



THE REPUBLIC OF UGANDA

MINISTRY OF HEALTH

THE NATIONAL PEDIATRIC AND ADOLESCENT HIV ADVOCACY STRATEGY AND ROAD MAP 2022-2026

Kampala - October 2022

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Foreword

Ending AIDS among children is vital to ending the AIDS epidemic as a public health threat by 2030 – the overarching goal of the Joint United Nations Programme on HIV /AIDS (UNAIDS) and the attainment of the Uganda National HIV and AIDS Strategic Plan 2021/25 goal and theme of Leaving no one Towards Ending AIDS by 2030.

Although Uganda is on the right trajectory to achieve the UNAIDS’ 95-95-95 super fast-track targets for PLHIV, children (0-9 years) and adolescents (10-19 years) are still lagging. This lag is sustained despite two decades of consistent efforts and innovations to improve HIV care and treatment outcomes for children and adolescents living with HIV. National ART coverage is 93%, but coverage for children (0 – 9 years) is 57% and that for adolescents (10 – 19 years) is 58% (MoH, 2021). By December 2020, retention of adolescents was at 43% compared to retention of 60% among children and retention of 60% among adults. Challenges with pediatric and adolescent HIV in Uganda include a) identification of children and adolescents living with HIV is still sub-optimal, b) suboptimal retention of children and adults, resulting in inadequate viral load suppression, c) sub-optimal adolescent-friendly service deliver centers, and d) limited human resources to adequately support national programs. This warrants re-strategizing for this demographic.

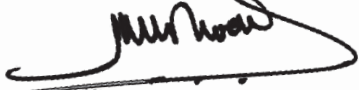
Through review of Uganda’s pediatric and adolescent HIV program trajectory with a focus on the challenges that continue to undermine progress toward the 2030 pediatric HIV elimination goals and through dedicated plenary sessions, program gaps that required advocacy for resolution were systematically identified, collated and documented. Advocacy has been identified as a key pivot for accelerated progress toward the elimination goal through reduction of the inequalities that plague pediatric and adolescent HIV. This necessitates the development and consequent operationalization of a national Pediatric and Adolescents HIV Advocacy Strategy.

The Uganda Ministry of Health in partnership with UNICEF and EGPAF held a National Pediatric HIV Advocacy Consultation workshop in April 2022. The workshop aimed to collectively identify advocacy needs that require urgent prioritization to further accelerate progress toward elimination of Pediatric AIDS by 2030. Following this, the development of a national Pediatric HIV Advocacy Strategy and road map – to operationalize it, were prioritized by Government, AIDS Development Partners (ADPs), networks of PLHIV and CSOs and commitment to drive advocacy by all parties was garnered. In national-level capacity assessment conducted in 2014, key line ministries identified advocacy as the most significant gap in national HIV/AIDS response pertaining to children and adolescents. This Advocacy strategy aims at galvanizing and coordinating synergic actions amongst Ministries, Departments and Agencies of Government (MDAs) and partners supporting the national response, building awareness and understanding of prioritized advocacy issues.

The overall objective of this strategy is to complement and catalyze the ongoing national programs targeted at improving pediatric and adolescents HIV outcomes by addressing the policy and resource allocation gaps. This will be through putting in place a uniform and harmonized technical approach to advocacy across the national response stakeholders. The strategy provides standardized practical approaches to guide stakeholders in planning, designing, implementing and evaluating advocacy initiatives in support of pediatric and adolescents HIV. The strategy will institute systems to keep track of ongoing and new advocacy initiatives to ensure they are aligned to the advocacy issues highlighted in the strategy for continuous process quality improvement and mitigate risks associated with uncoordinated advocacy initiatives.

A road map unpacks the strategy implementation framework and describes the advocacy trends in the country; various target audiences; each audience playing different roles in advancing the advocacy issues prioritized. This Advocacy strategy complements the National HIV and AIDS Strategic Plan (NSP) 2020/2021–2024/2025. It is my sincere hope that this strategy will serve as a key resource in the planning, formulation and implementation of the targeted programmes aimed at optimizing HIV services for the Ugandan Children and adolescents and at ensuring that meaningful investment is put in reducing the burden due to HIV among that demographic in the country.

For God and my Country



Henry G. Mwebesa

DIRECTOR GENERAL HEALTH SERVICE

Acknowledgments

The Ministry of Health sincerely appreciates the key contributors to the development of the Uganda National Pediatric HIV Advocacy Strategy and road map.

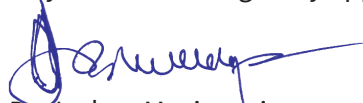
First and foremost, special thanks go to UNICEF Uganda Country Office for funding the development process, production and dissemination of the National Pediatric HIV Advocacy Strategy and Road Map.

Sincere appreciation is also extended to the government sectors, various development partners, non-governmental organizations, individuals and stakeholders who contributed to the development of the Uganda National Pediatric HIV Advocacy Strategy and road map [Full list in the appendix]. These include:

- Technical Officers from AIDS Control Program, Ministry of Health
- Technical officers from Uganda AIDS Commission
- The VIIV Paediatric Breakthrough Partnership comprising of UNICEF, EGPAF, Aidsfonds and PATA
- Technical officers from PEPFAR
- Technical officers from Ministry of Education and Sports
- Representatives of PLHIV networks
- Representatives of the religious leaders
- Representatives of cultural institutions

Finally, special thank you to the consultant, Dr. Denis Kayiwa, who led the Strategy and Road Map development.

All your efforts are greatly appreciated.



Dr. Joshua Musinguzi

Programme Manager STD / AIDS Control Programme

Glossary

In order to have a common interpretation of the Key words/phrases in the document, the Glossary describes such terms as described in the 2015 UNAIDS terminology guidelines.

Adolescent:	Person aged 10 to 19 years
Child:	Under the UN Convention on the Rights of the Child, 1989, a child is a person under 18 years of age, unless under domestic law the child reaches majority at an earlier age.
Caregiver/carer:	Differentiated from professional caregivers or carers, caregivers or carers are people who provide unpaid care for a family member, friend or partner who is ill, frail or living with disability. This could include provision of unpaid care to a child or adolescent living with HIV.
Constituency:	A group or people, often with similar backgrounds, ties, interests, and priorities, which is represented on a decision-making body. Representatives are often elected by the entire group, but they may also be selected through other mechanisms (by appointment, for example).
Stakeholder/ stakeholder group:	Individuals or organizations that have a vested interest in HIV prevention, quality health for Young People Living with HIV and youth in general. Key stakeholders in this context include YPLHIV and their families and communities; CSOs in the HIV & AIDS field; Health Service(s) providers, public health policymakers.
Community response:	A collective of community led activities in response to HIV. These activities are not only limited to service delivery but can include advocacy by civil society and community networks for policies and improved investment to HIV programmes that meet the needs of the community.
Comprehensive sexuality education:	An appropriate, culturally sensitive approach to teaching about sex and relationship by providing scientifically accurate, realistic information.
Enabling environment:	An enabling environment in the context of Pediatric and Adolescent HIV is not only to have conducive policies and laws relating to HIV/AIDS, but one with social protection strategies (e.g economic empowerment) in place and where social norms support knowledge, awareness and healthy behavior choices.
Gender:	The social attributes and opportunities associated with being male and female and the relationship associated with being women and men, girls and boys.
HIV treatment cascade:	The chain of events that are involved in an HIV-positive person receiving treatment until his or her viral load is suppressed to undetectable levels.
Investment case:	Document that makes case for optimized HIV investment. A means of demonstrating national leadership in the response.
Stigma:	The dynamic process of devaluation people either living with or associated with HIV and AIDS that significantly discredits him/her/them in the eyes of others
Discrimination:	ny form of arbitrary distinction, exclusion or restriction affecting a person usually (but not only) because of inherent personal characteristics or perceived membership of a particular group.

List of Acronyms and abbreviations

ACP	AIDS Control Program
ADPs	AIDS Development Partners
AIPs	AIDS Implementing Partners
AGYW	Adolescent girls and young women
AIDS	Acquired Immune Deficiency Syndrome
UNAIDS	Joint United Nations Programme on HIV/AIDS
ART	Antiretroviral Therapy
ARVs	Anti-Retroviral
BTP	Breakthrough Partnership
CBOs	Community Based Organizations
CHWs	Community Health Workers
CSO	civil society organization
EGPAF	Elizabeth Glazer Pediatric Foundation
EID	Early Infant Diagnosis
EPI	Expanded Program on Immunization
GBV	Gender-Based Violence
HCW	Healthcare worker
HDP	Health development partner
HSHASP	Health Sector HIV/AIDS Strategic Plan 2018/2023
HIV	Human Immunodeficiency Virus
HIVST	HIV self-testing
MDAs	Ministries, Departments and Agencies of Government
MoES	Ministry of Education and Sports
MoGLSD	Ministry of Gender, Labour and Social Development
MoH	Ministry of Health
MTCT	Mother to Child Transmission
NDA	National Drug Authority
NGO	Non-government organization
PEPDAR	Presidential Emergency Plan for AIDS Relief in Africa
PLHIV	People living with HIV
PMTCT	Prevention of mother-to-child transmission
PSS	Psychosocial support
SRH	Sexual and reproductive health
UAC	Uganda AIDS Commission
UNICEF	United Nations Children’s Fund
USAID	United States Agency for International Development

Executive Summary

According to the Ministry of Health (December 2021), of the estimated 1,414,183 PLHIV, 1,320,158 (93.4%) were on ART. However only 30,473 (56.7%) of the estimated 53,714 children LHIV, and 60,040 (58.1%) of the 103,358 adolescents LHIV were on ART. This lag is despite two decades of consistent concerted efforts and innovations to improve HIV care and treatment outcomes for children and adolescents living with HIV.

The comprehensive multi-sectoral set of pediatric and adolescent HIV program level interventions that the Government of Uganda and partners are pursuing is stimulated by the recognition that addressing the current HIV programmatic intervention challenges, requires the development and consequent operationalization of a national pediatric and adolescent HIV advocacy strategy. This is premised on the report findings of the MoH National pediatric and adolescent HIV program annual Update. The report underscored bottlenecks to existing programming as fueled by ineffective policies, policy gaps for a conducive pediatric and adolescent HIV intervention scale up and resource allocation gaps specifically to the pediatric and adolescent HIV national response.

Strategy and road map development process

This strategy and road map are a creation of a wide-ranging consultative and appraisal process that consisted of an array of key pediatric and adolescent HIV stakeholders' engagement in a series of workshops. The process additionally ensured there is a meaningful and systematic participation of adolescents both boys and girls through their direct engagement in a series of workshops leading to the prioritization of the advocacy issues. The Uganda Ministry of Health (MoH) in partnership with UNICEF and EGPAF held a National Pediatric HIV Advocacy Consultative workshop on 21st April 2022 at the Sheraton Hotel in Kampala, Uganda. The workshop was attended by policy makers, government officials (MoH, MoES, MoGLSD and UAC), healthcare providers, AIDS development partners (APDs), members of civil society organizations (CSOs) and representatives of young people living with HIV (YPLHIV). The Ministry of Health further organized consultative follow-on workshops for Adolescents and Young people living with HIV (LHIV) on 27th June at Imperial Royale Hotel, Kampala and a follow on for care givers of Children and Adolescents LHIV on June 28th, 2022, at Imperial Royale Hotel, Kampala.

The listed workshops enabled stakeholders to; a) review Uganda's Pediatric and Adolescent HIV trajectory and collectively identified advocacy needs which must be urgently prioritized to further accelerate progress toward elimination of Pediatric AIDS by 2030, (b) assess the current situation with regards to HIV care and treatment outcomes for children and adolescents; (c) scan the environment for Pediatric and adolescent HIV, policies, and programs and earmarked potential advocacy nature gaps; (d) review the strengths, weaknesses, opportunities, and threats associated with Pediatric and Adolescent HIV in Uganda; and formulate an advocacy agenda to address the challenges. Among the key potential advocacy related problems highlighted included: the high number of HIV infections among children and adolescents, Limited access to information and key SRHR services for AGYWs- CDE, Low coverage of PMTCT and EID services at lower health centers and private health provider's children, Limited community Health engagement systems, and Limited access to Viral Load Testing (VLTs). Through dedicated plenary sessions, program gaps that required advocacy resolution were systematically identified, collated and documented for each of the highlighted areas, the root cause associated with a policy gap (ineffective or missing) and limited resource allocation were identified and documented through a number of dedicated plenary sessions.

