for and discriminate against CSOs that support sexual and gender minorities and sex workers and can make the NGO registration process more difficult**Error! Bookmark not defined.**.

Other acts and laws target key and vulnerable populations, like the *Penal Code Act*, Cap 120 on sex work and same-sex relationships. This has led to the marginalization of sex workers and other key populations, which can make it difficult to reach these populations for TB care and treatment. This law also puts these individuals at risk of discrimination and stigmatization by the public and health workers and limits their access to justice when their rights are violated or when they are victims of crime**Error! Bookmark not defined.**.

The Medical and Dental Practitioners Code of Professional Ethics (2013), based on the *Medical and Dental Practitioners Act of 1998*, sets a code of professional conduct that includes a provision that requires medical practitioners to ensure patient confidentiality and privacy. The code allows the practitioner to disclose the patient information where such disclosure would "protect the public or advance greater good of the community." It is possible that details about key populations can be disclosed without their consent, as some of their activities are against the

[91] Sendagire I, Schim Van der Loeff M, Mubiru M, Konde-Lule J, Cobelens F. (2010). Long delays and missed opportunities in diagnosing smear-positive pulmonary tuberculosis in Kampala, Uganda: a cross-sectional study. *PLoS One* 5(12).

law. As such, key populations might not go to the health facilities for TB health services fearing inadvertent disclosure of their activities to law enforcement.

The situation in prison settings noted in section 4.1 above, including overcrowding, substandard living conditions, poor nutrition and poor access to medical services and healthcare, is exacerbating the TB epidemic. We were not able to identify specific laws or policies that facilitate the poor conditions in prisons, nor laws that could be used to advocate for safer conditions in prisons. The general sense is that overcrowding is due to a backlog of cases in the judicial system.

There is an opportunity for protective laws and policies to be developed and implemented to protect vulnerable populations that experience confined spaces or crowded conditions, such as prisoners, miners, migrants and slum dwellers, from conditions in which TB can be easily transmitted. For example, policies could be implemented to reduce over-crowding in prisons as well as to meet minimun standards for prisoners' health; and the provision of workman's comp benefits could support workers living with TB while they initiate TB treatment until they are non-infectious. Housing policies that support the development of safe dwellings with adequate ventilation and transition of people living in urban slum into these safer dwellings would also be beneficial. Such laws could also be extended to protect people who come into close contact with people living with TB, such as health care providers, and could include long-term workman's comp for providers who contract MDR-TB or XDR-TB through their workplaces.

The Government of Uganda has formed a National Coordination Committee for TB at the Ministry of Health to support the National TB and Leprosy Program. Further, political commitment to fight TB has been strengthened by the formation of the Parliamentary Caucus for TB, which will support advocacy, raise resources and initiate appropriate legislation for TB. CBOs and networks representing people living with TB can advocate with these Government bodies to put in place protective laws and policies which reduce vulnerability to TB infection and increase access to TB services.

4.4 Human Rights-Related Barriers to TB Services

Overview

The major barriers set out below were found to be prominent in discussions with key informants and with members of key and vulnerable populations in focus groups, including:

a) Stigma and discrimination
b) Punitive laws, policies, and practices
c) Health facility-level barriers; and
d) TB-related barriers in prisons.

Stigma and Discrimination related to TB

Despite the general treatability of TB, stigma associated with TB is high, and many people living with TB prefer not to disclose their positive TB status. Much of this stigma is due to the misconception that people with TB also have HIV.[92] Discrimination against people living with TB is also due to fear of becoming infected with TB, along with general associations between TB and poverty. Consequently, those with TB may avoid testing and diagnosis, and those who have tested positive for TB may not want to be seen receiving treatment, lest they be identified with TB and hence experience stigma and discrimination. However, non-adherence can also be stigmatized, and can lead to community rejection.[93]

Additionally, gender-based research supports the notion that men and women respond differently to illness and face different barriers when accessing TB care and treatment services[94]. For example, men tend not to use primary health care facilities because they are perceived to be for women and children.

Focus group discussions with people living with TB noted discrimination at the hands of community members, family members, workmates, health workers, and fellow prison inmates. Sex workers also reported losing some of their clients due to their TB status. People known to have multidrug-resistant TB experience higher levels of stigma and discrimination. Abandonment by family and avoidance by clients was reported to influence adherence to TB treatment in several ways, including limiting affordability of a nutritious diet.

Negative perceptions of people living with TB, as well as fear of infection, among healthcare workers appears to lead to stigma in health care settings against people living with TB. Poor knowledge of TB control among health service providers and limited infrastructure to ensure safe treatment contributes to this fear and subsequent stigma.[95]

One study, which sought to quantify levels of TB stigma in Uganda found that TB had higher levels of stigma than HIV at 47% vs. 25%, despite international studies displaying opposite findings.[96] Focus groups participants reported that TB stigma is higher than that of HIV because it consists of stigma and discrimination based on fear of infection by TB, as well as based on suspected HIV positive status. It was reported that stigma around TB initially decreased after a cure had been found and was popularized, but then TB became re-stigmatized due to its association with HIV. Because of the limited funding towards and low priority of TB education, TB information is often dispersed as a part of HIV awareness and messaging, linking the

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[92] Macfarlane L, Newell JN. (2012). A qualitative stud exploring delayed diagnosis and stigmatization of tuberculosis amongst women in Uganda. International Health 4(2), 143-147.
[93] Hassard S, Ronald A, Angella K. (2017). Patient attitudes toward community-based tuberculosis DOT and adherence to treatment in an urban setting; Kampala, Uganda. *Pan African Medical Journal* 27(1).
[94] P. Hudelson, "Gender differentials in tuberculosis: the role of socio-economic and cultural factors," Tubercle and Lung Disease, vol. 77, no. 5, pp. 391–400, 1996
[95] Bulage, L, Sekandi J, Kigenyi O, Mupere E. (2014). The Quality of Tuberculosis Services in Health Care Centers in a Rural District in Uganda: The Providers' and Clients' Perspective. *Tuberculosis Research and Treatment* 2014(11).
[96] Community level household surveys based on Lot Quality Assurance Sampling Methodology in Uganda. USAID/SITES, 2018. Kampala

diseases in the perception of the general population. Lower uptake of testing is associated with a fear that a positive TB diagnosis means a positive HIV diagnosis.[97]

Key populations that are vulnerable to HIV may also be vulnerable to TB and the same punitive approaches that affect their access to HIV services affect their access to TB services. For example, people who use drugs experience illegal police practices (e.g. harassment, extortion, arbitrary arrest and detention) causing them to avoid TB (as well as HIV) testing and treatment for fear of arrest. Because they are often perceived negatively in the community, people who use drugs can be voiceless in the face of stigma and discrimination at the hands of health services and police.[98]

Health Facility-Level Barriers

A number of structural barriers at the healthcare facility-level exist in Uganda leading to delays in diagnosis and treatment of TB, which may account for some of the low detection rates. Examples of these barriers include: a shortage of sufficient medical and laboratory staff and low levels of training of staff. These issues can result in multiple visits needed and extensive delays in testing, diagnosis and receipt of results. Studies suggest that even when a health provider suspects TB, they have little or no referral system or mechanism to test within the facility and are required to use a technical laboratory outside their facility.[99] One study found that health service delays were longer for patients who had tested positively for HIV.[100] Patient waiting times, for both testing and diagnosis, become an issue in TB control, as patients can wait up to a week between testing and diagnosis, and wait further until the onset of treatment.[101] These delays comprise deterrents for people living with TB to seek diagnosis and treatment, and are compounded by fear of experiencing stigma from healthcare providers, as well as onerous travel to health facilities, long wait times, and high costs of care.[102]

Insufficient integration of TB and HIV services signifies a gap in service delivery and diagnosis opportunities, ultimately leading to a low uptake of services for both diseases.[103] Understaffing, lack of skill to diagnose both HIV and TB, and limited guidelines in care options for co-infected

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[97] Wynne A, Richter S, Jhangri GS, Alibhai A, Rubaale T, Kipp W. (2014). Tuberculosis and human immunodeficiency virus: exploring stigma in a community in western Uganda. *AIDS Care* 26(8), 940-946.
[98] Uganda Harm Reduction Network (UHRN).
http://www.ugandaharmreduction.org/index.php?option=com_content&view=category&id=103&Itemid=522
[99] Wynne A, Richter S, Banura L, Kipp W. (2014). Challenges in tuberculosis care in Western Uganda: Health care worker and patient perspectives. *International Journal of Africa Nursing Sciences* 1, 6-10.
[100] Sendagire I, Schim Van der Loeff M, Mubiru M, Konde-Lule J, Cobelens F. (2010). Long delays and missed opportunities in diagnosing smear-positive pulmonary tuberculosis in Kampala, Uganda: a cross-sectional study. *PLoS One* 5(12).
[101] Bulage, L, Sekandi J, Kigenyi O, Mupere E. (2014). The Quality of Tuberculosis Services in Health Care Centers in a Rural District in Uganda: The Providers' and Clients' Perspective. *Tuberculosis Research and Treatment* 2014(11).
[102] Ayakaka I, Ackerman S, Ggita JA, Kajubi P, Dowdy D, Haberer JE, Fair E, Hopewell P, Handley MA, Cattamanchi A, Katamba A, Davis JL. (2017). Identifying barriers to and facilitators of tuberculosis contact investigation in Kampala, Uganda: a behavioral approach. *Implementation Science* 12(33).
[103] Bajunirwe F, Tumwebaze F, Abongomera G, Akakimpa D, Kityo C, Mugyenyi PN. (2016). Identification of gaps for implementation science in the HIV prevention, care and treatment cascade; a qualitative study in 19 districts in Uganda. *BMC Research Notes* 9(217).

patients are all barriers within the healthcare facility to the dual testing and treatment of the diseases, especially in lower-level health units.[104]

The key informants and focus group discussions reported poor quality TB services at the health facilities. Most health facilities can only access a Gene Xpert at regional hubs that are often far away. Facilities choose to either refer the suspected TB patient or send samples for testing at the hubs.

Financial and Economic Barriers

Key informants also reported that financial and economic barriers are also an impediment to accessing TB care and treatment services. They described settings where patients go off the TB drugs because they cannot afford meals. Further,, the economic costs of TB (loss of employment and income due to illness, cost of treatment and time involved) can mean that children in households with TB may be taken out of school due to lack of funding for schooling, or may have to work in order to pay for medications. These measures deprive children of their education and may put them in more frequent contact with family members with TB, which increases their own vulnerabilities to TB.[105] Sex workers described challenges associated with transport to health facilities and being able to afford nutritious meals.

Physical and Geographic Barriers

Geography and physical barriers are major barriers to health services for people living with TB in Uganda. Patients living with TB will frequently initiate, but not complete, the multi-day evaluation process, wherein testing is necessary over a period of a number of days. The distance from home to a health facility, as well as other geographical factors, such as road safety and travel time, contribute to the likelihood of test completion.[106]

TB in Prisons

Prisons and other closed settings in Uganda are places where there are high levels of vulnerability to TB (as well as HIV and malaria). These vulnerabilities are due to sub-standard conditions found in Ugandan prisons, including overcrowding and cramped cells; insufficient ventilation (due in part to small air vents); little daily exercise or movement for most prisoners; limited to no access to prevention and treatment for TB, HIV and malaria; forced labor; and denial by prison officials. For the country's 233 prisons, there is only one prison medical facility that has been approved to provide comprehensive and appropriate treatment for HIV and TB. Further, it has been reported that prison officials deny or delay access to medical treatment for many prisoners.[107]

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[104] Nansera D, Bajunirwe F, Kabakyenga J, Asiimwe PK, Mayanja-Kizza H. (2010). Opportunities and barriers for implementation of integrated TB and HIV care in lower level health units: experiences from a rural western Ugandan district. *African Health Sciences* 10(4), 312-319.

[105] World Health Organization, The Stop TB Partnership Secretariat. (2001). A human rights approach to tuberculosis.

[106] Ross JM, Cattamanchi A, Miller CR, Tatem AJ, Katamba A, Haguma P, Handley MA, Davis JL. (2015). Investigating Barriers to Tuberculosis Evaluation in Uganda Using Geographic Information Systems. *American Journal of Tropic Medicine and Hygiene* 93(4), 733-738.

[107] Todrys K. Human Rights Watch (2011). HIV and TB Spread Unchecked in Uganda's Prisons. https://www.hrw.org/news/2011/07/25/hiv-and-tb-spread-unchecked-ugandas-prisons

In one of the group interviews, the health workers located in a health facility in one prison reported that the male wing was highly crowded with poor ventilation, to an extent that it was common to mix in one crowded room prisoners living with TB who are on treatment with those who have a TB diagnosis but are not on treatment. Only completed TB cases are allowed out of prison into the health facility admission rooms. Key informants also told of inmates who come into the prison knowing their TB status but who try to hide their status for fear of isolation and mistreatment, leading to transmission of TB to other inmates.

On farm prisons, where forced labor is common, prisoners report abusive behavior from officers, including burnings and beatings to the point of temporary paralysis and loss of limbs. At these farms or other rural prisons, people living with HIV and people living with TB are forced to work until they are too weak to work. Despite there being no medical treatment at these rural prisons, prisoners with HIV and TB are often sent to these facilities, which creates a deadly problem. Multi-drug resistant TB emerges as a result of poor management of TB treatment, making disease control even more difficult. Prison officials at these rural prisons often refuse to acknowledge the health needs of their inmates, stating that all the prisoners are healthy.[108]

4.5 Programs to Address Human Rights-related Barriers to TB Services – from Existing Programs to Comprehensive Programs

Overview

To date, the focus of TB programming has been on improving the reach of TB-DOTS programs and early case identification and referrals. The Baseline Assessment was able to identify only a few existing programs to address human rights-related barriers to TB services in Uganda. Most of the key informants, including government officials, had little understanding of the human rights-related barriers to TB services described above, and the few who were aware of such barriers did not see them as sufficiently significant to TB epidemic control so as to warrant programmatic or policy attention. This lack of awareness is itself a barrier to reducing human rights-related barriers to TB services. Some key informants noted that this is because people vulnerable to or living with TB are not meaningfully involved in informing the programming of TB services; while others observed that the human rights-related barriers are not a priority given other challenges in improving TB services in Uganda.

Due to high levels of TB-HIV co-infection, people living with TB can often access and benefit from HIV services, including programs aimed at removing the human rights-related barriers to HIV services, including for some key populations such as sex workers and prisoners. For children, there have been attempts to integrate TB services into child-relevant health services (i.e. Reproductive, Maternal, Neonatal, Child, and Adolescent Health (RMNCAH)) in various health facilities across the country.

[108] Todrys K. Human Rights Watch (2011). HIV and TB Spread Unchecked in Uganda's Prisons. https://www.hrw.org/news/2011/07/25/hiv-and-tb-spread-unchecked-ugandas-prisons

PA1: Reducing TB-related stigma and discrimination

The *National TB and Leprosy Program (NTLP) Strategic Plan 2015/2020* recognizes stigma as one of the barriers to TB services. However, the Baseline Assessment could not identify any previous or current programs or activities aimed at reducing TB stigma, and as stated, stigma and discrimination as barriers to TB services appear not well understood. TB-related stigma has possibly been addressed to some degree by programs or program activities aimed at reducing stigma and discrimination related to HIV status or related to membership in a key population (see these programs to described under PA 1 in the HIV section of the report). However, even in programs that combine HIV and TB services, stigma reduction counseling is often focused on HIV or on reducing stigma related to the most at-risk populations status.

The newly launched *USAID/DEFEAT TB Project (2017-2022*) is planning to conduct a *TB Stigma Index* survey in Kampala, Mukono and Wakiso to collect information on stigma as a barrier to TB services access and utilization. One KI noted:

> "*No one is exploring it [stigma] to that magnitude you know in HIV where we explore the stigma right from the testing and continue dealing with it, but for TB you just go to the facility and test then you go to next door to get medicine without any one taking trouble to talk to [counsel] you."*

Recommendations to reach comprehensive programming:

- Integrate TB-related stigma concerns into the National Anti-Stigma and Discrimination Policy. Expand content to include TB-related stigma and develop TB-specific guidelines, including workplace guidelines
- Integrate TB-specific stigma, discrimination and other human rights concerns into the stigma and discrimination-reduction curricula mentioned above under PA 1 for HIV.
- Develop and conduct national a TB Stigma Index survey to collect more information on the prevalence of TB stigma and effects of stigma and discrimination on TB services in Uganda. The survey should also assess TB-related stigma and discrimination among health workers.
- Support TB community level structures such as CSOs/CBOs to implement stigma reduction campaigns. Train village health teams (VHTs) and community health education workers (CHEWs) to sensitize communities about TB (i.e. what causes TB, how it is transmitted, and whether it can be cured, etc.) and the causes/effects of TB-related stigma and discrimination.
- Increase frequency of mass media campaigns, both audio and visual, to reduce stigma and discrimination based on TB status, increase awareness on laws and policies protecting the rights of people living with HIV and/or with TB, and reduce fear of infection and subsequent avoidance behavior.
- Support TB stigma-reduction programmes to use religious and cultural media delivered through large, public events, combined with advocacy and engagement led by key populations, including ex-TB patients.
- Expand desk guide for diagnosis and management of TB in children to include guidelines on stigma reduction counselling for the family and the children

- Support advocacy for expansion of MARPI clinics across the country, or replication of the MARPI clinic model of services, to sex workers and their clients and other key populations and support the inclusion of TB-related human rights training and orientation of those providing such services.

