THE GLOBAL FUND

UGANDA

Progress Assessment

Global Fund Breaking Down Barriers Initiative

October 2023

Table of Contents

Disclaimer

This assessment was commissioned by the Global Fund to Fight AIDS, TB and Malaria as part of the operationalization of its 2023-2028 strategy. This report presents the findings of the independent research team that carried out the assessment. The views expressed do not necessarily reflect the views of the Global Fund.

Acknowledgements

The progress assessment of the *Breaking Down Barriers* initiative was led by a team of researchers assembled by the Drexel University Dornsife School of Public Health.

The Uganda progress assessment was conducted under a grant to Drexel University. The research team was comprised of Russell Armstrong, Mulshid Muwonge, Florence Obua, Amelia Vukeya Motsepe, and Julius Mukobe.

The authors would like to acknowledge the support of the Global Fund, as well as the country stakeholders, technical partners and many others who provided reports, insight and myriad contributions, and who demonstrated their dedication to their programs and beneficiaries.

1. Executive Summary

Since 2017, Uganda has been one of twenty countries to participate in the *Breaking Down Barriers* initiative, a groundbreaking effort of the Global Fund to Fight AIDS, Tuberculosis and Malaria to scale up programs to reduce or remove human rights and gender-related barriers to HIV, TB and malaria services. For the Grant Cycle 6 (GC6) period (2021-2023), Uganda received US$4.4 million in catalytic matching funds to scale up its efforts to reduce or remove human rights-related barriers to HIV, TB and malaria services. Uganda then allocated additional funding from within its GC6 funding allocation to achieve a total investment of approximately $9.5 million. This investment is complemented by other support under the *Breaking Down Barriers* initiative, particularly long-term technical assistance to program implementers and to support the Equity Plan Steering Committee.

In 2021, a Mid-Term Assessment was conducted of country progress to reduce or remove human rights-related barriers to HIV, TB, and malaria services during the period 2018 to 2020. In November 2022, a follow-up progress assessment was undertaken to document and assess the country's more recent achievements and to contribute to the development of the Grant Cycle 7 (GC7) funding request, including for addressing the new Program Essentials requirements and to update the scorecard that summarizes progress made towards comprehensive programming to reduce barriers.

The assessment considered three main questions: 1) has Uganda made measurable progress (since the last assessment) in scaling up comprehensive, quality-assured and sustainable interventions to reduce or remove human rights barriers to HIV, TB and malaria services? 2) have these scaled-up interventions reduced or removed human rights barriers? and 3) has the reduction of barriers improved access and uptake of services?

The process followed the methodology outlined by a team of researchers affiliated with Drexel University and approved by the Global Fund. The assessment for Uganda was done by a team comprised of one international lead consultant, an associate consultant and three national consultants. Data collection occurred during November and December 2022 and involved key informant interviews, group discussions, document reviews and, in addition to visits in Kampala, site visits to Busia, Lira and Mbale Districts in Eastern and Northern Uganda. Preliminary findings were presented to the Uganda Country Coordination Mechanism (CCM) and to the broader group of country stakeholders during the launch of Uganda's country dialogue for the development of the GC7 funding request.

1.1 Summary of Investments and Implementers

For the GC6 period, in addition to its overall allocation of US$579 million for HIV, TB and malaria programs, Uganda received US$4.4 million in matching catalytic funds to scale up programs to reduce human rights barriers to HIV, TB and malaria services. Following grant-

making and the signing of funding agreements, this amount was matched by an additional US$5.1 million from the country allocation (0.8% of the total allocation), bringing the total budgeted investment in programs to reduce barriers to US$9.5 million.[1]

Of this amount, 63% was allocated to The AIDS Support Organisation (TASO). The balance, totalling approximately US$2.3 million, was allocated to the Ministry of Health (MoH). Implementers under TASO included the Uganda Network on Law, Ethics and HIV/AIDS (UGANET), the Human Rights Awareness and Promotion Forum (HRAPF), International Community of Women Living with HIV East Africa (ICWEA), the Uganda Key Populations Consortium (UKPC), the Most-at-Risk Populations Initiative (MARPI), and the Uganda Stop TB Partnership (USTP).[2]

The implementers under the MoH were: the Office of the Director of Public Prosecutions (ODPP), Makerere School of Public Health (MSPH) and the Uganda AIDS Commission (UAC). Within the MoH itself, the AIDS Control Programme (ACP), the National TB and Leprosy Control Programme (NTLCP) and the National Malaria Control Programme (NMCP) also participated in the implementation of programs to reduce barriers. As of December 2022, with one year left until the end of the grant, from the information available it appears that fund absorption for programs to reduce barriers was >60%, with some implementers in both the civil society and the government indicating that funds would soon be fully absorbed for some program areas.

1.2 Assessment Findings

The findings of the assessment make clear that over the 2021-2022 period, Uganda made important progress in scaling up programs that reduce barriers to HIV, TB, and malaria services. Progress was also achieved to reduce human rights-related barriers in a number of program areas, leading to improvements in the uptake of and retention in services. Progress was greater in the HIV programs as compared to the TB and malaria programs. However, these gains remain fragile. For some population groups (particularly key populations), these gains remained at risk due to some negative trends emerging in the implementation environment, and the limited progress to address problematic aspects of the legal and policy context for KP-focussed interventions.[3]

HIV Component

[1] The allocated funding for programs to reduce barriers was complemented by additional investments in community systems strengthening (CSS) totaling US$5.9 million, some of which also addresses reducing human rights barriers.

[2] For CSS programs, the additional implementers were National Forum of People Living with HIV/AIDS Networks in Uganda (NAFOPHANU), Multi-Community Based Development Initiative (MUCOBADI), Centre for Health, Human Rights and Development (CEHURD), Uganda Harm Reduction Network (UHRN), Uganda Network of AIDS Service Organisations (UNASO), and Community Health Alliance Uganda (CHAU).

[3] By the time this report was validated in May 2023, Uganda had enacted the Anti-Homosexuality Act 2023, which was anticipated to have far-reaching negative impacts on the national HIV response.

In most program areas for HIV, there was substantive progress in scaling up interventions to reduce barriers, largely as a result of increased investments under GC6, but also the investments of other donors and partners. Particularly in the areas of eliminating stigma and discrimination, improving legal literacy, improving access to justice, and strengthening of community mobilization, participants in the assessment noted positive changes in the reduction of barriers with more people living with HIV (PLHIV) and key populations coming forward to access the continuum of HIV services and experiencing fewer risks in doing so. Instances of stigma and discrimination and poor quality of services in health facilities were also said to be declining, and community-level interventions to prevent and respond to gender-based violence (GBV) were showing encouraging results, with more individuals coming forward to report cases and to participate in collective efforts to end GBV in all its forms.

Less progress was achieved with regard to ensuring rights-based law enforcement practices as, despite the efforts of the ODPP to sensitize all criminal justice stakeholders regarding the human rights-based, public health approach, there was still an elevated frequency of harassment and abuse of key populations in communities, something that was increasing as the assessment was being finalized. Limited progress in achieving law and policy change, particularly regarding the criminalization of HIV transmission, drug use and sexual minorities (as with the enactment of the Anti-Homosexuality Act of 2023), was said to be among the drivers of this increase.

TB Component

With regard to TB, there was a smaller degree of program scale-up. To some degree, efforts to remove barriers to TB services leveraged HIV investments through the integration of TB-related topics in these interventions. The scale-up in community mobilization and advocacy, led by USTP with support from the NTLCP, resulted in increased engagement in communities regarding stigma and discrimination reduction and TB-related human rights literacy. TB stakeholders were of the view that this work had contributed to increased uptake of and retention in TB services and the overall improved performance of the TB program over previous periods. The completion of a gender and key population assessment in 2021 had raised awareness among TB stakeholders regarding additional barriers and the need to address them. By the end of the assessment period, TB stakeholders were actively engaged in developing an action plan to respond to the assessment findings, and were also preparing a more substantive program of interventions to reduce human rights-related barriers to TB services as part of the GC7 submission.

Malaria Component

Progress was also achieved by malaria stakeholders in the reduction of human rights-related barriers, particularly in the areas of reducing gender-related discrimination, promoting meaningful participation of affected populations, and strengthening community systems. By December 2022, a Malaria Matchbox Assessment was underway which is expected to be

completed in 2023. The NMCP had identified a focal point for programming to reduce human rights and gender-related barriers. Implementers under the U.S. President's Malaria Initiative (PMI) had developed a Gender Action Plan and were using this to guide all aspects of their programming, including applying a gender and equity lens to monitoring and evaluation (M&E) data. A new model for community ownership and engagement was being rolled out, the Household Action Against Malaria. (TASO has a complementary initiative under its Global Fund grant, known as Household Champions Against Malaria). The Household Action Against Malaria seeks to empower households and communities to identify malaria-related risks and to resolve them through collective action. Full and equal engagement of men and women as household leaders and champions was a main emphasis of this approach.

Priorities included removing barriers to women's and children's timely access to health services, including for antenatal care. Renewed efforts were being made to engage underserved populations, including those in rural and remote regions (Karamoja, for example), refugees, people with disabilities, and pregnant adolescents/young mothers. Under the PMI, new reporting tools were improving the availability of disaggregated data to track equity-related improvements. ODPP incorporated malaria within its policies and guidelines for criminal justice stakeholders, including prisons and other places of detention; and community mobilization and community led-monitoring (CLM) interventions, implemented as part of CSS investments, were incorporating malaria along with HIV and TB. More malaria-focused civil society organizations (CSOs) were being included in implementation arrangements and were being supported with capacity strengthening interventions. Malaria stakeholders were encouraged by the growing momentum and attention to equity and human rights concerns, and were intending to include a more robust plan to reduce barriers as part of the GC7 submission.

Other Findings

From the assessment findings, it was apparent that the Equity Plan had guided the development of a number of interventions and that there was growing awareness and commitment to the plan across an expanding range of stakeholders from all sectors. In 2022, the Equity Plan Steering Committee was established, along with a National Coordinator role and a Secretariat within the UAC. During 2022, the steering committee met routinely and, in October 2022, it convened a stakeholder retreat to review progress toward the implementation of the Equity Plan and the achievement of its goals and outcomes. Important findings from the review were included in this progress assessment.

With regard to program quality, there was a heavy emphasis on meetings, training workshops, sensitization activities and engagement sessions, and community dialogues, for example, with only limited investments in follow-on activities. While most implementers believed that these interventions and investments contributed to positive changes, there was no comprehensive system to track these outcomes, individually or collectively. Beyond grant

accountability reporting (output level only), and aside from the retreat convened by the Equity Plan Steering Committee, there were no cross-cutting mechanisms to track progress.

Implementers were conscious of the need to improve program designs, with clearer theories of change specifying outcome level results along with the pathways and interventions required to achieve the results. Clearer program design would also improve planning and budgeting and move towards realizing greater value for money from these crucial investments in the HIV, TB, and malaria responses for Uganda.

1.3 Scorecard Results

The scorecard results by disease component and program area and are shown below.

Programs to remove rights-related barriers to HIV services

HIV Program Area	Baseline (2018)	Mid-term (2020)	Progress (2022)
Eliminate stigma and discrimination in all settings	3.0	3.6	4.0
Ensure non-discriminatory provision of health care	2.0	2.3	2.6
Ensure rights-based law enforcement practices	2.0	2.3	2.6
Improve legal literacy (“know your rights”)	2.0	2.3	3.3
Improve access to justice (HIV-related legal services)	2.0	3.0	3.6
Improve laws, regulations and policies related to HIV and HIV/TB	1.0	1.0	2.0
Reducing HIV-related gender discrimination	2.0	2.0	3.0
Support community mobilization and engagement	*	*	3.6
Average Score	**2.0**	**2.4**	**1.9**

** = no score assigned in previous assessments.*

Programs to remove human rights-related barriers to TB services

TB Program Area	Baseline (2018)	Mid-term (2020)	Progress (2022)
Eliminate TB-related stigma and discrimination	0.0	2.3	2.6
Ensure people-centered and rights-based TB services at health facilities	0.0	*	2.0
Ensure rights-based law enforcement practices for TB	0.0	1.0	2.0
Improve TB-related legal literacy (“know your rights”)	0.0	1.0	2.3
Improve access to justice in the context of TB.	2.0	2.3	2.6

Improve laws, regulations and policies related to TB	0.0	1.0	1.0
Reduce TB-related gender discrimination	0.0	0.0	1.0
Support community mobilization and advocacy	0.0	2.0	3.0
Address needs of people in prisons and other closed settings	1.0	0.0	2.0
Average Score	**0.3**	**1.2**	**2.0**

Programs to remove human rights-related barriers to malaria services

Malaria Program Area	Baseline (2018)	Mid-term (2020)	Progress (2022)
Reduce gender-related discrimination and harmful gender norms	0.0	1.0	3.3
Promote meaningful participation of affected populations	1.0	1.0	3.0
Strengthen community systems for participation	1.0	2.0	3.3
Monitoring and reforming laws, policies, practices	*	*	1.0
Improve access to services for underserved populations	*	1.0	2.0
Average Score	**0.7**	**1.3**	**2.5**

1.4 Recommendations

The recommendations address both GC7 considerations as well as broader needs for strengthening the effectiveness and impact of programs to reduce barriers to HIV, TB, and malaria services in Uganda.

- In light of the evolving program context, implementers should rapidly scale up safety and security interventions for implementers and beneficiaries of HIV and key population programs and services. The scale-up should prioritize rapid program adaptations and other contingency measures to ensure continuity and accessibility of services for all PLHIV and key populations.

- Additional investment should be urgently made in strengthening and sustaining rapid response mechanisms at the local level, with effective linkages to the national level. In addition to swiftly responding to critical incidents in local communities, such mechanisms should also have more capacity to identify early-warning signs and to prevent escalation. All relevant stakeholders should be included in the mechanism, with defined roles and accountabilities - including key population constituencies,

government focal points, law enforcement focal points, and access-to-justice focal points.

- Regarding HIV program areas, for the remainder of 2023 and as part of GC7 planning, implementers should work to achieve a more effective balance between scale of programming and program quality. During 2021-2022, investments prioritized scale-up. However, challenges of quality have emerged, particularly for supporting ongoing monitoring and improvement processes, and for planning and implementing interventions aimed at achieving and sustaining outcomes.

- Accelerate the development of a web-based comprehensive M&E system covering all program areas. The design of interventions under GC7 should be linked to this framework. Use the remaining time in 2023 to pilot and adjust the framework.

- Linked to the framework, invest in digitization of data and systems for all programs to reduce human rights barriers (building on progress made in 2023).

- Scale up investments to strengthen the capacity of the NTLCP, the NMCP and other key stakeholders for TB and malaria in order to increase their technical and operational capabilities to identify and address human rights and gender-related barriers.

- As part of capacity strengthening, support TB and malaria stakeholders to develop prioritized scale-up plans, drawing from the Equity Plan and the results of the progress assessment, in order to significantly increase the scale and scope of programs to reduce human rights barriers. When developing these plans, clearly define outcomes for 2026 and beyond, and link investments and interventions to achieving these outcomes (and avoid short-term, once-off interventions). The plans should draw on all sources of technical and operational support, not just from the Global Fund.

- Undertake a comprehensive review of the Equity Plan, building on the results of the October 2022 retreat and the findings of this progress assessment. Based on the results of the review, propose a revision/extension to 2026 and beyond.

- Provide for adequate technical and operational investments (in 2023 and during GC7) for the Equity Plan Steering Committee and the National Secretariat to be fully functional and technically competent.

- Develop comprehensive budgeting guidance for programs, linked to lessons learned from the progress assessment. Engage implementers with expertise in specific program areas to develop the budgeting guidance. As part of the guidance, improve the equity of investments between national and sub-national levels. This would

address concerns that, during 2021-2022, investments were concentrated at the national level with only limited consideration of sub-national and local level needs.

Additional recommendations by disease component and program area are included in the main report.

2. Background and Country Context

Since 2017, Uganda has been one of twenty countries to participate in the *Breaking Down Barriers* initiative, a groundbreaking effort of the Global Fund to scale up programs to reduce or remove human rights and gender-related barriers to HIV, TB and malaria services. For the Grant Cycle 6 (GC6) period (2021-2023), Uganda received US$4.4 million in catalytic matching funds to scale-up its efforts to reduce or remove human rights-related barriers to HIV, TB and malaria services.[4] This was amount was fully matched from within the main GC6 funding allocation to achieve a total investment of approximately $9.5 million. This investment is complemented by other support under the initiative, particularly long-term technical assistance to program implementers and to support the Equity Plan Steering Committee.

In 2020, a Mid-Term Assessment was completed of country progress to reduce or remove barriers covering the 2018-2020 period. In November 2022, a follow-up progress assessment was undertaken to document and assess the country's more recent achievements, to update the scorecard and to provide support for the development of Uganda's GC7 funding request submission. This report sets out the findings and recommendations from the assessment.[5]

By 2022, the MoH, along with its partners and stakeholders, had continued to take important steps to address and mitigate the health and social impacts of the interlinked epidemics of HIV, TB and malaria. The country remained committed to ending these as public health threats to the population by 2030. A brief overview of the status of the HIV, TB and malaria epidemics is given below to set the context for the progress assessment.

Status of the HIV epidemic

According to recent data, in 2021 there were an estimated 1.4 million adults and children living with HIV in Uganda. In the same year, there were approximately 54,000 new HIV infections and 17,000 AIDS-related deaths. This represented a decline of since 2010 of 39% and 66%, respectively, indicating the significant progress the country has made to reduce its HIV/AIDS burden. With regard to the global 95%-95%-95% targets, in 2021 it was

[4] This amount was fully matched by the country stakeholders, bringing the investment to US$9 million.

[5] The methodology for conducting the progress assessment, including the value-for-money component, is explained in **Annex 3 Summary of Methods.**

estimated that 89% (or 1.3 million) PLHIV knew their HIV status, of which 82% were on antiretroviral treatment (ART) and 78% were virally suppressed.

However, these high figures mask inequities. The gendered dimensions of the HIV epidemic in Uganda remain complex and unresolved. The annual HIV incidence in 2020 for adult women (15-49 years) remained double that of male peers, at 0.42% and 0.21%, respectively.[6] However, HIV testing and treatment uptake was higher for adult women compared to men, with 83.5% of women living with HIV knowing their HIV status in 2020 as compared to 76.1% of men; 96.7% of these women were on ART, compared to 94.7% of the men. Rates of viral suppression were almost similar, at 92.6% and 91.3%, respectively. The elevated HIV incidence among adult women was an indicator of the limited progress achieved by the country's efforts to address and reverse the vulnerability of all women and girls in Uganda to HIV infection. Key populations are also disproportionately impacted by the HIV epidemic, including sex workers, with a prevalence of 31.5%, men who have sex with men (MSM) at 12.7%, people who use drugs (PWUD) at 17%, and prisoners at 4%. Transgender women have also been identified as experiencing high rates of HIV and violence. For the general population, HIV prevalence tends to be higher in urban areas (at 7.5%) than in rural settings (5.8%).

Status of the TB epidemic

According to the NTLCP, in Uganda, in 2021, 91,000 people developed TB, with an estimated total TB incidence of 200 cases per 100,000 population.[7] The number of incidence cases of drug resistant TB was estimated at 1,500 in 2021, or 3.4 cases per 100,000 population. The treatment success rate for new and relapse cases registered in 2021 was 85%, with TB treatment coverage reaching 82%, a significant improvement over previous periods. Uganda is one of the 30 highest-burden countries for TB/HIV co-infection. Of the total notified cases in 2021, 23,692 or 32% were HIV-positive. All were initiated on ART at the same time that they were treated for TB. Finally, there were an estimated 12,000 TB-related deaths in 2021, 50% of those among HIV/TB co-infected individuals.

Status of the malaria epidemic

Uganda remains one of five countries that account for 51% of all malaria cases globally. Malaria is endemic in approximately 95% of the country, with the rest of the country experiencing low and unstable transmission, with the potential for epidemics. In 2021, WHO reported that there were an estimated 13 million malaria cases and 19,600 deaths in the country.[8] The disease accounts for 30%-50% of outpatient visits and 15-20% of hospital admissions annually. The average economic loss in Uganda due to malaria annually is over

[6] See Uganda Population HIV Impact Assessment 2020-2021. Summary Sheet. August 2022. Available at: https://phia.icap.columbia.edu/wp-content/uploads/2022/08/UPHIA-Summary-Sheet-2020.pdf.
[7] Data in this paragraph is sourced from the WHO's World TB Report database. https://worldhealthorg.shinyapps.io/tb_profiles/?_inputs_&entity_type=%22country%22&lan=%22EN%22&iso2=%22UG%22.
[8] WHO. World Malaria Report 2022. https://www.who.int/teams/global-malaria-programme/reports/world-malaria-report-2022.