The ideas and discussions from the above workshops informed the five days advocacy writing workshop for the National Pediatric and Adolescent HIV Advocacy Strategy by key stakeholders organized by MoH at Imperial Golf view Hotel, Entebbe from 18th - 22nd July 2022. The National Pediatric and Adolescent HIV Advocacy Strategy and road map draft was developed during the workshop guided by the ten advocacy

steps including; i) Identity and consensus building on the advocacy issue/s, ii) Setting advocacy goals and objectives iii) Identifying a target audience iv) Building support in coalitions; identify allies and opponents , v) Developing targeted message, vi) Identifying and selecting the appropriate channels of communication, vii) Defining the advocacy activities, viii) Budgeting and fundraising for advocacy initiatives ix) Research and analysis (Data collection) and x) Monitoring and evaluation.

MoH with support from UNICEF organized the workshop on 9th – 10th August 2022 in which the final drafts of both the National Pediatric and Adolescent HIV Advocacy strategy and road map were further refined. A costed operational plan aligned with the current Pediatric and Adolescent HIV Costed Implementation Plan were developed as part of the road map. A small technical review team was set up by MoH to facilitate final review and subsequent approval of the National Pediatric and Adolescent HIV advocacy strategy and road map. The team of 20 included representatives from government officials (MoH, MoES, and MoGLSD), UAC, AIDS DPs, CSOs and young people living with HIV. The road map refined the strategy into an implementation blueprint including mechanisms for knowledge management, managing risks, monitoring, evaluation and learning, as well as the implementation costs. The road map is the basis for mobilizing resources and will guide the execution of the advocacy strategy as applicable to each of the 10 focal advocacy issues.

The challenge

Uganda is yet to achieve the global ambition of eliminating AIDS as a public health problem among children and adolescents living with HIV despite a decade of consistent efforts to improve services and outcomes for this demographic. The 2021- 2026 UNAIDS Global AIDS Strategy seeks to reduce the inequalities that drive the epidemic and to put people at the center to end AIDS as a public health threat by 2030, with infants, children, and adolescents high on the agenda. The new Global Alliance to end AIDS in Children points addressing to presently low high level political commitment to prioritize Pediatric and Adolescent HIV a gap that will be addressed through the 8 advocacy issues earmarked in the strategy. Similarly, The UNAIDS strategy underpins advocacy as a key pivot for accelerated progress towards the elimination goal. The gaps below have been earmarked as advocacy related.

Advocacy problems highlighted:

1. Lack of pediatric and adolescent specific data in the national health and HIV surveys and assessments respectively.
2. Low coverage of PMTCT and EID services at lower health centers and private health care providers
3. Limited community health engagement systems supporting C&ALHIV.
4. Limited access to Viral Load Testing (VLTs) among children and adolescents
5. High number of children living with HIV and yet undiagnosed (not on treatment)
6. Children from 6years spend most of their time in schools, of which schools as it is, have not adequately been prepared/equipped to support a child living with HIV.

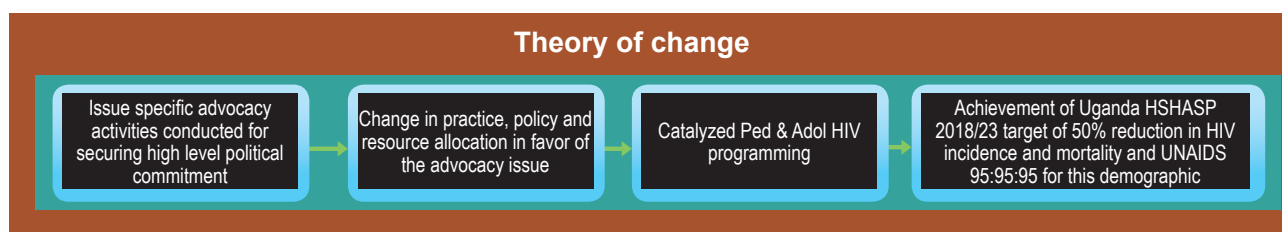
Theory of change

Achieving the UNAIDS 95:95:95 targets and the Uganda HSHASP 2018/23 goal of 50% reduction in HIV incidence and mortality among children and adolescents in Uganda is pivotal to achievement of the national UNAIDS targets for PLHIV by 2030. For this to happen, the current high level political commitment dynamics, in relation to development prioritization and investment underling the slow progress in the national response for children and adolescent HIV despite commendable programming, as was identified in the UNAIDS Survey 2022 must be urgently addressed.

The advocacy strategy and its road map propose eight advocacy issues listed below as the vehicle through which catalytic programming approaches like surge approach and deliberate focus on the three pillars of Global Alliance to end AIDS among others will be facilitated to attainment both the global UNAIDS 95:95:95 targets and the Uganda HSHASP 2018/23 goal. This will be through audience specific influencing actions to secure the much-needed high level political commitment for relevant policy reforms and increment in resource allotment in favor of improved HIV outcomes for children and adolescents. Such actions will align to the high political individual or institutional level aspirations by inspiring them to champion, implement, lead, take responsibility, and account for the actions and measures instituted to promote and sustain improved HIV care and treatment outcomes for children and adolescents.

These actions will contribute to:

1. The re-inclusion of children 0-14 HIV indicators in all National health survey and assessment system by 2025
2. The expedited policy reforms by the MoH to upgrade HCIIIs to HCIIIs to allow for HIV services provision in previously HCIIIs by 2024
3. Increased resource allocation by five (5%) to ACP community health HIV pediatrics and adolescents by 2023/24.
4. MoH ring-fencing 5% of the 30% non-wage recurrent in the health sub programme Grant, Budget and implementation guidelines to LG to prioritize HIV related activities with focus on support to expand both lay testers and Pediatric community resource persons.
5. Increased resource allocation to MoH-ACP programme for procurement and maintenance of stable supply chain systems for child friendly ARV formulations (from ABC to TAF) in the country post 2024.
6. The Cabinet expedited approval and roll out of the school health policy by 2024 for schools to play a supportive role in the management of C&ALHIV.
7. A five (5%) annual budgetary increment to the relevant school health vote functions under the MoH Division of Child Health and MoES Directorate of Basic and Secondary Education to facilitate implementation of school health policy.
8. A revised training modules by MoES Directorate of Education Standards by 2025 for pre-service teacher training and continuous professional development for in-service teachers with updated HIV information with a focus on psychosocial support.





CHAPTER ONE:

Introduction

1.1 Background

Globally by 2020, there were 1.7 million children living with HIV, almost half (46%) of whom were not receiving life-saving HIV treatment. An estimated 800,000 children were undiagnosed and not on treatment. In the same year there were 150,000 new HIV infections among children. Every hour, 26 adolescents get infected, with close to 2 million living with HIV worldwide (UNAIDS, 2022).

Most of these new child infections could have been prevented if adolescent girls and women had universal access to HIV testing, prevention and treatment services and the support they need to stay in prevention care or on HIV treatment throughout pregnancy and breastfeeding (UNAIDS, 2020).

Forty years since the first AIDS case was recorded in Uganda, HIV and AIDS continues to have a devastating impact on the social and economic life of the country. By 2022, global pediatric ART coverage is at 52% compared to adult coverage at 85%. Outcomes for children are worse than for adults (includes initiation on ART, adherence to ART and viral load suppression). Despite the commendable programming and support, the pediatric and adolescent cascades in Uganda remain sub-optimal warranting re-strategizing. Some of the persistent challenges with Pediatric and Adolescents HIV in Uganda below optimum levels include a) identification of children and adolescents living with HIV, b) retention of children and adolescents, resulting in inadequate viral load suppression; c) limited adolescent-friendly service delivery centers; and d) limited human resources for health to adequately support pediatric and adolescent HIV national programs. The UNAIDS 2022 survey attributes these challenges to limited high level political commitment to facilitate sufficient resource allocation within a conducive policy environment in favor of better children and adolescents HIV outcomes.

Advocacy therefore was identified as a key pivot for accelerated progress towards the elimination goal through addressing the policy and resource allocation barriers impeding successful HIV/AIDS program implementation to the plight of pediatrics and adolescents' specific national response. This necessitated the development and consequent operationalization of a National Pediatric and adolescent HIV Advocacy Strategy. The advocacy Strategy outlines the context and situation analysis of the eight advocacy issues around the thematic areas in focus (HIV Prevention, first 95-Locating/Case finding including EID, 2d& 3rd 95, Care and Treatment). This strategy aims at giving a strategic direction to The Uganda Ministry of Health Pediatric and adolescents HIV division's advocacy agenda together with partners.

1.2 Context

Uganda prioritized control of HIV and AIDS within the country's third National Development Plan 2020/21–2024/25 (NDP III) and other national and international commitments, such as the Sustainable Development Goals (SDGs). The country is also implementing the Presidential Fast-Track Initiative on Ending AIDS as a Public Health Threat in Uganda by 2030 (PFTI), launched by His Excellency Y.K. Museveni in June 2017. However, this is yet to be achieved because of several factors including poor access, availability and quality health care service provision in Uganda. The National HIV and AIDS Strategic Plan (NSP) 2020/2021–

2024/2025 under the theme; “Leaving no one behind towards ending AIDS by 2030” lays out strategies and actions to implement high-impact, evidence-informed interventions and innovations through program optimization. This clearly shows that the government of Uganda has a clear understanding of these challenges and has instituted policy options to address them. Nevertheless, progress to realization of improved health outcomes specific to pediatric and adolescent HIV is still slow with a National ART coverage for children (0 – 9 years) at 57% and that for adolescents (10 – 19 years) at 58% compared to the national coverage at 93%. The Uganda Ministry of Health Pediatric HIV division underpins a national advocacy agenda to catalyze implementation of some of these policies.

1.3 Situation Analysis

To date, over 38.4 million people globally live with HIV, with 1.5 million people becoming newly infected with HIV in 2021 (UNAIDS, 2021). In Uganda, the Ministry of Health (MoH) estimates that there were 1,460,000 people living with HIV in 2019. HIV incidence per 1,000 uninfected people of all ages was 1.4, but it was substantially higher in specific sub-populations and locations. The national estimates put HIV prevalence at 5.8% (7.1% among women and 4.3% for men).

Among young people aged 15-24 years, HIV prevalence is 2.8% and 1.1% among young women and young men (15-24 years) respectively. The estimates also indicate that 53,000 people were newly infected with HIV: 5,700 children aged 0 to 14 years and 48,000 adults aged 15 years and older (among them, 28,000 women aged 15 years and older). Among older adolescents and young people, HIV prevalence is almost four times higher among females than males. Whereas all data sources indicate declining HIV prevalence and incidence for more than a decade, there are wide variations by region and district: most parts of the central and western areas of the country and the South-West region report higher rates.

The same is true of urban and rural variations. Not all data are current or comprehensive for certain population groups, particularly key populations (KPs); still, HIV prevalence has been found to be significantly higher among these groups, ranging from 13.7% to as high as 37% for sex workers. Although AIDS-related deaths have declined over the past decade, males -on account of their lower antiretroviral therapy (ART) coverage and poor health-seeking behavior - are more disproportionately affected in mortality statistics (60%). Regarding the 90-90-90 target, country performance data available at UNAIDS indicate that, as of March 2020, eighty-nine (89%) of all adults (93% of women and 86% of men) living with HIV knew their HIV status and 84% (91% of women and 77% of men) were on treatment, among whom 75% (83% of women and 68% of men) had suppressed viral loads. Rates were 65-65-48 among children, and about 93% of pregnant women living with HIV were on ART.

1.4 Scope and Justification of the Advocacy Strategy

Ending AIDS among children and adolescents is vital to ending the AIDS epidemic as a public health threat by 2030 the overarching goal of the joint UNAIDS Programme. Expressed through a recent 2022 UNAIDS Survey, stakeholders are calling for a new political commitment and leadership to eliminate vertical transmission and end AIDS in Children by 2030. UNICEF, WHO, and UNAIDS working group is establishing a new Global Alliance to end AIDS in Children that integrates lessons learnt from past initiatives such as the Global Plan and the Start Free, Stay Free, AIDS Free framework. The Alliance will focus on three pillars identified through a global consultation: (i) early testing and optimized treatment for infants, children, and adolescents living with HIV; (ii) closing the treatment gap for pregnant and breastfeeding women living with HIV and (iii) optimizing retention in care and preventing new HIV infections among pregnant and breastfeeding women.

The Global Alliance’s vision is in line with the Uganda National HIV/AIDS strategic Plan theme of leaving no one

behind towards ending AIDS by 2030. Although overall, Uganda is on the right trajectory to achieving the global UNAIDS 95:95:95 targets, significant gaps are visible among children and adolescents. The current ART coverage for children (0 – 9 years) is 57% and that for adolescents (10 – 19 years) is 58% relative to the national ART coverage of 93%. This calls for re-strategizing to accelerate actions for addressing this gap among this demographic. The UNAIDS strategy underpins advocacy as a key pivot for accelerated progress toward the elimination goal. Advocacy is one of the most effective approaches to achieving public health goals by ensuring that necessary resources, policies and political will are available to support, scale up and sustain global health programs (Wallack, L et al, 1999).