PA 2: Reducing gender-related barriers to TB services

Gender-related barriers to TB services may take many forms, affecting both men and women. For example, women typically bear the burden of caring for children in the household, and are less able to travel for TB testing and treatment services, as they have no one to watch their children or not enough money to bring their children with them to the health facilities. As a result, women are more likely to seek care from traditional healers first, delaying entry into biomedical care and treatment for TB until symptoms are more severe. This in turn increases exposure of household members, especially children, to TB. As reported in the Uganda National TB survey 2014-15, men have a higher TB prevalence and highest prevalence to notification ratio as compared to women. However, the focus group discussions suggested that women living with TB are discriminated against more than men living with TB. Thus, programs aimed at analysis of gender norms and inequalities in access to care or exposure to TB risks are relevant for better health outcomes of the national level.

Current Programs

There were no formal programs reported through the fieldwork to remove gender-related barriers to TB services.

Recommendations to reach comprehensive programming:

- Develop, implement and evaluate strategies to reduce gender-related barriers to TB services in Uganda. This would include conducting a gender analysis of the current setup for provision of services and extending existing peer-leader approaches that use gender-specific interpersonal communication to encourage access and utilization of TB services. This could also include advocacy for financial or other assistance to support women's care roles while they are away from the home obtaining TB treatment.
- Advocate with MOH to reorganize the delivery of TB and HIV services to ensure that services are sensitive to gender issues to maximize health outcomes. For women, this would include establishing gender-sensitive TB and HIV diagnostic and treatment services. For men, this would include identifying a set of entry points into broader work being done to improve men's health seeking behaviors and integrating awareness of TB symptoms and treatment into these. For example, including information to support men to overcome the vulnerabilities of women and girls to TB and to reduce stigma and discrimination based on TB.

PA 3: TB-related legal services

Current Programs

There were no formal legal service programs being offered to people living with TB. However, both HRAPF and UGANET paralegal officers and legal aid services are intended for marginalized populations, and thus can be utilized by marginalized populations living with TB.

Recommendations to reach comprehensive programming:

- Develop a system to provide legal aid to people living with TB to address legal issues relating to their TB status. This would include training and support to peer paralegals currently working with people living with HIV and other key populations to provide TB-related legal advice at the community and health-facility levels for people living with or vulnerable to TB.
- Expand the number of paralegals linked with CBOs and NGOs working to support people living with HIV and TB. Train new paralegals on issues specific to people living with TB, as well as people living with HIV.
- Expand and support pool of lawyers willing and able to work with marginalized populations to be able to supervise expanded pool of paralegals and to provide legal representation as needed.

PA 4: Monitoring and reforming laws, regulations and policies relating to TB services

Current Programs

There are no laws or policies in Uganda that directly impede access or utilization of TB services. However, as stated, due to high co-infections of TB and HIV, some laws and policies that may impede access or utilization of services by people living with or vulnerable to HIV may also impede access to TB services. Further, existing regulations about isolation of suspected TB cases in enclosed settings such as prisons may be interpreted in an arbitrary or overly-broad fashion. UGANET has provided support to prisoners in 13 Prison Units since 2014, where they sensitized prison staff and helped to improve practices that were limiting the right to health services for prisoners.

Recommendations to reach comprehensive programming:

- Conduct an assessment of current policies and laws regarding isolation and compulsory treatment (in the community, prisons, schools, IDUs) as well as sentencing laws and policies that lead to overcrowding of prisons and substandard conditions.
- Support TB CSOs and networks of people affected by TB to conduct joint advocacy and lobbying for TB regulatory reform based on findings from the assessment of the current policies and laws noted above.

PA 5: Legal literacy (Know your TB-related rights)

Current Programs

There were no formal programs identified that aimed to increase awareness of TB-related rights and laws.

Recommendations to reach comprehensive programming:

- Recruit, train and supervise some women and men affected by TB as peer educators to empower communities with information on patient rights, laws and policies related to TB, knowledge of TB transmission and remission, and stigma reduction.
- Support TB peer educators to train members of the local councils and VHTs in providing information on "know your rights" related to TB.
- Support the current community structures, such as VHTs, CHEWs, local council, religious and cultural leaders, to include legal literacy and patient's rights education in their communications and activities.
- Support local CSOs/CBOs, especially those working with people living with TB and HIV and key populations, to become aware of and mobilize around TB-related legal literacy and patient rights, and engage in activities to reduce TB-related stigma and discrimination.

PA 6: Sensitization of law-makers, judicial officials and law enforcement agents

Training on human rights, TB and stigma for judges across sub-Saharan Africa has been implemented previously to improve judges' thinking about health and human rights and the decisions they make in cases where these issues are relevant. While none of the key informants interviewed reported improper or stigmatizing treatment specific to TB status from lawmakers, judicial officials or law enforcement agents, such training may be helpful in the Uganda context, particularly in terms of ensuring rights in the context of HIV/TB coinfection, implementation of compulsory treatment and isolation and the right to health of prisoners living with HIV and TB.

Recommendations to reach comprehensive programming:

- Support in-service training for law enforcement officers, judiciary, prison staff, and policy makers by: updating existing training curricula on HIV for lawmakers and law enforcement to include TB-related human rights issues, focusing on aspects that promote supportive, accepting, and responsive TB services for those vulnerable or living with TB; supporting in-service trainings for police, members of judiciary, and prison staff on HIV and TB policies, key and vulnerable populations, responsible and supportive policing in the context of HIV and TB and reduction of illegal policing practices; and expanding the training for prison personnel regarding TB prevention, health care needs and human rights of detainees living with or at risk of TB infection.

PA 7: Training of health care providers on human rights and ethics related to TB

Current Programs

Current and recent initiatives identified were focused on training health workers on medical ethics in relation to TB.

Recommendations to reach comprehensive programming:

- Integrate TB-related human rights and medical ethics concerns into HIV-related pre-service training curricula on human rights and medical ethics for health workers, health managers, as well as other people working in health facilities (e.g. laboratory technicians, receptionists, data clerks).
- Support routine assessments of health workers' knowledge, attitudes and behaviors towards people living with TB and support health administrators to identify and address any issues.
- Support in-service training of health-workers, managers and health care staff areas hard hit by TB and HIV on human rights and medical ethics relevant to TB and HIV services.
- Train health facility managers to implement routine surveys of health care worker /staff attitudes about people living with TB to inform training needs and policy changes at the facility-level.

PA 8: Ensuring TB-related confidentiality and privacy

Confidentiality and privacy are important for increasing uptake of and retention in TB and HIV services and preventing stigma and discrimination among people living with TB and people living with HIV. However, no programs were identified that focused specifically on these topics.

Recommendations to reach comprehensive programming:

- Conducting a service provision assessment at a range of health facilities throughout the country of the modalities of TB and HIV service delivery to determine whether procedural/facility level changes are needed to minimize the identification of people living with TB and people living with HIV.

PA 9: Mobilizing and empowering patient and community groups

No programs were identified that aimed to empower TB-related patient and community groups.

Recommendations to reach comprehensive programming:

- Support the formation of networks of people affected by TB and CSOs/CBOs that support them to advocate for human and patient rights related to TB, issues around gender inequality that increase vulnerability to TB, and rights to protective work places. CBO stakeholder meetings would explore creating/supporting networks and expanding CBO engagement in TB-related human rights work.
- Train CBO(s) on TB-related advocacy issues and support them to conduct community sensitization about types of support available to people with TB through the CBO(s) and advocate for the rights of people living with TB, including the need for the development of work place policies on TB management and infection control, and patient compensation.

- Support effective advocacy, communication and social mobilization to improve engagement of communities, including ex-TB patients and eldery TB patients, to improve case finding, monitor quality of TB health care and combat stigma and discrimination in communities and health care settings.
- In Karamoja, engage and support cultural leaders, herbalists and religious leaders through sensitization and trainings, as part of an outreach model to the communities and as a way to reduce TB-related stigma and discrimination and disputes.

PA 10: Programs in prisons and other closed settings

Current Programs

There are NGOs that have supported TB and HIV services in Ugandan prisons. There are about 36 TB units across the 233 prisons in Uganda, and service delivery is being supported by CDC/UPS project (2015-2020). TB services include screening at entry to prison and directly observed treatment (DOT) for TB patients. A peer educator model is being used to help inmates reach out to each other and also provide psychosocial support.

PEPFAR-supported regional projects also support outreach services to prisons for TB screening, HIV testing and treatment provision. Since 2014, UGANET has been providing legal support to prisoners and human rights awareness to prisoners and the prison staff in 13 prison facilities.

Nonetheless, the coverage of HIV and TB services is limited to a few prison facilities. A discussion with health workers supporting prisons noted several challenges, including limited support from CSOs and NGOs, unlike in the general population. Focus group discussions with people living with HIV and people living with TB also indicated challenges of poor diets that significantly affect adherence to TB drugs. There is a need to invest in improved service delivery in the prisons.

Recommendations to reach comprehensive programming:

- Support CBOs/CSOs working on prisoners' rights to scale up advocacy and interventions for prisoners related to TB, such as nutrition for people living with HIV and/or TB
- Support a national-level assessment of human rights-related vulnerabilities and barriers that are relevant to TB and HIV in prisons to fully elucidate the situation. This assessment should examine protection from dangerous and substandard living conditions leading to TB and HIV, including lack of adequate nutrition, sanitation and access to HIV and TB prevention and treatment services; protection from discrimination and violence, including sexual violence; and protection from discriminatory and arbitrary isolation based on health status.
- Advocate for increased investments in improved TB service delivery in the prisons through improving the prison conditions that are risk factors for TB acquisition or transmission and improving health facility structures and practices, and also through expanded integrated outreach models.

4.5 Costs for the comprehensive programs

In 2016 a total of around 37,400 USD was invested in Uganda to reduce human rights-related barriers to TB services. The GFATM was the only funder. The total amount was split across three program areas, as depicted in the following table:

TB Human Rights Program Area	**2016**
PA 1: Reducing stigma and discrimination	USD 0
PA 2: Reducing gender-related barriers to TB services	USD 4,800
PA 3: TB-related legal services	USD 0
PA 4: Monitoring and reforming laws, regulations and policies relating to TB services	USD 0
PA 5: Knowing your TB-related rights	USD 0
PA 6: Sensitization of law-makers, judicial officials and law enforcement agents	USD 4,600
PA 7: Training of health care workers on human rights and medical ethics related to TB	USD 28,000
PA 8: Ensuring confidentiality and privacy	USD 0
PA 9: Mobilizing and empowering patient and community groups	USD 0
PA 10: Programs in prisons and other closed settings	USD 0
Total	**USD $ 37,400**

Estimated costs for the recommended interventions for the five-year comprehensive program are set out in the table on the following page *(to be updated)*. Detailed intervention areas and costs are detailed in Appendix 6.

Costing for 5-year comprehensive program – TB

TB Human Rights Barriers Program Area	Year 1	Year 2	Year 3	Year 4	Year 5	Total
PA 1: Reducing TB stigma and discrimination*	183,657	338,255	302,653	287,959	260,034	**1,372,559**
PA 2: Reducing gender-related barriers to TB services	-	182,145	149,029	149,029	-	**480,202**
PA 3: TB-related legal services*	90,662	148,219	123,763	123,763	134,125	**620,532**
PA 4: Monitoring and reforming laws, regulations and policies relating to TB services*	-	60,972	67,716	84,645	84,645	**297,979**
PA 5: Knowing your TB-related rights*	70,320	146,932	141,895	141,895	118,885	**619,929**
PA 6: Sensitization of law-makers, judicial officials and law enforcement agents*	9,993	224,716	70,736	70,736	70,736	**446,918**
PA 7: Training of health care providers on human rights and medical ethics related to TB*	16,443	111,110	149,397	47,636	191,372	**515,957**
PA 8: Ensuring confidentiality and privacy	-	54,018	-	-	-	**54,018**
PA 9: Mobilizing and empowering TB patient and community groups	138,320	477,672	226,230	467,372	467,372	**1,776,966**

PA10: TB-related programmes in prisons and other closed settings*	84,211	13,415	11,498	13,415	11,498	**134,037**
Program management (22,07%)	131,008.81	387,870.11	274,311.97	305,989.89	295,444.12	1,394,625
M&E (1,21%)	7,182.63	21,265.19	15,039.31	16,776.07	16,197.89	76,461
Research (2,96%)	17,570.73	52,020.64	36,790.37	41,038.97	39,624.59	187,045
Total	749,368	2,218,610	1,569,059	1,750,257	1,689,935	**7,977,229**

* Some activities within this program area involve both the HIV and TB responses. For these program activities, costs were split 60% for HIV and 40% for TB, based on the suggestion of key stakeholders involved in financing decisions for these grants in Uganda.

Other interventions

Other interventions that are addressing broader right-to-health issues in the context of TB including accessibility, acceptability, availability and quality of services and efforts in these areas are critical to the success of a comprehensive response to remove human rights–related barriers to TB services, and funding for these programs, other than human rights funding, is recommended. Programs that reduce human-rights related barriers to TB and HIV services for people living with or vulnerable to TB and HIV, including sex workers, people who inject drugs, prisoners and other key populations should directly eliminate some of the human rights-related barriers to TB and HIV services documented in this report. Overall, programs that integrate TB and HIV services should be promoted and expanded to all health facilities across the country. Other interventions are given in the table below, followed by brief description.

<table>
<tr><th colspan="6">Other interventions: TB</th></tr>
<tr><td>Program</td><td colspan="4">Description</td><td>Limitations</td></tr>
<tr><td>Increasing accessibility, acceptability, availability, and quality of services</td><td colspan="4">These interventions sought to increase case-detection of TB and/or MDR-TB in vulnerable, hard-to-reach populations across the country using a range of methods including, in school, mobile van screening and home-based testing. Other project aims included improving resources at health clinics, improved data validating and record-keeping, technical assistance, quality assurance management, and facilitating the care continuum for diagnosis and treatment.</td><td>Programs have no activities targeted at TB-related stigma reduction</td></tr>
<tr><td>Implementer</td><td>Population targeted</td><td>Clients reached</td><td>Region(s)</td><td>Timeframe</td><td>Recommended scale-up</td></tr>
<tr><td>USAID/ Track TB</td><td>People living with TB</td><td>373 reached (TB and MDR-TB)</td><td>Data not available</td><td>2010-2016</td><td rowspan="3">More investment is required in early case detections, and increased number of XpertMTB/Rif at the district level</td></tr>
<tr><td>TB REACH/ SPARK TB</td><td>People living in urban slums in Kampala</td><td>473 TB cases identified in the first year</td><td>Kampala</td><td>2010-2016</td></tr>
<tr><td>USAID/DEFEAT TB</td><td>People living with TB, people living with HIV</td><td>Data not available</td><td>Kampala</td><td>2018-2021</td></tr>
</table>

In addition to TB services delivered directly through the Ministry of Health (with funding from several donors including the Global Fund), other donors also fund NGOs that implement service delivery aimed at increasing access to TB services. Many donors have supported the TB REACH program that started in 2010, with significant funding from the Canadian International Development Agency. USAID funded the TRACK TB program in Kampala and similarly is sponsoring the DEFEAT TB program. It should be noted that there are several programs providing TB services as an integral part of HIV services. These programs are already noted in the HIV section.

The Government of Uganda has also formed a National Coordination Committee for TB at the Ministry of Health to support the National TB and Leprosy Program. Further, political commitment to fight TB has been strengthened by the formation of the Parliamentary Caucus for TB. This will support advocate, raise resources and initiate appropriate legislation for TB..

Key informants in the survey also suggested further investment in community DOTs programs that target and reach elderly patients. The use of community-level structures, including the local council structures, VHTs, the grass-root networks of the religious institutions and cultural institutions, should be used to reach the community. Effective advocacy, communication and social mobilization would lead to improved engagement of communities, including ex-TB patients and elderly TB patients, to improve case finding and combat stigma and discrimination. The expansion of the DOTs program in Karamoja and Northern Uganda were seen as urgent.

Moving to more comprehensive programming

- Increase availability, accessibility and quality of health services for key and vulnerable populations. Integrate health services for HIV, TB, OST, and violence into general health services, etc.
- Design special mobile TB clinics for the hard-to-reach parts of the country including Karamoja, hilly areas and the islands.
- Provide standardized guidance on the constructions of houses and huts in rural areas, as a preventive strategy for TB infection control.
- Train more health workers in TB identification and effective referrals.

5. Baseline Findings: Malaria

5.1 Overview of Epidemiological Context and Key and Vulnerable Populations

Uganda is one of three countries in sub-Saharan Africa that account for more than 50 percent of estimated malaria cases in the world, and among the 15 countries accounting for 80% of estimated malaria deaths globally.[109] Uganda reported a two-fold increase in confirmed cases during 2015-2016 compared to 2013, which, according to the Ministry of Health's Malaria Bulletin, may be due to inadequate vector control, climatic factors, inadequate malaria-related behavior change communication and improved reporting.[110] According to Uganda's Ministry of Health, malaria is one of the most important diseases in Uganda in terms of morbidity and mortality. It accounts for 30 to 50 percent of outpatient visits and 15 to 20 percent of hospital admissions.[111] The climate in Uganda accounts for stable, year-round malaria transmission, and malaria is endemic in about 95 percent of the country.[112] Uganda has one of the highest levels of malaria incidence in the world, especially among children, where the pediatric mortality rate for severe malaria infection is noted as high as 21%.[113] Significantly, 52% of Ugandans have reported having malaria, with higher prevalence in the Eastern region of the country.[114]

As a disease that often affects those in poverty more strongly than those in better socioeconomic positions worldwide, economic barriers often prevent marginalized populations, including vulnerable and underserved populations, from accessing care and maintaining treatment. A poor family in a malaria-endemic area may spend up to 25% of the household income on malaria prevention and treatment,[115] Even when malaria prevention is free, health information and information regarding the disease may be difficult to access due to language and/or cultural barriers. These factors place certain groups in more vulnerable positions.[116] Additionally, according to the United Nations High Commissioner for Refugees, in 2017, Uganda is hosting 1.3 million refugees and asylum-seekers, the vast majority fleeing war and human rights abuses in South Sudan, the Democratic Republic of Congo and Burundi, providing unique challenges for malaria control.[117] [109]

In recent years, due to large-scale insecticide-treated net distribution throughout the country, at least 62% of children under the age of five and 64% of pregnant women sleep under a treated

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[109] World Health Organization (2017): World Malaria Report. Geneva: WHO.