US$500 million. People living in poverty, women and refugees are disproportionately impacted by malaria.

Law and policy context

Uganda's HIV response is guided by the *National HIV and AIDS Strategic Plan (2020-2025)* (HIV NSP). The HIV NSP aims to mainstream human rights and gender considerations throughout its four pillars: 1) prevention, 2) care and treatment, 3) social support and protection, and 4) systems strengthening. The pillar on social support and protection, in particular, includes a focus on increasing knowledge of laws and human rights, and increasing community responses to address human rights violations, including GBV. The HIV NSP also foresees improved financing for priority interventions, including activities related to human rights and gender.

Uganda's national plans for TB and malaria also incorporate some human rights-related elements. The *National Strategic Plan for Tuberculosis and Leprosy Control (2020-2025)* includes, as one of its six objectives, human rights and gender considerations, mainly regarding reducing stigma and discrimination among people with TB. Specific interventions include the training of health care workers (HCW) on TB and TB-related stigma and discrimination, the development of TB workplace policies, and activities within the criminal justice system on TB control.

The *Uganda Malaria Reduction and Elimination Strategic Plan 2021-2025* prioritizes a) integration of human rights, gender and equity concerns into the malaria response and b) analysis of gender-related equity barriers to malaria services using the Malaria Matchbox tool. However, aside from these two aspects, the plan lacks more specific strategies and interventions directly linked to identifying and reducing human rights, gender or other equity-related barriers to malaria programs.

The country's clearest statement of commitment to reducing barriers is outlined in *Leave No One Behind: A National Plan for Achieving Equity in Access to HIV, TB and Malaria Services in Uganda 2020-2024* (the Equity Plan). The plan has one overarching goal and nine crossing-cutting, key result areas, as shown below:

Goal	An HIV-, TB-, and malaria-free Uganda through protecting human rights, achieving gender equality, and improving health equity for all Ugandans in all their diversity.
Result Area 1	There is zero stigma, discrimination and violence in the context of HIV, TB and malaria.
Result Area 2	Health care services are non-discriminatory and respect, protect and promote the health and safety of all patients and staff.

Result Area 3	Lawmakers and law enforcement agents understand and fulfil their role to respect, protect and promote human rights and health.
Result Area 4	Individuals and communities are knowledgeable about and can secure their rights and responsibilities for health.
Result Area 5	Legal information and services are available and responsive (to individuals and groups) who seek redress.
Result Area 6	Laws, regulations and policies promote and protect health equity.
Result Area 7	Gender-related health inequities in HIV, TB and malaria services are resolved, particularly gender-based stigma, discrimination and violence.
Result Area 8	Equity barriers for specific key and vulnerable populations in the context of HIV, TB and malaria are addressed and reduced.
Result Area 9	The public health response to removing equity barriers is comprehensive, sustainable, and well-coordinated.

The Equity Plan remains the main reference document for all stakeholders to guide their collective efforts to reduce or remove barriers and to achieve health equity. In 2022, to strengthen alignment to the plan and to more systematically monitor progress, the stakeholders convened the Equity Plan Steering Committee and established a small coordination secretariat at the UAC. A comprehensive review of progress of implementation of the Equity Plan took place in October 2022. A number of the findings have been included throughout this progress assessment.

Despite the bold ambition of the Equity Plan, the legal context for HIV, TB and malaria programs remained relatively unchanged since the previous assessment, with some important negative trends beginning to emerge. Criminal laws against sex work, drug use, same-sex sexualities, and "wilful" HIV transmission remained in place and continued to be enforced. The Sexual Offences Bill 2019 was tabled and passed by the Ugandan Parliament in 2022. The bill contained additional penalties for sex work and for same-sex sexualities. The President of Uganda declined to authorize the Bill and sign it into law, however, referring it back to elected representatives for further review.

During the latter part of 2022, there were additional negative developments for the operating context for some HIV and key population programming. In August, the Ministry of Internal Affairs, through the NGO Bureau, halted the operations of Sexual Minorities Uganda (SMUG) over an allegation of non-compliance with laws and regulations governing non-governmental organizations (NGOs) in the country.[9] Investigations were also launched

[9] See: https://www.ngobureau.go.ug/~ngoburea/en/news-and-notices/statement-on-halting-the-operations-of-sexual-minorities-uganda. As of April 2022, efforts were continuing to resolve the areas of non-compliance and for SMUG to resume operations.

against other key population-led entities for similar irregularities. At the start of 2023, a private member's bill was introduced into the Ugandan Parliament proposing sweeping new restrictions and penalties regarding the expression of sexual diversity. Called the Anti-Homosexuality Bill, it was rapidly debated and, by April 2023, was passed by a majority of sitting Members of Parliament.[10] All of this has resulted in a new wave of heightened suspicion and growing negative action against key population communities and their allies, particularly the LGBT communities and those most closely associated with them.

The additional negative impacts of the legal context on progress to reduce human rights barriers is addressed throughout the findings of the assessment.

Effects of COVID-19

The Mid-term Assessment covered in detail the immediate impacts of the COVD-19 pandemic on programs to remove barriers, particularly as the country imposed strict lock-downs beginning in March 2020 and gave the Uganda Police Force (UPF) and the Uganda People's Defence Force (UPDF) the mandate to enforce them. During January-June 2021, some restrictions remained in place, particularly those related to public gatherings, including meetings, conferences and workshops. As a result, implementation of a number of planned activities was delayed until July 2021, when these remaining restrictions were removed. By November-December 2022, however, momentum had been regained and most implementers had fully recovered from any negative effects. What remained, however, were the lingering impacts of the significant increases in instances of violence and abuse against key populations during the period of more severe restrictions, as well as the exponential increase in incidence of GBV that a number of implementers under the *Breaking Down Barriers* initiative tracked, recorded and responded to.

3. Towards Comprehensiveness: Achievements and Gaps in Scope, Scale and Quality

The findings of the assessment are presented in the following sections, beginning with an overview of programs and investments to reduce human rights-related barriers to HIV, TB and malaria services.

3.1 Overview of investments and implementation arrangements

For the 2021-2023 period, in addition to its overall allocation of US$579 million for HIV, TB and malaria programs, Uganda received US$4.4 million in matching catalytic funds to scale up programs to reduce human rights-related barriers to HIV, TB and malaria services.

[10] On 29 May 2023, the Bill was signed into law by the President. See: https://www.monitor.co.ug/uganda/news/national/museveni-signs-tougher-anti-homosexuality-bill-into-law-4250416

Following grant-making and the signing of funding agreements, this amount was matched by an additional US$5.1 million (0.8% of the total allocation), bringing the total budgeted investment in programs to reduce barriers to US$9.5 million.[11] In addition, US$5.9 million was allocated to CSS interventions, a number of which included components to address human rights-related barriers in the HIV, TB and malaria contexts. This overall investment was substantive and represented the largest allocation to date for Uganda for such priorities.

A summary of the interventions included in this amount is shown below (**Table 1**) along with an indication of the division of funds between the two Principal Recipients (PRs): The AIDS Support Organisation (TASO), and the Ministry of Finance, Planning and Economic Development (MOFPED)/Ministry of Health (MOH).

Table 1: Summary of allocations by program area

Program Area	TASO	MoH	TOTAL	Percentage
Eliminate stigma and discrimination in all settings	842 048	1 054 037	1 896 085	23%
Improve legal literacy (“know your rights")	1 509 343	-	1 509 343	18%
Ensure non-discriminatory provision of health care	255 689	405 446	661 135	8%
Improve access to justice	657 268	-	657 268	8%
Ensure rights-based law enforcement practices	388 349	474 402	862 751	10%
Monitoring and reforming laws, regulations and polices relating to HIV and HIV/TB	1 169 684	263 457	1 433 141	17%
Reducing HIV-related gender discrimination, harmful gender norms and violence against women and girls in all their diversity	870 206	-	870 206	11%
Community mobilization and advocacy (HIV/TB)	199 662	1 317 748[12]	1 517 410	3%
Removing barriers to malaria services	-	99 907	99 907[13]	1%

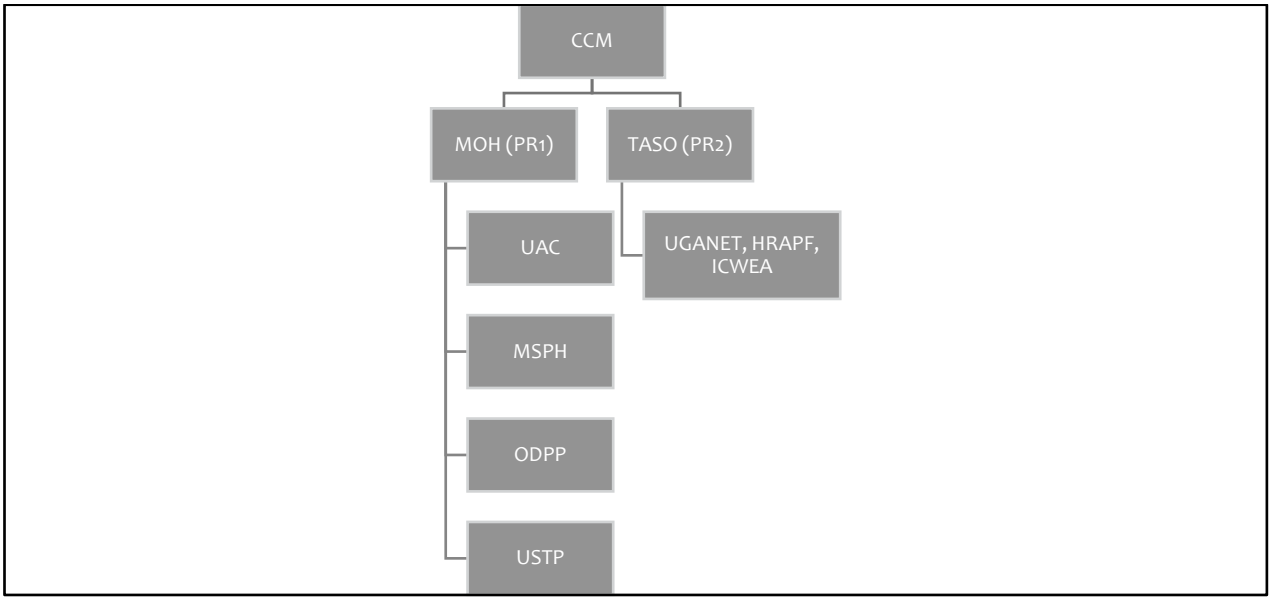
[11] The original grant submission included US$1,290,000 million for MoH salary support under the community mobilization and advocacy program area. An additional US$116,000 was included in the PAAR for HIV and TB for reducing barriers for MSM, sex workers, PWUD and transgender persons as integrated components of HIV prevention packages delivered through DICs. As of December 2022, these activities had not been shifted to the main allocation.
[12] See note 11 above.
[13] Interventions to address and remove human rights and equity barriers to malaria programmes were integrated under different modules, including Social and Behaviour Change (SBC), iCCM, and within CSS investments. Given this, the actual investment for malaria in programmes to reduce barriers would be greater if it were possible to disaggregate these other investments.

Total	**5 892 249**	**3 614 996**	**9 507 253**	**100%**
CSS Interventions				
Community-led monitoring	1,674,798	-	1,674,798	28%
Community-led advocacy and research	1,182,840	-	1,182,840	20%
Social mobilization, community linkages and coordination	3,122,232	-	3,122,232	52%
Total	**5,979,870**		**5,979,870**	**100%**

Of the funds for programs to reduce barriers, TASO was allocated 63% of the total to support non-governmental and civil society partners. The remaining proportion was allocated under the MoH to support public sector efforts to reduce barriers. Program areas for stigma and discrimination reduction, legal literacy and improving the legal environment received the most support across both PRs.

The implementation arrangements for programs to reduce barriers are shown below (**Figure 1**):

Figure 1: Implementation arrangements for programs to reduce barriers



UAC=Uganda AIDS Commission, MSPH=Makerere School of Public Health, ODPP=Office for the Directorate of Public Prosecution, USTP=Uganda Stop TB Partnership, UGANET=Uganda Network on Law, Ethics and HIV/AIDS, HRAPF=Human Rights Awareness and Promotion Forum, ICWEA=International Community of Women East Africa.

As part of these arrangements, UGANET, HRAPF, and ICWEA work as a consortium for the collaborative implementation of programs, with UGANET as the consortium lead.[14]

The program areas addressed by each implementer are summarized below (**Table 2**):

Table 2: Implementers and program areas

Implementer/ Program Area	MOH	TASO	UAC	MSPH	ODPP	UGANET	HRAPF	ICWEA	USTP
Eliminate stigma and discrimination in all settings	P	P	P	P	P	P	P	P	P
Improve legal literacy		P				P	P		
Ensure non-discriminatory provision of health care	P	P				P			P
Improve access to justice						P	P		
Ensure rights-based law enforcement practices					P	P	P		
Monitoring and reforming laws, regulations and polices relating to HIV and HIV/TB		P			P	P	P		P
Reducing HIV-related gender discrimination, harmful gender norms and violence against women and girls in all their diversity		P				P		P	
Community mobilization and advocacy (HIV/TB)	P	P							P
Removing barriers to malaria services	P								

As the table makes clear, different implementers worked within the same program areas. A workplan tracking measure was included in the TB grant for the MoH regarding conducting a TB gender assessment during 2021. For TASO, two measures were included: convening

[14]CSS interventions were implemented by ICWEA and two consortia: NAFOPHANU working with CEHURD and UHRN and MUCOBADI working with UNASO and CHAU.

of legal aid camps, and undertaking refresher trainings on health, human rights and gender equality for CSOs and networks.

4. Progress to Remove Barriers to HIV Services

Over the 2021-2022 assessment period, Uganda continued make progress to reduce human rights-related barriers to HIV services. For most program areas, there was a substantive scale-up of activities (an increase in outputs), largely as a result of the increased investment under the GC6 allocation, but also due to increased contributions from other funders and partners. A number of interventions undergoing scale-up were continuations from the previous grant cycle (2018-2020). Progress was less substantive or certain, however, with regard to whether these scaled-up interventions had reduced or removed human rights barriers (increase in outcomes), particularly given the emerging negative trends in the country context for some program areas; or whether the reduction of barriers improved access and uptake of services (emerging evidence of impacts). These changes are described in the detailed findings by program area set out below.[15]

4.1 Eliminate stigma and discrimination in all settings

Effectively addressing stigma and discrimination requires both evidence-based interventions and routine measurement processes. The elimination of stigma and discrimination in all settings is a program essential[16] and thus should be at the core of the national HIV response in Uganda. Global stakeholders have prioritized six settings for the elimination of HIV-related stigma and discrimination, including amongst individuals, households and communities; within health care, education, workplace, justice and legal systems; and in emergency and humanitarian settings.[17] Efforts to eliminate HIV-related stigma and discrimination in Uganda address all settings, but with varying degrees of focus and effectiveness. Uganda's commitment to eliminating stigma and discrimination is reflected in its participation in the Global Partnership for Action to Eliminate All Forms of HIV-Related Stigma and Discrimination (the Global Partnership). Interventions supported by the *Breaking Down Barriers* initiative contribute to Uganda's overall goals and commitments as part of the Global Partnership.

Uganda's progress to eliminate HIV-related stigma and discrimination in all settings is shown below:

[15] Starting with the GC7 funding cycle, the Global Fund introduced program essentials, defined as *"key evidence-based interventions and approaches identified by partners as being necessary for achieving the global goals of ending the three diseases as epidemics by 2030, and as such should be at the core of all national disease programs."* A number of program areas to reduce or remove human rights-related barriers are also considered to be program essentials. Where relevant, this is indicated in the findings.
[16] Global Fund Program Essentails are described on page 12 of the HIV Information Note
[17] See UNAIDS. 2020. *Evidence for eliminating HIV-related stigma and discrimination*. https://www.unaids.org/sites/default/files/media_asset/eliminating-discrimination-guidance_en.pdf.

Progress for eliminating stigma and discrimination in all settings

HIV program area	Score[18]		
	Baseline (2018)	Mid-term (2020)	Progress (2022)
Eliminate stigma and discrimination in all settings	3.0	3.6	4.0

Over the 2021-2022 period, Uganda continued to prioritize interventions to reduce HIV-related stigma and discrimination against PLHIV, building on and maintaining a number of interventions from the previous grant cycle and those supported by other partners. There was less emphasis on reducing stigma and discrimination against and key and priority populations, by comparison. As the overarching framework to guide the reduction of HIV-related stigma and discrimination, UAC in collaboration with NAFOPHANU continued to introduce and promote the *National Policy Guidelines on Ending Stigma and Discrimination* (see **Box 1**) at district levels, using the entry point of the District AIDS Committees (DACs) where these continued to function.[19] During these sessions, results of the 2019 PLHIV Stigma Index were presented and discussed, and district-level stakeholders were encouraged to identify priorities for HIV-related stigma and discrimination reduction and to propose action plans.

By 2022, the UAC stated that it had reached all 154 districts with the guidelines, using both the full and abridged versions. The policy guidelines were complemented by tools and materials including a "message book" covering different contexts (PLHIV, community members, health care providers, and religious and cultural leaders). A radio and television campaign took place between January and April 2022, using one-minute messages recorded by the President of Uganda. The campaign was estimated to have reached over 10 million Ugandans. However, in all of the tools and materials, including the media campaigns, there was little to no reflection of the diversity of PLHIV in Uganda. All activities were coordinated and monitored under the oversight of the multi-sectoral Technical Working Group (TWG) on Stigma and Discrimination convened by UAC on a quarterly basis. At the time when the progress assessment was under way, the TWG was finalizing a monitoring tool. Work was also underway to format the guidelines into an accessible version for persons with disabilities, and to translate them into relevant local languages.

[18] See **Annex A** for the interpretation of the scores.
[19] It should be noted that the *Policy Guidelines* contain no specific provisions for stigma and discrimination reduction against key populations (MSM, sex workers, transgender, people who use drugs, for example, although prisoners are included) in the HIV context, although some provisions (reducing sexual and gender-based violence) may nevertheless benefit these groups. Additionally, KPs are not included in the definitions of people living with or affected by HIV.

Box 1: Summary of National Policy Guidelines on Ending Stigma and Discrimination

Vision: A country where people living with or affected by HIV enjoy equal rights and privileges without stigma and discrimination

Goal: To eliminate all forms of stigma and discrimination towards people living with and affected by HIV and AIDS in Uganda

Objectives:

1. To provide an enabling environment for the elimination of all forms of HIV and AIDS-related stigma and discrimination in Uganda
2. To provide key stakeholders and the public with guidance on stigma and discrimination to enable them take appropriate actions to protect themselves and the communities against stigma and discrimination
3. To provide people living with and affected by HIV with the knowledge, skills, legal and social support they need, protect their rights and empower them on options for redress.
4. To improve access to and utilization of health and other services by people living with and affected by HIV, especially where there has been punitive laws, policies and practices which violate human rights.

Additional interventions to address stigma and discrimination are summarized below.

Description of activities/ interventions	Implementers	Location/Reach	Results (December 2022)
Deployment of 14 PLHIV as cadres in regions to monitor and address stigma in communities.	UGANET	Regions: Central, Western, South Western Eastern, West Nile, Northern, and Karamoja.	Results from an administered survey and the experience of cadres themselves showed that stigma and discrimination still affect PLHIV in communities (although to a lessening degree) and that more can be done collectively to reduce stigma, particularly for younger PLHIV as well as male PLHIV.
Regional dialogue meetings with youth leaders for their meaningful engagement in addressing HIV and TB-related stigma, discrimination and	ICWEA, NAFOPHANU, MUCOBADI, CEHAD, UHRN, UNASO, CHAU	53 “high-burden” districts	Dialogues were held engaging youth leaders throughout 2021-2022. Priorities were identified but with limited support for implementation. Dialogues were one-time events. There was no

violence within communities			consolidated tracking of results.
Engage and orient representatives of cultural, religious, and other leaders, and champions per region with facts and messages to address stigma and discrimination and gender barriers that relate to HIV, TB & malaria treatment outcomes.	ICWEA, NAFOPHANU, MUCOBADI, CEHAD, UHRN, UNASO, CHAU	53 “high-burden” districts	Regional meetings were held throughout 2021-2022 and would continue into 2023. Meeting reports indicated substantive engagement by participants. Priorities were identified but with follow-up support relying on participants themselves. There was no consolidating tracking of results.
Undertake a new PLHIV Stigma Index	MSPH, NAFOPHANU	Country-wide	By November 2022, the study was still in the development phase and is expected to be carried out in 2023.