During the MoH pediatric and adolescents HIV national stakeholders' workshop conducted in April 21, 2022 at Sheraton Hotel Kampala, it was established that addressing the gaps highlighted above among children and adolescents required a deliberate nationally guided advocacy intervention. During the workshop, the program gaps that required advocacy resolution were systematically identified, collated and documented. For each of the highlighted areas, the root cause associated with a policy gap (ineffective or missing) and limited resource allocation were identified and prioritized which forms the skeleton of the Uganda national Pediatric and adolescents HIV Advocacy Strategy. The strategy is based on 10-part validated advocacy framework that assesses the current policy framework's gaps pertaining Pediatric and adolescents HIV and make strategic recommendations about policy advocacy goals and activities. The 10-part framework provides a framework for the strategic advocacy engagement by player supporting the national HIV/AIDS response for pediatric and adolescents.

The strategy and road map offer a basis of creating tailor made advocacy initiatives. They also serve as tools for monitoring advocacy initiatives by stakeholders supporting pediatric and adolescents HIV and AIDS response. The strategy has benchmarked and made reference to relevant UNAIDS, WHO, UNICEF standards, EAC regional and national guidelines on pediatric and adolescent HIV. The absence of the national advocacy strategy for pediatric and adolescents leads to fragmented and uncoordinated individual partner and stakeholders' initiatives lacking uniformity especially in the advocacy technical approach and alignment to the current national gaps requiring urgent advocacy intervention, resource wastage, limited quality control and monitoring of such initiatives.

1.5 Users of the Strategy and Road map

The strategy has been developed for use by MoH ACP pediatric and adolescents HIV division, MDAs supporting pediatric and adolescents HIV interventions, AIDS development partners, implementing partners, foundation bodies and other pediatric and adolescents HIV/AIDS national response stakeholders including CSOs and CBOs.

1.6 Guiding Principle of the Strategy

1.6.1 Leaving No one behind

Leave no one behind (LNOB) is the central, transformative promise of the 2030 Agenda for Sustainable Development and its Sustainable Development Goals. The same principle resonates with The Uganda National HIV and AIDS Strategic Plan (NSP) 2020/25 under the theme; "Leaving no one behind towards ending AIDS by 2030. It is clear from the background that health outcomes related to Children and Adolescents HIV are lagging behind at global and national level. The advocacy strategy and its road map aligns to this SDG transformative promise and the national NSP theme through influencing actions for prioritization of policy and resource allocation in favor of children and adolescents HIV improved services and better health outcomes.

1.6.2 Support to meaningful and systematic participation of adolescents, children and care givers Children and Adolescents LHIV.

Meaningful participation of adolescents and care givers of children and adolescents LHIV formed the basis of the stakeholder's consultation workshop that feed into the strategy and road map writing workshop. During the strategy and road map development process, a special workshop was organized for only adolescents and caregivers of children and Adolescents LHIV to allow free and open contribution to shaping this national advocacy agenda out of their own voices in a receptive audience. The strategy implementation and road map roll out are designed to adhere to this principle through continuous meaningful participation of adolescents and care givers of children and adolescents LHIV in their respective existing platforms. This output area is integrated in the advocacy strategy monitoring and evaluation framework.

1.6.3 Partnership

Due to the diverse nature of HIV/AIDS national response policy framework and future resource allotment priorities, synergy, partnerships, and effective coordination will be key to the implementation of the strategy and its road map. This should take on a myriad of approaches including formation or rejuvenation of Pediatric, and Adolescents strategic advocacy platforms in form of alliances, networks and coalitions to give clout, leverage among stakeholders and advance the earmarked advocacy issues.

Building new partnerships and strengthening existing coordination platforms and advocacy technical competency of pediatric and adolescents HIV division networks like Global Advocacy work stream (GAW) of the Breakthrough (BT) Partnership will be pursued at both national, regional and district levels to maximize synergic relationships with relevant stakeholders. The major coordination platform will be through the existing ACP coordination forums like the Pediatric and Adolescent HIV Care & Treatment ECHO quarterly meetings. Advocacy is often confused with similar concepts including; Social Behavior Change (SBCC), Information, Education and Communication (IEC), Public Relations (PR), Community Mobilization and Social Marketing among others. Therefore, clarity of the technical tenets of advocacy and its purpose through building the advocacy technical competency of partners and the MoH structures supporting the implementation of the strategy road map will be critical.

1.6.4 Research and evidence-based advocacy

Collecting systematic and where possible rigorous scientific evidence through increased policy research, improved dissemination, partnership with academia, building long term relationships with policy makers at national, regional and district levels to utilize policy evidence will be key to delivering the strategy objectives. Topics and papers by ACP staff and partners (poster or presentation) to be made in HIV/AIDS pediatric and adolescent's related conferences, publication in peer review journals or local media during the strategy implementation period should be aligned to the seven advocacy issues. Such studies should generate more rigorous evidence to quantify the earmarked advocacy problems in terms of magnitude whilst proposing local solutions in terms of advocacy issues, achievable through policy reforms or change in budget allotment to Pediatric and Adolescent HIV Care & Treatment.

As a benchmark, study designs option for generating evidence for advocacy should illustrate that the positive change desired is directly linked to the advocacy solution. The study recommendations should not only show the strength of the solution but its long-term effect, resonate easily with both the technical and political stakeholders and consider broader beneficiaries (equity and inclusion).

1.7 Objective of the strategy

The overall objective of this strategy is to complement and catalyze the ongoing national programs targeted at improving pediatric and adolescents HIV outcomes. This is by addressing the policy and resource allocation gaps through putting in place a uniform and harmonized technical approach to advocacy interventions in support of pediatric and adolescents HIV across the national response.

The strategy provides standardized practical approaches to guide ACP and stakeholders in planning, designing, implementing and evaluating advocacy initiatives in support of pediatric and adolescents HIV. The strategy will institute systems to keep track of ongoing and new advocacy initiatives to ensure they are aligned to the advocacy issues highlighted in the strategy for continuous process quality improvement and mitigating risks associated with uncoordinated advocacy initiatives.



CHAPTER TWO:

Advocacy Objectives and Strategy

2.1 Goal of the strategy

The overall goal of this strategy is to influence the governance and relevant policy reforms for prioritizing pediatric and adolescents HIV response. The strategy will guide effective advocacy on priority issues of concern that will contribute to improved HIV care and treatment outcomes for children and adolescents living with HIV. The strategy recognizes that better pediatric and adolescent health outcomes hold great promise for the future of the Uganda and yet this demographic for long has been under priorities in HIV/AIDS programming and resourcing at various levels majorly driven by partners' priorities and resourcing.

2.1 Objectives of the strategy

In fulfillment of the above Goal, the strategy will pursue the realization of the following specific and interrelated objectives;

To rejuvenate high level political and partner's will in prioritizing pediatric and adolescent HIV response based on evidence-based advocacy.

To guide stakeholders in the formulation and implementation of advocacy activities and allocation of budgets to priority areas in HIV care and treatment services for children and adolescents LHIV at national and district levels.

To give strategic direction on how to influence decision makers and policy change including increased investments, prioritization and accountability within the health and social services sectors at national and district levels

To enhance collaboration among pediatric and adolescent HIV response stakeholders supporting advocacy-oriented initiatives.

2.2 Specific overarching strategies

2.2.1 Build the constituency of change

Effective advocacy requires that there is an active constituency working on pushing a uniform advocacy agenda aligned to the mainstream program implementation. This strategy recognizes that there is an existing constituency working on pediatric and Adolescents HIV advocacy.

However, this group is nether organized, representative, nor clear on effective advocacy strategies to adopt in light of the changing operational environment. Dwindling resources base for advocacy initiatives and limited political will later alone consensus on which advocacy issue/s to advance pertaining to pediatric and adolescent HIV are some of the areas to be streamlined by the strategy. Constituency building will thus form a foundational aspect of the advocacy strategies. This will be achieved through:

- Guiding on the level of formality of the constituency (formal with a written agreement- MoU or informal based on areas of common interest). Both approaches are acceptable.
- Quarterly meeting of the constituency actors working on any of the Eight (8) advocacy issues. This should not be a parallel meeting but integrated in the existing Pediatric and Adolescent HIV Care & Treatment ECHO meetings (monthly and quarterly) as appropriate.
- Identifying advocacy implementation challenges and discussing options for a collective push for their solution
- Unifying advocacy voices by identifying and collaborating with all actors in constituency to focus on advancing only the advocacy issues highlighted in the strategy
- Developing joint fundraising proposals, pre-teaming and resource mobilization to fund the strategy advocacy activities
- Joint engagement with and collaboration with donor's advocacy implementation as a distinct discipline separate from programming implementation.
- Monitoring and evaluation of the strategy road map

2.2.2 Create the implementation demand

While MoH is mandated to lead this strategy implementation as the lead player, the AIDS/HIV national response is uniquely supported enormously by partners. Therefore, in the advocacy process, the successful implementation of strategy requires active and engaged partners (AIDS development and implementing partners), the line ministries of Education and Gender and the foundation bodies.

Therefore, the strategy will prioritize:

- Awareness creation to these target audiences on the advocacy issues and rationale.
- Supporting the partners in evidence generation and partnership for evidence based advocacy.
- Leveraging on ongoing MoH and partners relevant implementation of multi-media communication and SBCC programs to enhance awareness on the advocacy issues.
- Advocacy technical support to MoH and partners to enhance their delivery responsibility.
- Develop and disseminate audience specific advocacy messages providing solutions or alternatives.
- Support networking and collation building amongst stakeholders to share experience and push for advancement of the advocacy issues.

2.2.3 Collaborative learning and adaptation

The strategy recognized already existing fragmented advocacy initiatives by partners. These and the actual strategy implementation process will generate lessons. The strategy will seek to harness and disseminate these lessons so as to guide the continued learning and adaptation in the advocacy implementation processes. Key strategies include:

- Developing a monitoring framework to continuously collect information on the implementation process, identify challenges and lessons for discussion and learning by all stakeholders.
- Produce regular implementation reports with policy and practical lessons during the quarterly Pediatric and Adolescent HIV Care & Treatment quarterly ECHO meetings.
- Use social media and other modern technologies to disseminate results from the monitoring process.

2.3 Priority advocacy issues

To frame the issues and set the Pediatric and adolescent HIV agenda, seven (7) advocacy issues were identified during the strategy and road map writing workshop. These reflect consensus built on advocacy related gaps and issues through stakeholder's extensive consultation and insights distilled a series of workshops. The key advocacy issues were prioritized under three thematic areas below.

2.3.1 HIV Prevention

- The re-inclusion of children 0-14 HIV indicators in all National health survey and assessment system by 2025
- The Cabinet expedited approval and roll out of the school health policy by 2024 for schools to play a supportive role in the management of C&ALHIV.
- A 5% annual budgetary increment to the relevant school health vote functions under the MoH Division of Child Health and MoES Directorate of Basic and Secondary Education to facilitate implementation of school health policy.
- Revised training modules by MoES Directorate of Education Standards by 2025 for pre-service teacher training and continuous professional development for in-service teachers with updated HIV information focusing on psychosocial support.

2.3.2 (First 95) Locate/Case finding including EID

- MoH ring-fencing 5% of the 30% non-wage recurrent in the Health sub programme Grant, Budget and implementation guidelines to LG to prioritize HIV related activities with focus on support to expand both lay testers and Peds community resource persons

2.3.3 (2d& 3rd 95) Care and Treatment

- Increased resource allocation by 5% to ACP community health HIV pediatrics and adolescents by 2023/24.
- The expedited policy reforms by the MoH to upgrade HCIIIs to HCIIIs to allow for HIV services in previously HCIIIs by 2024
- Increased resource allocation to MoH-ACP programme for procurement and maintenance of stable supply chain systems for child friendly ARV formulations (from ABC to TAF) in the country post 2024.



CHAPTER THREE:

Implementation Strategy

3.0 Implementation modalities

The success of advocacy strategy hinges on the advocacy expertise and participation of Children and Adolescents HIV stakeholders throughout the country. The Ministry of Health (MOH) through the ACP- Pediatric and Adolescent HIV Care & Treatment team leader will serve as the national coordinating body for the strategy road map. With three main advocacy issues targeting school policy reforms and increased resource allocation to ensure schools play a supportive role in the management of C&ALHIV, the Pediatric and Adolescent HIV Care & Treatment division will work very closely with the Adolescent and school health division and other school health supporting MDAs.

