



CIVIL SOCIETY FUND

Strengthening civil society for improved HIV&AIDS
and OVC service delivery in Uganda



The Technical Management Agent for the Civil Society Fund



Final Report

USAID Contract No. AID-617-C-10-00005
February 2010 to February 2014

This publication was produced for review by the Civil Society Fund and the United States Agency for International Development. It was prepared by Chemonics International Inc.

CONTENTS

ACRONYMS	i
EXECUTIVE SUMMARY.....	1
CHAPTER I. BACKGROUND.....	5
CHAPTER II. STRENGTHENING THE EFFECTIVENESS OF PARTNERSHIPS.....	10
CHAPTER III. STRENGTHENING THE CAPACITY OF CIVIL SOCIETY ORGANIZATIONS AND LOCAL GOVERNMENTS.....	16
CHAPTER IV. EXPANDING ACCESS TO AND USE OF HIGH-QUALITY OVC, HIV, AND AIDS SERVICES.	24
CHAPTER V. CROSSCUTTING THEMES.....	43
CHAPTER VI. APPLYING LESSONS FROM TMA.....	48

EXHIBITS

EXHIBIT 1: CSF STRATEGIC PARTNERS.....	1
EXHIBIT 2: TMA HIGHLIGHTS.....	4
EXHIBIT 3: CSF SERVICE DELIVERY FRAMEWORK	7
EXHIBIT 4: CSF BOARD OF DIRECTORS 2013 CONSTITUENCY REPRESENTATION.....	8
EXHIBIT 5: OUTCOMES OF IMPROVED CSF MANAGEMENT.....	10
EXHIBIT 6: CAPACITY ASSESSMENTS: BEFORE AND AFTER	18
EXHIBIT 7: CSF SERVICES COVERAGE 2010 – 2013.....	25
EXHIBIT 8: KEY POPULATIONS RECEIVING HIV PREVENTION MESSAGES.....	26
EXHIBIT 9: OVC SERVED WITH A COMPREHENSIVE OVC PACKAGE APRIL 2010 – MARCH 2012.	39
EXHIBIT 10: DETAILED ACCOMPLISHMENTS OF UGANDA TMA (2010-2013)	42
EXHIBIT 11: UNIT COSTS OF KEY CSF INTERVENTION AREAS.	43
EXHIBIT 12: FEMALE BENEFICIARIES ACCESSING CSF-FUNDED HIV AND AIDS AND/OR OVC SERVICES.....	45

Cover Photo: *Beneficiaries supported by CSF sub-grantee Kitovu Mobile AIDS Organization.*
All photos: CSF

ACRONYMS

ADP	AIDS Development Partner
AIDS	Acquired Immune Deficiency Syndrome
ART	Anti-retroviral Therapy
BCC	Behavioral Change Communication
CBO	Community-Based Organization
CPA	Core Program Area
CSF	Civil Society Fund
CSO	Civil Society Organization
DFID	Department for International Development (UK)
EMTCT	Elimination of Mother-to-child Transmission of HIV
FMA	Financial Management Agent
FP	Family Planning
GIS	Geographical Information System
GOU	Government of Uganda
HCT	HIV Counseling and Testing
HIV	Human Immune Deficiency Virus
IDI	Infectious Diseases Institute
IEC	Information Education Communication
JCRC	Joint Clinical Research Centre
JSS	Joint Support Supervision
LA	Lead Agency
LQAS	Lot Quality Assurance Sampling
MEA	Monitoring and Evaluation Agent
M&E	Monitoring and Evaluation
MGLSD	Ministry of Gender, Labour & Social Development
MIS	Management Information System
MoH	Ministry of Health

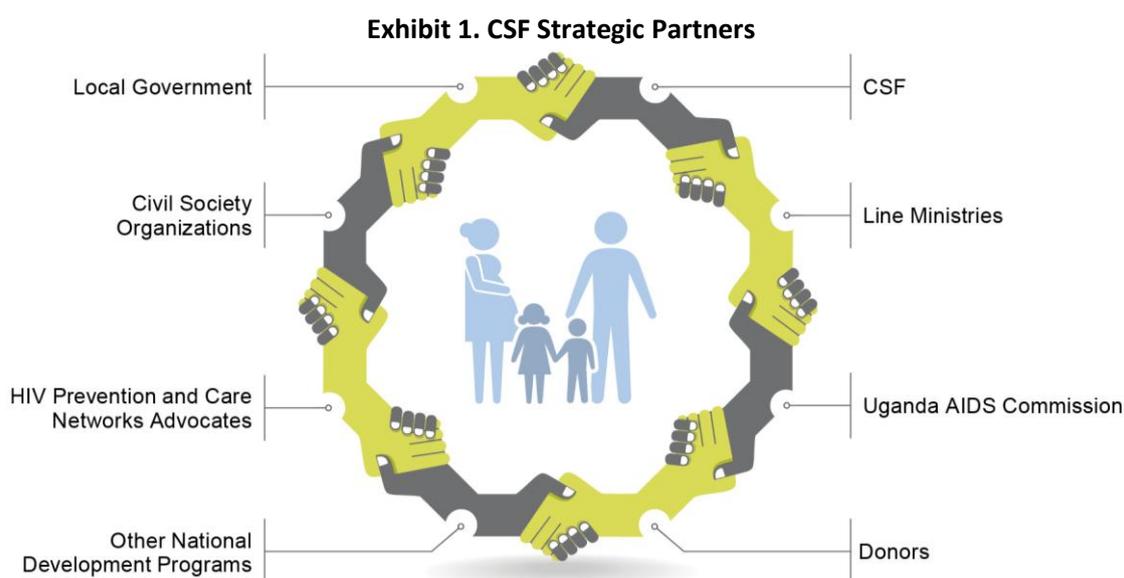
MoLG	Ministry of Local Government
NAFOPHANU	National Forum of People Living with HIV/AIDS Networks in Uganda
NGO	Non-Governmental Organization
NNGO	National Non-Governmental Organization
NPS	National HIV Prevention Strategy
NPAP	National Priority Action Plan
NSP	National Strategic Plan
NSPPI	National Strategic Program Plan of Interventions
OCAT	Organizational Capacity Assessment Tool
OI	Opportunistic Infection
OVC	Orphans and Other Vulnerable Children
PACT	Partnership for Accountability and Capacity Transformation
PLHIV	People Living with HIV/AIDS
PMP	Performance Management Plan
PMTCT	Prevention of Mother-to-child Transmission of HIV
PwP	Prevention with Positives
RFA	Request for Application
RTA	Regional Technical Assistance
SC	Steering Committee
SMC	Safe Male Circumcision
SMS	Short Message Services
SRH	Sexual and Reproductive Health
STI	Sexually Transmitted Infections
STF	Straight Talk Foundation
TB	Tuberculosis
TMA	Technical Management Agent
UAC	Uganda AIDS Commission
UGANET	Uganda Network of Law Ethics and HIV
UNASO	Uganda Network of Service Organizations

EXECUTIVE SUMMARY

Over the last three decades, Uganda has experienced a continuously challenging HIV and AIDS epidemic and orphans and other vulnerable children (OVC) crisis. In collaboration with multiple stakeholders, the country has demonstrated success by enacting various policies and making relevant interventions. Numerous civil society organizations (CSOs) have complemented these efforts by offering an array of health and livelihood services to target communities. Nevertheless, the insidious nature that characterizes the OVC crisis, and HIV and AIDS underscored the need for a comprehensive, multilateral, and coordinated strategy to better address this amalgam of challenges.

In 2007, the Uganda AIDS Commission established the Civil Society Fund (CSF) to ensure that civil society's provision of OVC, HIV, and AIDS services were harmonized, streamlined and effective, and in support of national plans and policies. Essentially, the purpose of the CSF was to bring together multiple donor funds and disburse grants to civil society, align grants with national plans and decision-making processes, and enable an effective, scaled up, and comprehensive response to HIV, AIDS, and OVC. Three management agents were relied upon to help coordinate CSO efforts and strengthen their capacity to contribute to a harmonized and effective response: the Technical Management Agent (TMA); the Monitoring and Evaluation Agent (MEA); and the Financial Management Agent (FMA). The TMA, under the management of Chemonics International, was contracted in 2010 to provide technical support to CSOs by building their programmatic and service capacity to deliver high-quality HIV, AIDS, and OVC services.

Over the last four years, TMA has worked with CSOs at all levels, public institutions at national, district, and community levels, the private sector, academic institutions, development partners, communities, and beneficiaries to implement sustainable interventions. In order to make an effective contribution to the national OVC, HIV, and AIDS response, TMA's strategic priorities focused on: strengthening CSF systems, strengthening the institutional and technical capacity of CSF



sub-grantees, and increasing service delivery in the National Strategic Plan (NSP) priority areas. Throughout the life of the project, TMA was responsible for providing the following outcomes:

Facilitated effective partnerships, collaboration and coordination between the Government of Uganda (GOU), civil society, and donors. TMA has played a leading role in strengthening the functional structures and partnerships that have been pivotal in the management and coordination of the CSF mechanism. By means of stakeholder workshops, joint planning and programming forums, meetings, and strategic coordination and integration initiatives, TMA explored opportunities for collaboration, knowledge exchange, and resource sharing, and fostered strategic partnerships across all levels. By enhancing governance and management capacity and strengthening collaboration and coordination among CSF stakeholders and partners, TMA has enabled CSF to institutionalize an effective, streamlined, and comprehensive response to the OVC crisis and HIV and AIDS in Uganda.

Strengthened the capacity of civil society organizations, local government, and private and academic institutions to effectively contribute to the national OVC, HIV, and AIDS response. TMA's mandate was to strengthen the institutional and technical capacity and the learning and knowledge management of all CSF sub-grantees to enable them to provide high-quality HIV and AIDS and OVC services. Beyond merely imparting knowledge and expertise, TMA systematically institutionalized meaningful capacity building initiatives in the processes, systems, structures, and services of all CSOs. TMA, in conjunction with MEA and FMA, used a suite of capacity building approaches, including onsite mentoring and coaching, self-administered blended learning, experience sharing and training workshops, and joint and targeted supportive supervision. In addition, TMA contributed to the reviews of different policies and guidelines at the national level that directly improved service delivery, such as the National HIV Prevention Strategy (2011-2015), National Strategic Plan (2011/12-2014/15), and the National Strategic Program Plan of Intervention (2010-2015). In carrying out innovative and varied approaches to capacity building, TMA enhanced the institutional and program effectiveness of its sub-grantees, who in turn meaningfully contributed to the national HIV and AIDS and OVC response.

Increased access and utilization of high-quality OVC, HIV, and AIDS services. The outcomes and efforts mentioned above were guided by a concerted focus to enable sub-grantees to expand the access to and use of high-quality services by target communities. TMA synced its activities and technical strategies with national priorities to support sub-grantees to improve the delivery of the following services and approaches: behavior change communication (BCC) interventions, HIV counseling and testing (HCT), integration of sexual and reproductive health, prevention of mother-to-child transmission (PMTCT), safe male circumcision (SMC), and non-clinical care and support services to people living with HIV/AIDS (PLHIV) and OVC and their households. TMA supported all sub-grantees in offering a stipulated minimum package for HIV and AIDS services in addition to improving the delivery of services to ensure that the response was aligned to the ever-changing dynamic nature of the epidemic. Moreover, TMA responded to the OVC crisis by strengthening the capacity of households and communities to protect and care for OVC and by increasing the access to and the use of high-quality services for OVC and their households. TMA also ensured that CSF expanded its coverage area to ensure equitable service delivery in underserved parts of the country

and increased access to key health services for key populations with a particular focus on women and girls.

TMA, with the support of the CSF team, GOU, and donor partners, made many strides in strengthening Ugandan CSOs to provide high-quality HIV, AIDS, and OVC services. TMA, in tandem with MEA and FMA, supported 243 CSOs and 79 local governments in 109 of Uganda's 112 districts. Nevertheless, the journey is not over, and many challenges remain. The evolving face of the epidemic, in addition to the continuing need to coordinate the efforts of CSOs and other implementing agencies, demands continuous support and collaboration to maintain and improve organizational and programming capacities and to avoid the overlap of services. It will be important for future CSF programming and health sector stakeholders to build on TMA's progress in the years ahead in pursuit of further reinforcing the OVC, HIV, and AIDS response in Uganda.

Exhibit 2. TMA Highlights



109

Number of Uganda's 112 districts where TMA-supported CSOs provide services

322

Number of CSF grants made, to 243 CSOs and 79 local governments

Additionally,
TMA supported
CSOs to serve:

1,115,307

People counseled, tested for HIV, and given results

1,785

HIV-positive children referred for complementary HIV and OVC services

98,795

Vulnerable children provided with services and monitored with the Child Status Index

78,383

People enrolled and retained in HIV care

9,986

Men provided with safe male circumcision in one year

2,585,771

People receiving HIV/AIDS prevention messages through small groups and individual sessions

37,278

Pregnant women mobilized for antenatal care and services to eliminate mother-to-child transmission of HIV

Other highlights:

- Scaled up automation of data collection and analysis to improve OVC and HIV/AIDS programming
- Re-engineering the granting process to expand funding opportunities to a larger portfolio of CSOs
- Partnered with the Transcultural Psychosocial Organization to develop the Child Status Index tool and database
- Spearheaded technical working committees to help develop the national CSO-focused combination HIV-prevention approach
- Helped develop the National OVC Vulnerability Index
- Developing the CSF OCAT by adapting the McKinsey & Company version to include organizational and technical areas
- Promoting cost-effective learning through a variety of adult learning interventions, such as blended learning modules
- Modeling and implementing three decentralized capacity building approaches customized for CSOs

CHAPTER I. BACKGROUND

A. Orphans and Other Vulnerable Children, HIV, and AIDS in Uganda

Uganda has been facing an HIV and AIDS epidemic for more than three decades, during which time the epidemic has had devastating effects on society. In the early 1990s, Uganda's concerted response against HIV yielded positive results when its prevalence declined and later stabilized. Despite the gains made in the 1990s to early 2000s, trends in the last decade indicated a rising prevalence, characterized by limited access and coverage of services, and inadequate behavior change. Resurgence of the epidemic has been particularly concerning because new HIV infections greatly affect the well-being of individuals and communities and impede socio-economic growth and development.

The orphans and other vulnerable children crisis is another burden affecting Uganda. There are at least 2.4 million children who have been orphaned, almost half of them because of HIV and AIDS. Nationally, 51 percent of children in Uganda are considered moderately or critically vulnerable, equivalent to a national total of approximately 8 million vulnerable children. Key drivers of child vulnerability include poverty, internal conflict in some parts of the country, HIV and AIDS, as well as other preventable diseases. Factors exacerbating child vulnerability include challenging socio-economic circumstances and family- and community-related factors, such as domestic violence, low income, household food insecurity, and poor childcare practices.

B. The National Response

The Ugandan government recognized that the situation demanded a concerted effort to reduce the sources of new infections and to scale up access to comprehensive and high-quality OVC-, HIV-, and AIDS-related services. The Government of Uganda developed several strategies to guide the response to HIV and AIDS, and OVC. The Multisectoral Approach to the Control of HIV/AIDS (MACA), developed in 1992, laid the foundation for the development of periodic national program mechanisms. The National Operational Plan for Sexually Transmitted Infections (STI)/HIV/AIDS activities governed the national response from 1994 to 1998; and the National Strategic Framework for HIV/AIDS Activities of 1998-2000, which was revised in 1999/2000 to form the National Strategic Framework 2000/1 – 2006/7, directed the national response to HIV and AIDS in the early 2000s.

