Joint Evaluation

SUPPORT TO THE NATIONAL RESPONSE TO HIV/AIDS IN UGANDA 2007-2012

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List of Abbreviations

AIDS	Acquired Immunodeficiency Syndrome
ART	Antiretroviral Therapy
BCC	Behaviour Change Communication
CBO	Community-Based Organisation
CSF	Civil Society Fund
CSO	Civil Society Organisation
DFID	UK Department for International Development
DHO	District Health Office
DKK	Danish Kroner
EUR	Euro
EVAL	Danida Evaluation Department
FBO	Faith-Based Organisation
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
GoU	Government of Uganda
HIV	Human Immunodeficiency Virus
IEC	Information, Education and Communication
LBGT(I)	Lesbian, Gay, Bisexual, Transgender (Intersex)
M&E	Monitoring and Evaluation
MADIPA	Masaka Disabled Persons Association
MADIPU	Masaka District Union of People with Disability
MADIPHA	Masaka Disabled People Living with HIV/AIDS Association
MARP	Most at Risk Population
MDG	Millennium Development Goal
MEEPP	Monitoring and Evaluation of the Emergency Plan Performance
MIS	Management Information System
MoH	Ministry of Health
MoU	Memorandum of Understanding
MSM	Men-who-have-Sex-with-Men
NGO	Nongovernmental Organisation
NNGO	National Nongovernmental Organisation (large)
NSP	National HIV & AIDS Strategic Plan 2007/08 to 2011/12
NUDIPU	National Union of Disabled Persons of Uganda
OVC	Orphans and Vulnerable Children
PEPFAR	US President's Emergency Plan for AIDS
PLHIV	People Living with HIV
PLWD	People Living With Disability
PMTCT	Prevention of Mother-To-Child Transmission (of HIV)
Revised NSP	National HIV & AIDS Strategic Plan 2011/2012 to 2013/2014
Sida	Swedish International Development Cooperation Agency
SMUG	Sexual Minorities Uganda
SRH(R)	Sexual Reproductive Health (and Rights)
TASO	The AIDS Support Organisation
UAC	Uganda AIDS Commission
UFFCA	Uganda Fisheries and Fishing Communities Association
UGX	Ugandan Shillings
UNFPA	United Nations Population Fund
UNGASS	United Nations General Assembly Special Session (on HIV & AIDS)
USAID	United States Agency for International Development
USD	United States Dollar
USG	United States Government

Glossary of Terms

Agency	A person's ability to make and act on his/her own decisions.
AIDS transition	Keeping AIDS deaths down by sustaining treatment while pushing new infections even lower, so that the total number of people living with HIV begins to decline.[1]
Biomedical intervention of HIV	Treatment as prevention, Prevention of Mother-To-Child Transmission (of HIV), safe male circumcision etc.
CD4 Count	A blood test used to determine when to begin ART and to monitor how well treatment for HIV infection is going.
Disinhibition	Loss of inhibition or loss of restraint on behaviour that had been restrained. For example in relation to circumcision disinhibition might cause men to abandon previous risk-reduction behaviours such as partner reduction or condom use.
Proximate determinants	These are the immediate causes of a behaviour (or illness).[2] Thus availability of condoms can influence ability to practice safer sex; or access to prevention of mother to child transmission services can influence whether the infant of an HIV infected woman is infected with HIV.
Structural issues	The ways in which society is organised: social structures and the ways in which these maintain oppression and privilege in relation to race, sexuality, class, ability, gender and age.
Viral load	The amount of HIV in a person's blood: the amount or viral load rapidly increases after a person is first infected and then decreases to low levels, before rising again as the infected person progresses towards AIDS. An aim of treatment is to reduce the viral load to very low levels, which reduce the likelihood that the PLHIV will pass on infection to others.

1 Mead Over (2011) *Achieving an AIDS Transition Preventing Infections to Sustain Treatment.* Center for Global Development, Washington, DC.

2 Lerer, LB., et al. (1998) *Health for all: analyzing health status and determinants.* World Health Stat Q, 51, 7-20.

Executive Summary

The assignment

This document reports on an evaluation of the joint support provided by Denmark, Ireland and United States Agency for International Development (USAID)[3] to the Ugandan response to HIV & AIDS from 2007 until 2012.

These three development partners have for many years been prominent members of the Uganda AIDS Partnership, a coordination mechanism between donors and government, and supported the Government of Uganda (GoU) and civil society efforts to curb the epidemic. They jointly support Uganda AIDS Commission (UAC) leadership and coordination through the AIDS Partnership Fund and provide sub-grants for civil society organisations (CSOs) through the Civil Society Fund (CSF).

The overall purpose of the evaluation is to analyse the past practices of government, donors and civil society in the Uganda AIDS response to determine what has been successful, what has not, and why? The key questions of the evaluation stems from the Terms of Reference and the following focused evaluation questions are a result of the scoping/inception process:

1. Has Uganda made progress towards the AIDS transition? Is the epidemic under control or is it still growing?

2. Has the Danish/Irish/USAID support contributed to achieving the results that the National Strategy set out to achieve?

    2.1 Have the donors' areas of support conformed to the needs, priorities and policies of Uganda?

    2.2 Has the policy dialogue regarding the 2007/2012 period and the new national AIDS strategy been relevant and effective?

3. What (recent) past practices of government, donors and civil society have been successful and what have not – and why?

4. Was the overall intervention design appropriate from the perspectives of relevance, efficiency, effectiveness, sustainability of results and impact?

The evaluation report is intended to inform future engagements by Danida, Irish Aid, USAID and other donors as well as the GoU, the UAC, Ugandan civil society and the many CSOs involved in the fight against HIV in Uganda.

3 The evaluation covers USAID support to the Civil Society Fund and the Partnership Fund only, and not wider USAID support or the US President's Emergency Plan for AIDS Relief in Uganda. Support provided by Danida beyond the focus of this joint evaluation, is covered in Annex B: Danida Wider Support to the Ugandan AIDS Response.

The methodology

A team of evaluators conducted the evaluation including extensive document review – from the inception phase, throughout the field data collection phase in Uganda from May to June 2013, and continuing during the drafting of the report. Two Ugandan cultural facilitators, both stakeholders in the Ugandan AIDS response but not direct beneficiaries of the joint support, assisted the field work. Field data was collected using:

(1) key informant interviews with GoU personnel, CSOs' staff and volunteers, and donor staff;

(2) semi-structured group discussions conducted with service users, beneficiaries, their families, and groups of people in communities served by CSO programmes; and

(3) observation of the programmes and services.

The HIV/AIDS situation in Uganda

With an estimated population of nearly 35 million and a fertility rate of more than 6%, one of the highest rates in Africa, Uganda has a population growth rate of 3.32%. HIV prevalence in Uganda declined from a high of 18.5% in 1992 to 6.4% in 2004/05. However, there has been a recent upturn in prevalence to 7.2%. Most new infections are in stable, long-term partnerships. Prevalence rates are much higher among some most at risk persons (MARPs), particularly sex workers, men-who-have-sex-with-men (MSM) and the fishing communities along the shores of Uganda's big lakes. Low education levels, availability of disposable incomes, violence including sexual violence, are common in fishing communities, which, compounded by high mobility of the men, geographical remoteness and lack of health services, contribute to the high levels of HIV.

Risk behaviours including sex work and homosexual sex are criminalised, leaving individuals open to stigma, discrimination and violence. These MARPs form bridges for transfer of HIV infection to the general population. Drivers of the epidemic include behavioural, socioeconomic and structural factors such as gender norms, multiple concurrent sex partners, sex between young women and men who are 10 or more years their senior, and early transactional sex: "something for something love", often fuelled by alcohol and substance abuse.

Antiretroviral therapy (ART) has become widely available in Uganda since 2005, primarily as a result of very significant funding provided by the United States' President's Emergency Plan for AIDS Relief (PEPFAR). The number of persons eligible for antiretroviral therapy continues to grow, and the number of new infections continues to outpace the increase in persons on antiretroviral therapy.

The response to the epidemic has been guided by the goals of the National HIV & AIDS Strategic Plan 2007/08 to 2011/12 (NSP), to reduce the incidence of HIV, improve the quality of life of people living with HIV (PLHIV), mitigate the social, cultural and economic effects of HIV and AIDS and build an effective support system for service delivery. Although increasing numbers of PLHIV are accessing treatment, prevention activities have not yet reduced new infections.

The donor supported initiatives on HIV/AIDS in Uganda (2007-2012)

Most of the funding for the AIDS response in Uganda has come from external donors. PEPFAR has provided at least 80% of the resource envelope, with the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) and other donors contributing 10 or more% and the GoU between 5 and 10%. Only 18% of the resources for the response is spent on prevention, and 20% is spent on coordination. Over 50% is spent on care and treatment. The 20% used for coordination mostly covers the expenses of the UAC.

Funding modalities
Danida, Irish Aid and other donors, e.g. UK Department for International Development (DFID), contributed to the common baskets for the Partnership Fund and the CSF at some time during the evaluation period. Within the basket, Danida earmarked some of its funds to continue core funding for three large CSOs it had supported prior to the inception of the CSF. In Uganda, these organisations are termed national nongovernmental organisations (NNGOs). USAID contributed to the CSF and Irish Aid gave almost all its funding through basket mechanisms, including as joint lead donor, with DFID, for the Joint United Nations Programme of Support on AIDS in Uganda.

The AIDS Partnership Fund
Established with pooled funds from Uganda's AIDS development partners, the Partnership Fund is the major source of funding for UAC leadership and coordination of the AIDS response at national and decentralised district levels. See Box 1.

Box 1 Donor Contributions to the Partnership Fund 2007-2012

Source	Amount in USD
Danida	4,176,145
DFID	1,101,957
Irish Aid	2,820,893
Sida	47,437
Total	**USD 8,146,132**

UAC had overall responsibility for implementing the Partnership Fund, to enhance its key function of coordinating government and non-government sectors in prevention, control and management of the HIV epidemic.

The Civil Society Fund
Civil society involvement is a prominent part of Danish, Irish and USAID joint support to the Ugandan AIDS response. Established in June 2007, the CSF is a partnership involving the UAC, development partners and civil society that offers grants and capacity building to scale-up effective, comprehensive HIV prevention and care services by CSOs. Total contributions 2007-2012 was USD 90 million, with Irish Aid contributing 30%, DFID and Danida each about 23%, USAID 20% and small contributions from the Swedish International Development Cooperation Agency (Sida) and Italian Cooperation. See Box 2.

Box 2 Donor Contributions* to the CSF 2007-2012

Source	Amount in USD
Danida	21,225,372
Irish Aid	26,984,000
USAID	18,052,606
DFID	21,184,000
Italian Cooperation	69,930
Sida	2,800,000
Total	**USD 90,315,908**

The CSF was intended to support coordinated capacity building and technical assistance, and harmonised national efforts and accountability towards achieving the goals laid out in the NSP and the CSF Strategic Plan.

Main findings and conclusions

This section provides the main findings and conclusions of the evaluation questions.

1. Has Uganda made progress towards the AIDS transition?[4] Is the epidemic under control or is it still growing?
The 2011 AIDS Indicator Survey showed that the proportion of adults with HIV had increased slightly since the 2004-2005 AIDS Indicator Survey. Viral studies suggest an increase in HIV incidence, too. The Uganda Country Report 2012 to the United Nations General Assembly Special Session (UNGASS) estimated that the annual number of new HIV infections in the country increased by 11.4% from 2007/08 to 2009/10. The rise in infections is associated with changing behavioural indicators particularly an increase in multiple concurrent sexual partnerships. At the same time more infected people were on treatment, reducing HIV-related mortality, increasing the gross number of infected people, and thus increasing HIV prevalence. *Overall, the evidence suggests that the epidemic in Uganda is essentially stable, but it has not yet made progress towards the AIDS transition.*

2. Has the Danish/Irish/USAID support contributed to achieving the results that the National Strategy set out to achieve?
The NSP was developed through a broad consultative process, aligned to the Country's Poverty Eradication Action Plan. The National Strategic Framework that integrates all sectors in the AIDS response was the basis upon which policies were developed and implemented within the thematic areas of prevention, treatment, care and support.

The joint donor support to the Partnership Fund has been vital to enabling UAC coordination of the national response. It has provided support to certain CSO self-coordinating entities ensuring their existence and removing the financial struggle to

4 Keeping AIDS deaths down by sustaining treatment while pushing new infections even lower, so that the total number of people living with HIV begins to decline.

survive. Self-coordinating entities are defined as "clusters of HIV & AIDS stakeholders that have something in common[5]. The joint donor support has also been important for funding CSO prevention and care and support programmes.

Whereas care and support programmes have been effective, prevention interventions predominantly use individualistic approaches that focus on influencing knowledge, attitudes and behaviour of individuals in defined populations. Prevention interventions have not been directed at structural determinants of behaviour including overarching society and familial influences that limit individuals' self-determination in decision-making and behaviour. Hence, the greatest barriers on attaining a reduction in new infections are structural, and they have not been directly influenced by the donor support.

The evaluation found that in Uganda, although increasing numbers of PLHIV are accessing treatment, the result of the low spending on prevention compared to treatment is that prevention activities have not yet reduced new infections and that the number of new infections outpace the increase in persons on ART. Hence, incidence is rising, as well as prevalence. This is strong evidence that inadequate priority has been attached to prevention. The AIDS transition cannot be achieved with such inadequate low focus on prevention.

The inadequate priority is two pronged, both inadequate funding and ineffective policy. Ugandan prevention efforts do not address structural barriers and neglect fishing communities and other MARPs such as sex workers and MSM. Prevention efforts don't even address biomedical interventions effectively since the effort doesn't link biomedical interventions to community based/society level interventions addressing structural barriers to uptake of and continuation/adherence to biomedical prevention.

Danida and several Ugandan CSOs identified the need for comprehensive approaches, which are underpinned by social change theory, behaviour change theory, and empowerment paradigm perspectives. *Donor support is unlikely to have contributed significantly to the NSP outcome result of improved health behaviours for prevention of HIV transmission by MARPs/key populations. However, donor support is likely to have contributed to the NSP goal to improve the quality of life of PLHIV by mitigating the health effects of HIV by 2012.*

2.1 Have the donors' areas of support conformed to the needs, priorities and policies of Uganda?

Between 2007 and 2012, donors' support to the Partnership Fund and the CSF aimed to:

(1) enhance coordination of the Ugandan AIDS response, and implementation of the NSP and revised NSP (National HIV & AIDS Strategic Plan 2011/12 to 2013/14);

(2) further enable, coordinate and harmonise civil society participation, reducing duplication and gaps; and

(3) reduce development assistance administrative costs.

5 The 12 self-coordinating entities are 1) government ministries; 2) Decentralised AIDS Response; 3) organisations representing PLHIV; 4) the private sector; 5) international NGOs; 6) NNGOs; 7) faith based organisations; 8) the multilateral (United Nations) and bi-lateral AIDS development partners; 9) research, academia and scientific institutions; 10) the youth representatives; 11) the media, arts and cultural institutions, and 12) Parliament.

The evaluation indicates that the NSP itself is not fully in line with Ugandan AIDS response needs. In response to the needs, Danida additionally provided direct funding to the MARPs Network and the United Nations Population Fund (UNFPA) for a sexual reproductive health and rights (SRHR) project that provides an innovative model for prevention with youth that might be replicated throughout Uganda. UAC expressed satisfaction that the donors came together to support implementation of the NSP, confirming the donors' stated commitments to the Paris Declaration on Aid Effectiveness. *Joint donor support will only effectively address Ugandan needs when the GoU addresses the gaps in the NSP and prevention policies.*

2.2 Has the policy dialogue regarding the 2007/2012 period and the new national AIDS strategy been relevant and effective?

The policy dialogue conducted by the three donors, has had its points of departure in the donor's policies. Irish Aid's Country Strategy Paper for Uganda 2010-2014 sets out its objective, to reduce the number of HIV infections particularly among the poor and vulnerable. Work with civil society and prevention is important parts of Irish policy. Supporting the CSF was a way for Irish Aid to meet its goals for development cooperation via a multi-donor funded initiative seeking to provide grants to CSOs, and to support scaling up of effective and comprehensive responses to HIV, and orphans and vulnerable children (OVC). Irish Aid has also stressed the importance of having a results-based approach and a strong monitoring and evaluation (M&E) system to be able to control and follow investments made by the Irish government.

From 2007 to 2010, the Danish policy towards the support to the NSP focused on enhancing coordination and leadership and to promote effective civil society contribution to the national HIV/AIDS response. In 2010, in a strategic response to gaps Danida perceived in the NSP, new features were brought up by Danida. These were integration of SRHR and funding to MARP in the support to the Uganda AIDS response efforts. This was directly funded to UNFPA and the MARPs Network. Danida's strategic provision of direct funding from 2010 for SRHR programmes in part compensated for the gap in funding for SRHR through the CSF.

The articulated United States Government (USG) policy has been to make strategic, scientifically sound investments to rapidly scale-up core HIV prevention, treatment and care interventions and maximise impact. Specifically, to focus on prevention of mother-to-child transmission (PMTCT), continue to increase coverage of ART, increase the number of males who are circumcised for HIV prevention and increase access to, and uptake of, HIV testing and counselling, condoms and other evidence-based, appropriately-targeted prevention interventions.

UAC states that its policy dialogue has been inclusive of government, civil society and donor stakeholders from national to district level. There has been a dialogue about the inclusion of new biomedical interventions in the revised NSP, as scientific evidence of their effectiveness has become available, which is relevant. However, the evaluation found a major disconnect in policy development in relation to the detailed and well-argued analysis of the dynamics of the Uganda HIV epidemic in the 2011 "Report of the Review of the Magnitude and Dynamics of the HIV Epidemic and Existing HIV Prevention Policies and Programmes in Uganda", available to the UAC National Prevention Committee during the preparation of the revised NSP.

The three donors of the joint evaluation do not have a jointly held position on prevention with which to engage in policy dialogue with Uganda AIDS Commission, limiting the possibility for and effectiveness of joint policy dialogue.

The resource envelope, largely donor funded, cannot increase to keep pace with the huge and increasing costs and demand for treatment and medical care services. Increased spending on treatment and medical care will further reduce the resources available for prevention, community- and home-based care services, leading to an upward trend in new infections and increased need for ART and other HIV services. Increasing numbers of new infections along with greater proportions of PLHIV eligible for ART, increases demand for spending on treatment. *Thus there is urgent need for further, effective policy dialogue around spending on the Uganda AIDS response.*

3. What (recent) past practices of government, donors and the civil society have been successful and what have not – and why?

Government
Uganda has been successful in attaining its targets for people on ART and in retaining people on AIDS treatment. However, GoU has not shown budgetary commitment to controlling the epidemic and the successes have been attained largely with PEPFAR support supplemented in part by the GFATM. *The UAC broadly consultative approach to development of the NSP and revised NSP was successful in gaining donor support for (1) its leadership and coordination of implementation, and for (2) CSO contributions to implementation of the NSP.* After the donor appointment of a financial management agent for the Partnership fund, after alleged corruption claims (see Section 3.1), and the resumption of donor funding, the UAC was slow to resume all its key functions particularly the provision of support to coordination of the decentralised response at district level.

There remain fundamental gaps in the NSP and National HIV & AIDS Prevention Strategy. Imbalance between treatment and prevention has given way to a further imbalance between biomedical interventions and prevention interventions that address structural factors and other determinants of behaviour. The new imbalance is invidious as it reduces the resources available for:

(1) prevention in Uganda socio-cultural settings that reduce individuals' ability to make decisions and change their behaviours;

(2) for addressing the needs of MARPs who are frequently bridge populations; and

(3) for youth.

The imbalance also reduces the effectiveness of biomedical prevention interventions that require new health seeking behaviour, adherence to ART, and sustained healthy behaviours, e.g. consistent and correct use of condoms in all risky sexual encounters, in order to be effective.

Over the evaluation period 2007-2012, the Ugandan AIDS response had relied heavily on PEPFAR implementing partners and received inadequate government resources for implementation of the NSP. The inadequate resourcing is particularly problematic for the Ministry of Health (MoH) which does not have the capacity to implement the revised NSP and its greater focus on biomedical services that are mainly delivered

through MoH facilities. This along with the gap in provisions for key MARPs, and the glaring gap between the GoU international commitments to human rights and its lack of attention to the rights and needs of MARPs including the 3 million in fishing communities. *In sum, lack of Ugandan political leadership and funding commitment, and denial at the highest levels in Uganda are limiting the Ugandan AIDS response.*

Donors
Donor collaboration with government in the AIDS Partnership Forum, and contributions to the Partnership Fund and CSF have had successes (1) in supporting UAC leadership and coordination of the AIDS response; and (2) in routing funds to civil society programmes that would otherwise not have had resources to provide or expand their activities. The donors have worked jointly through the Partnership Forum and in their decision making and response to the challenge of financial mismanagement of the Partnership Fund within the UAC. The joint donor support to the CSF has enabled coordinated and harmonised support to civil society programmes, reducing administrative costs for the donors. The joint decision to engage management agents for the CSF has positively influenced the efficiency of the Fund. *Donor support to the CSF has been less successful in (1) encouragement of CSO innovation; (2) provision of platforms for sharing civil society experience and meaningfully engaging civil society in policy dialogue; and (3) facilitating CSOs to define the role for civil society in the current environment in the AIDS response.*

Donor joint funding practices are relevant and good practice, although there is need for more alignment to the realities of civil society, i.e. longer periods of funding, in the implementation of the CSF.

Civil society
Civil Society programmes have had success in attaining their performance targets and especially in provision of care and support services. NNGOs provide gold standard care services through a stand-alone model for nongovernmental organisation (NGO) services, and a "partnership with government services" model that could be replicated throughout Uganda. In prevention programming, many CSOs are frustrated in being unable to use their comparative advantage in comprehensive behaviour change approaches because of the short-term grants and the strategic choices by the UAC and the CSF. The gap for enabling effective civil society prevention is in the NSP, which provides the framework for the CSF but not a vision for the role of CSOs in the national response. *From an empowerment paradigm perspective, the gap is lack of facilitation of civil society to define its niche and lack of empowerment to deliver their full potential.*

4. Was the overall intervention design appropriate – from the perspectives of relevance, efficiency, effectiveness, sustainability of results and impact?
Overall, the support by the three donors has been critical for UAC leadership and coordination, and civil society programming during the evaluation period. However, there was neither a clear or common design, nor a concept governing joint support. Hence, there was a lack of joint analysis of the risks and assumptions in the intervention logic and, as a consequence, an absence of a joint risk management plan.

The joint approach was a clear expression of donor alignment with principles of harmonisation. Another reason for labelling this as joint support was the coinciding of three donors' interests, to a reasonable degree, at the right moment.

The major assumption was, although it was not explicitly expressed, that the government would adequately fund line ministries to provide clinical and other services from national to health sub district levels to implement the NSP. With the revised NSP, the assumption became that the MoH had the capacity to deliver biomedical prevention services.

Enabling coordination and fostering Ugandan ownership of the national response through the Partnership Fund is *relevant*. The design encouraged *efficiency* in use of donor funds by alignment of donors behind the NSP, and harmonising and coordinating civil society programmes through the CSF.

Implementation of the design needed external financial management for the Partnership Fund and CSF, which was expensive and not so *cost effective*.

Coordination and technical support to civil society activities by the District AIDS Focal Person was not as effective as it should have been when UAC funds stopped flowing to districts following the suspension of funding after alleged corruption. This seems not to have changed, at least not everywhere, after funding was resumed, as observed by the team during the field visit.

The *effectiveness* of civil society prevention activities might be enhanced if they are within a framework that supports structural change with mutually reinforcing social and individual behaviour change approaches. This has been missing to date for CSF grants.

Sustainability of prevention results requires iteration and adaptation of comprehensive behaviour change activities to the new environment of each generation.

Earmarked funding for NNGOs was an important contribution to their on-going programming in care and support. Civil society HIV services in Uganda continue to require external funding because there cannot be full cost recovery if there is to be equitable access. Some NNGOs are able to sustain their results through continual resource mobilisation by their fundraising departments. Small local CSOs need a mechanism such as the CSF that provides access to donor funding. However they also need funding for longer implementation periods than have been available to date through the CSF for *sustainability of their results.*

Measuring impact is beyond the current evaluation. Even identifying the joint donor contribution to outcome level results is methodologically challenging when another donor (USG/PEPFAR) is contributing at least 80% of the resource envelope. At outcome level, donor support has improved the quality of life of some PLHIV and their families. For a period, donor support to the CSF provided for OVC and mitigated the effects of AIDS on these children through expanding the availability of civil society services.

Recommendations

Future joint donor support

Recommendation 1: Future joint donor support should have an overall logic model, hierarchy of inputs and expected results and full involvement of CSOs.

Future joint donor support should be formally designed with an agreed overall logic model in line with the NSP, hierarchy of inputs and expected results to enable the donors to monitor the performance of their joint support. The design intervention activities should ensure full involvement of CSOs, maximising their potential for generating societal change that paves the way and supports individual behaviour change, to reduce HIV transmission. The design requires an analysis of the Ugandan political economy of the AIDS response, and a risk analysis and management plan.

Recommendation 2: Donors should continue joint support to the Partnership Fund and the CSF, and include the agreed overall logic model (hierarchy of inputs and expected results) in their agreements with the GoU.

Recommendation 3: Donors should work through the CSF Steering Committee to address future CSF granting.