The MoH Health Promotion, Education and strategic Communication Department will provide technical assistance to integrate the strategy with already ongoing similar initiatives and will share available key advocacy communication resources with Pediatric and Adolescent HIV Care & Treatment division and partners. The MoH will actively co-ordinate the strategy road map implementation. The progress and implementation of the strategy will be discussed at monthly and quarterly ECHO Pediatric and Adolescent HIV Care & Treatment meetings, at Pediatric and Adolescents ART Sub –committee meetings and at the national HIV coordination meetings. The coordination function will ensure timely execution of activities, sharing of information among partners, and addressing any issues pertaining to the advocacy strategy road map. HCP will engage the services of an advertising agency for design and adaptation of advocacy key messages and materials, as well as media placement. ACP team will work closely with staff of partner organizations to transfer skills and strengthen their capacity to implement advocacy activities in a systematic manner on behalf of MOH and its partners.

A road map implementation matrix has been prepared (table 3) as the basis to operationalize the strategy guided by an advocacy work plan to be developed by the implementing partner (Table 4). The strategy will be implemented by advocacy issue. The response to and interventions on each of the 8 priority issues identified will be led and overseen by the technical working groups (TWGs) under the respective thematic areas indicated under sub section 2.3 above. These are composed of individual experts and representatives of organizations and agencies who are engaged with the given issue on a day-to-day basis.

Under the oversight of the MOH (ACP- Pediatric and Adolescent HIV Care & Treatment team leader), the ECHO meetings/forum will offer technical support and advise on a realistic detailed work plan selected for implementations by AIPs guided by the advocacy roadmap for each of the advocacy issue they are interested in. The work plan will lay out the modalities of execution including, for instance, conceptual elaboration of the advocacy issue (e.g., formative research as the basis of an authoritative policy brief), updated stakeholder analysis, a contextualized mechanism to track performance of the plan annually per issue, and a result framework to enable monitoring and evaluation of the entire strategy. Overall, all IPS and networks supporting implementation of the strategy road map will present progress towards set advocacy indicators or milestones during the quarterly ECHO Pediatric and Adolescent HIV Care & Treatment meeting for cross learning, synergies, support and addressing implementations challenges.

3.1 Advocacy Agenda Setting

Wide-ranging stakeholder consultations were conducted with policy framers, decision makers, power holders, duty bearers, frontline health workers and service providers. The consultations shed fresh light and generated new perspectives on many of the issues originally reflected in three major thematic areas namely: (I) HIV Prevention, (II) (First 95) Locate/Case finding including EID, and (III) (2d& 3rd 95) Care and Treatment.

3.1.1 Re-inclusion of children 0-14 HIV indicators in all National health survey and assessment system

Children between 0-14 years constitute 36% of the Uganda population (3-4 years constitute 8%, 5-9 constitute 15% and 14-19 the adolescents constituting 11% (UBOS, 2008). A desk review of all health-related national surveys revealed that indicators on children between 0-14 with HIV is not considered in all national health surveys both specific to HIV/AIDS or broadly health indicator surveys. Reference made to the first Uganda Population- Based HIV Impact Survey (UPHIA) conducted between August 2016 and March 2017, the follow on recent UPHIA conducted in 2020 and the Uganda Refugee Population-based HIV Impact Assessment survey (RUPHIA 2021) in 2021 did not assess children 01-4 years with HIV. Yet the UPHIA estimates HIV prevalence, assess viral load suppression among HIV-positive individuals, and collects information on uptake of and access to HIV-related services. The same applies to the Uganda Demographic Health surveys (UDHS, 2011, 2016).

This gap in data collection, reflects the level of low prioritization of children and adolescents HIV among the stakeholders. This defeats the essence of the national theme of leaving no one behind towards ending AIDS by 2030 under the National HIV and AIDS Strategic Plan (NSP) 2020/25 and subsequently slowing progress towards achieving the Presidential Fast- track initiative on ending HIV&AIDS in Uganda by 2030.

3.1.2 To advocate for Cabinet's expedited approval and roll out of the school health policy by 2024 for schools to play a supportive role in the management of C&ALHIV.

As noted in the sub section 1.2 above, the low ART coverage for children (0 – 9 years) and that for adolescents (10 – 19 years) is largely associated with the limiting policy framework in schools to offer direct HIV supportive role to this demographic (MoH, 2022). The current 2008 school health policy is general and under all the nine strategies highlighted, it lacks specific policy level directive on how the school systems can handle and support children and adolescents living with HIV later alone supporting other HIV/AIDS prevention initiatives. In addition, the school system structure lacks trained personnel at a minimum professional level of a counselor as a standalone cadre to support not only management of C&ALHIV but general support to other strategies in the policy including 4.4 (Psycho-social environment and health lifestyle), 4.9 (health promotion for school staff). The current model of senior women and male teachers may not be as effective in promoting learners' emotional, social and physical wellbeing with the emergency of chronic illnesses like HIV and its associated diseases which attract stigmatization and require a specific skill set under a conducive policy environment to manage and support.

Children from six (6) years spend most of their time in schools, of which schools as it is have not adequately been prepared/equipped to support a child living with HIV. This gap in the policy guidance has led to school systems implementing their own local appropriate strategies to manage and support children who report to their schools requiring support to adhere to their ART treatment. Such approaches have led to unintended negative effects where children and their parents choose not to disclose due to stigma leaving school going children unable to adhere to their ART treatment. The situation is considered to be worse for

children and adolescents living with HIV in boarding schools in addition to children (below 3 years) in Early Childhood Development Centers (EDCs) (MoH, 2022).

The national AIDS response stakeholder's dialogue and workshop conducted by MoH with support from UNICEF and EGPAF in April 2022, further revealed a glaring gap towards support to children 0-14 and adolescents with HIV at school level. This was considered among the key facilitators of to the low ART coverage for children (0 – 9 years) at 57% and that for adolescents (10 – 19 years) is 58% relative to the national 93%. Among the factors associated to this challenge was the outdated school health policy that does not provide a conducive policy framework to play a supportive role in the management of C&ALHIV. The Uganda School Health Policy published in 2008 was limited in policy guidance related to school level HIV/AIDS support. On a positive note, currently this policy has been updated to facilitate schools to play a supportive role in the management of C&ALHIV. The new school health policy links the school system to a nearby health care facility with a dedicated medical staff which address the need for a dedicated professional medical staff or counselor at the school. The Ministry of Health has in addition completed development of the school health implementation guidelines to guide the day-to-day operationalization of the school health policy.

However, it is noted that the updated/revised school health policy has been at the cabinet level for a final approval for more than four years to date. This is affecting partners and governments relevant MDA's active engagement in appropriate school health interventions inclusive of support in the management of communicable and non-communicable diseases C&ALHIV. This advocacy issue is targeted at influencing relevant stakeholders to cause expedited actions for cabinet to approve and facilitate roll out of the school health policy by 2024 in order for schools to play a supportive role in the management of C&ALHIV.

3.1.3 A 5% annual budgetary increment to the relevant school health vote functions under the MoH Division of Child Health and MoES Directorate of Basic and Secondary Education to facilitate implementation of school health policy.

Reference to subsection 3.1.2, the 2008 school health policy underscored the compounding benefits (health, education, economic and social) to the national development agenda. During its implementation since its launch in 2008, sectors budget allocation to this component indicates no deliberate budget allocation from the government (central and local) to strategy 4.1 (health education, 4.6 (medical and dental care) and 4.9 (health promotion for school staff) in the school health policy.

The trend gives a proxy indication of a possibility of the cabinet approving the revised school health policy with limited or no budgetary allocation to facilitate its implementation. With this scenario the revised policy would be approved but implementation takes another 2-4 other financial years. This advocacy issue highlights the programme level intervention approach promoted by the new NPDIII. In this approach, both MoES and MoH are under the Human Capital Development Programme in which the MoES is currently the chair. This implementation modality provides a fertile ground for an advocacy issues like school health which are multisector.

3.1.4 Revised training modules by MoES Directorate of Education Standards by 2025 for pre-service teacher training and continuous professional development for in-service teachers with updated HIV information focusing on Psychosocial support.

The thematic curriculum and the recently revised lower secondary curriculum calls for a revised teacher training curriculum, or subsequent continuous professional development especially for the in-service teachers. Whereas these new curriculum provide for better learners' assessment aligned to the new CPDs

for in-service and pre-service, the current Primary Teacher training curriculum and CPs guidelines lack relevant content in support and management of C&ALHIV. However, since the curriculum is new, it provides an opportunity to update the teacher training curriculum to integrate audience specific content on management of C&ALHIV. This will ensure that both in-service and preserve teachers are better prepared to management of C&ALHIV as first line before the senior women or counselors. This is in alignment to the implementation guidelines new school health The current teacher training curriculum for primary and lower secondary teachers provides general knowledge on school health with limited emphasis on C&ALHIV.

3.1.5 To advocate for expedited policy reforms by the MoH to upgrade HCIIIs to HCIIIs to allow for HIV services in previously HCIIIs by 2024

The national AIDS response stakeholder's dialogue and workshop conducted by MoH with support from UNICEF and EGPAF in April 2022 in addition underscored the need to extend specific HIV/AIDS service delivery at HCII. Stakeholders presented evidence of the fact that proximity to the formal health care facility affects pediatric and adolescents ART coverage and adherence. Many caretakers experience challenges traveling to far-end HCIII to access services for the children under their care and therefore end up missing contributing to the poor pediatric and adolescent's adherence and coverage of ART. Well, knowing that this demographic entirely relies on caretakers.

MoH policy reform to upgrade HCIIIs to HCIII in a staggered manner starting with HCIIIs in high volume patient settings is yet to be fully approved over five years in discussions later alone its implementation. This advocacy issue is aimed at influencing actions to expedite processing for implementing this new health systems service delivery reform that would ultimately improve HIV service delivery especially in the remote areas.

3.1.6 Increased resource allocation by 5% to ACP community health HIV pediatrics and adolescents by 2023/24.

Without reasonable dedicated funding, managers at the national and sub-national levels lack the means to undertake critical countrywide and community-based health HIV pediatrics and adolescents' initiatives. HIV pediatrics and adolescents' program ends up being sidelined in favor of better-resourced programs and uncontroversial health needs. Yet another troubling phenomenon is the disconnect between the overall positive policy environment for HIV pediatrics and adolescents in Uganda and the level of national financial resources allocated.

Generally, there is limited knowledge of HIV pediatrics and adolescents' issues across the social strata. This lack of basic information is related but not limited to the following areas: a) causes of the lower retention in care and adherence to ART in CALHIV b) sub optimal Identification of children and adolescents living with HIV c) inadequate viral load suppression due to suboptimal retention of children and adults, d) sub-optimal adolescent-friendly service deliver centers among others. The MoH has developed extensive communications materials under the national pediatric HIV communications strategy which are not funded.

Advocacy will be crucial in efforts to increase allocations for community health HIV pediatrics and adolescents by the central and local governments. To provide the necessary evidence to support advocacy around financing, it will be necessary to introduce and institutionalize the tracking/monitoring of community health HIV pediatrics and adolescents financing at the ACP. At the same time, it will be crucial to intensify efforts to sustain the current funding by development partners and to improve value for money within HIV pediatrics and adolescents' programs.

3.1.7 Increased resource allocation to MoH-ACP programme for procurement and maintenance of stable supply chain systems for child friendly ARV formulations (from ABC to TAF) in the country post 2024.

ART adherence is dependent of consistent ARV formulation supply for children and adolescents. This supply varies annually based on predetermined indicators for the demographic. Currently government's contrition of UGX 150 B and partners support to a tune of USD 39.5 Million (PEPFAR) and USD 88.1 Million (Global Fund) is already committed for the FY 2022/2023. However, there's no commitment post for 2024 and post 2024 yet over 1.2 million Ugandans are enrolled on ART. The lack of government or partners commitment to fund these commodities post 2024 needs urgent increased resource allocation by the government in the financial years building up to 2024 so that in the event that no partner contribution or commitment is secured to the tune of the demand needed, Ugandans enrolled on ART are not left to regress

3.1.8 MoH ring-fencing 5% of the 30% non-wage recurrent in the Health sub programme Grant, Budget and implementation guidelines to LG to prioritize HIV related activities with focus on support to expand both lay testers and Peds community resource persons.

Globally an estimated 800,000 children were undiagnosed and not on treatment by 2020. In Uganda, an estimated 20,060 children are living with HIV and yet not on treatment (MoH, 2022). Uganda is a member of the new Global Alliance to end AIDS in Children. One of the three focus areas of the Alliance is the early testing and optimized treatment for infants, children, and adolescents living with HIV. In response the MoH designed programmes for Identifying and linking to treatment all children and adolescents not yet on ART through an effective mix of interventions. And as such learning from FASTER, the MoH/PEPFAR supported surge approach proposed the two most effective Pediatric case finding strategies including; Use Peds Community resource persons to strengthen community index testing and use of lay screeners to administer peds screening tool. In addition, a report by the Accelerating Progress in PMTCT and Pediatrics (AP3) initiative, indicated significant contribution of both the Community resource persons and lay screeners towards addressing the plight of children with HIV and yet undiagnosed.