In 2006 the GOU, through the Uganda AIDS Commission (UAC), released the National Strategic Plan (NSP) 2007-2012. Building on previous national efforts, the NSP focused on the achievement of reducing HIV prevalence by 25 percent, mitigating the effects of HIV, and strengthening the nation's capacity to coordinate and manage a multisectoral response to the epidemic. More recently, the GOU revised its approach and launched the 2011/12-2014/15 NSP. The revised plan re-emphasized its commitment to galvanize an expanded, multisectoral, national response to the HIV epidemic with the aim of realizing "a population free of HIV and its effects." In 2011, Uganda launched another comprehensive strategy; the National HIV Prevention Strategy (NPS) (2011-2015) that has been

guiding HIV prevention interventions in a more holistic, strategic, and effective manner aimed to significantly reduce new HIV infections by 30 percent.

In addition, strategies for addressing HIV and AIDS are included in the Ministry of Health’s Health Sector Strategic Plan (I and II) and NSP. HIV and AIDS and OVC are also addressed by the Ministry of Labour, Gender and Social Development in the National OVC Policy and the National Strategic Programme Plan of Interventions for OVC (NSPPI-1 and -2), which govern the core services for OVC in Uganda.

The recognition that a truly effective response requires a coordinated multi-lateral effort between the government, civil society, private sector, and development partners has been critical to the GOU’s approach. The Ugandan government and development partners have continually recognized the critical and historic role civil society organizations (CSOs) have played in response to OVC, HIV, and AIDS challenges throughout the country. Specifically, CSOs have persistently shouldered the responsibility of reaching out to communities with services and behavior change messages. Although CSOs have addressed national and local priorities, maintaining their efforts as separate initiatives has resulted in fragmented and poorly coordinated OVC, HIV, and AIDS responses.

C. Working Together: The Civil Society Fund (CSF) Mechanism

Civil Society Fund’s Purpose and Goal

In an effort to harmonize and streamline donor support to CSOs providing OVC, HIV, and AIDS services and to align donor efforts with national strategies, a partnership led by UAC including line ministries, AIDS development partners, and civil society representatives established a unique multi-donor-funded mechanism in 2007. The CSF aimed to efficiently disburse funds to CSOs to enable a streamlined, effective, and aligned response to HIV, AIDS, and OVC. The five donors currently contributing to the fund are known collectively as AIDS development partners and consist of the United States Agency for International Development (USAID), the U.K. Department for International Development, Irish Aid, Danish International Development Agency, and the Swedish International Development Cooperation Agency. The Italian Development Cooperation also contributed to the CSF basket in the initial stages.

CSF GOAL AND PURPOSE

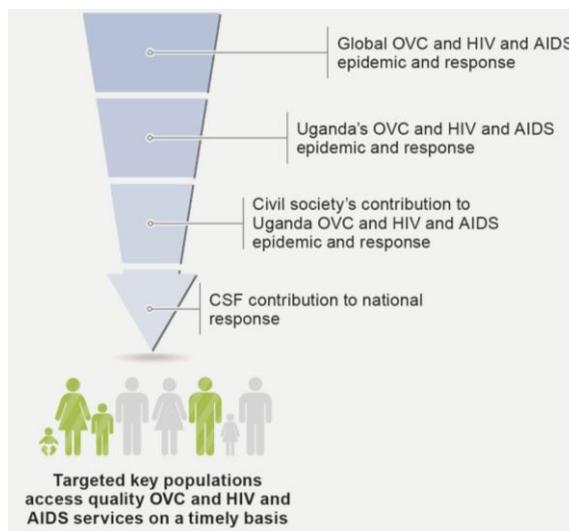
Goal: The goal of the Civil Society Fund is to ensure that civil society provision of prevention, care, treatment, and support services is harmonized, streamlined and effectively contributes to the attainment of the goals of the Government of Uganda National Strategic Plan, the National Programme Plan of Interventions for Orphans and other Vulnerable Children, the National Priority Action Plan, and other national policies and plans.

Purpose: The purpose of CSF is to bring together multiple donor funds and disburse grants to civil society organizations that are aligned with national plans and policies.

Central to CSF’s vision and management are several agreed-upon principles: a) support for a broad range of civil society partners will enable an effective response; b) building national capacity at all levels will enhance sustainability and ownership; c) a partnership between government, civil society and development partners will facilitate an effective national response; d) transparency and accountability will realize effectiveness and value for money; e) an effective response to HIV and

AIDS must be holistic and support access to prevention, treatment and care, and knowledge management; f) communication is essential; and g) it is important to mainstream gender and age.

Exhibit 3. CSF Service Delivery Framework



CSF has sought to achieve broad civil society participation and geographic coverage by engaging a wide range of civil society partners. The four categories of organizations supported by CSF are:

- CSOs, including non-governmental organizations (NGOs), faith-based organizations, and community-based organizations
- Technical support organizations
- Local governments
- Other organizations, such as private sector and academic institutions

CSF supports projects and programs at national, regional, district and community levels, with a focus on reaching geographically underserved areas. The activities are intended to expand service delivery, support strategic planning, coordination and technical assistance to civil society, develop institutional and organizational capacity, monitor and evaluate programs, activities and interventions, support operations research, and support and promote advocacy and lobbying initiatives.

To date, CSF has disbursed 322 grants, valued at more than UGX 271,040,904,037 (\$108 million), to 243 CSOs and 79 local governments in 109 of Uganda's 112 districts. Of the 322 grants disbursed, 191 were focused on HIV and AIDS prevention, 124 on OVC, three on pediatric AIDS, and four grants were administered to national NGOs to provide HIV and AIDS care and treatment.

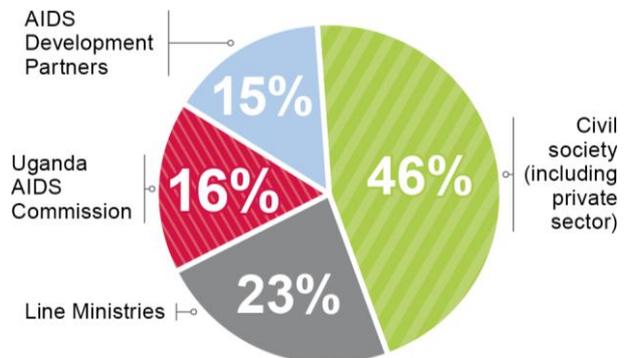
CSF Governance

The overall leadership, guidance, and direction of CSF is provided by the CSF Board (formerly referred to as the Steering Committee), which reports to the Uganda AIDS Commission's Board

**Exhibit 4. CSF Board of Directors
2013 Constituency Representation**

of Directors. The 13-member CSF Board includes representatives from the UAC, the Ministry of Gender, Labour and Social Development, the MoH, the Ministry of Local Government, the AIDS development partners, and participating CSOs.

The board plays an oversight role, ensuring that all implementing agencies at all levels respond to national priorities, collaborate with line ministries, and adhere to CSF guiding principles, values, and practices. It is also responsible for overall coordination and establishing policies, procedures, and systems for the management and implementation of the CSF, including processes for decision-making and managing conflicts of interest. The board also monitors CSO performance including accountability, transparency, effective communication, participatory planning, regular internal and external reporting, and coordination.



The Three Management Agents

To help coordinate CSO efforts and strengthen their capacity to contribute to a harmonized and effective response, three management agents were contracted: the Financial Management Agent; the Technical Management Agent; and the Monitoring and Evaluation Agent. Each agent had distinct, yet complementary, roles and responsibilities. Individually and collectively, all three agents were charged with ensuring that grants under the CSF were aligned with national priorities, accommodated the needs of all donors, and embraced feedback from civil society.

The Financial Management Agent

FMA, managed by Deloitte Uganda, provides management and financial oversight services to CSF and its sub-grantees. It manages all financial resources, grant commitments, disbursements, and liquidations. The FMA also provides technical assistance for financial monitoring and evaluation and capacity building to all CSF sub-grantees. Specific areas of support include:

- Partnership: collaboration, coordination, and management
- Funds management
- Grants management
- Financial monitoring and evaluation
- Financial capacity building

The Monitoring and Evaluation Agent

Implemented by Chemonics International until December 2012, MEA was responsible for establishing a comprehensive performance, monitoring, and reporting program aligned with the NSP, NSPPI, and other relevant M&E frameworks for CSF and its sub-grantees. Specific areas of support included:

- Partnership: collaboration, coordination, and management
- Monitoring the performance of CSF grant recipients
- Data analysis, reporting and dissemination
- Convening project progress review meetings
- Capacity building in M&E
- Communications

The Technical Management Agent

In 2010, the TMA, also under the management of Chemonics International, was contracted to:

- Support establishment of policies, procedures, and systems for the governance, management, and implementation of the CSF mechanism
- Strengthen technical and institutional capacities of sub-grantees to plan, manage, coordinate, and improve delivery of high-quality services in line with HIV and AIDS and OVC priorities outlined in the NSP and NSSPI
- Provide technical support for monitoring and managing CSF grants
- Establish effective and transparent partnering mechanisms within the sub-grantees as well as other CSF key stakeholders

Following the closing of the MEA project, TMA assumed specific M&E functions, including reporting and data management. TMA's operations have been guided by the following key principles: ensuring that transparency and accountability for resources are adhered to at all levels; civil society organizations have a fair and equitable chance to access funds; equitable geographic coverage of services is realized; and gender imbalances in the design, implementation, and evaluation of OVC, HIV, and AIDS projects are strategically addressed.

To make an effective contribution to the national OVC, HIV, and AIDS response, TMA focused its strategic priorities on the three key result areas of the CSF Strategic Plan (2010-2012):

- Key Result Area 1. Service delivery in the NSP program priority areas strengthened
- Key Result Area 2. Institutional and technical capacity of CSF sub-grantees strengthened
- Key Result Area 3. CSF systems strengthened

TMA was responsible for providing the following outcomes:

- Facilitated effective partnerships, collaboration, and coordination between the GOU, civil society, and donors
- Supported the grants program by ensuring that grants were disbursed in an effective and transparent manner
- Strengthened the capacity of civil society organizations, local government, and private and academic institutions to effectively contribute to the national OVC, HIV, and AIDS responses
- Increased access and use of high-quality OVC, HIV, and AIDS services

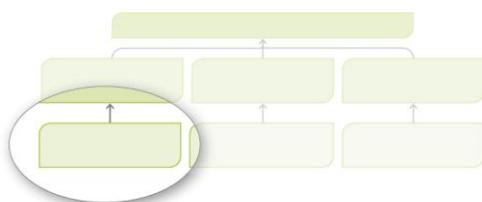
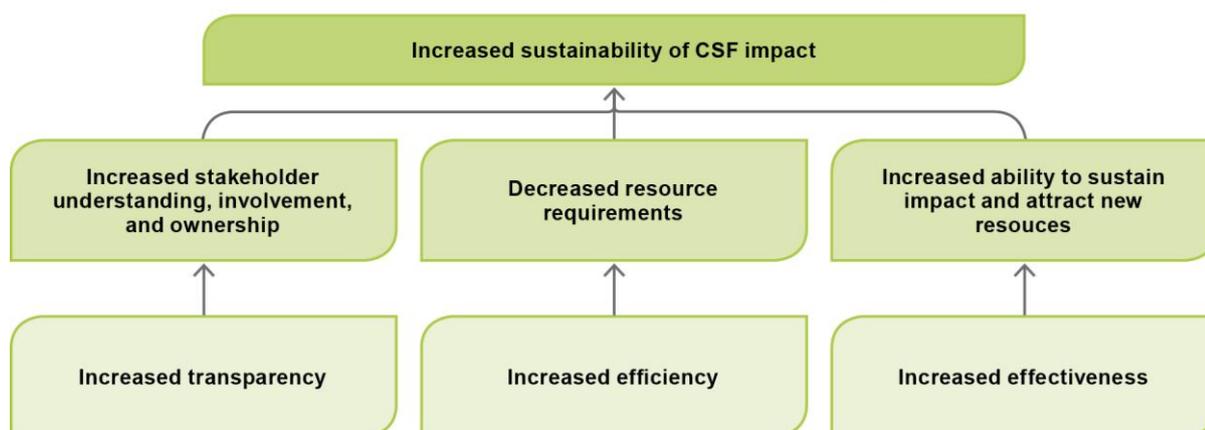
CHAPTER II. STRENGTHENING THE EFFECTIVENESS OF THE PARTNERSHIP BETWEEN THE GOVERNMENT, CIVIL SOCIETY, AND DONORS

Strengthening collaboration among CSF partners within the multisectoral approach is vital to effectively contribute to the national responses for OVC, HIV, and AIDS in Uganda. One of the most widely praised aspects of TMA’s work has been its leading role in strengthening the functional processes and structures that have been pivotal in the management of the CSF mechanism. By enhancing governance and management capacity and strengthening the collaboration and coordination among CSF stakeholders and partners, TMA enabled the CSF to institutionalize an effective, scaled-up, and comprehensive response to OVC, HIV, and AIDS in Uganda.

A. Improving the Civil Society Fund Mechanism

By assessing the CSF mechanism against the five key principles of the Paris declaration: Ownership, Alignment, Harmonization, Management for Development Results, and Mutual Accountability, the CSF leveraged a deepened engagement of CSOs by building accountability and transparency, promoting national ownership of donor programs, delivering results, changing aid conditionality, and increasing predictability of aid flow to CSOs. Throughout the life of the project, TMA, in conjunction with MEA and FMA, supported CSF in the areas of governance, communications, monitoring and evaluation, and data use. Exhibit 5 below illustrates the logical link between TMA’s improvements in the areas of transparency, efficiency, and effectiveness, and key positive outcomes.

Exhibit 5. Outcomes of Improved CSF Management



Improvements in strategic communications helped enhance **transparency**, which ultimately increases sustainability because stakeholders have a better understanding and greater ownership of the fund. Key improvements in communications and other activities that helped strengthen fund transparency since the

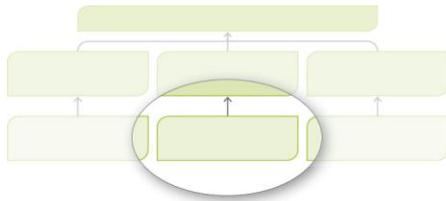
start of the project include enhanced communications between management agents and sub-

grantees, *The Link* e-newsletter that provides relevant HIV/AIDS and OVC information on a quarterly basis, increased communication between management agents and the steering committee, and overall increased visibility of the CSF. By actively communicating CSF activities and interventions, the CSF was able to improve coordination among stakeholders, enabling them to harmonize activities and address needs and gaps.

In addition to generating and sharing quarterly and annual reports, and project communication products that provide a transparent account of the use of funds to partners, stakeholders, and beneficiaries, the CSF mechanism was externally evaluated three times in its five years of existence. These evaluations — in 2009, 2011, and 2013 — assessed CSF's impact as well as determined its strategic direction and appropriate management structure. These evaluations assessed the CSF mechanism and prevention interventions in terms of relevance, effectiveness, efficiency, impact, and sustainability; evaluated results achieved by specific prevention interventions, and identified lessons learned to make recommendations for continued systems strengthening and service delivery. Highlighted achievements from these recommendations include promoting the role of CSOs (and the CSF) in the HIV and AIDS response, strengthening CSF governance systems and structures to deliver CSF service delivery targets, clarification on the purpose and scope of CSF, streamlining management structures and functions, and improving technical and organization support complementing financial support. Examples of other key accomplishments that have led to greater transparency include:

- *Increased visibility of the CSF.* To further enhance communications with stakeholders, CSF developed a range of communications products that could be accessed through the Internet and/or distributed in various fora. For example, TMA re-designed the CSF website to make it more user-friendly and to provide stakeholders with more updated and relevant information. Additionally, CSF prepared success stories, quarterly newsletters, and numerous presentations using project-generated data, and presented them to audiences at the district (e.g., through the experience-sharing workshops) and national level (e.g., MoH bi-annual review meeting). At the international level, CSF prepared and submitted abstracts to support international conferences, including the Global Health Conference, PEPFAR Implementers Conference, International Conference on AIDS and STIs in Africa, and International AIDS Society Conference. Participation in these forums allowed for increased visibility into activities and services supported by the CSF, generated feedback, increased publicity of the fund, and facilitated collective learning.
- *Increased communications between management agents and the CSF Board.* In addition to the quarterly meetings, CSF management agents provided the board with monthly updates on completed and planned activities. From 2010-2012, TMA served as the secretariat to the board, keeping stakeholders and management agents on track by maintaining systems (e.g., agenda, meeting minutes, and monthly updates) and collecting, documenting, and using feedback from all stakeholders to enable the smooth flow of information and action items. Supporting the coordination of management agents ensured strengthened collaboration, linkages, and the harmonization of CSF interventions and allowed the CSF to act as a single entity when representing the CSF and while reporting its achievements.