A number of other interventions included components addressing stigma and discrimination, either directly or indirectly. The UKPC members, and MARPI and its partners continued to convene engagement meetings and dialogues in local communities, particularly where key population programs were operating, either through drop-in centres or through the efforts of key population-led CSOs. These sessions typically involved a range of local stakeholders, including politicians, traditional leaders, health care workers, the police and others. The main objective of these sessions was to create and sustain safe and enabling environments for PLHIV and key populations to access available services.

There were some limitations to many of the efforts that affected what they could achieve in terms of durable changes in the frequency and intensity of stigma, discrimination and violence, and in terms of inclusiveness of the full diversity of PLHIV and those at risk of these negative events, particularly key populations. The UAC stated, for example, that there were limited resources available at district and sub-district levels for stakeholders to act on the priorities they had identified for implementing the policy guidelines. In addition, resources were insufficient for the UAC to be able to fully popularize and promote the guidelines in locally friendly formats and languages. Other activities were similarly once-off, with limited to no resources available for follow-up engagements, or for local actors to undertake their own initiatives to reduce stigma and discrimination. This situation was reflected in the 2022

results of the Community Scorecard, where a number of respondents noted the very limited number of activities on stigma and discrimination reduction in communities.[20] While the existence of the UAC-convened TWG is an opportunity to more strongly coordinate and prioritize collective efforts to reduce stigma and discrimination, it was not yet functioning in this role at the time of the assessment.

Finally, it must be noted that, throughout the period of the assessment, sex workers, members of sexual minorities, PWUDs, people with disabilities, and members of other vulnerable populations (fisherfolk in some areas), continued to endure varying levels stigma, discrimination, violence and abuse. While representatives from these groups noted a decline in the frequency of such occurrences, including following the end of COVID-19 containment measures by mid-2021, individuals were still being affected, with growing evidence of escalation for some groups (sex workers, sexual minorities and PWUDs, for example). This included arbitrary arrests and detention, bribery and extortion, as well as verbal, physical and sexual violence and abuse. Much of this is fuelled by the unfavourable legal context, as the recently completed Legal Environmental Assessments (see **Section 2.2.6** below) have documented. Further progress to eliminated HIV-related stigma, discrimination and violence may be impeded until the legal environment becomes more enabling. With the enactment of the Anti-Homosexuality Act, such impediments will only increase for some groups.[21]

4.2 Ensure non-discriminatory provision of health care

As noted above, health care settings are one of the priority settings for the elimination of all forms of stigma and discrimination. The Global Fund has also identified it as programme essential for the countries where it invests. Health care provision should occur in settings that are welcoming, accepting, caring and supportive for all, including those at risk of and affected by HIV, in all their diversity. Health services wherever they are offered should be free from any form of stigma or discrimination based on health condition, ability, socio-economic status or any other individual or group characteristic. For Uganda, efforts continue to be made, through the MoH and by its many partners, including through key population-led CSOs in communities, to achieve and maintain non-discriminatory provision of HIV and other related health care services.

Uganda's progress to ensure non-discriminatory provision of health care is shown below:

Progress to ensure non-discriminatory provision of health care

HIV program area	Score

[20] See, UAC, TASO and Socio-Economic Data Centre (SEDC). 2022. Strengthening Health and Community Systems for Improved Access to Services: A Report on Development and Implementation of a Community Score Card for Community-Based Monitoring of Health Service Delivery in 53 Districts of Uganda. pp49-50.

[21] Although occurring after the period covered by the data collection for this assessment, HRAPF's recent report on human rights violations against sexual minorities for the period March-April 2023 gives a startling account of the escalation in violence and abuse against these individuals as well as organizations working to support their needs. See: https://hrapf.org/hrapfs-report-on-violations-against-lgbtqpersons-for-the-first-month-since-the-passing-of-the-anti-homosexuality-bill-2023/.

	Baseline (2018)	Mid-term (2020)	Progress (2022)
Ensure non-discriminatory provision of health care	2.0	2.3	2.6

During 2021-2022, the MoH continued to strengthen its role as the lead duty-bearer for the health sector and the primary stakeholder with the responsibility to ensure non-discriminatory provision of health services in all settings. This included updating existing tools and guidelines (the Patient's Charter) and developing new tools and resources to support capacity development of HCWs across all implementers (DIC guidelines, and a training guide for HCW's on safe and equitable workplaces).

Following a revision of the Patient's Charter in 2o21, the MoH continued to disseminate and promote it. By December 2022, three rounds of training-of-trainer workshops had been conducted reaching 113 health workers. In addition, facility-based mentorship in 26 districts had reached 680 health workers. These activities addressed the human rights-based approach (HRBA) to health service provision, the roles and responsibilities of health care workers in this context, and the specific requirements and accountabilities of the Patient's Charter. The participants were also oriented on the Equity Plan. For the workshops, a pre-post-test tool was used to gauge short-term knowledge improvements; however, no longer term measurement of change and improvement was undertaken other than collecting periodic, anecdotal accounts for Global Fund grant performance reporting. A limited investment from Global Fund, and a similarly limited availability of the MoH's own resources, meant that the geographic scope of this activity (approximately 32 districts in total out of 146) was itself confined and only a proportion of the country's health workforce (estimated at some 400,000 individuals across all cadres) was reached.

Other interventions aiming to build the capacity of health workers for non-discriminatory service provision are summarized below.

Summary of interventions to ensure non-discriminatory provision of health services

Description of activities/ interventions	Implementer(s)	Location/Reach	Results (December 2022)
Convening of community-level engagement activities with key local stakeholders (including HCWs) to create enabling and supportive environments for the provision of services.	ICWEA, NAFOPHANU, MUCOBADI, CEHAD, UHRN, UNASO, CHAU	53 “high burden” districts	District-level meetings were convened with local stakeholders, including HCWs. There was only limited support for follow-up actions and no comprehensive consolidation of the results of these sessions.

Facilitation of district-level accountability forums (including HCWs) for TB, malaria, HIV and human rights to share best practices for facility, district and national level action and response.	ICWEA, NAFOPHANU, MUCOBADI, CEHAD, UHRN, UNASO, CHAU	53 “high burden” districts	One-day sessions were convened with a variety of local stakeholders, including HCWs. There was only limited support for follow-up actions and no comprehensive consolidation of the results of these sessions.
Inclusion of HCWs in training and sensitization activities on reducing human rights-related barriers through legal aid camps.	UGANET, HRAPF	30 districts	508 HCWs were included in these activities.
Development and piloting of training materials of HCWs on human rights and medical ethics.	OHCRH	Kampala	This activity was supported by UNAIDS under the Global Partnership. The materials were validated and piloted at one workshop in 2021. No additional resources were available for production and dissemination.

A number of stakeholders, including the MoH, MARPI, members of UKPC, and PEPFAR-supported partners provided training and other support to HCW's for the provision of KP-friendly services in drop-in centers s, referral hospitals, and other health facilities. While these activities were not always monitored for quality, and for the extent or durability of changes that may have occurred, all used training materials that were designed and approved by the MoH As of November 2022, there were over 70 drop-in centers s operating in districts across Uganda giving an indication of the geographic scope of key population--friendly service provision. However, no specific data were compiled on locations and quantities of HCWs trained or otherwise supported for capacity development during the 2021-2022 period.

Beneficiary groups that participated in the assessment, including some HCWs themselves, note improvements in the accessibility and quality of HIV services, both for PLHIV generally and more specifically for KPs. This was an encouraging development over previous periods. However, some important gaps were noted. These included limited resources (financial and additional training materials) for follow-up support to cascade trainings on the Patient's Charter and the human rights-based approach , for example, once the initial training-of-trainers had been conducted. Rotation of HCWs meant that individuals who had been trained in key population-friendly service delivery were moved elsewhere and replaced with

colleagues without such knowledge or skills. Not all key populatoinss can access key population-friendly services and must rely on their local facilities where HCWs have not been trained or sensitized, particularly in rural and remote areas. As a result, instances of poor service as well as stigma and discrimination were still being reported.[22] In all settings, people with disabilities, (including PLHIV and key populations living with disabilities) remained significantly disadvantaged in terms of access to HIV services. Across all interventions, however, few if any links were made to monitoring or accountability mechanisms (community scorecards, or human rights monitoring tools, for example) to ensure that service quality improved and was maintained.

Finally, since 2018, equipping HCWs for provision of non-discriminatory health services has relied almost exclusively on in-service modalities (training workshops, mentorship visits). Limited to no progress has been made in the **pre-service setting**. Through support from Global Fund's Human Rights Strategic Initiative, a mapping process was started to identify training institutions and opportunities for strengthening and expanding this component of training curricula. The results were expected in 2023 and were meant to inform the development of an action plan, with a view to potentially including this in Uganda's GC7 submission. It is unlikely that the MoH or other stakeholders can ever reach a significant proportion of HCWs without also considering the pre-service environment and the engagement of relevant training institutions.

4.3 Ensure rights-based law enforcement practices

The aim of this program area in Uganda is to equip the different duty-bearers and stakeholders involved in law enforcement and the administration of justice to understand and carry out their roles and responsibilities in such a way as to contribute to, and not impede, the attainment of important public health goals within the context of the HRBA. This work is particularly meaningful in Uganda's context where there is ongoing tension between the legal framework and the goals and ambition of the national HIV, TB and malaria responses. Along with the government of Uganda and other funders and partners, the Global Fund has been an important source of investment in building the capacity of stakeholders across the law and justice sector to ensure that law enforcement practices change and evolve to the extent that they do not interfere with access, uptake and retention in HIV and TB services, as well as other related health services and interventions.

In this regard, mixed progress was achieved during the 2021-2022 period to ensure rights-based law enforcement practices. While there was some scale-up of interventions involving relevant stakeholders, there was more limited change in law enforcement practices themselves. This is shown below:

[22] See UAC, TASO and SEDC. 2022. p109. A number of instances of encounters with 'unfriendly health workers' are described.

Progress to ensure rights-based law enforcement practices

HIV program area	Score		
	Baseline (2018)	Mid-term (2020)	Progress (2022)
Ensure rights-based law enforcement practices	2.0	2.3	2.6

Summary of interventions to ensure rights-based law enforcement practices

Description of activities/ interventions	Implementers	Location/Reach	Results (December 2022)
Support the UPF to develop a comprehensive health policy to address HIV, TB, and malaria services across police services.	ODPP, UPF	N/A	A policy addressing UPF, UPS and ODPP was developed and was validated in December 2022. Roll-out was planned for 2023.
Ensure health screening on admission and effective referrals for appropriate HIV, TB, or malaria cases in all facilities.	ODPP, UPS	All prisons are to be included.	A policy was developed and pending validation in December 2022. Roll-out will commence in 2023.
Provide training to all prison workers on the revised policy, including specific interventions to ensure the commitment of top management to the revised policy.	ODPP, UPS	The intention is to reach all prisons.	Implementation will take place in 2023.
Expand the number of HIV/TB peer educators in prisons and equip them to provide basic legal literacy interventions.	ODPP, UPS	The intention is to reach all prisons.	A training manual was developed and pending validation in December 2022. Training for prison staff was to take place in 2023.
Develop and reproduce guidelines on the human rights-based approach to mitigate HIV, TB, and malaria-related barriers to	ODPP	NA	Guidelines were validated in December 2022. Dissemination was planned for 2023 along with the establishment of

service uptake across the criminal justice system.			an inter-agency monitoring committee.
Support training of judicial and law enforcement officers in the criminal justice system institutions on HIV, TB and malaria and human rights-based approaches.	ODPP, HRAPF	Tororo and Gulu Districts	Two training workshops were held, reaching 55 participants. No additional sessions took place due to budget constraints. HRAPF developed a training manual focussing on marginalization and LGBTI.
Support and strengthen the capacity of senior-level policy-makers across the criminal justice system on their role to promote human-rights.	ODPP	Kampala and Mbarara	Two capacity-building workshops with senior level officials with 50 participants. F0llow up activities were planned for 2023.
Conduct sensitization sessions for Parliamentarians and political office bearers on the legal, health and human rights aspects of HIV, TB and malaria.	ODPP, UGANET, HRAPF, USTP	Kampala and selected districts	One session was attempted. Parliamentarians were unable to participate due to COVID-related restrictions. Additional sessions are planned for 2023.
Strengthen linkages between CSOs and law enforcers.	HRAPF, UGANET	Six regions	By November 2022, 13 meetings had been convened, reaching 476 participants. No details were available on types of participants or follow-up results from these sessions.
Development of a Judicial Handbook on HIV and the Law	UGANET and the Judiciary	N/A	The handbook was released on World Human Rights Day in December 2021.

As the table indicates, ODPP was supported in implementing a number of interventions. Some, such as the training of judicial and law enforcement officers across the criminal justice system institutions on HIV, TB and malaria and the human rights-based approach, were continuations from the previous grant cycle and were scaled up starting in 2021. The

implementation of these training interventions was delayed until the final COVID-related restrictions were lifted in mid-2021. Other elements of ODPP's progress during the 2021-2022 period involved the development of guidelines, policies and training materials for the criminal justice stakeholders, particularly the Uganda Prisons Service (UPS) and the Uganda Police Force (UPF). These tools addressed HIV, TB and malaria and the roles and responsibilities of these stakeholders to contribute to and not impede the public health response based on the HRBA to health. These materials largely addressed individuals living with or at risk of these diseases as generic individuals. They did not address specific topics and issues for key populations, for example.

Other important stakeholders continued their work with judicial and law enforcement officers to build knowledge, capacity and commitment to rights-based law enforcement practices. UGANET and HRAPF both convened regional meetings to bring CSOs and law enforcement stakeholders together to discuss issues and challenges in the legal environment and the law enforcement practices that interfered with HIV- and TB-related public health goals, particularly for PLHIV and key populations. MARPI and its partners, including the MoH, also continued to work with law enforcement stakeholders in the districts where it supports drop-in centers. UKPC's members, particularly local-level key population-led CSOs, continued their sensitization and “bridge-building” efforts, whether or not they received specific funding to do this work. Finally, through the formation of the Equity Plan Steering Committee, in addition to ODPP, other law enforcement stakeholders, including UFP, UPS, and the Uganda People's Defence Force (UPDF) were included in meetings and events to build greater awareness and commitment to their collective roles under the Equity Plan to reduce or remove barriers inhibiting the progress of the national HIV, TB and malaria responses.

The extent to which these interventions achieved success can be gauged by the trends in arbitrary arrests and detentions and other problematic law enforcement practices that were documented over the 2021-2022 period. As noted elsewhere in this analysis, HRAPF, UGANET and UKPC, among others, recorded elevated instances of arbitrary arrests, detentions and other problematic practices in some districts and regions, indicating the amount of change that still needs to occur to achieve and sustain rights-based law enforcement practices in the context of HIV, TB and other health priorities for Uganda. A common concern was the extent of rotation of police officers, for example, and the need to repeat engagement and sensitization activities when new individuals arrived. There was weak coordination and coherence between implementers in terms of the content of training and engagement, and with regards to ensuring adequate coverage to reach a critical mass of stakeholders (see **Box 2**).

Box 2-Lack of coherence: "When *we look at examples, at ODPP they are training police officers, we are training police officers, but nowhere are we meeting. What is the content that ODPP is training police on key population issues? And what is the content the HRAPF is training police officers on key population issues?"* **--Key informant**

Finally, as with other program areas, there was only limited progress in terms of “upstream” efforts to change institutional practices and to increase ownership and accountability among law enforcement stakeholders themselves to protect and promote human-rights-based approaches. The gap in the materials developed and rolled out by ODPP on issues of diversity reflects a significant missed opportunity in this regard. Progress will be difficult to sustain in the absence of these commitments and actions among the duty-bearers themselves. The enactment of the Anti-Homosexuality Act will further complicate or impede any additional progress in this area for some groups.

4.4 Improve legal literacy ("know your rights")

Promoting legal literacy amongst PLHIV and KPs is an ongoing priority for the national HIV response in Uganda. It is also a program essential under the Global Fund. Different partners and funders have contributed to supporting legal literacy over time. Through the additional resources under GC6, and investments from other funders, this activity increased in scale and reach during the 2021-2022 period. For example, HRAPF and UGANET jointly implemented activities through different modalities to teach individuals and organizations how to understand and protect their human rights to be free from stigma, discrimination and violence, and to have unimpeded access to HIV and other health services that are available, acceptable, affordable, and of high quality. Other implementers (such as the ICWEA, MARPI, ODPP, and UKPC and its CSO members, among others) worked in communities to promote and sustain human rights literacy, using both Global Fund and other resources. These investments and interventions occurred during a period where there were elevated levels of human and legal rights violations in some locations and for some key population constituencies, particularly sex workers, PWUD and sexual minority individuals. In many instances, these violations occurred in relation to COVID-19 containment measures and the use of violent and arbitrary measures to enforce lockdown provisions or to address other suspected violations such as illegal gatherings.[23]

Progress to improve legal literacy

HIV program area	Score		
	Baseline (2018)	Mid-term (2020)	Progress (2022)
Legal literacy	2.0	2.3	3.3

[23] See, for example, HRAPF. 2021. The Impact of Covid-19 Related Restrictions on Access to Justice for Key Populations In Uganda: A Case Study of LGBT Persons and Sex Workers in Kampala and Wakiso Districts.

Summary of interventions to improve legal literacy

Description of activities/ interventions	Implementers	Location/Reach	Results (December 2022)
Train and deploy community-based paralegals drawn from networks of key populations, PLHIVs, adolescent girls and young women (AGYW) and people affected by TB to provide legal information, support, and referrals.	HRAPF, UGANET	53 “high-burden” districts	166 paralegals were initially trained and deployed. UGANET reported that paralegals assisted 2,024 individuals and sensitized a further 18,000 on human rights-related topics (HRAPF did not track these numbers).
Strengthen the technical and operational capacity of PLHIV and key population networks and CSOs to ensure safety and security of information, staff, members, and volunteers.	HRAPF, UGANET, UKPC	12 districts	HRAPF developed a pamphlet and used this as the basis for 12 regional workshops, reaching 384 participants. UGANET collaborated with UKPC to design a five-day intensive training for organizations, using a safety and security toolkit modeled on FHI360 tools. By 2023, 40 key population-led CSOs had received the training and developed safety and security plans. Follow-up support was ongoing.
Develop, roll out and maintain community-level reporting tools and processes for documenting and responding to human rights violations.	HRAPF, UGANET, ICWEA	39 districts	By December 2022, HRAPF had finalized an electronic version of the REAct tool (originally designed by SMUG) and was providing training to CSOs and community monitors. UGANET developed its own (paper-based) monitoring and reporting tool which was rolled out in 55 districts. The revision to the community scorecard tool was ongoing. UKPC, HRAPF and UGANET are currently

			exploring an option of jointly developing a web-based human rights reporting system for key populations.
Revitalize and support District Human Rights Committees (DHRCs) to hold quarterly meetings and biannual dialogue sessions.	UGANET	56 districts	DHRCs in 56 districts were initially revitalized. By November 2022, DHRCs were functioning and biannual dialogues had been conducted. A standing item for DHRC meetings was reviewing reports of human rights violations and tracking responses.

To promote and sustain legal literacy in communities, UGANET and HRAPF engaged community paralegals. In addition to responding to individual cases, paralegals undertook outreach activities to promote legal and human rights literacy. Training materials and other tools were updated by both entities during 2021. Local CSOs and individuals participating in the progress assessment noted the positive contribution of the paralegals in communities, both as front-line responders when legal or human rights violations arose, but also as mobilizers and advocates for greater knowledge and awareness about legal and human rights among PLHIV and key populations in communities.