CSOs need reliable, longer term grant funding to be effective, with nurturing rather than control of their institutional development. They need longer term grants for effective comprehensive behaviour change interventions, and care and support programmes, to improve results and increase their sustainability. Most CSOs need grant support for their institutional development. Fewer, larger grants will likely have more sustainable results than the current relatively small, short-term grants.

Recommendation 4: There should be continued external management of the Partnership Fund and the CSF.

Donor funding of the Partnership Fund and CSF currently needs external management. Any future plan for integrating the Partnership Fund and CSF into the GoU system will require a stepwise approach with benchmarks for fiduciary competency before progression to the next step.

Donor and Government commitments to the Uganda AIDS Response

Recommendation 5: The GoU should contribute to the Partnership Fund and CSF, as evidence of its commitment to these mechanisms within the AIDS response.

A government contribution would be managed by UAC within the same Partnership Framework governance and decision-making as the donor funds and with consensus agreement on what activities/grants would be funded by the donor funds and by government funds. Government contributions during the next phase of the agreements should initially be about 10%, in line with current government funding of the overall Uganda AIDS response. The contribution should rise significantly annually during the next phase, a necessity for the financial sustainability of the mechanisms.

Recommendation 6: The GoU and donors should explicitly define their commitments to the Uganda AIDS response for the next five or more years.

Commitments to the Uganda AIDS response should be defined together with an agreement on the balance of funding for prevention, treatment, and care and support. Within the prevention budget, the government and donors should agree the balance between comprehensive behaviour change interventions and other prevention, including biomedical interventions. Discussions between the donors and the government should continue to seek government commitment to significantly increasing it's funding of the

AIDS response, and adequately funding the MoH to provide HIV and related health services.

Civil Society role within the Ugandan AIDS Response
Recommendation 7: The role of civil society in the Ugandan AIDS response should be defined.

As the NSP has not defined the role of civil society, it is important for CSOs to seize the opportunity and define their role in the Ugandan AIDS response, to fully harness their potential. This could be catalysed by the CSF managers hosting civil society workshops at national and district levels, with joint financing with the Partnership Fund, as a means for CSOs to define and develop their roles and accountability for implementing the NSP.

Policy dialogue
Recommendation 8: Donors should continue and intensify policy dialogue with the GoU through the AIDS Partnership Forum and other platforms, and identify commonalities in their approaches that might be drawn on for a joint policy dialogue.

It is of course crucial that the development partners are clear on working towards a future strategy that addresses the needs of the Uganda population. The dialogue should focus on (1) the balance between prevention and treatment; and (2) between biomedical prevention interventions and the comprehensive behaviour change interventions that are needed both to maximise the effectiveness of the biomedical interventions and for essential reduction in risk behaviours in Ugandan society.

Donors should draw on their experiences with comprehensive behaviour change interventions, addressing societal structural change, supporting individual behaviour change and social mobilisation around health and HIV issues, and bring in the evidence base and behaviour change theory. The dialogue should address evidence-based comprehensive behaviour change interventions as a core component of the Ugandan HIV prevention strategy, underlining that it is not separate from but part and parcel of effective biomedical prevention and HIV risk reduction. The dialogue should consider harnessing CSOs' comparative advantage in comprehensive behaviour change programming.

Human rights
Recommendation 9: International advocacy for improving human rights in Uganda is urgently needed.

Women empowerment is one important tool to address drivers of the epidemic. While "quiet diplomacy" is agreed to be the best way forward for addressing the rights of homosexual men, there is also pressing need for advocacy around the prevention, treatment, care and support needs of sex workers, the lesbian, bisexual, gay and transgendered community as a whole, and fishing communities. Effective prevention for these MARPs who form bridges for infection transmission to the wider community is crucial for controlling the epidemic in Uganda.

Recommendation 10: That the UAC advocates for Ugandan ratification of the East Africa Community HIV and AIDS Prevention and Management Bill (2012)

Leadership on and affect change in relation to human rights issues by the UAC is needed if the NSP is to be effective in achieving an AIDS transition. Advocacy for Ugandan parliamentary ratification of the East Africa Community HIV and AIDS Prevention and Management Bill (2012) in Uganda is urgently needed from a public health standpoint.

Recommendation 11: In the near term, donors should work with UAC and the CSF to address the omissions in the NSP and its implementation in relation to fishing communities and other MARPs.

Donors should provide technical assistance to the CSF managers for development of policy guidelines and implementation planning for meeting specific MARP needs.

1 Introduction

Danida Evaluation Department (EVAL) contracted Indevelop, a Swedish consulting company working for sustainable social development, to conduct a joint evaluation of the support of Denmark, Ireland and United States Agency for International Development (USAID)[6] to the Ugandan response to human immunodeficiency virus (HIV) & acquired immunodeficiency syndrome (AIDS) from 2007 until 2012. These three donors and a number of other like-minded donors, including the United Kingdom, Sweden and Italy, have for many years been prominent members of the Uganda AIDS Partnership and supported the Government of Uganda (GoU) as well as civil society efforts to curb the epidemic. They jointly support Uganda AIDS Commission (UAC) leadership and coordination through the AIDS partnership Fund and provide sub-grants for civil society organisation (CSO) programming through the Civil Society Fund (CSF). The Terms of Reference for the evaluation are included in Annex A.

1.1 The purpose of the evaluation

The evaluation purpose is to analyse the (recent) past practices of government, donors and civil society with a view to determining what has been successful and what has not – and why – to inform future donor interventions and enable them to be more effective. Uganda now has a unique opportunity to contain its HIV epidemic through application of advances in technologies over the last ten years along with knowledge learned from programmes in Uganda and other Sub-Saharan countries on what has worked and what not. Evaluation of the joint contributions Danida, Irish Aid and USAID have made to the Ugandan response to HIV & AIDS will allow more efficient and effective use of donor support in the next crucial phase of the epidemic.

1.2 The audience for the evaluation

The evaluation report is intended to inform future interventions by Danida, Irish Aid, USAID and other donors as well as the GoU, UAC, Ugandan civil society and the many CSOs involved in the fight against HIV in Uganda.

1.3 The key evaluation questions

The key questions of the evaluation stems from the Terms of Reference and the focused evaluation questions are a result of the inception process:

1. Has Uganda made progress towards the AIDS transition? Is the epidemic under control or is it still growing?

2. Has the Danish/Irish/USAID support contributed to achieving the results that the National Strategy set out to achieve?

6 The evaluation covers USAID support to the Civil Society Fund and the Partnership Fund only, and not wider USAID support nor the US President's Emergency Plan for AIDS Relief in Uganda.

2.1 Have the donors' areas of support conformed to the needs, priorities and policies of Uganda?

2.2 Has the policy dialogue regarding the 2007/2012 period and the new national AIDS strategy been relevant and effective?

3. What (recent) past practices of government, donors and civil society have been successful and what have not – and why?

4. Was the overall intervention design appropriate – from the perspectives of relevance, efficiency, effectiveness, sustainability of results and impact?

The Terms of Reference also included evaluation questions that were specific to Danida support that is wider than the joint donor support to the Ugandan AIDS response. As inclusion of detailed findings related to Danida wider support and discussion of the Danida specific evaluation questions did not fit well in the body of this report on the *Joint* Evaluation. It was therefore agreed with EVAL at the Stakeholder Workshop in September 2013, that these findings and analysis should be detailed in an annex to the main report; see Annex B.

1.4 The evaluators

Indevelop brought to the evaluation an experienced team of evaluators, including three international consultants and one Ugandan national consultant. They have a complementary mix of public health, HIV & AIDS, sexual reproductive health and rights (SRHR), gender, social development and social inclusion expertise; and qualitative and quantitative evaluation skills.

1.5 The evaluation schedule

Document review for the evaluation began in the inception period, from April 2013, and continued through the field work and analysis phases of the evaluation. The evaluation team developed the evaluation tools during the inception period and finalised them in Uganda prior to the start of the field data collection phase from May to June, 2013. The detailed schedule for the in-Uganda field data collection phase is included in Annex C. This provides details of the organisations consulted in key informant interviews and persons met with in informal discussions during the field work. The team held a stakeholder workshop to review the findings and recommendations in September 2013, and this report takes cognizance of feedback received.

1.6 Approach and methodology

The Indevelop approach to evaluation is participatory, broad, inclusive, and gender sensitive. The evaluation team included men and women equally, with strong gender, SRHR, and social inclusion expertise. The field data collection teams included expatriates and Ugandans equally.

The team approached the evaluation in phases:

(1) inception with initial document review and evaluation design;

(2) field data collection in Uganda; and

(3) analysis of additional documentary evidence and field findings, and report writing.

During the inception phase, the team defined the principal evaluation questions and the likely sources of the quantitative and qualitative data required to answer the evaluation questions, and developed data collection and analysis tools. In the field data collection phase, the evaluation team finalised the data collection tools, decided the sampling frame (stratified by stakeholder and district) to ensure respondents representing all the major stakeholders as well as current and past CSF grant recipients/beneficiaries both in and outside Kampala.[7] The team continued to collect documentary sources of evidence throughout the data collection phase. These were analysed along with the field data in phase (3) analysis and report writing.

The intended impact of the joint donor support – and of the Ugandan AIDS response through implementation of the NSP – is reduced transmission of HIV. Further, a contribution analysis at impact level is problematic where the budget for the joint donor support is relatively modest in comparison to the overall resource envelope. Over the life of the intervention, United States' President's Emergency Plan for AIDS Relief (PEPFAR) contributed at least 80% of the AIDS response budget – supporting prevention including prevention of mother-to-child transmission of HIV (PMTCT), care and treatment that all impact on incidence of new infections. The size of the PEPFAR contribution overwhelmingly determines the impact on the Ugandan AIDS Response. Therefore, this evaluation was conducted at outcome level, not researching higher-level impact of the activity.

For detailed information on methodology used, see Annex D.

1.7 Guide for the reader of the report

The basic structure of the report was outlined in the Terms of Reference for the evaluation and agreed on in the Inception Report.

As a background to better understand the findings and the response to the evaluation questions, the next chapter of this report (Chapter 2) contains a brief history and context of the AIDS epidemic in Uganda. For the same reason, the chapter that follows (Chapter 3) gives the details about the Danish, Irish and USAID support to the National HIV and AIDS Strategic Plan. This chapter starts with an overview of donor support and funding modalities, mainly through the AIDS Partnership fund and the CSF and then describes the content of the support from Danida, Irish Aid and USAID. The chapter ends with an assessment of an overall intervention design of the joint support from the three donors.

7 The evaluation conducted the field work interviews and discussions in Kampala, Entebbe, Mukono, Masaka, Mbarara and Kasese.

The findings from the evaluation are presented in Chapter 4. It is divided in two parts, the first part analysing the support through the GoU, and the second part analysing the support through civil society.

Based on the findings, Chapter 5 presents the conclusions of the evaluation and responds to the evaluation questions. Recommendations are presented in Chapter 6.

Only two annexes are included in the printed report, Annex A and Annex G. The other annexes can be found on www.evaluation.dk.

2 History and Context of the AIDS Epidemic in Uganda

2.1 Prevalence and response

The national average adult HIV prevalence (total number of people living with HIV (PLHIV) infection) declined substantially from a high of 18.5% in 1992 to 6.4% in 2004/05,[8] especially among younger age groups, an achievement considered to be one of the earliest and best success stories in overcoming HIV.[9] Available surveillance data indicate that HIV prevalence stabilised from 2000 to 2007 in most parts of the country.[10] Although data on incidence (number of newly infected people) is less readily available, studies indicated that incidence also declined, in Masaka District from 7.6 per thousand per year in 1990 to 3.2 per thousand per year by 1998.[11]

During this period, before the availability of antiretroviral therapy (ART), the falling prevalence was considered to be a result from changes in age of sexual debut, declines in casual and commercial sex, partner reduction, and condom use, associated with high-level political support and multi-sectoral response.[12] CSOs spearheaded a campaign of ordinary Ugandans to care for the sick, educate the healthy and demand access to treatment with strong faith- and community-based support. Widely disseminated behaviour change communication (BCC) raised awareness and fought discrimination against PLHIV and AIDS stigma while advocating abstinence, being faithful, and condom use (known as the "ABC" strategy).

In the early years of the epidemic, Uganda's AIDS response was characterised by strong political commitment and support, open dialogue and multi-sectoral interventions and coordination. There was also involvement of religious leaders, decentralised planning, early involvement of civil society working in care and support addressing stigma and discrimination against PLHIV. Supportive policy environment, the availability of local and donor resources, the involvement of local communities and investment in research were other factors that contributed to the early successes.

Since 2005, with PEPFAR providing at least 80% of the total resource envelope for HIV & AIDS[13,14] ART has become widely available throughout Uganda. People living with HIV on treatment live longer. HIV-related disease has become chronic not rapidly fatal.

8 UNAIDS (2013) http://www.unaids.org/en/regionscountries/countries/uganda/ (Accessed 25 June 2013).

9 Hogle, JA Ed. (2002) *What Happened in Uganda? Declining HIV Prevalance*, Behavior Change, and the National Response. The Synergy Project, Washington, DC.

10 Report (2009). *The HIV/AIDS Epidemiological Surveillance Report 2005-7*. Ministry of Health, Kampala.

11 Hogle, JA Ed. (2002) *What Happened in Uganda? Declining HIV Prevalance*, Behavior Change, and the National Response. The Synergy Project, Washington, DC.

12 ibid.

13 By 2010, PEPFAR had allocated over USD 1 billion of funding to Uganda, with a significant increase from USD 20 million in 2004 to greater than USD 280 million in 2010. At that time PEPFAR currently contributed over 85% of the national HIV/AIDS response budget http://www.pepfar.gov/documents/organization/145738.pdf accessed 1 April 2013. The PEPFAR Uganda budget for Financial Year 2011 was over USD 298 million. http://www.pepfar.gov/documents/organization/199705.pdf accessed 1 April 2013.

14 PEPFAR (2012) *Uganda Operational Plan Report 2011*. Depart of State, Washington, DC.

The GoU established the UAC in 2001 under the Office of the President through an Act of Parliament to spearhead and coordinate the national and decentralised HIV response. Since 2002, Uganda's AIDS response has been mainly coordinated through the National HIV & AIDS Partnership arrangement. At district level, the response is coordinated through a technical District AIDS Committee and a political District AIDS Taskforce, structures that (in theory) are mirrored down through local government to grass roots community levels.[15]

In addition, the GoU has developed over the years a series of policies, strategies and plans aimed at mitigating and controlling the HIV epidemic. Key among these is the National Strategic Framework for HIV & AIDS Activities in Uganda 2000/01-2005/06 and the National Strategic Framework for Expansion of HIV & AIDS care and support in Uganda 2001/02-2005/06. In November 2004, the UAC released an "Abstinence and Being Faithful" policy to guide the implementation of abstinence-until-marriage programmes throughout the country, intended as a companion to the country's existing strategy on the promotion of condoms.[16]

From 2005, the United States Government (USG) through PEPFAR rapidly became the largest donor to the Ugandan AIDS response. Initially, 20% of the PEPFAR budget was earmarked for prevention and of this, one third, or 6.7% of the total budget, was stipulated for abstinence and monogamy programmes. This requirement was retained until the reauthorisation of the PEPFAR budget in 2008. The 2005 PEPFAR guidance on prevention of sexually transmitted HIV[17] stated that "Emergency Plan funds may be used for abstinence and/or be faithful programmes that are implemented on a stand-alone basis. For programmes that include a "C" component, information about the correct and consistent use of condoms must be coupled with information about abstinence as the only 100% effective method of eliminating risk of HIV infection; and the importance of HIV counselling and testing, partner reduction, and mutual faithfulness as methods of risk reduction."

The National HIV & AIDS Strategic Plan 2007/08-2011/12 (NSP) was developed through a broad consultative process, aligned to the Country's Poverty Eradication Action Plan, led by the UAC. This involved the government, donor and civil society stakeholders. Currently, the revised NSP (National HIV & AIDS Strategic Plan 2011/12 to 2013/14) and the National Prevention Strategy 2010/11-2014/15 guide the AIDS response. These, too, were developed through a participatory and consultative approach involving relevant stakeholders at multiple levels, as well as donors and implementing partners.[18] The National Strategic Framework that integrates all sectors in the AIDS

15 UNAIDS (no date) *Uganda –- Key elements of the national response*. http://www.unaidsrstesa.org/region/countries/uganda/uganda-key-elements-national-response (Accessed 26 June 2013).

16 *Human Rights Watch* (2005) Vol. 17, No. 4 (A).

17 PEPFAR (2005) *ABC Guidance #1 For United States Government In-Country Staff and Implementing Partners Applying the ABC Approach To Preventing Sexually-Transmitted HIV Infections Within The President's Emergency Plan for AIDS Relie*f. Office of the Global AIDS Coordinator Washington DC.

18 UAC (2012) *National Strategic Plan for HIV & AIDS 2011/12 -2014/15 (Revised)*. Uganda AIDS Commission, Kampala.

response was the basis upon which policies were developed and implemented within the thematic areas of prevention, treatment, care and support.[19]

Within the response to the generalised epidemic, the NSP identified key populations at higher risk for whom a special focus was advocated. These key populations included fisher folk, people with disability, uniformed services, persons internally displaced through conflict, and commercial sex workers, but *not* men who have sex with men (MSM) although they are at substantially higher risk for HIV infection than the general population in Kampala.[20] Key populations were considered to be hard to reach or unable to benefit from general population programmes.[21] The National HIV Prevention Strategy also does *not* address MSM and injecting drug users as "In Uganda, we do not have sufficient information on these population groups…..It will be important to keep an eye on these population groups since we do not have sufficient information on them."[22] The result was that there were little efforts to reach these groups with prevention.

2.2 Ugandan progress towards the AIDS transition

UNAIDS estimates indicate HIV prevalence was 7.2%[23] in 2011. This and other estimates of HIV and AIDS are presented in the following table:

Table 1 HIV and AIDS estimates 2011[24]

Number of people living with HIV	1,400,000
Adults aged 15 to 49 prevalence rate	7.20%
Adults aged 15 and up living with HIV	1,200,000
Women aged 15 and up living with HIV	670,000
Children aged 0 to 14 living with HIV	190,000
Deaths due to AIDS	62,000
Orphans due to AIDS aged 0 to 17	1,100,000

19 These include voluntary counselling and testing; PMTCT, treatment of opportunistic infections; palliative care; paediatric AIDS care; the Second National Health Policy, 2010, the National HIV & AIDS Policy, 2011; Safe Male Circumcision Policy, 2010; Public Private Partnership for Health Policy, 2010; HIV & AIDS Workplace Policy, 2010; Nutrition Policy – policy on infant and young child feeding, 2010; Care and Treatment Policy, revised 2011; Uganda Antiretroviral Treatment Policy, 2011; Home Based Care Policy, 2011; and HIV & AIDS Policy for the Roads Sub-Sector, 2010 among others.

20 Crane Survey Report (2010) *High Risk Group Surveys Conducted in 2008/9 Kampala, Uganda*. Makerere University, Centers for Disease Control and Prevention, Ministry of Health, Kampala.

21 UAC (2007) *Moving Toward Universal Access: National HIV & AIDS Strategic Plan 2007/8 –2011/12*. Uganda AIDS Commission, Kampala.

22 UAC (2011) *National HIV Prevention Strategy 2011-2015 Expanding and Doing HIV Prevention Better*. Uganda AIDS Commission, Kampala.

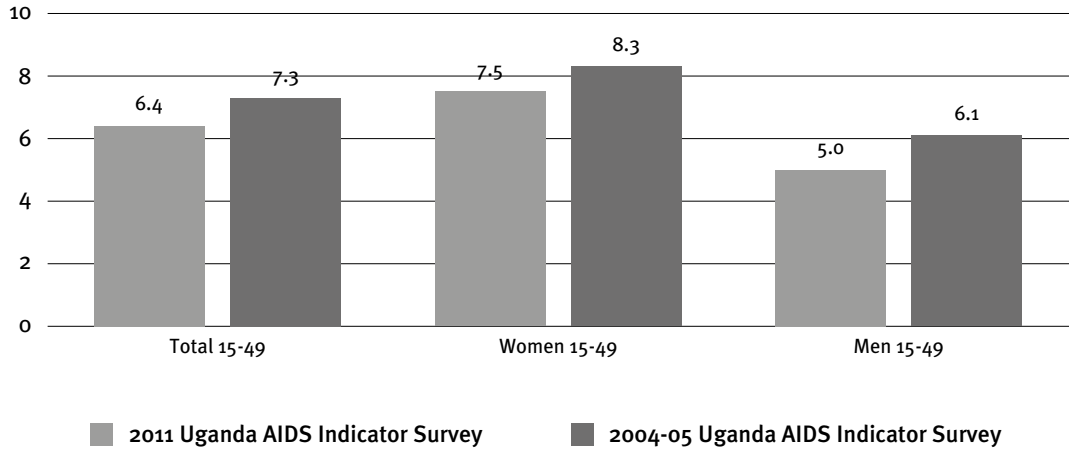
23 UNAIDS (2013) http://www.unaids.org/en/regionscountries/countries/uganda/ (Accessed 25 June 2013).

24 Source: UNAIDS factsheet, 2012: http://www.unaids.org/en/regionscountries/countries/uganda/ (Accessed 25 June 2013).

When the results of the 2011 AIDS Indicator survey were published,[25] the Ministry of Health (MoH) announced that the proportion of adults with HIV had increased slightly since the 2004-2005 survey. (See Figure 1,[26] below). Viral studies in Rakai and elsewhere suggest an increase in HIV incidence, too, although there is some controversy about the test used and extrapolating incidence from small scale surveys in high prevalence areas.[27] The Uganda Country Report 2012 estimated that the annual number of new HIV infections in the country increased by 11.4% from 2007/08 to 2009/10. The number of new infections in Uganda reflects a decline in new infections particularly among children less than 15 years of age resulting from increased availability and uptake of PMTCT services.[28] The rise in new HIV infections is associated with changing behavioural indicators particularly an increase in multiple concurrent sexual partnerships.[29]

The changes in HIV prevalence also have to be viewed in the context of the investments in ART – more people living with HIV have access to treatment, reducing HIV-related mortality and enlarging the pool of PLHIV, and thus affecting prevalence. There are also differences in the prevalence by sex and age. More females than males are infected and at a younger age. Youth have only 2% prevalence overall, but the ratio of HIV-positive boys to girls 14-19 years old is 1:9. The peak in HIV prevalence is age 35-39 at 10.3%.[30]

Figure 1 Trends in HIV Prevalence among Women and Men age 15-49, Uganda



25 Press Release (2012) *Release of Key Results of the 2011 Uganda AIDS Indicator Survey.* Ministry of Health, Kampala.

26 Figure from: Press Release (2012) *Release of Key Results of the 2011 Uganda AIDS Indicator Survey.* MoH, Kampala.

27 Hallett, T and Garnett, G. (2009) *Estimating Incidence of HIV Infection in Uganda.* JAMA 301(2): 159-161. doi:10.1001/jama.2008.953.

28 *The National HIV & AIDS Strategic Plan 2007/8 to 2011-12.* Objective 2: aimed to reduce HIV transmission from mother-to-child by 50% by 2012.

29 Ministry of Health (2012). *2011 Uganda AIDS Indicator Survey: Key Findings.* ICF International, Maryland.

30 Report (2012) *Global AIDS Response Progress Report: Country Progress Report.* Uganda AIDS Commission, Kampala.

Uganda's HIV epidemic is predominantly heterosexually transmitted (80% of infections), with mother-to-child infections accounting for almost 20%. Most new infections occur in stable long-term partnerships, driven by multiple sexual partners, extra-marital sexual relations, transactional sex and sex between young women and men 10 or more years older (cross generational sex).[31]

Among populations that are considered to be most at risk (MARPs) prevalence is very high[32] although the evidence for this is from a few, small size, recent studies. The Crane Survey[33], conducted in Kampala only,[34] found HIV prevalence of 33% among sex workers and 18% among clients and partners of sex workers. HIV prevalence in sex workers increases dramatically with age, from 29% among those aged less than 25 years to 48% among those aged 35 years or more.[35]

The 2012 Country Progress Report details that 46 fishing communities in Lake Victoria Basin of Uganda in 2010 were found to have HIV prevalence of 22%. HIV prevalence was 13.7% among MSM and 7.4% among motorcycle taxi drivers who are primarily male youth.[36] Various MARP have different risk behaviours associated with their different HIV prevalence, but many individuals at risk including MSM, who in Uganda often have sex with women too, are bridges for transfer of HIV infection into the general population. Risk behaviours including sex work and MSM, are criminalised in Uganda and individuals are not protected by the law. Sex workers and MSM often suffer violence, coercion, stigma and discrimination and are underserved by services of prevention, diagnosis and treatment of HIV and other sexually transmitted infections.[37] This corresponds to findings also reported to the evaluation by sex workers and MSM.[38]

The drivers of the HIV epidemic in Uganda include behavioural, socio-economic and structural factors like gender norms and constructs of masculinity, gender relations, gender-based violence, and stigma and discrimination. Deeply rooted practices such as polygamy, multiple concurrent sexual partnerships, cross-generational, early and transactional sex and sex work, alcohol and substance abuse, foster fertile ground for increasing HIV prevalence.[39] Gender norms including "something for something love",[40] age disparity,[41] acceptance of sexual coercion, marital rape and widow inheritance greatly

31 Report (2009) *Uganda – HIV Prevention Response and Modes of Transmission Analysis.* Uganda AIDS Commission, Kampala.
32 Report (2012) *Global AIDS Response Progress Report: Country Progress Report.* Uganda AIDS Commission, Kampala.
33 Crane Survey Report (2010) *High Risk Group Surveys Conducted in 2008/9 Kampala, Uganda.* Makerere University, Centers for Disease Control and Prevention, Ministry of Health, Kampala.
34 *Note:* the Crane Survey Report seems to have not been well edited as it contains a number of presentation errors, but it is the only comparative study of different MARP available, and was drawn upon by UAC for the 2012 Country Progress Report.
35 Report (2012) *Global AIDS Response Progress Report: Country Progress Report.* Uganda AIDS Commission, Kampala.
36 ibid.
37 Crane Survey Report (2010) *High Risk Group Surveys Conducted in 2008/9 Kampala, Uganda.* Makerere University, Centers for Disease Control and Prevention, Ministry of Health, Kampala.
38 Evaluation key informant interviews, May 2013.
39 Report (2009) *Uganda - HIV Prevention Response and Modes of Transmission Analysis.* Uganda AIDS Commission, Kampala
40 Hope, R (2007) *Addressing Cross-generational Sex: A Desk Review of Research and Programs.* Population Reference Bureau, Washington, DC.
41 ibid.

limit women's ability to negotiate safer sex.[42] Thus for many women in stable long-term unions, "ABC" messages do not meet their prevention needs.