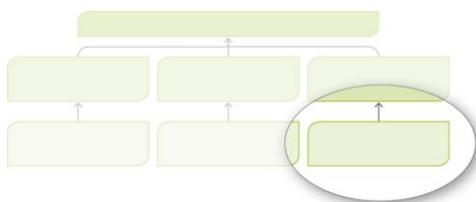
Three Agents, One Voice
“TMA fostered communication and coordination between all three agents. Agents spoke (with) one voice.”
— Dr. Joel H. Okullo, CSF board chair



TMA improved **efficiency** at the governance and management levels by streamlining processes that in turn have allowed actors to focus more time and resources toward direct support of HIV prevention, care and support, and OVC services. By pooling aid and harmonizing donor support to civil society, the CSF mechanism allowed for a targeted CSO

response to OVC, HIV, and AIDS in Uganda based on national plans and policies. Examples of key accomplishments that led to greater efficiency include:

- *Role of stakeholders streamlined.* In an effort to reduce delays in implementation of CSF activities and to eliminate the duplication of roles between the board and management agents, the role of the board was re-articulated and codified through an approved revision of the CSF Governance, Management, and Operations Manual. This revision allowed the board to focus on high-level strategic decisions, while the role of management agents was modified to focus on day-to-day operational decisions, implementation of activities, and the duties of the secretariat.
- *Capacity building approach decentralized.* The process for decentralizing the technical capacity building of sub-grantees, which was also codified through the Governance, Management, and Operations Manual revision, shifted essential resources to cost-effective local organizations that have greater familiarity with the context of each region/district. This increased efficiency through a less expensive and more locally adapted approach.
- *Data collection, analysis, and reporting streamlined.* To improve data quality while reducing manual, labor-intensive processes, TMA together with MEA automated data collection, analysis, and reporting functions. Web-based or electronic data entry into a central CSF registry allowed for more rapid and less error-prone aggregation and analysis of data. By the end of 2010, 100 percent of all sub-grantees had received training in web-based data entry with continued training each year of all new sub-grantees. In addition, web-based standardized reports and an interactive results framework were designed and made accessible to stakeholders. These reports have provided data on CSF results according to user-selected geographic, demographic, and time variables.



Improved **effectiveness** paved the way for the CSF to achieve greater, more equitable, and sustained impact. The board decisions focused more on achieving greater geographic coverage as well as inclusion of different categories of CSOs. Highlights of management decisions and activities that supported increased effectiveness

include:

- *Improved civil society representation in decision-making.* Civil society representation on the board increased from 33 percent at inception to 50 percent in 2010. Active participation of sub-grantees on the board helped to identify capacity needs, promoted ownership, and institutionalized learning. Representation in governance structures and meetings provided an

opportunity to members of the civil society to harmonize their voices and form positions on prevailing contemporary issues and enabled their input on decision-making. Examples of key decisions taken by the Board in Year 6 included the approval of the FY 2012/2013 work plan; the appointment and supervision of consultants to lead the operationalization of the CSF management study; and the approval to contract successful applicants under RFA 11- 001 (HIV3).

- *Improved gender programming.* Sub-grantees were guided to implement gender-sensitive interventions. CSF monitoring and supervision tools were revised to track all gender-related activities and results. CSOs made commendable progress in designing gender-inclusive interventions, including couple testing for HIV, taking services where men commonly congregate, gender-sensitive timing of events to suit both men and women, and applying gender-sensitive beneficiary selection criteria.
- *Data use and analysis improved.* To ensure the effective use of data and to align CSF data to national HIV and OVC indicators, CSF revised data collection tools and reporting formats. All database modules were revised to ensure that they produced online real-time reports. The reports were made available on the CSF website so that sub-grantees could easily access the data and better inform their programs. Moreover, in an effort to expand the scope of data analysis and reporting, CSF used a geographic information system (GIS) to perform spatial analysis of its program data. Thematic maps depicting spatial coverage of the different interventions and health trends enabled CSF management and sub-grantees to better determine geographical coverage during RFA and sub-grantee proposal development, and ultimately avoid overlaps and duplication of services. CSF systematically strengthened sub-grantees' capacity for data use over the years, from 23% in 2009 to 54% in 2010, 57% in 2011, 71% in 2012, and 85% in 2013.
- *Granting process re-engineered.* To streamline the granting process, TMA, in partnership with MEA and FMA, re-designed the granting process to allow for full participation of all stakeholders at the Request for Application (RFA) development stage through technical working groups. At this stage, the RFAs were streamlined to meet local, national, and international HIV intervention policies and guidelines. The new granting process also required applicants to write concept papers which followed a standardized format. The qualified applicants were thereafter guided in developing proposals from the approved concept papers. Consequently, it was easier to review many concept papers and also allow for the qualification of many smaller CSOs that do not have sufficient proposal writing experience. In 2011, of the 42 applicants received, 15 organizations submitted passing applications, and of those, nine proposals from eight NNGOs were awarded, at a total value of UGX 34.4 billion.

B. Impacting National Policies and Strategies for OVC, HIV, and AIDS

One of CSF's key mandates has been to contribute to a harmonized OVC, HIV, and AIDS response in Uganda. To execute this mandate, CSF has strengthened coordination and collaboration, and

developed strategic links with key stakeholders including line ministries (MoH, MGSLD, and MoLG), CSOs, the private sector, and local governments.

In an effort to ensure that civil society's provision of OVC, HIV, and AIDS services were streamlined effectively and made consistent with GOU's national plans and policies, TMA, in close collaboration with MEA and FMA, developed a three-year strategic plan that served as CSF's operational framework. The 2009-2012 Strategic Plan clearly defined the purpose of the CSF, established goals and objectives, ensured the targeted use of CSF resources on key priorities, provided a base from which progress could be measured, and established a mechanism for informed change when needed. Additionally, TMA participated in several national decision-making processes and collaborative interactions, including:

- *National strategies and policies.* TMA has supported and ensured that the design and implementation of HIV interventions are consistent with national guidelines, such as the National HIV and AIDS Strategic Plan (NSP), National Strategic Program Plan of Interventions for Orphans and Other Vulnerable Children (NSPPI) and the AIDS Indicator Survey (AIS). During fiscal year 2011-2012, CSF staff and selected sub-grantees participated in the review and the subsequent development of the revised NSP 2011/12- 2014/15 and the National HIV Prevention Strategy 2011-2015.
- *National strategic information.* TMA in collaboration with MEA participated in the establishment and management of a coordinated and effective national strategic information system for the HIV and AIDS response. All CSF sub-grantees reported data to the MoH's District Health Information System either through the health centers they collaborated with or by ensuring that their health facilities were accredited by MoH and allowed to report directly to the districts. During the TMA supportive supervision visits conducted in June 2013, it was noted that 100 percent of sub-grantees' HCT and HIV care data was being reported in the Health Management Information System. Additionally, CSF-generated data were analyzed, disseminated, and used to showcase the contribution of civil society to the national HIV and AIDS response during the September 2013 Joint Annual AIDS Review meeting.
- *Strategic partnerships.* CSF has also been instrumental in bolstering sub-grantees' engagement in strategic partnerships with local governments, health facilities, and other partners to ensure that services get to the most needy beneficiaries and in coordinating implementation. CSF collaborated with MoH, UNFPA, and the World Bank in the development of the 2013 National Combination Prevention baseline survey in six focus districts, as well as with Management Sciences for Health and 10 districts to conduct the 2012 Lot Quality Assurance Sampling surveys. Additionally, CSF leveraged resources and expertise by partnering with the Transcultural Psychosocial Organization and MLGSD to adapt and pilot the Child Status Index (CSI) tool.

As a requirement for RFA 2011 and 2012, all applicants formally conducted discussions with district health officers (DHO) and HIV focal point persons to understand the gaps and needs of their respective districts. Furthermore, applicants agreed to develop memoranda of understanding (MOU) with district local governments to define the distinct roles of each partner and to help sub-grantees collaborate with district-based health centers where referrals for care,

treatment, and support were conducted. Uniquely, the Joint Clinical Research Centre (JCRC) prepared MOUs with 19 DHOs to enhance collaborative HIV prevention and care service delivery. The selected CSOs, health facilities, and community volunteers worked together to provide integrated services.

- *Academic partnerships.* TMA collaborated with Makerere University School of Women and Gender Studies to roll out gender training in all courses offered at Makerere University. TMA and MEA also partnered with Makerere University School of Public Health and Makerere University School of Social Sciences to conduct five studies to address knowledge gaps that had been identified through the analysis of CSF-generated data.

- *Technical working groups and meetings.* To improve the coordination of implementing partners' activities and their participation in knowledge-sharing, TMA actively participated in fora such as the Joint AIDS Review meeting, the Partnership Committee meetings, and national technical working groups meetings. Key TMA contributions to the technical working groups include: reviewing the indicator handbook for the Monitoring and Evaluation plan of the NSP 2012-2015; reviewing the Monitoring and Evaluation Framework and Plan for the NSPPI II 2011/12-2015/16; and participating in the National OVC coordination meeting conducted by Ministry of Gender, Labour & Social Development (MGLSD) that validated the Vulnerability Index and UNICEF's Three Factor Selection criteria for OVC. TMA also participated in the compilation and validation of the Global AIDS Indicator Progress report for Uganda, as well as the costing of the NPS in 2013.

CHAPTER III. STRENGTHENING THE CAPACITY OF CIVIL SOCIETY ORGANIZATIONS AND LOCAL GOVERNMENTS TO EFFECTIVELY CONTRIBUTE TO THE NATIONAL OVC, HIV, AND AIDS RESPONSES

One of the cornerstones of TMA's mandate is to strengthen the institutional and technical capacity as well as the learning and knowledge management of all CSF sub-grantees, to enable them to provide high-quality HIV, AIDS, and OVC services. However, a number of sub-grantees when first contracted and assessed by CSF were found to lack the appropriate technical and institutional capacities required to effectively deliver services appropriate to the needs of intended beneficiaries. To address this situation, TMA conducted capacity assessment exercises for all its sub-grantees and subsequently developed organization-specific capacity building plans that provided the operational framework for strengthening the technical and institutional capacity of each individual CSO in a more systematic, coordinated, and effective manner. In carrying out comprehensive and varied approaches to capacity building, the TMA has enhanced the institutional and program effectiveness of its sub-grantees, who in turn have contributed meaningfully to the national HIV and AIDS and OVC responses.

Stakeholders interviewed for this report consistently identified TMA's success with building sub-grantees' awareness, competence, and overall ownership as a major accomplishment of the program. To improve sub-grantee organizational and programming capacities, TMA, in conjunction with MEA and FMA, used various capacity building approaches. These included onsite mentoring and coaching, self-administered blended learning, experience sharing and training workshops, joint and targeted supportive supervision, exchange visits, peer-to-peer learning, and offsite technical support. To ensure ownership and commitment to capacity building interventions, sub-grantees were required to play an active role in all the above processes and to regularly monitor and learn from their progress by documenting their experiences. Each sub-grantee was required to demonstrate learning and act on emerging lessons for effective organizational functioning and service delivery.

TMA developed, piloted, and evaluated three CSO capacity building models:

- *The Partnership for Accountability and Capacity Transformation Model.* This model consisted of three tracks. Track 1: Capacity building by CSF management agents; CSF used this track to directly support and supervise the lead agencies as well as the four regional technical assistance teams. Track 2: Sub-contracts; this track involved building capacity through selected short-term technical assistance. Track 3: CSF sub-grantees implemented their own capacity building activities using in-house approaches.
- *The Lead Agency (LA) Model.* This model was characterized by pairing larger and more experienced CSF sub-grantees (lead agencies) with smaller sub-grantees for the purpose of

building their capacity. In the first phase, seven NNGOs were selected as lead agencies. These were reduced to five after a performance assessment of the first phase.

- *The Regional Technical Assistance (RTA) Model.* A private firm was contracted to manage four regional technical assistance teams under this model. The firm contracted coaches with the needed competencies from each region to support capacity building interventions and to address the identified gaps for the selected CSOs in the region. The coaches came from local governments, experienced NGOs, and the private sector.

THE CSF OCAT – A SELF-DIAGNOSIS TOOL

“We had never realized that our M&E system was this incomplete. We have always submitted reports to donors previously without much trouble. This self-assessment exercise exposed us to what a good M&E system should be like. Our strategic plan had also expired but we had never noticed because it was never thought of as important. We now feel more poised to take this organization to the next level if what was agreed upon during the development of the capacity building plan is fully implemented. The OCAT opened our eyes and helped us to identify our capacity gaps and the solutions to address them.”

— A participant in the organizational self-assessment in Kasese District

TMA maintained the overall quality assurance role for all three models. This was done through regular supportive supervision exercises as well as periodic review meetings attended by representatives from the lead agencies and regional coaches.

INNOVATING FOR RESULTS

CSF implemented innovative strategies to strengthen the capacity of sub-grantees to deliver high-quality services:

1. *CSF promoted cost effective learning through blended learning modules.* One of the biggest challenges that CSF encountered in its capacity building programs was the cost and time of conducting training for the numerous sub-grantee staff and volunteers across the country. To address this, TMA developed blended learning modules on performance management, change management, gender, and communication. These four modules enabled several learners at sub-grantee sites to acquire new skills and knowledge at work, at their own pace, and at marginal cost. The modules generated interest and praise from stakeholders, including the School of Women and Gender studies, Makerere University, which adopted the gender module as a training aid for all university students.
2. *CSF implemented capacity building interventions through public-private partnerships.* CSF selected a private management consultancy firm to manage the RTA model, bringing in competencies from the private sector. Together with this firm, CSF identified 32 specialists in HIV, OVC, gender, communications, M&E, management, and organizational development, and formed four regional technical assistance teams. Of this pool of specialists, seven were from the local governments, 15 from CSOs, and 10 from the private sector. Over two years, these technical assistance teams supported CSF to strengthen the capacity of 22 sub-grantees. This collaboration has proved to be fruitful to the CSF sub-grantees and the public and private sector staff involved; specifically, sub-grantees received more consistent and closer mentorship, and the public sector staff has better appreciated the role of CSOs in service delivery.
3. *CSF improves the M&E System using EaZy Konnect® HIV Prevention database.* In an effort to improve programming and reporting, as well as address IT infrastructure challenges, TMA developed and rolled out an offline data entry system, dubbed CSF EaZyKonnect, to its sub-grantees. With this system, each sub-grantee’s database is available on their organizational computers. Since they can update this data off line and upload it onto the main CSF database at their convenience, sub-grantees are able to continue with data entry regardless of challenges with Internet connectivity, which is experienced in most parts of the country. The system has also been designed to improve the process of data analysis, reporting, and exporting to different formats such as Microsoft Excel spreadsheets and PDF reports. EaZyKonnect has low IT system requirements, does not require license renewal by CSF, and enables multiple users to conduct offline data entry. Reviews from those that piloted the system were positive. It is expected that the system will improve timeliness and completeness of sub-grantee reporting.