However, the challenge to implementation of these two strategies is the lack of resources. Some of these are currently funded by partners including PEPFAR and yet the country needs to achieve an enrollment of over 3,674 new children every quarter to close the pediatric gap across the 95-95-95. Without case findings/testing it is not possible to treat or retain on treatment yet even with improved case identification but with delayed or no enrollment on treatment, the cascade is incomplete. This has contributed to the low ART coverage for children (0 – 9 years) at 57% and that for adolescents (10 – 19 years) is 58% relative to the national 93% (MoH).

This calls for urgent increased resource allocation to the Conditional Non-Wage Grant to DLG which are mandated to implement these two strategies among others. To facilitate the day-to-day appropriation, addition guidance to the DLG to ring-fencing 5% of the 30% non-wage recurrent will be required to prioritize HIV related activities with focus on support to expand both lay testers and Peds community resource persons. This advocacy issue is geared at influencing the MoH top leadership through the PS to issue these policy directives through the annual Health sub programme Grant, Budget, and implementation guidelines to LG. The proposed increment will be in a staggered manner over the 5-year HCD implementation period prioritizing districts and regions with the highest burden of undiagnosed children including; Midwest and Central Uganda which account for 71% of our unmet need (MoH, 2022).

3.4 Monitoring and Evaluation (M&E)

3.4.1 Monitoring and Evaluation

As with data collection, monitoring and evaluation will occur throughout the advocacy process during the strategy road map implementation. It is important to note that M&E for Advocacy as a discipline measures the steps to change as opposed to the change itself. This is so because the influencing processes may not follow the result chain logical model from inputs, outputs, outcomes to impact. However, the road map implementation matrix has earmarked specific measurable indicators for each of the advocacy issues. It is on this basis that the implementing partner supporting advancement of each advocacy issue should further build on this framework to suit their context but aligned to the M&E framework in the national strategy and road map.

In practical terms, upon approval and dissemination of the strategy, the Pediatric and Adolescent HIV Care & Treatment team will appoint an advocacy desk officer or Focal Person with a clear revised JD and Key Performance Indicators (KPIs) if this task is an add on to their core roles. The team leader will then cause an adhoc ECHO meeting for MoH and partners to build consensus on the following among others to facilitate the M&E function.

- a) Who (AIP, network, coalition, CSO/CBO, MoH, MDAs) is leading implementation of each of the advocacy issue/s based on their niche and resources.
- b) Which resources are already in-house or to be outsourced and by when,
- c) Review and contextualize the proposed monitoring and evaluation framework in the strategy to decide the level of how progress and results will be evaluated/measured
- d) Frequency of reporting and to which platforms.

During the forthcoming annual planning forums for the ACP, the strategy M&E plan should be refined with support of the RM&E component of the Pediatric and Adolescent HIV treatment, care and prevent units jointly with support from the Strategic Communication and Health Promotion Department, supporting MDAs, ADPs and AIPS M&E portfolios to align to the reporting routine timeframes. The M&E framework is integrated in the road map matrix and attempts to predict what difference is expected following the completion of implementation of the road map strategy in final review phase. It lists a few indicators to ascertain if the situation has changed (advocacy issues achieved) or not.

3.4.1.1 Monitoring

Monitoring will include the systematic collection and analysis of information as the advocacy strategy is being rolled out by any designated entity (refer to users' section 1.5). This will be a continuous activity through the strategy road map implementation period. Monitoring will be aimed at improving efficacy and effectiveness of the advocacy initiatives through effective coordination of all stakeholders supporting the strategy. It is based on targets, activities and actions highlighted in the road map.

The following will be areas to consider for monitoring implementation of the strategy by routinely updating the advocacy monthly journal (Annex 3) and log frame matrix Annex 4;

- Record of planned activities that have been implemented
- Record of lobbying meetings and communications with primary and secondary target audience
- Significant communications received and responded to by the targeted audience
- Use of advocacy materials, reports, position papers, policy briefs

- Coalition development (e.g. coalition meetings or development of coalition- Pediatric Breakthrough Partnership (BTP))
- Partnership development (e.g. the building of capacity of AIPs to carry out advocacy)
- Advocacy materials produced and distributed
- Public speaking engagement of the advocacy issue
- Media monitoring progress (Press release sent out during say WADs, editorial media coverage etc.)
- Mass campaign events or activities advancing the advocacy within forums heavily attended by targeted audience e.g. petitions
- Any change in our targeted audience action, opinion or attitudes towards the advocacy issue
- Any policy change or signs of improving resource allocation in alignment to the advocacy issues

3.4.1.2 Evaluation

The evaluation of the advocacy strategy road map will take on the form a retrospective assessment of performance and key milestones achieved mid phase (delivery) and end (review phase). The evaluation process for the strategy road map will consider majorly process evaluation since advocacy's success is measured by the steps to change as opposed to the change itself. However, elements of outcome evaluation will be integrated during the review phase.

3.4.1.2.1 Process evaluation

This will evaluate the process, examine whether advocacy activities in the strategy are reaching the intended primary and secondary target audience and are occurring as planned and whether they are adequately funded. This evaluation will be used to assess if the planned advocacy activities are on track by answering some of the questions below;

- How many primary and secondary target audiences have received the key advocacy messages?
- How many engagements (meetings- breakfast, dialogues, face to face among others) were held with them?
- How many active members during ECHO meetings are reporting progress on the strategy implementation?
- How many active pediatric and adolescent HIV advocacy coalition have been created or rejuvenated?
- How many articles covering the advocacy issues were published in media?

3.4.1.2.2 Outcome evaluation

This evaluation will measure the national Pediatric and adolescent HIV (coalition, network or ACP and partners) intermediate impact around improved resource allocation and policy reforms in line with the advocacy issues highlighted in the strategy. This level of evaluation will answer questions including;

- Has awareness of the advocacy problem increased among the primary and secondary target audiences?
- How many opinion leaders (Targeted Top leadership of MDAs, ADPs, AIPs and Foundation/faith bodies) and the primary target audiences are in support of the advocacy issues?
- Has the public support (especially among the Pediatric and adolescent HIV technical teams and political leaders at various levels) for the advocacy issue increased measurably?
- Have the advocacy issue/s achieved?



CHAPTER FOUR:

Road Map to Operationalize the Advocacy Strategy

4.0 Introduction

The road map spells out the strategy key priorities, setting out the major stages and processes, including critically how and when political and financial commitment will be secured. Engaging ADPS at this stage is of paramount importance for the National advocacy strategy to serve as a coherence framework for multilateral and bilateral assistance since national response to HIV/AIDS is heavily partner funded. The road map answers the following questions, among others: How do we ensure that the strategy is relevant to national development objectives and is nationally owned?

- What outputs will be produced and when?
- What arrangements should be made for the proposed strategy to be delivered in an efficient manner?
- What are the timelines?
- Who will be the main actors?
- How do we ensure that the strategy is practical and can be implemented with the myriad of partners support?
- What will be the mechanisms for political support, endorsement and reporting?
- Do we as a country have the in-house advocacy technical capacity and skills within the institutions supporting the response to undertake the advocacy task or do, we need assistance? If so, what form should it take? Funding and/or technical assistance and how will it be sourced?
- Management and resourcing the strategy; the adequacy of domestic financial resources to fund the strategy implementation or partner support to advocacy issues aligned to their respective country programmes advocacy strategic directions.

4.1 Implementation schedule

This Roadmap establishes a framework of activities to be implemented over a period of four to five years. For this period of time, an overall calendar that schedules the implementation of the activities will be developed by the stakeholder leading implementation of a specific advocacy issue guided by the narration and M&E framework in the strategy. This implementation schedule calendar will help to monitor the state of implementation of the roadmap per issue. For this implementation Schedule, activities should be divided into three phases:

4.1.1 Start-up phase (0-1 year)

During this phase which should not be more than one (1) year, the following should be undertaken.

- The Governance structure of the advocacy strategy needs to be established not later than a month from date of dissemination, if it is not already in existence (e.g. Pediatric Breakthrough Partnership or Pediatric and Adolescent HIV Care & Treatment ECHO team quarterly meeting rotating chairs)

- Depending on the context, if the governance should be incorporated in existing ACP Technical working group structures. However should the governance structure require a new parallel structure which option is not recommended, three tiers could be instituted; a) Top level strategy steering group- which is a high level strategy management group- provides ongoing high level support for the road map, commits budgets, leads face to face engagement with the primary target audience, ensure active collaboration of line ministries of Education and Gender, MDAs and resolves any conflicts among the three ministries if any pertaining the advocacy agenda, b) high level advocacy strategy management group- responsible for delivery of the of the road map, supervises sub-working group, strengthens collaboration and coalition building among ADPs and AIPS, offer technical oversight, c) Advocacy implementation level working/subgroup- responsible for implementing the various activities in the road map, drafts project plans and reports, liaises with advocacy technical expertise and consultants. The Pediatric and Adolescent HIV Care & Treatment would have to lead the process of developing TORs for each subgroup. The composition may vary according to stakeholder's niche and expertise in the response.
- This means, for instance, that the lead agency is appointed to lead on each advocacy issue but not more than two advocacy issues as part of this sub working group. That lead agency may have a constituency of likeminded entities implementing or advancing that particular advocacy issue which meets routinely/monthly to feed into the quarterly ECHO Pediatric and Adolescent HIV Care & Treatment meetings.

In summary, for the startup phase, activities will focus on streamlining governance, monitoring, and reporting, advocacy resources and capacity assessment, future consensus building on advocacy issue on need basis, broader stakeholders' sensitization, communication, collaboration into this phase. This will ensure that all participating stakeholders have a common understanding of the advocacy issues, objectives and the scope of the activities of the roadmap. Moreover, there could be some quick-win advocacy activities that can already be implemented in the start-up phase. The start-up phase includes any activities that aim to develop and approve detailed implementation plans for the implementation of long-term advocacy initiatives which will be undertaken in the delivery phase.

4.1.2 Delivery phase (1-3 years):

This will be the longest phase of the implementation of the Pediatrics and Adolescent HIV advocacy roadmap. It includes the delivery of all activities that need to be realized over a period of one to four years in alignment with relevant national framework timelines including NDPIII, HSSIP and the NSP 2020/25. During this delivery phase, goal performance indicators should be thoroughly monitored in order to make sure that the strategy is on the right track to achieve the identified advocacy issues and that partners are not introducing new advocacy issues during the strategy period.