Economic factors associated with vulnerability to HIV infection in Uganda are geographic mobility, migrant work, poverty and wealth. These are framed in society and on a structural level with policy related issues including: inequitable access to health services, governance, accountability, coordination, and stigma and discrimination that further worsen the situation or hamper initiatives for prevention, treatment and care. Factors that shape or constrain individual behaviours such as condom use, number of sexual partners, comprehensive knowledge about HIV & AIDS, and uptake of this information and services including BCC, counselling and testing, PMTCT, ART etc., can reduce the effectiveness of individual-level behavioural interventions intended to protect individuals from infection.[43, 44]

ART has become more widely available to eligible individuals over the last 10 years, and is one of the key components of the NSP. Yet the number of those in need of ART continues to grow, and new HIV infections continue to far outpace the annual increase in new patients on ART in Uganda by a ratio of 2:1.[45] In 2005, 42% of those in need of ART accessed treatment. A total of 270,000 PLHIV were estimated to be eligible for ART in 2007. This number was projected to reach 332,000 in 2012, far outstripping system capacity and available finances making it extremely difficult to stay ahead of the epidemic.[46] The number of PLHIV in Uganda eligible for treatment also increased with the adoption of new WHO guidelines on when to commence ART and for prevention of mother-to-child transmission. Uganda's own investments are still moderate and it is heavily dependent on external support and investments, principally from PEPFAR.

Although increasing numbers of PLHIV are accessing treatment, prevention activities have not yet reduced new infections. This is evidence that the HIV epidemic in Uganda is by UNAIDS definition, not yet moving towards an AIDS transition.

42 Hope, R (2007) *Women's empowerment and HIV prevention – donor experience.* OECD, Paris.
43 Report (2009) *Uganda – HIV Prevention Response and Modes of Transmission Analysis.* Uganda AIDS Commission, Kampala.
44 Report (2012) *Global AIDS Response Progress Report: Country Progress Report.* Uganda AIDS Commission, Kampala.
45 Table 1 in PEPFAR (2012) *PEPFAR Blueprint: Creating an AIDS-free Generation.* Office of the Global AIDS Coordinator, Washington, DC.
46 Report (2012) *Global AIDS Response Progress Report: Country Progress Report.* Uganda AIDS Commission, Kampala.

3 Donor Funded Initiatives

3.1 Joint donor support contributing to achieving the national strategy results

Universal access to prevention, treatment, and care and support was a key pillar of the NSP with scaled-up coverage targets to an average of 75% across the interventions, and with specific targets for each thematic area.[47] The goals of the NSP 2007/08-2011/12 were to:

(1) reduce the incidence of HIV by 40% by the year 2012;

(2) improve the quality of life of PLHIV by mitigating the health effects of HIV by 2012;

(3) mitigate the social, cultural and economic effects of HIV and AIDS at individual, household and community levels;

(4) build an effective support system that ensures high-quality, equitable and timely service delivery.

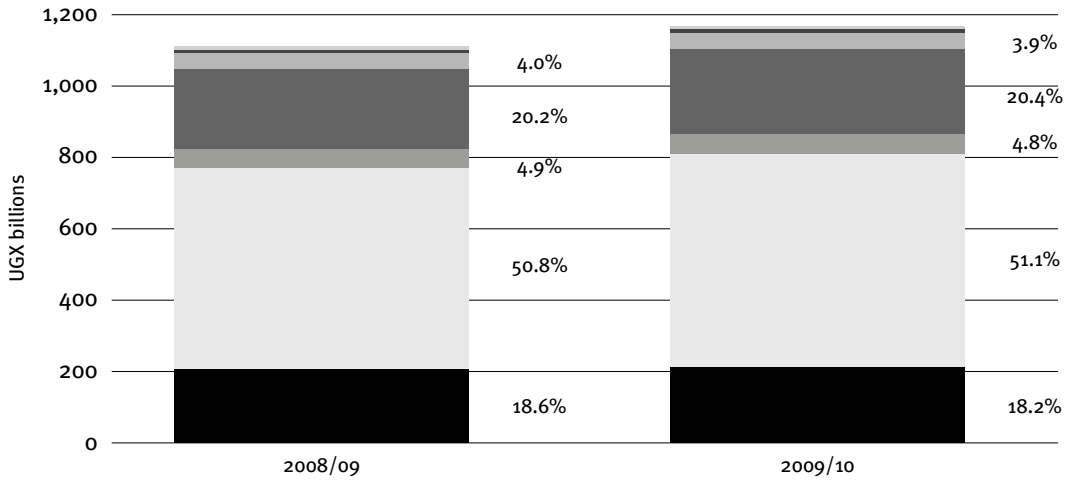
In addition to policy discussions through the AIDS Partnership Forum, donors were consulted by UAC in its process for developing the NSP, and the revised NSP, and the National HIV Prevention Strategy. However, several evaluation respondents stated that the USG/PEPFAR had a particularly strong influence on the revised NSP and the National HIV Prevention Strategy because of the size of its investment.[48] The adoption in the strategy of combination HIV prevention, involving multiple biomedical, behavioural and structural prevention interventions, is closely aligned with PEPFAR approaches.[49]

47 UAC (2007) *Moving Toward Universal Access: National HIV & AIDS Strategic Plan 2007/8 - 2011/12*. Uganda AIDS Commission, Kampala.

48 Evaluation Key Informant Interviews with donors and CSOs.

49 PEPFAR (2012) C*ombination Prevention in PEPFAR.* Office of the Global AIDS Coordinator, Washington, DC.

Figure 2 Ugandan Expenditure by AIDS Spending Categories for 2008/09 and 2009/10



Source: UAC (2012) National AIDS Spending Assessment, Uganda 2008/09 to 2009/10, Uganda AIDS Commission, Kampala. Figure 12.

There was not donor consensus on prevention, nor consensus in relation to the funding emphasis on treatment and medical care in the implementation of the NSP, amounting to about 51% (see Figure 2). But the donors jointly supported UAC leadership and coordination of the NSP implementation, and civil society prevention and care programmes, thus contributing to national efforts for attainment of NSP Goals 1) and 2). The limitations in the NSP in relation to prevention are likely to have contributed to Uganda's inability to attain Goal 1), to reduce HIV incidence, despite its success in getting PLHIV onto ART.

A great many bilateral and multilateral donors support Uganda's AIDS response[50,51] organised as AIDS Development Partners in the Uganda AIDS Partnership. The major bilateral donors are PEPFAR, Irish Aid, UK Department for International Development (DFID), Danida, Swedish International Development Cooperation Agency (Sida) and Italian Cooperation. Multilateral donors are UN agencies and the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM). Most of the bilateral agencies provide support through the Partnership Fund and the CSF. However, PEPFAR is the major and dominant funder overall for the national HIV & AIDS response. Indeed, the PEPFAR contributions in 2009/10 and 2010/11 were respectively 83% and 93% of all the resources availed by all the external funders as is shown in Table 2 below.

50 A study in 2006 indicated that the health sector in Uganda was "most congested" with 20 development partners; in 2008/09 there were 16 development partners in the health sector Chapman, N. et al (20XX) *Evaluation of the Irish Aid (Uganda) Country Strategy Paper 2007-2009*. ITAD, Brighton, UK, pp. 16-17.

51 From 2008-11 Kaiser Family Foundation mapped 23 donors present in HIV assistance in Uganda. See Kates, J et al (2013) *Mapping the donor landscape in global health: HIV/AIDS*. Kaiser Family Foundation, Menlo Park, CA http://kff.org/global-health-policy/report/mapping-the-donor-landscape-in-global-health-hivaids/ (Accessed 21 June 2013).

Table 2 Contribution of Development Partners to AIDS Response in USD[52]

	2007/08	2008/09	2009/10	2010/11
Bilateral				
Irish Aid	3,630,000	13,010,000	6,930,000	6,000,000
DFID	4,430,000	4,750,000	4,780,000	4,000,000
Danida	4,650,000	4,880,000	5,430,000	1,000,000
Sida	1,200,000	50,000	-	
Italian Cooperation	220,000	-	70,000	
PEPFAR	228,880,000	269,830,000	256,99,000	289,000,000
Multilateral				
UN Agencies	13,190,000	6,560,000	10,000,000	N/A
GFATM[53]	-	-	24,170,000	4,350,000
Total	256,200,000	299,080,000	308,270,000	308,350,000

Most of the resources to finance the AIDS response in Uganda to date have come from external donors. The National AIDS Spending Assessment report[54] funded by Irish Aid indicates that during 2008/09, 68% of the funding for HIV/AIDS was from donors and 80% of this was from the USG through the off-budget funding mechanism.[55]

Funding from the government is about 11% of the total resource envelope. Much as HIV prevention is a priority for Uganda, only 18% is spent in this area, 20% on coordination and over 50% is on care and treatment.[56] (See Figure 2, above). The skewed resource allocation to the components of the HIV response, with greatest priority given to treatment, is likely also to have contributed to the recent increase in HIV prevalence because of the lower funding priority given to prevention of new infections.

Resource mobilisation to fund the AIDS response has also been influenced by donor fatigue and by high levels of corruption within government ministries as evidenced in the

52 Adapted from Table 9: Contribution of Development Partners to AIDS Response in Report (2012) *Global AIDS Response Progress Report, Country Progress Report Uganda*. Uganda AIDS Commission, Kampala.

53 The Global Fund to Fight AIDS, Tuberculosis and Malaria.

54 UAC (2012) *National AIDS Spending Assessment, Uganda 208/9 to 2009/10.* Uganda AIDS Commission, Kampala. p56.

55 Although this conflicts with PEPFAR documentation that it provided at least 80% of the resource envelope at that time. By 2010, PEPFAR had allocated over USD 1 billion of funding to Uganda, with a significant increase from USD 20 million in 2004 to greater than USD 280 million in 2010. At that time PEPFAR currently contributed over 85% of the national HIV/AIDS response budget: http://www.pepfar.gov/documents/organization/145738.pdf (Accessed 1 April 2013). The PEPFAR Uganda budget for Financial Year 2011 was over USD 298 million. http://www.pepfar.gov/documents/organization/199705.pdf accessed 1 April 2013. PEPFAR (2012) *Uganda Operational Plan Report 2011*. Depart of State, Washington, DC.

56 UAC (2012) *National AIDS Spending Assessment, Uganda 2008/9 to 2009/10*. Uganda AIDS Commission, Kampala.

recent "Office of the Prime Minister" scandal[57] when direct aid was halted after evidence of fraud by the Prime Minister's office. Donors noted that if future donor funds are moved to direct funding of projects rather than basket funding, institutions like UAC will be paralysed by the loss of funding.

Partnership principles and approaches
"Like-minded" donors have collaborated since 1999. Channelling funds through multi-donor mechanisms is driven by donor commitment to:

(1) harmonisation of donor practices for effective aid delivery,[58]

(2) support to country-led development in line with the Paris Declaration,

(3) reach more CSOs through pooling of resources, and

(4) reduce transaction costs.

Commitment to working with civil society, particularly smaller CSOs at community level, requires umbrella mechanisms for reaching grass roots organisations and building their capacity to manage and report on grant funding, as logistics and administrative costs prevent direct engagement with a myriad of small CSOs. Uganda took a lead in aid collaboration through development of its Poverty Eradication Action Plan, revised twice, in 2000 and 2004, that now reflects both the goals of the GoU and the United Nations Millennium Development Goals (MDGs). Donors responded by creating the Uganda Joint Assistance Strategy in 2005.[59]

The donors jointly aligned themselves behind the NSP and to an extent behind the revised NSP,[60] and supported implementation of the National HIV & AIDS Prevention Strategy. Good Partnership practice prevents unnecessary duplication of work both for partner governments and development agencies, and reduces the cost of managing aid.

The Uganda partnership coordination mechanism consists of the *AIDS Partnership Forum*, the *Partnership Committee*, 12 Self-Coordinating Entities[61] and the *AIDS Partnership Fund*. Development partners interact with the GoU in the major policy and technical fora on HIV & AIDS. At policy level, donors participate jointly through the AIDS Partnership Forum, an annual meeting of all stakeholders at national and lower levels that attracts political, policy and technical representation to share information on the

57 Tran M, & Ford, L (2012) *UK suspends aid to Uganda as concern grows over misuse of funds* http://www.guardian.co.uk/global-development/2012/nov/16/uk-suspends-aid-uganda-misuse

58 DAC Guidelines and Reference Series (2003) *Harmonisation donor practices for effective aid delivery*. OECD, Paris.

59 Ernst, J (2001) *Aid Collaboration in Uganda.* International Affairs Review Vol. XX, No. 1: Winter 2011.

60 Although Danida added core support to certain CSOs as a strategic effort to counter what it saw as a too strong reliance on biomedical prevention activities in the revised NSP – evaluation key informant interview with Danida.

61 Self-coordinating entities are clusters of HIV & AIDS stakeholders that have something in common. It was conceived that members of these clusters would collectively contribute to the management and coordination of the response if they had opportunities for dialogue to address concerns, share experiences and identify gaps and then share these with other stakeholders through the Partnership Committee and Partnership Forum. The coordination activities of most SCEs are facilitated through the Partnership Fund.

status of the epidemic and response and agree on national priorities for action. Donors are represented on the Partnership Committee, which steers the partnership coordinating mechanism and includes representatives from the 12 Self-Coordinating Entities, and UAC, UNAIDS, MoH, Ministry of Gender Labour and Social Development, and Ministry of Finance and Economic Development. Donors support UAC leadership, coordination and capacity building of the Uganda AIDS response, through the AIDS Partnership Fund. Donors are also represented on the CSF Steering Committee, which is similar to a board of directors and is responsible for the strategic direction addressing policy and technical matters concerned with CSF management and grants.

The AIDS Development Partners working in Uganda signed a memorandum of understanding (MoU) regarding the operations of the AIDS Partnership Fund with the UAC. The overall objective of cooperation under the MoU is to strengthen capacity for coordination of activities under the National Strategic Plan in addressing HIV & AIDS. The AIDS Development Partners committed to support with financial and/or technical assistance as requested by UAC. Donors making financial contributions do so through the basket funding arrangement. USAID is unable to contribute to basket funding of the Partnership Fund but is a signatory to the MoU. The donors' financial contributions are under their bilateral arrangements or agreements with the GoU. The MoU is not a legally binding document.

Similarly, donors signed a MoU with UAC regarding the technical, finance and grants management services of the CSF to increase civil society participation in the national response to health and HIV & AIDS in Uganda. The MoU included first year funding commitments and for some donors second year funding commitments, too. USAID committed to provide administrative and technical support to the CSF contracting with a competitively selected firm to provide financial and grants management services to the CSF and participants.

Funding modalities (basket, earmarked, direct)
Danida, Irish Aid and other donors, e.g. DFID, contributed to the common basket for the Partnership Fund and CSF at some time during the evaluation period. The first round of grants processed by the CSF consisted of rolling forward existing agreements for nine large CSOs with national scope (NNGOs). The nine had been receiving support from the participating donors prior to the CSF inception. Within the common basket, Danida earmarked some of its funds as core funding for three NNGOs, Straight Talk Foundation, The AIDS Support Organisation (TASO), and Hospice Africa, Uganda. From 2010, Danida provided strategic direct funding to certain CSO programmes and a United Nations Population Fund (UNFPA) SRHR project in addition to contributing to the basket funding mechanisms. Danida added direct core funding for the MARPs Network in 2011. Funds that USAID contributed to the CSF were earmarked for orphans and vulnerable children (OVC), paediatric AIDS and improving local government performance in planning services for OVC. USAID also funded the management of the CSF by the financial, technical and monitoring and evaluation (M&E) agents. From 2011, Irish Aid earmarked funds for HIV & AIDS activities in Karamoja Region.

The AIDS Partnership Fund
Established in 2002 as a pooled source of funds from Uganda's AIDS Development Partners, the Partnership Fund is critical as it is the major source of funding for leadership and coordination of the Uganda AIDS response at national and decentralised district local government levels through the UAC. Its purpose is to:

(1) support operations of the UAC partnership mechanism;

(2) enhance UAC coordination capacity and the self-coordinating entities' organisational development; and

(3) plan, monitor and evaluate information and resources.[62]

In 2008, UAC signed an MoU with the AIDS Development Partners to strengthen capacity for coordination of activities under the NSP through the Partnership Fund.[63] Contributors to the Partnership Fund to June 2012 include Danida, DFID, Irish Aid, USAID (funding the Financial Management Agent, Deloitte, Uganda) and UNAIDS. The UAC expressed to the evaluation satisfaction that it had achieved its objective of aligning the Partnership Fund donors in support of the NSP and revised NSP. Without the alignment, civil society actors would have been pulled in the direction of donors' individual agendas rather than the Ugandan AIDS response.[64]

Table 3 Donor Contributions to the Partnership Fund[65]

Source	Amount in USD				
	2007/08	2008/09	2009/10	2010/11	2011/12
Danida	867,603	690,846	1,106,859	117,802	1,393,035
DFID	275,010	556,530	-	270,417	-
Irish Aid	291,332	490,064	683,497	615,200	740,800
Sida	-	47,437	-	-	-
Total	1,433,946	1,784,879	1,790,357	1,003,420	2,133,835

The fund also covers costs of the National AIDS Indicator Survey, the National AIDS Spending Assessment, the NSP Mid Term Review & Joint AIDS Review, as well as the UAC Secretariat. The Partnership Fund is one of the few sources of funding for core structures and activities – where other donor funds meet only programmatic expenses – leading one NNGO to inform the evaluation "Quite frankly, without the Partnership Fund, we would no longer be in existence."[66]

Unfortunately, throughout 2008, rumours of fraud related to use of funds in the UAC increased and culminated in an anonymous whistle-blower, claiming to be an employee at UAC, calling the fraud hotlines of USAID, Irish Aid, DFID and UNAIDS. The donors froze the funds, and received no objection to a forensic audit from the Uganda Auditor General. They contracted the accounting firm KPMG Kenya to conduct the

62 Report (2013) *HIV/AIDS Partnership Mechanism Review Final Report 30 May 2013*. Uganda AIDS Commission, Kampala.

63 MoU (2009) Memorandum of Understanding between Uganda AIDS Commission and the AIDS Development Partners Concerning support to the Operations of the HIV/AIDS Partnership Fund. Uganda AIDS Commission. Kampala.

64 Evaluation Key Informant Interview.

65 Financial years 2007/08-2010/11 Adapted from Table 11: Contribution to Partnership Fund by Bilateral Agencies in: Report (2012) *Global AIDS Response Progress Report, Country Progress Report Uganda*. Uganda AIDS Commission, Kampala. Financial Year 2011/12 added from data supplied by the Financial Management Agent Deloitte, Uganda.

66 Evaluation Key Informant Interview.

audit,[67] which demonstrated mismanagement of funds. As a result Deloitte Uganda Limited was appointed financial manager of the Partnership Fund, and an action plan was agreed with UAC, including repayments, laying off staff, and creating new positions. Until the funds were frozen, several areas of coordination of the national response were supported through the Partnership Fund. The donor freeze on funds and UAC inaction when the funds were passed to Deloitte Uganda caused serious lack of coordination (joint planning, implementation, M&E) at the district level.[68] UAC funding to districts for technical leadership and coordination was still not flowing at the end of 2012. Then in November 2012, UAC issued an internal audit report indicating that they had concerns about how the Partnership Fund was being managed. KPMG was requested by the AIDS development partners to conduct a special audit of the Partnership Fund *and* the CSF. KPMG's findings, presented as expenditure verification for the period 1 May 2010 to 31 December 2012, were that *both* the UAC and the Financial Management Agent were not strictly adhering to the financial management guidelines. Corrective measures to improve the financial management were to be implemented in 2013.

The Civil Society Fund

Civil society is a prominent part of Danish, Irish and USAID joint support to the Ugandan AIDS response, with the largest share of the funds going to CSOs and their activities.

From 2007, Danida, DFID and Irish Aid started coordinating in a Joint AIDS Development Partner Framework[69] as these donors had been supporting many of the same NNGOs and wanted improved coordination. Sida, Italian Cooperation, and USAID joined, and later DFID withdrew when their strategy changed. However, after USAID funding for the financial management agent ended, DFID took on funding the financial management agent for a period that has been extended to the end of 2013.

The CSF was established in June 2007 as a partnership involving the UAC, development partners and civil society.[70] It was intended to offer grants and capacity building for CSOs to scale-up effective, comprehensive HIV prevention and care services. CSF *initially* also funded multi-sectoral OVC services, and CSO programmes in tuberculosis and malaria. The CSF was intended to fund coordinated capacity building and support to CSOs, harmonising national efforts and accountability towards achieving the goals laid out in the NSP, the National Strategic Programme Plan of Interventions for Orphans and Vulnerable Children, and the CSF Strategic Plan. The CSF steering committee, a sub-committee of the Partnership Committee provides the overall leadership, guidance and direction to the CSF. The CSF steering committee is chaired by a UAC commissioner with its Director General as member.

The CSF Secretariat was initially housed in the UAC. The Financial Management Agent provided management and financial oversight services to the CSF and its grantees.[71] The M&E Management Agent was added in January 2009 with responsibility for establishing

67 Evaluation key informant interviews with AIDS Partnership Fund donors.

68 Evaluation key informant interviews with District Chief Administrative Officers, District Health Officers and District AIDS Focal Persons.

69 Danida (2007) *Programme Document: HIV/AIDS Support: Strengthening Uganda's Response to HIV/AIDS 2007-2010*. Ministry of Foreign Affairs, Copenhagen.

70 Please see Annex D that gives details of donor support to the CSF from May 2007 to June 2012 and of 125 CSF grantees (taken from the CSF website 19 May 2013).

71 UAC (2008) *Civil Society Fund FY08 Annual Report*. Uganda AIDS Commission, Kampala.

a comprehensive performance, monitoring and reporting programme for the CSF and its grantees that is aligned with the NSP and other relevant M&E frameworks.

Danida, DFID and USAID have earmarked funds in the CSF. Earmarking was seen as problematic for harmonising donor approaches by Irish Aid.[72] Donors' rationale for earmarking (2007-2010) was that the support was on-going from before the CSF existed. Danida considers that earmarking (and direct funding from the Embassy through the so-called "local grant authority") allows for flexibility and for supporting new and emerging needs/gaps. However, Danida does not intend to continue with earmarking in the future, as it defeats the purpose of basket funding which promotes Ugandan ownership and costs less to administer.

In 2007/08, nine NNGOs received earmarked funds and 31 CSOs became sub-grantees under Round 1 solicitation.[73] In 2008/09, CSF awarded 85 new grants worth UGX 12,388,612,743 that included 54 grants for HIV prevention, 28 grants for orphan and vulnerable children services and three grants for providing support in paediatric AIDS. By the year end, the CSF was managing 125 grantees operating in 65 districts out of the 111 Ugandan districts. The CSF also extended the contracts for the nine NNGOs receiving funds in 2007/08 for a third year to June 2010.[74]

The total donor funding for the five years being evaluated is summarised in Table 4 below.

Table 4 Donor Contributions Committed to the CSF, 2007/8-2011/12 in USD[75]

Donor:	2007/08	2008/09	2009/10	20010/11	2011/12
Danida	3,800,000	4,200,000	4,407,190	4,409,091	4,409,091
Irish Aid	3,340,000	5,124,000	6,300,000	5,850,000	6,370,000
USAID	204,678	3,490,438	6,704,884	3,826,303	3,826,303
DFID	4,200,000	4,200,000	4,784,000	4,500,000	3,500,000
Italian Co-operation	-	-	69,930	-	-
Sida	-	-	-	1,400,000	1,400,000
Total	11,544,678	17,014,438	22,266,004	19,985,394	19,505,394
Five-Year Total:					USD 90,315,908[76]

72 Chapman, N. et al (20XX) *Evaluation of the Irish Aid (Uganda) Country Strategy Paper 2007-2009*. ITAD, Brighton, UK, p40.

73 UAC (2008) *Civil Society Fund FY08 Annual Report*. Uganda AIDS Commission, Kampala.

74 UAC (2009) *Civil Society Fund 2008-09 Annual Report*. Uganda AIDS Commission, Kampala.

75 Adapted from Table 10: Committed donor contributions (USD) to the Civil Society Fund, 2007/08-2011/12 in Report (2012) Global AIDS Response Progress Report, Country Progress Report Uganda. Uganda AIDS Commission, Kampala.