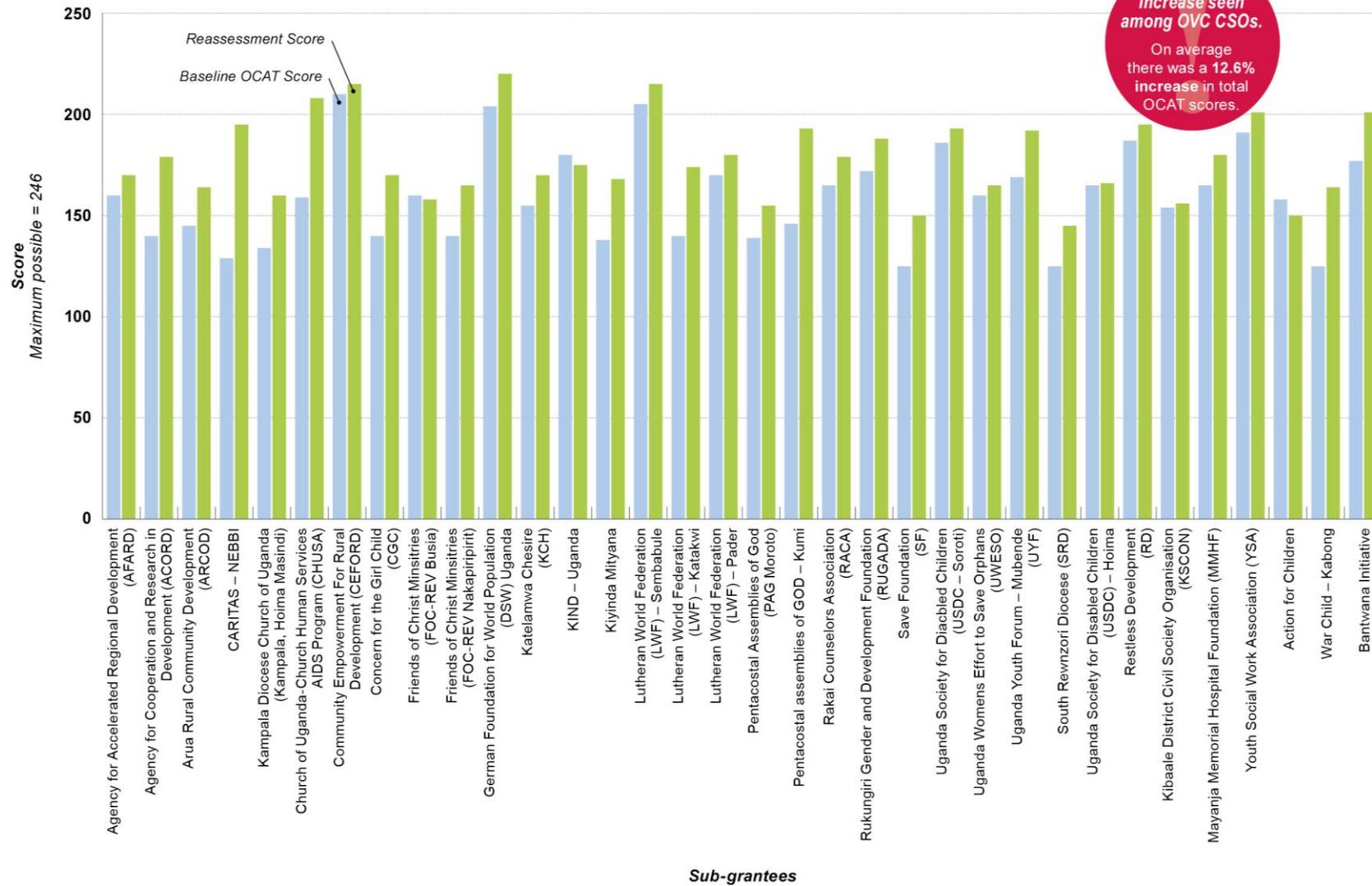
An evaluation of CSF capacity building interventions conducted at the end of 2012 showed that all three models contributed to the management of the capacity building needs of CSF and its sub-grantees. As demonstrated by an overall increase in Organizational Capacity Assessment Tool (OCAT) scores, all models contributed to the strengthening of sub-grantee capacity, especially in monitoring and evaluation, planning, finance management, and HIV programming. The evaluation also established that all of the sub-grantees used the CSF-adapted OCAT to assess their capacity levels before and after capacity building interventions and found it to be beneficial. Exhibit 5, on the following page, shows capacity improvement of selected sub-grantees.

A. Assessing Capacities and Planning for Capacity Building

TMA used an adapted OCAT to identify and prioritize specific capacity needs and to develop customized capacity building plans of individual sub-grantees. Specifically, the tool included organizational and technical areas of OVC, HIV, AIDS, and M&E.

The tool has proved valuable in promoting self-assessments, enabling quantification and comparisons of capacities across various organizations, identifying crosscutting issues, and facilitating the monitoring of capacity improvement. To improve the process of organizational self-assessments, CSF has compared sub-grantees' performance and provided evidence-based support to those who need targeted interventions to enhance their capacity to deliver high-quality services.

Exhibit 6. Capacity Assessments: Before and After



Of the 64 organizations that had an OCAT baseline and reassessment, 55 percent had more than a 10 percent improvement in the total OCAT score, while 40 percent had a percentage increase of 5 to 10 percent. Sub-grantees identified the following as examples of the benefits of the decentralized models: an enhanced culture of self-assessment and learning; improved M&E systems; development of relevant new policies; and improved partnerships.

The evaluation recommended that CSF should review and re-package the models to improve its overall capacity building strategies by clearly articulating techniques, start-up processes, capacity building standards, data flow, and relationships among actors. It also recommended that the linkage between capacity building and improved service delivery, transition management and, sustainability of capacity building benefits be clearly defined.

In early 2013, after revising the OCAT according to the evaluation's recommendations, the CSF conducted detailed capacity assessments of 19 HIV3 sub-grantees. These assessments were facilitated by the CSF lead agencies and were aimed at identifying capacity strengths and weaknesses. Subsequently, the assessments were used to develop capacity building plans. It is envisaged that the findings of the assessments will be used as a baseline to measure future organizational capacity progress for the 19 sub-grantees leading to long-term sustainability. Further, the revised OCAT and assessment process was useful in creating a sense of ownership of the capacity building intervention.

As a result of TMA's technical assistance and capacity building efforts, all sub-grantees have demonstrated significant improvements in institutional capacity and staff knowledge and skills due to the interventions implemented.

B. Strengthening Institutional Capacity

An important area of success for TMA has been building the institutional capacity of civil society organizations. Supporting sub-grantees to build functional internal systems and processes within their organizations has enabled them to continuously improve implementation and deliver high-quality OVC, HIV, and AIDS services. Additionally, the increased capacity has enabled a number of CSOs to receive more funding from other sources because of the capacity accruing from CSF's interventions.

Strengthened sub-grantees capacity in strategic planning and grant management. Under the LA and RTA capacity building models, 43 sub-grantees identified as having gaps in strategic planning were supported to either start the process of developing or improve their existing strategic plans. This effort improved long-term strategic planning and management of these organizations in areas such as organizational development, finance, marketing, and human resources. As a result, many sub-grantees have prioritized strategic planning to better inform their projects and organizational goals. Under the LA model, 18 members from 10 sub-grantees were trained in grants management.

VOICES FROM SUB-GRANTEES

"TMA laid the foundation for sustainability. TMA provided technical support to our project under existing structures. That in itself is a success."

— Fiona Kalinda, JCRC- SCIPHA Project Manager

"CSF brought us many innovations which have allowed us to secure funding from various donors. Many other NGOs have come to us to learn our models. As a result of the capacity building we received, we now provide capacity building to other CBOs."

— Roger Kasirye, Uganda Youth Development Link Executive Director

Strengthened sub-grantee capacity in monitoring and evaluation. Sub-grantee M&E capacity has been strengthened through data management training, data quality assessments, M&E technical support supervision, and on-the-job mentoring and coaching. TMA, together with MEA and FMA, undertook a number of training workshops and provided mentorship of its sub-grantees in data analysis and usage to improve programming. Sub-grantees were supported to set up systems that allowed easy access, retrieval, and use of information and data at all times, thus enabling TMA and sub-grantee organizations to use their own experiences and those from others to enhance programming and service delivery.

With respect to quality assurance, all NNGO proposals met the required technical, targeting, and value-for-money standards. A data quality assessment exercise conducted in seven NNGOs in 2012 showed a marked improvement in the quality of data collected and reported, taking into consideration the four quality assurance standards: validity, reliability, integrity, and timeliness. Follow-up visits conducted during the June 2013 joint supportive supervision (JSS) among 31 sub-grantees also showed that 57 percent demonstrated capacity to collect, analyze, report, and use data. Specifically, 90 percent were using appropriate data collection tools, 60 percent were reporting in a timely manner, and 60 percent demonstrated satisfactory levels of data analysis, compared to 2010, where all indicators were below 40 percent. Furthermore, about 85 percent of the sub-grantees attested they had used data to improve programming. The strengthened use of data has improved programming through instituting more effective interventions. It has specifically addressed gender gaps; for instance, male uptake of HIV Counseling and Testing (HCT) services improved from 32% in 2010 to 50% in 2011; male uptake of HIV care services improved from 28% to 34% and couple uptake of HCT services improved from 6% in 2010, to 11% in 2011 and 15% in 2012. CSF further analyzed and used program data to inform proposal development and produced 7 abstracts that were accepted for presentation in international conferences.

C. Strengthening Technical Capacity

In an effort to ensure that service providers were effectively delivering high-quality services aligned with national best practices and adapted to the needs of intended beneficiaries, TMA imparted continual onsite and offsite technical support to sub-grantees. Some key examples of these efforts are highlighted below:

- *Joint support supervision visits.* JSS has been a key component of TMA’S approach in providing sub-grantees with on-the-spot technical support and guidance for improved service delivery, programming, and M&E systems. During these visits, CSF teams helped sub-grantees handle technical issues in accordance with current best practices in HIV, AIDS, and OVC programming, and discussed the progress against set targets, the challenges, and promising practices that are being undertaken by the sub-grantees. For instance, to address the unique drivers of the epidemic, sub-grantees were guided on how to align HIV prevention activities to the combination HIV prevention approach. During the June 2013 JSS, CSF conducted JSS visits to all current 31 sub grantees. The CSF management agents established that 64 percent of the sub-grantees were implementing interventions fully aligned to the NPS based on the following criteria: extent to which sub-grantee, aligned project to national policies and guidelines;

implemented project according to approved proposal; obtained and utilised update national policies and guidelines; ensured that staff have the required training to implement project activities; conducted supportive supervision to project teams, district technical teams or line ministry staff; and set up internal quality control tools and systems.

- *Organizing experience-sharing workshops.* TMA took a leading role in organizing experience sharing workshops to provide CSF sub-grantees and stakeholders an opportunity to share information, experiences, achievements, lessons learned, challenges, and strategies for improving HIV, AIDS, and OVC programming. In addition, the workshops oriented and built capacities of the sub-grantees in various programmatic and crosscutting areas fostered collaboration and networking among stakeholders in HIV and AIDS and OVC service delivery, and served as a forum for the exchange of resources, tools, and materials. For example, community dialogue sessions not only provided an opportunity for the service providers to make gap analyses on the services rendered but also a platform for the networks to lobby for these services. NAFOPHANU, a CSF sub-grantee, worked with district health officers to identify HCT service providers for Wakiso, Mbale and Masindi and also successfully lobbied for Mildmay to provide ART outreach services in Wakiso and Masindi. Evaluations conducted at the end of the workshops showed that the workshops generated knowledge that can contribute towards improved sub-grantees programs. All sub-grantees present developed action plans of how they were to use the new ideas they obtained at the workshop, in order to improve their programs. Evaluation of the regional experience sharing workshops showed that all participants valued the time spent at the workshop greatly. They noted that the practical experiential learning from their peers had enabled them to gain more skills and knowledge in advocacy, documentation of project achievements, and better ways of addressing issues of sustainability at all stages of the project cycle, resource mobilization and practical ways of solving common M&E challenges. The bringing together of other non-CSF partners resulted in the creation of new partnerships and linkages. In addition to peer-learning, sub-grantees were also able to receive feedback on performance from key stakeholders, particularly members of the CSF steering committee as well as ADPs.

- *Developing and conducting specialized training.* Following the launch of the 2011-15 National Prevention Strategy, TMA conducted start-up training workshops for program staff of 84 sub-grantees. Overall, 168 staff were oriented on thematic areas related to combination HIV prevention and comprehensive M&E. On the whole, the trainings oriented the sub-grantees on the national HIV Prevention Strategy, equipped participants with skills in combination HIV prevention, and supported them in defining how they would effectively implement their CSF-supported projects. Moreover, the workshops emphasized the value of quality standards in project implementation through the sharing of proven community health practices, training guidelines, and relevant policy materials. The training also provided participants the opportunity to evaluate their readiness for implementing their projects, identifying gaps in their strategies, and proposing issues to refine their respective implementation strategies. Each sub-grantee developed an action plan identifying what they would do to enhance their effectiveness. Action plans included strengthening existing partnerships, approaches used in implementing combination HIV prevention, and capacity building. Participants of the workshop also assessed the sustainability of their projects and identified areas that needed improvement, including the

level of involvement by other stakeholders, leadership competencies, adequacy of funding/funding base, level of program flexibility and program impact.

Additionally, 31 sub-grantees received specialized training to improve their communication skills. As a result of the training, they developed relevant organizational communications strategies with notable improvement in the quality of their success stories.

- *Strengthening learning and knowledge management.* CSF promoted a culture of continual learning and improvement through best practices, lessons learned, and sharing these lessons with other stakeholders. To this effect, TMA regularly identified, adapted, and disseminated relevant resource materials for sub-grantees. These included national policies and guidelines, manuals and job aids. For example, CSF developed a *Pocket Guide for Capacity Building Facilitators to support* trainers, coaches and mentors. This pocket guide prescribes key roles, qualities and standards and provided practical insights on how trainers, coaches and mentors can manage their work under different settings and stages. The pocket guide also gave key guidelines to follow under each of the three capacity building approaches for more effective interventions. CSF followed up on the use of the shared materials during scheduled JSS visits for improved service integration and delivery. Furthermore, TMA invested in systematic documentation and sharing of experiences and research findings at different levels. This practice enabled CSF to contribute to national dialogues and policy perspectives on HIV- and AIDS-related issues, and helped CSF to learn from other HIV and AIDS stakeholders to enrich their own strategies. At the sub-grantee level, efforts were made to institutionalize practices that enhance information and knowledge sharing within and among peers. Sub-grantees were supported to set up systems that allowed easy access, retrieval, and use of information and data at all times, thus enabling TMA and sub-grantee organizations to use their own experiences and those from others to enhance programming and service delivery. Additionally a number of CSOs have reported receiving more funding from other sources because of the capacity accruing from CSF's interventions.

Snapshot

CARA IMPROVES GENDER PROGRAMMING

Community Awareness and Response on AIDS (CARA) has positioned itself to improve gender programming in all its operations. Since 2009, CARA has been supported by the Civil Society Fund to implement various projects in HIV prevention through Behavior Change Communication and supporting orphans and other vulnerable children in Kayunga district.



Faridah Namatovu conducts a gender mainstreaming training session at CARA offices.

CSF supported CARA to implement a combination HIV prevention project in Mayuge district. CSF routinely provides capacity building support. CARA had never taken into consideration the issue of gender mainstreaming in its programs.

“Our programs were so gender insensitive. It was after a gender mainstreaming workshop organized by CSF in Masaka that we realized that our programs had a lot to be desired as far as gender mainstreaming was concerned. The gender blended learning modules provided by CSF have increased my knowledge in gender programming. This knowledge has been passed over to the rest of the staff and CARA sub-grantees. The modules have made my life easy when I am going to conduct any capacity building activities such as trainings because I use them for reference.” said Faridah Namatovu, CARA M&E officer.