[110] Uganda Ministry of Health. 2015. *Uganda Malaria Quarterly Bulletin* (Issue 10: April—June 2015). Kampala.

[111] Uganda Ministry of Health. 2014. *Uganda Malaria Reduction Strategic Plan*. Kampala.

[112] Uganda Ministry of Health. 2014. *Uganda Malaria Reduction Strategic Plan*. Kampala.

[113] Sundararajan R, Mwanga-Amumpaire J, Adrama H, Tumuhairewe J, Mbabazi S, Mworozi K, Carroll R, Bangsberg D, Boum Y 2nd, Ware NC. (2015). Sociocultural and structural factors contributing to delays in treatment for children with severe malaria: a qualitative study in southwestern Uganda. *American Journal of Tropical Medicine and Hygiene* 92(5), 933-940.

[114] Murungi I, Bukare A, Atim S, Boyle A, Dauvergne M. Women of Uganda Network (WOUGNET) (2015). Final Report for the GEKS Uganda National Assessment.

[115] Uganda Ministry of Health. 2014. *Uganda Malaria Reduction Strategic Plan*. Kampala.

[116] The Global Fund. (2017). Technical Brief: Malaria, Gender and Human Rights. Geneva, Switzerland.

[117] U.S. President's Malaria Initiative. (2017). *Malaria Operational Plan FY 2018*. USAID.

mosquito net.[118] Other areas of marked progress are found in the distribution of residual sprays for indoor spaces, and the utilization of combination therapy for uncomplicated malaria. In 2010, the Ministry of Health adopted a strategy for integrated community case management (iCCM) to facilitate access to, and reduce the treatment gap, for malaria, pneumonia and diarrheal disease treatment. By 2016, districts with iCCM had achieved a 21% increase in care-seeking for fever, compared with districts without an iCCM in place.[119]

However, the burden of malaria remains high in Uganda. In 2016, the demographic and health survey showed that 33% of the children under five suffered from fever, and indicator of malarial disease, within the past 2 weeks preceding the survey.[120] Among children under the age of five, the malaria prevalence is 44.7%. Although a significant portion of families seek treatment, many families cannot afford the full extent of care needed.[121]

Compared to non-pregnant women, pregnant women have a higher susceptibility to malaria, and face higher risk of a severe infection. The consequences of a malaria infection during pregnancy can result in stillbirth, low birth weight, and maternal anemia, even when symptoms are absent.[122]

5.2 Overview of the policy, political and social context relevant to gender and human rights-related barriers to malaria services

5.2.1 Laws, Policies and Regulations

As detailed in section on 3.2.1 on page 36, Uganda is a signatory to several human rights-related international human rights instruments that provide general protective provisions regarding access to health services, including for HIV, TB and malaria.

A National Plan has been developed specifically for malaria, titled the *Uganda Malaria Reduction Strategic Plan 2014-2020*, which aims to improve quality of malaria services in both prevention and treatment with goals towards accountability, technical empowerment, efficiency, value, and multi-stakeholder involvement[33].

It is important to note that many of the legal barriers affecting access to health generally are very relevant to malaria, particularly as they relate to underserved, marginalized and vulnerable populations. For example, the Non-Governmental Organizations Law (NGO Law) may discourage or make more difficult community-based responses to malaria as it may make more

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[118] Murungi I, Bukare A, Atim S, Boyle A, Dauvergne M. Women of Uganda Network (WOUGNET)(2015). Final Report for the GEKS Uganda National Assessment.

[119] Uganda Bureau of Statistics (UBOS) and ICF. 2018. Uganda Demographic and Health Survey 2016. Kampala, Uganda and Rockville, Maryland, USA: UBOS and ICF.

[120] World Malaria Report 2017 Yeka A, Gasasira A, Mpimbaza, Achan J, Nankabirwa J, Nsobya S, Staedke G, Donnelly MJ, Wabwire-Mangen F, Talisuna A, Dorsey G, Kamya MR, Rosenthal PJ. (2012). Malaria in Uganda: challenges to control on the long road to elimination. I. Epidemiology and current control efforts. Acta Trop 121(3), 184-195.

[121] Nabyonga Orem J, Mugisha F, Okui AP, Musango L, Kirigia JM. (2013). Health care seeking patterns and determinants of out-of-pocket expenditure for malaria for the children under-five in Uganda. *Malaria journal* 12, 175.

[122] Rassi C, Graham K, King R, Ssekitooleko J, Mufubenga P, Gudoi SS. (2016). Assessing demand-side barriers to uptake of intermittent preventive treatment for malaria in pregnancy: a qualitative study in two regions of Uganda. *Malaria Journal* 15:530.

difficult for civil society organizations to form and operate, and support provision of community-based health services.This law came into force in 2016 and enables the Government to restrict the way NGOs operate, requiring them to register with an NGO Bureau and apply for permits to operate. It also restricts NGOs from working in districts without approval from the district's Monitoring Committee and entering a memorandum of understanding (MOU) with local governments where they operate. This law prohibits organizations from engaging in activities that are considered by the Government to be prejudicial to the security and laws of Uganda. CSOs that support highly marginalized populations affected by malaria, for example, may have difficulty registering and operating. [Error! Bookmark not defined.]

5.3 Human Rights-Related Barriers to Malaria Services

Overview

The populations particularly vulnerable and underserved, facing barriers to accessing primary healthcare services including malaria, that were identified during this Baseline Assessment and its inception meeting include children under 5 years, pregnant women, refugees, mobile populations in Karamoja, older people and prisoners. The Uganda Malaria Reduction Strategic Plan (UMRSP) 2014-2020 lists children under 5 and pregnant women as the most vulnerable populations to malaria, while noting that the entire Ugandan population is vulnerable and in need of malaria prevention services. The major barriers to accessing primary healthcare generally, and malaria services as part of it, set out below were found to be prominent in discussions with key informants from the National Malaria Control Program, district health teams and with mothers of children under five in focus groups, including:

a) While there is no stigma associated with having malaria, stigma and discrimination based on age, ethnicity, socio-economic status, health status including real or perceived HIV positive status, and other grounds limits access to primary healthcare generally, and to malaria services specifically, by vulnerable and underserved populations. This stigma, also influenced by cultural norms and myths, can be internalized or experienced within the community and/or from healthcare providers.
b) Gender inequality, including decision-making power at household level, occupational exposure, higher burden of household chores, and gendered preferences in care-seeking behavior
c) The voices and concerns of some particularly ffected populations, especially prisoners, refugees, and mobile populations, may be absent in decision-making on health programs and malaria programs in particular, and these populations may face particular barriers to malaria services and information.
d) Broader barriers to access to health services, including inadequate access to information resulting from low literacy rates, limited coverage of services in hard-to-reach areas such as dry and mountainous parts of Karamoja, and high poverty levels in some parts of the country.

5.3.1 Cultural norms, stigma and discrimination

Certain fears and stigma exist within the society about blood being taken from the body, especially from children, due to cultural beliefs about witchcraft, as well as the perception of risk of exposure to HIV infection.[123] Pregnant women are often fearful about treatment for malaria and its effects, due to a lack of knowledge of the disease and treatment outcomes.[124] [125] These views affect uptake of malaria prophylaxis, diagnosis and treatment.

In the focus group discussions, some key informants reported discriminatory practices by health workers against older patients. One woman noted:

> *"I have seen health workers refuse to attend to old persons, even to myself. I was told to go and buy medications without being tested for malaria. Since then I am forced to go with my daughter to get their attention"*

Low access to information about malaria due to language barriers or low literacy, was also identified as a barrier.

5.3.2 Gender Inequality

Subordination of women in households, including lack of autonomy in control of household resources and decision-making, constitutes an important barrier to health services for women and children in Uganda, affecting access to malaria services among many other health services. In Uganda, a common gender-related barrier to care for pregnant women is a combination of the need for spousal approval for health care and overcrowded days of housework and childcare. In one study, ten percent of pregnant women targeted for a malaria treatment study said they could not receive treatment because they had too much household work which prevented them from participating in the intervention study.[124] A 2019 study among Ugandan women measured "family obligation stress" – based on factors such as how many children or old people are cared for in the house, family income, women's education level and whether she works outside the house – and found high levels of this stress to be a crucial barrier to women's seeking of some types of preventive services.[126] Lack of support from families, including extended families, was found to impede women in Uganda from initiating some health services.[127]

5.3.3 Structural Barriers

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[123] Mukanga D, Tibenderana JK, Kihuli J, Pariyo GW, Waiswa P, Bajunirwe F, Mutamba B, Counihan H, Ojiambo G, Kallander K. (2010). Community acceptability of use of rapid diagnostic tests for malaria by community health workers in Uganda. *Malaria Journal* 9, 203.

[124] Mbonye AK, Bygbjerg I, Magnussen P. (2007). Intermittent preventive treatment of malaria in pregnancy: Evaluation of a new delivery approach and the policy implications for malaria control in Uganda. Health Policy 81, 228-241.

[125] Mbonye A, Mohamud SM, Bagonza J. (2016). Perceptions and practices for preventing malaria in pregnancy in a peri-urban setting in Southwestern Uganda. *Malaria Journal* 15, 211.

[126] Scheel JR, Parker S, Hippe DS et al. (2019). Role of family obligation stress on Ugandan women's participation in preventive breast health. *The Oncologist* 24, 624-631.

[127] Odongo J, Makumbi T, Kalungi S, Galukande M. (2015). *BMC Research Notes* Sep 22;8:467. doi: 10.1186/s13104-015-1438

Overall challenges regarding malaria prevention, diagnosis and treatment in Uganda include transmission intensity, limited resources in healthcare, growing resistance to drugs, and limited knowledge of the disease among health care providers and the general population.[128]

Structural issues bring about delays in care for many children with malaria in Uganda. Besides numerous cultural reasons for a delay in treatment, such as traditional ideas over what is a significant disease and use of traditional healers as primary caregivers, the significant issues of healthcare resource distribution and impoverishment represent barriers to adequate and appropriate care for children with malaria.[129]

5.3.4 Limited engagement of some affected populations, especially prisoners, refugees andmobile populations

Health workers in the health facilities in prisons and in refugee settlements described a health care system where their clients or patients are very little, if ever, involved in the design and programming of health service delivery. The health workers in prisons reported more limited technical support than that received by their peers in other health services and health managers at the district level. In many cases, they missed some relevant trainings and sensitizations, especially those done by NGOs. They pointed out that few prisons in Uganda have well-organized healthcare systems in place.

To date, malaria continues to be the leading cause of death amongst people living in refugee-hosting districts in Uganda. However, a study conducted by UNHCR in December 2017 showed that only one-third of refugee households (36%) owned at least one long-lasting insecticide treated nets (LLIN), while in the host population, 63% owned one. This underscores the need to provide more resources for malaria prevention, diagnosis and care for refugees, including equitable access to LLIN, as well as the need to meaningfully involve refugees in the programming of malaria services.[130] This evidence also signals a need to ensure that information on malaria prevention and care is provided in a way that is linguistically and culturally accessible to refugees.

5.3.5 Health Facility-Level Barriers

Health facility-level barriers in the context of malaria underline the importance of communication between healthcare providers and individual patients. One study determined that better health outcomes arise from higher patient satisfaction with the quality of services, and their perception of the quality of the healthcare system. In some cases, patients may reject a

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[128] Yeka A, Gasasira A, Mpimbaza, Achan J, Nankabirwa J, Nsobya S, Staedke G, Donnelly MJ, Wabwire-Mangen F, Talisuna A, Dorsey G, Kamya MR, Rosenthal PJ. (2012). Malaria in Uganda: challenges to control on the long road to elimination. I. Epidemiology and current control efforts. Acta Trop 121(3), 184-195.

[129] Sundararajan R, Mwanga-Amumpaire J, Adrama H, Tumuhairewe J, Mbabazi S, Mworozi K, Carroll R, Bangsberg D, Boum Y 2nd, Ware NC. (2015). Sociocultural and structural factors contributing to delays in treatment for children with severe malaria: a qualitative study in southwestern Uganda. *American Journal of Tropical Medicine and Hygiene* 92(5), 933-940.

[130] https://www.unicef.org/uganda/media_18274.html , Accessed 20th July 2018.

malaria test result if the patient did not find their rapid testing service reputable and efficient.[131] Lack of sufficient trust between healthcare workers, malaria patients and their families is noted as a barrier to care. For pregnant women, fear linked to limited knowledge about malaria treatment and its effects leads to a lack of initiative to get diagnosed and treated for malaria.[124] Further, among the healthcare system and its different partners, coordination in intervention implementation and engagement is irregular, creating gaps in coverage. Referral rates from small local clinics to higher-level health facilities is low, likely due to lack of knowledge of costs of treatment.[132] [133] Other healthcare barriers were linked to insufficient resource availability. Many facilities experience stock-outs of malaria treatment and do not keep sufficient records. There is also limited availability of guidelines and job aids for malaria screening and treatment.[134] Physical barriers also affect access to healthcare services. Rural isolation limits knowledge and availability of treatment, and healthcare that is accessible to rural communities may be limited in quality and scope due to fewer resources available for rural clinics.[135]

Prices of medicines and treatments for malaria, especially for families of children with malaria, also become a significant barrier to treatment. Spending on malaria treatment is a much greater burden for poor families in Uganda, who spend 34% of their income on malaria treatment on average compared with 1% for wealthier families..[136]

In one of the focus group discussions with mothers, they reported cases of intimate partner violence due to delays in returning from the health facilities. Since long waiting queues are common at health facilities, mothers may hesitate to take children with fever for a test, and instead buy medications from pharmacies nearby their home without diagnosis.

5.4 Programs to Address Human Rights-Related Barriers to Malaria Services

Overview

It is recognized that in order to achieve impact, successful malaria strategies should include interventions that are:

[131] Altaras R, Nuwa A, Agaba B, Streat E, Tibenderana JK, Martin S, Strachan CE. (2016). How do patients and health workers interact around Malaria Rapid Diagnostic Testing, and how are the tests experienced by patients in practice? A qualitative study in Western Uganda. *PLoS One* 11(8).

[132] Yeka A, Gasasira A, Mpimbaza, Achan J, Nankabirwa J, Nsobya S, Staedke G, Donnelly MJ, Wabwire-Mangen F, Talisuna A, Dorsey G, Kamya MR, Rosenthal PJ. (2012). Malaria in Uganda: challenges to control on the long road to elimination. I. Epidemiology and current control efforts. Acta Trop 121(3), 184-195.

[133] Nanyonjo A, Bagorogoza B, Kasteng F, Ayebale G, Makumbi F, Tomson G, Kallander K. (2015). Estimating the cost of referral and willingness to pay for referral to higher-level health facilities: a case series study from an integrated community case management programme in Uganda. *BMC Health Services Research* 15, 347.

[134] USAID, CDC. (2016). Strengthening IPTP Service Delivery Through Facility-Initiated Supervision: Lessons from a Quality Improvement Approach in Uganda.

[135] Graffy J, Goodhart C, Sennett K, Kamusiime G, Tukamushaba H. (2012). Young People's Perspectives on the Adoption of Preventive Measures for HIV/AIDS, malaria, and family planning in South-West Uganda: focus group study. *BMC Public Health* 12, 1022.

[136] Nabyonga Orem J, Mugisha F, Okui AP, Musango L, Kirigia JM. (2013). Health care seeking patterns and determinants of out-of-pocket expenditure for malaria for the children under-five in Uganda. *Malaria journal* 12, 175.

- Integrated: addressing malaria not only as a health issue, but multi-sectorally, as a developmental, economic, political, environmental, agricultural, educational, biological, legal, security and social issue.
- Equitable: ensuring that vector control, diagnosis and treatment services reach populations at risk of malaria, including consideration for the hardship that certain populations face in accessing services.
- Person-centred: ensuring that the experiences of populations in need of services actively inform the design of malaria interventions, including decisions about community versus facility-based deployment and the dynamic of interactions between service provider and client.

In general, interventions aimed specifically at reducing the human rights-related barriers to malaria services are few, although the national malaria control program aims to ensure equitable access to services and commodities. There are some programs aimed at removing gender barriers and strengthening service availability in hard-to-reach places in Uganda. Most of these, however, have been in project form, with limited coverage across the country. Overall, no studies on human rights-related and other equity barriers specifically to malaria services in Uganda were identified, but barriers to health services generally, including barriers related to subordination of women, are important. The following section describes existing or recent programs in Uganda to remove human rights-related barriers to services, as well as a comprehensive response to remove these barriers (see also Annex 3 for a chart summarizing the comprehensive programs).

Sources and uses of funds for interventions to address barriers to malaria services

The majority of funding for malaria control in Uganda is donor-dependent, channeled mainly through the Ministry of Health. Financing of the response to malaria in Uganda comes from the Government of Uganda, the Global Fund and bilateral donors, such as the US President's Malaria Initiative (PMI) and the UK's Department for International Development (DFID). Others donors include the United Nations Children's Fund (UNICEF), the Clinton Health Access Initiative (CHAI) and the United Nations High Commissioner for Refugees. This funding is utilised mainly for the purchase of drugs and supplies, such as mosquito nets (long lasting insecticide treated nets, LLINs), insecticides for indoor residual spraying (IRS), rapid diagnostic test kits, as well as for salaries and behavior change communication (BCC).