Another component of this program area involved equipping individuals in communities to document and respond to human rights violations. Similar mechanisms have been in place in Uganda prior to 2021, utilising the Frontline AIDS REAct system, for example, and both HRAPF and SMUG had produced annual reports on the nature and extent of human rights violations in communities. Starting in 2021, additional investments from the Global Fund enabled a scaling-up of this activity, although progress was slower than originally planned. UGANET developed a new reporting tool and had deployed it in 53 districts by 2022. UGANET linked the roll-out of the reporting tool to the revitalization of DHRCs. The DRHCs are part of local government structures but do not function due to lack of resources. UGANET, using Global Fund resources, was able to revive these structures (largely through supporting the participation of five civil society members on the ten-member platform). A standing item for these committees was monitoring and addressing human rights-related priorities, including individual human rights violations where relevant. The piloting of the community reporting tool was also an opportunity to combine human rights literacy with empowering communities to monitor and report human rights violations. Using an alternative approach, HRAPF adopted the REAct tool in an electronic reporting format. By November 2022, it had begun training monitors on the electronic system (previously, REAct had operated as a paper-based system). By the end of 2022, preliminary discussions were underway between TASO, UGANET, HRAPF, UKPC and the Equity Plan Secretariat to

create a digital reporting system and consolidated data repository utilising the same open-source software as the DHIS2 system in Uganda. This has the potential to digitize and consolidate a number of reporting tools and processes, including community scorecards and community reporting of human rights violations.

Investments to improve the capacities of implementers of HIV and key population programs for safety and security were prioritized during 2021-2022. These investments drew from a rapid assessment of safety and security capacities and practices for CSOs that was undertaken in 2020 following an increase in security threats. HRAPF, UGANET and UKPC subsequently collaborated to design and deliver capacity-building interventions for improving safety and security systems and responses at organizational and individual levels. Different approaches were used. HRAPF developed a pamphlet and conducted regional workshops. UGANET and UKPC undertook in-depth capacity-building workshops using a safety and security toolkit (adapted from an FHI360/Frontline AIDS model) and providing follow-up support for implementation of policies and action plans designed during the workshop. An important challenge for a number of CSOs was a lack of funding to address identified safety and security gaps. Finally, a number of implementers continued to integrate human rights literacy into their activities. Key population-led CSOs under UKPC, for example, routinely implemented human rights literacy activities whether or not they had specific funding. Some used innovative modalities, including one individual that hosted a weekly chat session on WhatsApp, where he addressed topics related to human rights for PWUDs in his community.

Implementers encountered some challenges to derive maximum benefit from these interventions and investments. The support and supervision requirements were inadequate for the number of paralegals recruited and deployed, meaning that productivity and accountability could vary from one individual or one time period to the next. Paralegals themselves noted that the low level of facilitation and late payment of allowances affected their motivation or their ability to perform their roles. While the expansion of community-based reporting and engagement on human rights violations was a positive move, there was no common approach and no pathway toward developing a country-wide approach that would allow for consolidating national reporting and analysis (the development of the digital repository will, hopefully, address this). Legal literacy interventions have been repeated over different implementation periods and although there may be a need for ongoing efforts as key populatoin communities evolve, there is no monitoring process for measuring the quality or outcomes of this work (see **Box 3**).

Box 3--The need for a theory of change: *"Maybe these interventions are leading to changes, but who is capturing those changes? Who is documenting them? Who is consolidating this information? Are they having it linked to the support that Global Fund gives? So, for me, that is still the missing link. That thing of developing a theory of change, and developing indicators, that one is very important. Because even these interventions that my colleagues are explaining, they are already leading to some changes. But who is concretely documenting these changes?"*--**Key informant**

There was little to no investment or attention for institutionalizing legal literacy, either within key population CSOs or as part of comprehensive key population services. While UGANET's efforts to revitalize the DHRCs was important, there was no planning as to how these government-mandated structures would or could operate independent of Global Fund support.

4.5 Improve access to justice

Similar to legal literacy interventions, supporting access to justice for PLHIV and members of key and vulnerable populations also continues to be a core component of the national response to HIV in Uganda. It too is a program essential. The Global Fund has supported access to justice interventions through a number of grant cycles along with other donors and partners. It represents one of its more significant investments given that it aims to ensure that individuals in Uganda who experience legal and human rights challenges have access to locally available, timely and high-quality legal representation and support. As long as the legal and socio-cultural environment continues to pose human rights-related risks to access and uptake of HIV services in Uganda, interventions to ensure access to justice for affected individuals and communities will remain critical.

Current progress to improve access to justice in Uganda is shown below:

Progress to improve access to justice

HIV program area	Score		
	Baseline (2018)	Mid-term (2020)	Progress (2022)
Improve access to justice (HIV-related legal services)	2.0	3.0	3.6

Summary of interventions to improve access to justice

Description of activities/ interventions	Implementers	Location/Reach	Results (December 2022)
Provide legal services to PLHIV, key populations and vulnerable groups through different modalities, including a call center, legal aid camps, and direct legal services.	HRAPF, UGANET	Country-wide through paralegals linked to centrally and regionally based legal aid lawyers from HRAPF and UGANET.	By November 2022, UGANET conducted 29 legal aid camps for PLHIV and individuals affected by HIV or TB. A total of 1,188 cases were registered as a result of the camps. An additional 480 individuals were assisted through the call center or by staff lawyers. Over the same period, HRAPF conducted 17 legal aid camps specifically for key populations and recorded 650 participants. Through these camps and through direct referrals from communities, HRAPF had provided legal assistance to 744 individuals.
Expand the network of lawyers capable of providing legal services to PLHIV, key populations and vulnerable groups.	HRAPF, UGANET	Kampala	A total of 12 training session were held, reaching 274 lawyers. UGANET collaborated with the Uganda Law Society to deliver three of these trainings.
Train registered legal aid service providers to assist PLHIV, key populations and vulnerable groups.	HRAPF, UGANET	Kampala	A total of five sessions were convened, reaching 133 legal aid service providers.
Train and sensitize court mediators on topics related to HIV, human rights and key populations.	HRAPF, UGANET	18 districts	HRAPF was able to train 620 mediators through 18 sessions. UGANET used a combination of training and monthly coordination/ mentorship calls (using Zoom). Through 11 different activities, 310 mediators were engaged.

Engage in strategic litigation.	HRAPF, UGANET	N/A	UGANET convened consultation sessions with senior litigators to undertake research into potential cases. Two possibilities were identified by December 2022.
Monitor and evaluate the quality of legal services for PLHIV, key populations and vulnerable groups.	HRAPF, UGANET	Kampala	Different modalities were used. HRAPF held quarterly meetings with CSOs to gain feedback on the quality of their services. UGANET developed a tool for monitoring and evaluating the quality of legal aid services for PLHIV, key populations and vulnerable groups. Training of the data collectors is scheduled to start in 2023.
Convene circuit courts to review and resolve cases involving HIV, TB or malaria.	ODPP	Bututumula prison in Luweero district and Maruk Prison in Mbale District.	Two circuit sessions were held. In addition to providing access to legal services, this activity had a built-in component of sensitizing inmates on HIV, TB and human rights issues which reached a total of 206 inmates, 51 in Bututumula and 151 in Maruk prisons.

Overall, this program area was able to integrate training of lawyers, paralegals, and community leaders within the overall aim of scaling up access to legal services to address and prevent legal and human rights violations. A number of interventions had interlinked objectives. For example, mobile legal aid camps provided legal services and also promoted legal and human rights literacy. Circuit court sessions assisted inmates in resolving cases while also providing information to others on HIV and TB in prisons. Finally, community paralegals worked as "front-line responders" to identify individuals in need of assistance and to link them to legal service providers through HRAPF or UGANET (see **Box 4**).[24]

[24] Recognizing the importance of paralegals in communities, HRAFP offers an annual scholarship for a community paralegal to complete a diploma in law and paralegal services through the Uganda Law Society.

Box 4-Building community capacities and linkages through paralegals: *"For example, if a case happens somewhere, we shall be connected to that case through a community paralegal attached to a community organization in that area. And when we do legal aid camps, the community organizations are the ones that organize the legal aid camps. And they invite community members [to attend] through those organizations. If a case happens, for example, in Mbara, there's a community paralegal attached to that organization that the lawyers will contact and then do the preliminary assessment before they can come in. We are only connected through those community organizations."**--Key informant***

Since 2021, investments in the provision of legal services, as one component of access to justice, have been sustained and scaled up allowing more individuals opportunities to know about the legal system in Uganda and the protections it is meant to provide, although these protections are sometimes limited (See **Box 5**).

UGANET, HRAPF and ODPP were the main implementers of interventions under *Breaking Down Barriers* to improve access to justice over the 2021-2022 period. Other funders and implementers also aim to provide access to justice support, but not to the same level of coverage or comprehensiveness.[25] As in previous periods, UGANET and HRAPF have shared the provision of HIV-related legal services with UGANET, focusing mostly on cases involving PLHIV and vulnerable women (inheritance, GBV, property ownership, for example) while HRAPF primarily responded to the needs of key populations (sex workers, MSM and PWUD for the most part, but with emerging coverage for transgender and intersex individuals). Both implementers reported high volumes over the 2021-2022 period.[26] For part of 2021, COVID-19 restrictions remained in place, escalating the frequency of GBV as well as harassment and abuse of all key populations, but particularly sex workers and PWUD. By the end of 2022, there were some important developments with a ruling made by the Constitutional Court that “rogue and vagabond” provisions of the penal code were unconstitutional, primarily for their vagueness as statutes and because of the inability to apply them in a clear and consistent manner. It was just these provisions that were most frequently used to arrest street-based sex workers, for example, or PWUD.

Within the administration of justice, Uganda places an emphasis on mediation and alternative dispute resolution. Given the important of this function, both HRAPF and UGANET worked with court mediators to sensitize and equip them with knowledge on HIV and TB-related topics relevant to their functions. UGANET also organized follow-up virtual mentoring and networking activities on a periodic basis. ODPP continued to work with public prosecutors by providing training opportunities to create greater awareness of the public health implications of their work. While circuit courts are a routine part of the administration of justice in Uganda, Global Fund resources helped to increase their frequency and to focus specific sessions around HIV and TB-related priorities. A number of inmates affected by HIV

[25] These included OSIEA, the EU, Aidsfonds and others.
[26] See, for example, HRAPF's Uganda Report on Human Rights Violations Based on Sexual Orientation and Gender Identity 2021, available at: https://hrapf.org/other-publications/. See also HRAPF's.

and TB were able to earn early release and, overall, this activity contributed to reducing the congestion in some facilities. There is the intention to have additional sessions as the implementation of the grant proceeds during 2023. Finally, some new resources were made available in 2021. With support from UNAIDS through the Global Partnership, the Women's Pro-bono Initiative developed and released a toolkit on the provision of HIV-related legal services.

Some challenges and limitations arose for implementers under this program area. Demand for legal support far exceeds available resources, both in terms of lawyers' availability and the available budgets, according to key informants. Clearly it was difficult to predict what the level of demand would be. While implementers reported some details on the characteristics of the individuals they assisted and the nature of the legal support they required, this was not done in a comprehensive manner to enable any overall tracking and analysis, or to provide a mechanism for quality assurance. It was not clear, for example, how cases linked to reducing human rights barriers to services were prioritized over other legal needs. Activities such as legal aid camps and circuit courts were implemented independently without a closer collaboration among stakeholders (ODPP was not routinely engaged in legal aid camps, for example, nor were UGANET or HRAPF engaged in circuit courts). There was no clear follow-up plan to support newly trained lawyers to become involved in HIV and human rights issues and to build their caseload accordingly. Similarly, although UGANET convened follow-up session with mediators, it was not clear what these achieved in terms of monitoring and quality assurance. Planned activities to monitor the quality and comprehensiveness of legal service provision were not fully implemented (although some will still be implemented in 2023).

While legal support services have become very responsive in Uganda, more “upstream” efforts to prevent legal issues from arising (prevent arbitrary arrest and detention, for example) have not moved forward at the same pace. Both HRAPF and UGANET held routine meetings with different stakeholders to assess opportunities for strategic ligation as one upstream pathway. While ODPP's aim was to have a critical mass of criminal justice stakeholders, including prosecutors, who could understand and be sensitive to the public health implications of their work, this was not clearly defined and there was no monitoring and accountability mechanism in place (at the time of the assessment) to measure the extent to which such progress was being achieved. Some key population-led CSOs and networks raised the issue of delays in legal support and limited investment in building local connections and capacities. They highlighted the risks involved when legal support is delayed and key populations are kept in holding cells where they face a high risk of violence and abuse. Implementers raised a number of concerns regarding the financing and monitoring of access-to-justice interventions. Grant agreements set monthly and quarterly targets for cases resolved without being sensitive to the fact that some legal interventions require different amounts of time and resources to successfully complete, depending on the type of case and its complexity.

4.6 Improve laws, regulations and policies related to HIV and HIV/TB

Creating an enabling law and policy environment is one of the core pillars of the national HIV response in Uganda. In 2022, two legal environment assessments were completed, one addressing HIV and one focused on key populations (it was not clear from stakeholders why this approach was used). They found that although efforts had been made to improve the law and policy environment, key barriers remained for the HIV response overall (see **Box 6**), and for key populations more specifically (see **Box 7**).

Box 6-Findings of the legal environment assessment for HIV: There is a contradiction between laws and policies. While Uganda's HIV-related policies are largely progressive, enabling service delivery and access to all, the effect of the punitive laws (including sections 13, 18 and 41 of the HIV Prevention and Control Act) is that those who suspect they may be HIV-positive may fear to test, and those who test positive for HIV may hesitate to disclose their status to their partners for fear of being accused of transmitting HIV or of losing their relationship or their livelihood. As a result, they may choose not to disclose their HIV status, enroll for treatment, or maintain their care regimen. Indeed, such persons may have no choice but to avoid treatment and other HIV services, if that is the surest way to safeguard their relationships and their sources of livelihood in the short- and medium-term. **General Conclusion:** While Uganda has laws and many policies that provide for non-discrimination and equality in access to services, as detailed above, some of punitive and restrictive clauses in various laws effectively discriminate against some categories of vulnerable and at-risk populations, thus creating barriers to access to services. Therefore, it is critical that they are reviewed, amended or repealed and adequate protective laws are enacted, implemented and enforced in Uganda.

Key components of an effective approach to monitoring and reforming laws and policies include recently completed legal environment assessments; a coordinated multi-sectoral action to address the findings and to reduce or remove law or policy-related barriers; coordinated and sustained engagements with Parliamentarians; coordinated and sustained community mobilization and advocacy; and ongoing monitoring and review. All of these components are in place in Uganda, but they do not yet function optimally to address and remove critical law and policy-related barriers.

Box 7-Findings and conclusion of the legal environment assessment for key populations: It was established that several laws and policies exist through which important steps have been taken to protect human rights in Uganda. It was found that the key human rights issues include the right to equality and freedom from discrimination; the right to health; access to justice; the freedom from torture, cruel and inhuman treatment; the right to work; the right to privacy, confidentiality and informed consent. It was clear that whereas these rights were established in law, their enforcement was weak. It was clear that the rights of key populations were rarely respected when in conflict with the law. Mostly, law enforcement officers especially the police did not appreciate the rights of key populations and often branded them as criminals outright. The field interactions revealed that a lot more needed to be done to enhance the rights of key populations. Moreover, those living with HIV required additional measures to be effectively protected from violations within the criminal justice system. **General Conclusion:** Punitive laws contribute significantly to human rights-related barriers to HIV services, stigma and discrimination of key populations. Therefore, it is critical that these be reviewed, amended or repealed and that adequate protective laws be enacted, implemented and enforced in Uganda.

Progress to improve laws, regulations and policies related to HIV and HIV/TB

HIV program area	Score		
	Baseline (2018)	Mid-term (2020)	Progress (2022)
Monitoring and reforming laws and policies	1.0	1.0	2.0

Summary of interventions to improve laws, regulations and policies

Description of activities/ interventions	Implementers	Location/Reach	Results (December 2022)
Engage Parliamentarians on policy and law reform, including amendments to the HIV/AIDS Control and Prevention Act, section 129 and to table briefs on the problematic sections of the Sexual Offenses Bill.	ODPP, HRAPF, UGANET, UAC, UKPC and others.	National	COVID-19 restriction prevented direct engagement with Parliamentarians. However, a number of submission and other interventions were made. Further progress is planned for 2023. Through the Equity Plan Steering Committee, the Uganda Law Reform Commission will also be engaged.

Support district councils and sub-county councils to develop and pass ordinances and bylaws to end violation of human rights among key populations.	HRAPF	Six municipal councils were initially approached: Kasese, Jinja, Mbara, Fort Portal, Arua, and Gulu.	Three councils were preparing drafts with support for HRAPF. Kasese Municipality was furthest along, with a draft pending additional review and potential adoption. However, the process was suspended in early 2023.[27]
Develop a scorecard as an accountability tool for monitoring the utilization and impact of all relevant laws, regulations, policies, and guidelines.	UGANET	National	Only limited progress was made. The activity was not sufficiently resourced to achieve its intended outputs/outcomes.
Develop advocacy agendas and materials for law and policy review and reform.	UGANET, HRAPF	National	Most efforts were directed towards the Sexual Offences Bill in 2021.

Over the 2021-2022 period, the legal and policy context for HIV in Uganda remained complex, particularly for key populations and PLHIV. Criminal provisions regarding sexual minorities, aspects of sex work, drug use, and the "wilful" transmission of HIV remained in place. These helped sustain a "permissive" atmosphere where key populations were harassed and abused in local communities, including by the police, and where the public discourse continued to vilify and exclude such individuals and groups. In May 2021, the Uganda Parliament passed the Sexual Offences Bill of 2019 which aimed, among other objectives, to further criminalize sex work and same-sex sexual relations (these were in addition to existing provisions within the penal code). This occurred despite the tremendous efforts of many stakeholders to persuade Parliamentarians and others of the looming harms to the HIV response that could ensue.[28] After a period of uncertainty, the Presidency returned the Bill to the national assembly for further review.[29] As already noted, in 2023, a new Anti-Homosexuality Bill was introduced and by March 2023 had been debated and approved by Parliament (a slightly amended version was subsequently signed into law in May 2023). These processes highlighted how certain populations remain controversial in the country despite the MoH's ongoing assurances that such legislative efforts should not

[27] Implementation was temporarily suspended after a negative intervention by the Deputy Speaker of the National Assembly in January 2023 suggesting that the proposed by-law for Kasese was ultra vires and contrary to the Laws of Uganda. He demanded that HRAPF's support of the council be investigated
[28] See, for example, Nakkazi, E. (2021). *Uganda's Sexual Offences Bill—a step backwards. The Lancet Infectious Diseases, 21(7), 920.*
[29] See: https://www.parliament.go.ug/news/5200/president-defers-signing-sexual-offences-succession-bills

interfere with access to HIV and other health services for all Ugandans that need them, regardless of their personal or social characteristics.[30]

Further progress was also limited by how interventions to engage Parliamentarians, for example, were implemented independently with limited coordination or coherence between implementers. This could reduce their effectiveness, particularly when it involved shared challenges, such as the Sexual Offences Bill, the Anti-Homosexuality Act, or seeking amendments to the HIV Prevention and Control Act. While different stakeholders have a bold ambition for comprehensive law and policy change, including decriminalization, there was little information or evidence on how this would be approached in a coordinated, multi-phased plan, for example, such as is needed for decriminalization. The results of the legal environment assessments should provide a blueprint for improving coordination and coherence of efforts to anticipate and respond to rapid changes in the law and policy context. The Equity Plan Steering Committee should provide the platform and coordinating mechanism for these efforts.

4.7 Reduce HIV-related gender discrimination

As noted above, the gendered dimensions of the HIV epidemic in Uganda remain complex and unresolved. The elevated HIV incidence among all adult women is an indicator of the limitations of the country's efforts to address and reverse the vulnerability of all women and girls in Uganda to HIV infection. While comprehensive, cross-cutting efforts are made to address gender-related discrimination and inequalities in the context of HIV (and for health more generally), progress to achieve durable change is in need of acceleration.