The modules have also helped CARA appreciate gender-sensitive staffing where out of the four top management personnel, two are female and two are male. They have also helped CARA to come up with gender analysis indicators and CARA is now proactively tracking gender integration through program reports and support supervision exercises.

In addition, the modules have also helped CARA to clearly specify gender programming as a key crosscutting issue that must be systematically planned for, implemented, and monitored. This happens during preparation of requests for applications.

Due to the insight obtained by using gender-aggregated data, CARA has designed strategies to reach more men with HCT services because the available data show that more women were being tested. To help coordinate all the gender issues and concerns, CARA is developing a gender-mainstreaming strategy.

CHAPTER IV. EXPANDING ACCESS TO AND USE OF HIGH-QUALITY OVC, HIV, AND AIDS SERVICES

Since its inception, CSF has had significant achievements in expanding access to and use of high-quality OVC, HIV, and AIDS services. In the last four years, TMA's overarching focus has been to bolster sub-grantees to expand access and use of high-quality OVC, HIV, and AIDS services in targeted communities in accordance to national priorities. TMA supported sub-grantees in a range of HIV, AIDS, and OVC interventions, services, and approaches to ensure that their response was kept aligned to the ever-changing dynamic of the epidemic. The engagement of the community as key partners in response to the challenges of HIV and AIDS and OVC was central to the delivery of these services.

The map on the following page illustrates the districts where CSF sub-grantees have implemented OVC, HIV, and AIDS services between 2010 and 2013.

A. HIV Prevention

No single HIV prevention strategy will be sufficient to control the HIV pandemic. Therefore, it is important to encourage multiple high-impact HIV prevention interventions to maximize population-level effects. TMA supported sub-grantees in a range of approaches, including BCC, condom promotion and distribution, HCT, integration of SRH, PMTCT, and SMC in an effort to increase the number of people accessing appropriate and comprehensive HIV and AIDS services and to reduce new infections.



Dissemination of IEC materials and condoms.

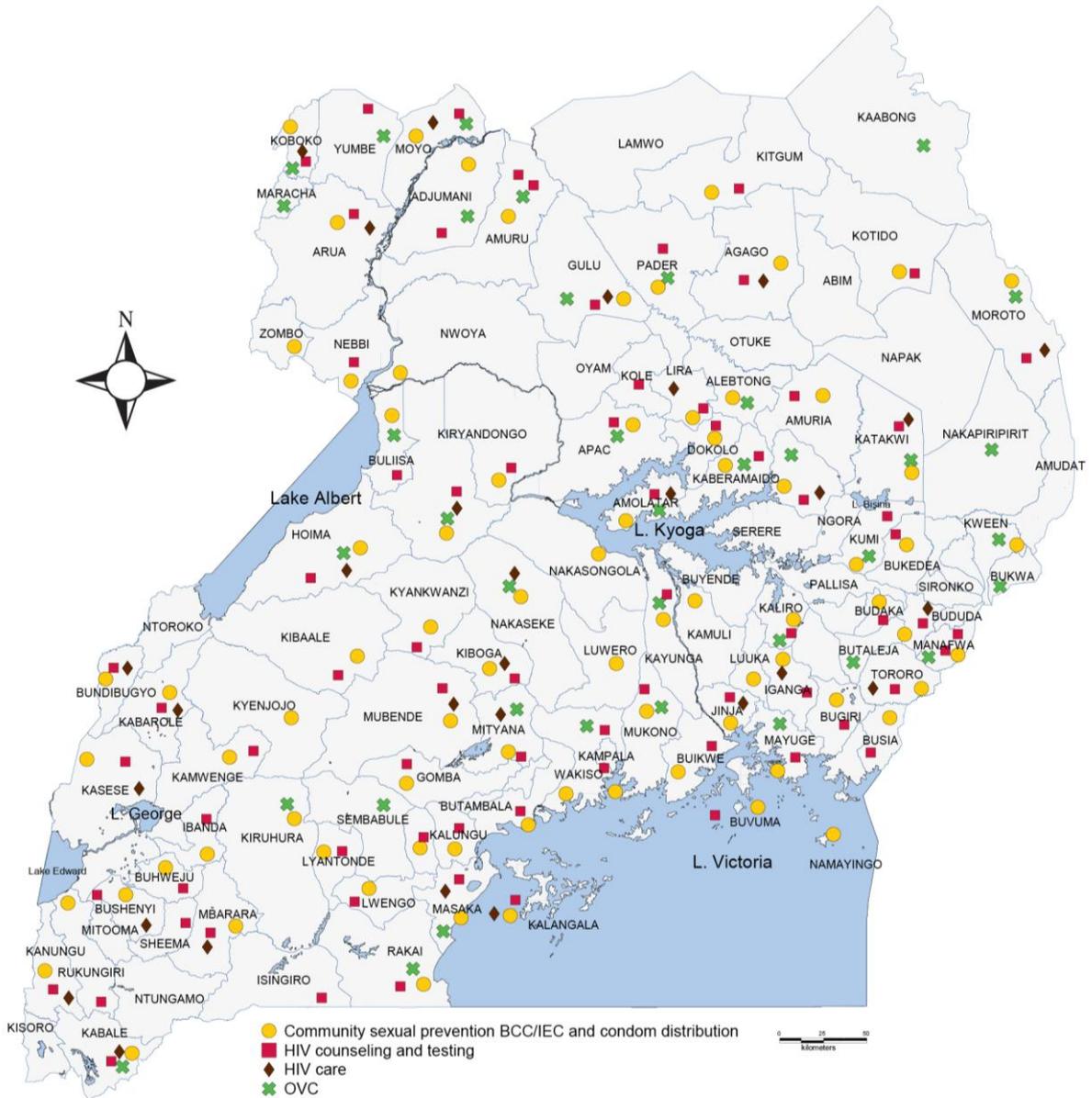
In addition to behavioral and bio-medical interventions, CSF, through its sub-grantees, addressed structural and socio-cultural barriers to HIV prevention and engaged leadership at all levels in the community to support HIV prevention efforts with the aim of reducing the risk of transmission and vulnerability to HIV infection. Deliberate efforts were made in the RFAs and implementation stages to ensure equitable service delivery and to target key populations over time.

CSF sub-grantees focused on expanding coverage and scaling-up HIV prevention services and uptake in targeted communities of 104 districts.

Behavior Change Communications for HIV Prevention

Promoting adoption of safer sexual behaviors and uptake of HIV prevention services. Sexual behavior is at the root of HIV transmission in Uganda. Having correct information on HIV and AIDS is a key step in changing attitudes and adopting safer sexual behaviors. Thus, the major focus has been to provide information to targeted beneficiaries to motivate them to adopt safer sexual practices and reduce risky behaviors. TMA, through 129 sub-grantees, used BCC to encourage target populations

Exhibit 7. CSF Services Coverage 2010 – 2013

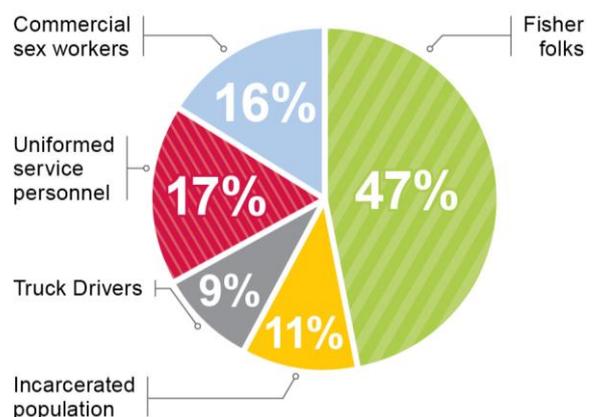


to adopt safer sexual behaviors and access to and use of HIV prevention services. Specifically, TMA vetted prevention messages disseminated by sub-grantees to ensure they were aligned to national messages and were guided by evidence-based approaches and best practices, such as peer-to-peer education, small group sessions, and community dialogues, selective mass media and “edutainment.” Each approach was tailored to the needs of the community to ensure that the targeted beneficiaries are key players in program development and implementation.

Focusing on key populations. The National HIV prevention strategy for Uganda 2011-15 set guidance for increased focus, coordination and collaboration efforts aligned to the drivers of the epidemic. In line with the revised NPS, CSF’s strategies focused on key populations that are the major drivers of the HIV epidemic. Messages on the risk of HIV and AIDS and its effects on the individual, families and communities were delivered to 2,585,593 targeted beneficiaries (47 percent women). The messages centered on delaying the first sexual encounter, the adoption of safer sexual behaviors, the benefits of HCT and PMTCT, family planning and safe male circumcision, as well as gender-based violence and human rights.

CSF reached 122,209 individuals in key populations (48 percent women), including fisher folk, migrant workers, people with disabilities, commercial sex workers and truckers, through the following fora: community dialogue sessions; peer-to-peer education; individual and group counseling; support group discussions; hotlines; and the provision of related IEC materials. Individuals from these groups were trained as community health volunteers to provide HIV and AIDS education and counseling, and to distribute condoms to their peers. Exhibit 8 shows the distribution of messages among the targeted key populations.

Exhibit 8. Key Populations Receiving HIV Prevention Messages



To further enhance behavior change, CSF sub-grantees proactively linked messaging to service delivery points in HIV prevention, care, treatment, and support. Overall, CSF reproduced and disseminated 14,192,611 HIV information, education, and BCC materials aimed at addressing varying needs of the population. All these evidence-based interventions were designed to ensure change in high-risk behaviors rather than simply raising awareness about HIV and AIDS. They aimed at delaying initiation of sex, reducing the number of sexual partners, increasing the use of condoms and increasing uptake of safe male circumcision and HIV counseling and testing services. Feedback reports from sub-grantees indicate that social behavior change education has led to positive changes like increased uptake of HCT services and demand for condoms.

Increased Information on Condom Use and Access to Condoms

Promoting correct and consistent condom use was a major approach employed by CSF sub-grantees to promote safer sex among beneficiaries. Through MOUs with the districts and partners such as

Uganda Health Marketing Group, successful links were created between sub-grantees and condom supply sources with the aim of ensuring regular condom supplies. CSF sub-grantees distributed 26,352,001 condoms, of which 5.4 percent were female condoms. Condom distribution was complemented with sex education sessions, where the risks of unprotected sex and the advantages of using condoms correctly and consistently were discussed. In total, 374,012 people received messages on correct and consistent condom use. The impact evaluation report of the Straight Talk Foundation, a CSF sub-grantee, showed that 50 percent of out-of-school girls and 51 percent of boys aged 15-24 years who had received these messages used a condom during their most recent sexual encounter, compared to 36.3 percent and 37.1 percent seen nationally, according to the UDHS 2006.

HIV Counseling and Testing

HCT is a critical entry point for the beneficiaries to access appropriate integrated HIV prevention, care, and treatment and support services. CSF sub-grantees, with ongoing technical assistance from TMA, have implemented innovative strategies to increase access to HCT services. From January 2010 through September 2013, TMA-supported CSF sub-grantees provided HCT services at primarily community service points in line with the Ministry of Health HCT policy standards and guidelines. CSF sub-grantees counseled, tested, and provided results to 1,115,307 individuals (45.6 percent females) which accounted for about 28 percent of the national target for 2011-2015. Of all the individuals that received HCT and were given results, 42,643 (3.82 percent) tested positive; these individuals were referred for treatment and care services. HCT services were provided in combination with other services, such as health education on SRH and FP, condom distribution, PMTCT education, and the distribution of IEC materials. Another notable accomplishment was the improvement in gender equity in access to HCT services.

Community mobilization and targeted HCT services. TMA has encouraged sub-grantees to integrate community mobilization approaches to their HCT effort with special emphasis on first-time testers. In addition, married and cohabiting individuals were encouraged to test as couples. To target hard-to-reach populations, innovative community mobilization approaches were used, including “moonlighting testing” (night-time HIV prevention services to commercial sex workers), HCT camping, and mobile boat HCT testing. Furthermore, all testers were encouraged to engage in post-test activities to support primary and secondary prevention among HIV-negative beneficiaries and to enable HIV-positive individuals to access care, treatment, and support services. Post-test club activities included risk-reduction

**IMPROVING ACCESS, INTEGRATING CARE:
ONE STOP MOBILE CENTERS**

CSF sub-grantees involved in delivering HIV prevention and care have identified one-stop mobile centers as a cost efficient mechanism for the continuum of prevention and care. Notably, health workers, counselors and Village Health Teams (VHTs) come together at a community health center to provide integrated services in SRH, PMTCT and HIV/AIDS education, STI screening and treatment, dispensing FP methods including condoms and oral contraceptives, HIV testing and counseling, and CD4 testing. One-stop mobile centers have been key in bringing services to hard to reach communities, enabling beneficiaries to access multiple services in terms of information, tests and commodities; this in turn reduces beneficiaries’ waiting time and transportation costs as there is no need for return trips to get other services. Only beneficiaries that need referrals are required to return or referred to a bigger health facility for further care and treatment services. A similar model is the four-tent model used specifically by one of the CSF sub-grantees to provide a comprehensive package of HIV and AIDS prevention, care, and support products and services to individuals within their localities.

counseling for HIV-negative individuals, referral of men for SMC, referral of HIV-negative women for antenatal care (ANC) and the mobilization of communities to seek HCT.

HCT for couples to promote harmonious relationships. Evidence in Uganda indicates that there is increased HIV infection among married couples. CSF sub-grantees, therefore, made concerted efforts to ensure couples' access to and use of HCT services. As a result, 90,812 couples accessed HCT services. HCT provides an opportunity for couples to co-exist positively irrespective of HIV test results. Counseling focuses on understanding the basics of HIV infection and prevention and on defusing possible conflict situations arising from test results. Couples then make joint plans to co-exist by avoiding harmful practices, such as gender-based violence, alcohol abuse, or engaging in unprotected sex.

Integration of Sexual and Reproductive Health

There is increasing recognition of the need to integrate SRH services into HIV prevention interventions. From 2011, all CSF sub-grantees were mandated to align their SRH-related services to national requirements. CSF, in partnership with the MoH AIDS Control Program oriented all HIV prevention sub-grantees on the integration of SRH services, including STI screening and treatment, cervical cancer screening, and family planning (FP) services to women, into HIV prevention services. Integrating SRH and HIV services has allowed sub-grantees to make the best use of limited health resources to improve access to and use of key HIV and SRH services; efficiencies in providing similar services jointly rather than separately; and, reduced HIV related stigma and discrimination. For example, integration has allowed service providers to reach more women with modern FP services and long-term methods which has consequently been conducive to reducing unintended pregnancies. A total of 2,243 female beneficiaries received FP commodities through six CSF sub-grantees in the July 2012 - June 2013 reporting period.

In addition to services, a total of 78,939 beneficiaries, both male and female, received SRH education linked to HIV prevention. The messages focused on family planning; STIs prevention and management, gender based violence; sex and sexual abuse among the disabled; education on correct and consistent condom use; pregnancy and antenatal care; and the linkage between sexual reproductive health rights and HIV infection.

Community Prevention of Mother-to-Child Transmission of HIV

Mother-to-child transmission (MTCT) is the second major mode of HIV transmission in Uganda. More than 50,000 children born to HIV-positive mothers are infected perinatally every year. To tackle new HIV infections due to MTCT and the low use of PMTCT services, CSF sub-grantees delivered PMTCT messages to 32,782 individuals, referred 21,654 pregnant women to health facilities for ANC services and 11,698 pregnant women for safe delivery, and 5,213 mothers for post-natal care services. 2,051 mother-baby pairs were followed up in the community. PMTCT messages



An HIV-positive couple depicting male involvement in PMTCT services at a hospital in Eastern Uganda supported by BACHI, a CSF sub-grantee.

focused on the prevention of HIV and AIDS in women and men, PMTCT, safer sex practices, HCT, family planning, safe motherhood and anti-retroviral treatment. Vital strategies and activities that contributed to this achievement included the provision of community based PMTCT services, distribution of condoms among pregnant women and their partners, mobilization of male partners to participate in PMTCT activities, education to women and their partners on proper infant and young child feeding practices.