Gaps, challenges, and opportunities

Malaria control programs in Uganda have led to large reductions in the prevalence of malaria over the past five years. According to the 2016 national Demographic Health Survey (DHS), some areas, like the West Nile region, saw a dramatic decrease, from 51% to 25%. Several other regions, however, experienced increases. Further, according to 2016 data from Uganda's Health Management Information System (HMIS), malaria accounts for 20% to 34% of outpatient visits and 25% to 37% of hospital admissions. In addition, despite the universal coverage of distribution of LLINs in early 2018, the percentage of under-five children or pregnant women who sleep under these nets has stagnated at around 60% in many districts.

It was also noted by some key informants that there is limited coordination of malaria services, implementing partners involved in behavior change communication (BCC) or community- level structures engaged in malaria service programming. Some of the partners have developed behavior change communication materials and messages with limited participation and endorsement by the National Malaria Control Program (NMCP). Limited realization of the right to health is discussed in behaviour change communication and also in the Patients Charter. Further, there is limited attention to the strengthening of community-level structures, leading to inadequate impact of messages.

Data on malaria services are collected through Uganda Demographic and Health Survey(UDHS) and the Multiple Indicator Cluster Survey (MICS), both of which provide an opportunity to collect more detailed data on gender and human rights-related barriers to access and utilization of health services, including barriers that are relevant to malaria preventive and therapeutic interventions. These could provide evidence to engage the key stakeholders and healthcare providers on gender and human rights-related barriers.

PA 1: Reducing gender-related discrimination and harmful gender norms relevant to health services, including malaria

The table below provides an overview of current programmatic efforts to reduce gender-related discrimination and harmful norms, as well as recommendations for scale-up. The content of the table is then further elaborated upon.

Reducing gender-related discrimination and harmful gender norms					
Program	***Description***				***Limitations***
Gender analysis and mainstreaming activities	Gender analysis and mainstreaming into programming of malaria service delivery at health facilities, and school and community level activities to reach men, women, girls and boys effectively				Project activities have just begun and their effectiveness is not known
Implementer	***Population targeted***	***Clients reached***	***Region(s)***	***Timeframe***	***Recommended scale-up***
USAID/PMI/Malaria Action program for Districts (MAPD)	Men, women, youth and children	Data not available	44 districts in the Central, Western and West Nile	2017-2021	Strengthen the capacity of key malaria stakeholders, managers, and data analysts to understand, prioritize, and use age and gender equity-related information in the fight against malaria. Gender responsiveness should be mainstreamed at all levels of malaria program design, implementation, monitoring and evaluation. Involve young men and women, and older men and women, meaningfully in advocacy and education around malaria through participatory approaches such as peer education initiatives.

Current programs

The study respondents could not identify any malaria programmes that integrated gender issues in design and implementation, except for the newly launched USAID/Malaria Action Program for Districts (MAPD) Project (2017-2022) that has integrated gender issues in its behavior change communication, community and school level activities. MAPD currently covers 44 districts in Uganda.

Recommendations to reach comprehensive programming:

- Conduct operational research to explore gender and health dynamics, including those related to malaria, and develop a gender analysis framework. Malaria Matchbox (or elements of it) may be used.
- Strengthen the capacity of key malaria stakeholders, managers, and data analysts to understand, prioritize, and use age and gender-disaggregated data and other gender related information in the fight against malaria.
- Mainstream gender issues, including gender equality and nondiscrimination, at all levels of malaria program design, implementation, and evaluation.
- Involve young men and women in in promoting malaria prevention and control, and in broader advocacy and education around malaria through participatory approaches such as peer education initiatives.
- In the context of SASA! incorporate malaria concerns and develop and implement counseling and educational sessions on equity barriers to malaria services alongside malaria symptoms and care information, with messages targeted at different groups including mothers, pregnant women, men, fathers, male and female adolescents, and schoolchildren.

PA 2: Promoting meaningful participation of malaria-affected populations

The table below provides an overview of current programmatic efforts to promote meaningful participation of key populations, as well as recommendations for scale-up. The content of the table is then further elaborated upon.

<table>
<tr><td colspan="6">Promoting meaningful participation of affected populations</td></tr>
<tr><td>Program</td><td colspan="4">Description</td><td>Limitations</td></tr>
<tr><td>Community-level dialogues on maternal and child health care services</td><td colspan="4">Aiming at evidence-based social and behavioral change communication in priority areas using targeted communication strategies, community dialogues, and other interactive activities designed to engage audiences in dialogue on social norms using a life stage approach that addresses evolving health needs over different stages of life, including malaria prevention and treatment services.</td><td>The VHT system and health unit management committees are weak and poorly supported by the health facilities in the mobile populations of Karamoja and in hard-to-reach mountainous areas. Further, the coverage of VHTs across villages is still limited because of challenges surrounding lack of tools, resources, motivation, and regular supervision, which has resulted in high attrition among VHTs.</td></tr>
<tr><td>Implementer</td><td>Population targeted</td><td>Clients reached</td><td>Region(s)</td><td>Timeframe</td><td>Recommended scale-up</td></tr>
<tr><td>Communication for Healthy Communities/ FHI 360</td><td>Data not available</td><td>Data not available</td><td>Country-wide</td><td>2013-2018</td><td>Create a system for mapping, identifying, and engaging hard-to-reach, minority and socially disadvantaged populations affected by malaria, especially on the islands and mountainous areas of Karamoja.

Use the local religious or cultural structures within these areas, and promote projects that support community-level dialogues on malaria and integration of feedback into service delivery.

Support the implementation of community scorecard at health facility level for malaria services</td></tr>
</table>

Program	***Description***				***Limitations***
Improving maternal and child health at community level health services at public and private level facilities	The aim of the program is improved prevention, diagnosis and treatment of malaria with increased access to measures and initiatives at the community level. Increase coverage and usage of intermittent preventive treatment of malaria in pregnancy, indoor residual spraying, and insecticide-treated mosquito nets.				Limited coverage of services in refugee settlement, mountainous areas of Karamoja and mobile population in Karamoja
Implementer	***Population targeted***	***Clients reached***	***Region(s)***	***Timeframe***	***Recommended scale-up***
USAID/PMI/ Malaria Action program for Districts	Women and children	Data not available	Data not available	2016-2021	Integrating women and child rights considerations and patient information relevant to malaria into efforts to improve MCH services.
President's Malaria Initiative/ PEPFAR	Women and children	Data not available	Data not available	2006-	
Government of Uganda/ iCCM/ Village Health Teams strategy	Women and children	Data not available	19 districts	2010	
USAID/Stop Malaria Project	People living with malaria	Data not available	34 districts in three regions	2008-2015	

Current programs

Overview

Malaria programs in the country utilize community-level structures, notably the VHTs, to implement interpersonal communication and mobilize the community for behavior change and create demand for malaria services at the health facility. The focus group discussions indicated that interactions with VHTs has helped the communities to give feedback about the malaria program implementation and service delivery at the health facilities. Many health facilities also have health unit management committees with representatives from the community that participate in decision-making at the health facility level.

There have been projects, such as the USAID/Communication for Healthy Communities (CHC) Program (2013-2018), that have supported community-level dialogues on maternal and child health care services relevant to malaria and provided feedback to health facilities and health service managers.

Limitations/challenges

The VHT system and health unit management committees are weak and poorly supported by the health facilities in the mobile populations of Karamoja and in hard-to-reach mountainous areas. Further, the coverage of VHTs across the different villages is still limited because of challenges surrounding lack of tools, resources, motivation, and regular supervision, which has resulted in high attrition among VHTs. The key informants also noted poor utilization of local structures in prisons and refugee settlements for meaningful engagement of prisoners and refugees.

Recommendations to reach comprehensive programming:

- Create a system for mapping, identifying, and engaging hard-to-reach, minority and socially disadvantaged populations affected by malaria, especially on the islands and mountainous areas of Karamoja. Use the local religious or cultural structures within these areas, and promote projects that support community-level dialogues and integration of feedback into malaria service delivery. Ensure meaningful involvement of refugee communities in the process.
- Support the implementation of community scorecard assessment of quality at health facility-level for malaria services.
- Develop content on gender equality and patients' rights alongside malaria symptoms and care for inclusion in SBCC, with messages targeted at different groups including mothers, pregnant women, men, fathers, male and female adolescents, refugees, and schoolchildren. These sessions could focus not only on early recognition of malaria, but also encourage prevention, more equitable household decision-making and the sharing of caregiving activities.

PA 3: Strengthening community systems for participation in malaria programs

The table below provides an overview of current programmatic efforts to strengthen community systems for participation in malaria programs, as well as recommendations for scale-up. The content of the table is then further elaborated upon.

Strengthening community systems for participation in malaria programs					
Program	***Description***				***Limitations***
Management and capacity-building training	Promoting the wellbeing of village members and reducing gaps in malaria health service provision between households and health care providers through six-day training on management at village level.				There are no recent structured programs or activities to empower the community to participate in malaria services programming
Implementer	***Population targeted***	***Clients reached***	***Region(s)***	***Timeframe***	***Recommended scale-up***
Government of Uganda/ Health Sector Strategic Plan/ Village Health Team	Village members	500 people	All districts	2008	Strengthen the capacity of VHTs further with regard to understanding human rights and gender concerns
Program	***Description***				***Limitations***
Home-integrated management /community case management expansion	Improving community-level access to malaria diagnosis and treatment through home-integrated or community case management of malaria.				Limited to few districts
Implementer	***Population targeted***	***Clients reached***	***Region(s)***	***Timeframe***	***Recommended scale-up***

Global Health Research Initiative Stakeholders' Perceptions of Integrated Community Case Management	Community health workers (CHW)	196 CHW trained	98 villages	2010 – to date	Strengthen malaria service delivery by building the capacity of VHTs on human rights and gender concerns related to malaria and facilitating the activities

Current programs

Overview

There appear to be no programmes aimed at strengthening community systems to support malaria programs. There are, however, general projects such as the USAID/Advocacy for Better Health Project (2014-2019) and the integrated community case management (iCCM), adopted by Ugandan Government in 2010, where each VHT works with community volunteers to identify danger signs, refer newborns, and treat malaria, pneumonia, and diarrhea, among other things. The USAID/Advocacy for Better Health Project has built the capacity of 20 local CSOs and communities across 35 districts to advocate to decision-makers at both the local and national levels for better health services and hold them accountable.

Recommendations to reach comprehensive programming

- Advocacy to strengthen VHT system through trainings and supportive supervisions and provide funds for facilitation and village level activities, including on promotion of access to non-discriminatory care, patients' rights, rights/legal literacy.
- Advocacy to strengthen the capacity on human rights and gender-related aspects of malaria prevention and control of health unit management committees and local CBOs and facilitate them to hold community-level dialogues.

PA 5: Malaria programs in prisons and other closed settings

There were no special programs to overcome human-rights related barriers to malaria services noted by the key informants for those in prisons, including pre-trial detainees, and in other closed settings. There should be a structured process to enable technical support to prison health care providers, including training on measures to ensure that malaria prevention and control supplies reach all prisoners, including those awaiting trial.

Elements of the comprehensive program in this area would include:

- Support advocacy or other efforts to ensure that malaria services in prison are overseen and given technical support by health ministries
- Develop and implement prevention and case management services for both men and women in prison
- Support advocacy for improved malaria service programming and delivery in prisons and other closed settings
- Support advocacy for training and targeted measures to ensure that malaria prevention and control supplies are rolled out in prisons.

PA 6: Improving access to services for underserved populations, including refugees and others affected by emergencies

Poverty, social and geographic exclusion, harmful gender norms and financial barriers are just some of the many health determinants that disproportionally affect people's wellbeing, bringing severe hardship and ill health to underserved and marginalized groups. People living in fragile settings or affected by conflicts, such as refugees and internally displaced people often experience deprivation of basic healthcare services, linked to discrimination or lack of security. Research has found that marginalized populations can be particularly vulnerable to malaria and face barriers to accessing health services, including those for malaria.

Guiding principles of The Uganda Malaria Reduction Strategic Plan include equity and non-discrimination, as well as universal coverage for all populations, including vulnerable populations such as children under the age of five, pregnant women, people living with HIV, internally displaced populations and refugees.

Current programs or initiatives included behavior change communication, with messages through radios and community-level dissemination by the VHTs; and HIV and malaria integrated services at the health facilities. The messages promote the availability of malaria services without discrimination at the health facility level.

Some recommendations include:

- In the framework of High Burden to High Impact action planning and response, further assess people's ability to access and utilize healthcare services, ensure that no one is left behind, irrespective of who and where they are, and consider the root causes of health inequity across different contexts, populations and groups of individuals.
- Develop guidelines for integrated service delivery that includes non-discriminatory equitable access
- Integrated service delivery with a patient-centered approach

Unfortunately, it was not possible to conduct FGDs with refugees or key informant interviews with experts working with refugees in Uganda as a part of the baseline assessment. Therefore, our understanding of human rights-based barriers to malaria in the context of refugees and other affected by emergencies is limited to what we learned from interviewing malaria experts. The same applies to TB and HIV. It is clear that work is needed to improve healthcare services in general to refugee populations. Further investigation at the various refugee camps in Uganda is warranted to better understand key areas for improvement to remove existing human rights-related barriers to services. The multi-stakeholder meeting should aim to include experts working on ensuring access to health services for refugees.

5.5 Costs for a comprehensive program – Malaria

No funding was spent on removing human rights-related barriers specifically in the context of malaria programs in 2016; the baseline assessment has not covered primary healthcare stakeholders more generally, so was unable to assess whether investments existed in context of broader efforts geared at eliminating barriers to primary healthcare. Costs for the 5-year

comprehensive response proposed are shown in the following table and further details are included in Annex 6. Programs to remove human rights-related barriers to primary healthcare services, and specifically to malaria services, can and should be integrated in the overall planning and delivery of effective responses. The estimated costs outlined below could be reduced significantly through effective human rights-based approaches to the malaria vector control and case management, as wells as specific preventative interventions. However, it is recognized that appropriate funding and staffing are needed for the National Malaria Control Program, including securing expertise geared at ensuring equity in addition to traditional technical expertise, to reorient program delivery to reach those most underserved, and ensure Universal Health Coverage.

Costing for 5-year comprehensive program – Malaria

Malaria Human Rights Barriers Program Area	Year 1	Year 2	Year 3	Year 4	Year 5	Total
PA 1: Reducing gender-related barriers and harmful gender norms^	23,263	76,330	189,053	110,730	82,400	**481,776**
PA 2: Promoting meaningful participation of affected populations	-	171,838	216,718	145,289	62,659	**596,503**
PA 3: Strengthening of community systems for participation in malaria programs	26,806	26,806	268,697	445,701	445,701	**1,213,710**
PA 4: Improving services in prison and pretrial detention	187,314	646,220	599,463	608,917	209,683	**2,251,598**
PA 5: Improving access to services for underserved populations, including refugees and others affected by emergencies	39,020	27,158	47,613	-	-	**113,791**
Program management (22,07%)	61,002.09	209,301.23	291,664.69	289,257.55	176,657.68	1,027,883
M&E (1,21%)	3,344.47	11,475.06	15,990.68	15,858.71	9,685.36	56,354
Research (2,96%)	8,181.52	28,071.21	39,117.69	38,794.85	23,693.10	137,858
Total	**348,931**	**1,197,199**	**1,668,317**	**1,654,548**	**1,010,479**	**5,879,474**

Other interventions (not to be funded by human rights funds)

Engage local CSOs/CBOs and schools to conduct community dialogue forums, drama, film shows, sports events and other social mobilization interventions to boost behavior change for malaria control, diagnosis and treatment among the community members. Other engagements can be done through school programs, religious leaders and local council members to champion malaria intervention messages and act as change agents among those affected and in the community.

Other interventions: Malaria					
Program	***Description***				***Limitations***
Increasing accessibility, acceptability, availability, and quality of malaria services	Providing training on data validation and record-keeping, capacity-building, technical assistance, resource growth, provision of prevention measures and scaling up existing initiatives.				
Implementer	***Population targeted***	***Clients reached***	***Region(s)***	***Timeframe***	***Recommended scale-up***
JSI/ USAID/ Government of Uganda – NUMAT	People living with HIV, TB, Malaria/ health care workers	Data not available	Data not available	2006-2012	
PMI/ US Government	People living with HIV, TB, Malaria; women, children	9,765 health workers trained, 112,330 ACT treatments distributed	Country wide	2016	

6. Limitations, Measurement Approach and Next Steps

Limitations

Given the rapid nature of this assessment, it is possible that some programs or interventions that have been conducted to address the human rights-related barriers to HIV, TB or malaria services in Uganda have been missed. However, the inclusion of several stakeholder meetings, such as the inception meeting, prioritization meeting and validation meeting, as part of the assessment allowed for several opportunities for program implementers and funding agencies to share documentation about programs that were missing from the review.

Another limitation is that only 14 focus group discussions with key population representatives were conducted during the fieldwork, and thus views from different populations in all the different geographical regions in Uganda might be not appropriately represented. However, there were several opportunities for networks of key populations to inform the assessment. The analysis of the focus group and key informant interview data suggests that saturation was reached on the human rights-related barriers to HIV, TB and malaria services.

As stated above, the Baseline Assessment team did not conduct focus group discussions with refugees or key informant interviews with experts working with refugees. It is clear that work is needed to improve access to healthcare services in general for the refugee populations. Further investigation at the various refugee camps in Uganda is warranted to better understand key areas for improvement to remove any human rights-related barriers to HIV, TB and malaria services.

It was not possible to assess the effectiveness of the program approaches identified, namely because so few were evaluated in a manner that would enable such an assessment. However, rich details on the programs identified were gathered, including implementer perceptions of what worked well and what could be improved, which informed the comprehensive response proposed.

Measurement approach for assessing impact of scaled up programs to remove human rights-related barriers to services

Qualitative Assessment
In order to understand how the comprehensive response is influencing human rights-related barriers to HIV, TB and malaria services, it will be useful to conduct midline and endline qualitative assessments. Such assessments will provide greater understanding of the various approaches being implemented and their impact and will help to evaluate the combined influence of the structural, community-level and individual-level interventions being proposed. Qualitative assessments could also shed light on new programs, such as MAPD and TB stigma reduction programs, that have not been previously implemented in Uganda.