Progress to reduce HIV-related gender discrimination

HIV program area	Score		
	Baseline (2018)	Mid-term (2020)	Progress (2022)
Reducing HIV-related gender discrimination	2.0	2.0	3.0

Summary of interventions to reduce HIV-related gender discrimination

Description of activities/ interventions	Implementers	Location/Reach	Results (December 2022)
Strengthened the capacity of networks and CSOs to undertake community-led campaigns to promote gender	ICWEA	21 districts	Eleven regional meetings were conducted in 2021, reaching 232 participants. One

[30] In March 2023, with the passage of the Anti-Homosexuality Bill, the MOH was rapidly preparing new guidance on provision of health services to sexual minorities, particularly given provisions within the Bill requiring HCWs to report individuals suspected of engaging in same-sex behaviour to the police or to face penalties.

equality consultative and capacity-building engagements in districts to promote gender equality.			national meeting was convened to share and validate results.
Training of advocacy champions, particularly adolescent girls and young women (AGYW) and key populations	UGANET, HRAPF, ICWEA, NAFOPHANU, MUCOBADI, CEHAD, UHRN, UNASO, CHAU	53 “high burden” districts.	Sessions were held with advocacy champions throughout 2022. There was no disaggregation available of the characteristics of the champions. There was no comprehensive reporting of the activities of the champions following the training.
Scale up CSO-led legal literacy and advocacy interventions addressing GBV.	UGANET	Intent is national coverage.	By December 2022, one quarterly meeting had been held in which at least 38 of the 240 targeted participants attended the meeting to identify issues.
Integrate gender issues into community scorecard and roll out revised scorecard.	ICWEA, NAFOPHANU, MUCOBADI, CEHAD, UHRN, UNASO, CHAU	53 “high-burden” districts	By November 2022, the scorecard tool had been revised to include more indicators on HIV-related gender priorities. Training was underway on the new tool. Some districts had also started data collection.
GBV hotline and establishment of temporary shelters for GBV survivors and their children (using C19RM resources).	UGANET	Hotline (national), Shelter (Kampala)	By December 2022, the shelter in Kampala had supported 195 adults and children.

Within the context of *Breaking Down Barriers*, specific interventions focused on reducing HIV-related gender discrimination were limited. Once ICWEA completed the capacity-building workshops in 2021, for example, there were no follow-on interventions included in the program area to know to what extent capacities were improved and gender-related barriers addressed.

Under TASO, a cadre of GBV champions was supported to work in communities to assist individuals to come forward and to support them through the processes of seeking care and support, as well as to seek legal redress (the work of these individuals is described in detail in **Section 3.2** below). Gender was a component of interventions in other program areas. Through legal aid camps, the call center and the work of paralegals, both UGANET and HRAPF addressed a number of gender-related legal concerns, including those related to key populations. Gender was a component of the different sensitization trainings and community dialogues. Concepts of gender and gender-diversity were included in HCW training for providing key population-friendly services. However, overall, according to a number of key informants, the activities that were supported under this program area were not sufficiently resourced to achieve a level of comprehensiveness to potentially achieve and sustain significant change. As noted previously, the planned PLHIV Stigma Index in 2023 may provide some information on the extent to which women living HIV experience challenges because of their gender.

4.8 Support community mobilization and engagement

Community mobilization around human rights has been central to the HIV response in Uganda since the response began. With the creation of TASO in 1987, the country was an early leader in Africa and globally for the central role that communities, and particularly PLHIV, have played to empower themselves to drive the response to HIV. In spite of the challenging country context, key population constituencies in Uganda have also shown leadership in their continual efforts towards empowerment and the extraordinary resilience they demonstrate. During 2021-2022, stakeholders undertaking community mobilization and empowerment interventions benefitted from substantially increased levels of support, particularly through the CSS interventions, and through investment by other funders (such as Hivos and PEPFAR, among others).

Current progress for community mobilization and engagement for the protection and promotion of human rights and gender equality in the context of HIV (and to a more limited extent TB and malaria) is shown below.

Progress to support community mobilization and engagement

HIV program area	Score		
	Baseline (2018)	Mid-term (2020)	Progress (2022)
Support community mobilization and engagement	*	*	3.6

A number of implementers undertook interventions to mobilize communities. Some of these were specific to the promotion and protection of human rights, others incorporated aspects

of this within broader intervention designs. Important examples of both these approaches are summarized below.

Summary of interventions to support community mobilization and engagement

Description of activities/ interventions	Implementers	Location/Reach	Results (December 2022)
Facilitation of district-level accountability meetings for TB, malaria, HIV and human rights to share best practices for facility, district and national level response and action.	ICWEA, NAFOPHANU, MUCOBADI, CEHAD, UHRN, UNASO, CHAU	53 “high burden” districts	By December 2022, at least one round of meetings had been conducted in all districts. Meetings typically had 30-40 participants.
Advocacy skills development for ten CSO representatives in high-burden districts.	ICWEA, NAFOPHANU, MUCOBADI, CEHAD, UHRN, UNASO, CHAU	53 “high burden” districts	Trainings were conducted at the regional level. As ICWEA noted: "These individuals act as our eyes and ears on ground and are now leading advocacy activities in districts."
Conduct quarterly community sensitization/dialogue meetings to create awareness on HIV, TB and malaria for improved HIV treatment adherence and follow-up.	ICWEA, NAFOPHANU, MUCOBADI, CEHAD, UHRN, UNASO, CHAU	53 “high burden” districts	By December 2022, multiple rounds of dialogues (two or more) had been conducted in all districts. These typically engaged 20-30 participants.
Support districts to hold quarterly coordination meetings.	ICWEA, NAFOPHANU, MUCOBADI, CEHAD, UHRN, UNASO, CHAU	53 “high burden” districts	By December 2022, multiple rounds of coordination meetings (two or more) had been conducted in all districts.
Mentor and empower community advocates to deepen and sustain district-level social mobilization around HIV, TB and malaria	ICWEA, NAFOPHANU, MUCOBADI, CEHAD, UHRN, UNASO, CHAU	53 “high burden” districts	[No consolidated data were available.]

The table is indicative of the range and coverage of interventions for community engagement, particularly for Uganda's 53 high-burden districts. In reports and action plans emanating from the community dialogues, sensitization sessions, coordination meetings, and accountability meetings, a number of human rights-related issues were tabled by community participants, particularly for PLHIV, people affected by TB, people with disabilities (in some cases), and key populations. The issues raised included ongoing stigma and discrimination in a variety of forms and contexts (within families and local communities, and amongst HCWs); misinformation and misunderstanding about HIV (including HIV prevention); abuses from police or local religions and cultural authorities; the non-inclusion of people with disabilities; challenges for reliable supplies of prevention commodities (condoms and lubricants), and, in some districts, stock outs of medications (but not ARVs). These sessions were also attended by “duty-bearers”, including local- and district-level government officials, HCWs, police, teachers and others. The sessions were opportunities for open engagement among community members on issues of common concern. They filled gaps for other coordination structures (such as DACs) that were no longer functioning in many locations. They drew attention to the need for continuous engagement on HIV, TB and malaria needs and concerns that were not being adequately addressed by other stakeholders.

Although the scale and volume of community-level engagement activities were significant, a number of limitations were also apparent. Community engagement took place mostly in the form of different types of meetings. Although follow-up actions were suggested in meeting reports, and some activities also produced action plans, it was not clear how any of this was monitored in terms of follow-through. Dialogues and coordination meetings had flexible agendas (a relevant approach in the community engagement context); however, this sometimes led to sessions focusing on items not directly related to reducing human rights-related barriers. Many events occurred only once, largely as a result of budget constraints, according to key informants. Moreover, what was also apparent was the lack of linkages to other ongoing structures for monitoring and accountability.

As a result, the many once-off events appeared to have a limited effect in terms of catalyzing longer-term change and improvement. They also raised questions of sustainability beyond Global Fund investments. Such changes may have occurred (or be occurring) but there are no comprehensive mechanisms in place for tracking this. Other than maximizing community engagement for community engagement's sake, broader objectives and outcomes for this program area were not clearly defined. There was a high risk that, absent ongoing support from the Global Fund or another funder, none of these activities would continue on their own. Investments were positioned to fill gaps; they were not directed towards equipping community actors to demand for existing institutional structures and process to be more responsive and accountable to community needs. While the challenge of the non-functionality of DACs was raised in some community engagement activities, for example, there was no evidence of implementers of these activities liaising or coordinating with UAC to try to resolve this challenge. At the same time, UAC was investing in strengthening

selected DACs, using Global Fund resources, but there was no evidence of connection to these other interventions.

5. Progress to Remove Barriers to TB Services

Removing human rights and gender-related barriers to TB services is a priority for the national TB response in Uganda. These interventions are also program essentials. However, the scope and scale of these efforts is different from HIV and, as a result progress to reduce or remove barriers has only advanced somewhat since the previous assessment. While a number of interventions to reduce human rights-related barriers under HIV, and under CSS, were meant to include topics related to TB, this was not always achieved.

5.1 Eliminate TB-related stigma and discrimination

While the national TB response in Uganda has identified the need to more comprehensively understand and address TB-related stigma in all its forms, it has so far made only initial steps. During 2021-2022, different actors worked in communities to improve knowledge and understanding regarding TB, including the need for stigma and discrimination reduction. However, these efforts were not yet part of a comprehensive approach. Nevertheless, they did constitute a baseline upon which further work could be built and additional progress made.

Progress to eliminate TB-related stigma and discrimination

TB program area	Score		
	Baseline (2018)	Mid-term (2020)	Progress (2022)
Eliminate TB-related stigma and discrimination	0.0	2.3	2.6

While there was some scale-up of community-level activities by the USTP to address TB-related stigma and discrimination, the geographic reach of these efforts was limited, particularly given the extent of the TB burden for the country. USTP addressed stigma and discrimination using different modalities, including training workshops for community-level TB advocates and TB survivors that included topics on human rights and gender in the TB context. National stakeholders collaborated to implement activities to improve general awareness about TB, including marking World TB Day and a first-ever Uganda TB Marathon, held in March 2022. These interventions were implemented in the absence of a measurement framework, however, to track to what extent TB-related stigma was reduced or mitigated. Interventions under HIV-related program areas, such as community mobilization or empowerment, or improving rights literacy, uncovered instances of ongoing TB-specific stigma and discrimination faced by individuals in communities (see **Box 8**).

Box 8-Persistence of TB-related stigma in communities: *"There is a lack of awareness about TB by the local communities. They can't differentiate between a cough and TB. They think TB is witchcraft. The immigrants think that it's a Ugandan disease and can't affect them."***--Participant, Kyankwanzi District Coordination Meeting, August 2022**

This gave some indication of the extent of the challenge still to be addressed.[31] While some of these interventions were meant to include TB as a component of stigma-reduction efforts, it was not clear to what extent this was effective, as most results were reported in the context of HIV alone. As a program essential, TB stakeholders acknowledge that there is still some distance to cover to fully meet this requirement.

5.2 Ensure people-centered and rights-based TB services at health facilities

TB services are provided throughout Uganda, utilizing both public and private sector HCWs. To the extent that these are people-centered or rights-based is not comprehensively known beyond anecdotal accounts.

Progress to ensure people centred and rights-based TB services at health facilities

TB program area	Score		
	Baseline (2018)	Mid-term (2020)	Progress (2022)
Ensure people centered and rights-based TB services at health facilities	0.0	*	2.0

Some efforts are made to sensitize HCWs in different settings on non-discriminatory service provision in the context of TB. UTSP included HCWs in its regional training workshops for CSOs and also addressed quality-of-service topics in its engagement with private sector TB providers. However, beyond training reports, there was no tracking of what proportion of HCWs were reached with these interventions and whether or not the quality of service was improved or sustained from a human rights-based perspective. In addition to what USTP undertook, topics on TB were included in the roll-out workshops for the Patient's Charter linked to the human rights-based approach. However, given that the roll-out was led by the ACP, it was not clear to what extent these topics received emphasis. Finally, the training manual on safe and equitable workplaces for HCWs, completed by November 2022,

[31] As an additional example of the extent of TB-related stigma still to be addressed, a study conducted amongst 204 people living with TB (49% co-infected with HIV) in the Makindye Division in Kampala in 2021 found that 50% of participants had significant levels of TB-related stigma (assessed through an individual's attitudes, beliefs or practices). See: Ashaba C, Musoke D, Wafula ST, Konde-Lule J. Stigma among tuberculosis patients and associated factors in urban slum populations in Uganda. African Health Sciences. 2021 Dec 14;21(4):1640-50. https://scholar.google.co.za/scholar?hl=en&as_sdt=0%2C5&q=Stigma+among+tuberculosis+patients+and+associated+factors+in+urban+slum+populations+in+Uganda.&btnG=.

contains specific sections on TB-related human rights. Roll-out of the manual, through training and mentorship, was expected to commence in 2023

5.3 Ensure people-centered and rights-based law enforcement practices

There is growing awareness in Uganda of the need to address TB-related risks across the law and justice sector, including in relation to law enforcement practices. Efforts to address these were limited during 2021-2022, however, partly due to limited investment.

Progress to ensure people centered and rights-based law enforcement practices

TB program area	Score		
	Baseline (2018)	Mid-term (2020)	Progress (2022)
Ensure people-centered and rights-based law enforcement practices	0.0	1.0	2.0

ODPP was the main implementer to address rights-based law enforcement practices in the context of TB. TB was included in policies, guidelines and training activities along with HIV and malaria. These activities were discussion in **Section 2.2.3** above. The topic of TB was included in other activities with law and justice actors (implemented by UGANET and HRAPF, for example) but no TB-specific results were reported from these activities. In addition to the work of ODPP, USTP worked with partners and stakeholders to develop a manual for more effective engagement of Parliamentarians. The manual was validated at the end of 2022. USTP intends to start using the manual in 2023.

5.4 Improve legal literacy

Empowered and knowledgeable individuals regarding TB-specific legal and human rights are a critical component of an effective TB response. It is also a program essential. Achieving this is a priority for TB stakeholders in Uganda, although only limited progress has been made to date.

Progress to improve TB-related legal literacy

TB program area	Score		
	Baseline (2018)	Mid-term (2020)	Progress (2022)
Improve TB-related legal literacy (“know your rights”)	0.0	1.0	2.3

During 2022, USTP conducted a capacity-building workshop with TB experts and survivors drawn from two regions in Uganda (resource constraints limited their ability to expand this

activity). A consultative process was used to develop the materials. Among the topics covered was human rights and gender in the context of TB. Throughout 2022, periodic follow-up meetings were held with experts/survivors to monitor the results of the capacity-building workshops on their work in communities. USTP also reported that, by December 2022, in collaboration with the NTLCP, regional advocacy meetings had been convened in all 15 MoH regions. One of the purposes of these sessions was to empower communities to increase their demand for TB services within the "right to health" framework. No specific tracking was done, however, regarding subsequent increases in service volumes or related improvements.

Paralegal training materials used by UGANET and HRAPF included content on TB. However, no data were collected to measure the extent to which the content was used by paralegals to assist individuals in communities (it may, for example, have been part of the outreach events conducted by them). UGANET's community-led human rights violations monitoring tool included a section on TB but there was no consolidation of the data from the tool and no indication of any TB-related violations being recorded by December 2022.

5.5 Improve access to justice

Individuals living with or at risk for TB will, from time to time, experience legal and human rights challenges. The fact that these are not well documented in Uganda is not an indication that they do not occur. Ensuring access to justice for individuals experiencing TB-related human rights challenge is a program essential. For Uganda, stakeholders made only limited progress to improved access to justice in the context of TB as shown below.

Progress to improving access to justice

TB program area	Score		
	Baseline (2018)	Mid-term (2020)	Progress (2022)
Improve access to justice	2.0	2.3	2.6

A number of the community engagement activities described in **Section 2.2.8** above included opportunities for individuals to raise TB-related concerns and many did. Some of these involved legal and human rights challenges, affirming that there is an ongoing need for improved access to justice in the TB context, particularly given the burden of the disease across Uganda. In their provision of legal services in communities, neither UGANET nor HRAPF recorded any TB-specific cases. This was most likely an indication of gaps in community-level knowledge regarding TB-related human rights and legal concerns, rather than an absence of cases themselves. ODPP's convening of circuit courts included TB-related concerns as grounds for expediting the resolution of cases. In addition, the guidelines for criminal justice stakeholders developed by ODPP included topics on TB with

the intent that these would influence the administration of justice once the guidelines were rolled out in 2023. Overall, however, a significant gap remained regarding access to justice in the context of TB.

5.6 Improve laws, regulations and policies relating to TB

The legal and regulatory environment for TB in Uganda has not been comprehensively assessed in recent years. To the extent that it may be either enabling or impeding has not been clearly determined by TB stakeholders as a result.

Progress to improve laws, regulations and policies related to TB

TB program area	Score		
	Baseline (2018)	Mid-term (2020)	Progress (2022)
Improve laws, regulations and policies related to TB	0.0	1.0	1.0

While there may be no evident TB-specific legal provisions that act as a barriers to access, uptake and retention in TB services, other legal or regulatory provisions may have indirect effects. These could include provisions in the penal code or other criminal provisions against populations at higher risk for TB, such as PWUD, who may, as a result, endure higher rates of arrest and imprisonment, something that elevates their risk of acquiring TB. ODPPs development policies inclusive of TB for the criminal justice stakeholders has already been highlighted. In addition, it has already been noted that the TB strategic plan contains strong commitments to addressing and removing human rights and gender-related barriers (more so than previous strategic documents). However, until a more comprehensive assessment of laws, regulations and policies is completed, such risks cannot be completely determined and nor can action plans be developed or implemented to reduce or remove such barriers. Gaps may also exist for the protection of individuals living with or affected by TB, particularly with regard to stigma and discrimination.

5.7 Reduce TB-related gender discrimination

While gender-related differences in TB risk, as well as for access, uptake and retention in TB services, is acknowledged by TB stakeholders in Uganda, up until recently no comprehensive evidence was available to better understand and address these differences. Gathering and using such evidence is a program essential.

Progress to reduce TB-related gender discrimination

TB program area	Score		
	Baseline (2018)	Mid-term (2020)	Progress (2022)
Reduce TB-related gender discrimination	0.0	0.0	1.0

In 2022, the NTLCP partnered with the MSPH to undertake a TB gender assessment. This was combined with an analysis of key populations for TB in the Ugandan context, utilizing the guidance and tools of the Stop TB Partnership. The assessment was completed and validated by December 2022. During 2023, the NTLCP along with other national TB stakeholders, intends to develop an action plan to address the findings of the assessment. TB stakeholders also intended to use the results of the assessment to guide the development of the TB component of the GC7 funding submission.

5.8 Support community mobilization and advocacy

Community mobilization and engagement on TB is a priority for the national TB response in Uganda. It is also a program essential. This work is mostly led by the USTP and its member CSOs and networks, although with a strong endorsement from the NTLCP.

Progress to strengthen TB-related community mobilization and advocacy

TB program area	Score		
	Baseline (2018)	Mid-term (2020)	Progress (2022)
Support community mobilisation and advocacy	0.0	2.0	3.0

There was a significant scale-up of TB-related community mobilization and advocacy starting in 2021, with increased support to USTP and through interventions led by other partners, including ICWEA, NAFOPHANU and MUCOBADI as part of CSS investments (see **Section 2.2.8** above). All partners conducted rounds of workshops and engagement meetings to mobilize communities to identify advocacy priorities and to address them. USTP worked at the regional level with TB-specific interventions, while other implementers included TB as part of their activities at the district level. USTP conducted some follow-up activities during 2022; however, the extent of what was achieved was not comprehensively documented or assessed.

5.9 Address the needs of people in prisons and other closed settings

People in prisons and other closed settings in Uganda remain at high risk for TB, given the weight of the disease burden in the country. Addressing TB for people in prisons and other

closed settings is a priority for the NTLCP, although a number of factors have limited what can be achieved in these settings, including prison conditions and the availability and quality of health services. Access to comprehensive health care free from human rights barriers is also a priority for UPS, despite limitations in technical and operational resources to make this a reality for all staff and inmates under their care.

Progress to address needs of people in prisons and other closed settings

TB program area	Score		
	Baseline (2018)	Mid-term (2020)	Progress (2022)
Address needs of people in prisons and other closed settings	1.0	0.0	2.0

As noted previously, the ODPP developed revised health policies for criminal justice stakeholders, including UPF and UPS. The policy specifies that voluntary screening and treatment for TB must be made available to detainees in both police and prison settings. Where isolation is warranted, for both an individual's health and the health of those around them, this must be carried out in a way the respects human rights and that promotes positive outcomes for TB prevention and control. The policies were validated in December 2022. Training and dissemination were to commence in 2023. In addition, new training materials and guidelines had been developed for peer educators in prisons, which included TB and the importance of addressing it using the human rights-based approach. Roll-out of the materials was to begin in 2023. Finally, UPS participates in the Equity Plan Steering Committee and uses this forum as a way to improve collaboration with ODPP and others on addressing the TB and other health-related needs of staff and inmates.

