

The PEPFAR Local Capacity Initiative Interventions in Uganda

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The Local Capacity Initiative (LCI) strengthened the capacity of civil society organizations (CSOs) to support policy advocacy, with the ultimate goal of improving health services for key populations (KPs) affected by the HIV epidemic.¹ The United States President's Emergency Plan for AIDS Relief (PEPFAR) funded the initiative from 2013–2018 to help local CSOs create an enabling environment for PEPFAR's objectives.

¹ Key populations include men who have sex with men, sex workers, people who use injectable drugs, and transgender people.

Under the LCI, the United States Centers for Disease Control and Prevention (CDC) worked in Uganda between 2015 and 2018 to strengthen the policy advocacy capacity of CSOs that worked with men who have sex with men (MSM), transgender women, and sex workers and develop the capacity of public health officials (PHOs) to consider gender and sexual diversity issues. MEASURE Evaluation, which is funded by the United States Agency for International Development (USAID) and PEPFAR, conducted an evaluation of LCI Uganda (referred to hereafter as LCI) between 2017 and 2018.



This brief summarizes LCI's effort to create an enabling environment for policy advocacy by identifying key interventions. Additional briefs provide overviews of work to develop organizational capacity through coalition building,² the community scorecard (CSC) strategy to improve HIV clinical services in Uganda,³ and methods that the evaluation team used to study the efficacy of LCI's work and measure resulting change.⁴

LCI implemented a three-part, district-level strategy to improve HIV services for KPs in six clinics in the Entebbe-Kampala-Wakiso region. Five interventions fall underneath this three-part strategy. First, LCI strengthened the policy advocacy capacity of CSOs working with KPs, while simultaneously conducting capacity building in gender and sexual diversity (GSD) for PHOs, especially HIV service providers. Once CSOs and PHOs were better equipped to work with one another, LCI implemented quarterly CSC

meetings at each of the clinics. These meetings brought together members of key populations, CSO workers, and HIV service providers to score the availability and accessibility of selected HIV and reproductive health services. LCI provided the following support: management of the meetings, data analysis to generate scores, and action planning for each clinic and corresponding district.

Part 1: KP CSO Capacity Development

LCI conducted capacity strengthening and staff training with 15 CSOs specializing in KP issues. Of 132 CSO staff evaluators interviewed, 93 (71%) had participated in an LCI-sponsored training during this program. CSO staff reported attending five trainings, on average, and 13 CSO staff reported that they facilitated at least one LCI training. Fifty-seven CSO staff (43%) reported participation in LCI mentorship sessions.

Part 1A: Training and Mentorship for KP CSO Organizational Development

LCI conducted trainings and mentorship activities to improve staff skills in organizational development. On average, a CSO reached by LCI had 16 staff members. By 2018, almost all CSOs (87%) had a strategic plan: a commonly used organizational development indicator. Figures 1 and 2 present results from a 2018 survey asking how many staff participated in these trainings, used training material, and received mentorship.

² Andrinopoulos, K., Namisango, E., Taylor, T., Glover, A., & Freyder, M. (2020). The PEPFAR Local Capacity Initiative Supports a Coalition of Civil Society Organizations Serving Key Populations in Uganda. <https://www.measureevaluation.org/resources/publications/fs-19-412>

³ Freyder, M., Namisango, E., Taylor, T., Glover, A., & Andrinopoulos, K. (2020). The PEPFAR Local Capacity Initiative Supports the Community Score Card to Improve HIV Services for Key Populations in Uganda. <https://www.measureevaluation.org/resources/publications/fs-19-413>

⁴ Freyder, M., Namisango, E., Taylor, T., Glover, A., & Andrinopoulos, K. (2020). The PEPFAR Local Capacity Initiative Evaluation Methods in Uganda. <https://www.measureevaluation.org/resources/publications/fs-19-411>

Figure 1. Percentage of CSO workers who participated in an LCI training (2018 N=132)



More than 9 out of 10 training participants reported using materials from the training in their everyday work.