Quantitative Assessment
While it may not be possible to quantitatively evaluate all of the programs implemented as part of the comprehensive response, Uganda should consider strategically evaluating some of the

interventions. For example, it will be important to determine the magnitude of change in police behaviour, and referral to harm-reduction services, if the stigma and human rights trainings for the police are conducted. In addition to evaluations of specific programs, the impact of the comprehensive response can be assessed with several outcome and impact level indicators, most of which are already being collected in Uganda as part of the national monitoring systems for HIV, TB and malaria. The indicators, baseline values (where possible), data sources and proposed level of disaggregation are described in Annex 4. Data sources include: the 2016 Uganda DHS, the 2013 *PLHIV Stigma Index*, the 2017 UPHIA, the 2015 TB Survey and 2018 MICS. Outcome indicators are proposed for people living with HIV, key populations, people living with TB, people living with malaria, the general population, healthcare workers, institutions and financing.

Measurement Limitations

It will not be possible to directly link the activities supported under the comprehensive response with key outcomes and impacts, however, comparison of baseline values with values collected at midline and endline, and examination of the findings of the repeated qualitative assessments, will provide a sense of how the addition or expansion of efforts to remove human rights-related barriers to HIV, TB and malaria services has influenced Uganda's progress towards reaching the 90-90-90 targets for HIV, the NTLP targets for TB and the National Malaria Control Program (NMCP) targets for malaria.

Next steps

This baseline assessment will be used as the basis for dialogue and action with country stakeholders, technical partners and other donors to scale up to comprehensive programs to remove human rights-related barriers to HIV, TB and malaria services. Towards this end, the Global Fund will arrange a multi-stakeholder meeting in country where the key points of this assessment will be presented for consideration and discussion towards using existing opportunities to include and expand programs to remove human rights-related barriers to HIV, TB and malaria services.

7. Priorities for scaling up towards comprehensive programs to reduce barriers to HIV, TB and malaria services

The full list of programs and activities proposed in the comprehensive response are summarized in Annex 1 for HIV, and Annex 2 for TB and Annex 3 for malaria. In terms of priorities for scaling up comprehensive programs to address human rights-related barriers, HIV and TB are discussed first, followed by malaria below.

HIV and TB

Given the nature of human rights-related barriers to HIV and TB services in Uganda, it is recommended that the early focus be on activities to update and finalize the National Anti-stigma and Discrimination Policy, develop training curricula on stigma and discrimination reduction and human rights for key duty bearers and the integration of these curricula into the appropriate professional training schools and colleges. The launch of the Anti-stigma and Discrimination Policy should be followed by mass media campaigns, capacity-building of community-level structures and CSOs in campaigning against stigma and discrimination; and

involvement of religious and cultural leaders. In addition, the Government of Uganda should set up human rights and gender focal points in MoH AIDS/STD Control program and MoH National TB and Leprosy Program. The development/updating of advocacy and legal literacy tools and subsequent training for advocacy groups should also be prioritized, to ensure that networks, CSOs and patient advocacy groups are able to actively support the comprehensive response throughout its 5-year implementation. The paralegal officers system and the training of local council members to promote human rights and gender equality related to HIV, TB and malaria services should be expanded countrywide.

Following the completion of these initial activities, the next stage in the response would focus on training-of-trainers and training of instructors/professors, followed by the rollout of routine training/re-training of key duty-bearers (i.e. health workers, police, prison staff, teachers, lawyers, judges, etc.) both pre-service and in-service. Linked with the scale-up of training activities, mid-term efforts should focus on developing and implementing appropriate monitoring tools for the various duty-bearers (i.e. health workers, police, prison staff, teachers, lawyers, judges, etc.) with a feedback loop for institutional administrators to ensure appropriate action and support following the trainings. In addition, this phase of the response would also include outreach and engagement with *pro bono* lawyers and paralegals to support clients utilizing the new monitoring mechanism or the rapid response unit. The PLHIV Stigma Index and TB stigma index should be implemented in year 2. Additional funding support to people living with HIV and people living with TB networks to conduct follow-on advocacy and awareness raising activities in the final year of the comprehensive response.

Malaria

For malaria, the first step should be to collect data on gender-related barriers to health services that are pertinent to malaria services, followed by the integration of this information into the programming of the malaria services. Concurrently, the collection of community feedback on malaria services and service programming should be conducted, including in refugee settings. The Ministry of Health and NGOs should adopt and roll out community scorecard events in a representative sample of health facilities to collect feedback and also conduct consultations with VHTs and community leaders to collect information on cultural barriers, gender issues, community-level specific barriers to adoption of preventive strategies against malaria.

8. List of Annexes

Annex 1: Comprehensive programs to reduce human rights-related barriers to HIV services

Annex 2: Comprehensive programs to reduce human rights-related barriers to TB services

Annex 3: Comprehensive programs to reduce human rights-related barriers to malaria services.

Annex 4: Retrospective costing calculations – HIV

Annex 5: Retrospective costing calculations – TB

Annex 6: Prospective costing calculations

Annex 7: Costing considerations

Annex 8: Baseline indicators and values for comprehensive response

9. References

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Annex 1: Comprehensive Response to Remove Human Rights-related Barriers to HIV services in Uganda

Strategic Objective	Specific activities	Expected Results	Implementation suggestions (person/group responsible, coverage, location, key populations, etc.)	Implementation Period	Observations
PA 1: Stigma and Discrimination Reduction					
Advocate for the updating and finalization of the HIV Anti-stigma and Discrimination Policy and associated guidelines.	CBOs and key population networks to advocate for the expansion of content in the policy to include key population status-related stigma to cater to key population groups living with HIV.	Effective guidance on stigma and discrimination; reduction in stigma and discrimination practices against people living with HIV and key populations.	This policy and the guidelines should be augmented to cater for key population status-related stigma to be relevant to the key population groups vulnerable to and/or living with HIV.	Year 1	This activity would be conducted by local CBOs and networks of people living with HIV and other key and vulnerable populations.
Stigma-reduction curricula updated for key stakeholders at the community, organizational and institutional levels through pre- and in-service trainings	Update existing stigma-reduction curricula. Expand content to include human rights sensitization and information on relevant laws and policies influencing HIV services.	Revised and finalized integrated curricula on HIV, human rights and stigma; training of trainers rolled out among networks of key and vulnerable populations and NGOs/CBOs supporting them. Broader reach of human rights and stigma reduction programming. Improved attitudes and behaviors of service providers and duty bearers towards people living with HIV and key and vulnerable populations.	Existing curricula, including USAID-supported curricula for both community and health settings, have been tested in multiple contexts and are available for updating. The updated tool should include information on human rights and the legal context and replace outdated information. Key to the development of curricula is the acknowledgement of healthcare workers rights in being protected from occupational transmission of HIV. This is in keeping with UNAIDS approach:	Year 1 – Year 2 (development and training of trainers) Years 3-5 (Implementation)	This will be a standardized tool with specific sections as needed for various populations (i.e. police, health workers, teachers, community member, etc.).

			rights being balanced by expected responsibilities. The implementation of this activity is to be done at two levels: (i) curriculum development for institutions and NGOs to use and (ii) integrating training curriculum among duty bearers and their respective training institutions. The second to be done in partnership with relevant authorities and NGOs.		Integrating human rights should include a focus on key populations and their access to effective HIV/TB prevention and treatment support services. The curriculum should include women, girls, adolescents and their needs as part of vulnerable populations.
Mass media campaigns, advocacy, and engagement of PLHIV and other key and vulnerable populations to reduce stigma and	Increase frequency of mass and community media campaigns, both audio and visual, to reduce stigma and discrimination based on HIV status – e.g. reducing fears and ignorance about transmission, seeing PLHIV as people, raising awareness on laws and policies	Increased awareness on laws and policies protecting the rights of people living with HIV; reduced fear of infection by HIV; decreased avoidance behavior towards people living with HIV; increased acceptance and support; will reach general population in ways that trainings and	Mobilize local mass media, both radio and television and print. Utilization of different forms of social media must also be used in this context to reach younger and wider audiences. Collaboration between NGOs and government entities is critical.	Years 1- 5	Need to structure messages to varying literacy levels. National survey and UDHS 2016 findings show that

discrimination related to HIV	protecting the rights of people living with HIV.	workshops will not be able to do.			stigmatizing attitudes and practices are held by 40% of individuals who did not reach secondary school. This group of individuals, who never went to secondary school, constitutes about 60% of Ugandan population.
Support stigma-reduction programs that use cultural and religious media delivered through large, public events, combined with advocacy and engagement led by key populations.	Integrating stigma-reduction messages into cultural and religious media, such as traditional dance, art, Friday prayers, etc, has been demonstrated to shift harmful attitudes by creating a safe space for discussion. Such stigma-reduction activities should be included alongside traditional mass media campaigns and scaled-up throughout the country	Increased awareness on laws and policies protecting the rights of people living with HIV; reduced fear of infection by HIV; decreased avoidance behavior towards people living with HIV; increased acceptance and support; will reach general population in ways that trainings and workshops will not be able to do. Effective reach to the rural communities	Traditional cultural media, like song, dance, and theater, provide a unique way to reach people in rural and urban areas with messages on challenging topics like stigma and taboos. Paired with discussions led by people living with HIV and/or members of key and vulnerable populations, such activities can help shift deep-seated norms and stereotypes that may be more difficult to shift with mass media style campaigns.	Year 1	Networks of people living with HIV and other key and vulnerable populations can recommend the most appropriate cultural media for stigma-reduction messages.

Repeat the national *PLHIV Stigma Index* and Crane Surveys on a 2-year basis and provide support for follow-up based on results	Survey design and implementation and follow-up activities	Will provide updated data for assessing impact of programs to remove human rights-related barriers to HIV services.	National-wide among the people living with HIV and other key populations	Year 1, 3, 5	This activity will provide data that can be used by advocates representing key and vulnerable populations and can be linked to the activities listed under legal literacy and monitoring and reforming laws and policies under PAs 4 and 6.
Establish a national-level monitoring system to capture stigma, discrimination and other rights violations experienced by people living with HIV and key populations for support and redress	Convene stakeholder meetings, agree on indicators to collect, who does the collecting, to whom do they report, what are response mechanisms, develop and pilot monitoring system, roll-out reporting system nationally	To support redress for people living with HIV and other groups of key and vulnerable populations based on monitoring data.	The monitoring system should be tied into existing, functioning mechanisms of redress. These systems will also need to be developed and supported.	Year 1 (development) Year 2 (pilot) Year 3-5 (roll-out)	Currently, there is no formal mechanism to capture individual cases of stigma, discrimination and rights violations and to provide these

					individuals with redress. The PLHIV Index does capture this information, but from a sample of people living with HIV that is not representative of all people living with HIV and key populations in Uganda.

Strategic Objective	Specific activities	Expected Results	Implementation suggestions (coverage, location, key populations, etc.)	Implementation Period	Observations
PA 2: Training for healthcare providers on human rights and medical ethics related to HIV					
Integrate HIV sensitization, stigma and discrimination-reduction and human rights sensitization into curricula of health provider training schools, e.g. medical school, nursing school, etc.	Incorporating HIV-related human rights and medical ethics sensitization information into pre-service training existing curricula for medical professionals.	Reduced negative attitudes and actions towards people living with HIV and other key and vulnerable populations among health care workers; a greater understanding of the issues facing key and vulnerable populations and the types of services needed (i.e. harm reduction, linkage to support organizations, etc.). Increased knowledge of current protective policies and laws. Reduction in stigmatizing health care practices and increase in culturally competent/sensitive care provision. .	USAID/HP+ curriculum can be used as a basis for developing this curriculum.	Year 1 – Year 2 (development and training of trainers) Years 3-5 (Implementation)	While there would certainly be initial costs related to securing buy-in, incorporating content into existing curricula and building capacity to implement, the long-term costs would be relatively minimal and the broader human rights focus would have impacts in the context of HIV and beyond. Both private and public institutions should be included in this effort.
Measurement of stigma and discrimination in health care settings	Support routine assessments of knowledge, attitudes and practices of health care workers towards people living with HIV and other key populations to support health facility administrators to	Measurement conducted annually or every other year using MERG-approved, validated short survey to inform need for re-training or other action by health facility administrators.	Healthcare setting-based surveys can be done among providers and exit interview with key patients throughout the country with the help of proper guidelines executed for this. HP+ also has a validated tool	Year 1 and 5	Proper Data collection must be done and monitored. Community engagement in monitoring health care delivery is essential and should be supported. A monitoring framework for indicators and its

Strategic Objective	Specific activities	Expected Results	Implementation suggestions (coverage, location, key populations, etc.)	Implementation Period	Observations
	identify and address any issues.		available for use/adaptation.		measurement need to be developed and adopted.
Scale up in hard hit areas in-service training on human rights and medical ethics related to HIV at key healthcare facilities delivering HIV-related prevention and care	Routine, in-service trainings on HIV, human rights, key populations, stigma reduction, non-discrimination and medical ethics for current health facility staff providing HIV-related care, including non-health care provider staff like receptionists and data clerks; engage administrators and identify champions within the health sector/or facilities for the sustainability and follow-up.	Improved attitudes and behaviors of service providers towards people living with HIV and other key and vulnerable populations.	Improve orientation of health facility managers and administration in key health facilities providing HIV care. Expansion of training to other people working in the health facility who interface with people living with HIV and other key and vulnerable populations (e.g. community health workers, social workers, etc.) will present a greater opportunity to address issues across the health systems. People living with HIV and members of other key and vulnerable populations should be involved in implementing the in-service trainings (e.g. as facilitators, co-facilities, guest speakers.	Year 1-5	Providing in-service training on human rights and medical ethics to health facilities staff will strengthen the current interactions between the health-workers and the networks of people living with HIV and other key and vulnerable populations. The frequency and repetition of in-service trainings should be informed by the routine data on health worker attitudes and perceptions proposed in the previous activity.
Scale up the roll out of the Community	Support increased training and activities to	Increased accountability of health care workers to provide	Should be done across the country where HIV and TB		

Strategic Objective	Specific activities	Expected Results	Implementation suggestions (coverage, location, key populations, etc.)	Implementation Period	Observations
Score Card to all areas hard hit by HIV and TB	engage and expand community-based monitoring by CBOs and networks of key and vulnerable populations of health care provision.	acceptable, quality, supportive health care and increased capacity/engagement of affected populations to monitor and provide feedback on health care provision	prevalence are high. Can be a part of the work of peer paralegals and community health care agents.		

Strategic Objectives	Specific activities	Expected Results	Implementation suggestions (coverage, location, key populations, etc.)	Implementation Period	Observations
PA 3: Sensitization of lawmakers and law enforcement agents					
Update and integrate HIV sensitization, stigma and discrimination-reduction and human rights sensitization into curricula at police academies, as well as reduction in HIV vulnerbility and risk among police. relevant human rights and HIV information on police HIV vulnerability,	Update existing training curricula and introduce the trainings while in police academies. Content should include information on responsible and supportive policing for PLHIV, other key and vulnerable populations, and with	Reduced negative attitudes and actions towards people living with HIV, and other key and vulnerable populations among new police officers; a greater understanding of national HIV strategy and the issues facing key and vulnerable populations and the types of services needed (i.e. harm reduction, linkage to support organizations, etc.). Increased knowledge of current protective laws.	These trainings should be conducted with the support of the Ministries of Justice and Interior and with the engagement of the Ministry of Health in collaboration with representatives of key and vulnerable populations and NGOs that support them.	Year 1 – Year 2 (development and training of trainers) Years 3-5 (Implementation)	While there will be initial costs related to securing buy-in, incorporating content into existing curricula and building capacity to implement, the long-term costs would be relatively minimal and the broader

Strategic Objectives	Specific activities	Expected Results	Implementation suggestions (coverage, location, key populations, etc.)	Implementation Period	Observations
responsible and supportive policing for PLHIV, key and vulnerable populations, and with regard to gender- based violence into pre-service training in police academies	regard to gender-based violence.	Reduction in illegal police practices and increase in supportive policing. Reduced HIV vulnerability of police.			human rights focus would have impacts in the context of HIV and beyond.
Routine measurement of knowledge, attitudes, and behaviors of police, correctional officers and members of the judiciary to inform the scope of in-service training	Support routine assessments of law enforcement agents' knowledge, attitudes and behaviors towards people living with HIV and other key populations and support police administrators to identify and address any issues.	Annual or bi-annual measurement using MERG-approved, validated short survey to inform need for training/re-training or other action by law enforcement administrators.	Monitoring and evaluation can be done in police academy and police headquarters. Must be stated that this is not disciplinary action, but rather a check on how the institution is doing.	Year 1, 5	MERG-approved tool for health settings can to be expanded to be adapted for use with police.
Support in-service training for law enforcement officers, judiciary, and prison staff, after careful assessment based on need and impact of training.	Support in-service trainings for police, members of judiciary, prison staff on HIV policies and key populations; responsible and supportive policing in the context of HIV;	Improved attitudes and treatment of people living with HIV and other key populations (i.e. sex workers, men who have sex with men, injection drug users, transgender people) by police, judges and prison staff. Increased knowledge of	MOI to lead training for police and correctional officers; MOJ to lead on training for judges. People living with HIV and members of other key and vulnerable populations should be involved in implementing the in-service trainings (e.g. as	Years 1-5	The frequency and repetition of in-service trainings should be informed by the routine data on police attitudes and perceptions

Strategic Objectives	Specific activities	Expected Results	Implementation suggestions (coverage, location, key populations, etc.)	Implementation Period	Observations
	reduction of illegal police practices and HIV vulnerability. Expand the training for prison personnel regarding the prevention, health care needs and human rights of detainees living with or at risk of HIV infection.	current protective laws. Reduction in illegal police practices and increase in supportive policing and judicial decisions.	facilitators, co-facilities, guest speakers, etc.)		proposed in the previous activity.
Routine post-training measurement of knowledge, attitudes, and behaviors of police, correctional officers, and members of the judiciary to assess the impact of the trainings	Support routine assessments of law enforcement agents' knowledge, attitudes and behaviors towards people living with HIV and other key populations and support police administrators to identify and address any issues.	Annual or bi-annual measurement using MERG-approved, validated short survey to assess the impact of the training and whether there is a need for re-training or other action by law enforcement administrators.	Monitoring and evaluation can be done in police academy and police headquarters. Must be stated that this is not disciplinary action, but rather a check on how the institution is doing.	Year 1, 5	MERG-approved tool for health settings can to be expanded to be adapted for use with police.
Support key population networks/community-based advocacy and joint activities with law enforcement to address	Engagement with law enforcement to prevent harmful policing practices, such as arresting sex workers and peer	Improved attitudes and behaviors of law enforcement; empowerment of key populations; reduced arrests and detention of key populations.	Different key population networks should be involved. Years 1-5	Years 1-5	This support should enable people living with HIV and other key and vulnerable populations to

Strategic Objectives	Specific activities	Expected Results	Implementation suggestions (coverage, location, key populations, etc.)	Implementation Period	Observations
key challenges affecting their communities	educators for carrying condoms and incarcerating people who inject drugs on criminal drug charges rather than referring to them to harm reduction programs.				lead and be involved in designing joint activities with police at community level to increase protective policing for key populations and for women and girls facing gender-based violence
Train members of the local council in the rights-based approach to HIV, health and justice, and in sensitizing their communities so they may support the messages conveyed in the legal literacy campaigns.	Support local networks of PLHIV and other key populations, as well as the peer human rights educators described below, to work with local councils so that they are aware of protective laws and policies and support them at local level in local disputes.	Increased knowledge, awareness of local councils to support protective action for people living with and affected by HIV, including women, girls and other key populations.	Local council members administer justice at village-level for minor cases. Their training in human rights approach to HIV is relevant.		Need several levels of authorities, including local ones, to reinforce and support nondiscrimination.