6. Progress to Remove Barriers to Malaria Services

Understanding and addressing human rights and gender-related barriers to malaria services in Uganda continues to be an emerging priority for malaria stakeholders. While, under the leadership of the NMCP, the commitment is clear, progress to translate this into human rights-informed strategies and interventions is at an earlier stage of development than for the two other disease programs. To the extent that, as a program essential, malaria programs must integrate human rights and gender-equality norms and principles, Uganda has only recently begun to do this in a specific and systemic manner. By December 2022, there was, nevertheless, progress to act on these commitments even though not all of the malaria-specific findings and recommendations of the MTA from 2020 had been addressed. The NMCP had appointed a focal point for advancing on equity-related priorities for malaria and was an active participant in the Equity Plan Steering Committee. The implementation of the Malaria Matchbox survey was proceeding and the PMI Uganda Malaria Reduction

Activity (MRA) can completed a Gender, Youth and Social Inclusion Analysis (see **Box 9**) and had also set out a Gender Action Plan to guide all interventions supported during the 2022-2023 programming period.

Box 9-Excerpt from Gender, Youth and Social Inclusion Analysis: *"Data show that women, youth, people with disabilities, refugees, and other groups including migratory and nomadic populations, and pastoralists in the Acholi, Busoga, Karamoja, Lango, and West Nile sub-regions experience differential patterns of malaria infection, factors affecting who becomes infected, and factors affecting responses to infection, leading to differential vulnerability to poor malaria outcomes compared to men and their national counterparts. These differential vulnerabilities are determined by a range of environmental, economic, social and cultural factors at the household, community, district, and national levels related to roles, responsibilities and time use, cultural norms and beliefs, access to and control over assets and resources, and decision-making power."*

These developments were helping to bring about an increasing focus on gender and equity as cross-cutting components of malaria interventions, particularly those that support community mobilization and engagement, such as the Mass Action Against Malaria and Household Action Against Malaria (HAAM)/Household Champions Against Malaria (HOCAM) initiatives. With these steps, momentum for addressing equity-related barriers for malaria was expected to continue to increase during 2023. The NMCP and malaria stakeholders were also planning to include a more substantive allocation for programs to reduce barriers as part of the country's GC7 submission.

6.1 Reduce gender-related discrimination and harmful gender norms

Progress to reduce gender-related discrimination and harmful gender norms in the context of malaria is shown below:

Progress to reduce gender-related discrimination

Malaria Programme Area	Score		
	Baseline (2018)	**Mid-term (2020)**	**Progress (2022)**
Reduce gender-related discrimination and harmful gender norms	0.0	1.0	3.3

Starting in 2021, under both Global Fund and PMI-supported interventions, there was a renewed focus on gender and gender norms and their influence on the effectiveness of malaria programming, particularly at the community and household levels. This was achieved through a scaling up over the 2021-2022 period of community dialogues, some of which were gender-focused (separate dialogues for men and for women, for example, to explore gender roles and gender barriers). There were more specific efforts to engage men,

as decision-makers and gatekeepers for household and community action regarding malaria prevention and control. This included work at the household level, where implementers were more diligent to ensure male engagement in Smart Malaria Household assessments and action planning. One implementer, Programme for Accessible health, Communication and Education (PACE) Uganda, had developed on organization-wide Gender Action Plan for all of its interventions (including but not limited to malaria) and had updated its monitoring tools to collect more comprehensive gender/age disaggregated data on its activities in communities. Other implementers under TASO and PMI had also given more prominence to topics related to gender in facilitation guides and training materials for community actors and advocates. By the end of 2022, between TASO and PMI, such dialogues were being routinely conducted in 66 districts.

Beyond these improvements in gender-sensitivity of malaria programming, there was more limited progress in terms of gender-transformative approaches. One implementer was working to connect women in communities to economic empowerment interventions as a way to limit male dominance and control of household resources, which can negatively influence access to health services, including diagnosis and treatment for malaria for women and young children. TASO, as a main feature of its HOCAM approach was aiming to empower women as the leaders and custodians of household-level actions to prevent malaria. As the time of the assessment, most implementers agreed that their efforts were still in the roll-out and scale-up phases and would need more time to generate substantive results in terms of reducing or transforming gender-related barriers and challenges for effective malaria prevention and control. All agreed that more focus on the gendered aspects of malaria, in terms of technical support, exchanges among stakeholders, and more in-depth analysis of performance data using a gender-transformative lens, were needed to generate more robust and durable results regarding this aspect of the national malaria response.

6.2 Promote meaningful participation of affected populations

The national malaria stakeholders in Uganda recognize the importance of community and household engagement and ownership as a critical success factor for malaria prevention and control, and, ultimately, elimination.

Progress to promote meaningful participation of affected populations

Malaria Program Area	Score		
	Baseline (2018)	Mid-term (2020)	Progress (2022)
Promote meaningful participation of affected populations	1.0	1.0	3.0

Malaria stakeholders are guided by the 2021-2025 Uganda Malaria Reduction and Elimination Strategic Plan, which identifies a range of priority and vulnerable populations,

including children, youth, pregnant women, refugees, people with disabilities, migratory and nomadic populations, and pastoralists. Implementers of malaria interventions are aware of these populations and the fact that programmatic adaptations are needed to ensure their full inclusion in malaria programs. Starting in 2021, there has been a greater emphasis on working at the community and household levels for a more effective malaria response and, in doing so, to place more emphasis on community engagement and community ownership for identifying and resolving malaria-related risks and challenges. In some cases, implementers have held focused dialogues with specific groups, including pregnant women, people with disabilities, or elderly people, to find a pathway towards more accessible, acceptable and, ultimately, more effective programming that embraces such diverse needs. This was also the case for regional differences (adapted approaches for the Karamoja region, or example), as well as for more uniquely situated groups such as refugees. There has also been an expansion of work in schools to engage learners, particularly adolescents, on their risk of malaria and the role they can play in households and communities to mobilize action to prevent malaria. By 2022, between TASO and PMI, this collective range of interventions was operating in at least 66 districts.

With the greater emphasis on community development approaches, such as HOCAM or PMI's Household Action Against Malaria, implementers were increasing their knowledge and skills regarding adapting and tailoring malaria responses based on the circumstances, needs and opportunities in local settings. As with the efforts to address gender, this work was still in the roll-out and scale-up phases and was needing more time before substantive results could be measured. Implementers had monitoring systems in place, however, although not necessarily consolidated or linked, including (using web-based tools such as Kobo Toolbox) to track progress on locally generated action plans at community and household levels and to link these to local and district trends in malaria incidence and case management.

6.3 Strengthen community systems for participation

Malaria-focused CSOs are recognized as important stakeholders in efforts to build and sustain community-led and community-owned capacity for health in Uganda. Community components of the public health system are also considered essential, particularly Village Health Teams (VHTs) and Community Health Extension Workers (CHEWs).

Progress to strengthen community systems for participation

Malaria Program Area	Score		
	Baseline (2018)	Mid-term (2020)	Progress (2022)
Strengthen community systems for participation	1.0	1.0	3.3

Interventions to strengthen community systems were scaled up during 2021-2022 through a number of complementary approaches. Under the CSS component the GC6 grant, for example, ten malaria CSOs were included in CSO capacity-building interventions (mentoring and small grants for programming). Malaria was included as a topic in community mobilization workshops and events, but there was no specific monitoring of the extent to which this strengthened community engagement for malaria prevention and control. The Uganda Civil Society Alliance Against Malaria (UCAAM) participated in the Equity Plan Steering Committee to highlight the importance of additional investments to strengthening community engagement and ownership for malaria.

Among the PMI stakeholders, sub-granting to local CSOs was expected to roll out in 2023. Between TASO and PMI, some CSOs were selected either because they work in under-served regions or districts or because they represent specific vulnerable population, including pregnant women, or adolescents and young people, for example. One implementer (PACE Uganda) was more systematic than others in utilizing a "community-empowered design" approach, which required conducting participatory rapid assessment before interventions were planned and delivered in communities. The assessment tool poses specific questions regarding gender and equity in order to prompt focused and locally tailored solutions.

As part of the MAAM, HOCAM and HAAM approaches, VHTs and CHEWs are being trained and equipped to monitor and coordinate local malaria initiatives. As part of their action planning, communities and households are being encourage to monitor the quality and availability of what VHTs deliver, including malaria commodities. Finally, as part of the Community Scorecard initiative, developed under GC5, malaria is included. The tools are gender-disaggregated (there are separate questionnaires for men and women, for example). While they address the quality and availability of malaria services, no specific questions or measure focus on human rights and equity in the malaria context. In the consolidated report for 2022, quantitative data is not disaggregated but quotes are featured from both men and women, sometimes differing in their views on the local service provision related to malaria. No deeper analysis is done, however, to further explore such differences.

6.4 Monitoring and reforming laws, policies, practices

Malaria stakeholders are only beginning to address this program area. As already noted, while the malaria strategic plan prioritized integration of human rights, gender and equity concerns into the malaria response using evidence generated through the Malaria Matchbox Assessment. n addition, the strategic plan identified a wider range of populations for whom equity-related concerns were paramount, including children, youth, pregnant women, refugees, PWDs, migratory and nomadic populations and pastoralists. By December 2022, there was emerging progress to realize these commitments, with some acceleration expected during 2023.

Progress for monitoring and reforming laws, policies and practices

Malaria Program Area	Score		
	Baseline (2018)	Mid-term (2020)	Progress (2022)
Monitoring and reforming laws, policies and practices	*	*	1.0

The desk review for the Malaria Matchbox Assessment has highlighted the policy context for malaria and where human rights and gender-related components may be included. PMI's Gender, Youth and Social Inclusion Analysis also reviewed the law and policy context. It noted that opportunities within existing laws and policies to highlight and address inequities in the malaria response are not well known or utilized (some examples include Comprehensive Refugee Response Framework, Refugee and Host Population Empowerment Response Framework, and the Settlement Transformation Agenda). The Matchbox analysis also notes how recently re-enforced provisions around age of consent for sexual activity (18 years) has had a negative impact on adolescents, particularly the 25% of 15-19-year-olds in Uganda who being child-bearing at this early age but face intense discrimination and exclusion across health, social and education sectors. These AGYW are also at high risk for malaria. As a result, a number of implementers have prioritized reaching pregnant adolescents.

As already noted, ODPP has included malaria in its revised policies and guidelines for criminal justice stakeholders with dissemination/roll out planned to occur in 2023. In general, malaria stakeholders were expecting that through the results of the Matchbox Assessment they would have more clarity in 2023 on how to approach this program area moving forward, not only to address law and policy barriers but also to identify gaps where additional laws or policy would be needed to strengthen the national malaria response from an equity and human rights perspective.

6.5 Improve access to services for underserved populations

Progress to improve access for underserved population

Malaria Program Area	Score		
	Baseline (2018)	Mid-term (2020)	Progress (2022)
Improve access to services for underserved populations	*	1.0	2.0

Work to improve access to malaria services for underserved populations was linked to efforts to promote meaningful participation of affective populations and to strengthen community mobilization and engagements. During 2021-2022, increased efforts were made

by the NMCP and other malaria stakeholders, including TASO and PMI, to identify and address access to services for underserved populations. This included adaptations in program design and delivery for certain population groups (nomadic populations, and fisherfolk) and for groups in rural and remote areas (implementation of SMC in addition to routine interventions). Both TASO and PMI had specific engagements with UNHCR regarding expanding malaria interventions for refugees. Through community dialogues and work with households, there was more effort to build awareness regarding the need for pregnant women and young children to access health facilities for malaria prevention and treatment. The dialogues were also an opportunity for people with disabilities to raise issues and concerns regarding how local responses were designed and implemented. Some malaria interventions were prioritized for specific vulnerable groups, such as indoor residual spraying (IRS) in refugee settings and seasonal malaria chemoprevention (SMC) in priority locations where access to routine services is limited. As with other program areas, implementers felt that implementation needed to continue for a longer period in order to generate substantive results for increased access to services, as well as reduction in malaria risks. More effort was also needed to more closely examine data from routine reporting to be sure that the situation for underserved populations was improving. In general, malaria stakeholders felt that, with increased emphasis on locally driven responses, barriers for underserved populations would gradually be resolved, given the increased flexibility of this approach.

7. Emerging Evidence of Impact of Programs to Reduce Barriers

By the end of the GC6 period (December 2023), Uganda will have benefited from six years of additional investment to reduce barriers to HIV, TB and malaria programs. The aim of this investment is three-fold: to increase the scale and comprehensiveness of programs to reduce barriers (outputs); to achieve tangible gains to reduce or remove human rights-related barriers (outcomes); and to contribute to improved access and uptake of services and positive shifts in health equity (impacts).

As the assessment results illustrate, during 2021-20222 there was an expanded engagement on the part of all stakeholders to identify human rights-related barriers and to strengthen and scale up efforts to reduce or remove them. While this occurred mostly in the context of HIV, there was also some movement for TB and malaria, either in specific program areas, or as components of cross-cutting programs under CSS. In the context of HIV, to the extent that these led to improved outcomes was attested to by representatives from key population communities who participated in the assessment and who gave largely positive views on improved access to services as well as increased retention and adherence linked to the expansion of programming, particularly key population-led interventions, but also linked to improvements in some aspects of the program environment. Many had been

reached with human rights literacy interventions and had been assisted by paralegals or lawyers, for example. Some had registered the emerging changes in their local environments where law enforcement agents were less threatening or intrusive, and local communities were more accepting of the presence of key populations, and more supportive of their needs and entitlements to access health services. hese changes were not always durable or sustained, however, and could be reversed quickly when staff in health facilities changed, new police officers were deployed, or the local political leadership shifted. Without more systemic shifts in the legal environment, or in the institutional behaviors of key local stakeholders (such as law enforcement agents or some religious and cultural leaders), the outcomes achieved through increased investments to remove human rights-related barriers will remain at risk.

With regard to other constituencies and communities, there were also some emerging signs of positive change. The improving levels of uptake of HIV testing, ART and the results for viral suppression give some indication that HIV-related stigma and discrimination is declining in the country. Stigma and discrimination is still being highlighted in communities and in household settings, but more and more individuals are becoming resilient in these settings and resistant to stigma's negative effects, at least as it concerns access to services. The PLHIV Stigma Index planned for 2023 will provide more comprehensive data on this situation, and will help to guide multi-sectoral efforts to more precisely plan and move forward with efforts to reduce and ultimately end HV-related stigma and discrimination for the country.

Whether efforts to reduce barriers to TB and malaria services are generating outcome and impact level results was less clear. The scale up of programs to reduce barriers to TB services, although less comprehensive than for HIV, has at least begun to more clearly identify where there are challenges and, as these efforts are sustained, will evolve further into focused efforts to reduce or remove the barriers. At the time of the assessment, malaria stakeholders were only in the initial stages of intensifying and scaling up their commitment to identifying and addressing equity barriers. The results of the Matchbox Assessment will provide important baseline information against which to measure changes at the outcome and impact levels during future assessments.

As awareness of the Equity Plan has grown across national stakeholders and institutions, the commitment to its goal of achieving equity in access to HIV, TB and malaria services for all Ugandans in all their diversity was also improving. This was particularly evident for the MoH, which has continued to articulate the importance of addressing and removing human rights barriers to services as the critical enabler for the national ambition to end AIDS, TB and malaria as public health threats in Uganda by 2030. Through the revision of the Patient's Charter, the MoH also reasserted that access to health care services was the entitlement of all Ugandans, regardless of their diversity. Throughout the assessment period, the MoH maintained its commitment to the principle of differentiated service delivery, including its support for the expansion of key population-friendly services, and for the introduction of new

components to these service packages, particularly medically assisted therapy (MAT) for PWUD, and the scaling-up of PrEP services for key populations, among others. As a result, at least in the context of HIV, stakeholders were seeing tangible improvements in the demand for and utilization of services and the country's efforts to meet or exceed its coverage goals were accelerating.

Two additional examples further illustrate these important gains in outcomes and impacts within local communities.

7.1 The strength of local synergies – Example of Busia District

Busia District is located in Eastern Uganda near the border with Kenya. A number of key population communities are present in the district, including sex workers, MSM, transgender people, PWUDs, and long-distance truck drivers. MARPI supports a drop-in center linked to Busia Health Centre IV. A number of CSOs and networks work in collaboration with the drop-in center and key population constituencies. Starting in 2021, in addition to scaling up programs to reduce barriers to HIV, TB and malaria services, there was a similar scale up of community-led interventions focusing on advocacy, social mobilization, coordination and accountability. These interventions worked in tandem with the different interventions related to reducing human rights barriers to generate overall results for the community which were increases in access, uptake and retention in health services for key populations as well as some more general improvements in quality of life.

For example, community sensitization and dialogues, repeated over time by the different local partners, helped to change community attitudes regarding the presence of key populations. As one peer outreach worker said, "We have seen a lot of change in our communities, the female sex workers, because they can access the area easily, the clinical services. We have released the stigma. They come and they access services so easily." Peer outreach workers also find their work in communities less risky and state how it is easier to access condoms and lubricants and to promote PEP and PrEP and to refer individuals to health facilities.

MARPI has noticed significant changes since 2021. As one health care worker said, "When you reduce stigma, when you reduce violence, you see more people accessing services. And that goes for both the public and the private sectors which are the CSO drop-in centers." In reviewing their performance and reporting this information to the DAC, they see how they consistently meet or exceed important targets, particularly for HIV and TB diagnosis and treatment. Now, as a result of the all of the interventions to create an enabling environment, their achievement consistently meets or exceeds 80% or 90% of their service delivery goals from one period to the next.

One of the most important local stakeholders they have engaged is the police. Through dialogues and sensitization sessions, leaders from the sex worker community were able to negotiate change in police attitudes and practices. As one of the community member stated,

"We intervened. We said we are human beings. Some of us are also parents, we also have young ones. Through our sensitizations and our dialogues, we said you should be listening to them. They are not always on the wrong side just because they are sex workers." Now, more sex workers are willing to report abuses to the police and the police are more responsive in providing assistance. Community paralegals support these women to pursue their issues, even to the extent of open legal cases. However, there is still some reluctance to be more assertive regarding legal rights. As one paralegal stated, "Some of our women pull out of the processes. They are afraid of what may happen to them from the men they are accusing."

In Busia District, the community scorecard is implemented and there is community-level reporting of human rights violations. UGANET supports the DHRC to convene and this has become a forum for reviewing reported cases and for engaging different stakeholders to resolve the violations and to prevent them from recurring. Data from the community scorecard is shared with the DAC (among others) to monitoring the availability and quality of HIV services in the district from the perspective of PLHIV and key population community members.

Not all challenges have been addressed, however. PWUDs still experience conflicts with the police, largely because of rotation, where new officers arrive and have not had opportunities for sensitization and engagement with the community. "Some police officers will just put any crime on them (PWUDs) just to arrest and abuse them," according to a peer outreach worker supporting PWUDs. Services for drug users are not comprehensive, with rehabilitation and MAT services only available in Kampala, too far away for many individuals and families looking for support. As a result, some parents arrange for their children to be arrested and kept in prison to prevent drug use. As one health worker stated, "That is a human rights violation but parents have become desperate because of the lack of services they can access." There is also a concern for the young children of sex workers. here are no safe spaces or other dedicated supports for these children while their mothers are working.

Being near the border, the population in Busia is highly mobile, including for key populations. This means that the different community actors, including MARPI, struggle to reach everyone with integrated services, including components related to human rights. As one individual stated, "We need to more in terms of coverage. People are mobile. We need to do more integration to reach more people. We've not reached 50% surely. Our work needs to be more at the community, family, and individual levels." It was also noted that some important health needs were not being met, particularly for psychosocial support and mental health. Health workers and community leaders were linking these unmet needs to lower retention for young key populations in services, for example.

7.2 Investing in community actors – the role of GBV Champions

GBV champions participated in the progress assessment in Busia, Lira and Mbale Districts. Most were women, although more men were coming forward to be champions in their communities. The intervention is funded by the Global Fund and implemented through TASO. Under GC6, the intervention was a continuation from previous funding periods. Many have had this role for some years (some had five-year contracts that were expiring in 2023). They are proud of their contributions and have a strong commitment to their work that far exceeds the modest allowances they are paid to cover transport and other costs.

GBV champions are embedded in their communities; they are known individuals. Through community dialogues, and training and sensitization sessions, they destigmatize GBV. The champions also look for opportunities for raise GBV topics in other meetings and events in their communities. In this way, they create channels for individuals to reach out about their experiences and to report cases when they occur, including what they observe in their communities. "People are now reporting," stated one champion from Busia. Another champion from Lira agreed: "There is awareness. People know. They know the signs of GBV. They have become our whistle-blowers. They see those small, small indicators and they come and find us so we can intervene."