76 This five year total commitment by donors USD 90,315,908 published by UAC is slightly different from the USD 92,535,908 five year total donor contributions to the Civil Society Fund provided to the evaluators by the Financial Management Agent: Deloitte, Uganda.

A full list of all the CSF grantees is provided in Annex E, Table E1. Yet, except for the earmarked grants to the NNGOS, many of the grants are relatively small and short-lived, and grantees are scattered throughout Uganda. CSF grant monitoring data at output level is available from USAID's Monitoring and Evaluation of the Emergency Plan Performance (MEEPP) project from 2008. A summary of the CSF grant achievements reported to MEEPP against the targets for PEPFAR indicators is included in Annex E, Table E2: Performance of CSF Grants 2008-2012. Although there is some variability from year to year, over all CSF in most service delivery areas has exceeded its grants' targets. One exception is that the number of condom outlets has been no more than 72% of target. The figures for MARP reached with individual and or small group HIV preventive interventions are considerably higher than target. For clinical care services, the data fluctuates widely year to year which might result from inappropriately low early targets. Overall from 2008 to 2012, the clinical care targets have been met.

Many CSOs reported to the evaluation that they received an 18-month grant[77] only and were not aware that their grant would be renewed. Only after some CSOs had closed out grants and laid off staff hired under their grant, had CSF informed them that there would be a further period of funding. With a limited grant for a short period, there was no potential for sustainability of the services established with the grant funding. Creating community structures to maintain grant funded services requires a long timeline with planning and capacity building for attracting future funding.[78]

However, the CSF ability to provide grants is limited by the donor funds available – donors put funds in the basket on an annual basis – and changing donor commitments. Release of solicitations and award of grants requires Steering Committee approvals, which have been subject to delays. Without a guaranteed funding pipeline, the CSF is unable to guarantee uninterrupted funding of CSO programmes from year to year.

The management agents developed a three-year strategic plan to guide the CSF leadership and contributing partners to determine priorities and allocate resources, as well as provide a platform for promoting the CSF through advocacy and fundraising.[79] The CSF has also supported research on various relevant subjects.[80]

3.2 Danida's contribution

The strategic objectives of the NSP that the Danida supported from 2007 to 2012 were to:

a) Provide best support to enhance national leadership and coordination of the overall response.

77 Some earlier grants were two years, renewable for a further two years, but such grantees were not found during the evaluation field visits.

78 Evaluation key informant interview with an AIDS service CSO.

79 M&E Management Agent, Financial Management Agent &Technical Management Agent (2010) *Civil Society Fund 2009-2010 Annual Report.* Uganda AIDS Commission, Kampala.

80 See CSF Technical Management Agent/M&E Management Agent (2012) *Community Knowledge and Practices Survey Reports in the Districts of Adjumani, Mukono, Masindi, Mubende and Burisa, Kampala:* Civil Society Fund and Chemonics International Inc., Kampala and Research Report (2012) *Factors influencing knowledge levels regarding identifying ways of preventing sexual transmission of HIV, rejecting major misconceptions and the correct steps on condom use in Uganda.* Civil Society Fund, Kampala.

b) Promote greater harmonisation of funds and strategies among contributing stakeholders.

c) Help to address gender inequalities in the causal factors and responses to the HIV/AIDS epidemic.

d) Revitalise condom use in the current socio-political climate and support Uganda in moving toward universal access for HIV/AIDS services.[81]

Attaining these strategic objectives required long-term and predictable funding.

From 2007 to 2010,[82] Danida provided basket funding to the Partnership Fund and CSF addressing core needs in the NSP, and earmarked funds within the basket for continued core support to three NNGOs (Straight Talk Foundation,[83, 84]TASO,[85] and Hospice Africa Uganda[86]). In 2010, in a strategic response to gaps Danida perceived in the NSP, two new features appear in Danida's logical framework: integration of SRHR and MARP in the support to the Uganda AIDS response efforts. These were directly funded to UNFPA and the MARPs Network (DKK 80 million or 40% of its development assistance to the Ugandan AIDS response). Component A in the Danish Programme Document 2010-2015, strengthening UAC, included a sub-component on operational research. Operational research was to be strengthened through support to the national M&E system and to AIDS research coordination. Another subcomponent was support to SRHR. Funds for integrating SRHR have been channelled through a UNFPA programme, through an agreement between the Embassy of Denmark and UNFPA. The programme comprises support to comprehensive condom programming and reproductive health-HIV integration through youth friendly services. It is being implemented by MoH, UNFPA, Reproductive Health Uganda, and four faith-based organisations (FBOs). Detail of Danish support to SRHR is included in Annex B.

Danish support through the Partnership Fund aimed at strengthening UAC through two sub-components, one supporting implementation of the NSP, and one supporting capacity building for a sustainable HIV & AIDS knowledge management system that would enable continuous improvement of HIV & AIDS programming performance. However, when the report on the forensic audit of the Partnership Fund showed mismanagement of funds in UAC, there was a hiatus in Partnership Fund disbursement until the external financial management agent was appointed. This explains why some activities such as (support to) the UAC knowledge management centre has not been realised. Meetings, including the annual review meeting were also put on hold.[87]

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81 Danida: Programme Document: HIV/AIDS Support "Strengthening Uganda's Response to HIV/AIDS" 2007-2012, p. ii.

82 Danida (2007) *Programme Document: HIV/AIDS Support: Strengthening Uganda's Response to HIV/AIDS 2007-2010.* Ministry of Foreign Affairs, Copenhagen.

83 Report (2009) Annual Reports 2008. Straight Talk Foundation, Kampala.

84 Report (2011) Annual Reports 2010. Straight Talk Foundation, Kampala.

85 Report (2010) Annual Report 2010. The AIDS Support Organisation, Kampala.

86 Report (2013) Annual Report 2011-12. Hospice Africa Uganda, Kampala.

87 Danida informed the evaluation that their funds are still available and a knowledge management system will be very much on the agenda, once the fund management issue is fully resolved. Danida foresees that the National Document Institute at UAC will be supported to take over the role of coordinating HIV & AIDS Research in Uganda. The MoH, PEPFAR (through MEEPP), and DFID are also interested in supporting this. Danida reported that the Technical Working Group is still alive and was meeting at the end of May 2013.

Danida support to the CSF had one sub-component for youth NGOs and another for conflict areas. In the first phase, Danida earmarked funds within the basket 2007-2010 for core support to the three NNGOs mentioned above. (Detail of Danida support to these three NNGOs is included in Annex B).

In order to intensify the support to MARPs, an agreement was signed between the Embassy of Denmark and the MARPs Network. This covers knowledge management for effective HIV prevention among MARPs; strengthening of member organisations; and advocacy for access to prevention services. The four-year project has a budget of DKK 8 million. Detail of Danish support to the MARPs Network is included in Annex B.

Danida's strategic provision of direct funding from 2010 for SRHR programmes in part compensated for the gap in funding for SRHR through the CSF.

Recipients of Danida earmarked and direct funding were positive about such use of funds. They testified to advantages such as support for innovative potential (UNFPA: Integration of SRHR in the work of church networks), complementarity (Danida earmarked funding enabled Straight Talk to continue supporting prevention among youth who were not prioritised for CSF grants), and relevance (creating a forum for all MARPs through the MARPs Network). The recipients also highlighted the value of on-going personal contact with Embassy staff who are on steering committees, participate in annual review meetings and go on monitoring visits, as well as the flexibility in re-assessing needs and approaches (for example branding of condoms) and reallocation of funds to more feasible approaches. However, Danish embassy staff explicitly stated that they do not have enough human resources to support directly funded projects, and that Danida policy is to move away from that aid modality.

3.3 Irish Aid's contribution

From 2000, Uganda has been the largest recipient of Irish Aid development assistance across sectors including education, poverty reduction, governance, health, and HIV & AIDS. Irish Aid successfully collaborated with USAID around the President's Initiative on AIDS Strategy for Communication to the Youth.[88] From 2007 to 2009, Ireland's strategy focused on poverty reduction through a multi-donor Joint Assistance Programme, reflecting 12 development partners' response to the GoU poverty reduction strategy.[89] HIV was addressed through multiple channels, including direct support to the UAC and civil society through the CSF. Ireland decided to work with the GoU as "the GoU had not been a traditional partner of the largest HIV & AIDS funding sources from the US".[90] Irish Aid's funding modality was mixed: nearly half Irish assistance was to the Poverty Action Fund, introduced in 1998 to channel resources for priority programmes with direct poverty benefits, 20% sector support, and 30% projects.

Since 2009, Irish Aid moved from project assistance to basket funding as a strategy for development cooperation with other donors. Irish Aid's Country Strategy Paper

88 Chapman, N. et al (20XX) *Evaluation of the Irish Aid (Uganda) Country Strategy Paper 2007-2009.* ITAD, Brighton.
89 ibid.
90 ibid.

for Uganda 2010-2014[91] set out its objective: to reduce the number of HIV infections particularly among the poor and vulnerable. But in 2011, Irish Aid earmarked funding for Karamoja Region through which AMICAALL (Alliance of Mayors and Municipal Leaders' Initiative for Community Action on AIDS at the Local Level) is strengthening the capacity of local governments for efficient and effective HIV service delivery and institutional capacity.[92] And Irish Aid provided funding to TASO for strengthening the institutional and technical capacity of 50 CSOs to strengthen coordination among networks of CSOs and local governments; and to support them to engage with grass roots socio-cultural institutions to positively influence risky practises and behaviours driving new HIV infections.[93]

The expected output level result was increased access to quality prevention services for the most vulnerable with activities:

(1) development and implementation of a joint HIV & AIDS programme with other donors (DFID/Danida);

(2) improve accessibility and quality of services provided by non-state actors; and

(3) national and decentralised level coordination and M&E systems strengthened for delivery of quality and equitable services.

Irish Aid stresses the importance of having a results-based approach and a strong M&E system to be able to control and follow investments made by the Irish government.

Irish Aid, along with DFID, is a founding sponsor of the Joint UN Programme of Support on AIDS in Uganda. The aim is to maximise the comparative advantage of each agency to provide technical assistance for policy work, advocacy for political commitment, building an enabling environment and ensuring a more informed society. UN agencies in turn support CSOs with funding for HIV & AIDS, supporting Uganda's AIDS response.

Work with civil society and prevention is important parts of Irish policy. Supporting the CSF was a way for Irish Aid to meet its goals for development cooperation via a multi-donor funded initiative seeking to provide grants to CSOs, and to support scaling up of effective and comprehensive responses to HIV, and OVC. Irish Aid cannot directly follow its contributions to the CSF without earmarking, which Irish Aid considers not in keeping with the ethos of basket funding. Due to the misappropriation of more than EUR 4 million Irish Aid funds earmarked for Northern Uganda by the Prime Minister's Office in November 2012, all funding through government systems totalling EUR 16 million was suspended (non-government partners were not affected by the suspension). Although the misappropriated funds have been returned, the suspension will remain in

91 Irish Aid (2010) *Irish AID Country Strategy Paper Uganda 2010-1014*, Department of Foreign Affairs, Dublin http://www.irishaid.gov.ie/news-publications/publications/publication-sarchive/2010/october/uganda-csp-10-14/

92 MoU (2011) *Embassy of Ireland and the Alliance of Mayors and Municipality Leaders' Initiative for Community Action on AIDS at Local Level for support towards strengthening local government sector HIV response in Karamoja region.*

93 MoU (2011) *Embassy of Ireland (Uganda) and TASO for support towards decentralised capacity building of HIV/AIDS civil society organisations in the Karamoja sub-region.*

place until the Irish government is fully confident that the GoU has strengthened its internal financial controls and acted against all officials implicated in the fraud.[94]

3.4 USAID's contributions

USAID supports strengthening of Uganda's decentralised health system and strives to improve the quality of and access to HIV & AIDS, maternal and child health services. Prior to joining the joint donor support to the CSF, USAID supported a number of CSOs to address HIV prevention, care & treatment programmes, including provisions for OVC through direct grant funding to NNGOs, the Inter-Religious Council of Uganda, and mechanisms such as the USAID-funded CORE Initiative. The latter, a global project USAID Washington awarded in 2003 and that USAID Uganda bought into from December 2005 to September 2008, was implemented by CARE Uganda and partners. The CORE Initiative expanded services for youth and for OVC by facilitating collaboration between the GoU and civil society. This included enhancing the effectiveness of the UAC in coordinating efforts to reduce vulnerability to HIV among youth; and providing capacity building and technical support to NNGOs and CSOs for improving programme quality and scaling-up youth prevention, and care and support activities for OVC.

In addition to the CORE Initiative, many of the CSOs that were eligible for or received sub-grants from the CORE Initiative were also the constituency for the CSF. Although USAID is unable to donate to basket funding mechanisms, from 2007, USAID supported the CSF by contracting a CSF management agent on behalf of the CSF Steering Committee. USAID initially funded CARE Uganda through the CORE Initiative to be the management agent for the CSF, and contracted Deloitte Uganda as Financial Management Agent.

As a result of financial irregularities at the Partnership Fund, USAID also contracted Deloitte to manage the Partnership Fund. Unfortunately, through no fault of its own, CARE became embroiled in political controversy in Washington, and USAID Washington was unable to renew the CORE Initiative agreement from September 2009.[95,96] In early 2009, USAID was asked to continue contracting the Technical Management Agent after the agreement with CARE Uganda came to an end. USAID awarded the Technical Management Agent and M&E Management Agent to Chemonics International Inc. from February 2010.[97]

94 Irish Aid webpage: http://www.irishaid.gov.ie/what-we-do/countries-where-we-work/our-partner-countries/uganda/

95 Kaiser Health News (2006) *AP/Yahoo! News Examines PEPFAR Grants Given to Religious, Nontraditional Groups.* http://www.kaiserhealthnews.org/Daily-Reports/2006/January/30/dr00035087.aspx?p=1

96 Morera, AF (2006 updated 2012) *Cooperative for Assistance and Relief Everywhere Inc.* (CARE) The Center for Public Integrity. http://www.publicintegrity.org/2006/12/13/6397/cooperative-assistance-and-relief-everywhere-inc-care

97 MEA, FMA &TMA (2010) *Civil Society Fund 2009-2010 Annual Report.* Uganda AIDS Commission, Kampala.

USAID's early HIV prevention programmes with their emphasis on abstinence until marriage and marital fidelity with condoms only being promoted for high risk sexual encounters[98] have been criticised as being "values based". However, USAID emphasises that it fully supports human rights and has a long history of supporting the right to information and services. For example, its family planning services have always been mandated to offer full information and an array of family planning methods without service delivery pressure on clients to choose a particular method or no method. Incentives (for client or provider) and provider targets for family planning delivery are specifically not permitted for programmes receiving USAID technical assistance. USAID/Uganda's prevention portfolio comprises bilateral and centrally funded and managed activities that are linked to treatment and care activities to provide a continuum of care.

USAID/Uganda is prevented by the US Congress from contributing to basket funding by required accountability to its programme offices, the President, and Congress on all foreign assistance it provides.

In addition to PEPFAR financial contributions, the USG has provided technical assistance to the GoU and national advisory bodies; and supported service delivery at the district level and national programmes.[99] PEPFAR published guidance on biomedical interventions for prevention of sexual transmission in 2011[100] following advocacy around efficacy of biomedical prevention services in 2010.[101] Creating an AIDS-free generation is a new policy imperative for the USA.[102] The USG policy is to make strategic, scientifically sound investments to rapidly scale-up core HIV prevention, treatment and care interventions and maximise impact. Specifically, to:

(1) focus on PMTCT: working toward the elimination of new HIV infections among children by 2015 *and* keeping their mothers alive;

(2) continue to increase coverage of ART both to reduce AIDS-related mortality and to enhance HIV prevention;

(3) increase the number of males who are circumcised for HIV prevention; and

(4) increase access to, and uptake of, HIV testing and counselling, condoms and other evidence-based, appropriately-targeted prevention interventions.

98 The 2001 *Presidential Initiative on AIDS Strategy for Communication to Youth* programme in Ugandan schools promoted abstinence only messages; this was followed by the *New Partners Initiative* to channel abstinence and be faithful funding to FBOs, along with PEPFAR's ABC guidance emphasizing abstinence until marriage and marital fidelity for young people.

99 Report (2012) *Global AIDS Response Progress Report, Country Progress Report Uganda.* Uganda AIDS Commission, Kampala.

100 http://www.pepfar.gov/documents/organization/171303.pdf (Accessed 6/6/13).

101 http://www.pepfar.gov/documents/organization/166389.pdf (Accessed 6/6/13).

102 PEPFAR (2012) *PEPFAR Blueprint: Creating an AIDS-free Generation.* Office of the Global AIDS Coordinator, Washington, DC.

3.5 The overall intervention design

The three donors' overall logic model for the joint support
As the joint support was not formally designed and not synchronised between the donors, the documentation provided by the three donors did not include an overall logic model for the joint support. The evaluators constructed the logic model for the joint support from documents provided by Danida but with very little documentation from Irish Aid, and without the benefit of documentation from USAID and other donors to the CSF. None of the documentation available provided a clear intervention logic model for the joint support to the Partnership Fund and CSF although the Danida documentation provides information on two, similar, logical frameworks for the period 2007 to 2010[103] when it was providing basket funding to the Partnership Fund and CSF, and for 2010 to 2015[104] when it additionally used direct funding to UNFPA and the MARPs Network.

The Danida logical frameworks' aim is reducing the number of new infections and mitigate the effects of the epidemic, with enhanced national institutional capacity. The Irish Aid documentation positioned its support in an overall economic strengthening framework. The USAID/Uganda Mission did not have a results framework when it joined the joint collaboration;[105] USAID stated that its logic for joining the joint donor support was concerned with efficiencies, coordination and harmonisation: USAID was providing grants to CSOs that would be potential beneficiaries of the CSF and so it made sense to join with rather than duplicate the other donor efforts.

The overall logic model the evaluation constructed (see Figure 3) demonstrates the hierarchy of inputs, activities and expected results for the three donors' support to the Ugandan AIDS response, with the development hypothesis underpinning this. All three donors stated that they could position their support within the model.[106]

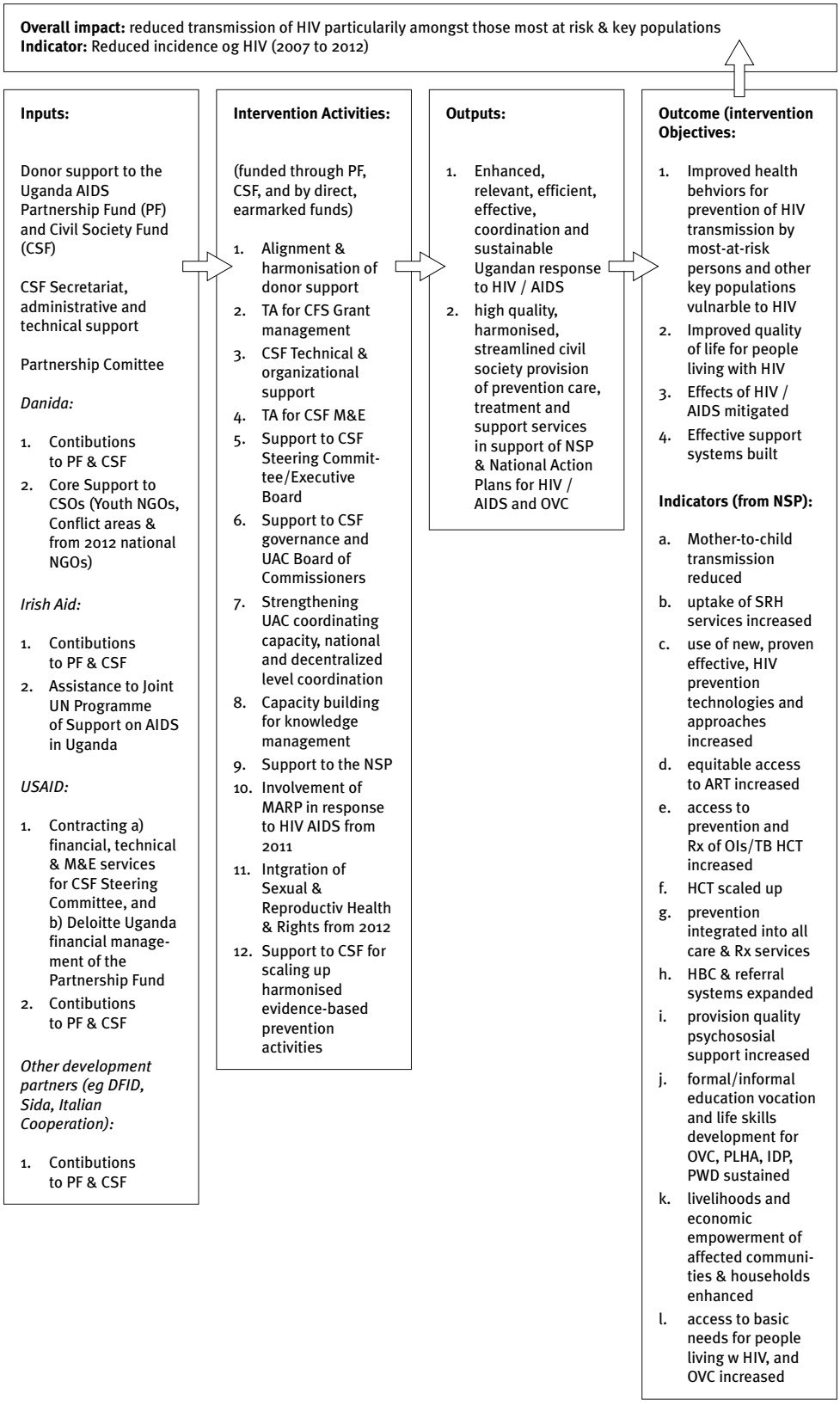
The assumptions and risks in the overall logic model
A major assumption of the joint donor support was that the GoU would adequately fund the line ministries to provide the clinical and other services from national to health sub district levels as articulated in the NSP. With the revised NSP increased focus on biomedical prevention of HIV infection (treatment as prevention, PMTCT, safe male circumcision etc.) and the assumption became that the MoH would have the human resource and systems capacity to deliver these services. These assumptions regarding GoU funding and MoH capacity were demonstrated to be false over the period being evaluated.

103 Danida (2007) *Programme Document: HIV/AIDS Support: Strengthening Uganda's Response to HIV/AIDS 2007-2010.* Ministry of Foreign Affairs, Copenhagen.
104 Danida (2010) *Programme Document: Support to HIV/AIDS Programme in Uganda 2010-2015.* Ministry of Foreign Affairs, Copenhagen.
105 Although USAID/Uganda now has a Mission Results Framework that would place support to the CSF under its Development Objective 3: Improved health and nutrition status in focus areas and population groups, see: USAID (2010) *Uganda Country Development Cooperation Strategy.* United States Agency for International development, Kampala.
106 Reference Group Meeting, 7th May, 2013.

With the exception of a small number of NNGOs, CSOs cannot provide biomedical prevention services on their own. Their comparative advantage is in mobilising communities around issues related to HIV, supporting social and individual behaviour change, addressing some of the structural and other barriers to accessing information and services. To be effective and to sustain individual and societal change, CSO activities must be iterative, responsive to changing local environments and continued over years. A further important assumption of the joint donor support was that the CSF as a mechanism would provide CSO grant funding to facilitate social and individual behaviour change, addressing the barriers to accessing information and services.

Risks involved in joint funding of governments and basket funding of CSO programmes include misuse or diversion of funds from their intended purpose. The donors managed this by appointing a financial management agent for the CSF and, in 2010 after UAC mismanagement of the Partnership Fund, for the Partnership Fund also. The cost of a financial management agent must be balanced against projected increased results of the investment and, for CSO grantees, the burden of stringent financial reporting that diverts effort from programming.

Figure 3 Overall Logic Model for the Joint Support



4 Key Findings

Donor support, described in Chapter 3 above, has funded two thirds of the implementation of the NSP. This section includes findings on the implementation on the strategic plan, by the government (Section 4.1) and civil society (Section 4.2). Detailed evaluation findings on the implementation of the NSP thematic areas are included in Annex F.

4.1 Implementation of the NSP through GoU

Coordination of stakeholders
UAC with support from the Partnership Fund has provided assistance that facilitated district coordination. The district level AIDS focal person and other district personnel's work coordinating and supervising district and sub-district activities was enabled. The funding paid for District AIDS Committee meetings, transportation costs and refreshments for the participants, and enabled the AIDS Focal person to attend community meetings, including community dialogues, and make supportive supervision visits to community level service providers. These activities ceased when the Partnership Fund was frozen and funding from UAC to districts had not restarted by the end of 2012. AIDS focal persons in districts visited during the data collection in 2013 were no longer attending community meetings.

For example, one community dialogue attended by the evaluation was less than two miles from the district offices but the AIDS focal person did not attend, although she had been invited. The civil society organisers of the event had walked to the meeting venue, as had the community leader participants. AIDS focal Persons and District Health Officers reported that they called Districts AIDS Committee meetings far less frequently than previously (twice a year or annually) and they had to break for lunch so that participants could go off and get their meal – with some not returning for the afternoon session. Previously, lunch was provided at meetings. By coincidence UAC staff were visiting three of the same districts that the evaluation visited, and District Health Officers and AIDS Focal Persons were informed that now Partnership Funds are flowing again "UAC is returning" to support district level coordination.[107]

UAC used the Partnership Funds for both its own coordination of the AIDS response, at national and district level, and also provided core funds to self-coordinating entities (see Footnote 61) to enable their coordination activities within their membership. UAC also provided funds for capacity building around specific issues, such as advocacy. Finding core funding is very difficult for many CSOs and seems to be even more difficult for "network of networks" type of organisations, and other umbrella organisations that are unable to levy sustaining membership dues from small CSO members. CSF grants are for programming and do not cover organisations' core expenses. Thus self-coordinating entities reported their appreciation of partnership funding through UAC, which is for some a lifeline.