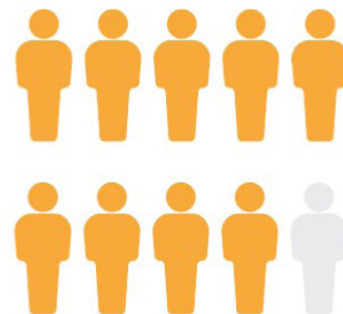
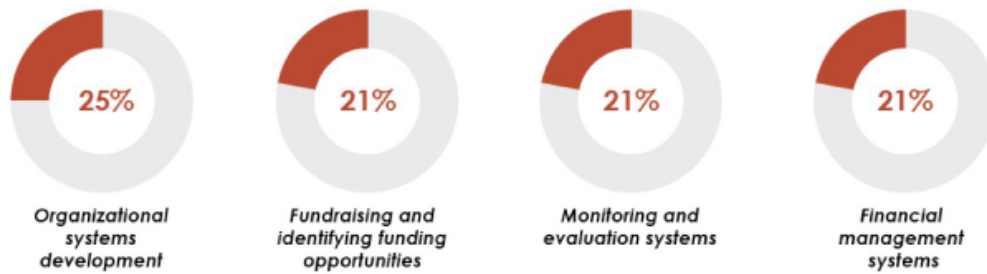


Figure 2. Percentage of CSO workers who participated in LCI mentorship activities (2018 N=132)



A little less than half of CSO staff members participated in trainings on resource mobilization and proposal writing, and the same number reported taking part in training on strategic planning. A smaller number were trained on financial management and grant compliance. In some instances, mentorship sessions built on trainings such as those on fundraising and financial management. In other instances, LCI used mentorship instead of training to address important topics—specifically, organizational system development with 25 percent of the staff and program monitoring and evaluation with 21 percent of the staff.

During in-depth interviews, CSO staff were also asked about their experiences with LCI training and mentorship. One CSO worker said the following:

LCI has built our capacity in organizational development, advocacy, and general self-esteem. This has been achieved through a series of trainings. Such trainings include strategic planning training. For example, now as an organization, we . . . have a strategic plan in place. We know what we want for the next three years.

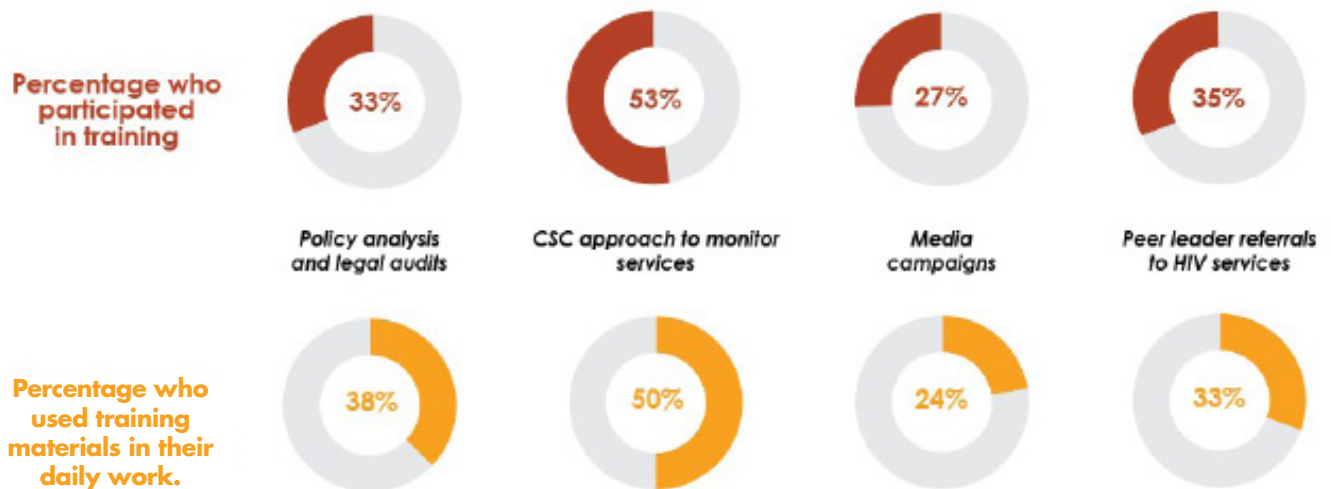
Part 1B: Training and Dialogue Meetings to Build KP CSO Policy Advocacy Capacity

LCI offered trainings and opportunities for policy dialogue to improve staff skills in public advocacy and thus increase the capacity of CSOs to influence health policies affecting KPs. Figure 3 details the results of a 2018 survey asking how many staff participated in these trainings and used training materials.

About one-third of CSO staff were trained in policy analysis and legal audits; another third were trained to conduct peer referral to HIV services. Slightly fewer of the staff attended training on media campaigns (27%), and most used the training in their work. In the survey, 70 CSO staff (53%) reported participating in a CSC training. (However, program reports show that only 30 staff were trained.⁵) Almost all of the staff reported using the trainings in their day-to-day work.