The GBV champions are integrated within local systems and structures. They work closely with local CSOs and NGOs supporting access to justice and those providing practical and emotional support to children and families in crisis. They are linked with District Community Development Officers, local councils and, particularly, the police. As one champion described, "Whenever there is a case of rape or defilement, from the Central Police Station they call us to come and help to do the counselling, to provide psychosocial support, and to help the family. We have a good working relationship with the police." This relationship, over time, has included many interventions to build police capacity and to change attitudes and practices towards the issue of GBV in communities.

As part of the support they provide in communities, GBV champions are often first responders when individuals reach out to them to report a case. In these situations, champions attempt mediation to defuse a conflict and also make referrals and follow-ups to local health facilities. With the consent of an individual, they will assist them to report the case to the police and to be linked with legal aid service providers active in the community, including UGANET and HRAPF. Once a case is registered and proceeds through the legal system, champions will stay involved for as long as they can, even though delays are frequent and some complainants eventually abandon their case. As one champion said, "When a case is not handled to conclusion, it demoralizes us!" They have had successes, though, with champions in Busia celebrating each other during the discussion over recent convictions of male perpetrators that had occurred linked to their efforts.

Champions intervene in a range of situations, including verbal and physical violence between family members in households as well as in cases of sexual assault and defilement. They try to be “gender neutral” and are open to assist whomever comes forward, whether male or female. "We target anyone who is affected by violence, women or men." They noted the strong sociocultural barriers preventing men from coming forward, "If a woman beats you, you cannot be a man." Some of the male champions are themselves survivors of violence or abuse, which helps to challenge and remove the barriers.

During the COVID-19 lockdowns in 2020 and for part of 2021, champions were very limited in terms of the support they could provide. Many survivors of GBV at that time could not access support. This was at the same time that there was a sharp increase in the incidence of GBV in households. As one champion said, "That staying together caused a lot of GBV." Another champion described it this way: "It [COVID-19] exposed more of the causes of GBV. Before COVID 19, most communities in Busia thought it was teachers defiling their learners, but COVID 19 showed that perpetrators are in families and that parents have neglected their role." As a result, post-COVID, champions felt that, "Families are starting to hold themselves accountable following our interventions." While survivors can now more freely access services after all COVID-related restrictions were lifted by mid-2021, champions still felt there were many individuals who were missed and had not receive any support to address what may have happened to them during the lockdowns.

Although the champions describe how stigma and discrimination on the basis of an individual's HIV or TB status is declining in their communities, there can still be family disputes that involve these conditions, particularly among sero-discordant couples where one partner is on treatment and the other not. As one champion described, "Some are on treatment. One partner is positive and the other is not. This causes conflict. Some will even abandon their treatment." In response, the champions provide mediation and conflict resolution support: "We encourage the families to support the person taking medication. Especially those with HIV or TB, so they don't stop taking those drugs."

GBV champions face challenges to fulfil their role in communities. They are often accused of interfering in the private affairs of families and of promoting sex work in their defence and support of GBV survivors. They still grapple with corruption in some cases where individual authorities demand payment before they will assist a GBV survivor or when money exchanges hands to force a resolution in a particular case. Sometimes the women they are supporting will be coerced into accepting settlements despite the criminal nature of what they have endured. When they intervene to reduce child labor and to remove young children from working in the streets in their communities, some families accuse them of destroying livelihoods: "When you try to remove children from the streets, some parents complain that you are interfering with their source of income, their businesses."

GBV champions have a high degree of commitment to their roles in communities. They would like to see their work better integrated with local government structures. They would

also like to see increases in the level of financial support they receive. Sometimes they use their own funds to respond to emergencies or to support their community mobilization and outreach activities (champions in Mbale had pooled funds together to buy airtime on local radio stations, for example). Although they diligently write up and report cases to TASO, this information does not filter back down to their communities in the form of data or other evidence that could better inform local authorities and communities about GBV trends and whether or not they are increasing or declining. Finally, champions were still working to have more functional links with key populations in their communities. More training and support was needed to have more skills regarding the experiences and needs of key populations and to better understand and support people in their communities in all their diversity.

8. National Ownership and Enabling Environment

This section discussed two cross-cutting components of the progress assessment: improvements in national ownership for reducing or removing barriers, and important trends in the program environment that either enable or impede progress to remove barriers.

Starting in 2022, the Equity Plan Steering Committee was convened using resources from the GC6 grant and C19RM funds, with additional support from UNAIDS. A comprehensive terms of reference had been completed during 2021; what remained by the start of 2022 was to convene the committee. To support the Steering Committee, UAC established a small Secretariat and engaged a coordinator. To complement this support, TASO also engaged a human rights focal point. Routine committee meetings were held throughout 2022, engaging a range of stakeholders from government, civil society and development sectors. UAC and MoH co-chaired the meetings. A progress review of the implementation of the Equity Plan took place in October 2022. At the event, implementers of programs to reduce human rights and gender-related barriers to HIV, TB and malaria services provided reports on progress linked to the Equity Plan, as well as in relation to indicators and targets included in grant reporting. The event was an important opportunity to examine and debate program quality and the extent of coordination and coherence across implementers.

In general, while a significant amount of progress was being made, participants noted challenges for coordination for similar interventions (engagement of Parliamentarians, for example) as well as for program coherence (implementers of similar programs used different approaches and modalities with limited sharing and interaction regarding best practices and results). Implementers also noted the significant gap created through the lack of a shared set of outcome level indicators and targets, and a comprehensive monitoring and accountability mechanism. This included the lack of a shared theory of change linking interventions to improvements in access, uptake and retention in HIV, TB or malaria programs. Should these have been in place, implementers agreed that potentially more could be achieved at the outcome and impact levels with the current interventions and investments.

Some areas of improvement were also noted for the Equity Plan Steering Committee itself, and for improving monitoring and accountability for stakeholders working to implement the Equity Plan. These included having clearer agendas for routine meetings linked to monitoring and reporting of progress of interventions to reduce or remove barriers; development of a monitoring and accountability framework (expanding on the Performance Framework contained in the Equity Plan); development of routine, potentially digitized, systems for routine reporting on progress;[32] better utilization of the committee as a platform for improving coordination and coherence through thematic sub-committees, for examples, linked to each of the result areas; stronger linkages between the committee and other relevant platforms, such as the UAC's Stigma & Discrimination TWG or stakeholder coordination forum for the Global Partnership; and, finally, increasing the technical and operational capacity of the Secretariat using technical assistance as well as by increasing the operational budget.

Despite these achievements, some negative features of the country context persisted, limiting and sometimes reversing these important gains. As this assessment has highlighted, key populations in Uganda continue to experience elevated levels of stigma, discrimination and violence in communities, and the frequency of arbitrary arrests and detention of individuals, including PWUD, sex workers, and sexual minorities, was not decreasing. This was in spite of interventions that engaged with law enforcement stakeholders and religious and cultural leaders, among others. As the assessment was being concluded, preparation were being made to introduce a new Anti-Homosexuality Bill and a number of key population-led CSOs were undergoing investigations by the NGO Bureau, the results of which could have major implications for the availability of key population-led interventions in communities. It was not clear the extent to which the Equity Plan Steering Committee would take up these concerns and attempt to mediate a resolution. As the results of the legal environment assessment made clear, until the legal environment is improved in Uganda, and until these improvements become the basis broader change in sociocultural attitudes, beliefs and practices, the achievements made through investments and interventions in programs to reduce barriers to services will remain at risk and further progress may be limited.

[32] A retreat was convened by the Steering Committee in January 2023 to begin the development of this mechanism.

Annex 1: Abbreviations and Acronyms

ACP	AIDS Control Programme
ART	Antiretroviral treatment
CCM	Country Coordinating Mechanism
CEHURD	Centre for Health, Human Rights and Development
CHAU	Community Health Alliance Uganda
CLM	Community-led monitoring
CSO	Civil society organization
CSS	Community systems strengthening
GBV	Gender-based violence
GC	grant cycle (as in Grant Cycle 7)
HCW	Health care worker
HIV NSP	HIV National Strategic Plan
HRAPF	Human Rights and Awareness Promotion Forum
ICWEA	International Community of Women Living with HIV East Africa
IRS	Indoor residual spraying
M&E	Monitoring and evaluation
MARPI	Most-at-Risk Population Initiative
MoH	Ministry of Health
MSM	Men who have sex with men
MSPH	Makerere School of Public Health
MUCOBADI	Multi-Community Based Development Initiative
NAFOPHANU	National Forum of People Living with HIV/AIDS Networks in Uganda
NGO	Non-governmental organization
NMCP	National Malaria Control Programme (MoH)
NTLCP	National Tuberculosis and Leprosy Programme (MoH)
ODPP	Office of the Director of Public Prosecutions
PEPFAR	President's Emergency Plan for AIDS Relief (U.S.)
PLHIV	People living with HIV/AIDS
PMI	President’s Malaria Initiative (PMI)
PR	Principal Recipient
PWUD	People who use or inject drugs
TASO	The AIDS Support Organization
TWG	Technical Working Group on Stigma and Discrimination
UAC	Uganda AIDS Commission
UGANET	Uganda Network on Law, Ethics and HIV/AIDS
UHRN	Uganda Harm Reduction Network
UKPC	Uganda Key Populations Consortium
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNASO	Uganda Network of AIDS Service Organisations
UPDF	Uganda People's Defence Force
UPS	Uganda Prisons Service

UPF	Uganda Police Force
USTP	Uganda Stop TB Partnership

Annex 2: Recommendations

The recommendations address both GC7 considerations as well as broader needs for strengthening the effectiveness and impact of programmes to reduce barriers to HIV, TB and malaria services in Uganda.

Cross-cutting Recommendations	
	• In light of the evolving program context, implementers should rapidly scale up safety and security interventions for implementers and beneficiaries of HIV and key population programs and services. The scale-up should prioritize rapid program adaptions and other contingency measures to ensure continuity and accessibility of services for all PLHIV and key populations.
	• Additional investment should be urgently made in strengthening and sustaining rapid response mechanisms at the local level, with effective linkages to the national level. In addition to swiftly responding to critical incidents in local communities, such mechanisms should also have more capacity to identify early warning signs and to prevent escalation. All relevant stakeholders should be included in the mechanism with defined roles and accountabilities, including key population constituencies, government focal points, law enforcement focal points, and access-to-justice focal points.
	• For HIV program areas, for the remainder of 2023 and as part of GC7 planning, implementers should work to achieve a more effective balance between scale of programming and program quality. During 2021-2022, investments prioritized scale-up. However, challenges for quality have emerged, particularly for supporting ongoing monitoring and improvement processes, and for planning and implementing interventions aimed towards achieving and sustaining outcomes.
	• Accelerate the development of a web-based comprehensive M&E system covering all program areas for reducing barriers in the context of all diseases. The design of interventions under GC7 should be linked to this framework. Use the remaining time in 2023 to pilot and adjust the framework.

	• Linked to the framework, invest in digitization of data and systems for all programs to reduce human rights barriers (building on progress made in 2023).
	• Scale up investments to strengthen the capacity of the NTLCP, the NMCP and other key stakeholders for TB and malaria in order to increase their technical and operational capabilities to identify and address human rights and gender-related barriers.
	• As part of capacity strengthening, support TB and malaria stakeholders to develop prioritized scale-up plans, drawing from the Equity Plan and the results of the progress assessment, in order to significantly increase the scale and scope of programs to reduce human rights barriers. When developing these plans, clearly define outcomes for 2026 and beyond, and link investments and interventions to achieving these outcomes (and avoid short-term, once-off interventions). The plans should draw on all sources of technical and operational support, and not just from the Global Fund.
	• Undertake a comprehensive review of the Equity Plan, building on the results of the October 2022 retreat and the findings of this progress assessment. Based on the results of the review, propose a revision/extension to 2026 and beyond.
	• Provide for adequate technical and operational investments (in 2023 and during GC7) for the Equity Plan Steering Committee and the National Secretariat to be fully functional and technically competent.
	• Develop comprehensive budgeting guidance for programs to reduce barriers, linked to lessons learned from the progress assessment. Engage implementers with expertise in specific program areas to develop the budgeting guidance. As part of the guidance, improve the equity of investments between national and sub-national levels. This would address concerns that, during 2021-2022, investments were concentrated at the national level with only limited consideration of sub-national and local level needs.

HIV Recommendation

Eliminate stigma and discrimination in all settings.	• The national policy guidelines should be complemented by a comprehensive, costed, multi-sectoral action plan to eliminate HIV-related stigma, discrimination and violence in the Global Partnership's priority settings for Uganda (community, health care settings, and workplace). Relevant, already costed sections of the Equity Plan can provide the initial framework. The action plan should contain outcome-level indicators and milestones for monitoring progress towards elimination of HIV-related, stigma, discrimination and violence. The planned PLHIV Stigma Index for 2023 can serve as the baseline. • The Stigma & Discrimination TWG should urgently convene to develop and share rapid guidance for prevention and response to escalating levels of stigma, discrimination and violence against key populations which have impeded access to services. This should include advice to all stakeholders on mitigating the effects of the Anti-Homosexuality Act on access to health services for key populations. • Implementers should re-think/update their understanding of effective theories of change for reducing and eliminating HIV-related stigma and discrimination. More is needed to eliminate stigma than the many different types of one-off engagement activities that have been implemented (sensitization sessions, workshops, dialogues, for example). Multiple, coordinated strategies and interventions are needed that are sustained and routinely measured over time.[33] • Further progress can be made regarding the integration of components addressing reduction/elimination of stigma, discrimination and violence in other interventions, including tailored services for drop-in centers, and interventions to equip all cadres of HCWs for the provision of non-discriminatory health care services (see next section).
Ensure non-discriminatory provision of health care	• The MoH, in collaboration with national key population networks and other stakeholders, should urgently prepare rapid adaptation advice for HCWs, in order to ensure continuity and accessibility of HIV, TB and malaria services for key populations and other

[33] See UNAIDS. 2020. *Evidence for eliminating HIV-related stigma and discrimination*. Available: https://www.unaids.org/sites/default/files/media_asset/eliminating-discrimination-guidance_en.pdf

	populations potentially affected by the Anti-Homosexuality AcT. • Further scale-up of interventions to ensure non-discriminatory provision of health care should prioritize the pre-service environment. By 2026, at least some of the main training institutions in Uganda should be implementing a revised curricula to address this program area. • Further scale-up of interventions to ensure non-discriminatory provision of health care should more clearly prioritize and integrate content addressing TB and malaria, using information generated from the proposed TB Stigma Assessment, findings from the Malaria Matchbox Assessment, and routine data generated through the community scorecards. • The MoH should lead in the creation of a coordination and accountability mechanism for interventions to ensure non-discriminatory provision of health care (this could be done through the Equity Plan Steering Committee, for example). The accountability mechanism should include measures and modalities for monitoring and maintaining changes in the quality of health service provision related to human rights and non-discrimination. It should also link to mechanisms, including community scorecards, for reporting human rights violations in health service provision and for responding to and resolving such occurrences (through District Human Rights Committees, for example). • Future investments in monitoring and accountability at district and local levels should aim to make functional existing health governance and accountability mechanisms rather than create or maintain additional or parallel mechanisms that may not be sustainable over time (such as the Global Fund-supported district accountability meetings and other similar activities implemented under the community mobilization and empowerment program area [see below]). Such investments can be reprioritized to support empowering communities to participate in these mechanisms rather than paying for the operational costs of the mechanisms themselves. • Additional efforts should be made to plan, resource and fully implement comprehensive responses to address the HIV-related needs of people with disabilities within

	health care service provision, including for PLHIV and key populations living with disabilities.
Ensure rights-based law enforcement practices	• Key implementers (particularly UGANET, HRAPF, ODPP and UKPC) should urgently improve the coordination and coherence of their joint efforts to engage law and justice stakeholders, particularly given recent legislative developments. Roles and responsibilities should be more clearly delineated and acknowledged (ODPP to facilitate and support institutional change; UGANET, HRAPF, UKPC to monitor and demand for accountability; all to collaborate on comprehensive training and capacity building materials and approaches, for example). • At the same time that local level engagement activities may still be required, national stakeholders such as UGANET, HRAPF and ODPP should develop a joint strategy for greater ownership and accountability on the part of key institutions (such as UPS) to end problematic practices that impede progress for the national HIV, TB and malaria response, including arbitrary arrests, detentions and other abuses against key populations that inhibit their access, uptake and retention in services. • Opportunities should be created for peer-to-peer exchange between UPS and other countries in the region (Kenya or Ghana, for example) where law enforcement agents have built their own capacity to end or reduce problematic practices and to strengthen their commitment and contribution to the human-rights-based-approach to public health. Participants in these exchanges should have accountabilities introduce and lead change at UPS as a result. • A robust monitoring and accountability framework should be designed to articulate the longer-terms goals and outcomes of engagement with law enforcement stakeholders, and to define indicators and targets for measuring progress. Currently, indicators and targets only address output-level results. The revised framework should also track the longer-term consistency and sustainability of changes in law enforcement practices related to removing human rights barriers to services. ODPP's proposed inter-agency monitoring committee can be the “owner” of the framework and the monitoring process. Routine updates should be provided to the Equity Plan Steering Committee.

Improve legal literacy	• Implementers should collaborate to design an efficient, user-friendly system to periodically measure and monitor legal literacy among PLHIV and key populations. A simple electronic survey circulated through social media networks is one way that this could be achieved. • Implementers should improve the coordination and coherence of legal literacy interventions and link them to a clearer theory of change with specific indicators and targets at both the output and the outcome level. Routine monitoring can indicate where there are gaps, and efforts can be prioritized towards addressing these rather than continuing to follow a maximalist approach (reach as many individuals as possible with repeated rounds of training workshops). • Implementers should collaborate to design and roll out more efficient and adaptable modalities for promoting and sustaining human rights literacy beyond the current preferred modalities of workshops and meetings. Opportunities available through social media networks could be more comprehensively explored, for example. Ensuring full integration of these activities as part of drop-in centers and other key population-led community interventions should be a priority. • Implementers should increase the level of investments in community paralegals, particularly the budget for facilitating their day-to-day work in communities. They carry out a range of important functions and should be adequately equipped to perform well. These paralegals are the crucial link between improving legal literacy, improved efficacy of communities to recognize and respond to human rights violations, and referral to legal services and other processes for redress. • The distribution of paralegals should also be reviewed to ensure an equitable mix across the different populations that require these services and that the paralegals are closely linked to local programs and services for key populations and other vulnerable groups. There should be one comprehensive allocation and deployment plan guiding the different implementers. • Implementers should accelerate their work to create a digital system for monitoring and reporting on human rights violations. At the moment, given the individualized

	approaches, there is no ability to monitor country-wide trends by population and location, for example.
Improve access to justice	• UGANET and HRAPF should revisit their approach to training legal service providers and create a more robust plan for increasing such capacities linked to key population networks and CSOs in local communities, and to community paralegals. There should be a clearer balance between access to justice in communities and strategic leadership and quality assurance from stakeholders based in Kampala. • The planning and implementation of legal aid camps should be reviewed to ensure that there is a stronger triage and more comprehensive reporting of legal cases that are registered to ensure that this support is aligned to the objectives of the *Breaking Down Barriers* investment (which is to remove barriers to HIV, TB and malaria services and not more generally to resolve gaps in access to justice). • Implementers of HIV and TB programs should make a stronger effort to incorporate TB-related priorities into access-to-justice interventions. Community dialogues, for example, have highlighted the ongoing challenge of TB-related stigma and discrimination and the low awareness of people living with or affected by TB of their options for legal redress. • The planned web-based monitoring and reporting system for human rights violations should also capture detailed data on their referral to legal services, allowing for analysis of legal service provision, including geographic coverage, types of cases, characteristics of individuals assisted, and case outcomes. The system should also include data on the support provided by paralegals. • Implementers should use the opportunity of the Equity Plan Steering Committee to routinely coordinate and monitor their collective work to improve access to justice in the context of HIV and TB. At a minimum, UGANET, HRAPF, ODPP and representatives from PLHIV and key population constituencies should convene on a quarterly basis to review progress. • Implementers should collaborate to develop user-friendly mechanisms for PLHIV, key populations and others to provide feedback on the quality and comprehensiveness of the legal support they receive (from either paralegals or

	lawyers). This would help to better substantiate the value of investments made in these interventions and also provide implementers with information on coverage and quality gaps.
Monitoring and reforming laws and policies	• To bring this program area to scale, key stakeholders should develop a prioritized and costed action plan to respond to the findings of the legal environment assessments and well as emerging legal and regulatory barriers. This should include opportunities during 2023 as well as needed investments under GC7. Consider creating a sub-committee of the Equity Plan Steering Committee to closely monitor the plan and to drive a coherent and well-coordinated effort to achieve law and policy reform. • Implementers should work to achieve more coordination and coherence with joint actions and interventions to engage Parliamentarians on law and policy reform. This approach is essential for stronger impact in the face of challenges such as responding to the Anti-Homosexuality Act or seeking amendments to the HIV Control and Prevention Act. It is also essential for achieving progress towards penal code amendments and changes to the and the Narcotic Drugs and Psychotropic Substances (Control) Act 2015 which affect key populations. • Investments in strategic litigation should be sustained. owever, clearer strategic litigation priorities should be set out linked to the findings and recommendations of the legal environment assessments.
Reduce HIV-related gender discrimination	• As new information is available during 2023 regarding progress to reduce HIV-related gender discrimination (through the new PLHIV Stigma Index and the revised community scorecard), implementers should highlight these findings and ensure that they are prioritized as part of UAC's action planning to eliminate all forms of HIV-related stigma and discrimination in priority settings in Uganda. • Create focused tools and materials to be used by all implementers engaged in dialogues, sensitization meetings, and community mobilization interventions so that reducing HIV-related gender discrimination is a consistent focus of these interventions rather than a topic that may or may not arise at any particular session.