M&E systems
The NSP does not detail how to monitor and evaluate its objectives and defined goals, or how to measure the performance of the process for managing the epidemic. Instead

107 Reported through district-level key Informant Interviews, and also, informally, directly by UAC staff to the Evaluators when they met up in district centres.

the NSP argued for the need to manage for development results through a national Performance Monitoring and Management Plan.[108] The NSP intended that the national monitoring plan would foster and mainstream a culture of evidence-based planning and decision-making in the national response. It planned to harmonise the existing systems of data collection, reporting and review and thereby facilitate the use of M&E information in HIV policymaking, implementation and resource allocation.

Meanwhile, USAID/Uganda funded the MEEPP project in 2004. MEEPP established and operates a data management system, external to GoU systems, to collate, clean, validate, and analyse service output data from all PEPFAR implementing partners and the CSF, against the PEPFAR Country Operational Plan. Some of the NNGOs, including TASO and Hospice Africa, Uganda have established M&E systems that collect service and programmatic data, and support operational research.[109]

In 2010, the UAC developed a new national M&E system with support from the Partnership Fund[110] for strengthening national AIDS responses at country level. Its building blocks are the sector management information systems (MIS):

(1) the Orphans and other Vulnerable Children Management Information System under the Ministry of Gender, Labour and Social Development;

(2) the Local Government MIS under the Ministry of Local Government;

(3) the Education MIS under the Ministry of Education and Sports.

The MoH MIS was planned to link to the UAC MIS using outcome indicators. A national database and tools are being developed for the UAC M&E system that will include PEPFAR indicators. Once it is operational, all development partners will use the system which it is hoped will minimise duplication and strengthen HIV information – within the next two years. Meanwhile, MEEPP is reporting to GoU nationally, in addition to reporting to PEPFAR, and working with GoU ministries and agencies to strengthen M&E of the national AIDS response.

The review of NSP in 2010 found several weaknesses in implementation of the Performance Monitoring and Management Plan including insufficient staffing for M&E compounded by unclear roles and responsibilities, lack of M&E skills, vertical programme demands and multiple reporting arrangements that greatly impede the performance of the M&E system. The UAC Directorate of Planning, Monitoring and Evaluation was operating with only 37% of the intended staffing. UAC does not have an overarching data collection system to guide an evidence based response, and relies on national surveys. There is currently no centralised database tracking key indicators of the epidemic or the national response; thus, there are very many indicators in NSP for which no baseline data is available and no plans in place to collect the information. Of the 58 indicators included in the Performance Monitoring and Management Plan, 65% were not collected with the planned frequency, creating difficulties to verify results by the GoU as well as for the evaluation.

108 UAC (2007) *Moving Toward Universal Access: National HIV & AIDS Strategic Plan 2007/8 – 2011/12.* Uganda AIDS Commission, Kampala.
109 Evaluation key informant interviews.
110 UAC (2011) *National HIV and AIDS Monitoring and Evaluation Plan 2011/12 to 2014/15.* Uganda AIDS Commission, Kampala.

UAC changed priorities in the revised NSP

Priorities were changed to include important new scientific advances in HIV treatment and prevention that UAC believes indicate for the first time that the opportunity exists to end AIDS. The interventions are high impact and cost effective, which UAC considers very appropriate for least developed countries with generalised epidemics such as Uganda.[111] UAC appears to have assumed that if the high impact, cost effective interventions are provided, people who need the services will take them up and the epidemic will be controlled.

UAC priorities and guidance have however not included a focus on reducing the structural barriers to uptake of these services, and have not addressed how to achieve the individual and societal changes needed to sustain adoption of health seeking behaviours and reduction of risk behaviours. The 2012 Progress Report to the United Nations General Assembly Special Session (UNGASS) acknowledged the importance of operating at society level to influence the risk factors for HIV infection. The report also stated that complex and intertwined factors shape or constrain individual behaviour such as condom use, number of sexual partners, comprehensive knowledge about HIV & AIDS, uptake of HIV & AIDS services including BCC, counselling and testing, PMTCT, ART services etc.[112] Structural factors including gender norms, gender relations, gender-based violence and stigma and discrimination are key drivers of the HIV epidemic in Uganda. Yet, in practice, little attention is given to these areas.

Further, little attention is given to meeting access to prevention, treatment, care and support by Ugandan fishing communities that total about 3 million persons and are the single largest MARP. HIV seroprevalence in this population is estimated to be 33%[113] – more than four times that of the general population. Low education levels, availability of disposable incomes and sex workers, violence including sexual violence and coerced sex are common in fishing communities. These are compounded by high mobility of men in fishing communities, geographical remoteness and inaccessibility; and lack of health service delivery infrastructure which combine to limit access to health care and HIV & AIDS services.[114]

Prevention

In the 1990s, messages supported a package of **A**bstain, **B**e faithful, and use **C**ondoms (ABC), with "zero grazing", a faithfulness slogan popularised by the Head of State. In 2004, the political climate change to favouring abstinence-only approaches in Uganda and UAC released a draft "Abstinence and Being Faithful (AB)" policy.[115]

From 2007, the NSP[116] established priorities for prevention and outlined imperatives for strengthening systems for service delivery. However, there are significant gaps in the

111 UAC (2012) N*ational Strategic Plan for HIV & AIDS 2011/12 -2014/15 (Revised).* Uganda AIDS Commission, Kampala.

112 Report (2012) *Global AIDS Response Progress Report, Country Progress Report Uganda.* Uganda AIDS Commission, Kampala.

113 Estimated by Uganda Fisheries and Fishing Communities Association from their work on HIV & AIDS with fishing communities throughout Uganda.

114 UAC (2007) *Moving Toward Universal Access: National HIV & AIDS Strategic Plan 2007/8 –2011/12.* Uganda AIDS Commission, Kampala.

115 http://www.hrw.org/en/reports/2005/03/29/less-they-know-better (Accessed 25 June 2013).

116 UAC (2007) *Moving Toward Universal Access: National HIV & AIDS Strategic Plan 2007/8 –2011/12.* Uganda AIDS Commission, Kampala.

situation analysis[117] and in the implementation imperatives. The NSP defines key populations at higher risk as "commercial sex workers and their clients, the military (uniform services), people engaging in transactional sex, truckers, fishermen, people who use condoms inconsistently, people engaging in multiple sexual relations, and people engaging in extramarital sexual relations." The NSP prevention goal had five objectives with partly measurable outcomes[118] detailed in Annex F. The National HIV Prevention Strategy for Uganda[119] identified key populations with HIV prevalence exceeding that in the general population as: sex workers (37%), fishing communities (15%), partners of sex workers (18%), "the small group of men with a history of having sex with men" (13%), and men who operate motor-cycle taxis (8%).

The UAC National Prevention Committee also received a detailed report[120] analysing the dynamics of the HIV epidemic against existing policies and provisions, that strongly argued that AB prevention had been disproportionately funded compared with other prevention interventions; and that "attention to structural and other underlying drivers of the epidemic is manifestly suboptimal". The National HIV Prevention Strategy affirmed that, "The first priority for HIV prevention in Uganda is to align HIV prevention interventions to the drivers of the epidemic. With approximately 80% of HIV infections arising from sexual transmission … the priority for Uganda is to adequately address the key driver of the epidemic within a generalised epidemic, i.e. HIV transmission through unprotected sex."[121] The Prevention Strategy rests heavily on biomedical interventions and individual behaviour change promoted by information, education and communication (IEC).

Sustaining comprehensive prevention initiatives needs a long-term strategy as well as a structural support mechanism. A general problem expressed to the evaluation by prevention grantees is that short funding periods combined with changes of focus in the solicitations have resulted in prevention initiatives coming to an halt after the CSF grant ends. Any structural approach to enabling and supporting CSOs seems to be weak, a shortcoming of the NSP and UAC as the Ugandan AIDS response is heavily dependent on CSOs. As it is the systems works against sustainable, comprehensive prevention efforts and programme design.

WHO and UNAIDS are unequivocal "with the right prevention interventions delivered within a human rights framework, infection with HIV can be controlled and possibly even eliminated".[122] A strong focus on preventing new HIV infections is highly relevant to achieving an AIDS transition. **A**bstain and **B**e faithful messages are often far from peoples' realities in Uganda and are not evidence-based but rather driven by political ideology and religious values. The MARPs Network reports that HIV efforts have not

117 op. cit., p12.
118 op. cit., p21-22.
119 UAC (2011) *The National HIV Prevention Strategy for Uganda: 2011-15.* Uganda AIDS Commission, Kampala).
120 Anon (2011) *Development of Uganda's HIV Prevention Strategy 2011-15 and National HIV Prevention Action Plan 2011/12- 2012/13 Volume 1: Report of the Review of the Magnitude and Dynamics of the HIV Epidemic and Existing HIV Prevention Policies and Programmes in Uganda.* Report submitted to UAC, Kampala. p. vi.
121 UAC (2012) *National Strategic Plan for HIV & AIDS 2011/12 -2014/15 (Revised).* Uganda AIDS Commission, Kampala.
122 http://www.who.int/hiv/pub/mtct/programmatic_update_tasp/en/ (Accessed 29 June 2013).

adequately focused on the needs of different MARP and that current interventions do not match the magnitude of the problem,[123, 124] leaving a huge HIV prevention service delivery gap for MARP. A 2009 review found that "there are no clear guidelines and policies guiding IEC, mass media, behavioural intervention, targeted services for MARP. Additionally that there are few outreach programmes for MARP and vulnerable populations. Despite the evidence of the risk factors and drivers of the epidemic, there are no policies targeting MARP."[125]

Prevention of mother-to child transmission

In line with the revised NSP for integration and linking prevention services, the Ministry of Health Sexually Transmitted Diseases/AIDS Control Programme published Integrated National Guidelines on ART, PMTCT, and Infant and Young Child Feeding in 2011.[126] In turn the objectives of the guidelines are with in line with the PMTCT scale up plan 2010-2015. However, PMTCT service provision is still very low in health centre-IIs, which make up the majority (70%) of health facilities in Uganda[127]. Further, the GoU acknowledges that "in some health units the mothers do not get quality PMTCT services, some get single dose nevirapine which offers low protection and have no capacity to try alternatives to breastfeeding and thus continue to expose babies".[128] In common with other countries in Sub-Saharan Africa, demand side barriers to PMTCT are likely to be structural. Lack of transportation and resources to attend antenatal care; pregnant women in labour unable to get to health facilities – particularly after dark – stigma and fear of violence and other abuse if a pregnant woman discloses to her partner that she is HIV positive[129]. CSOs are well placed to work with the MoH and other PMTCT service providers to address partner involvement and structural barriers to uptake of PMTCT services.

Treatment as prevention

Recent science has shown that when ART results in suppressed viral loads, it is also highly effective in preventing transmission to others. ART has the highest efficacy so far seen for any "real-world" HIV-prevention intervention. ART has a significant secondary prevention benefit for both HIV and tuberculosis[130] meaning that PLHIV on treatment are less likely to transmit HIV and tuberculosis to others. However, the efficacy of ART is limited by PLHIV knowledge of their HIV serostatus which is often years after they are first infected and become infectious. No HIV prevention intervention will be fully

123 Report (2011) *MARPs Network Programme Document 2011-2014.* MARPs Network, Kampala.
124 Report (2012) *Annual Performance Draft Report.* MARPs Network, Kampala.
125 UAC (2009) *Uganda HIV Prevention Response and Modes of Transmission Analysis.* Uganda AIDS Commission, Kampala.
126 Guidelines (2011) *Integrated National Guidelines on ART, PMTCT, and IYCF.* Ministry of Health, Kampala.
127 Report (2012) *Annual Health Sector Performance Report FY 2011/12.* Ministry of Health, Kampala.
128 Report (2012) *Global AIDS Response Progress Report: Country Progress Report.* Uganda AIDS Commission, Kampala.
129 Pregnancy is a time of increased experience of violence in Uganda as globally; research has demonstrated fear of violence is an important determinant of willingness to disclose HIV status: see Hope R (ed) (2004) *Women's Experiences with HIV Serodisclosure in Africa: Implications for VCT and PMTCT. Meeting Report.* USAID/The Synergy Project, Washington, DC.
130 Programmatic Update (2012) *Antiretroviral Treatment as Prevention (TasP) of HIV and TB.* World Health Organization, Geneva.

protective, and so there will always be need for multiple HIV prevention strategies as well as interventions that reduce HIV infectiousness & susceptibility.[131]

HIV counselling and testing
The GoU regards counselling and testing as a prevention strategy with the assumption that knowing their status is effective in enabling people to make risk reducing changes in their behaviour. From 2010 to 2011, the MoH rapidly scaled up HIV counselling and testing services to being available at all hospitals and health centre-IVs (county level health centres), 80% of health centre-IIIs (sub-county level health centres) and 22% of health centre-II facilities, (parish level health centres), although only 5% of facilities offer youth-friendly HIV counselling and testing.

The number of clients tested for HIV increased from 1,176,822 in 2008 to 1,846,175 in 2009 and 2,037,342 in 2010.[132] These figures are not clear cut: in evaluation interviews, significant numbers of respondents in fishing communities in Kampala said that they went for an HIV-test every second week as they did not believe in the results given (that they were HIV negative). One respondent's father had been pressed into taking a test by a programme even though he was on ART, seemingly as a result of the programme need to attain targets for numbers tested. Respondents said that they gave no personal data when they went for a test. Thus, the MoH HIV counselling and testing programme had no system for tracking a person's results over time.

Safe male circumcision
Research in Uganda and elsewhere[133] has demonstrated that medical male circumcision reduces the risk of female-to-male transmission by 60%.[134] This influenced the revised NSP and the HIV and AIDS Prevention Policy and the MoH issued a Safe male circumcision *policy* in 2010.[135] Provision in public health facilities is free. Nonetheless, uptake of services is slow due as much to demand side issues – men's fear of the operation – as it is to supply side issues such as staff training or resource constraints. One barrier is a male perception that circumcision is "Islamisation". Sexuality is not discussed in the Ministry policy, but male (and female) beliefs about sexuality are likely to be a further barrier to demand.

Male and female condom use
Although having multiple sexual partners is common for men in Uganda, almost one in five of all men age 15-49 (19%) reported having two or more sexual partners in the previous year in 2011, condom usage is low. Among those with two or more partners, condom use at the last sexual intercourse is 15% for men. Only 38%[136] of men reported

131 Ryan, C (2010) *Meeting Objectives and HIV prevention in the PEPFAR Context.* Presentation at PEPFAR Expert Consultation on Unresolved Issues in HIV Prevention Programming in Generalized Epidemics (November 8-9 2010) http://www.pepfar.gov/documents/organization/166389.pdf (Accessed 29 June 2013).
132 Report (2012) *Global AIDS Response Progress Report: Country Progress Report.* Uganda AIDS Commission, Kampala
133 Kenya and South Africa.
134 http://clinicaltrials.gov/show/NCT00425984 (Accessed 1 July 2013).
135 MoH (2010) *Safe Male Circumcision Policy.* Ministry of Health, Kampala.
136 This represents a sharp decline from the 47% of men and women in this age group who used condoms during high-risk sex in 2005: http://reliefweb.int/report/uganda/condoms-continue-confound-uganda (Accessed 1 July 2013).

using condoms at the most recent high-risk sex.[137] If condom promotion is to work, supplies need to be sustainable, affordable and of good quality.

A MoH condom programme coordinator reported that although Uganda requires some 240 million condoms annually, the public sector procures just half that and some years, as few as 80 million.[138] Uganda financial expenditure on condoms in 2008/09 was only USD 2 million per annum.[139] Following a pilot initiative for the re-introduction of the female condom, a national condom strategy that addresses sustainable access and utilisation of quality male and female condoms was launched in 2011.[140] The 2012 Annual Health Sector Performance Report indicates that 78% of health facilities provide male condoms and 8% female condoms in 2011/12.[141] The UNFPA programme supported by Danida has been instrumental in development of the MoH condom strategy, making condoms more widely available and in reaching youth with life skills through FBO networks (See Annex B).

Prevention knowledge gaps
There is limited data on behavioural interventions, incidence trends, and size and geographic spread of many MARPs. There is evidence from small scale surveys in Uganda on the need to prioritise HIV information and services to couples where one partner has tested positive for HIV and the other not. Evidence from these surveys also suggests that MARP groups with high prevalence of HIV, being marginalised and underserved, should be prioritised. No systematic assessment of gaps in knowledge has however been conducted as a basis for prioritisation of funding of HIV research in Uganda. [142] The five year behavioural surveillance surveys do not include all the indicators needed for understanding prevention outcomes.

There is therefore a pressing need for operational research to (1) fill knowledge gaps on how best to increase uptake and continued use of prevention information and services particularly by MARP and couples where one partner is HIV positive; (2) ensure prevention information and services are meeting the needs of those most affected: and (3) enable scale up of what works.

Treatment
Uganda was among the first African countries where provision of ART was available. In the late 1990s treatment was initially available in the private sector followed by more widespread public sector provision from 2004.[143] Since 2005, availability of ART has increased dramatically with assistance from PEPFAR and a contribution from GFATM. Increased access to treatment has reduced HIV-related mortality, and reduced transmission of HIV to others by people living with HIV on treatment (secondary prevention).

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137 Ministry of Health (2012). *2011 Uganda AIDS Indicator Survey: Key Findings.* ICF International, Maryland.
138 Irin Africa (2013) A*nalysis: Condoms continue to confound Uganda* http://www.irinnews.org/report/97573/analysis-condoms-continue-to-confound-uganda
139 Health systems 20/20 (2012) *Uganda Health Systems Assessment 2011.* Abt Associates, Bethesda, Maryland.
140 Report (2012) *Global AIDS Response Progress Report: Country Progress Report.* Uganda AIDS Commission, Kampala.
141 Report (2012) *Annual Health Sector Performance Report FY 2011/12.* Ministry of Health, Kampala.
142 Evaluation key informant interview with UAC.
143 http://www.mrcuganda.org/research/hivaids-care-research-programme/ (Accessed 28/06/213).

The NSP treatment goal was to increase equitable access to ART by those in need, from 105,000 to 240,000 by 2012.[144] Uganda enrolled an estimated 65,493 new PLHIV on ART in 2012, bringing to 356,056 the number of those receiving ART, nearly 50% more than the NSP target.

In line with the revised NSP and National HIV Prevention Strategy and Plan, the MoH published detailed guidelines on integrated ART, PMTCT and infant and young child nutrition in 2011.[145] UAC reported that in 2009, the proportion of clients still on treatment after 12 months was 82.5%. This increased to 83.6% and 84.1% in 2010 and 2011 respectively. The improvement in ART outcomes over time has also been recorded in terms of the facilities providing data that also increased from 186 in 2010 and 191 in 2011.[146]

A study in Uganda showed that those who adhere to effective antiretroviral treatment and care experience a very similar life expectancy to the national average of 55.[147] Unfortunately, Uganda's HIV programmes have been hit hard by a funding crunch, due to the financial crisis, limiting its ability to operate HIV programmes. Of the 700 health facilities listed by the government as offering ART, only 532 were doing so by end of March 2012.[148]

Care and Support

Access to care services and support is one of the four key components in the National AIDS Strategy and is prioritised in the NSP, and the MoH AIDS Control Plan. NSP budget allocations for care services only are, however, very modest, reflecting the expectation that these services will be largely provided by CSOs. The NSP goal for treatment and care was: to improve the quality of life of PLHIV by mitigating the health effects of HIV/AIDS by 2012[149] (updated to 2015 in the revised NSP[150]). The objectives specifically related to care in NSP are to: increase access to prevention & treatment of opportunistic infections including tuberculosis; integrate prevention into all care and treatment services by 2012; support and expand the provision of home based care and strengthening referral systems to other health facilities, and provide complementary support including nutrition to PLHIV. The model of care integral to the NSP is an adaptation of the "continuum of holistic care" model promoted by UNAIDS since 2000.[151] The model for comprehensive, quality care services is promoted in the various MoH policies and guidelines and in the training programmes offered by organisations

144 UAC (2007) *Moving Toward Universal Access: National HIV & AIDS Strategic Plan 2007/8 –2011/12.* Uganda AIDS Commission, Kampala, p. 24.

145 Guidelines (2011) *Integrated National Guidelines on ART, PMTCT, and IYCF.* Ministry of Health, Kampala.

146 Report (2012) *Global AIDS Response Progress Report: Country Progress Report.* Uganda AIDS Commission, Kampala.

147 Mills, EJ et al (2011) *Life Expectancy of Persons Receiving Combination Antiretroviral Therapy in Low-Income Countries: A Cohort Analysis from Uganda.* Ann Intern Med; 155(4): 209-216.

148 http://www.irinnews.org/report/97184/hiv-aids-uganda-still-behind-on-arv-target (Accessed 2 June 2013).

149 UAC (2007) *Moving Toward Universal Access: National HIV & AIDS Strategic Plan 2007/8 –2011/12.* Uganda AIDS Commission, Kampala, p. viii.

150 UAC (2011) *National HIV and AIDS Monitoring and Evaluation Plan 2011/12 to 2014/15.* Uganda AIDS Commission, Kampala.

151 Best Practice Series (2000) *AIDS: Palliative Care: UNAIDS Technical Update.* Joint UN Programme on HIV/AIDS, Geneva.

including TASO and Hospice Africa, Uganda. The biggest obstacle to improving the quality of life of PLHIV by mitigating the health effects of HIV & AIDS is that most PLHIV have inadequate access to care (57% of people in Uganda do not have access to a health worker.)[152] Health facility-based care is generally outpatient, focused on prevention, diagnosis and management of tuberculosis, other opportunistic infections, and sexually transmitted infections, and addressing wider positive health needs such as need for family planning.

The essence of care and social support services is outlined in the NSP and in a number of additional guiding documents. A very diverse set of MARP is prioritised in the revised NSP and some of their specific needs are alluded to. However, a description of what the specific needs are and how to meet them is lacking. For PLHIV with special needs, such as MSM and sex workers, the evaluation only heard of one treatment and care service designed to meet MSM and sex workers specific needs – MARPI, a unit of the Mulago Teaching Hospital Sexually Transmitted Infections Clinic. There the staff are said by MSM and sex worker representatives the evaluation interviewed, to be accepting and supportive, and protect the clients' privacy. The MSM and sex worker representatives told the evaluation that staff at MoH facilities in general still have stigmatising and negative attitudes towards men who have sex with men and sex workers and so these clients only go to MoH facilities when they have no alternative and are very ill.

HIV/AIDS and human rights

Human rights are fundamental to the health and wellbeing of people, including access to health care and treatment. The NSP states it is responsive to international and regional HIV and rights agreements. These international agreements are crucial as they inform the work of development actors, help set common standards, sensitise stakeholders on their role as duty-bearers, and respond to the obligation to promote, assist, protect, and fulfil human rights. They also promote a human rights approach that will ultimately empower rights claimants through ensuring their participation in programmes designed to address gender inequity and HIV & AIDS.

The Open Society Initiative for East Africa and the Open Society Initiative's Law and Health Initiative consider that widespread human rights abuses and lack of legal services is fuelling Uganda's HIV epidemic. Their 2008 publication *HIV/AIDS, Human Rights, and Legal Services in Uganda*[153] documents common abuses faced by people living with AIDS or at high risk of HIV, including: barriers to employment or education; discrimination in gaining access to medical care; violations of the right to medical privacy; forced HIV testing; and eviction from housing. This is especially true for marginalised populations who are most vulnerable to HIV-related human rights abuses: women; sex workers; OVC; lesbian, gay, bisexual, transgender, intersex (LGBTI) individuals; and internally displaced persons.

In the outline of the three NSP thematic service areas, human rights is only addressed in the social support section, where it states that the impact of HIV & AIDS has affected all realms of social life. Discrimination on the basis of HIV status sets in motion a string of human rights violations and calls for legal protection. Uganda has not expanded services for sex workers, MSM and injecting drug users, and does not report on these services

152 Report (2013). *Annual Report 2011-2012.* Hospice Africa Uganda, Kampala.

153 Mukasa, S & Gathumbi, A (2008) *HIV/AIDS, Human Rights, and Legal Services in Uganda: A Country Assessment.* Open Society Institute for East Africa, Nairobi.

to WHO/UNAIDS. Also, the NSP remains silent on how to meet the HIV & AIDS prevention, diagnosis, treatment care and support needs of these individuals who it acknowledges are at most risk of HIV infection. They are also a significant bridge for HIV infection into the wider community.

Uganda has signed international key documents for human rights. However, the GoU is not applying these human rights instruments to everyone in Uganda and is under criticism internationally. Provisions of the HIV/AIDS Prevention and Control Bill[154] prohibit LBGTI individuals from practicing their sexuality.

The NSP assumes that an individual has autonomy to make and act on his/her own choices. Little consideration is given to individual agency in decision making and behaviour being constrained or shaped by structures in the social context. Yet the limited research on MSM in Uganda[155] demonstrates that the majority of MSM have at some stage had sex with women or have been married: situations that occur because of family and societal pressure to marry, and violence and discrimination against MSM. For effective prevention, coordination is needed so that interventions are supported on a structural level and are not implemented in isolation. Thus, the issue of human rights is of crucial important as it directs the way interventions can work effectively and meet the health and HIV needs of different populations in society.