Strategic Objective	Intervention activities	Expected Results	Implementation suggestions (coverage, location, key populations, etc.)	Implementation Period	Observations
PA 4: Legal literacy ("know your rights")					
Legal literacy 'Know-your-rights' and patients' rights	Support activities by CBOs and networks of PLHIV and other key and vulnerable populations to increase legal literacy, including patient's rights education, through awareness campaigns and workshops, development and dissemination of legal/patients' rights materials in hard hit district	Greater awareness of rights and laws, including patient rights, and greater ability to organize communities around advocacy for specific needs.	Activities should be rolled out in districts and communities most vulnerable to HIV and should follow community prevention and treatment efforts.	Year 2-3	Networks of people living with HIV and/or key and vulnerable populations should be supported to implement legal literacy/patients' rights campaigns. To effectively empower people living with HIV and other vulnerable groups, including women and girls, it is important that varying media platforms are utilized for engagement.

Strategic Objective	Intervention activities	Expected Results	Implementation suggestions (coverage, location, key populations, etc.)	Implementation Period	Observations
Deploy cadres of peer human rights educators to districts hardest hit by HIV following the national prevention and treatment strategies.	Recruit, train and support peer human rights educators to increase community and indiviudal human and patients' rights literacy and raise awareness through "know your rights" campaigns and community mobilisation around health-related rights.	Community-based legal and patients' rights education through peer educators recruited from among community health care workers, CBOs and/or networks of key populations; greater awareness of rights and increased access to HIV services	Peer human rights educators should come from community based health care providers or other support following and integrated into national/local HIV prevention and treatment efforts. They should include peer human rights educators among women and girls and adolescents.	Years 1-5	

Strategic Objective	Intervention activities	Expected Results	Implementation suggestions (coverage, location, key populations, etc.)	Implementation Period	Observations
Expand capacity-building on HIV-related human and patients' rights, women's rights and rights of children (as appropriate) of CBOs and networks working with people living with HIV, women, adolescents and other key and vulnerable populations	NGO/CSO-led activities to support people living with HIV and other key and vulnerable populations to foster resilience and mobilise around rights related to access to HIV services, nondiscrimination and violence against women and girls.	Reduced internalized and anticipated stigma among people living with HIV and other key and vulnerable populations; greater awareness of health-related and patients' rights, improved mental and social health and increased willingness to engage in care/adhere to treatment.	Working with NGOs such as NACWOLA, NAFOPHANU, POM, UHRN, Sexual Minorities Uganda, Women's Organization Network for Human Rights Advocacy (WONETHA), Spectrum Uganda, Lady Mermaid, OGERA, Tranz Network, etc. that are currently supporting HIV and TB services to the HIV Kps	Year 1-5	Building capacities of people living with HIV and vulnerable groups to seek and claim their own rights is linked with effective community mobilization against stigma and discrimination. Training in human rights and legal literacy increases ability to mobilize around and demand rights.

Strategic Objective	Specific activities	Expected Results	Implementation suggestions (coverage, location, key populations, etc.)	Implementation Period	Observations
PA 5: HIV-related legal services					
Expansion of peer paralegal programs to all districts hardest hit by HIV and TB and to all prisons in the country	Recruit, train, remunerate and supervise peer paralegals for key and vulnerable populations as each population has different legal challenges and need different forms of support	Expanded legal support available to address community and health care discrimination, property and custody disputes, GBV, forced and underage marriage, etc.	Peer paralegals should be recruited from networks of affected populations or community based prevention and treatment outreach workers. They should benefit from some level of remuneration and supervision.	Years 1-5	
Expansion of *pro bono* or low cost attorneys to support and supervise paralegals and take up cases that need actual representation in court	Identify and recruit in context of CBOS/NGOs and/or existing legal services lawyers willing and able to work with marginalized populations to supervise paralegals and provide legal representation where necessary.	Broader pool of lawyers supporting legal services for key and vulnerable populations	Numbers of lawyers can be relatively low and should be strategically recruited to support key and vulnerable populations and/or geographic areas not sufficiently served.	Year 1-5	There are different models to support a community based legal support system, and therefore a framework has to be created that will include various activities such as: reporting protocols between and among CSOs, geographic scope, advisory committees, etc.
Assessment of access to justice for people living with or vulnerable to HIV	This assessment should be done as part of the PLHIV	Data for assessing need for legal services and impact of legal services on removing	Conduct surveys every 2 years.	Year 1, 3, 5	

Strategic Objective	Specific activities	Expected Results	Implementation suggestions (coverage, location, key populations, etc.)	Implementation Period	Observations
	Stigma Index surveys and the Crane surveys for sex workers, men who have sex with men, and people who inject drugs.	human rights barriers to HIV services.			

Strategic Objective	Specific activities	Expected Results	Implementation suggestions (coverage, location, key populations, etc.)	Implementation Period	Observations
PA 6: Monitoring and reforming policies, regulations and laws related to HIV					
Monitoring of impact of HIV laws and policies	Support to local networks of people living with HIV and other key and vulnerable populations to enable them to monitor the impact of problematic laws (civil and penal codes) that impede HIV services, as well as the impact of failure to implement protective laws and advocate for change as needed.	Removal or revision of problematic laws and policies, greater implementation of protective laws and policies	Routine monitoring of the legal environment should be conducted by networks of people living with HIV and key and vulnerable populations to inform advocacy efforts to create, amend or repeal laws to protect the rights of key and vulnerable popualtions and to increase access to HIV services. .	Year 1-5	It is noted that UNDP undertook a comprehensi ve legal assessment in 2013. Therefore, given that not much legislative change would have occurred, an audit of the legal environment

Strategic Objective	Specific activities	Expected Results	Implementation suggestions (coverage, location, key populations, etc.)	Implementation Period	Observations
					is not recommended prior to initiating monitoring efforts.
Joint advocacy and lobbying for law and regulatory reform	Funding for groups to support the legal/policy reform process and advocate for and monitor the implementation of supportive policies and laws and advocate for changes	Updated and protective laws and policies implemented; reduced legal barriers to accessing HIV services.	Support to different advocacy groups that are already doing the groundwork.	Years 1-5	To effectively implement law reform and advocacy, funding of legal and policy support across organizations have to be considered. Data from PLHIV Stigma Index and Crane surveys can be used to inform this advocacy.
Creation of an office on gender and human rights established as part of Monitoring and Evaluation	This office would support the process to begin replacing or updating the problematic laws, practices and policies. In	Routine data collection for programming responses in	Work in collaboration with NGOs/CBOs/networks working on human rights and gender, and the Ministry of	Year 2	Most of the analyses of policy impact on people

Strategic Objective	Specific activities	Expected Results	Implementation suggestions (coverage, location, key populations, etc.)	Implementation Period	Observations
section at the Ministry of Health STD/AIDS Control Program	addition, this office would also support other key aspects of the comprehensive response, such as the national monitoring and redressal system for stigma, discrimination and rights violations, and the routine assessments of attitudes of the healthcare workers in the contexts of HIV and TB.	collaboration with relevant NGOs/CBOs/networks. Policy analysis and dissemination of results regardng impacts of different policies, plans, guidelines on access to HIV and TB services.	Gender, Labour and Social Development		living with HIV and other and vulnerable key populations are being done by NGOs. Formation of a government unit at MoH would support government engagement in reducing barriers to HIV and TB services.

Strategic Objective	Specific activities	Expected Results	Implementation suggestions (coverage, location, key populations, etc.)	Implementation Period	Observations
PA 7: Reducing discrimination against women in the context of HIV					

Strategic Objective	Specific activities	Expected Results	Implementation suggestions (coverage, location, key populations, etc.)	Implementation Period	Observations
Community-based capacity-building on rights of women and girls and advocacy and mobilization around rights and services relevant to HIV and TB prevention and treatment.	Support networks of women living with HIV, adolescent girls living with or vulnerable to HIV, female sex workers, and women who use drugs to know their rights, have access to legal services, and to advocate and organize against stigma, discrimination, harmful gender norms and GBV.	Increased awareness of rights, support to moibilize around rights and advocate for rights in the context of health, HIV and TB.	Human rights literacy, services and advocacy should be integrated into existing activities and strategies to empower women and girls to avoid HIV infection and GBV or deal sucessfully with these. Peer human rights educators and peer paralegals should be recruited from and deployed among vulnerable women and girls and can be recruited from women/girls activists in existing efforts.	Years 1-5	Data gathered from women and girls participating in the PLHIV stigma index survey, as well as data gathered from health workers on attitudes towards women and girls affected by HIV could also be used to inform efforts.
Engagement with Government to encourage the adoption and rollout of the SRH/eMTCT guidelines for women living with HIV and the dissemination of patients' rights materials relevant for women and girls	Advocacy to approve and adopt the guidelines chosen by women's groups and ensure development of patients rights materials for dissemination in SRH/eMTCT settings. Distribution of guidelines and patients rights materials and sensitization of health workers and health care	Reduced stigmatization of HIV positive pregnant women at health facilities Improved access to quality healthcare at health facilities for women and adolescent girls	Women's groups to choose what they want to monitor/change; they should have a mechanism by which to monitor PMTCT healthcare provision and provide feedback to service providers.	Year 1 (advocacy) Year 2 (sensitization)	It was noted that some HIV positive pregnant women face discrimination or are stigmatized by some health-workers for the choice to be pregnant.

Strategic Objective	Specific activities	Expected Results	Implementation suggestions (coverage, location, key populations, etc.)	Implementation Period	Observations
	managers about the guidelines.				
Community-based advocacy and mobilization of women, including women living with HIV and adolescent girls to reduce gender-based violence and support redress for survivors of violence using a rights-based approach and including access to legal services	Increased support to HIV-related networks that work to combat violence and support survivors to seek legal redress and needed services. Continue gender-based violence mitigation and prevention programming for those living with HIV, particularly women living with HIV and expand to other regions in the country.	Link survivors of violence to existing support services and increase access to legal services. Increase awareness of gender-based violence at both community and national level.	Several projects are currently being implemented that can be continued or expanded.	Year 1- 5	Programs to eliminate GBV and other aspects of discrimination against women have always been in project mode, with limited sustainability programming.

Strategic Objective	Specific activities	Expected Results	Implementation suggestions (coverage, location, key populations, etc.)	Implementation Period	Observations
Reduction of harmful gender norms and gender-based violence	Implement community and school-level campaigns and dialogues to promote gender equality, reduce harmful gender norms and reduce gender-based violence. Continue with community dialogues such as through SASA! that promote gender equality at every level – from the national to the grass-roots level. Train women living with HIV, including young women and adolescent girls, as peer educators in ongoing gender equality efforts and in the reduction of harmful gender norms.	Shift harmful gender norms and increase equality among women and men. Reduced violence against and mistreatment of women and girls.	The Ministry of Education should strengthen education efforts to support the teaching of gender equality and reduce harmful gender norms in primary and secondary schools, technical schools and colleges. Such training should be made compulsory in both private and public institutions. Community Dialogues can be organized to promote gender equality in the community. This can be done in collaboration with organizations focused on gender, such as CEDOVIP and UGANET. Women living with HIV and adolescent girls should be involved in these efforts (e.g. co-facilitating sessions, guest speakers, etc.)	Year 2-5	For prevention of gender-based violence, and empowerment of women.

Strategic Objective	Specific activities	Expected Results	Implementation suggestions (coverage, location, key populations, etc.)	Implementation Period	Observations
Integrate training on gender and sexuality diversity in-service trainings for duty bearers (i.e. doctors, nurses, lawyers, judges, law enforcement agents, etc.)	Continue in-service trainings of duty bearers and community leader/stakeholder trainings.	More gender equitable attitudes among duty bearers and community leaders.	Involve experienced organizations such as MARPI.	Year 1-5	This activity would be done in conjunction with the in-service training curriculum development and implementation of stigma and discrimination reduction and human rights sensitization efforts proposed for duty bearers in PA 1, PA 2 and PA3.
Increase programs that seek to address socio-cultural dynamics that create barriers to accessing HIV services	Programs and services should more systematically incorporate gender and relational perspectives into their activities to ensure adequate access and support for women; implement training around gender mainstreaming within the context of HIV; assist NGOs and other service providers in utilizing gender-based screening tools and score cards to better respond to issues around violence, legal,	Improved social and health outcomes for women and members of key populations.	Mainstream gender across all program areas to ensure gender dynamics and issues relating to gender-based violence are considered.	Years 1-5	Efforts narrowly focused on key populations are inherently limited.

Strategic Objective	Specific activities	Expected Results	Implementation suggestions (coverage, location, key populations, etc.)	Implementation Period	Observations
	financial and psycho-social services.				
Integration of gender-sensitization training into pre-service training for health care providers, law enforcement officers and law makers	Incorporating gender-related human rights sensitization into pre-service training for medical professionals, lawmakers and law enforcement officers into the existing curricula	More gender equitable attitudes among duty bearers and community leaders.	Involve experienced organizations such as MARPI.	Years 1-5	Integrating into pre-service training will be a cost-saving measure in the longer term. This activity would be done in conjunction with the pre-service training curriculum development and implementation of stigma and discrimination reduction and human rights sensitization efforts proposed for duty bearers in PA 1, PA 2 and PA3.

Intervention	Specific activities	Implementation Period	Expected Results/Comments
Other HIV programs that are not to be funded by human rights funds, but are necessary to support the roll-out of a comprehensive response to HIV			
There is need for greater government funding for HIV and TB services, specifically to increase quality of counseling, and to increase the availability of HIV and TB services by well-trained professionals in health facilities in prisons	Coordinated funding of the HIV services in KP section Effective budget allocations	Year 1-2	Improved access to HIV quality care and reduced duplication of interventions
Population size estimation of HIV key populations (sex-workers, MSM, and IDUs)	Design and implement the surveys or studies	Year 2	Population sizes for better programming of HIV services

Annex 2: Comprehensive Response to Remove Human Rights-related Barriers to TB services in Uganda

Strategic Objective	Specific activities	Expected Results	Implementation suggestions (coverage, location, key populations, etc.)	Implementation Period	Observations
PA 1: Stigma and Discrimination Reduction					
Develop and integrate TB-related stigma and discrimination concerns and strategies into National Anti-Stigma and Discrimination Policy	**Expand content to include TB-related stigma and discrimination and develop TB-specific guidelines, including workplace guidelines.**	Effective guidance on TB-related stigma and discrimination; reduction of stigma and discrimination practices against TB.	This policy should require development of specific guidelines for addressing (1) vulnerabilities to TB infection in the workplace, including at health facilities, mine sand in prisons, with workers compensation for infection, and (2) discrimination against those affected by TB (patients and workers) in communities and workplaces, and in health care facilities and prisons.	Year 1	Currently, there are no activities aimed at reduction of stigma and discrimination for those affected by TB. There is no well-defined system for supporting people living with TB whose infections are work-related. Intervention requires attention to integrating HIV and TB services where advisable. .