	• Additional capacity building, including tools and guidelines, is needed for some stakeholders to improve their grasp of gender diversity and the cross-cutting phenomenon of sexual and gender-based violence for individuals of all genders. This would close gaps for key populations who are sometimes poorly supported or not supported at all by GBV interventions because of these gaps in knowledge and capacities. • The role of GBV champions in communities should be strengthened with better remuneration and support, and by integrating them within district- and local-level community and social development structures (currently they are a cadre on their own). GBV champions should be trained and equipped to take an inclusive approach to GBV and to assist and advocate for all survivors and all individuals at risk, in all their diversity. • Strengthen the capacity of community paralegals, using peer-to-peer exchange with GBV champions, to also address GBV in communities in all its forms.
Support community mobilization and engagement	• Implementers should define a clearer theory of change for interventions and investments in community engagement, building on progress and lessons learned during 2021-2022. Such efforts should have a greater emphasis on empowering communities to demand that existing institutional structures function and are accountable rather than seeking to fill gaps with externally supported processes with limited prospects for sustainability. • Implementers should collaborate to define a monitoring and accountability mechanisms for tracking follow-up actions and for measuring gains in reducing stigma, discrimination and violence, for example, and for measuring improvements in the availability and quality of HIV, TB and malaria services. • The roll-out of the revised community scorecard should be accelerated. This work should be adequately resourced and sustained during the next grant cycle. • A strategy should be put in place to link the community scorecard to community-level human rights monitoring using the remaining time in 2023 to design and pilot these linkages. A fully linked system should be a priority for GC7. • Continue to invest in strengthening and sustaining key population- and community-led coalitions and networks, linking the community to the national level. These entities are

	essential for building and sustaining community empowerment for reducing and removing barriers.
TB Recommendations	
Eliminate TB-related stigma and discrimination	• The national TB stakeholders should prioritize conducting a TB Stigma Assessment, either through reprogramming under the current grant cycle, or as a prioritized intervention under GC7. • Based on the results of the assessment (and combined with the results of the Gender and key population assessment), TB stakeholders should develop a clear theory of change and comprehensive, prioritized action plan for eliminating TB-related stigma through using both targeted and integrated modalities. Where relevant, TB stakeholders should leverage the work led by UAC to eliminate HIV-related stigma and discrimination (using combined materials and approaches, for example). • TB stakeholders should be more visible and active in the planning and implementation of activities implemented by HIV stakeholders that aim to include TB-related components for stigma and discrimination reduction. This aspect of these interventions requires stronger stakeholder guidance and commitment on the part of TB actors.
Ensure people-centered and rights-based TB services at health facilities	• As part of conducting a TB Stigma Assessment (which includes a component on the health service environment from both service user and HCW perspectives), data should be collected and analyzed on the current state of people-centered, rights-based TB services in Uganda. • Findings of the assessment should be used by implementers to strengthen interventions ensuring non-discriminatory provision of all health services, including HIV, TB and malaria services. TB and malaria stakeholders should take a more proactive role to ensure that this occurs. • TB stakeholders should take a more proactive approach to ensure that the roll-out of the Patient's Charter includes specific components related to TB and the importance of a rights-based approach to TB services.
Ensure people-centered and rights-based law enforcement practices	• TB stakeholders, led by the NTLCP, should develop and document clearer objectives for efforts to improve people centred and rights-based law enforcement practices in the context of TB. The new policy guidelines developed by ODPP can provide a framework for this work. Once these

	objectives are articulated, a set of prioritized interventions can be set out linked to a clear theory of change and a monitoring framework. • TB stakeholders should increase their visibility and strengthen their participation in ongoing interventions with judicial officers and law enforcement stakeholders to ensure that TB-related issues and priorities are addressed and integrated within these efforts.
Improve legal literacy	• HIV stakeholders should work with TB stakeholders to identity how TB-related content can be more fully integrated into legal literacy materials and modalities, including for community paralegals and advocacy champions, among other opportunities. This would accelerate the scale-up of legal literacy interventions for people living with/affected by TB. • HIV and TB stakeholders should develop an integrated monitoring framework and measurement tools (brief electronic survey shared via social media, for example) for routinely assessing changes in the level of legal literacy among the different constituencies. • Legal literacy materials and strategies should clearly distinguish human rights-related priorities for the different populations most affected by TB. TB-related legal literacy requirements for PWUD or PWD will be both distinct from and similar to other at-risk populations, for example.
Increase access to justice	• HRAPF and UGANET should work with TB stakeholders to review their modalities for the deployment of paralegals and for legal services provision to identify opportunities for improving the availability, accessibility and acceptability of these interventions for individuals with TB-related legal concerns. Training tools and legal guides should also be reviewed to ensure that, where appropriate, they adequately address TB-related access-to-justice priorities. • Tools and modalities for monitoring access to justice should be reviewed to ensure that they include TB-related indicators. • ODPP should accelerate the roll-out of the new guidelines. At the same time, it should develop and implement a comprehensive monitoring framework to measure the results of the new guidelines for the administration of justice in the context of TB (as well as for HIV and malaria).

	• ODPP should review its circuit court strategy to ensure that it appropriately accommodates priorities for TB and that TB-specific results are documented and shared.
Improve laws, regulations and policies relating to TB	• TB and HIV stakeholders should collaborate to undertake a rapid assessment of the TB-related laws, regulations and policies using the Stop TB Partnership tools. This could be addressed through reprogramming during 2023. • Action planning linked to the legal environment assessments should incorporate both TB-specific priorities and shared priorities for HIV and TB stakeholders. • To support the roll-out of the recently completed advocacy manual, TB stakeholders should develop and implement an engagement strategy for Parliamentarians, with defined outcomes in terms of legal and policy changes, and increases in levels of political commitment to ending TB.
Reduce TB-related gender discrimination	• Accelerate the completion of the costed action plan to address the findings to the TB gender and key population assessment. Use the action plan to guide proposed investment as part of GC7 and to identify opportunities for reprogramming in 2023. • Linked to the action plan, integrated monitoring of progress to reduce TB-related gender discrimination into existing processes, particularly the community scorecard. • Use the results of the gender assessment to strengthen TB-specific content in gender-related interventions included community engagement and advocacy interventions support under CSS. • Ensure that community paralegals and GBV champions can address TB-related priorities as part of their work in communities.
Support community mobilization and advocacy	• HIV and TB stakeholders should strengthen the component of TB in interventions and investments under CSS to support community mobilization and advocacy for health. • In sustaining these interventions throughout GC7, monitoring and accountability mechanisms, including the community scorecard, should be improved to more clearly identify and track TB-related issues and priorities, including the nature and extent of any human rights violations against people living with/affected by TB. • Scale up investments to strengthening the capacity of TB survivors/TB advocates and TB-focussed CSOs. This

	should include strengthening USTP and sub-national coordination platforms for community mobilization and engagement for TB.
Address needs of people in prisons and other closed settings	• ODPP should accelerate the roll-out of the new screening guidelines and peer-education training modules for UPS. • ODPP and national HIV, TB and malaria stakeholders, should strengthen the coordination and coherence of interventions to address the needs of people in prisons. Consider ODPP's proposed inter-agency monitoring committee as the platform for achieving this.
Malaria Recommendations	
Reduce gender-related discrimination and harmful gender norms	• Continue to scale up and sustain community-level interventions to reduce the effects of harmful gender norms on equitable access, uptake and benefit from malaria interventions. This includes community dialogues, the HAAM/HOCAM interventions, equipping VHTs and CHEWs to identify and address gender-related barriers and challenges. • Continue to invest in increasing the capacity of traditional structures (household leadership, clan leadership, tribal leadership) to understand and take action on the gendered dimensions of effective household and community responses to malaria prevention and control. • Continue to invest in processes (PMI's SBC surveys, DHIS2 data analysis, community scorecard data analysis) to monitor, track and evaluate the outcomes of interventions in communities to address harmful gender norms and to monitor their influence on access, uptake and outcomes of malaria interventions. • Strengthen the capacity of NCMP and malaria stakeholders (through technical assistance and through improving tools and guides for data interpretation and use) to understand, prioritize, and use age- and gender-disaggregated data and other gender-related information in the fight against malaria. • Develop content on gender equality and patients' rights to be delivered alongside all malaria malaria interventions, including social and behavioral change (SBCC) in different formats, with messages targeted at different groups including mothers, pregnant women, men, fathers, male and female adolescents, refugees, and schoolchildren. The content of the materials should include topics such as

	more equitable household decision-making and the sharing of caregiving activities, in addition to content on basic knowledge about malaria.
Promote meaningful participation of affected populations	• Use the results of the Malaria Matchbox Assessment to further prioritize affected populations for meaningful participation. • Design and implement an engagement plan, and a tracking and accountability mechanism, for prioritized populations utilizing community-based actors and taking into account the diverse nature of communities in Uganda. • Conduct targeted community dialogue meetings and orient affected communities, such UPDF, security guards, night workers, and truck drivers, on suitable measures for malaria prevention while conducting their night duties. • Involve youth in promoting malaria prevention and control, and in broader advocacy and education around malaria, through participatory approaches such as peer education initiatives. Advocate for greater inclusion of youth in malaria programming, including recruiting youth VHTS for ICCM (this will influence their fellow youth to support malaria reduction activities). • Malaria, HIV and TB stakeholder should strengthen the malaria component in community mobilization and engagement interventions. Malaria-specific activities should be programmed to involve key affected populations for malaria.
Strengthen community systems for participation	• Provide additional technical and operational support to UCAAM to galvanize and sustain community engagement to reduce human rights and gender-related barriers to malaria programs. • Support UCAAM to develop tools and guidelines for sustained community engagement and ownership for malaria prevention, control and elimination at the community and household levels. • Support UCAAM to engage and equip malaria-focused CSOs working in communities to significantly scale up community mobilization and engagement for malaria. • Scale up and sustain current investments and interventions to strengthen the capacity of local malaria-focused CSOs for community mobilization and engagement.

	• Prioritize capacity-building investment and interventions for CSOs that strengthen the technical and operational capability for programs to reduce barriers to services in communities. • Prioritize for capacity development those CSOs led by or working directly with key affected populations for malaria. • Ensure that malaria CSOs and other community-level actors continue to meaningfully participate in the community scorecard and that they can interpret and use the results to identify and reduce equity barriers.
Monitoring and reforming laws, policies, practices	• Undertake a comprehensive analysis of the law and policy context and the degree to which it does or does not promote human rights and gender equality in the context of malaria • Ensure that ODPP, in collaboration with NMCP and other malaria stakeholders, tracks and reports on malaria-specific results as the new policies and guidelines for HIV, TB and malaria are rolled out. • Ensure that ODPP, in collaboration with NMCP and other malaria stakeholders, tracks and reports on malaria-specific results as peer educators are trained and deployed across UPS. • Leverage the expertise of HIV and TB stakeholders to undertake a rapid assessment of law and policy environment and the degree to which it does or does not promote human rights and gender equality in the context of malaria. Work with HIV and TB stakeholders to design interventions to included under GC7 to address and reduce identified gaps. • Develop and disseminate for malaria stakeholders a guideline and checklist for ensuring the all malaria interventions integrate components that address and remove human rights, gender and other equity barriers.
Improve access to services for underserved populations	• Based on the results of the Malaria Matchbox Assessment, create a system for mapping, identifying and engaging hard-to-reach, minority and socially disadvantaged populations affected by malaria, including populations in remoted and hard-to-reach areas (mountainous regions in eastern Uganda, Karamoja, island communities).

	• Periodically generate reports based on the mapping system for the identification and resolution of emerging issues to inform advocacy efforts. • Develop differentiated delivery systems for malaria programs, such as mobile community outreach teams, that respond to the results of the mapping. • Scale up engagement with disability stakeholders from the national to the local level to respond to and resolve the barriers to malaria programs that this constituency has identified, particularly modalities for ITN distribution, access to care and treatment at health facilities, and inclusion in SBCC materials and interventions, among others. • Sensitize community actors, including CSOs and other structures, to specifically engage identified underserved populations in district-level dialogues, decision-making processes, intervention planning activities, implementation of interventions, and M&E mechanisms. • Introduce components to document high-risk and underserved persons during household registration for ITN distribution and monitoring. • Strengthen tools and approaches for microplanning to including data and observations on barriers and to support action-planning and budgeting to address the barriers. • Involve youth in the development, implementation, review and implementation of malaria services programs in ways that create a sense of mutual respect and a sense of ownership of, importance to, influence within, and belonging to that service or program.

Annex 3: Summary of Methods

The assessment was conducted in November-December 2022 following a methodology developed by the Global Fund and reviewed and endorsed by stakeholders in Uganda. The assessment team was comprised of a senior technical expert, a research consultant and three national consultants, including a value-for-money focal point. The steps used to conduct the assessment were the following:

- **Stakeholder engagement and agreement on scope and approach:** Following communication by the Global Fund to the Uganda Country Coordination Mechanism about the assessment (September 2022), two virtual engagement sessions (October-November 2022) were conducted by the assessment team to present the purpose, scope and methods and to gain stakeholder agreement and comment. The detailed assessment methodology was also made available for review and comment.

- **Document review**: An extensive review document was completed (October-December 2022). The sources included Global Fund grant documents (grant agreements, budgets, Progress Update and Disbursement Request submissions, implementation letters, and grant performance reports); implementer grant agreements and reports (Sub-recipient agreements, and monthly, quarterly, semesterly and annual financial and programmatic reports); program outputs (activity reports, tools, training manuals, guidelines, policies, etc.); documentation on human rights-related barriers (violations reports, press statements, etc.); national plans and strategies for HIV, TB and malaria; and other documents and sources related to progress to reduce or remove human rights barriers

- **Data abstraction**: Data was abstracted from routine grant accountability reports (M&E data), community-led monitoring, and community monitoring reports of human rights violations. Financial data was abstracted from routine grant accountability reports, including progress reports and budget documents.

- **Key informant interviews and group discussions**: Key informant interviews (using interview guides) were conducted with 30 stakeholder representatives (November-December 2022). Group discussions were conducted with representatives of key populations (sex workers, people who use or inject drugs [PWUD], gay men and other men who have sex with men [MSM], transgender people), implementers, health workers, law and justice stakeholders, and others participating in or benefitting from programs to reduce barriers.

- **Site visits:** In addition to Kampala, site visits were conducted (December 2022) to Busia, Lira and Mbale Districts in Eastern and Northern Uganda. Sites were selected to represent some of the diversity of settings where programs to reduce barriers are

currently implemented, as well as where there were opportunities to see synergies between the different programs, implementers and other stakeholders.

- **Sharing of preliminary findings**: Preliminary results for the progress assessment, including the scorecard results, were shared with the UCCM (December 2022), as part of the Country Dialogue for the preparation of the GC7 submission (January 2023), and during a session with implementers (January 2023). This provided an opportunity for the assessment to check the comprehensiveness and usefulness of the assessment results.

- **Stakeholder validation**: Final review and validation of the assessment report, including the scorecard results, took place on October 12, 2023.

To generate the scorecard results, the following definitions were applied:

Rating	Definition
0	No formal programs or activities identified.
1.0	One-off activities that are time-limited, pilot initiative.
2.0	Small-scale ongoing initiative with limited geographic scale (e.g., a single or small number of locations – less than 20% of national scale) and capacity for reaching <35% of targeted population.
2.3	Small-scale ongoing initiative with limited geographic scale (e.g., a single or small number of locations – less than 20% of national scale) and capacity for reaching 35-65% of targeted population.
2.6	Small-scale ongoing initiative with limited geographic scale (e.g., a single or small number of locations – less than 20% of national scale) and capacity for reaching >65% of targeted population.
3.0	Operating at subnational level (btw 20% to 50% national scale) and reaching <35% of targeted population
3.3	Operating at subnational level (btw 20% to 50% national scale) and reaching 35-65% of targeted population
3.6	Operating at subnational level (btw 20% to 50% national scale) and reaching >65% of targeted population
4.0	Operating at national level (>50% of national scale) and reaching <35% of targeted population
4.3	Operating at national level (>50% of national scale) and reaching 35-65% of targeted population

4.6	Operating at national level (>50% of national scale) and reaching >65% of targeted population
5	At scale is defined as more than 90% of national scale, where relevant, and more than 90% of the population
Program is assessed to have achieved the goal when there is impact on service continuum	
Goal	Impact on services continuum is defined as: a) Human rights programs at scale for all populations; and b) Plausible causal links between programs, reduced barriers to services and increased access to HIV/TB services.

Annex 4: List of Documents Reviewed

The following types of documents were used a sources for the assessment:

Global Fund materials

GC6 application materials (funding request forms, detailed budgets, performance frameworks)

Progress Updates/Disbursement requests (for both PR1 and PR2)

Grants management correspondence (Global Fund, UCCM, and PRs)

SR financial and narrative reports (monthly, quarterly, semesterly)

National documents

National Strategic Plans for HIV, TB and malaria

Programme Review reports for HIV, TB and malaria

Other relevant policies, plans and strategies (the Equity Plan, for example)

Programming guidance documents (treatment guidelines, DIC guidelines, training manuals, etc.)

Legal Environmental Assessments

Materials from implementers

Training materials

Training reports

Reports for community dialogues, community engagement events, etc.

Reports on human rights violations (HRAPF, SMUG, for example)

Meeting reports

Annex 5: List of Stakeholders

Representatives from the following stakeholders participated in the progress assessment:

- AIDS Control Programme (MoH)
- Centre for Health, Human Rights and Development
- Equity Plan Secretariat (National Coordinator)
- Human Rights and Awareness Promotion Forum
- Innovation Programme for Community Transformation
- International Community of Women Living with HIV East Africa
- Joint United Nations Programme on HIV/AIDS (UNAIDS)
- Most-At-Risk Population Initiative
- Makerere School of Public Health
- National Forum of People Living with HIV/AIDS Networks in Uganda
- National Malaria Control Programme (MoH)
- National Tuberculosis and Leprosy Control Programme (MoH)
- Office of the Director of Public Prosecutions
- Office of the High Commissioner for Human Rights
- Program for Accessible Health Communication and Education (PACE)
- Positive Women with Disabilities
- The AIDS Support Organisation
- United States President's Malaria Initiative
- Unites States President's Emergency Plan for HIV/AIDS
- Uganda AIDS Commission
- Uganda Civil Society Alliance Against Malaria
- Uganda Country Coordination Mechanism
- Uganda Network on Law, Ethics and HIV/AIDS
- Uganda Network of Young People Living with HIV
- Uganda Harm Reduction Network
- Uganda Key Populations Consortium

- Uganda Network of AIDS Service Organisations
- Uganda Network of Sex Work Organisations
- Uganda Police Force
- Uganda People's Defence Force
- Uganda Prisons Service
- United Nations Development Programme
- Uganda Stop TB Partnership
- Women's Pro-bono Initiative