UAC reported to UNGASS in 2012 "... sexual intercourse between consenting adults of the same sex is a crime in Uganda. In this regard, (a) the proposals in the Anti-Homosexuality Bill aims to extend this criminal sanctions even further (b) a number of provisions of the HIV/AIDS Prevention and Control Bill prohibit of Lesbian, Gay, Bisexual, Transgender and Intersex (LGBTI) persons from practicing their sexual beliefs. This is despite the findings from a study conducted by the School of Public Health of Makerere University and the AIDS Control Programme of the Ministry of Health on Men who have Sex with Men (MSM) that: 31% of MSM had ever been married and 20% of them were currently married; 78% of them had ever had sex with a woman; 44% had ever lived with a female sex partner; 16% were currently living with a female sex partner and 29% had fathered children. Against this background the NSP 2007/08-2011/12 did not cover MSM. Hence, there are virtually no tailored services available for MSM; the minimal services such as sensitization and awareness are mainly provided by CSOs and no direct service at all for MSM is provided by government.

Religious leaders including Muslim, Catholic, Anglican and Pentecostal and other Christian churches in Uganda have expressed almost violent hatred and repressive attitudes against LGBTI individuals. The Ugandan response to the HIV epidemic is heavily influenced by religious values, and these MARP are excluded on all levels, in violation of their human rights. MSM interviewed by the evaluation reported that many sexual

154 This draft Bill may be made obsolete by the East Africa Community HIV and AIDS Prevention and Management Bill (2012) that was passed on 23 April 2012. The President of Uganda assented to the EAC Bill in March 2013. All five the EAC Heads of State must assent to the bill before it can become an Act of the East African Community. Kabumba Busingye, a Ugandan lecturer of law and gay rights advocate, asserts that national parliaments will then have to ratify the East African bill and synchronise it with local law.

155 Report (2010) *The Crane Survey Report: High Risk Group Surveys Conducted in 2008/9.* Kampala, Uganda: Makerere University, Kampala.

minorities, particularly transgendered persons, only seek medical care when they are very sick because of the fear of discrimination and lack of confidentiality by health workers.

Prostitution is a criminal offence in Uganda punishable with seven years' imprisonment, although there is no law against procuring the services of sex workers. This effectively limits criminal punishment to sex workers who are mainly women, and not to the persons to whom sex workers provide services, who are overwhelmingly men. That sex work is illegal under the provisions of the Ugandan Penal Code Act, affects and restricts HIV prevention, treatment, care and social support that are available to sex workers.

The evaluation visited fishing communities in Kampala, Entebbe, Buikwe and Kasese. It was clear to the evaluation that the fishing communities are a large and important at risk population and yet they are marginalised and excluded from effective health promotion and virtually all HIV services, in violation of their human rights. This is a widespread, not an isolated, problem and there seemingly isn't the political will or leadership within the health sector to address the communities' needs.

Donor perspectives on human rights:
Human Rights are of prime importance to Danida and Irish Aid, as they are to Sida and other Scandinavian donors in Uganda. USAID emphasized USG strong domestic commitment and legislation addressing discrimination which is mirrored in USAID's approaches. Danida specifically treats the rights of MSM as a human rights issue at the highest level and supports rights of sexual minorities by:

1) engaging in human rights policy and dialogue at the highest level;

2) inclusion of MSM in MARP support;

3) dialogue on MARP in the CSF;

4) supporting services inclusive of MSM through health facilities; and

5) support to "Ice Breakers", a regional project implemented by the International HIV/AIDS Alliance, ensuring availability of health services for MSM in Uganda (at Mulago Hospital, Kampala), and in Tanzania, Kenya and Zimbabwe.

Donors reported that their embassies are involved in quiet diplomacy in relation to the Anti-Homosexuality Bill, where the issue is tabled in all high level meetings with the GoU. They stated that overt action by donors would be counterproductive. The evaluation met with three office bearers from Sexual Minorities Uganda (SMUG) who confirmed the difficulties and widespread harassment experienced by MSM and others in the LBGTI community, and that quiet diplomacy is the best way forward.

4.2 Implementation of NSP through civil society

The CSF was established to support CSOs to implement their role within the NSP as reflected in the objectives for the CSF and its strategic planning. The NSP also gives direction on how the CSF should facilitate achievement of the GoU goals to tackle the HIV epidemic, as CSO programmes are a crucial component of the national response.

The DFID-funded review of the CSF[156] identified that the NSP, which provides the framework for the CSF, does not provide a vision for the role and comparative advantage of CSOs in the national response. Resulting from compromises made during the design phase, the scope of the CSF was broad and included OVC, malaria and tuberculosis and the CSF purpose statement became long and unspecific. This context fosters continuing debates among stakeholders about CSF priorities and strategies that hamper progress.[157]

CSOs often have collegial organisational cultures arising from their activities either (1) representing specific stakeholders, with office bearers democratically elected for fixed terms, or (2) working in communities, developing rapport and trust by being facilitative in style and responsive to local needs. In contrast, the CSF is managed by management agents who are accountable through their contracts to USAID, and have adopted a top down, directive style designed for business efficiency in getting activities done, monitored and reported on.

The evaluation elicited countless complaints from CSOs from national to community level about their lack of voice in the management of the CSF and the lack of platforms within the CSF for sharing CSO programming experience and perspectives.[158] Some of the complaints, for example CSO representatives being asked to step out of Steering Committee meetings, may indicate a lack of CSO understanding of conflict of interest procedures. Such a misunderstanding, if it exists, is indicative of communication problems within the management and governance of the CSF.

A civil society group was observed by the evaluation conducting community dialogue. The District AIDS Focal Person had been invited to participate as a technical resource person, but had not because she had no longer had Partnership Funds from UAC for travel.[159] The civil society group were enthusiastic and clearly committed but expressed anger that they had been instructed by their national umbrella organisations to form a local consortium, in order to receive CSF grant funding. These local organisations had had no input into the grant-funded project design and no control over commitments made for them to conduct activities. They had determined to take back control over their organisations by developing a constitution and rules for their local consortium to enable it to register as association, and again having a voice.

Civil society advocacy

CSOs in Uganda have long engaged in AIDS-related advocacy and were vocal in advocating for access to treatment, and universal prevention, treatment and care. Yet, the CSO role in advocacy has not been clearly articulated making it difficult to hold CSOs accountable for their action or inaction. CSOs have a place at the table on three of the most important forums for decision making regarding HIV, the GFATM Country Coordinating Mechanism, the UAC Partnership Committee and CSF Steering Committee, and are also on major national consultative forums. Civil society is a co-chair on Country Coordinating Mechanism and CSF Steering Committee. Civil society also

156 Janssen, PL & Mwijuka, B. (2009) *Review of The Civil Society Fund, Uganda*. DFID Health Resource Centre, London.

157 ibid.

158 Only one of the presentations at the CSF Annual Review Meeting Day 1 was by a CSO representative and this presentation stated as a challenge "Lack of platform for sharing information and leveraging among sub-grantees".

159 The CSO staff and volunteers also had no funding for travel but were willing to walk to the meeting.

facilitated the long-term institutional arrangements provision by identifying their own principal recipient for the GFATM: TASO was appointed as the second principal recipient through a competitive bidding process.

CSOs have played a critical role through activities like shadow reporting on:

(1) performance of the health sector[160],

(2) availability and regular supply of antiretroviral drugs to government health centres; and

(3) advocacy for allocation of resources for ART by government and development partners;

(4) for a return of female condoms to the public domain. Civil Society is part of the Annual Performance review of sectors including the health sector Joint Review Mission and Joint Health Assembly.

However, UAC reports that CSOs in general remain weak in their capacities for governance, management, advocacy and service delivery. There is no comprehensive strategic direction for capacity building for CSOs in advocacy that partners might contribute to.[161]

Networks, linkages and partnership

The MoH approved a public private partnership policy for health paving the way for a more organised engagement for civil society with the health sector in health facility-based services. To this end, the civil society related self-coordinating entities established the Civil Society Inter-Constituency Coordination Committee which helps in coordinating and harmonising civil society views.[162] Coalitions and partnerships have also been formed to address areas of concern. For example, in 2008 a Consortium of Advocates for Access to Treatment comprising of both treatment providers and the beneficiaries (PLHIV), government and development partners, private not for profit and private for profit organisations, health action groups and human rights and advocates groups was established. The purpose was to advocate for immediate and sustainable comprehensive access to treatment to at least 80% of Ugandans in urgent need of treatment.

Information sharing within networks at national and district level remains weak due to weak leadership and limited inter-network linkages even with the existence of umbrella organisations such as Uganda Network of AIDS Service Organisations, the National Forum for PLHIV Networks in Uganda, Uganda Network on Law, Ethics and HIV/AIDS, Uganda Network of Religion Leaders Living and Affected by HIV/AIDS, National Community of Women Living with AIDS, National Guidance and Empowerment Network of People Living with HIV/AIDS. This has affected the referral mechanisms, documentation and knowledge management, leveraging of resources and

160 Report (2012) *Civil Society Organisation (CSO) shadow report on the performance of the Health Sector in 2011/2012*. Action Group for Health, Human Rights and HIV/AIDS, Kampala.

161 UAC (2011) *Midterm Review of the National HIV/AIDS Strategic Plan 2007/8-2011/12: Systems strengthening component*. Uganda AIDS Commission, Kampala.

162 Galla, AS et al. (2008) *Harmonizing civil society organizations in Uganda*. AIDS 2008 - XVII International AIDS Conference: Abstract no. MOPE0927.

in effects, effective delivery of services. Efforts to exploit synergies have been replaced with competition for available funding sources.[163]

Prevention
The CSF provides CSOs with grants in a competitive manner through solicitations for applications. The solicitations direct the focus of the grants to be awarded. The early CSF prevention grants awarded were aligned with the NSP prevention Objective 1, prevention activities, largely built around individual behaviour change fostered by IEC.

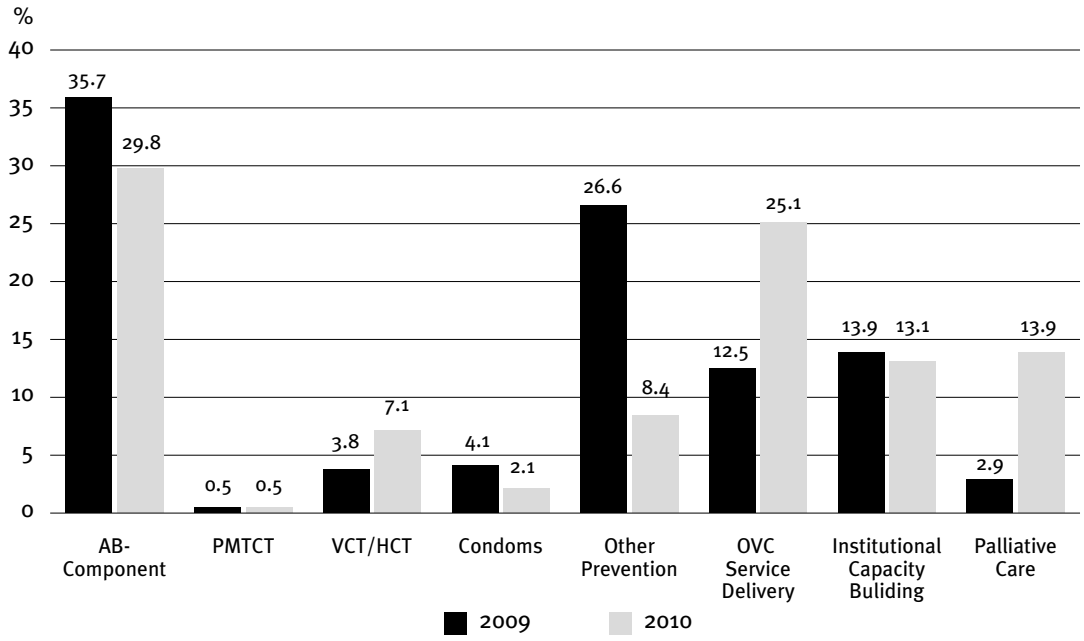
The National HIV Prevention Strategy informs that "The Civil Society Fund, by June 2009, … had disbursed 51% of its HIV prevention resources … to abstinence and be faithful activities, 0.7% to PMTCT, 5.4% to HIV counselling and testing, 5.8% to condoms and 38% to other HIV prevention activities (MARP, medical infection control, and circumcision). The disbursements are not aligned to the Modes of Transmission, being mainly behavioural, socio-economic and structural factors."[164]

Figure 4, below, shows the distribution of CSF grants for 2009 and 2010. The DFID-funded 2009 review identified that nearly half of the prevention grants at that time focused on abstinence and faithfulness.[165] By June 2009 it was reported as 51%.[166] Latterly, the distribution of grants has reflected the five objectives outlined in the NSP and currently the Minimum Package of HIV Prevention Services for Adults defined by the National HIV Prevention strategy.

Most CSF grants are now awarded for combination prevention themes: BCC programming, condom distribution, HIV counselling and testing, and PMTCT.

163 UAC (2011); *Midterm Review Report of the National HIV/AIDS Strategic Plan 2007/8-2011/12; Systems strengthening component*. Uganda AIDS Commission, Kampala.
164 Triangulated with: Janssen, PL & Mwijuka, B. (2009) *Review of The Civil Society Fund, Uganda*. DFID Health Resource Centre, London Table 4, which was based on data from the FMA.
165 Janssen, PL & Mwijuka, B. (2009) *Review of The Civil Society Fund, Uganda*. DFID Health Resource Centre, London, Table 4. (Based on data provided by the FMA).
166 UAC (2011) *The National HIV Prevention Strategy for Uganda: 2011-15*. Uganda AIDS Commission, Kampala (draft only accessed).

Figure 4 Distribution of CSF Grants for Financial Year 2009 and for 2010[167]



Legend: VCT/HCT = voluntary counselling and test for HIV/HIV counselling and testing

MEEPP data for performance trends from 2010 to 2013 indicate that CSF grants are reporting against sexual prevention (ABC/AB). CSF grants report by the audience for HIV prevention activities. MEEPP provided data for 2010 to 2013 on total number of MARP reached with individual and or small group level HIV preventive interventions that are based on evidence and/or meet the minimum standards required; and from 2011 the numbers of commercial sex workers, truckers, fisher-folks, incarcerated populations (prisoners) uniformed services group reached. Total MARP reached (2011-2013) is reported as 184,155 with 47% reported as fisher folk. The indicators do not capture whether the prevention activities are iterative, quality BCC that might influence structural, social change as well as individual behaviour change.

HIV counselling and testing is offered in the community by an increasing number of CSOs. Some CSOs have adjusted counselling and testing service hours to increase availability to men who are only free after working hours.

No grantees interviewed had received technical capacity building in prevention. Several CSOs interviewed had relatively developed individual behaviour change and IEC strategies with different synergetic components, such as peer education, counselling and supporting radio shows. Because CSF solicitations clearly direct organisations on what they can do and where they can carry out an activity, such developed strategies with a comprehensive design cannot be implemented with CSF funding.

Safe male circumcision
In 2012 CSF grantees had a target of providing 2,000 Safe Male Circumcisions and reported 3,526 to MEEPP, a performance achievement of 176%. The evaluation visited

167 Adapted from Figure 36: Utilization of CSF in the AIDS Response in Report (2012) *Global AIDS Response Progress Report, Country Progress Report Uganda*. Uganda AIDS Commission, Kampala.

a CSF grantee in Mbarara that offers male circumcision. The service, in a static clinic in a residential neighbourhood, seemed well organised, safe and appropriate for a low income setting. Unfortunately, the grantee is dependent solely on the CSF grant of 18 months duration and thus the sustainability of the service is in doubt. The evaluation visited another CSO safe male circumcision service organised in one-day camps. The organisation did not allow for pre-counselling or follow up care, and thus opportunity for education about HIV prevention and for discovering post circumcision complications was lost.

Male and female condom use
The CSF made available 14,500,000 condoms through 3,500 outlets in 2012/13[168] although the targeting is not known. The evaluation did not see a prioritised distribution plan or list.

Treatment
Although some of the NNGOs provide ART services, as PEPFAR implementing partners or with the support of the MoH, no CSF grant funding is offered for ART services.

Care and Support
Most care is provided in the home by family and community members, supplemented by support from CSOs and FBOs, and the GoU health and welfare systems. Many patients are referred after being diagnosed with HIV; others are referred by community volunteers, and again others through self- or family-referral.

At all CSO programmes visited, the evaluation was told that their staff are trained to be inclusive and non-discriminatory. The CSOs stated that MSM and sex workers are served as PLHIV, and not registered as belonging to any particular risk population. It was acknowledged by the CSOs that the specific needs of MSM in particular are only partially met in this manner. Examples and anecdotal evidence of improvements of quality of life of PLHIV through provision of care services were plenty in Hospice Africa, TASO, and in some of the smaller CSOs.

The numbers of CSOs involved in providing community-based and home-based care has increased. Access to care services and support is prioritised in the CSF Three-Year Strategic Plan 2009-2012 and solicitations. "HIV care" is a prioritised area in the current CSF portfolio.[169] However, CSF supports only a small proportion of the CSOs in Uganda: in 2012/13 only four grantees in 26 districts were supported to provide HIV care and support. The majority of CSOs providing care and support are not supported by the CSF. As of financial year 2012, CSF grantees were providing care and support, clinical and non-clinical services, to 78,383 adult and children PLHIV.[170,171] Between April 2008 and March 2012, CSF-funded CSOs provided services to more than 300,000 OVC who benefitted from improved access to education, social economic empowerment, food security, child protection, psycho-social support, care and support, and legal support. In

168 Evaluation Key Informant Interview with a CSO in Mukono District.
169 CSF (2013) *Annual Review Meeting Presentation: CSF Results Chain, 2013/2014.*
170 MEEPP data.
171 Additionally MEEPP confirms that in financial year 2011, 98,795 eligible orphans and vulnerable children received assistance through CSF grants; this fell to 76,646 in financial year 2012 as OVC grants expired.

FY 2012,[172] 89% of PLHIV served received psychological counselling, although far fewer received social support, because the grant funding for OVC from USAID had ended.

Continuity of care services is not guaranteed beyond the grant-funding period that CSF offered. The evaluation heard of CSOs that had either stopped or would stop providing care services once their CSF grant was over. The Technical Management Agent confirmed that some CSOs ceased to be after their CSF grant ended. The lucky few have access to superior care services provided in a holistic manner, for example from Hospice Africa Uganda and TASO; many others only have access to more basic forms of care support in the home or health centres or to services that do not meet their needs. Many MSM, sex workers, migrants, and fishing communities have very limited or no access to services. In terms of equal and universal access to care, there is still a long way to go.

Of the CSOs visited, only the bigger and longstanding NNGOs (Hospice Africa Uganda and TASO) were able to provide comprehensive, quality care services as a standard. Many others provide adequate treatment support, physical, emotional and sometimes spiritual care to the PLHIV, but often ignore the social, nutritional and other needs of the PLHIV and the family (future orphans). Hospice Africa, Uganda's "Centre of Excellency" model[173] offers a very high standard of palliative care. Compared with other care programmes such as TASO, the number in home-based care is relatively low, but the care is comprehensive, personalised, and frequent. TASO provides high quality care through collaboration with the public health system. The approach links prevention, counselling, early diagnosis, treatment, care and social support. TASO focuses on the individual client and his/her family *and* on communities. TASO has developed other comparative advantages: (1) vast experience in building institutional capacity of smaller CSOs and (2) ability to conduct research that improves quality of care.

Resource mobilisation

The evaluation key informant interviews with CSOs elicited that resource mobilisation among NNGOs and CSOs at community level remains a big challenge. Although some NNGOs have central fundraising departments adept at proposal writing and attracting donor funds, others are suffering greatly from diminishing flow of donor funds. CSF grants to NNGOs are clearly important sources of resources and it was apparent to the evaluation that many, if not all NNGOs, have taken on grant activities outside their traditional roles and core competencies in order to attract CSF funding. Smaller CSOs are very vulnerable to loss of CSF grants and have limited capacity to compete for funding with the larger more established NNGOs. There were several reports to the evaluation, confirmed by the Technical Management Agent, that there were CSOs set up solely to receive a CSF grant that closed down at the end of the grant. Although the Partnership Fund was supposed to strengthen capacities of CSOs, it is limited to building capacities of NNGOs that are self-governing entities. Self-coordinating entities are defined as "clusters of HIV & AIDS stakeholders that have something in common (see Footnote 61). Smaller CSOs often perceive that the CSF favours the established NNGOs and has little focus on supporting small CSOs to access funding, although there have been solicitations that are set aside for smaller CSOs.

172 CSF (2013) *Annual Review Meeting Presentation.*

173 See details in Annex B Summary of Danida Support to three NNGOs.

5 Overall Conclusions

This chapter provides the evaluation of key findings and main conclusions related to the key evaluation questions.

1. HIV epidemic in Uganda is essentially stable, and is not yet moving towards an AIDS transition.

(1. Has Uganda made progress towards the AIDS transition? Is the epidemic under control or is it still growing?)

In 2007, despite a drop in prevalence over the previous two decades, there was still a high and increasing number of PLHIV, and high incidence among specific MARP. The NSP gave directions, an outline of the work that had been undertaken and also changes and adjustments needed to more adequately address the epidemic. Since then, research studies have indicated an increase in incidence in some areas of the country. UNAIDS defines stable epidemics as being in those countries with incidence rate changes less than 25% up or down.[174] As the increase in incidence indicated by the research studies is less than 25%, the evidence is that the HIV epidemic in Uganda is essentially stable, and is not yet moving towards an AIDS transition.

However, a more nuanced assessment requires a comparison of Uganda's own ability to handle and address the HIV epidemic to the overall investments required to reverse the epidemic. With domestic investments only about 10% of the AIDS resource envelope,[175] and with a revised NSP that lacks key components for effective prevention,[176] progress towards controlling the epidemic has come to a halt. The prevention goal of the revised NSP was revised downwards from the NSP, and became "reduce HIV incidence by 30% by 2015" whereas it had been "reduce HIV incidence by 40% by 2012". UAC needed to re-assess the goal in an attempt to reach a target that was initially too ambitious or that the structural set up could not meet. Nonetheless, the revised NSP and its targets represent a new compact of national commitment in responding to the epidemic.[177] This might potentially be implemented with civil society effectively mobilised to facilitate comprehensive behaviour change with individuals and society, and effectively address many of the structural barriers to effective prevention.

174 UNAIDS (2012) *Report on the Global AIDS epidemic.* Joint United Nations Programme on HIV/AIDS, Geneva.

175 UAC (2012) National AIDS Spending Assessment, Uganda 208/9 to 2009/10, Uganda AIDS Commission, Kampala.

176 Including silence on how to address the prevention, diagnosis, care and treatment of key MARP, and lack of guidance on addressing structural issues, with bald emphasis on biomedical prevention interventions without due linking to sustained community mobilisation and BCC for social as well as individual change.

177 Report (2012) *Global AIDS Response Progress Report: Country Progress Report.* Uganda AIDS Commission, Kampala.

Historically, before the availability of ART, the falling prevalence[178] in Uganda was seen internationally as a success story. CSOs played a vital role[179] widely disseminating BCC messages that raised awareness, fought HIV stigma, and advocated for prevention through abstinence, faithfulness, and condom use. However, the key role played by CSOs, and defined by civil society at the time, seems not now part of the collective memory. Civil society potential within the Uganda AIDS response is no longer fully harnessed; the original civil society role needs iterating and adapting again and again with each generation, particularly now that scientific advances have identified biomedical prevention interventions that can only be effective if fully utilised and new health behaviours are adopted and sustained.

There remains huge need for civil society involvement, drawing on CSO comparative advantage, addressing societal structural change that can make the way for and support individual behaviour change. Societal structural change supporting individual behaviour change is vital for both (1) pushing the rate of new infections down and (2) sustaining demand for and adherence to treatment, keeping HIV-related mortality down. Only then will the total number of people living with HIV begin to decline. Further, with 90% of the resource envelope for the Ugandan AIDS Response coming from external sources, the services currently provided are vulnerable to changes in donor priorities. The MoH is in dire need of adequate resources to deliver the necessary HIV services. To sustainably achieve an AIDS transition, Uganda will need to fully harness the CSO potential particularly in the area of comprehensive behaviour change for effective prevention and increase government commitment through greater national resourcing of the AIDS response.

2. Outcomes of the National Strategic Plan and donors' contributions

(2. Has the Danish/Irish/USAID support contributed to achieving the results that the National Strategy set out to achieve?)

The joint donor support to the Partnership Fund has been vital to enabling UAC coordination of the national response. It has provided cost support to certain CSO self-coordinating entities ensuring their existence and removing the financial struggle to survive. The joint donor support has also been important for funding CSO prevention and care and support programmes.

The importance of donor support is demonstrated by the hiatus in availability of resources from the Partnership Fund[180] at district level. This greatly hampered coordination and technical oversight of the district level response by District AIDS Focal Persons, with district structures being in name only rather than active in the AIDS response.

However, the National Strategy has not achieved its prevention results in part because of (1) serious gaps in its approach to prevention, (2) skewed allocation of resources to implementing the components of the NSP with inadequate funding for prevention, and (3) because of GoU under-funding line ministries, particularly the MoH, resulting

178 Attributed to changes in age of sexual debut, declines in casual and commercial sex, partner reduction, and condom use associated with high-level political support and multi-sectorial response.