4.1.3 Review phase (3-4 year):

This phase aims at 1) Evaluating whether the goals of the roadmap have been achieved, by referring to the goal performance Indicators and 2) Drafting a new roadmap for the 3 – 5 years to come if necessary. Ideally, the review phase should start between 6 and 12 months before the deadline for closing the roadmap. The three phases of the implementation of the roadmap are represented in the figure below:

PHASE I: START UP (0-1 year)

ESTABLISHING GOVERNANCE STRUCTURE/S FOR THE ADVOCACY STRATEGY

- Adopt existing similar structure
- Establish new structure-subgroup to relevant MoH technical working group
- Formalize partnership- Developing TORs, MoUs signing and partnership agreements.
- Appointment of lead agency for each or more advocacy issue in the strategy
- Adopt or adjust the M&E plan in alignment with the MoH and MDAs relevant Division- Child Health, Strategic Communication, Basic Education and Gender Units- MoES, MoGLSD

PREPERATION FOR DELIVERY OF ADVOCACY INITIATIVES

- Develop costed advocacy project plans with clear source of funding
- Appointment or recruitment of advocacy technical staff
- Adopt evidence to support advocacy initiative per issue from existing rigorous studies.
- Based on advocacy problem if there a gap in evidence for advocacy, plan to conduct studies. Such studies should link Pediatrics and Adolescent HIV to health systems broadly, resonate easily with Pediatrics and Adolescent HIV technical stakeholders, more rigorous with realistic recommendations/ solution (see annex 1)advocacy study designs)

Quick win action implementation

PHASE II: DELIVERY (1-3 years)

- Actions implemented
- Completion of actions is reviewed using performance
- Indicators
- Report cycles to ensure institutionalization of Advocacy action
- At the middle of the delivery phase, Key performance indicators in the advocacy log should be monitored to make sure that the strategy is on the right track to achieve the identified advocacy issues and set objective

PHASE II: CLOSING PHASE (0-1 year)

- Documentation
- Monitor and Evaluation actions
- Drafting a new advocacy road map (next 3-5 years)

Figure 1: Pediatrics and adolescents HIV advocacy road map implementation diagram

Table 3: Road map implementation summary matrix for Pediatric and Adolescent HIV Advocacy strategy 2022/2026

ADVOCACY ISSUE 1 : Re-inclusion of children 0-14 HIV related in all National health survey system								
FRAMING THE ISSUE	Children and Adolescents are identified as a priority population (HIV programming) there is a need to establish the baseline and to plan better and address the case identification gaps however these are always being missed out in national surveys including the two UPHIA, RUPHIA and UDHS.							
ADVOCACY GOAL 1.0	UBOS jointly with MOH to establish a country baseline of children 0-14 with HIV to ensure that 95% of all C&A in Uganda have known HIV status.							
LEAD AGENCIES & KEY PARTNERS	Lead Agencies: GoU Ministries of Health (Aids Control Program children and adolescents' prevention, care and treatment units) and UBOS Secondary audience/ Influencing agency: ADPs- PEPFAR coordinator, CDC- Head of Health and HIV, USAID, UNICEF, UNAIDS among others							
ADVOCACY OBJECTIVES	TARGETS (PRIMARY TARGET AUDIENCE)	TACTICS	ACTIVITIES, TOOLS AND PRODUCTS	Key messages	Audience specific Channel mix	Indicators (Process level)	MoV	PHASE
1.1 To integrate children 0-14 HIV related indicators in all National health survey system by 2025	DG, Head SI-ACP program Manager, UBOS	Lobbying and negotiating with top MoH management, Face to face meeting between MOH and UBOS Breakfast meeting presentations Dialogues with stakeholders	-Hold an internal meeting in the ACP to address reasons why children have been missing out and develop consensus on the technical justification for the proposed inclusion -Develop advocacy materials for use during target audience engagement -Hold a face-to-face meeting with MoH top leadership to secure buy in -Hold a breakfast meeting with UBOS, MoH and stakeholders to integrate the indicators in relevant survey	The lack of accurate child-specific HIV data on key parameters in national HIV related surveys affects appropriate resource allocation, programme design, linking information to KAP to improve behavior.	-Face to face meetings, press kits/media - Press conference - fact sheets, position papers, petitions, public debates, special forums, Technical Working Groups...	% /Number of surveys re-designs with children and adolescents' indicators of HIV of interest integrated. - No of Partnership developed - No MoUs -No Memos -No Letters -No of meetings	-Meeting Minutes -Attendance lists - Survey tools	Phase 1 activity- 0-1 year

ADVOCACY ISSUE 3 A 5% annual budgetary increment to the relevant school health vote functions under the MoH Division of Child Health and MoES Directorate of Basic and Secondary Education to facilitate implementation of school health policy								
FRAMING THE ISSUE	Implementation of 2008 school health policy was challenged with limited or no budget allocation to from the government (central and local) to strategy 4.1 (health education, 4.6 (medical and dental care) and 4.9 (health promotion for school staff) in the school health policy. The strategies aligned to Pediatric and adolescent HIV The trend gives a proxy indication of a possibility of the cabinet approving the revised school health policy with limited or no budgetary allocation to facilitate its implementation of the updated school health policy. With this scenario the revised policy would be approved but implementation takes another 2-4 other financial years. This advocacy issue highlights the programme level intervention approach promoted by the new NPDIII. In this approach, both MoES and MoH are under the Human Capital Development Programme in which the MoES is currently the chair. This implementation modality provides a fertile ground for an advocacy issues like school health which are multisector.							
ADVOCACY GOAL 3	A 5% annual budgetary increment is realized to the relevant school health vote functions under the MoH Division of Child Health and MoES Directorate of Basic and Secondary Education (DBSE) to facilitate implementation of the updated school health policy.							
LEAD AGENCIES & KEY PARTNERS	Lead Agencies: MOH (PS, DG, Director planning, Director Child health, ACP PM) in consultation with PS-MOES, DBSE							
ADVOCACY OBJECTIVES	Secondary audience/ Influencing agency: Development partners including UNFPA, UNESCO, UNICEF, USAID, UNYPA, UYP							
	TARGETS (PRIMARY TARGET AUDIENCE)	ACTIONS	TACTICS	ACTIVITIES, TOOLS AND PRODUCTS	Key messages	Indicators (Process level)	MoV	PHASE
3.1 To advocate for increased government funding by 5% to the relevant school health support votes to facilitate and operationalize the implementation of the school health policy	<ul style="list-style-type: none"> Cabinet through line ministers MOFPEP and Education committees of Parliament 	<ul style="list-style-type: none"> Influence budget allocation by addressing the root cause of underfunding in the previous school health policy Align to national budgeting cycle 	<ul style="list-style-type: none"> Technical support Capacity building Dialogues and lobbying and negotiating Breakfast meetings 	<ul style="list-style-type: none"> Dependent on approval of the updated school health policy Engage the secondary audience (PA's, family friends etc.) before engaging the primary target audience Document learnings related to advocacy from previous school health policy Establish the exact vote functions to benefit and the multispectral coordination Cost implementation guide Breakfast meeting with Health and Education committee of parliament. Prepare in advance well branded; Policy briefs, Factsheets, Information sessions ,position papers, petitions Hold roundtable meetings 	The lack of sufficient resource allocation to facilitate the school health policy affects the ability of schools to play a supportive role in the management of C&ALHIV	<ul style="list-style-type: none"> % Increase in resource allocation in favour of school health implementation Number of Memos No of letters No of meetings No partnership development No of mass campaign events reaching target 	<ul style="list-style-type: none"> -Meeting Minutes -Attendance lists Advocacy materials produced and distributed 	Phase I and II activities - 0-3 years

ADVOCACY ISSUE 4		Revised pre-service teacher training curriculum and continuous professional development training modules for in-service teachers with updated HIV information with a focus on Psychosocial support by MoES Directorate of Education Standards by 2025						
FRAMING THE ISSUE	The thematic curriculum and the recently revised lower secondary curriculum calls for a revised teacher training curriculum, or subsequent continuous professional development especially for the in-service teachers. Whereas this new curriculum provides for better learners' assessment aligned to the new CPDs for in-service and pre-service, the current Primary Teacher training curriculum and CPs guidelines lack relevant content in support and management of C&ALHIV. However, since the curriculum is new, it provides an opportunity to update the teacher training curriculum to integrate audience specific content on management of C&ALHIV. This will ensure that both in-service and preserve teachers are better prepared to management of C&ALHIV as first line before the senior women or counselors. This is in alignment to the implementation guidelines new school health The current teacher training curriculum for primary and lower secondary teachers provides general knowledge on school health with limited emphasis on C&ALHIV.							
ADVOCACY GOAL 4	Teacher training curriculum revised and in use for both pre-service and in-service CPDs with updated HIV information with a focus on Psychosocial support by MoES Directorate of Education Standards by 2025							
LEAD AGENCIES & KEY PARTNERS	LEAD AGENCIES: MoES-DBSE and Directorate of Education Standards, NCDC supported by MoH-Child Health Division Secondary audience/ Influencing agency: Development partners including UNFPA, UNESCO, UNICEF, USAID, UNYPA, UYP							
ADVOCACY OBJECTIVES	TARGETS	ACTIONS	TACTICS	ACTIVITIES, TOOLS AND PRODUCTS	Key messages	Indicators (Process level)	MoV	PHASE
4.1 To advocate for the revision of the teacher training curriculum by updating HIV information with a focus on Psychosocial support by MoES Directorate of Education Standards and NCDC by 2025	Director NCDC Director BSE Commissioner-Child Health MoH PS-MoES D-Education Standards	Influence teacher training curriculum through secondary and tertiary audiences. Lobby for funding to support the process since government may not have the funds	<ul style="list-style-type: none"> Lobbying and negotiating Policy dialogue 	<ul style="list-style-type: none"> In-person briefings One-on-one meetings face to face meetings 	Teachers acquiring basic competencies in C&ALHIV for learners would tremendously improve HIV services linkage between schools and nearby HCs as stipulated in the new school health policy	<ul style="list-style-type: none"> Number of Memos No of letters No of meetings No partnership development Approved revised curriculum 	<ul style="list-style-type: none"> -Meeting Minutes -Attendance lists Advocacy materials produced and distributed 	Phase I and II activities - 0-3 years

ADVOCACY ISSUE 5									
Increased resource allocation for procurement and maintenance of stable supply chain systems for child friendly ARV formulations (from ABC to TAF) in the country post 2024									
FRAMING THE ISSUE									
<p>ART adherence is dependent on consistent ARV formulation supply for children and adolescents. This supply varies annually based on predetermined indicators for the demographic. Currently government's contribution of UGX 150 billion and partners support to a tune of USD 39.5 Million (PEPFAR) and USD 88.1 Million (Global Fund) is already committed for the FY 2022/2023. However, there is no commitment post for 2024 and post yet over 1.2 million Ugandans are enrolled on ART. The lack of government or partners commitment to fund these commodities past 2024 needs urgent increased resource allocation by the government in the financial years building up to 2024 so that in the event that no partner contribution or commitment is secured to the tune of the demand needed, Ugandans enrolled on ART are not left to regress.</p>									
ADVOCACY GOAL 5									
<p>MoH to ensure a stable national supply chain system for HIV commodities including ARVs through increase on budget support to ARVs formulations procurement by 2024</p>									
LEAD AGENCIES & KEY PARTNERS									
<p>Lead Agencies: MOH [ACP, Pharmacy Department], NIMS, NDA Key Partners: USAID, WHO, JMS, Director HIV Care and Treatment UAC, CoAG Coordinator ACP</p>									
ADVOCACY OBJECTIVES	TARGETS	ACTIONS	TACTICS	ACTIVITIES, TOOLS AND PRODUCTS	Key messages	Indicators (Process level)	MoV	PHASE	
5.1: Advocate to the GOU to Commit and actualize resource allocation for procurement of ARVs, sustained management of the supply chain system in country	Cabinet through line ministers MOPPED Health committees of Parliament	Push for an increase in the MOH budgets to facilitate a stable national supply chain system of ARVs	<ul style="list-style-type: none"> Lobbying and negotiating Policy dialogue Breakfast meeting 	In-person briefings <ul style="list-style-type: none"> One-on-one meetings with legislators in the respective parliamentary committees Face to face meetings Hold dialogue joint planning meetings with relevant MDAs 	<i>The lack of sufficient resource allocation from the government post 2024 due to over reliance on partners will affect Ugandans lives who are already enrolled on ART.</i>	-Number of Memos -No of letters -No of meetings -No partnership development No significant communications received and responded to by the targeted audience No of coalition developed Any policy change or signs of improving resource allocation in alignment to the advocacy issues	-Meeting Minutes -Attendance lists Advocacy materials produced and distributed	Phase I and II activities - 0-3 years	

ADVOCACY ISSUE 6 Increased resource allocation by 5% to ACP community health HIV peditrics and adolescents by 2023/24

FRAMING THE ISSUE
 The knowledge, attitudes, practices and behavior of HIV peditrics and adolescents' care givers have an impact on the quality of care. Care givers should be supported through continuous provision of information that addresses the different needs and situations of HIV peditrics and adolescents. This is not possible due to limited resource allocation to community HIV literacy activities since the major ADPs support commodities and supplies with limited support to software activities. Children and adolescents entirely depend on community (family or adult caretaker) support for their ART adherence. The poor community literacy on HIV services and their roles pertaining to children and adolescents is considered to adversely affect ART adherence.

ADVOCACY GOAL
 Government of Uganda through relevant MoH votes to increase resource allocation to facilitate role out of community HIV literacy materials developed by MOH, so as to improve community support of children and adolescents HIV services.

LEAD AGENCIES & KEY PARTNERS
Lead Agencies: MOH [DG, PM-ACP, HPECD]
Key Partners: UNICEF, WHO, USAID

ADVOCACY OBJECTIVES	TARGETS	ACTIONS	TACTICS	ACTIVITIES, TOOLS AND PRODUCTS	Key messages	Indicators (Process level)	MoV	PHASE
6.1: To advocate for 10 % increase in budget allocation to HIV community programs for the MoH relevant budget votes by 2025	Cabinet through line ministers MOFPED Health committees of Parliament	Lobby for increased resource allocation to community literacy program	Lobbying and negotiating • Policy dialogue • Breakfast meeting	<ul style="list-style-type: none"> • Information sessions • In-person briefings • Roundtable meetings • Roundtable meetings 	<i>The lack of sufficient resource allocation to community HIV activities affects the ability of communities' health structures to effectively play a supportive role in the management of C&ALHIV</i>	<ul style="list-style-type: none"> -Number of Memos -No of letters -No of meetings -No partnership development No significant communications received and responded to by the targeted audience No of coalition developed Any policy change or signs of improving resource allocation in alignment to the advocacy issues 	<ul style="list-style-type: none"> -Meeting Minutes -Attendance lists Advocacy materials produced and distributed 	Phase I and II activities - 0-3 years

MoH top management expedited policy reforms to upgrade HCIIIs to HCIIIs to allow for HIV services in previously HCIIIs by 2024.