HIV-positive mothers were given health education on option B+ and were referred to accredited sites for highly active antiretroviral therapy, in addition to having their babies tested for HIV using early infant diagnosis approach at six weeks of age. Sub-grantees were encouraged to use existing structures, such as the community resource persons, VHTs, and mentor mothers to augment service delivery. One notable intervention was the creation of *Mama Clubs*, and most recently, *Baba Clubs* to mobilize pregnant women and their partners to access PMTCT services and offer peer support. These clubs have exemplified the impact community groups can make to boost the sustainability of HIV/AIDS prevention interventions in target communities, specifically increasing access to psycho-social services, the uptake and referral of HCT, PMTCT, FP, and early infant diagnosis, and visits to health centers. See the text box below.

Safe Male Circumcision (SMC)

In Uganda, only 26 percent of Ugandan men aged 15 to 49 are circumcised. To increase this rate and avert new HIV infections, TMA incorporated SMC into its HIV prevention technical support, complemented by appropriate behavior change. Efforts targeted male adults aged 15 years and above, largely because of their risk to HIV infection. Between July 2012 and September 2013, 9,986 men received high-quality SMC services through AIC static and community-based CSF supported SMC sites. All male beneficiaries received pre-operation medical examination, HCT, STI screening and treatment, SMC post-operative care, and follow-up according to MoH SMC policy guidelines and standards. No severe adverse events have been reported.

Furthermore, CSF sub-grantees mobilized, counseled, and referred men to accredited health facilities for circumcision. Female partners were given information and counseled for the purpose of dispelling negative myths associated with SMC. They were also educated on the overall health benefits of SMC for the couple so that they could encourage their partners to undertake this service.

MAMA CLUBS JOIN FIGHT AGAINST HIV AND AIDS



A Mama Club meeting in Kabarole district promotes PMTCT in rural communities.

The Joint Clinical Research Center and the Uganda Health Marketing Group, with funding and support from the CSF, established peer support groups to sensitize and mobilize pregnant women and their partners to access HCT, ANC, and PMTCT services in 19 districts in Uganda. Women are sensitized at markets, in places of worship, and via door-to-door outreach. The clubs have proved to be a good strategy for increasing uptake and referral of HCT, PMTCT, FP, and early infant diagnosis. These clubs also act as psychosocial support networks to new mothers enrolled into PMTCT. In an area that previously had a very low turnout for services, one *Mama Club* has been able to mobilize 82 HIV-positive mothers to access PMTCT in health centers in just one week.

The clubs' impact is expected to increase as it continues to use innovative ways to reach more people. One such initiative has been the recent creation of *Baba Clubs*. These consist of men who are either married to or related to *Mama Club* members. *Baba Clubs* promote individual and couple HCT and mobilize men to support and promote male involvement in PMTCT activities. JCRC is also exploring avenues to partner with other organizations to provide vocational training to club members and to help women form savings and credit cooperatives. As demonstrated by these groups, supporting the development and strengthening self-sustaining community groups is an innovative mechanism that boosts the sustainability of HIV/AIDS prevention interventions in target communities.

Snapshot

LOCAL LEADERS SUPPORT BEHAVIOR CHANGE AMONG SEX WORKERS

Local leaders in Mbale and Mbarara municipalities are at the forefront of a behavior change campaign which is fast transforming commercial sex workers (CSWs) into model entrepreneurs. The former CSWs in Mbale, a municipality in eastern Uganda, have become the proud owners of a hair salon while their counterparts in Mbarara, a municipality in western Uganda, are running a restaurant.



The Mayor of Mbale Municipality cuts a ribbon to officially open the salon owned by former CSWs.

The salon and restaurant are the results of deliberate efforts made by the Alliance of Mayors Initiative for Community Action on AIDS at the Local Level (AMICAALL) to engage local leaders in implementing a behavior change project targeting key populations in urban areas. AMICAALL is a sub-grantee of CSF.

AMICAALL involved local leaders in project activities, including planning meetings, training sessions and mass media programs. This generated acceptance and ownership of the project by the leaders and a commitment to its successful implementation. Consequently, when the CSWs started a restaurant, the Mbarara municipality mayor and the town clerk offered them a license exemption and permitted the construction of a kitchen on the municipal reserve land. This gesture encouraged other CSWs to abandon the trade and join their colleagues to run the restaurant.

Similarly, while officiating at the opening ceremony of the salon in December 2011, the mayor of Mbale urged residents to use the salon services and the available HIV/AIDS prevention services. He said the municipal leaders saw the project as an icon of transformed lives and pledged continued support to such efforts.

Between January 2010 and June 2012, AMICAALL reached 3,726 CSWs in 11 urban centers with HIV prevention messages and equipped them with entrepreneurship skills. Since its inception in July 2007, CSF has reached 3,068,262 people (48.7% women) with HIV prevention messages through one-on-one and small group discussions. Of these, 83,501 (48% women) are key populations, including commercial sex workers, truckers and public transport providers.

B. HIV and AIDS Care, Treatment, and Support

In addition to the need for continual prevention strategies aimed at averting new infections, there is an equal need to focus on access and use of HIV and AIDS care, treatment, and support services for those who are already infected. The CSF sub-grantees scaled-up access to and use of HIV care, treatment, and support services to PLHIV with the aim of improving their quality of life and reducing mortality. CSF continually provided technical assistance, supportive supervision, and ensured that sub-grantees adhered to national guidelines. Interventions carried out by the sub-grantees included: increasing equitable coverage of high-quality HIV non-clinical care and support services; promoting comprehensive adult and pediatric HIV care, treatment, and support; integrating counseling and a minimum package of prevention with positives to PLHIV in care; and increased retention efforts.

Increased equitable geographic coverage of high-quality HIV Care, Support and Treatment Services

CSF worked with four sub-grantees to leverage resources and strengthen referral mechanisms for the provision of care and support services to communities in 26 districts that were underserved yet had the highest burden of PLHIV.

To improve links between HCT sites and HIV care services, the sub-grantees were guided to provide point-of-care CD4 testing and free Cotrimoxazole once an individual tested positive. This greatly increased the tracing and continual follow up of HIV-positive clients. TMA proactively sought to increase the enrollment of children into care by stipulating guidelines for sub-grantees providing HIV care, support, and treatment services; TMA also ensured that the guidelines were adhered to and the population was included during supportive supervision.

Practical and client-friendly approaches, such as community drug distribution points and home-based care, were used to ensure provision of services among the hard-to-reach communities. These approaches enabled clients to access high-quality services while minimizing indirect costs and reducing waiting times. CSF sub-grantees were also supported to target key populations such as commercial sex workers, incarcerated persons, fishing communities and adolescents. Evidence from the June 2013 end-of-project assessments indicate these targeted services have resulted in an increase in enrollment and retention of these populations



An outreach team in Bundibugyo District provides HIV care services to the Batwa community, one of the most underserved communities in Uganda.

Promoted comprehensive adult and pediatric HIV Care, Support, and Treatment interventions

Between July 2010 and September 2013, HIV care and treatment services were provided to 1,115,307 people, most of whom (65 percent) were women and girls. This represents a contribution of about 9 percent of all PLHIV in care nationally.

Of those individuals receiving care from CSF sub-grantees, 11 percent were below 18 years of age, which is above the current national performance, where individuals 18 years and less constitute 7 percent of all individuals in care. This was due to the CSF's deliberate attempt to scale-up pediatric and adult HIV care interventions in tandem. CSF sub-grantees worked with health providers, family members, and communities to provide standard packages of care to adults and children living with HIV, which included clinical monitoring, prevention and management of opportunistic infections (OIs), and the provision of Cotrimoxazole prophylaxis, nutritional support, psychosocial and spiritual support, among other services. Internal and external reviews showed that all sub-grantees were adhering to national standards (Strategic Objective (SO) 2 of service thematic area 2 of the revised NSP) as 76,472 (97.5 percent) of PLHIV clients in CSF sub-grantee care programs were monitored and treated for opportunistic infections. The clinical monitoring aimed at keeping close observation of the patient's clinical parameters (i.e. weight and other signs and symptoms) over time to monitor disease progression as well as early identification and management of opportunistic infections. The Infectious Diseases Institute (IDI), a sub-grantee of the CSF, has provided care and treatment to more than 40,000 beneficiaries through a CSF grant. See snapshot/text box on page 13.

CSF sub-grantees also provided TB information, screening, and treatment. Specifically, the implementing sub-grantees screened 62.02 percent of PLHIV in care at least once in a quarter during clinical monitoring sessions. The sub-grantees ensured that all those found to have active TB received standard treatment according to the 2010 Uganda National TB and Leprosy program guidelines. Since 2010, internal and external program assessments have shown full adherence to national TB/HIV collaborative guidelines at all sites visited.

Provided integrative counseling and minimum package of prevention with positives (PwP) to PLHIV in care

As PLHIV are living longer, an increasing number of transmissions may stem from people who know they are positive and still engage in unprotected sex. CSF ensured that all sub-grantees offered HIV care that consisted of both behavioral and biomedical PwP interventions in clinic and community-based settings. Examples of behavioral interventions included risk reduction counseling, health education on correct and consistent use of condoms, disclosure of status to partners, partner and family testing, reduction in number of sexual partners, reduction of alcohol and substance use, and adherence to HIV medications. Examples of biomedical interventions included management of STIs in PLHIV and their partners and services to reduce MTCT of HIV. A survey in late 2012 of HIV care sites showed that 53 percent of all individuals over the age of 18 in care at CSF-supported sub-grantee sites had adopted safer sexual behaviors, which is above the range of 30-50 percent seen in other national surveys. The same survey showed that 75 percent had disclosed their status to partners, which is above the 65 percent documented in other national surveys.

All HIV care sub-grantees integrated supportive counseling into HIV care. Psychosocial support (PSS) was provided in form of supportive counseling to 92 percent of PLHIV in care and their families. This strengthened their ability to cope with HIV and AIDS, enabling the affected individuals to live prolonged and meaningful lives. PSS was provided formally in clinics and informally through peers and self-help groups.

Increased retention of PLHIV in care programs

Currently, the average retention rate for PLHIV in care is 70 percent, and this has been steadily increasing over time. A focus area for CSF has been the need for sub-grantees to monitor and improve retention rates as this has been identified as a long-term challenge for HIV care programs in the country. The specific strategies to improve retention included providing continual medical education sessions to nurses, counselors, medical and clinical officers to improve their knowledge levels on the prevention and management of OIs among HIV-positive patients. Some sub-grantees have improved retention through innovative mechanisms such as calling patients on their cell phones to remind them of their appointment days. Another critical intervention was improving the overall record management system by ensuring all clients records were entered into an electronic recording system and by improving the filing system of hard copy records.

Ensuring continuity of HIV care, treatment, and support services

Public-private partnerships. CSF sub-grantees collaborated with private medical facilities such as drug shops, clinics, and pharmacies located in their coverage areas to enhance enrollment and improve retention of PLHIV into care. This allowed sub-grantees to refer all HIV-positive patients and those with complications to hospitals for appropriate care and for services that may not be accessed at their private facilities. One notable example was the development of the *Regional Technical Assistance (RTA)* model in which CSF selected a private management consultancy firm to manage this model and bring in competencies from the private sector. Together with this firm, CSF was able to identify 32 specialists in HIV, OVC, gender, communications, M&E, management and organizational development of whom seven were from the local governments, 15 from CSOs and 10 from the private sector to form four regional technical assistance teams.



Before



After

A manual filing system brings order and improved efficiency to Mubende Hospital after an intervention by Infectious Diseases Institute, a CSF sub-grantee.

Another such example was the establishment of formal agreements, through signed MOUs, between the CSF sub-grantees and private facility owners to refer all those in need of care. For effective referrals, a focal desk was instituted in all regional referral hospitals/public facilities and private facilities to ensure that all the individuals referred from the private facilities are attended to by public health providers. The public-private partnerships brought a number of benefits to the care

program that included increased enrollment of new PLHIV into care, improved retention of clients in care, increased link of newly diagnosed individuals into care and anti-retroviral Therapy (ART) programs within the national health systems, and improved collaboration between private health facilities and government health facilities.

Working within government structures and district involvement. To ensure consistent HIV care, some CSF sub-grantees worked within the government regional referral hospital structure. Additionally, projects are implemented largely by hospital staff whose capacities are strengthened by CSF sub-grantees that conduct regular training and CMEs on HIV care and treatment services. In terms of sustainability, it is expected that individuals whose capacity has been strengthened will continue to work at the hospitals even when CSF funding ceases. CSF sub-grantees participated in District AIDS Committee meetings and program reviews at the district level and in PLHIV network activities in an effort to harmonize their work plans with district HIV plans.

A WOMAN GETS A NEW LEASE ON LIFE



On the road to recovery

Annet Bamanya, 41, a resident of Hoima district in northwestern Uganda, is elated about regaining the use of her legs after she almost lost them to Kaposi's Sarcoma, an opportunistic cancerous condition which she developed after contracting HIV. She says that were it not for the help from the Infectious Diseases Institute (IDI), a sub-grantee of the Civil Society Fund (CSF), she could have lost her life.

IDI is a national nongovernmental organization that has provided care and treatment to 43,232 beneficiaries through a CSF grant, between January 1, 2011, and June 30, 2013. Bamanya developed itching toes, fever, and body weakness in January 2011. She informed a village health worker who referred her to Hoima Hospital where she did an HIV test that turned out positive and she was immediately enrolled into care. "In March 2011, I became very sick and was admitted on the medical ward where I was referred to ART clinic for more investigations. The doctor found ulcers under my feet and ordered an x-ray. When the results came back he suspected Kaposi's Sarcoma and referred me to Little Hospice for palliative care," Bamanya says.

At the hospice, she was given painkillers and advised to go to Mulago Hospital Cancer Institute in Kampala which is over 200 km from Hoima.

"I did not have money to cover my transport and basic needs for a stay in the hospital, so I decided to keep going back and forth to ART clinic in Hoima for my HIV treatment only," she says.

By July 2012, the cancer had spread to both legs and Bamanya could not even walk. When a relative that Bamanya lived with asked her to leave, she had to rely on her 16-year-old daughter to care for her.

"Everyone lost hope and my children pleaded to me to stop taking HIV drugs so that I could die. 'Mummy it's too much pain for you, may God take you to rest' they would cry day and night. I just kept praying to God for a second chance," Bamanya says.

On February 26, 2013, she was called to the hospital to see a doctor secured by IDI. The doctor examined her and told her that if she got the correct treatment there was still a chance that she could walk. IDI provided an ambulance that took her to the Mulago Cancer Institute. Nine doses of chemotherapy, to be administered once a month, were prescribed for her. In addition to helping Bamanya get to the hospital each month, IDI continued to follow up with her and provided complementary care services including Septrin prophylaxis and regular screening for other opportunistic conditions.

As a result of the mentioned interventions, a thrilled Bamanya says, "I gained my legs again even before completing my treatment. I now walk, take myself to the toilet and do my housework. God exists!"

"My message to all people in the world is to know their HIV status early. Maybe if I had tested early I would have survived getting this cancer!" she says.

C. OVC Protection, Care, and Support Services

With more than 8.1 million children considered to be either critically or moderately vulnerable and more than 53 percent of this number living with caregivers other than their biological parents, CSF, through 48 sub-grantees, responded to Uganda's OVC crisis by ensuring that integrated and equitably distributed protection, care and support services were provided to OVC and their households. Furthermore, TMA responded by supporting sustainable interventions that strengthened coping capacities of families and communities to better withstand the future impact of AIDS. Interventions guided by the National Operational Plan and the NSPPI-2 strengthened the capacity of household and communities to protect and care for OVC, increased access to and the use of essential services for OVC and their households, and strengthened inter sectoral links for improved access and use of high-quality services by OVC and their households. These interventions improved child well-being by mitigating the impact of AIDS, reducing children's risk and vulnerability, and increasing their resilience.