179 Spearheading the way for ordinary Ugandans to care for the sick, educate the healthy and demand access to treatment, with strong faith-based and community-based support.

180 Resulting from freezing of donor support in connection with mismanagement of donor contributions to the Partnership Fund.

in gaps in MoH capacity to deliver HIV services. Almost all attempts to develop prevention interventions have adopted individualistic approaches that focus on influencing knowledge, attitudes and behaviour at individual-level among defined populations. This is despite the domination of structural determinants in the behavioural change process and the overarching influences from society and family in traditional culture limiting the individual in decision-making and behaviour. The NSP and revised NSP codify efficacy of individual-focused biomedical and behavioural approaches and assume that each individual has the autonomy to make and act on his/her own choices to use prevention knowledge and services provided by the MoH, development partners and CSO services delivery providers. Little or no consideration is given to the individual being constrained or shaped by social structures and context. Thus, the greatest influences on attaining a reduction in new infections are structural, and thus not directly influenced by donors to the Partnership Fund and CSF.

Some of the gaps in the NSP – key components for effective prevention – require political and legal change that donors can influence only through "quiet diplomacy" in relation to human rights, and greater investment in more extensive research around risk behaviours, and information and service needs for MARP. Addressing the huge unmet needs for effective prevention, treatment, care and support in the fishing communities and for other MARP certainly requires further donor involvement and support. The bald emphasis in the revised NSP on biomedical prevention lacks links to interventions to sustain community mobilisation and BCC for social as well as individual change. Danida and Ugandan CSOs identified to the evaluation the need for comprehensive approaches, which are underpinned by social change theory,[181] behaviour change theory,[182] and empowerment paradigm perspectives.[183] CSOs are best placed to address many of the structural barriers to adoption of behaviours that reduce risk of HIV infection, that need social as well as individual behaviour change.

For the NSP to be effective, support for sustained adoption of new health seeking behaviours must be available to all persons at risk. Gaps in the NSP related to MARP and limitations on human rights for MARP; by marginalisation of fishing communities that are at risk of HIV transmission; and short-term CSF grants limit the effectiveness of donor support. However, donor support has improved the quality of life of some PLHIV and their families,[184] and for a period for OVC, and mitigated the effects of AIDS on these individuals through expanding the availability of CSO provided care and support services.

Thus donor support is unlikely to have contributed significantly to the NSP outcome result of improved health behaviours for prevention of HIV transmission by MARP/key populations. It is likely to have contributed to the NSP goal (2): improve the quality of life of PLHIV by mitigating the health effects of HIV by 2012.

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181 Rotheram-Borus, M.J., D. Swendeman and G. Chovnick. (2009) *The past, present, and future of HIV prevention: integrating behavioral, biomedical, and structural intervention strategies for the next generation of HIV prevention*. Annu Rev Clin Psychol, 5: p. 143-67.

182 Eaton, L., A.J. Flisher and L.E. Aaro (2003) *Unsafe sexual behaviour in South African youth*. Soc Sci Med, 56(1): p. 149-65.

183 Slocum R et al. (1995) *Power, process and participation – tools for change*. Intermediate Technology Publications, London.

184 This is an outcome level result for the NSP and the hierarchical logic for the Joint Donor Support constructed by the evaluation, but is an impact level result for Danida's logical framework.

2.1 The joint donors support conforms to Ugandan needs, priorities and policies

(2.1 Have the donors' areas of support conformed to the needs, priorities and policies of Uganda?)

The donors have jointly supported the Partnership Fund and CSF, from 2007 to 2012, (1) to enhance UAC coordination of the Ugandan AIDS response, implementing the NSP and revised NSP; (2) to further enable, coordinate and harmonise CSO participation in the Ugandan response, reducing duplication and gaps; and (3) to reduce development assistance administrative costs. This joint support clearly conforms to Ugandan needs, priorities and policies. Danida earmarked funds to selected CSOs, Hospice Africa, Straight Talk Foundation and TASO, organisations Danida had been supporting prior to the inception of the CSF. Additionally, Danida responded to gaps it perceived in the NSP, providing strategic direct funding to the MARPs Network and UNFPA for its SRHR project. The SRHR project provides an innovative model for prevention with youth, a strategic population for achieving "a generation free from AIDS", which might be replicated throughout Uganda.

UAC expressed satisfaction that its AIDS response partners have come together in support of implementation of the NSP, which UAC views as indicating donor support to country leadership in the Ugandan response. Yet the GoU contributes only 10% of the funding envelope, which largely comes from external sources. The joint donor support confirms the three donors stated commitments to the Paris Declaration on Aid Effectiveness.

Such joint donor support to implementing the NSP does not necessarily mean that the three donors each see all their own special interests, nor agree with all the GoU policies and strategies in the Ugandan response. Nor that they fully support the content of the NSP/revised NSP as is, with its *omissions* of guidance on how to meet the needs of important key populations/MARP; and how to address structural changes in support of biomedical prevention. Undoubtedly there is divergence in donors' prevention paradigms that range from values-based to rights-based, but with middle ground; and in their perception of donor influence on Ugandan policy.[185] Donor support to the Partnership Fund and CSF is indicative that they support the principles of the "Three Ones" and UAC's coordination role. Joint donor support will only fully address Ugandan needs when the GoU addresses the gaps in the NSP and prevention policies, and enforces human rights for all.

2.2 There is urgent need for further, effective policy dialogue around spending on the Uganda AIDS response

(2.2 Has the policy dialogue regarding the 2007/2012 period and the new national AIDS strategy been relevant and effective?[186]*)*

185 Specifically USG/PEPFAR influence. The evaluation is not concerned with PEPFAR, only USAID's support to the Partnership Fund and CSF.

186 The related area of coordination of (1) research that generates evidence on which to base policy, and (2) programmatic information on implementation of the NSP – what is working, what is not and where additional effort could be focused – to underpin both policy and planning is addressed in Annex F.

UAC states that its policy dialogue has been extensive from national to district level and inclusive of government, civil society and donor stakeholders in Uganda's AIDS response. Including new biomedical interventions in the NSP and revised NSP, as scientific evidence of their effectiveness has become available, is relevant. However, the focus on biomedical interventions has to some extent allowed the dialogue to drift away from core issues that need to be addressed for community effectiveness. This seems to be a major disconnect in policy development in the face of the detailed and well-argued analysis of the dynamics of the Uganda HIV epidemic available to the UAC National Prevention Committee during the preparation of the revised NSP.[187]

The three donors do not have a jointly held position on prevention with which to engage in joint policy dialogue with UAC. The strong focus on efficacy and the power of specific biomedical interventions has blocked the policy debate and strategic planning. Danida's comprehensive approach to prevention, DFID's strategy for linking CSO programming to MoH biomedical services, and the lessons learned from USAID's child survival and family planning programmes have not been adopted in the NSP or implemented by the GoU to increase the effectiveness of prevention programming including biomedical prevention services. Nevertheless, several recent reports acknowledge that the drivers of the HIV epidemic in Uganda are built on behavioural, socio-economic and structural factors including gender norms, gender relations, gender-based violence, traditionally accepted behaviours, and stigma and discrimination. These sensitive issues need to be addressed, but are not spoken about to the point of indicating denial at higher political and organisational levels.

By continued engagement in policy dialogues with the GoU through the AIDS Partnership Forum, donors may be able to influence the implementation of the revised NSP to support achievement of its goals and attainment of the AIDS transition. By supporting individual donor specific special interests, such as biomedical prevention, human rights, gender equality, and SRHR, rather than focusing on their common goal,[188] the three donors might dilute their combined influence on policy dialogue and programming both within the UAC and in the CSF. Nonetheless, the special interests are all relevant to an effective Ugandan AIDS response and a harmonised donor position on these issues would strengthen joint policy dialogue with the GoU.

In line with World Health Organisation (WHO) policy, Uganda has recently adopted new standards for when positive pregnant women should commence ART and for how long they should remain on ART. The WHO has also revised its policy guidance on when to commence ART for PLHIV in general. Each such policy revision has huge cost implications for the Ugandan national response. The number of PLHIV needing treatment continues to rise with Uganda's high population growth (and thus growth of vulnerable populations) and as effective prevention is not being implemented. The resource envelope, largely donor funded, cannot increase to keep pace with demand for treatment and medical care services. Increased spending on treatment and medical care will further reduce the resources available for prevention, community- and home-based care services, leading to an upward trend in new infections and increased need for

187 Anon (2011) *Development of Uganda's HIV Prevention Strategy 2011-15 and National HIV Prevention Action Plan 2011/12- 2012/13 Volume 1: Report of the Review of the Magnitude and Dynamics of the HIV Epidemic and Existing HIV Prevention Policies and Programmes in Uganda*. Report submitted to UAC, Kampala.

188 Of enabling CSOs to play a larger and more effective role in the Uganda AIDS response, particularly addressing structural issues that affect prevention diagnosis, treatment care and support.

ART and other HIV services. Increasing numbers of new infections along with greater proportions of people living with HIV eligible for ART, increases demand for spending on treatment. Thus there is urgent need for further, effective policy dialogue around spending on the Uganda AIDS response.

3. Successful past practices: inconsistent picture among stakeholders

(3. What (recent) past practices of government, donors and the civil society have been successful and what have not – and why?)

Government: Lack of Ugandan political leadership and funding commitment, and denial at the highest levels in Uganda are limiting the Ugandan AIDS response
Uganda has achieved success in attaining its targets for people on ART and in retaining people on ART. However, Uganda has not shown budgetary commitment to controlling the epidemic and the successes have been attained largely with PEPFAR support supplemented in part by the GFATM. The UAC broadly consultative approach to development of the NSP and Revised NSP was successful in gaining donor support for (1) UAC leadership and coordination of implementation of the NSP/Revised NSP and (2) for CSO contributions to the NSP/revised implementation. However, as discussed in Conclusion 2.2 of the current chapter, the fundamental gaps in the NSP/Revised NSP indicate a flaw in the policy development process.

Further, imbalance between treatment and prevention has given way to a further imbalance between biomedical interventions and prevention interventions that address structural factors and other determinants of behaviour. The new imbalance is invidious as it reduces the resources available for (1) prevention in Uganda socio-cultural settings that reduce individuals' ability to make decisions and change their behaviours; (2) for addressing the needs of MARPs who are frequently bridge populations; and (3) for youth. It also reduces the effectiveness of biomedical prevention interventions that need new health seeking behaviour, adherence to ART, and sustained healthy behaviours – e.g. consistent and correct use of condoms in all risky sexual encounters.

Over the evaluation period, 2007-2012, the Ugandan AIDS response relied heavily on PEPFAR implementing partners and received inadequate government resources for implementation of the NSP. The inadequate resourcing is particularly problematic for the MoH which does not have the capacity to implement the revised NSP and its greater focus on biomedical services that are mainly delivered through MoH facilities. Inadequate resourcing, the gap in provisions for key MARPs, and the glaring gap between the government's international commitments to human rights and its lack of attention to the rights and needs of MARPs including the 3 million strong fishing communities are hampering Uganda's response. In sum, lack of Ugandan political leadership and funding commitment, and denial at the highest levels in Uganda are limiting the Ugandan AIDS response.

Donors: Donor joint funding practices are relevant, although there is a need for better alignment to the reality of civil society organisations
Undoubtedly, donor collaboration with GoU in the AIDS Partnership Forum, and contribution to the Partnership Fund and CSF, have had successes (1) in supporting Uganda AIDS Commission leadership and coordination of the AIDS response; and (2) in routing funds to civil society programmes that would otherwise not have had resources to provide

or expand their activities, despite the challenges that have occurred. Challenges have included UAC financial mismanagement that has disrupted donation and cash flows, hampering coordination of the AIDS response at national and district levels. The donors worked jointly through the Partnership Forum and in their decision-making and response to the challenge of financial mismanagement of the Partnership Fund within UAC. Ensuring fiduciary probity has its costs – as do interventions to correct financial mismanagement – that divert funds from other Partnership Fund and CSF uses.

There is question over the full success of the current management by an external accounting firm, Deloitte Uganda Ltd. Determining why there is such a long history and high level of corruption in Uganda is beyond the current evaluation although much has been written on the subject.[189,190] Many donors in the AIDS Partnership Forum have already engaged in dialogue with the GoU on good governance and GoU need to effectively address corruption. More remains to be done to ensure GoU good governance and financial probity.

The role of the Partnership Fund supporting UAC coordination of the Uganda AIDS response at national and district level appears to have been successful when the donor funds were flowing. Synergies between the Partnership Fund and CSF were evident in CSO self-coordinating entities that received Partnership Fund support to funding their secretariats and CSF funding for their programming. Greater synergy at district level, with enhanced technical oversight and coordination of CSO programmes was a potential of donor support, and might have been evident if there had not been the hiatus in cash flows from the Partnership Fund to district level.

The CSF as a mechanism has provided coordinated and harmonised support to CSOs, reducing administrative costs for each of the donors. The joint decision to engage management agents for the CSF has positively influenced the efficiency of grant management and reporting from technical and financial perspectives although this has to be balanced against the cost effectiveness of three separate management agents.

What has been less successful is (1) encouragement of CSO innovation; (2) provision of platforms for sharing CSO experience and meaningfully engaging in policy dialogue; and (3) facilitating CSOs to define the role for civil society in the current environment and in response to the Ugandan HIV epidemic.

Donor joint funding practices are relevant, although there is need for better alignment to the reality of CSOs, i.e. by providing funding for longer periods in the implementation of the CSF.

Civil society: CSO programmes have had success in attaining their performance targets and especially in provision of care and support services

NNGOs provide gold standard care services through a stand-alone model for NGO services, and a "partnership with government services" model that could be replicated throughout Uganda. In prevention programming, many CSOs are frustrated in being unable to use their comparative advantage in comprehensive behaviour change

189 Ssewakiryanga, R., Aid Effectiveness Experiences from Uganda: Is the aid agenda a collusion between donors and political elite in developing countries? Uganda National NGO Forum, Kampala.

190 Report (2006) *Annual PEAP Implementation Review Report*. GoU, Kampala pp. 50-52 cited by GoU (2008) *Evaluation of the Implementation of the Paris Declaration in Uganda* (First Phase 2005-2007) Office of the Prime Minister, Kampala.

approaches. CSF grants, which have been relatively short-term, have steered CSOs away from media that they have had prior success with (including radio and drama).

However, CSOs have largely lost the anger, energy, determination and self-efficacy that they had 10 to 20 years ago. The changes in civil society may in part be as a result of a natural progression of CSOs to bureaucracies as they enlarge and mature, or may be as a result of leadership fatigue, particularly for CSOs that had early charismatic leadership. CSOs took an early lead in provision of care and support for PLHIV and their families. This comparative advantage has continued to develop – by NNGOs with earmarked support from Danida (Hospice Africa Uganda and TASO). There are CSOs that represent people with high risk behaviours including sex workers, sexual minorities and fisher folk. They have not received CSF funding, although they have a comparative advantage in meeting the needs of their constituents, and should be involved in policy dialogue and service delivery.

By and large CSOs thrive where they have a clear comparative advantage and a voice, and where funds are available to build CSO institutional capacity. Funding activities only puts the ultimate power in the hands of the funder for determining where, what and, often, how activities are carried out. CSOs feel compelled to apply for grants just to survive even when the terms of the grants are more like contracts to deliver specific services that are not the CSO core business. Without core funding for strategic planning, and organisation development and innovation, CSOs are vulnerable to becoming agents of the grant-makers, and cease to exist when the grants end (as they have by then lost their core purpose).

4. Intervention design

(4. Was the overall intervention design appropriate – from the perspectives of relevance, efficiency, effectiveness, sustainability of results and impact?)

Overall, the support by the three donors has been critical for UAC leadership and coordination, and civil society programming during the evaluation period. However, there was neither a clear or common design, nor a concept governing joint support. Hence, there was a lack of analysis of the risks and assumptions in the intervention logic and, as a consequence, an absence of a joint risk management plan. It appears as if the main reason for labelling this as joint support was merely the coinciding of three donors' interests, to a reasonable degree, at the right moment.

The major assumption of the joint donor support to the Ugandan AIDS response appears to have been that the GoU would adequately fund the line ministries to provide the clinical and other services from national to health sub district levels as articulated in the NSP. With the revised NSP, the assumption became that the MoH has the human resource and systems capacity to deliver biomedical prevention services. MoH procurement and supply management systems have proven inadequate for both condom security and drug security. MoH human resources and training capacity, largely determined by lack of budget, but exacerbated by loss of human resources to AIDS partner programmes, are inadequate for provision of the biomedical services required in the NSP and the National HIV/AIDS Prevention Strategy.

Donors reported to the evaluation that there is tension between the coordination leadership role of UAC, which doesn't have a budget for implementing the NSP, and the technical leadership of the MoH, which has been inadequately resourced to implement the NSP. Thus an omission in the intervention design is the lack of analysis of the political context and available financial resources impacting the intervention. Furthermore, there is a lack of a risk management plan arising from this context.

Relevance
Enabling coordination and fostering Ugandan ownership of the national response through the Partnership Fund is clearly highly desirable and necessary. Without joint donor support to UAC, its ability to lead the necessary periodic review and updating of the NSP as the HIV epidemic in Uganda changes, and coordinate the implementation of the NSP would be severely compromised. Although official development assistance has been calculated as contributing only 10% of the Ugandan economy,[191] throughout the implementation period 2007 to 2012 being evaluated, donors contributed 90% or more of the resource envelope for the AIDS response. The need for involvement of civil society in the Uganda AIDS response is self-evident. Yet CSOs, with the exception of a few of the NNGOs, find mobilising resources a huge barrier to their ability to conduct activities implementing the NSP. As with all attempts at social change, CSOs are critical to catalysing the needed change and sustaining social and individual change in health behaviours (until the desired health seeking behaviour becomes the new norm).

Efficiency
From the perspective of efficiency, the intervention design encouraged efficiency in use of donor funds by alignment of donors behind a single plan, the NSP, and harmonising and coordinating civil society programmes through the CSF. The management costs might have been reduced by having a single management agent rather than three separate agents as occurred for a part of the implementation period, but the need for external financial management was certainly proven by the mismanagement of the Partnership Fund. As well as reducing duplication of administrative costs, the costs for administrating the joint donor assistance, because of economies of scale, were likely to have been less than if each donor had administered its funds itself.

In terms of care and support, the widespread involvement of NNGOs, CSOs and communities in provision of care and support for a large number of patients and families affected by HIV has increased the quality of their lives to some extent. With a commitment to universal access to care and a rapidly increasing number of patients in need of care, only basic low cost models of community based care and support will be affordable in the future.

Effectiveness
Looking overall at the joint intervention's effectiveness in promoting the attainment of the NSP goals, two thematic areas, prevention, and care and support, are considered, each contributing to the overarching goal of the NSP and revised NSP of reduction in new infections.

Coordination and technical oversight of CSO activities at district level was not as effective as it should have been once districts stopped receiving funds from UAC. Undoubtedly, there are good CSO staff and volunteers who have been enabled to

191 Ssewakiryanga, R., Aid Effectiveness Experiences from Uganda: Is the aid agenda a collusion between donors and political elite in developing countries? Uganda National NGO Forum, Kampala.

do more by receipt of a CSF grant. Activities by positive people living with disability (PLWD) peer educators both in MoH health facilities and catalysing community-based peer support groups with innovative approaches such as community theatre, is a clear example. Trained PLWD are not as geographically mobile as the general population and are likely to remain in their communities addressing issues of importance to them. In general, training and deploying volunteers to raise awareness and mobilise their peers around a cause is often very effective.

The effectiveness of CSO prevention activities might be enhanced if it is within a framework that supports structural change with mutually reinforcing social and individual behaviour change. For HIV prevention in Uganda, within the revised NSP, there is a huge gap linking the biomedical prevention activities with mechanisms for addressing uptake of the services. To be fully effective, biomedical interventions need more than one off acceptance of services whether that is HIV counselling and testing, PMTCT, ART, safe male circumcision or use of male or female condoms. All these biomedical interventions require sustained change in health seeking behaviour for adherence to treatment and PMTCT; optimum and exclusive breast feeding for the first six months of life for PMTCT; to prevent disinhibition after safe male circumcision and for those on ART; and to support consistent and correct use of condoms.

Some NNGOs involved in awareness raising and HIV prevention have communications departments at national level that develop and test IEC materials and messages for use with specific risk populations, for example for youth, by Straight Talk Foundation. Their IEC is likely to be more effective than smaller CSOs' that do not have any form of quality review of their BCC activities to ensure that messaging is effective and not creating misunderstanding and misconceptions.

For care and support, Danida's earmarked funding for NNGOs such as Hospice Africa, Uganda and TASO was an important contribution to their on-going programming in care and support. It also supported their role as trainers of smaller CSOs. For such large institutions, a large and reliable resource envelope is necessary and NNGOs find it expedient to have specific departments continually raising funds through grant applications and soliciting donations. Smaller CSOs, particularly those at grass roots level, have their programmes limited by the short length of CSF competitive grants. The lack of long-term commitment to OVC through CSF grants raised some criticism and even anger among CSOs that had received grants for services for OVC. CSOs find dealing with people who are dependent on AIDS services they provide, after a grant ends, very difficult. Their clients feel let down, communities feel loss of trust in the CSO, and the CSO staff feel guilty,[192] and may even be laid off if the CSO can no longer afford to pay salaries.

Sustainability of results

Some NNGOs that initially received core funding for care and support are able to sustain their results through continual resource mobilisation by specific national level departments addressing this. HIV services require external funding. If there is to be equitable access, there cannot be full cost recovery. Straight Talk Foundation is in a different situation, although it received earmarked funding from Danida to continue its strategic prevention work with youth, before its competitive CSF grant funding. Straight Talk Foundation was hit hard by the change in focus of the revised NSP away from prevention

192 Situations clearly articulated as experienced by a previous orphans and vulnerable grant holder during the evaluation.

with youth to biomedical interventions as it was no longer eligible for grants for its core work with youth. That youth in Uganda have a lower than expected HIV prevalence is very likely to result in part from the success of Straight Talk's work over the last nearly 20 years. This work needs to continue if succeeding generations are to remain "AIDS free" (or, more accurately "HIV free").

For smaller CSOs providing awareness raising and/or care and support services in the community, sustainability of activities beyond limited grant funding cycles (18 months for some grants) is a concern. This is a concern for the smaller CSOs, as they do not have the mechanisms for continual resource mobilisation – even completing documentation in response to requests for applications is a significant drain on their resources. Such local CSOs need mechanisms that provide access to funding for much longer implementation periods. Small community-based organisations are unlikely to develop institutionally to the level that they will be able to compete with NNGOs for funding. Small community-based organisations (CBOs) will thus continue to need mechanisms that enable them to access grants. Other CSOs might be grown institutionally until they are able to compete more generally for grant funding. However, the process of institutional development to independence is a lengthy one, requiring at least medium-term commitment from donors, with the goal of being able to sustain their activities and results. This longer commitment to sustaining results has not to date been available through the CSF.

Impact
Measuring impact is beyond the current evaluation. Even identifying the joint donor contribution to outcome level results is problematic when another donor (USG/PEPFAR) is contributing at least 80% of the resource envelope and has been supporting expansion of provision of/access to ART, PMTCT and other biomedical prevention services throughout Uganda throughout the period 2007 to 2012. The results of large scale provision of ART and PMTCT completely overwhelm the ability to demonstrate reduction in HIV transmission through relatively small scale CSO prevention care and support services.

However at outcome level, donor support has undoubtedly improved the quality of life of some PLHIV and their families,[193] and for a period for OVC. Donor support has also mitigated the effects of AIDS on these individuals through expanding the availability of CSO provided care and support services.

The joint donor intervention ability to improve health behaviours for prevention of HIV transmission by MARPs and other key populations vulnerable to HIV was compromised by:

(1) gaps in the NSP and its implementation,

(2) criminalisation of MARP risk behaviours, and

(3) flaws in grant design. The grants to CSOs were for too short a period to enable them to address structural issues, proximate determinants of health behaviour, and affect social and individual behaviour change.

193 This is an outcome level result for the NSP and the hierarchical logic for the Joint Donor Support constructed by the evaluation, but is an impact level result for Danida's logical framework.

6 Recommendations

6.1 Future joint donor support

1. Future joint donor support should be formally designed with an agreed overall logic model, hierarchy of inputs and expected results to enable the donors to monitor the performance of their joint support. The design intervention activities should ensure full involvement of CSOs, maximising their potential for generating societal change that paves the way and supports individual behaviour change, to reduce HIV transmission. The design requires an analysis of the Ugandan political economy of the AIDS response, and a risk analysis and management plan.

2. Donors should continue joint support to the Partnership Fund and the CSF, and include the agreed overall logic model (hierarchy of inputs and expected results) in their agreements with the GoU.

3. Donors should work through the CSF Steering Committee to address future CSF granting. CSOs need reliable, longer term grant funding to be effective, with nurturing rather than control of their institutional development. They need longer term grants for effective comprehensive behaviour change interventions, and care and support programmes, to improve results and increase their sustainability. Most CSOs need grant support for their institutional development. Fewer, larger grants will likely have more sustainable results than the current relatively small, short-term grants.

4. Donor funding of the Partnership Fund and CSF currently needs external management. Any future plan for integrating the Partnership Fund and CSF into the GoU system will require a stepwise approach with benchmarks for fiduciary competency before progression to the next step.