Stigma-reduction curricula updated to include TB-related issues for key stakeholders at the community, organizational and institutional levels for use in pre- and in-service trainings	Integrate TB-specific stigma, discrimination and human rights concerns into the curricula mentioned in PA 1 of Annex 1 for HIV. Hold stakeholder workshop to integrate TB stigma reduction training modules into the HIV curricula on stigma, discrimination and violence reduction	Revised and finalized integrated curricula on HIV and TB, human rights and stigma; training of trainers rolled out among key populations and NGOs. Broader reach of human rights and stigma reduction programming. Improved attitudes and behaviors of service providers towards people living with HIV and TB and key and vulnerable populations.	The updated curriculum should include information on TB-related human rights and the legal context and replace outdated information. Key to the development of curricula is the acknowledgement of healthcare workers rights in being protected from occupational transmission of HIV and TB.	Year 1 – Year 2 (Development and training of trainers) Years 3-5 (Implementation)	This will be a standardized tool/curriculum to reduce TB/HIV stigma and discrimination with specific sections as needed for various populations (i.e. police, health workers, teachers, community member, prison wardens, etc.). Integrating TB related human rights should include a focus on the needs of key and vulnerable populations (including women and girls) and their access to effective prevention and treatment support services for HIV and TB.
Conduct regular national TB Stigma research to collect more information on nature and effects of stigma and discrimination on TB services in Uganda.	Design and implement survey that will capture TB related stigma in communities, workplaces and health care facilities	Will provide updated data for assessing impact of programs to remove stigma and discrimination as barriers to TB services	The survey should have a module for health facility-based health workers	Year 1, 5	There is limited documentation on TB related stigma in the country. It may be feasible to add a TB module to the PLHIV Stigma Index, sampling both people living with TB and HIV, and people only living with TB.

Support community level structures, including networks, CSOs/CBOs involved in TB prevention and treatment to implement stigma reduction campaigns.	Train village health teams (VHTs) and community health education workers (CHEWs) to sensitize the communities about TB (i.e. what causes TB, how it is transmitted, and whether it can be cured, etc.), and the effects of TB stigma and discrimination.	Reduced TB stigma among community members.	Similar to VHTs, the CHEWs and other community workers should be given data collection tools to document and report the traced index cases, follow-up with linked families and referrals.	Year 1-5	
Mass media campaigns, advocacy, and engagement of key and vulnerable populations to reduce TB-related stigma and discrimination	Increase frequency of mass media campaigns, both audio and visual, to reduce stigma and discrimination based on HIV and TB status, increase awareness on laws and policies protecting the rights of people living with HIV and/or TB, and reduce fear of infection and subsequent avoidance behavior.	Reduced fear of infection for TB, decreased avoidance behavior towards people living with TB, increased acceptance and support	Mobilize local mass media with both audio and visual. Utilization of different forms of social media must also be used in this context to reach younger and wider audiences. Collaboration between NGOs and government entities critical	Year 1-5	**Need to structure messages to literacy levels.**
Support stigma-reduction programmes to use religious and cultural media delivered through large, public events, combined with advocacy and engagement led by	Build the capacity of the community based organizations at the community level to reach out to and work with t community and religious leaders.	Wide reach in the community to understand and implement less stigmatizing infection control in the context of TB.	Updated curriculum indicated above could be used to inform community-based TB stigma reduction activities.	Year 2-5	Limited understanding of TB infection control and treatment was reported as a driver of stigma and discrimination Use of community level understanding of myths and concerns will help to

people living with TB and ex-TB patients and other key and vulnerable populations					the communities to understand and readily acquire the desired changes
Expand desk guide for diagnosis and management of TB in children to include guidelines on stigma reduction counselling for the family and the children	Develop the guidelines; role-out training for health workers and health managers nationally.	Improved coverage of high quality, stigma-free pediatric TB services.		Year 1 (Guidelines development) Year 2 (Roll-out training of new guidelines)	

Strategic Objective	Specific activities	Expected Results	Implementation suggestions (coverage, location, key populations, etc.)	Implementation Period	Observations
PA 2: Reducing gender-related barriers to TB services					
Develop, implement and evaluate strategies to reduce gender-related barriers to TB services	Conduct gender analysis of the current setup for provision of TB services. Expand existing approaches utilizing peer leaders to include gender-specific interpersonal communication and strategies to encourage access and utilization of TB services.	Reduction of gender-related barriers to TB services	Community level interventions such as community outreach and DOTS should consider gender dimensions in their programming. Current activities implemented by TASO could be expanded. Other CBOs and NGOs working on TB in Uganda could be involved in these activities, in concert with networks of people living with or affected by TB where possible.	Year 2-3	Current evidence shows that men are not often found at home, and some rarely attend community outreach meetings. Better strategies to reach men especially, those working in TB acquisition high-risk settings, should be considered.
For women, establish gender-sensitive TB services through mainstreaming gender-sensitive services into existing TB and HIV diagnostics and treatment.	Advocate with MOH to reorganize the delivery of TB and HIV services to ensure that services are sensitive to gender issues to maximize health outcomes.	Improved health outcomes for women and girls	Networks or people living with TB and HIV can use data from gender analysis recommended in following activity on men to advocate with the MOH. CBOs and NGOs working on TB and HIV can support health facilities to implement changes in TB and HIV services delivery	Year 2-3	Research suggests that some women who get TB are abandoned by their husbands, which, among other things, often compromises their social support for treatment adherence. Specific programs to support such women will be relevant.

			approaches to enhance gender sensitivity.		
For men, identify a set of entry points into broader work being done to improve men's health seeking behaviors and work to include awareness of TB symptoms and treatment in these.	Advocate with MOH to reorganize the delivery of TB and HIV services that are sensitive to gender issues to maximize the health outcomes.	Improved health outcomes for men and boys	Cultural norms should be integrated in service delivery models to reach men. Work place outreach to men should be expanded.	Year 2-3	Routine health facility data in Uganda have shown that men are almost twice as likely to have TB. Whereas, some cases might be due to type of occupation, it was noted that the health facility settings are typically more favorable to women than men and cultural and gender norms are a potential limiting factors.

Strategic Objectives	Specific activities	Expected Results	Implementation suggestions (coverage, location, key populations, etc.)	Implementation Period	Observations
PA 3: TB-related legal services					
Develop a system to provide legal aid to people with TB for legal issues relating to their TB status	Train and support peer paralegals working with PLHIV to provide legal advice at the community level for TB patients, among key populations and/or in health care facilities. Expand and support sufficient lawyers to	Community-based legal support in present CBOs or networks of key populations, greater awareness of rights and better ability to get redress.	Legal services for people living with HIV and/or with TB and key and vulnerable populations should be available at district-level network organizations.	Year 2-3	Integrate with HIV training for paralegals and local council members. Peer paralegals should be recruited from TB community health outreach

	supervise these paralegals and provide legal representation where needed.				workers and from ex-TB patients
Expand paralegal support to people living with HIV and people with TB	Expand the number of paralegals linked with CBOs and NGOs working to support people living with HIV and people living with TB. Train new paralegals on issues specific to people living with TB, as well as people living with HIV.	Improved legal services coverage to support TB patients for legal issues related to their TB status	CBOs and NGOs working in the TB sector can partner with CBOs and NGOs working in the HIV sector to train and share paralegals amongst their organizations as needed.	Years 2-5	

Strategic Objective	**Intervention activities**	**Expected Results**	**Implementation suggestions (coverage, location, key populations, etc.)**	**Implementation Period**	**Observations**
PA 4: Monitoring and reforming policies, regulations and laws that impede TB services					
Conduct an assessment of current policies and laws regarding isolation and compulsory treatment (in the community, prisons, schools, among IDUs) as well as sentencing laws and policies that lead to overcrowding of prisons	Design and implement a review of the current policies and their health and TB impact	Policy review results fed into programming of TB services, including with regard to isolation an compulsory treatment and in confined facilities such as prisons	Improved policies and practices to ensure greater uptake of and access to high quality HIV and TB services.	Year 2-3	

and substandard conditions					
Joint advocacy and lobbying for TB regulatory reform	Funding for advocacy groups to support the legal reform process and advocate for and monitor the implementation of supportive policies and laws	Updated laws; reduced legal barriers to accessing HIV services.	Support to different advocacy groups that are already doing the groundwork	Year 4-5	To effectively implement law reform and advocacy, funding of legal and policy support across organizations have to be considered.

Strategic Objective	**Specific activities**	**Expected Results**	**Implementation suggestions (coverage, location, key populations, etc.)**	**Implementation Period**	**Observations**
PA 5: Legal literacy (Knowing your TB-related rights)					
Support the current community structures, such as VHTs, CHEWs, local councils, religious and cultural leaders, to include TB-related legal literacy and patient's rights education in their communications and activities	Training of local council members and VHTs using peer educators to focus on the group's needs/rights.	Improved understanding of TB-related human and patient rights and responsibilities	Strategies to facilitate reach of VHTs or CHEWs, including involving ex-TB patients in hard to reach local communities, such as highly mountainous areas, Karamoja and the. islands, should be integrated in the intervention programming.	Year 2-3	

Recruit, train and supervise women and men affected by TB as human rights peer educators to empower the communities with information on stigma reduction, patient rights, and knowledge of TB transmission and remission.	Peer human rights educators would work with the group and its members to know and organize around those rights for change.			Year 2-3	Peer human rights educators should be recruited from among community health/TB outreach workers engaged in TB prevention and treatment strategies.
Empower local CSOs/CBOs especially those working with PLTB and PLHIV and other key populations with TB-related legal literacy and patient rights, in addition to stigma reduction messaging to their members	Design modules for capacity building Train and mentor the CBOs/CSOs on human rights in the context of HIV and TB	Empowered communities with meaningful involvement		Year 1 (Design modules) Year 2 (Capacity strengthening) Year 3 (Implementation of legal literacy)	

Strategic Objective	**Specific activities**	**Expected Results**	**Implementation suggestions (coverage, location, key populations, etc.)**	**Implementation Period**	**Observations**
PA 6: Sensitization of lawmakers, judicial officials and law enforcement agents					

Support in-service training for law enforcement officers, judiciary, prison staff, and policy makers.	Update existing training curricula on HIV for the police and law students to include TB, focusing on aspects that promote supportive, accepting, and responsive services. Support in-service trainings for police, members of judiciary, and prison staff on HIV and TB policies and key populations; responsible and supportive policing in the context of HIV; reduction of illegal police practices. Expand the training for prison personnel regarding the prevention, health care needs and human rights of detainees living with or at risk of HIV infection.	Improved attitudes and treatment of people living with TB and HIV and key populations affected by HIV and TB by police, judges and prison staff. Increased knowledge of current protective laws. Reduction in illegal police practices and increase in supportive policing and judicial decisions.		Year 1 – Year 2 (development and training of trainers) Years 3-5 (Implementation)	This training module would be part of the standardized module for HIV and TB services that is mentioned above under PA 1 and also under PA 7. There are existing modules of TB stigma trainings for members of the judiciary in the East African context, implemented by KELIN and others, that could serve as models.

Strategic Objective	Specific activities	Expected Results	Implementation suggestions (coverage, location, key populations, etc.)	Implementation Period	Observations
PA 7: Training of health care workers on human rights and ethics related to TB					
Integration of TB-related human rights and medical ethics into curriculum at pre-service health provider training schools, e.g. medical school, nursing school, etc.	Integrate TB-related human rights and medical ethics concerns into pre-service training curriculum for health workers, health managers, as well as other people working in health facilities (e.g. laboratory technicians, receptionists, data clerks).	Reduced stigmatizing attitudes and practices by all health-workers	Updated curricula routinely offered (e.g. on an annual basis) in health facilities for new staff, etc.	Year 1 (Updating curriculum) Years 2-5 (Implementation)	Integrate the training with HIV training on human rights and medical ethics
Routine assessments of health workers' knowledge, attitudes and behaviors towards PLHIV and PLTB and support health administrators to identify and address any issues.	Design data collection tools for routine data capture and implement periodic assessments through surveys	Generation of information relevant to health managers' programming to address human rights, medical ethics issues across the health system	Engage administrators and identify champions within the health sector and/or facilities for the sustainability and follow-up	Year 3, 5	Integrate the TB training with HIV training on stigma reduction
Tn-service training of health-workers and health managers in hard hit areas on human rights and medical ethics relevant to HIV and TB services.	Design in-service training curriculum that incorporates both HIV and TB status related human rights and medical ethics and roll out in areas heavily affected by TB and HIV	Improved attitudes and behaviors of service providers towards TB patients	Develop capacity of some of the community level TB CSOs to support and participate in-service training	Year 2-5	
Conduct routine monitoring of health care	Update MERG approved tool for assessing HIV-related stigma to include questions on TB.	Reduction in stigma towards people living with TB.	Combine monitoring of attitudes towards people with TB to routine monitoring of	Years 1,3,5	

workers attitudes about people living with TB	Train health facility managers to implement routine surveys to inform training needs and policy changes at the facility-level	Improved quality of service provision for people living with TB.	attitudes towards people living with HIV and key populations		

Intervention	Specific activities	Expected Results	Implementation suggestions (coverage, location, key populations, etc.)	Implementation Period	Observations
PA 8: Ensuring confidentiality and privacy					
Assessment of the modalities of TB and HIV service delivery leading to recommendations for reducing situations where people are identified as TB or HIV positive when they come in for health services or treatment drugs, etc (that would amount to	Conduct a service provision assessment at a range of health facilities throughout the country (i.e. urban and rural, different sized facilities, etc.) to determine if procedural changes are needed to minimize the identification of people living with HIV and people living with TB	Reduction in inadvertent disclosure of a patient's TB status	Involve health facility administrators and staff in the process of identifying procedures that may impede confidentiality at their facility and come up	Year 1 (Assessment) Year 2 (Develop plan for addressing procedures/practices) Year 3-5 (Implement plan)	Issues of confidentiality and privacy exist for HIV patients and patients of other diseases as they do for TB patients. For this reason, it is recommended that confidentiality is emphasized in institutionalized training of health-workers on TB, peer educators and

disclosure of confidential information).			with solutions to address any procedural issues identified.		community health workers.

Intervention	Specific activities	Expected Results	Implementation suggestions (coverage, location, key populations, etc.)	Implementation Period	Observations
PA 9: Mobilizing and empowering patient and community groups					
Support the formation of networks of people affected by TB and CSOs/CBOs that support them to advocate for TB-related human and patient rights, issues around gender inequality that increase vulnerability to TB, and rights to protective work places.	CBO stakeholder meeting to explore creating/supporting networks and expanding CBO engagement in TB related human rights work; training of selected CBO(s) on TB-related advocacy issues; support to conduct community sensitization about types of support available to people with TB through the CBO(s); Implementation of TB patient rights advocacy. Development of work place policies on TB management and infection control, and patient compensation.	Community-level patient advocacy groups for people with TB throughout the country.	Involve former TB patients as resource persons in empowering the TB patients. These CBOs could advocate for different strategies to support treatment access for vulnerable populations and stigma reduction	Year 1 (Start-up) Year 2 (Community sensitization; and development of work place policy guidelines) Year 3-5 (Implementation of patient advocacy services)	It could be that existing CBOs that support HIV services could expand their services to provide TB-related advocacy and support work. Or new TB CBO(s) could be formed with this specific agenda.

Intervention	Specific activities	Expected Results	Implementation suggestions (coverage, location, key populations, etc.)	Implementation Period	Observations
PA 10: Programs in prisons and other closed settings					
Support CBOs/CSOs working on prisoners' rights to scale up advocacy and interventions across all prisons and closed setting related to TB, such as nutrition for people living with HIV and/or TB	Ensure that all types of closed settings benefit from CBO/SCO advocacy, support and oversight related to TB. Advocate for the development of a program to provide supplementary food to TB and HIV patients in the prisons. Cluster prison farms to produce specific crops for prisoners' consumption.	Improved adherence to TB-related human rights in prisons and treatment and improved health outcomes	Prisons have farms that should be capacitated to produce	Year 1 (Program development) Year 2-5 (implementation)	Default rates of TB treatment and poor adherence were directly related to poor diets in the prisons.

A national-level assessment of human rights related vulnerabilities to TB in prisons and protection provided to prisoners in terms of access to TB and HIV treatment should be conducted to fully elucidate the situation in prisons and closed settings.	Design and implement human rights and health assessments in prisons and closed settings in collaboration with all relevant stakeholders Revise policies and procedures for health care service provision to prisoners accordingly.	Clearer understanding of the human rights and health care situation in prisons and improved services as a result.	This assessment should examine protection from dangerous living conditions leading to TB, protection from sexual violence, and protection from discrimination and arbitrary isolation and access to TB and HIV health services.	Year 2 (assessment) Year 3-5 (revisions and implementation to services)	

Annex 3: Comprehensive Response to Remove Human Rights-related Barriers to Malaria services in Uganda

Strategic Objective	Specific activities	Expected Results	Implementation suggestions (coverage, location, key populations, etc.)	Implementation Period	Observations
PA 1: Reducing gender-related discrimination and harmful gender norms relevant to malaria					
Based on the results from the gender assessment/operational research, strengthen the capacity of key malaria stakeholders, managers, and data analysts to understand, prioritize, and use age and gender-disaggregated	Training in gender mainstreaming in the delivery of malaria services. Training in gender and agesensitive data gathering and analysis.	Gender issues will be mainstreamed at all levels of malaria program design, implementation, and evaluation.		Year 2-3	

Strategic Objective	Specific activities	Expected Results	Implementation suggestions (coverage, location, key populations, etc.)	Implementation Period	Observations
information in the malaria response.					
Conduct operational research to explore gender and health dynamics as relevant for malaria and develop a gender analysis framework.	Train key stakeholders in relevant gender analysis frameworks. Design and implement operational and implementation science research.	Gender analysis framework to be utilized during program design and implementation for malaria interventions developed.		Year 1	
Involve young men and women in promoting malaria prevention and control, and in broader advocacy and education around the gender-related vulnerabilities to malaria through participatory approaches such as peer education initiatives.	Increase support to networks, including peer education initiatives, that combat gender discrimination and harmful norms Building the capacity of community health workers including VHTs in effectively engaging the youth	Increase awareness of gender issues related to malaria at the community and national levels.	Behavior change communication through interpersonal communication (IPC) should be scaled up and sustained country-wide	Year 2-3	

Strategic Objective	Specific activities	Expected Results	Implementation suggestions (coverage, location, key populations, etc.)	Implementation Period	Observations
Support or expand efforts such as SASA! aimed at empowerment of both men and women at the community level, especially targeting decision-making at household level about health care and health-seeking behavior.	Develop and implement counseling and educational sessions alongside treatment on human and gender-related barriers to malaria services, with messages targeted at different groups including mothers, pregnant women, men, fathers, male and female adolescents, and schoolchildren.	Greater empowerment of women to make decisions related to their health and their children's health. Improved access to malaria services for pregnant women and children under five.	These sessions could focus not only on early recognition of malaria, but could also encourage prevention, more equitable household decision-making and the sharing of caregiving activities	Year 1-5	This activity is costed under PA 7 in the HIV section, as malaria would represent a small component of the larger SASA! Training.