<p>FRAMING THE ISSUE</p>	<p>Proximity to the formal health care facility affects pediatric and adolescents ART coverage and adherence. Many caretakers experience challenges traveling to far end HCIII and IVs to access services for the children under their care and therefore end up missing contributing to the poor national pediatric and adolescent's adherence and coverage of ART. Well, knowing that this demographic entirely relies on caretakers a recommendation to extend these services closer would contribute to improvement of ART coverage. Cognizant of the fact that HCIIIs are in the process of phasing out in the Uganda health systems structure, as this discourse is undergoing, the national policy should be reviewed to provide for task shifting roles of caretakers deployed at HCIIIs to support C&ALHIV</p>							
<p>ADVOCACY GOAL 7</p>	<p>The MoH expedite reviews the national health policy to allow for task shifting roles of caretakers deployed at HCIIIs to support to PMTCT and EID services By 2025.</p>							
<p>LEAD AGENCIES & KEY PARTNERS</p>	<p>Lead Agencies: MOH (Director General in consultation with UAC-DG) Secondary audience/ Influencing agency: PEPFAR Supply Chain Focal Point, PEPFAR Country Lead, CoAG Coordinator ACP, Global Fund Country Lead, Global Fund Supply Chain Focal Point</p>							
<p>ADVOCACY OBJECTIVES</p>	<p>TARGETS</p> <ul style="list-style-type: none"> •Director General Health Services •NMS •DG-UAC 	<p>ACTIONS</p> <p>Ensure that the national health policy, guidelines and service standards are reviewed and updated to include specific guidance on providing HIV selected services through programmes such as integrated PMTCT and EID</p>	<p>TACTICS</p> <ul style="list-style-type: none"> •Technical support • Capacity building • Policy monitoring • Policy dialogues 	<p>ACTIVITIES, TOOLS AND PRODUCTS</p> <ul style="list-style-type: none"> • Implementation guide • Policy briefs • Factsheets • Information sessions • In-person briefings • Roundtable meetings 	<p>Key messages</p> <p>Majority of caretakers experience challenges traveling to far-end HCIII to access services for the children under their care and therefore end up missing contributing to the poor pediatric and adolescent's adherence and coverage of ART</p>	<p>Indicators (Process level)</p> <ul style="list-style-type: none"> -Number of Memos -No of letters -No of meetings -No partnership development -Approved policy directive letter upgrading HCII in high volume areas 	<p>MoV</p> <ul style="list-style-type: none"> -Meeting Minutes -Attendance lists Advocacy materials produced and distributed 	<p>PHASE</p> <p>Phase I and II activities - 0-3 years</p>
<p>7.1 To advocate for MOH expedited policy reforms around upgrading HCIIIs to allow for HIV services in previously client high volume HCIIIs by 2024</p>								

ADVOCACY ISSUE 8								
MoH ring-fencing 5% of the 30% non-wage recurrent in the health sub programme Grant, Budget and implementation guidelines to LG to prioritize HIV related activities with focus on support to expand both lay testers and Peds community resource persons								
FRAMING THE ISSUE	<p>Community resource persons and lay screeners are contributing tremendously towards addressing the plight of children living with HIV and yet undiagnosed. However, the challenge to implementation of these two strategies is the lack of resources. Some of these are currently funded by partners including PEPFAR and yet the country needs to achieve an enrollment of over 3,674 new children every quarter to close the pediatric gap across the 95-95-95. Without case findings/testing it is not possible to treat or retain on treatment yet even with improved case identification but with delayed or no enrollment on treatment, the cascade is incomplete. This has contributed to the low ART coverage for children (0 – 9 years) at 57% and that for adolescents (10 – 19 years) is 58% relative to the national 93% (MoH).</p> <p>This calls for urgent increased resource allocation to the Conditional Non-Wage Grant to DLG which are mandated to implement these two strategies among others. To facilitate the day-to-day appropriation, additional guidance to the DLG to ring-fencing 5% of the 30% non-wage recurrent will be required to prioritize HIV related activities with focus on support to expand both lay testers and Peds community resource persons. This advocacy issue is geared at influencing the MoH top leadership through the PS to issue these policy directives through the annual Health sub programme Grant, Budget and implementation guidelines to LG. The proposed increment will be in a staggered manner over the 5-year HCD implementation period prioritizing districts and regions with the highest burden of undiagnosed children including Midwest and Central Uganda which account for 71% of our unmet need (MoH, 2022).</p>							
ADVOCACY GOAL 8	5% of the 30% non-wage recurrent is ring-fenced for HIV related activities Conditional Non-Wage Grant to DLG							
LEAD AGENCIES & KEY PARTNERS	LEAD AGENCIES: MOH ACP (Pediatric and Adolescent HIV Care & Treatment) KEY PARTNERS: PEPFAR Supply Chain Focal Point, PEPFAR Country Lead, CoAG Coordinator ACP, Global Fund Country Lead, Global Fund Supply Chain Focal Point							
ADVOCACY OBJECTIVES	TARGETS	ACTIONS	TACTICS	ACTIVITIES, TOOLS AND PRODUCTS	Key messages	Indicators (Process level)	MoV	PHASE
8.1: To advocate for policy directive by the MoH top leadership (PS) ring-fencing 5% of the 30% non-wage recurrent in the Health sub programme Grant, Budget and implementation guidelines to LG for prioritizing HIV related activities with focus on support to expand both lay testers and Peds community resource persons services	<ul style="list-style-type: none"> •PS Minister of Health -Director Planning 	Influence internal MoH leadership to prioritize children and adolescent HIV interventions at DLG level through issuing such directives.	<ul style="list-style-type: none"> • Technical support • Capacity building • Policy monitoring • Policy dialogues 	<ul style="list-style-type: none"> • Document and produce advocacy materials with intermediate outcome or impact level evidence of the effect of lay testers and Peds community resource persons services towards achieving the global UNAIDS 95:95:95 targets among children and adolescents • Roundtable meetings -Breakfast meeting 	Community resource persons and lay screeners are contributing tremendously towards addressing the plight of children living with HIV and are undiagnosed	<ul style="list-style-type: none"> -Number of Memos -No of letters -No of meetings -No partnership development - Approved policy directive effecting the ring-fencing 	<ul style="list-style-type: none"> -Meeting Minutes -Attendance lists Advocacy materials produced and distributed 	Phase I and II activities - 0-3 years

Table 4: Generic cross cutting messaging for both primary and secondary target audience

Target audience	Generic key message	Channel mix
Any political target audience (Ministers)	<p>Policy change or increment in resource allocation to Pediatric and Adolescent HIV Care and Treatment will save over 14,456 children annually and increase your political support.</p> <p>Children are the future of our nation and yet an estimated... children and adolescents die in Uganda every day to HIV preventable related causes and partly do over 20,060 children estimated to be living with HIV and yet undiagnosed and not on treatment.</p> <p>We are petitioning you to urgently approval the a) School Health Policy b) Ring-fencing budgets at DLG to HIV work.... add other advocacy issues.</p> <p>Your approval will lead to a reduction of children and adolescent dying due to HIV, facilitate attainment of the Presidential Fast-Track Initiative on Ending AIDS as a Public Health Threat in Uganda by 2030 (PFTI), UNIADS ending the AIDS epidemic as a public health threat by 2030.</p> <p>Ultimately, your decision will contribute to ending of the devastating impact on the social and economic life of the country due to pediatric and adolescent HIV, improve the government's image in general and community support for you and the ruling party.</p>	-Face to face meetings, press kits/media, press conference, fact sheets, position papers, petitions, public debates, special forums, Technical Working Groups meetings

Note:

- For all key messages for the various target audience, the tagline below should always be stated first alongside other advocacy issue specific key message/s.
The effects of HIV on children are long lasting and profound. Since children are the future of Uganda, it is much urgent than never before to ensure that as many children as possible who are born to HIV-positive mothers are not infected and those living with HIV have a clear chance at achieving their full potential. This is by increasing resource allocation and relevant policy reforms in their favour (Robert Basaza et al, 2004).
- Long-term impacts of HIV/AIDS on children and adolescents below are generic and should be used interchangeably alongside other advocacy issue specific key message/s.
 - Reduced productivity
 - Reduced socialization
 - Entrenched poverty
 - Further breakdown of traditional extended family structures
 - Reduced quality of human capital
 - Increased inequalities
 - Reduced economic growth, development
 - Increased social, political instability
 - Diversion of resources for orphan care (double burden of disease-national)
- Generic advocacy activities catalogue
 - Budget/policy analysis,
 - Field visit to model sites
 - Negotiation meetings
 - Media sourcing/support
 - Network/coalition formation
 - Development of appropriate advocacy materials
 - Designing messages
 - Participating in campaigns
 - Civic education
 - National events dialogues
 - Breakfast meetings,
 - Lobbying parliamentary caucus
 - Evidence generation-studies.
 - MoH structures engagement- HPAC, TWGs, SMT, ToP Management
 - Regional/global presentations/position papers

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Annex 1: Strength of evidence generated for advocacy by research based on study type

Level of evidence	Study design	Purpose
I	Systematic review (experimental)	Strong evidence for advocacy- existing studies
II	RCT- Randomized Control Trials (observational)	Strong evidence- Positive change is directly linked to solution proposed
III	Cohort (Observational)	Strong- Not only shows the strength of the solution + its long-term effect
IV	Case control –cross-sectional	Weaker than experimental but strong for advocacy is rigorous
VI	Descriptive studies, expert opinions, case studies, clinical experiences, project/NGO reports (annual, baseline, end line)	Very weak for advocacy. Easy to secure and tendency to relay on it.

Annex 2: Pediatric and adolescent HIV advocacy log frame sample matrix

Objective Hierarchy (narrative summary and intervention logic)	Performance questions and indicators (OVI and targets)	Monitoring mechanism (MoV)	Assumptions and risks
Re-inclusion of children in all HIV related surveys by 2025		Survey tools	No assumption at goal level
Objective: To establish a country baseline to ensure that 95% of all C&A in Uganda have known HIV status		Survey tools	Support of top MoH leadership
Outputs; UBOS integrates Children 0-14 HIV related indicators in all national health related surveys	Number of surveys deployed with children's indicators fully integrated	Resource allocation	
Activities: Conduct a stakeholder's dialogue meeting to integrate Children 0-14 HIV related indicators in UPHIA, RUPHIA, UDHS and NSP mid and end term reviews as and when the cycle is read for each separately		Accounts records	Funds mobilized timely

Annex 3: Table 1: Description of advocacy problems and issues

Uganda National Pediatric HIV Advocacy Strategy and roadmap summary structure template 2022					
Area/Theme	HIV Prevention	(First 95) Locate/Case finding including EID	(2d& 3rd 95) Care and Treatment	Home setting:	School Setting
Advocacy Problem	High number of HIV infection among children and adolescents (case identification gaps) Females <10years 8,567 (8%) Males <10years 8788 (10%) Females 10-19 years 17,925 (16%) Males 10-19 years 7,166 (8%) COP2022	1. Low coverage of PMTCT and EID services at health center IIs 2. private health providers	Limited community Health engagement systems	Low Viral Load Suppression of 74% among ALHIV and 76% among CLHIV	
Advocacy issue	- Re-inclusion of children 0-14 in all National survey system	Review the national health policy to allow for supplies in Health center IIs Increased resource allocation to expand service delivery to HC IIs.	-Increased resource allocation to community health HIV pediatrics and adolescents by 2023/24	Increased resource allocation for procurement and maintenance of stable supply chain systems for child friendly ARV formulations (from ABCto TAF) in the country -Increased resource allocation for the roll out of Community literacy materials developed by MOH	School Setting -Review school health policy and other guidelines for schools to play a supportive role in the management of C&ALHIV -Policy formulation for the revision of staff structure in schools to include a professional counsellor -Increased Resource allocation for revised teacher training curriculum and ongoing professional development for teachers
Advocacy Goal	MOH to review guidelines in as far as children inclusion in HIV surveys are concerned by 2025.	Sufficient commodity allocation and HRH to health center IIs for PMTCT and EID services	MOFPED to facilitate strengthening of community structures so as to increase community engagement on health including Pediatric and adolescent HIV by FY 23/24	-A Stable National supply chain system -Communities educated on supportive role to C&ALHIV and their families	All C&ALHIV freely receiving HIV services in schools by 2025
		MOH/MOFPED to allocate sufficient funds to MOH/ MOES to implement the school health policy to increase demand for SRHR services for AGYW, including PMTCT services by FY 23/24			