The key accomplishments that contributed to improved OVC service delivery during implementation included:

- Provided 98,795 OVC (49 percent girls) with services of at least one core program area
- Strengthened monitoring of OVCs' well-being using the Child Status Index, contributing 12 percent of the National Strategic Program Plan of Intervention for Orphans and Other Vulnerable Children's national target
- Improved the well-being of children and their care givers across all CPAs
- Enabled 90 percent of the funded CSOs to clearly understand set and achieve project objectives. Additionally, these interventions enabled CSOs to use project data to acquire additional and continued funding of OVC projects. For example, the Uganda Youth Development (UYDEL), a CSF sub-grantee that seeks to achieve positive behavior change among street and slum youth through imparting practical skills, has been able to secure additional funding from various donors as a result of TMAs support to build their capacity to implement best practices and achieve significant results.
- Supported OVCs in a variety of business ventures such as motorcycle repairs, metal fabrication, hair salons, and tailoring
- Enhanced efficient delivery of comprehensive OVC services through the integration of psychosocial support and child protection into other core program areas
- Funded 79 local governments to provide supportive supervision as well as monitor OVC programs within their districts
- Involving the community in the selection of the most vulnerable children
- Worked with community resources (VHTs, peer educators, child rights committees, and LCs) and involved local governments in implementation to enable the project to attain a certain degree of sustainability

Strengthening the capacity of household and communities to protect and care for OVC

OVC and their caregivers are caught in a cycle of poverty which has a direct negative correlation with well-being, thus compounding children's vulnerability. Many families caring for OVC are already

impoverished and overextended. Children in these households often face a great risk of malnutrition, disease, and limited access to care and essential services. For that reason, TMA, with support from MEA and FMA, carried out sustainable interventions to support families and communities to meet their immediate needs and accumulate resources to better withstand the future impact of AIDS. CSF, through its sub-grantees, strengthened the capacity of caregivers and communities to function as social safety nets for OVC.



An OVC, supported by CSF sub-grantee FOCREV, has started his own metal workshop.

For example, to ensure that each affected household and community had the capacity to feed themselves, OVC caregivers were afforded training in food production and nutrition, the provision of seeds and farm tools, and crop/food storage technologies with the aim of increasing food production at the household level. Analysis of the food security intervention using LQAS in 2012 indicated that 35.6 percent of the children were food-secure, as opposed to the 46.4 percent reported in the CSF 2012 LQAS survey.

To be able to meet basic household needs and increase income, CSF sub-grantees equipped OVCs and caregivers with socio-economic skills such as training in enterprise management and apprenticeship, life skills, provision of start-up kits, and village savings and loan associations and credit schemes. For example, the associations have proved to be a promising model for socio-economic support to OVC household as caregivers are now using the skills and savings to provide basic items for their households.

Particularly for girls, CSF sub-grantees trained OVC households to make sanitary towels using locally available materials. This initiative increased hygiene and decreased school absenteeism for girls who have hit puberty. To improve sanitation and hygiene conditions at the household level, the promotion of key primary health care practices was emphasized. Moreover, having worked with the child protection committees in the communities, sub-grantees were able to increase awareness of child rights. Child protection committees were supported to report and follow-up on child abuse cases, as well as sensitize the community on service availability and referral for appropriate services.

Increasing access to and the use of essential services for OVC and their households

In partnership with MEA and FMA, TMA supported sub-grantees in ensuring that OVC and their households had access to and utilized essential services. TMA supported sub-grantees to deliver services within the framework of the CPAs¹ as specified in the NSSPI-2. CSF also recognized that the factors that are responsible for children's vulnerability occur at different levels (household,

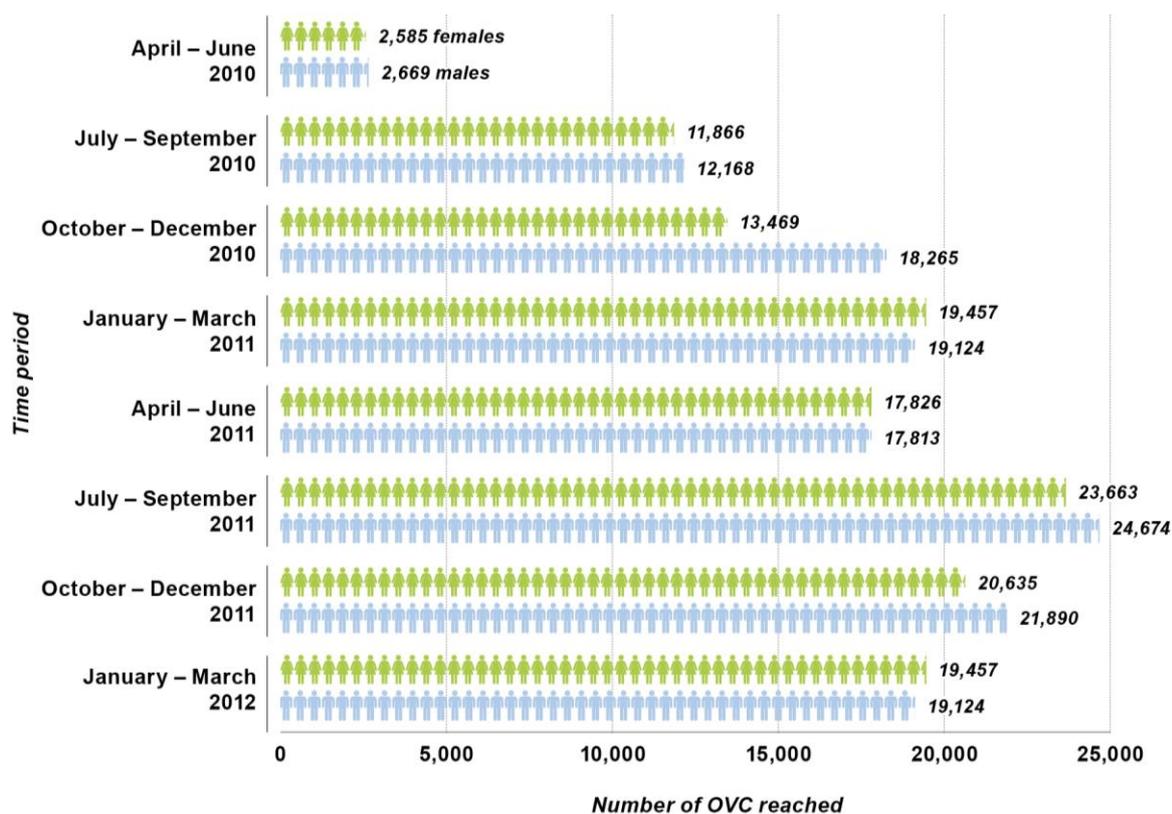
¹ There are eight CPAs. These are socio-economic support, psychosocial support, health care services, care and support, food security and nutrition services, child protection, legal support, and education support.

community, and institutional) of which all must be addressed to cause a sustainable change in the lives of children.

Of OVC services provided, 91 percent were dedicated to the domain of psychosocial support, 73 percent to socio-economic support, 60 percent to food and nutrition, 39 percent to education services, 65 percent to child protection, 34 percent to basic health care, 0.4 percent to care and support, and 2 percent to legal support services. Of the total OVC served by CSF in Year 4 (2012) 66,327 (88 percent of the annual target) received services in a minimum of four CPAs, which was a proxy measure for having received comprehensive services.

To ensure OVC and households receive comprehensive care, CSF-supported sub-grantees integrated HIV services into the OVC programs. This integration also ensured that the long-term health impact

**Exhibit 9. OVC Served with a Comprehensive OVC Package
April 2010 – March 2012**



of HIV and AIDS on OVC was addressed. Because OVC are more vulnerable to abuse and exploitation and are more likely to engage in unsafe behaviors, HIV prevention messages and HCT for the supported households were included.

Strengthening inter-sectoral links for improved access and use of high-quality service by OVC and their households

Improving access and the use of high-quality OVC services requires synergies for effective collaboration at all levels to maximize effectiveness, offer comparative strengths, minimize

duplication and inequities in resource and service distribution, and ensure sustainability. Through strategic partnerships, CSF strengthened the coordination of OVC interventions by relying on an effective referral system and by sharing best practices and leveraging resources among CSF sub-grantees, thus ensuring that beneficiaries accessed services. Notably, CSF enhanced dialogue and links among partners such as MoH, MGLSD, SUNRISE, SCORE, SDS, and STAR, to promote a greater degree of collaboration and coordination across stakeholders. Such links promoted access to and use of the needed services by OVC.

CSF and its partners have supported the strengthening of links from the sub-county to the district level for stakeholders who were directly involved in implementation. Local governments were also involved to strengthen the monitoring function of the supported interventions. Through three pediatric AIDS sub-grantees, CSF supported the coordination of HIV and OVC services in 79 districts by facilitating activities of district OVC coordination committees and OVC referrals. Additionally, through the same sub-grantees, 1,785 HIV positive OVC were referred for complementary HIV and OVC services during the first half of 2010. Ninety-four percent of those referred received services at health care facilities. CSF also promoted links between sub-grantees and government development initiatives like the National Agricultural Advisory Services and Northern Uganda Social Action Fund projects.

Snapshot

CSF EMPOWERS OVC CAREGIVERS TO BENEFIT FROM GOVERNMENT PROGRAMS

The Kabale Diocese has organized the caregivers of orphans and other vulnerable children (OVC) into groups so that they can benefit from government development programs to improve their livelihood. In 2009, such a group was formed in Kahesi village, Kanungu district with 21 members. By September 2011, the group had benefitted from agricultural inputs worth UGX 700,000 (US\$280) and other extension services under the National Agricultural Advisory Services (NAADS) program.



Members of Kahesi OVC caregivers' groups review the progress of their savings scheme.

With support from the Civil Society Fund (CSF), Kabale Diocese implements a project aimed at contributing to strengthening the capacity of OVC and their households to meet basic needs.

Before 2009, OVC caregivers in Kahesi village worked as individuals without clear income targets. They were involved in subsistence farming characterized by poor farming tools and poor quality seeds that, as a result, affected their crop yields and kept them in a poverty cycle. The diocese intervened and organized them into one group for easy mobilization and regular experience sharing purposes. The diocese provided the group with 13 goats as an income generating project and their droppings to be used as manure for their crops.

Through meetings over the goat project and continued support from project staff, a plan was developed to boost their portfolio. The group registered with the sub county to qualify for government support and opened up a savings account with a government supported savings and credit cooperative society (SACCO). Registration with the sub county qualified them to benefit from the NAADS program whose target beneficiaries are organized farmers. Two members of the group received improved seeds worth UGX 700,000 (US \$280) from NAADS and later shared the yields with their colleagues to propagate the improved crop varieties. The group also benefitted from extension services regarding improved farming practices and good nutrition from sub county extension staff.

With their savings of UGX 850,000 (US \$350) in the SACCO, members also qualify for low interest agricultural loans. They have set an income target of UGX 500,000 (US \$200) per household every farming season. As a result, each household is food secure and has saved some money with the group. The goat project has expanded from the original 13 goats to 28 goats and 19 pigs.

Between April 2011 and March 2012, Kabale Diocese supported 3,954 (2,121 female) OVC with services in socio-economic security, food security and nutrition, education, care and support, psychosocial support and child protection.

Exhibit 10. Detailed Accomplishments of Uganda TMA (2010-2013)

Contributed to Improvement of the Civil Society Fund (CSF) Mechanism by:

- Developing the 2010-2012 Strategic Plan that provided the CSF operational framework
- Increasing mutual accountability through involvement of multiple stakeholders in key TMA-led processes and products
- Scaling up automation of data collection and analysis to improve OVC and HIV/AIDS programming for CSF stakeholders at national, district, and community levels
- Initiating geographic information system techniques that have proven valuable to addressing problems and questions by presenting data in a quickly understood and easily shared format
- Re-engineering the proposal and granting process to expand funding opportunities to a larger portfolio of CSOs
- Improving CSF's visibility and knowledge sharing among stakeholders by documenting achievements, innovations, lessons learned, and recommendations
- Collaborating with Management Sciences for Health and 10 districts to conduct the 2012 lot quality assurance sampling assessments that identified and addressed major gaps to improve the effectiveness of the national HIV/AIDS response
- Partnering with the Transcultural Psychosocial Organization to leverage resources and expertise to develop the Child Status Index tool and database linked to the national OVC database
- Partnering with Makerere University's School of Public Health and School of Social Sciences to conduct five research studies to address knowledge gaps identified through analysis of CSF-generated data
- Supporting 79 local governments to monitor implementation of OVC programs
- Scaling up social protection interventions by providing apprenticeship training and village loan schemes and linking them to national programs such as the Northern Uganda Social Action Fund and National Agricultural Advisory Services
- Affecting national policies for HIV/AIDS and OVC by:
 - Spearheading technical working committees to help develop the CSO-focused combination HIV-prevention approach
 - Participating in development of the National OVC Vulnerability Index

Strengthened the Capacity of Civil Society Organizations by:

- Developing the CSF OCAT by adapting the McKinsey & Company version to include organizational and technical areas
- Promoting cost-effective learning through a variety of adult learning interventions, such as blended learning modules
- Modeling and implementing three decentralized capacity building approaches customized for CSOs
- Forming public-private partnerships to support implementation of capacity building interventions
- Strengthening gender-sensitive programming through the framework provided by the CSF gender mainstreaming strategy
- Partnering with multiple stakeholders to provide regular joint technical and supportive supervision to CSOs nationally
- Initiating programmatic start-up training for new sub-grantees to reduce the lead time needed to begin effective delivery of services

Strengthened Service Delivery by:

- Increasing access to and use of OVC and HIV/AIDS services by:
 - Providing 98,795 vulnerable children with services in at least one core program area and monitoring their well-being using the Child Status Index, contributing 12 percent of the national target of the NSPPI for Orphans and Other Vulnerable Children
 - Identifying and referring 1,785 HIV-positive children for complementary HIV and OVC services
 - Enhancing delivery of comprehensive OVC services by integrating psychosocial support and child protection into other core program areas
 - Providing 1,115,307 people (45.6 percent women and girls, 8.8 percent couples) with HIV care and treatment services
 - Enrolling and retaining 78,383 people (65 percent women, 11 percent children) into HIV care
 - Providing safe male circumcision to 9,986 men between July 2012 and September 2013; all were screened for sexually transmitted infections
- Scaling up comprehensive HIV/AIDS prevention services through community engagement by:
 - Delivering messages through small groups and individual sessions to 2,585,771 people (1,221,593 women)
 - Strengthening and expanding condom health education and distributing 26,352,001 condoms (1,431,513 female condoms)
 - Reproducing and disseminating 14,192,611 HIV IEC/BCC materials aimed at addressing varying needs of the population
 - Mobilizing 37,278 pregnant women for antenatal care and for elimination of mother-to-child transmission services
 - Integrating provision of sexual and reproductive health and HIV services and reaching 3,065 people with family planning products

CHAPTER V. CROSSCUTTING THEMES

Efficiency, Effectiveness, and Sustainability

CSF in general and TMA in particular proactively promoted a culture of funding interventions that were effective, efficient, and sustainable.

Efficiency and effectiveness. With the aim of leveraging results and making sub-grantee projects more accountable, TMA took advantage of CSF's unique structure to harness the benefits of partnerships between donors, the government, and CSOs. TMA ensured that proposed outputs corresponded with proposal budgets and that implementation plans were designed in a manner that steered timely and high-quality project interventions.

To ensure the CSF mechanism delivered services to the intended beneficiaries in a cost-effective way, a performance assessment framework was developed. The framework tracked unit costs for all services and ensured they stayed within expected limits. The table below shows the range of unit costs of the key intervention areas for CSF seen between 2010 and 2013. Based on the average unit cost, CSF programs have provided favorable and/or comparable value compared to equivalent national programs.