During an in-depth interview, a CSO worker described the cumulative effect of the trainings offered by LCI:

Figure 3. Participation in policy advocacy training and use of training materials in daily work (2018 N=132)



They had joined the movement before the LCI. But maybe it [training] has strengthened their capacity and their understanding and advocacy strategies. But also, I think it created that unity in some way. And if member organizations are strengthened, even, the network is also strengthened.

To collectively improve the policy advocacy environment for KPs at the facility, district, and national levels, LCI conducted meetings to provide opportunities for CSO leaders to form relationships with stakeholders engaged in this work. Based on the 2018 survey, 51 staff members of CSOs (39%) participated in LCI-facilitated coordination, learning, and sharing meetings, and 41 CSO staff (31%) participated in wider, district-level coalition-building meetings. One CSO worker described coalition building with district health offices as follows:

They [LCI] have given us . . . fora as KPs to discuss our issues with the top district health officials, and they have given us . . . fora to be recognized that we are there in communities. Actually, for me, I have taken up a big position at the district, am a KP representative at the DAC, . . . and also represent KP on . . . [the] district HIV coalition, and in those forums we can voice our concerns.

Part 2: HIV Provider Capacity Development

LCI conducted targeted interventions with PHOs at the facility and administrative levels, with the ultimate goal of improving HIV response and services provided to KPs in Uganda. Program records indicate that 147 health workers were trained to provide KP-friendly services as a part of LCI. The interventions described below detail LCI’s strategy for PHOs, LCI’s reach among this population, and feedback about the impact of these interventions on PHOs’ day-to-day work in the health system.

Part 2A: Training Health Workers in Gender and Sexual Diversity

LCI conducted GSD training for PHOs working in the health sector to improve their ability to provide health services and education to KPs. Of 120 PHOs surveyed in 2018, 65 (54%) attended a GSD training. These PHOs provided HIV services in health facilities. HIV providers who received the GSD training were asked how much of a difference these meetings made in their work. All 65 PHOs that attended this training said it made a difference in their policy priorities, and 97 percent said participating in the GSD training changed their thinking about sex workers and men who have sex with men. Figure 4 shows the percentages of HIV providers who responded “no difference,” “somewhat of a difference,” and “a big difference.”

Figure 4. Assessment of gender and sexuality diversity training (2018, N=65)



Many PHOs who participated in in-depth interviews discussed the power of meeting with a sex worker or a man who has sex with men for the first time. One healthcare worker said the following:

We trained with KPs themselves; we trained with lesbians, sex workers, MSM . . . all of them, even the transgender. We got peers from each group. The more we trained them, the more we interacted with them, the more we realized that actually stigmatizing them or discriminating [against] them wouldn't help.

Part 2B: Policy and Guideline Training for PHOs to Improve HIV Services for KPs

To improve the experience that KPs have in seeking health services, elevate the importance of HIV services in the health system, engage health sector PHOs in policy development, and ensure that PHOs have information on pre-exposure prophylaxis, LCI conducted additional trainings for PHOs at the facility and administrative levels.

Out of 34 total PHOs working in administrative positions, 20 (60%) attended a training on the public health importance of the most at-risk populations (MARPs) in the HIV response and how to include them in program

planning, and 13 (38%) attended a policy development training on the Patients' Rights and Responsibilities Bill. Thirty-two (37%) attended a training on pre-exposure prophylaxis guidelines and services. These groups were surveyed in 2018 about the difference that these trainings made in their work. The results are outlined in Figure 5. Although the results are favorable, the trainings provided to administrative PHOs were not as well received as the trainings provided to facility-level workers presented above.