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<p>Objectives</p>	<p>Obj1: establish a country baseline 95% of all C&A in Uganda have known HIV status.</p>	<p>1. To advocate for facilitation of coordination (MOES, MOH, MOGLSD) of line ministries to support the implementation of the school health policy</p> <p>2. To advocate for increased resources to operationalize and monitor the implementation of school health policy</p>	<p>Obj1: MOH to review commodity allocation policy to HC IIs</p> <p>Obj2: MOH to review HRH allocation policy to HC IIs.</p>	<p>1. To advocate for facilitation of community stakeholders to support HIV awareness including prevention, care and treatment even for children and adolescents</p> <p>2. To build / strengthen capacity of community stakeholders to support all health including pediatric and adolescent HIV care and treatment</p>	<p>Obj 1: Advocate to the Parliamentary Health Committee to actualize resource allocation for procurement of ARVS, sustained management of the supply chain system in country and rollout of the community literacy material</p>	<p>Obj 1: Advocate for proper medicine handling and handling in schools Obj II: Advocate for inclusion of training on HIV in curriculum for Teachers</p>
<p>Target audience -Primary -Secondary</p>	<p>MOH PEPFAR CDC UVRI UBOS UNAIDS WHO WESTAT ICAP Secondary NPA MOE MOPPED MGLSD MOLG DLGs Parents/caretakers / Guardians</p>	<p>Primary: MOPPED Secondary: MOES, & DG-HSMOH, UNFPA, UNESCO, UNICEF, PEPFAR, Global Fund</p>	<p>Primary Director General Health Services NMS Secondary -Program Manager ACP -PEPFAR Supply Chain Focal Point -PEPFAR Country Lead -Director HIV Prevention UAC -CoAG Coordinator ACP -Global Fund Country Lead -Global Fund Supply Chain Focal Point</p>	<p>Primary: MOPPED Secondary – MOH, MOLG, MOGLSD</p>	<p>Primary Director General Health Services Secondary -Program Manager ACP -PEPFAR Supply Chain Focal Point -PEPFAR Country Lead -Director HIV Care and Treatment UAC -CoAG Coordinator ACP</p>	<p>Primary Director General Health Services Secondary -Minister of Education -Program Manager ACP -Director HIV Care and Treatment UAC</p>

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Partners and opponents analysis	<p>Partners MOH PEPFAR CDC UVRi UBOS UNAIDS WHO WESTAT ICAP Opponents Parents/caretakers / Guardians CSOs</p>	<p>Religious leaders [Think it promotes immorality] Parents [Think children are too young to understand such messages. Myths & misconceptions Promote immorality] Cultural leaders[Myths & misconceptions]</p>	<p>Partners MOH PEPFAR CDC NMS UAC MICT and NG Opponents 1. MOF 2. NMS 3. NPA</p>	<p>MOFPED [No funds] DLGs [Priorities may not include this]</p>	<p>Partners Nafophanu ICW JABASA UNYPA IPs Opponents Minister MOH HIV committee UAC MOF</p>	<p>Partners MOH School Health Committee Opponents</p>
Audience specific key messages	<p>Children and Adolescents are identified as a priority population there is a need to establish the baseline and to plan better and address the gaps</p>		<p>Decentralize HIV testing among children and adolescents up to H/C IIs.</p>		<p>Stable National Supply Chain for ARVs stable Children -Educated Communities Stable children and families</p>	<p>Review school health policy reduce NS Viral Load -Revise Teacher Trainings Curriculum improve livelihood of C&ALHIV -Professional counsellors in schools improve management of HIV+ students</p>
Communications channel mix	<p>Print media, make use of existing Government Protocol, UBC</p>		<p>Print media, make use of existing Government Protocol, UBC</p>			
Influencing channels/ advocacy entry points	<ul style="list-style-type: none"> -Support in making reports to the PS/SMT on vote activities- Vote 0881 (Primary Health Care and Sanitation Services grant) - MoH-Intranet-Send through email evidence on the gap, its magnitude impact and proposed budget solution - Technical Working group meetings (HCD-MoH, MoES and MoGLSD) - Budget consultation meetings - Prior to submission of Human Capital Development Programme MoH& MWE sectors BFPs - National budget conference - Before Presidential Advisory committee discusses the budget -Parliamentary committee consultations - Prior to issuance of second budget call circular -Presentation of Ministerial policy statement to Parliament -ADPs forums-Influence ADPs opinion in favor our advocacy issue through meetings and media - Amplifying the urgency our advocacy issue by putting human interest story through media during national days commemorations (WAD..) 					

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Strategy/ Tactics

Media and PR:

- Strong partnership and proactive, as well as reactive with media work to reflect the plight of children and adolescents HIV response and put advocacy agenda at the front of mind of public opinion as relevant.

Coalition building:

- Strategic and tactical work with high level allies and coalitions on the advocacy issues (Budget, Pediatric Breakthrough Partnership)

Research:

- Strong program and policy level evidence.
- Package findings relevant national studies/assessments to further qualify the advocacy problem and issue
- Develop a budget analysis paper focusing on the attributable potential impact of the advocacy problem towards achievement of 95's by 2030

Lobbying:

- Lobbying during the MoH NTF, HPAC and other similar meetings
- Leveraging specific national 'moments'- World AIDS Day World TB Day, Day of the African Child. Every year one of the advocacy issues should be among the WTD thematic areas.
- One on one face meetings

Annex 4: Table 2: Advocacy Partners

Government	NGOs / CSOs	Private Sector	Cultural Institutions	Foundation bodies (Faith-Based organizations)	International and Development organizations
<ol style="list-style-type: none"> 1. President's Office 2. Cabinet 3. National Population Council 4. Professional Councils 5. Public Service Commission 6. Uganda AIDS Commission 7. GFATM Country Coordination Committee 8. Parliament: Social Services Committee; Finance Committee; HIV/AIDS Committee 9. Ministry of Finance, Planning and Economic Development 10. Ministry of Health 11. NCDC 12. PTCs 13. Health Training Institutions 14. MoGLSD 15. MoES 	<ol style="list-style-type: none"> 1. Elizabeth Glazer Pediatric Foundation 2. CARE International in Uganda 3. Aid Information Centre (AIC) 4. The AIDS Support Organization (TASO) 5. Marie Stopes International (MSI) 6. Straight Talk Foundation 7. Johns Hopkins University Center for Communication Programs (JHU-CCP) 8. Save the Children 9. Reproductive Health Uganda 	<ol style="list-style-type: none"> 1. Media – newspapers 2. Media – radio 3. Media – TV 4. Media – Online 5. Rotary and Rotaract Clubs 6. Lions Club 7. Uganda Manufacturers Association 	<ol style="list-style-type: none"> 1. Tooro Kingdom 2. Tieng Adhola (The Padhola Cultural Institution) 3. Iteso Cultural Union 4. Buganda Kingdom 5. Bunyoro Kitara Kingdom 6. Buruli Chiefdom 7. Bunyala Chiefdom 8. Busoga Kingdom 9. Uganda Kings and Cultural Leaders' Forum 10. Nkore Cultural Trust 11. InzuYaMasaaba 12. ObwaKamuswaga Bwa Kooki 13. Alur Kingdom 14. Ker Kwaro Acholi 	<ol style="list-style-type: none"> 1. Inter-Religious Council of Uganda 2. Catholic Secretariat 3. Uganda Catholic Medical Bureau 4. Uganda Muslim Supreme Council 5. Uganda Muslim Medical Bureau 6. Church of Uganda 7. Uganda Protestant Medical Bureau 8. Aga Khan Foundation 9. Uganda Orthodox Church 10. Hindu Union 	<ol style="list-style-type: none"> 1. UNICEF 2. DANIDA 3. DfID 4. EU 5. Global Fund (GFATM) 6. Irish Aid 7. UNFPA 8. Enable 9. USAID 10. WHO 11. World Bank

Annex 5: Developing an Advocacy Work Plan

In the top row of each table, list one of your objectives from the previous worksheet. For each objective, write in Column A two to four activities you will conduct to achieve that objective. In Columns B and C, indicate the specific staff and partners who will carry out each activity. In Columns D and E, estimate the approximate cost and timeline for each activity.

OBJECTIVE#				
A. Advocacy activity	B. Responsible staff	C. Partner(s)	D. Cost	E. Timeline

Annex 6: Measuring success tool

Write your objectives in the top row of each chart below. Then list three to five expected outputs and three expected outcomes in the areas beneath

OBJECTIVE # 1:

OUTPUTS

- 1.
- 2.
- 3.
- 4.
- 5.

OUTCOMES

- 1.
- 2.
- 3.
- 4.
- 5.

OBJECTIVE # 2:

OUTPUTS

- 1.
- 2.
- 3.
- 4.
- 5.

OUTCOMES

- 1.
- 2.
- 3.
- 4.
- 5.

Annex 7; Comparison of similar concepts to advocacy where advocacy is often confused with- SBCC, IEC,PR, Community mobilization and social marketing.

Approach	Actors	Target	Objective	Measure
IEC-Information, Education and Communication	Service providers	Individuals, segments of a community (Women, men, youth)	Raise awareness with aim of behavior change	Knowledge about desired behavior is increased
SBCC- Social Behavior Change communication	Same for advocacy, IEC and Community mobilization	Beneficiaries	systematic application theory-based research-driven communication processes and strategies to address tipping points for change at the individual, community, and social levels.	Sustained behavior change
Public relations (PR)	Commercial, public and private institutions	Consumers, beneficiaries	Improve organization brand/image	Improved brand visibility
Community mobilization	Community members and organizations	Community members and leaders	Build community's capacity to rank needs and take action	Actions from community local solutions
Advocacy	CSOs, CBOs, NGOs, Foundation bodies, Networks of special interest groups, Professional bodies	Public institutions, policy makers and traditional or culture leaders	Change in; a) Practice b) Policy c) Resource allocation in favor of advocacy issue	The steps to the change

Appendix 1: Stakeholder's who contributed to the development of the Uganda National Pediatric HIV Advocacy Strategy and road map.

NAME	ORGANISATION
Dr. Joshua Musinguzi	MoH/ACP
Dr. Katureebe Cordelia	MoH/ACP
Dr. Mudiope Peter	MoH/ACP
Dr. Eleanor Namusoke Magongo	MoH/ACP
Dr. Katusiime Christine	MoH/ACP
Dr. Miriam Nakanwagi	MoH/ACP
Dr. Arinaitwe Ivan	MoH/ACP
Dennis Adoa	MoH/ACP
Livingstone Matsiko	MoH/ACP
Atuhaire Edgar	MoH/ACP
Katto Edward	MoH/ACP
Dinah Kwarisiima	MoH/ACP
Dr. Linda Nabitaka	MoH/ACP
Jean Promise Mbonye	MoH/ACP
Juliet Cheptoris	MoH/ACP
Nangobi Stella	MoH/ACP
Dr. Daniel Byamukama	UAC
Henry Ssemakula	MOES
Pimer Sylvia	MGLSD
Friday Madinah	MGLSD
Charity Namara	MGLSD
Dr. Esther Nyamugisa	UNICEF
Dr. Barbara Asire	UNICEF
Miriam Lwanga	UNICEF
Ider Dungerej	UNICEF
Dr. Lazeena Muna-McQuay	UNICEF
Dr. Denis Kayiwa	Consultant
Masaba David	Consultant
Dr. Esther Nazziwa	CDC
Dr. Esther K Nkolo	USAID
Nicole Buono	USAID
Dr. Denis Tindyebwa	ANECCA
Dr. Vennie Nabitaka	CHAI
Dr. Happy Betty Paul	EGPAF
Dr. Khamasi Ronald	EGPAF

NAME	ORGANISATION
Immaculate Otim	EGPAF
Moses Nsubuga Supercharger	JABASA
Pastor Richard Magongo	Pentacostal/ IRCU Born again
Ilaborot Emmanuel Otim	YAPS
Nsubuga Moses Supercharger	JABASA
Merian Musinguzi	AIDS FONDS
Dr. Elang Margret	PATA
Dr. Fiona Kalinda	Buganda Kingdom
Dr. Stephen Watiti	CHAU
Armstrong Mukundane	JHU/ MUH
Ajok Daphine Oryem	YAPS
Dr. Stephen Watiti	CHAU
Charity Namara	Consultant



**Elizabeth Glaser
Pediatric AIDS Foundation**
Fighting for an AIDS-free generation