Strategic Objective	Specific activities	Expected Results	Implementation suggestions (coverage, location, key populations, etc.)	Implementation Period	Observations
PA 2: Promoting meaningful participation of affected populations, especially prisoners, refugees and mobile populations					

Strategic Objective	Specific activities	Expected Results	Implementation suggestions (coverage, location, key populations, etc.)	Implementation Period	Observations
Create a system for mapping, identifying, and engaging hard-to-reach, minority and socially disadvantaged populations affected by or vulnerable to malaria, especially on the islands and mountainous areas and in Karamoja sub-region. Sensitize the local religious or cultural structures within these areas and promote projects that support community-level dialogues and integration of feedback into malaria service delivery.	Stakeholder meeting to inform development of mapping system. Strengthen capacity of community health workers including VHTs in effectively engaging the minority and socially disadvantaged populations in participating in design and delivery of malaria services.	Integrated feedback into health delivery systems. Improved malaria health services for hard-to-reach and socially disadvantaged populations.	Use local religious or cultural structures within these areas to promote projects that support community level dialogues and integration of feedback into service delivery.	Year 2-3	Strategies should be developed to effectively use district level and community level structures in coordination with NGOs supporting the hard-to-reach, minority and socially disadvantaged populations.
Support the implementation of community scorecard assessment of quality at health facility-level for malaria services	Training in use of scorecards by the health-workers, health unit management teams and community members Implementation of CSC events	Improved dialogue between the health-workers and the service users, and development of community level action plans. Improved quality in service delivery.	The communities should be empowered to support the CSC events and hold health-workers accountable in conducting and auctioning the gaps identified in the CSC meetings	Year 3-4	

Strategic Objective	Specific activities	Expected Results	Implementation suggestions (coverage, location, key populations, etc.)	Implementation Period	Observations
Develop guidelines for integrated service delivery that includes non-discriminatory equitable access, for vulnerable populations seeking malaria services	Refresher training of health workers and VHTs in interpersonal communication for not only behavior change but to collect community feedback on the programs	Improved behavior change messaging integrating community perspectives	These counselling and educational sessions could focus not only on early recognition of malaria, but could also encourage prevention, more equitable household decision-making and the sharing of caregiving activities. Hold community dialogues.	Year 2-3	Most health education programs are focused on behavior change by the community and rarely in collecting community feedback into service programming.

Strategic Objective	Specific activities	Expected Results	Implementation suggestions (coverage, location, key populations, etc.)	Implementation Period	Observations
PA 3: Strengthening community systems for participation in malaria programs					
Strengthen VHT system through trainings, supportive supervisions, and provide funds for facilitation and village level activities, including on promotion of access to non-discriminatory care,	Trainings and mentorship by health facility workers.	Community system with ability to develop local solutions to malaria high prevalence challenges. Empowered community with capacity to feedback on malaria service programming and delivery to the health-workers, other duty bearers and NGOs.	Work in collaboration with Community based organizations working to strengthen community systems in prevention of malaria incidences.	Year 2-3	

Strategic Objective	Specific activities	Expected Results	Implementation suggestions (coverage, location, key populations, etc.)	Implementation Period	Observations
patients' rights, rights/legal literacy					
Strengthen the capacity of health unit management committees and local CBOs and support them to hold community level dialogues on vulnerability to and access to prevention, diagnosis and treatment of malaria, including human rights and gender-related concerns.	Trainings of health unit management committees and local CBOs. Community level dialogues on malaria service programming and delivery.	Wide coverage of community level dialogues that generates information relevant to health managers		Year 4-5	

Strategic Objective	Specific activities	Expected Results	Implementation suggestions (coverage, location, key populations, etc.)	Implementation Period	Observations
PA 4: Improving services in prisons and other closed settings					

Strategic Objective	Specific activities	Expected Results	Implementation suggestions (coverage, location, key populations, etc.)	Implementation Period	Observations
Advocacy or other efforts to ensure that malaria services in prison are overseen and given technical support by health ministries and not interior or corrections ministries	Conduct advocacy with key government ministries to ensure malaria vector control are readily available in prisons and are appropriately distributed to inmates.	Expand access to malaria services among prison populations	CBOs and MOH should work together to ensure that malaria services are made available to prisoners and that appropriate malaria control measures are in place.	**Years 1-3**	
Programs to serve women in prison and to overcome both gender-based barriers and prison-related stigma and marginalization	Sensitization activities with corrections officers on right to health and healthcare of prisoners, gender-related barriers to healthcare access, and the importance of following public health guidance on minimizing exposure to malaria, ensuring early diagnosis and access to treatment	Reduced stigma and marginalization of female prisoners; increased access to healthcare services for women in prison, including malaria services.	Local CBOs would implement trainings together with MOH staff to ensure.	**Years 1-5**	

Strategic Objective	Specific activities	Expected Results	Implementation suggestions (coverage, location, key populations, etc.)	Implementation Period	Observations
Develop programs to support improved malaria service programming and delivery	Organize consultation and advocacy meetings with relevant stakeholders at Central and regional levels Structured trainings of health workers who support prison facilities Invest in infrastructural improvements	Skilled prison medical staff as well as other staff Improved health facility structures	There should be a structured process by MoH and DHOs to enable technical support to the prisons health care providers and should benefit from targeted trainings and measures to ensure that malaria prevention and control supplies reach prisoners	Year 2-4	Health-workers in prisons reported infrequent support supervisions.
Ensure prison health providers are provided with training and targeted measures to ensure that malaria prevention and control supplies reach prisons	Develop and implement training o measures and procedures to ensure availability of malaria prevention and control supplies in prisons.	Consistent availability of supplies for malaria prevention and control at all prisons in Uganda.	CBOs and MOH staff to work together on developing training materials and targeted measures.	**Years 1-5**	

Strategic Objective	Specific activities	Expected Results	Implementation suggestions (coverage, location, key populations, etc.)	Implementation Period	Observations
PA 5: Improving access to services for underserved populations, including for refugees and others affected by emergencies					
Develop guidelines for integrated service delivery that includes non-discriminatory equitable access for vulnerable populations seeking malaria services	Stakeholder meeting with MOH representatives, services providers, and relevant implementing partners to draft guidelines and develop plan for implementing them.	Enhanced access to malaria services for vulnerable and underserved populations	Integration of malaria services with HIV services for PLHIV, and with TB services for people with TB.	Year 1-3	Integrated service delivery, particularly integration into primary healthcare, would enhance access to services.
Expand in-service trainings regarding stigma and discrimination and other human rights, ethical concerns, and on patient rights to all health workers including VHTs and community leaders/local councils providing malaria services.	Design in-service training curriculum that incorporates equity barriers to primary healthcare and HIV, TB and malaria services	Improved attitudes and behaviors of service providers towards vulnerable and underserved populations who are at risk of or diagnosed with malaria.	Develop capacity of some of the community level CSOs to support in-service training	**Year 2-5**	These training should be combined with similar pre- and in-service trainings for health workers included in Annexes 1 and 2 for stigma-reduction with health workers, especially for staff who provide malaria-

Strategic Objective	Specific activities	Expected Results	Implementation suggestions (coverage, location, key populations, etc.)	Implementation Period	Observations
					related services.
Integration human rights and medical ethics into health provider training schools, e.g. medical school, nursing school, etc.	Integrate human rights and medical ethics concerns into training curriculum for health workers, health managers, as well as other people working in health facilities (e.g. laboratory technicians, receptionists, data clerks) and VHTs	Sensitized healthcare providers providing patient-centered care	Updated curricula routinely offered (e.g. on an annual basis) in health facilities for new staff, etc.	**Year 1 (Updating curriculum) Years 2-5 (Implementation)**	Integrate the training with other efforts aimed at training on human rights and medical ethics

Annex 8. Proposed indicators, baseline value, source, and level of disaggregation for evaluating the impact of comprehensive programs to remove human rights-related barriers to HIV, TB and malaria services in Uganda.

Indicator	Baseline value (national)/N	Source	Suggested level of disaggregation
Outcome indicators: People living with HIV			
Percentage of people living with HIV who know their status	81% N= 1,100,000	UNAIDS 2017	Region; gender; age
Percentage of people living with HIV who report any internalized (self) stigma	50% N= 403	Stigma Index 2013	Region; gender; age
Percentage of people living with HIV who report experiences of HIV-related stigma and discrimination in healthcare settings	Data not available	Stigma Index 2013	Region; gender; age
Percentage of adults and children living with HIV currently receiving ART	72% N= 969,569	UNAIDS 2017	Region; gender; age; key population
Percentage of people living with HIV who report experiencing social exclusion, exclusion from places of worship, or family exclusion	Social exclusion: 16% (N=177) exclusion from religious activities/places of worship: 7% (N=77) Exclusion from family activities at	Stigma Index 2013	Region; gender; age

	least once in the last year: 10% (N=111)		
Percentage of people living with HIV who report experiencing an abuse of their rights in the last 12 months (in relation to assault, abuse, exclusion)	23% N= 255	Stigma Index 2013	Region; gender; age
Percentage of people who attempted to seek legal redress among those who experienced a human rights violation	25% N=254	Stigma Index 2013	Region; gender; age
Percentage of people living with HIV who were denied health care due to HIV status	5% N=50	Stigma Index 2013	Region; gender; age
Percentage of women living with HIV who were coerced into sterilization by health care workers.	11% N=121	Stigma Index 2013	Region
Percentage of people living with HIV who confronted, challenged or educated someone who was discriminating against or stigmatizing them	48% N= 122	Stigma Index 2013	Region; gender; age
Percentage of people living with HIV who have heard of the National HIV Policy	41% N= 433	Stigma Index 2013	Region; gender; age
Outcome indicators: Key populations			
Coverage of prevention programs among key populations	Data not available	UNAIDS/GAM	Region/district; sex; age; specific key populations
Percentage of key populations who received an HIV test in the past 12 months and know the result	MSM: 70% SWs: 55%	UNAIDS narrative 2014	Region; age
Percentage of people who reported losing jobs or incomes in the past 12 months due to HIV status	27% N = 255	Stigma Index 2013	Region; sex; age; specific key populations

Percentage of people living with HIV who confronted, challenged or educated someone who was discriminating against or stigmatizing them	48% N = 254	Stigma Index 2013	Region; sex; age; specific key populations
Percentage of people living with HIV who reported being denied health services, including dental care, because of their HIV status	5% N = 1093	Stigma Index 2013	Region; sex; age; specific key populations
Percentage of key populations who avoided seeking health care due to fear of stigma and discrimination	Data not available	Recommended for inclusion in Stigma Index and/or IBBS	Region; sex; age; specific key populations
Percentage of key populations who are aware of their legal rights	No data available	New, recommended for inclusion into IBBS	Region; age; specific key populations
Percentage of key populations who report any internalized stigma in the past 12 months	No data available	New IBBS survey (2018)	Region; gender; age; specific key populations
Percentage of key populations who report any experienced stigma	51%	PLHIV Stigma Index 2.0	Region; gender; age; specific key populations
Percentage of key populations who reported being treated unfairly because of their sexual orientation in the past 12 months	Data not available	IBBS	Specific key populations
Percentage of key populations who have experienced forced sex acts or rape in the past 12 months	SWs: 32%	Friedland et al. 2018 JIAS[137]	Region; gender; age; specific key populations

[137] Friedland B, Sprague L, Nyblade L, Baral S, Pulerwitz, et al (2018). Measuring intersecting stigma among key populations living with HIV: Implementing the people living with HIV Stigma Index 2.0. Journal of International AIDS. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6055043/

Outcome indicators: People living with TB			
Percentage of people living with TB who are aware of their legal rights	No data available	New	Region; gender; age
Number of new and relapse TB patients with documented HIV status occurring during the year	No data available		
Outcome indicators: People at risk of malaria			
Proportion of confirmed malaria cases that received first-line antimalarial treatment at public sector health facilities/ in the community/ private sector sites	No data available		<5, 5+, gender, wealth quintile, education level, rural/urban, geographic region, ethnicity
Proportion of suspected malaria cases that receive a parasitological test at public sector health facilities /in the community/ private sector sites	No data available		<5, 5+, gender, wealth quintile, education level, rural/urban, geographic region, ethnicity
Access to insecticide-treated net	65% has access (70% in urban vs 63% in rural areas)	DHS 2016	Gender; age
Proportion of households with at least one insecticide-treated net for every two people and/or sprayed by indoor residual spraying within the last 12 months	51%	DHS 2016	Rural/urban, geographic region, ethnicity
Proportion of population that slept under an insecticide-treated net the previous night	62% of children <5 and 70% <1 year slept under ITN night preceding survey	DHS 2016	<5, 5+, gender, wealth quintile, pregnant women, education level, rural/urban

	54% of pregnant women with no education vs 83% of pregnant women with more than secondary education 61% urban vs 53% rural		
Proportion of health facilities without stock-outs of key commodities within the last 12 months	Data not available	DHS	
Reported malaria cases	30% of children <5 tested positive Data for children above 5 years not available	DHS 2016	<5, 5+
Proportion of children under 5, proportion of pregnant women that slept under an insecticide-treated net the previous night	62% of children <5 64% of pregnant women age 15-49 slept under an ITN the night before the survey	DHS 2016	
Access of refugees and emergency-affected communities to malaria services	Data not found		Gender; age

Coverage of migrant workers in endemic regions with mobile or community-based malaria prevention, diagnosis and treatment services	Data not found		Gender; age
Number of community campaigns on malaria patients' rights to care	Data not found	Program data	
Number of malaria NGOs trained by HIV NGOs on advocacy and lobbying	Data not found	Program data	
Number of people reached with ITNs through outreach interventions without formal registration	Data not found	Program data	Rural/urban, geographic region, ethnicity
Number of migrant workers covered with information sessions or materials on occupational risks and malaria prevention in the past 12 months	Data not found	Program data	Sex, education level
	Data not found		
Amount of individual, indirect costs related to accessing health services, such as transport or childcare	Data not found	Malaria Matchbox	Key populations; regions; districts
Outcome indicators: General population			
Percentage of women aged 15-49 who have ever tested for HIV	85%	DHS 2016	Region; age
Percentage of men aged 15-49 who have ever tested for HIV	73%	DHS 2016	Region; age

Percentage of men and women who report discriminatory attitudes towards people living with HIV (new, 2-item composite)	Women: 34% Men: 29%	DHS 2016	Region; age
Percentage of adults who report fear HIV infection due to contact with saliva of a person living with HIV	No data available	DHS 2016	Region; gender; age
Percentage of adults who would be ashamed if a person in their family was living with HIV	No data available	DHS 2016	Region; gender; age
Outcome indicators: Healthcare workers			
Percent of health facility staff who worry about getting HIV when providing care or services to patients living with HIV	No data available	UNAIDS Indicator Registry/HP+ tool	n/a
Percent of health facility staff that hold stigmatizing views about people living with HIV	No data available	UNAIDS Indicator Registry/HP+ tool	n/a
Percent of health facility staff who report that their facility has written guidelines to protect patients living with HIV from discrimination.	No data available	UNAIDS Indicator Registry/HP+ tool	n/a
Number of HCW and prison staff trained on human rights, non-discrimination and medical ethics related to malaria in the past 12 months	Data not found	Program data	Geographic region
Number of HCW reached through training sessions about access to services for refugees and IDP in the past 12 months	Data not found	Program data	
Access to personal protection measures among workers with occupational exposure risks	Data not found	Program data	Gender; geographical region

Number of community-based malaria services providers reached through training sessions in the past 12 months	Data not found	Program data	Gender; geographical region
Outcome indicators: Institutions			
Stigma and discrimination-reduction (i.e. HIV, TB and human rights) course institutionalized in degree programs for duty bearers	Medicine: Nursing: Social Work: Law enforcement: Law:		Type of profession (i.e. medical, nursing, social work, police, law)
Number of harmful laws impeding access to HIV services removed or replaced	Data not found		Note specific laws removed or replaced
Proportion of health facilities without stock-outs of key commodities during the reporting period	Data not found		
Community-led monitoring of access to and quality of malaria service delivery institutionalized as part of national health information systems and human rights violations documentation mechanisms	Data not found		
Outcome indicator: Financing			
Total spent on programs to reduce human rights barriers to HIV services	$511,442 USD	Retrospective costing (2016)	Source of funding (i.e. public resources; international funding); type of implementer
Total spent on programs to reduce human rights barriers to TB services	$37,400 USD	Retrospective costing	Source of funding (i.e. public resources;

		(2016)	international funding); type of implementer
Total spent on programs to reduce human rights barriers to malaria services	$0 USD	Retrospective costing (2016)	Source of funding (i.e. public resources; international funding); type of implementer
Impact indicators			
HIV prevalence in people aged 15-49	5.9	UNAIDS 2017	Region, key population, gender
HIV incidence rate per 1,000 population (15-49)	2.52	UNAIDS 2017	Region, key population, gender; age
TB/HIV co-infection rate	96.2/100,000 (TB among PLHIV)	The Uganda National Tuberculosis Prevalence Survey, 2014-2015 Survey Report	Gender
TB Case Notification Rate (CNR)	45,284/41 million (all forms)	The Uganda National Tuberculosis Prevalence Survey, 2014-2015 Survey Report	Region, gender, age
Malaria mortality rate	Data not found		Region, gender, age, key populations
Malaria morbidity rate	Data not found		Region, gender, age, key populations