Exhibit 11. Unit Costs of Key CSF Intervention Areas

Intervention	Average Unit Cost of CSF Programs (UGX/Person Reached with the Service)	Range Seen with Other Similar National Programs
BCC messages on behavioral and structural HIV prevention	UGX 15,000-30,000 /person reached	Data not available, especially on structural prevention interventions
HCT	UGX 9,000-11,000/person tested	10,000-28,500
Condoms (excluding cost of the condom)	UGX 150/piece distributed	25-3,000
HIV care (Non-ART)	UGX 108,000 /person/year	88,000-240,000
OVC	UGX110,000/OVC/year	67,000 - 300,000
Safe male circumcision (excluding cost of circumcision kits)	UGX 65,000	UGX 85,000, including SMC kit

Sustainability. The TMA spearheaded the efforts to foster the sustainability of the funded HIV and AIDS and OVC interventions beyond the contract duration. In this regard, CSF sub-grantees were required to institutionalize sustainability efforts from the proposal development stage and throughout the entire project cycle. In addition, a customized sustainability framework was developed by TMA. This guided subsequent baseline and annual assessments of critical areas that had shown to affect sustainability. The findings of these assessments guided sub-grantees to promote sustainable approaches as well as maintain the accrued benefits within the community after CSF funding has ceased. Because TMA worked with existing community based structures such as the Child Protection Committees (CPCs) and Village Health Teams (VHTs), it promoted community

participation, empowerment and sustainability of OVC and HIV service delivery. The guide also promoted financial sustainability by encouraging sub-grantees to develop long-term, evidence-based strategic financing approaches. TMA also developed and disseminated a training manual on resource mobilization for the sub-grantees with the aim of addressing the challenges that the sub-grantees encountered in mobilizing resources for their OVC and HIV and AIDS programs.

The focus on entrenching sustainability across all of TMA's activities and technical support boosted CSO ability to respond to CSF and other agency calls for proposals, which in turn ensured continuity of programs and service delivery. Per interviews and follow-up discussions with grantees, TMA's support and institutionalization of knowledge and skills permeated into sub-grantee interventions in the target communities and has sustained even in instances when donor funding has been interrupted.

Quality Assurance

Interventions to promote quality assurance in all the key result areas have been an integral part of TMA project functions. The objective of the interventions was to institutionalize quality assurance and promote a culture of continuous quality improvement among sub-grantees. Among the key interventions undertaken to mainstream quality assurance were:

- Aligning RFA scopes of work to national policies and guidelines and assessing sub-grantee interventions to established national program standards
- Disseminating national technical resource materials
- Establishing requirements to include a section of quality assurance in proposal guidelines
- Conducting start-up training at project inception to ensure harmonized understanding of requirements
- Identifying technical assistance and capacity development needs of sub-grantees, assessing the extent of implementation of and measuring adherence to established standards during the joint supportive supervision visit
- Training sub-grantees in quality assurance and establishing quality assurance teams within sub-grantee project teams
- Encouraging sub-grantees to conduct client exit interviews

As a means of tracking adherence to quality standards, TMA developed and frequently revised the checklist used during supervision to assess adherence to minimum quality standards. Program reviews using this checklist showed that sub-grantees meeting these minimum quality assurance standards increased from 80 percent in 2011 to 95 percent in 2013.

Gender Mainstreaming and Integration

HIV and AIDS and OVC affect women and men differently. Power imbalances between men and women have a direct influence on an individual's ability to make choices and decisions about their health and other social rights. Moreover, gender inequality has been cited as one of the social factors that limit access and use of HIV and AIDS services. Thus, addressing gender disparities and inequities is essential to reducing HIV risk and increasing access to services.

TMA, in conjunction with partners and stakeholders, ensured that sub-grantees' interventions were equitable for both sexes and that the disaggregated data provided information that would be used to inform gender programming decisions from the design stage through the project cycle. To date, data analysis in Exhibit 12 shows the number of female beneficiaries in several OVC and HIV and AIDS services. It is important to note that in many incidents an individual would access numerous services, thus the reason for not giving a generalized total number of females served.

Exhibit 12. Female Beneficiaries Accessing CSF-Funded HIV and AIDS and/or OVC Services

Thematic area	Total	Female
HIV Prevention BCC	2,585,771	1,221,593 (47.2 percent)
HIV Counseling and Testing (HCT)	1,115,307	508,290 (45.5 percent)
HIV Care and Support	78,383	51,121 (65.2 percent)
OVC	98,795	49,117 (49.72 percent)
Community PMTCT	32,782	32,782 (100 percent)
Condoms	35,178,517	1,431,513 (4.24 percent)

Additionally, TMA has made deliberate efforts to ensure increased male involvement in HIV-prevention activities such as family planning, HCT, and EMTCT. Some key TMA accomplishments include:

- Revising CSF monitoring and supervision tools to track all gender-related activities and results
- Requiring CSF sub-grantee projects to track gender-sensitive indicators
- Supporting CSF sub-grantees to conduct community dialogues on gender-related topics, such as early marriage, widow inheritance, gender-based violence, and issues of masculinity
- Supporting gender-based violence training programs for key duty-bearers such as the police, probation officers, religious leaders, and political leaders
- Mobilizing men to support their spouses for PMTCT and other health services



In a CSF gender workshop for sub-grantee staff, participants role play gender roles in the home.

Many CSOs made commendable progress in designing gender-inclusive interventions, such as couples testing for HIV, bringing services where men congregate, gender-sensitive timing of events to suit both men and women, and applying gender-sensitive beneficiary selection criteria. Overall, CSF trained 247 (94 female) staff from 115 OVC and HIV and AIDS sub-grantees.

To further augment its efforts of mainstreaming gender, TMA developed a gender training manual and adapted it into a blended learning format. The Department of Women and Gender Studies at Makerere University has been using the CSF Gender Blended Learning Module to expedite the plan of mainstreaming gender in all its academic programs.

To increase the overall effectiveness and impact of CSF’s interventions, programming for gender was articulated as a priority in key CSF program documents. In 2012, TMA spearheaded the development of the CSF Gender Strategy that provides the framework of mainstreaming gender in order to enhance the effectiveness and gender equity at CSF’s governance, management, and CSO service delivery levels. As with other aforementioned initiatives and approaches, the strategy was aligned with national plans such as the NSP and the NSPPI.

Advocacy and Networking

Advocacy and networking have played a pivotal role in supporting the national HIV and AIDS and OVC responses. To this effect, CSF in general and TMA in particular have made great strides in mainstreaming advocacy interventions throughout each of its three Key Results Areas.

TMA has supported development of CSF communication products such as video documentaries, flyers, and brochures highlighting its role and achievements. Having been disseminated to key stakeholders to further promote sharing of CSF success and best practices, these communication products have served as powerful advocacy and fund raising tools. Whenever a new RFA was issued, geographic information system maps are used to identify underserved/high-risk areas and advocate for appropriate services and allocation of funds to be allocated. During annual experience-sharing workshops, TMA facilitated sessions where the sub-grantees could exhibit their advocacy skills for emerging OVC and HIV and AIDS issues. Mock “community dialogues” were held where the sub-grantees engaged in and advocated for relevant social issues. These exercises proved to be useful in developing persuasive public speaking skills, which are critical for advocacy.

CSF has supported strengthening of the capacity of sub-grantees to advocate for key emerging issues. CSF provided financial and technical assistance to a consortium of three partners, namely UNASO, NAFOPHANU, and UGANET. The consortium played a key role in building the capacities of 25 district networks in policy advocacy, activism, coordination and networking to respond to the effects of HIV and AIDS. UGANET, for example, was at the forefront in advocating for law reform, enforcing existing laws in building the capacity of key stakeholders, and in empowering PLHIV or those affected by HIV and AIDS and their communities to know and to enforce their human rights. With support from CSF, UGANET implemented an advocacy and capacity building project with the goal of creating a response that provides for appropriate, systematic, and timely action to address human rights violations arising in the context of HIV and AIDS. At the national level, UNASO and NAFOPHANU are active members of several coalitions that influenced HIV and AIDS legislation and policy. For instance, *The Civil Society Budget Advocacy Group*, in which UNASO is a member of the health sub-committee, has advocated for increased

IMPROVING SERVICE DELIVERY THROUGH EFFECTIVE ADVOCACY

The Nebbi district network identified legal and policy issues that needed to be addressed, including: inappropriate disposal of condoms; uncensored video shows to children and adults; stigma and discrimination by health personnel toward PLHIV; limited access to HIV and AIDS services in the district due to unequal distribution of health services within the district; and limited access to socio-economic services by PLHIVs. All these issues were brought to the attention of the District AIDS Committee and to the sub-county finance and planning committee. As a result the distribution of ART services at the Health Center III level has improved, by-laws for censoring videos have been made and health workers have been trained in the management of Option B+. In Wakiso, Kaberamaido and Nebbi, the district networks successfully lobbied for the availability of CD4 machines.

budget allocation to the health sector and contributed to the debates of the 2010 Finance Bill. Additionally, the *Civil Society Coalition on the HIV and AIDS Bill*, another group UNASO is a member of, contested Uganda's draft HIV and AIDS Prevention and Control Bill (2010). The concerns specifically raised by UNASO on behalf of grassroots stakeholders included clauses on mandatory HIV testing, disclosure to a third party and criminalization of HIV transmission and were being debated in the Parliament of Uganda.

During the delivery of HIV/AIDS and OVC services, sub-grantees are required to demonstrate strong community advocacy interventions relevant to the services they are delivering. This has helped increase the uptake of many facility-based interventions. For example, by collaborating with health center staff to provide combined outreach services such as HCT, FP, health education on SRHR, and provision of CD4 testing machines, sub-grantees have successfully lobbied district local governments for increased access to HIV and AIDS services.

CHAPTER VI. APPLYING LESSONS FROM TMA

Over the life of TMA, there were numerous important and lasting achievements and results. Although the team faced various challenges, TMA managed to adapt to and overcome these obstacles and leave behind sustainable strategies that will yield better OVC, HIV, and AIDS services. It is from this experience that the following lessons learned, challenges, and recommendations have been compiled. It is hoped that by sharing this information, current and future programs can use the TMA experience to continually enhance CSO programming.

Lessons Learned

Targeting key populations. Recognizing that key populations are major drivers of the HIV epidemic and engage in high-risk behavior, targeting and reaching these populations as both beneficiaries and participants in project implementation proved highly effective. Key populations understand the social, cultural, economic, and behavioral drivers that increase their risk to HIV and know the barriers that prevent access to HIV and AIDS services. Individuals from these groups were trained as community health volunteers to provide HIV and AIDS education and counseling, and to distribute condoms to their peers. Their involvement brought legitimacy and relevance to interventions and outreach activities.

Forging partnerships. One of TMA's top successes is the strong relationships it established with multiple stakeholders. TMA, along with the other CSF agents, the GOU, local governments, CSOs, and donors, continuously collaborated on the development of RFAs, guidelines, and capacity building efforts. The involvement of multiple stakeholders in the development of the CSF gender policy, the combination prevention RFAs, the CSF Governance manual, and the gender-blended learning modules was critical for promoting ownership, increasing visibility, and enabling CSF to influence policy at all levels.

Defining objectives and expectations early. The success of CSF capacity building programs was boosted by the deliberate efforts to ensure a clear understanding of their objectives and expectations by all stakeholders from their inception. To this effect, interventions such as designing, implementing, and evaluating capacity building models, conducting custom-made startup workshops, identifying capacity gaps using the CSF OCAT and designing appropriate capacity building plans for each individual sub-grantee were implemented.

Promoting a family-centered approach to child care. Interventions that focus solely on the child overlook the key role played by families and communities on well-being. The need to promote family-centered care — whereby the family and the community at large meaningfully participate in the upbringing of children — is critical given the huge numbers of vulnerable children. The family-centered approach promoted by TMA was significantly different from most of the previous OVC programs, which solely focused on supporting individual children, despite there being several other vulnerable children in the same household. The shift from a child-centered approach to a family-

centered one greatly increased the number of both households and children receiving multiple OVC services simultaneously.

Varied approach to care. As per the national HIV and AIDS treatment and care standards and guidelines, it is important to ensure that all services provided by the sub-grantees follow the defined quality standards. To meet these standards, the sub-grantees used a combination of proven strategies, such as phone call reminders to ensure drug refill appointments, and having expert clients and peer-support groups follow-up and encourage individuals to adhere to ART. These strategies proved to be critical in preventing attrition and enhancing the retention of PLHIV in care programs.

Challenges

Broad results. Part of TMAs success stemmed from harmonizing targeted support to CSOs in their response to OVC, HIV, and AIDS. However, measuring CSF's contribution to the national response at the outcome and impact level was difficult due to the involvement of multiple players in HIV, AIDS, and OVC-related interventions across sectors, administrative levels, and the country at large.

Vast portfolio. Despite the gains in funding and despite supporting numerous services and projects, a diverse CSF sub-grantee portfolio created issues during the grant solicitation process and during capacity building interventions. The vastly different capacity levels of the sub-grantees required TMA to design a wide variety of appropriate interventions and training methodologies. This often created heavy workload periods for the TMA technical staff that needed to implement these interventions as well as follow up with sub-grantees.

Lack of commitment. Despite the overwhelming demand for HIV, AIDS, and OVC services, the capacity of sub-grantees to deliver effective services is limited. Even with the targeted TMA interventions, some CSF sub-grantees did not integrate capacity building into their mainstream activities. In such situations, capacity building was viewed as a parallel program that came second to service delivery, rather than an initiative that would reinforce and complement it. This resulted in limited technical and organizational improvement of some of the CSF sub-grantees.

Weak referral system. Future programming needs to strengthen the referral system, which has been overwhelmed by the high number of beneficiaries being referred. Service providers are sometimes unable to take on the persons referred by CSF sub-grantees. In addition, referral cards are often not correctly completed or returned to the sub-grantees. Thus it is still a challenge to determine the proportion of individuals referred by CSF sub-grantees who actually receive OVC, HIV, and AIDS services.

High demand, low supply. Despite efforts to increase access and uptake of services, frequent stock outs of essential HIV commodities have created disruptions in the delivery of targeted services. Stock outs or low supplies of commodities such as HIV test kits, female and male condoms, and safe male circumcision surgical kits undermined community mobilization and HIV prevention education efforts. This not only results in a lack of services or commodities, it also undermines previous demand-generating efforts.

Looking Ahead and Recommendations

TMA made many strides in strengthening Ugandan CSOs to provide high-quality HIV, AIDS, and OVC services. Yet given the sheer number of CSOs found in Uganda and the evolving face of the epidemic, continuous support is necessary to improve CSOs' organizational and programming capacities. It will be important for future CSF programming and health sector stakeholders to build on TMA's progress in the years ahead. There is an opportunity to capitalize on the project's work, but it will require sustained support, collaboration, and harmonization. Key recommendations include:

- Focus future programs and projects on establishing indicators and measurement tools for institutionalizing quality assurance systems among the CSF mechanism and the sub-grantees. This will support the effective measurement of CSF's contribution to the national OVC, HIV, and AIDS responses.
- Evidence has proven that effective advocacy and networking play a key role in lobbying for the rights and well-being of HIV- and AIDS-infected and affected persons. To this effect, there is need to strengthen the advocacy and networking mechanisms of CSOs to enable them to meaningfully contribute to sustainable OVC, HIV, and AIDS responses at all levels.
- The Child Status Index is a key tool in monitoring the needs of OVC across the six domains (health, nutrition, shelter/care, education, protection, and psychosocial support). It is therefore important to scale-up the use of the index by all OVC programmers and service providers at all levels. This will provide much needed evidence documenting the impact of different programs on the well-being of each individual child.