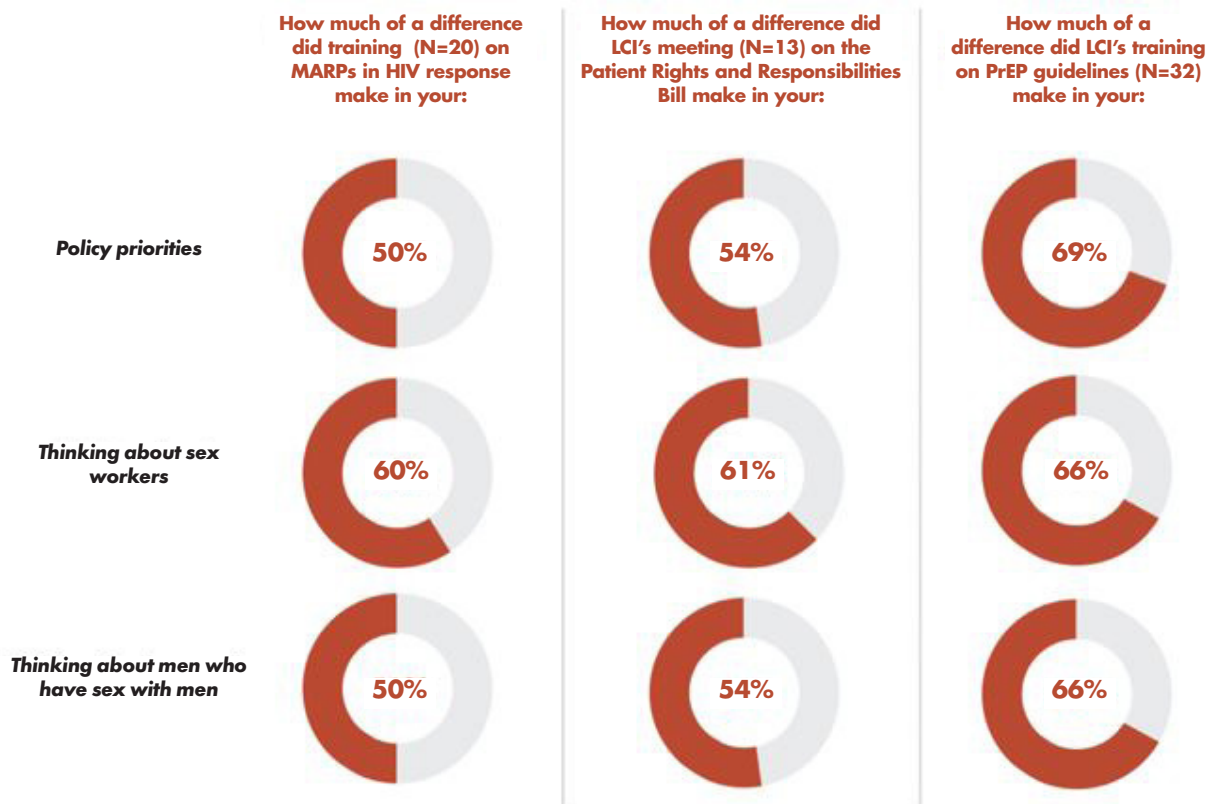
A healthcare provider said the following:

I don't think there is any problem. I told you, before the training, I had such negative attitudes, but with time . . . and we have been talking to them, and it seems very normal and very OK to all of us. Services are not tagged. But, whoever they come across, we have been telling them that whenever you come, please open up and tell us, because you might need a special service and you miss it because we don't know what category of the population you are coming from.

Part 3: Community Scorecard Approach with HIV Providers and KPs

The CSC approach is a citizen-driven accountability tool that guides improvements in and oversight of the delivery

Figure 5. Assessment of PHO HIV services training intervention



of health services. LCI encouraged the adoption and integration of this approach in the health sector to monitor availability and accessibility of HIV services at the facility, district, and national levels. Out of 120 PHOs surveyed in 2018, 53 (44%) had participated in a CSC meeting. Of these meetings, nearly half (26) were at the health facility level, 23 percent were at the district level, and 28 percent were at another unspecified level. The CSC is a collaborative health system intervention, and CSO workers were also involved in these meetings; 90 CSO workers (68%) reported that they participated in the CSC intervention.

PHOs who received the CSC intervention were asked how much of a difference these meetings made in their work. Ninety-eight percent of PHOs said the CSC made a difference in their policy priorities; 72 percent said it made a big difference. Most public officials (98%) said the CSC activity made a difference in their thinking about sex workers, and 94 percent said it made a difference in their thinking about men who have sex with men. This information is detailed in Figure 6.

A PHO working at the facility level said the following:

The LCI project has carried out community scorecards; it has advocated for many things. For example, we didn't have the lubricants, but currently, the lubricant is there in plenty. We didn't have the STI [sexually transmitted infection] drugs, but now we have them; the KPs didn't want to come for services in the facilities, but they do come. They [LCI] advocated for the KP peers in the facility, and now we have the KP peers. They advocated for things like sensitization of KPs in the community and the facilities, and we are doing the sensitization. So, for most of the things they advocated for, we have seen the results.

A CSO worker who was engaged in the CSC activity reported the following:

The most significant change for me is that at least now, sex workers can go to public health facilities and get treatment because of this scorecard. Now, even the government recognizes it. We have got contact people in some of the health facilities (Kisenyi; Kawaala) to whom we can send sex workers and other key populations groups. Initially, it would take a long process, and at times, we had to give bribes to health workers to get a service. But these activities that were done opened up health care providers' minds to realize that we are people and we need these services. To me this changed a lot.

Figure 6. Assessment of PHO HIV services training intervention