6.2 Donor and Government commitments to the Uganda AIDS response

5. The GoU should contribute to the Partnership Fund and CSF, as evidence of its commitment to these mechanisms within the AIDS response. A government contribution would be managed by UAC within the same Partnership Framework governance and decision-making as the donor funds and with consensus agreement on what activities/grants would be funded by the donor funds and by government funds. Government contributions during the next phase of the agreements should initially be 10%, in line with current government funding of the overall Uganda AIDS response. The contribution should rise significantly annually during the next phase, a necessity for the financial sustainability of the mechanisms.

6. The GoU and donors should explicitly define their commitments to the Uganda AIDS response for the next five or more years, and come to an agreement on the balance of funding for prevention, treatment, and care and support. Within the prevention budget, the government and donors should agree the balance between comprehensive behaviour change interventions and other prevention, including biomedical interventions. Discussions between the donors and the government should continue to seek government commitment to significantly increasing its funding of the AIDS response, and adequately funding the MoH to provide HIV and related health services.

6.3 Civil Society role within the Ugandan AIDS response

7. As the NSP has not defined the role of civil society, it is important for CSOs to seize the opportunity and define their role in the Ugandan AIDS response, to fully harness their potential. This could be catalysed by the CSF managers hosting civil society workshops at national and district levels, with joint financing with the Partnership Fund, as a means for CSOs to define and develop their roles and accountability for implementing the NSP.

6.4 Policy dialogue

8. Donors should continue and intensify policy dialogue with the GoU through the AIDS Partnership Forum and other platforms, and identify commonalities in their approaches that might be drawn on for a joint policy dialogue. The dialogue should focus on (1) the balance between prevention and treatment; and (2) between biomedical prevention interventions and the comprehensive behaviour change interventions that are needed *both* to maximise the effectiveness of the biomedical interventions and for essential reduction in risk behaviours in Ugandan society. Donors should draw on their experience with comprehensive behaviour change interventions, addressing societal structural change, supporting individual behaviour change and social mobilisation around health and HIV issues, and bring in the evidence base and behaviour change theory. The dialogue should address evidence-based comprehensive behaviour change interventions as a core component of the Ugandan HIV prevention strategy, underlining that it is not separate from but part and parcel of effective biomedical prevention and HIV risk reduction. The dialogue should consider harnessing CSOs' comparative advantage in comprehensive behaviour change programming.

6.5 Human rights

9. International advocacy for improving human rights in Uganda is urgently needed. While "quiet diplomacy" is agreed to be the best way forward for addressing the rights of homosexual men, there is also pressing need for advocacy around the prevention, treatment, care and support needs of sex workers, the lesbian, bisexual, gay and transgendered community as a whole, and fishing communities. Effective prevention for these MARPs who form bridges for infection transmission to the wider community is crucial for controlling the epidemic in Uganda.

10. Uganda AIDS Commission must show leadership on and affect change in relation to human rights issues if the NSP is to be effective in achieving an AIDS transition. Advocacy for Ugandan parliamentary ratification of the East Africa Community HIV and AIDS Prevention and Management Bill (2012) in Uganda is urgently needed from a public health standpoint.

11. In the near term, donors should work with UAC and the CSF to address the omissions in the NSP and its implementation in relation to fishing communities and other MARPs. Donors should provide technical assistance to the CSF managers for development of policy guidelines and implementation planning for meeting specific MARP needs.

Annex A: Terms of Reference

1. Background

The present Terms of Reference form the basis for an evaluation of the support of Denmark, Ireland and USAID[194] to the response to HIV/AIDS in Uganda from 2007 till 2012[195]. The three countries and a number of other donors have for years been prominent members of the Uganda AIDS Partnership and supported government as well as civil society efforts to curb the epidemic. Given the importance of donor support to Uganda in this field and the history of the epidemic, including the initial success and the setback of later years, it is deemed important to take a closer look at the possible reasons for the positive and negative trends in the development of the disease control efforts.

1.1 An Introduction to HIV/AIDS in Uganda

The first case of AIDS in Uganda was reported in 1982[196]. Since then HIV spread rapidly and the number of people living with HIV peaked in the early 1990s when the average national antenatal HIV prevalence was 18% in rural areas and 25%-30% in major urban areas. This marked the first phase of the epidemic.

The second phase (1992-2000) saw declining HIV prevalence and incidence, particularly in urban areas. In the 1990s HIV prevalence declined among antenatal clinic attendees and voluntary counselling and testing clients. Similarly, a decrease in HIV incidence and prevalence were observed in population- based surveys in the rural areas of the Masaka and Rakai districts. The decline in HIV incidence and prevalence was attributed to delayed sexual debut among young people, reduction in sexual partners outside of marriage and an increased use of condoms.

The third phase of the Uganda HIV epidemic (since 2000) has been characterised by the stabilisation of HIV prevalence between 6.1 and 6.5% in some antenatal care (ANC) sites and even a rise in others. According to the 2011 Uganda AIDS Indicator Survey, the HIV prevalence in Uganda was estimated at 6.7% in 2011.

The rise in HIV prevalence is accompanied by worsening of behavioural indicators especially an increase in multiple concurrent partnerships. There has also been a shift in the epidemic from people in single casual relationships to those in long-term stable relationships. Incidence modelling reveals that 43% of new HIV infections are among monogamous relationships while 46% are among persons reporting multiple partnerships and their partners.

According to UNAIDS 1.2 million persons in Uganda were living with HIV at the end of 2009. The UNAIDS 2009 Country Situational Analysis report estimates that 200,000 people were on antiretroviral treatment – 39% of all those in need – and that the percentage of HIV pregnant women receiving antiretroviral treatment to prevent mother-to-child transmission was 53%. The aide memoire of the Fourth Joint Annual AIDS Review Conference 1-3rd November 2011 gives an updated figure of 290,563 persons

194 This evaluation will cover USAID support to the CSF and the Partnership Fund (PF).

195 Important events taking place in 2013 when the evaluation is conducted should also be taken in account as deemed relevant by the evaluation.

196 The text in this subsection is based on the UNAIDS 2009 Country Situational Analysis www.unaidsrstesa.org (Accessed on 24 January 2012), updated with recent figures from the 2011 Uganda AIDS Indicator Survey.

on antiretroviral treatment in June 2011, almost tripling the 2007 figure of 105,000. A particularly worrying aspect of the epidemic in Uganda is that the ratio of HIV-positive boys to girls in the 14-19 years age group is 1:9. It is noteworthy that much of the rise in incidence is due to high population growth.

1.2 Key Elements of the National Response

The Uganda AIDS Commission (UAC) was established in 1992 under the Office of the President to ensure a focused and harmonised response. Uganda's response to the epidemic has been characterized by strong political commitment and support, open dialogue, multi-sectoral interventions and coordination, the involvement of religious leaders, decentralised planning, programmatic targeting for discrimination issues, supportive policy and social environment, the availability of local and external resources, the involvement of local communities and investment in research.

The National HIV & AIDS Strategic Plan 2007- 2011 (NSP) was developed through a broad consultative process aligned to the Country's Poverty Eradication Action Plan (PEAP). It focuses on Human Development and emphasizes preventive health care and commodities for basic curative care. The NSP's main objectives are:

- Reduce the incidence of HIV by 40% by 2012
- Improve the quality of life of people living with HIV by mitigating the health effects of HIV by 2012
- Mitigate the social, cultural and economic effects of HIV at individual, household and community levels
- Build an effective support system that ensures high-quality, equitable and timely service delivery.

A revised NSP for the period 2011/12 to 2014/15 was ready in early 2012. It was created through a thorough process of review and has an updated and to-the-point situation analysis. A number of documents were produced in preparation of the plan; the document entitled "Status of HIV Prevention Policies and Programmes in Uganda. Review Report 2011" in particular has many findings related to the response in the previous plan period.

Since 2002 Uganda's response to HIV has been mainly coordinated through the National HIV & AIDS Partnership arrangement. At district level, the response is coordinated through a technical District AIDS Committee and a political District AIDS Taskforce. This arrangement is translated at all Local Government levels down to the grass roots community.

Strong civil society organisations (CSOs) have participated actively in the response; this is considered one of the factors behind Uganda's success in fighting the epidemic.

Around 2005, development partners decided to harmonise their funding for civil society in a basket fund for CSO grants and to align support for CSOs with the national HIV/AIDS strategy (NSP), in line with their commitment to increasing aid effectiveness.

After a long and consultative design phase, the Civil Society Fund (CSF) was established in 2007 through an MoU between the Uganda AIDS Commission (UAC) and Danida,

DFID, Irish Aid and USAID. Swedish Sida and the Italian Cooperation have later joined. The goal of CSF is to ensure that civil society provision of prevention, care, treatment, and support services in HIV/AIDS is high quality and harmonised, streamlined in support of the GoU National HIV/AIDS Strategic Plan, and national action plans for HIV/AIDS and OVC (Orphans and Vulnerable Children) services. Three management agencies were contracted for grant management, technical and organisational support, and M&E respectively. A CSF Secretariat at the UAC supports a Steering Committee (SC) which acts as the executive board. Governance of the CSF is the responsibility of the Partnership Committee (PC), which is a multi-stakeholder advisory board to the UAC Board of Commissioners.

CSF was externally reviewed in 2009[197] and 2011[198].

1.3 Institutional Arrangements for Implementation of the National Response
Implementation is undertaken by stakeholders working together in accordance with the multi-sectoral approach.

The Role of Uganda AIDS Commission (UAC) under the Office of the President is to provide the overall coordination, planning, resource mobilization and allocation, as well as monitoring and evaluation of the activities in the country in order to harmonise the response and its effects. It provides strategic leadership by ensuring effective harmonisation of the activities of the various actors within the agreed policy.

The Role of the Ministry of Health is to be responsible for coordination and technical guidance of the public health response (e.g. ARV treatment, Prevention of Mother-to-Child Transmission and treatment of sexually transmitted infections). The Ministry's own AIDS Control Programme coordinates service delivery in public and private facilities and other public health programmes. Together with the National Medical Stores, the MoH is responsible for drug quantification, procurement and supply chain management of commodities for HIV prevention. The MoH also tracks the magnitude and the dynamics of the epidemic through its surveillance systems.

The Role of other ministries is to support the national response according to their mandate and comparative advantages. For example, the Ministry of Local Government ensures planning and budgeting for HIV prevention by all departments and oversees development of district HIV strategic plans, Ministry of Justice addresses rights violation-related drivers of HIV infection and enforces regulations against stigma and discrimination, Ministry of Education and Sports supports HIV prevention in educational institutions, and Ministry of Internal Affairs provides leadership for workplace programmes amongst police and prison staff.

The Role of District Local Governments. Since the DLGs are responsible for service delivery, the districts shall develop district strategic multi-sectoral HIV prevention work plans in line with the national plan. These plans will incorporate activities of all implementing partners operating in the district.

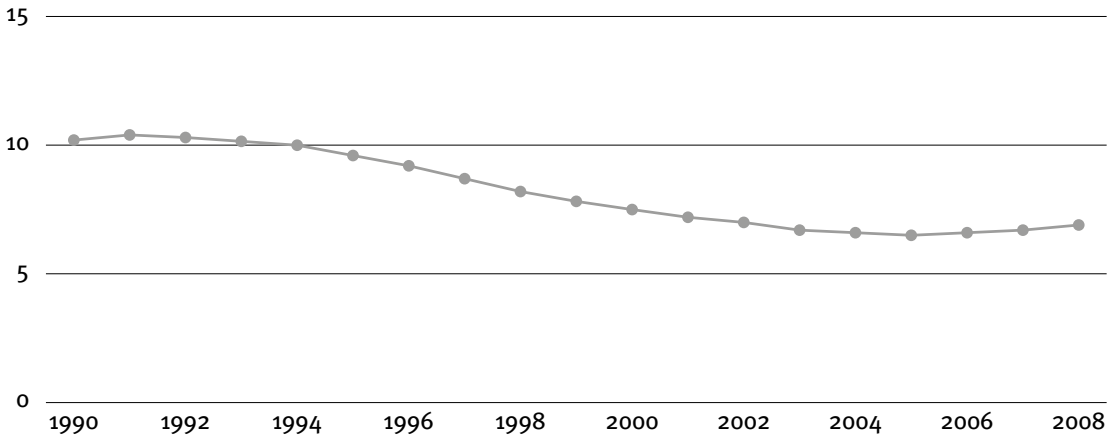
197 REVIEW OF THE CIVIL SOCIETY FUND UGANDA. Paul L. Janssen, MD, MPH and Bernad Mwijuka. 3 July 2009.
198 Mid-Term Review of Civil Society Fund Uganda. EASE International, Copenhagen August 2011.

The Role of Implementing Partners. IPs comprise civil society organisations of all types, including national NGOs, networks of People Living with HIV/AIDS, networks of Most-At-Risk-Populations, and private sector entities. Their specific role will be in line with their mandate and comparative advantage. These organisations are critically important in delivering services to the general public, especially MARPs. Some examples are TASO (The AIDS Support Organisation, established in 1987) reaching more than 800,000 persons with targeted prevention education, Straight Talk Foundation (established in 1997) with extensive media and radio networks operated by young people, and the MARPs Network (established in 2009) which supplements government activities with a grassroots approach. The Civil Society Fund channels donor funds (through a total of 149 grants up till 2011) to eight national NGOs, 140 CSOs, and 79 local governments.

1.4 Main Characteristics of the Epidemic

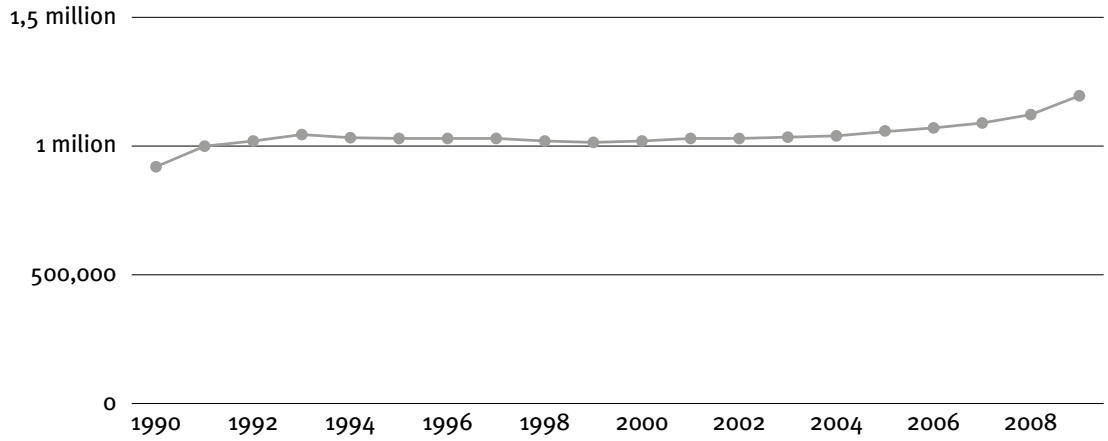
The latest national prevalence figure (total number of HIV-positive people alive) is 6.7% of the population between 15 and 49 years. Incidence figures (number of new infections per year) are harder to determine, but it is estimated that each year around 130,000 new HIV infections take place, and roughly 77,000 people die due to the complications of AIDS. HIV prevalence is higher among women than men, and correlates with higher education and higher income.

Fig. 1 HIV prevalence (% of 15-49 year olds). UNAIDS 2009



The epidemic is generalised across the country, but worse in cities and towns. Figure 2 below shows the number of People Living With HIV/AIDS (PHA) over the years since the start of the epidemic.

Fig. 2 People living with HIV/AIDS in Uganda. UNAIDS 2009



The main drivers of the epidemic are multiple concurrent partnerships, combined with low levels of condom use and high levels of sexually transmitted infections (STIs). 99% of HIV transmission among adults is through sex, and projections estimate that more than 90% of sexual transmissions take place in stable, but sero-discordant (either husband or wife is HIV-positive) relationships. In around half of these cases, one or both partners have extramarital sexual partners, but the other half of these couples are monogamous, so the HIV infected partner acquired the infection earlier. Mother-to-child transmission of HIV accounts for an estimated 18% of total new infections, resulting in more than 20,000 paediatric HIV cases per year. Transactional sex (sex for gifts or favours) is common, especially among young people. Concentrated epidemics exist amongst most-at-risk populations (MARPs) with many concurrent partners. Examples are commercial sex workers (47%); uniformed services; prison inmates; long distance truck drivers; boda drivers; men who have sex with men (MSM) (43%); migrant populations, and fishing communities (HIV prevalence estimates 28%).

1.5 Overview of Contextual Factors of Relevance for the Support

The Paris Declaration

Denmark, Ireland, The United Kingdom and several other donors as well as the Government of Uganda (GoU) are signatories to the Paris Declaration of 2005. This means that these donors have pledged to harmonise their support, align it with national strategies and use country systems. The United States Government is interested in applying lessons learnt from joint donor-government interventions. Support to the response to HIV/AIDS has been designed against the backdrop of the PD, and many interventions are therefore jointly designed. The Paris Declaration emphasizes the importance of mutual accountability; this concept implies (among other things) that evaluations should, as far as possible, be joint exercises. The large number of donors in Uganda makes it all the more important to abide by the Paris principles, and the evaluation should take this contextual factor into consideration when assessing the support of Denmark, Ireland and possibly other donors.

The National AIDS Strategy
The National Strategic Plan (NSP)[199] is the main strategic framework for the assistance, and an important feature of the evaluation will be to assess the extent to which the support has contributed to the attainment of the four specific goals of the plan (reduce incidence by 40%, improve quality of life for PHAs, mitigate the effects of HIV/AIDS and build effective support systems).

The National Performance Measurement and Management Plan (NPMMP) is an integral part of the NSP; the aim of the plan is to provide the framework for monitoring the achievements of the NSP, and it is therefore important in the context of the evaluation. There is a special challenge regarding the NPMMP. The set-up for the plan is very ambitious: The NPMMP has at its core the collection and processing of 58 national indicators, 47 district output indicators, and 22 outcome indicators covering prevention, care, and treatment and social support. The system is challenging because several organizations must collaborate at the national level, and appropriate staff at the district level need to be in place and trained in new procedures of data collection. In addition, this data is supplied to district planning offices that may or may not be functioning and the cooperation of civil society organisations (CSOs) is necessary even though their participation is entirely voluntary. Ultimately, it is difficult to say whether the NSP has succeeded if the indicators are not measured; the aide memoire of the latest (fourth) Joint Annual AIDS Review Conference from 2011 does not systematically provide data for the agreed indicators. This was confirmed during the pre-visit in May 2012.

The dilemma of prevention versus treatment is not specific to Uganda alone; it is an important consideration in all countries that are struggling with the epidemic. It has been said that "prevention has no constituency", and it is an acknowledged fact that it is difficult for politicians to insist on large sums for prevention when sick and dying people and their families are demanding action, i.e. access to medicine. Yet, if prevention is not given proper attention, the cost of treating the ever growing number of patients becomes impossible to shoulder for a poor government and its supporters. It should be mentioned that the split of funds between prevention and treatment is not the only issue here; the cost- effectiveness of the expenditure is equally important – i.e. how much is spent on abstinence campaigns compared to PMTCT. The National AIDS Spending Assessment, see below, has more on this. This context is important for any assessment regarding HIV/AIDS and will have to be part of the present evaluation.

The high population growth rate
Uganda's very high population growth rate, 3.4% p.a., makes it difficult to keep up with the epidemic. The 125-130,000 people who become infected every year will eventually need treatment, and the growing numbers mean growing treatment costs because the price of ART has stabilized. The high number of births puts strain on the PMTCT activities; although the Total Fertility Rate (TFR, number of births per woman) started declining in 1992 it has only come down from 6.9 to 6.2. The difficulties posed by the high population growth rate are relevant in the context of the evaluation.

The very large sums of money flowing to the subsector
It is ironical that the response to HIV/AIDS has not always been hampered by lack of funds. Uganda has received very large sums of money in a relatively short time period;

199 The 2007/12 version was revised and extended to align to the National Development Plan 2015. However, the 2007/12 NSP is the relevant version for the evaluation as it covers the entire period under evaluation.

in 2005 the sum earmarked by donors for HIV/AIDS exceeded the envelope available for all other diseases combined in the national health budget[200]. The efforts to make all this money active in a sensible way caused many disturbances in the sector, and the effects of these disturbances were, at least in the beginning of the period of the present evaluation, a challenge to the national health system. The evaluation should take this contextual factor into consideration when assessing the effectiveness of the response. An essential tool for this part of the evaluation will be the National AIDS Spending Assessment (May 2012), a major undertaking which provides a very thorough mapping of where the money comes from and what it is spent on.

The human rights issues
In later years human rights issues have taken on a greater importance in the response to HIV/AIDS in Uganda. International human rights declarations stipulate that all people have the right to live a healthy life, and in an HIV/AIDS context this means that the right to information on how to avoid infection is universal. In Uganda sexual minorities are facing difficulties in this respect, and general discrimination against sexual minorities means that in reality health services are not equally accessible. Surveys have shown that commercial sex workers and MSM have a higher prevalence than the general population; this is a human rights issue, but it is also an issue in relation to public health. Experience shows that infection will spread from any high-prevalence group to the general population, and the national response is therefore less effective if it does not address this challenge. The evaluation should look into this.

Targeting of Prevention Efforts
There is a growing realisation that prevention efforts have not been sufficiently targeted. The following areas have been mentioned among those needing more attention:

- Prevention of Mother-To-Child Transmission (PMTCT) as only about half of eligible pregnant women receive antiretroviral prevention before birth

- Commercial sex (and transactional sex) because this phenomenon still plays a large role in spreading the virus

- Fishing communities, especially in the islands of Lake Victoria, where ready cash, poor health services and a lower-than-normal women-to-men ratio together form a dangerous environment

- MSM because they have much higher prevalence than the rest of the population and often do not only have sex with men. In the present political climate in Uganda they are discriminated against and do not have access to prevention at an adequate level

- Uniformed services, boda drivers, and prison inmates, although the latter is a difficult issue that requires operational research.

Three other factors have a bearing on the effectiveness of prevention, and it would seem a relevant option to include them in the description of the national response that will serve as a background to the evaluation:

- Government services regarding STIs because such services are essential in reducing the transmission of HIV

200 www.cgdev.org/content/publications/detail/13029

- Condom availability, as this is often cited as insufficient
- Male circumcision, a fairly new intervention with promising results.

1.6 Overview of the Donor Support to Uganda's Response to HIV/AIDS

The Donor Landscape
Many bilateral and multilateral donors support Uganda's national HIV/AIDS response. They are organised as AIDS Development Partners in Uganda's HIV/AIDS Partnership, cf. Section 1.2. Among the most prominent are the following:

USAID supports strengthening Uganda's decentralized health system and strives to improve the quality of and access to HIV/AIDS, maternal and child health services. USAID collaborates with government, civil society and the private sector organizations to scale up HIV/AIDS prevention, care, and treatment efforts. USAID has supported the CSF by contracting the financial, technical and monitoring and evaluation services from 2007 on behalf of the CSF Steering Committee. USAID also contracted Deloitte to manage the Parnership Fund (2010) of the Uganda AIDS Commission.

DFID is another major donor with a strong presence in the sector. USAID, DFID, Irish Aid and Danida consider themselves 'like-minded', and have all contributed to the Partnership Fund and the Civil Society Fund since the beginning. DFID now employs a district-based strategy and focuses much energy on documenting the effects of its support.

Sida is among the founders of the PF and CSF. Sida works from a strongly rights-based platform and emphasizes capacity development of civil society organisations. Sweden prioritises efforts that ensure the rights of homosexual, bisexual and transgender people. Other areas of concern include young people, the role and responsibilities of men, as well as the rights of women and girls promoting their increased influence and participation. Finally, the **Italian Cooperation** is also among the contributors to the CSF.

The UN system has adopted the One UN approach and has formulated the Joint UN Programme of Support on AIDS in Uganda 2011-2014. The organisations active in providing technical assistance to the AIDS response are UNAIDS, UNFPA, WHO, UNICEF, UNDP, ILO, FAO, IOM, UNHCR, UM Women, UNESCO and UNODC. UNFPA heads the Technical Working Group on HIV Prevention, WHO the one on Treatment, Care and Support, while UNDP heads the one on Governance and Human Rights.

The Danish Support
The Danish support covers two periods, 2007 to 2010 and 2010 to 2015. The table below shows the main characteristics of the two phases.

The two phases show several similarities: The main modality is core budget support to two funds, civil society receives the majority of the funds, and in both phases there is a component for strengthening the Uganda AIDS Commission UAC. It is notable that the biggest share of the support goes to civil society.

Table 1 Comparison of two phases of Danida support to Uganda's hiv/aids response

Criterion	2007-2010	2010-2015
Duration	3 years	5 years
Budget	DKK 90 million (approx. USD 15 million)	DKK 200 million (approx. USD 35 million)
GOU/CSO split	GOU 17%, CSO 83%	GOU 30%, CSO 70%
Funding modality	AIDS Partnership Fund, UAC Civil Society Fund CSF	AIDS Partnership Fund, UAC Civil Society Fund CSF Core support to selected CSOs (DKK 80 million or 40%)
Components	Component A: Strengthening UAC with two subcomponents, one on support to NSP and one on CB for knowledge management Component B: Support to CS with two subcomponents, one on Youth NGOs, one on conflict areas	Component A: Strengthening UAC with two subcomponents, one on support to OR and one on SRHR Component B: Support to CS with one subcomponent on core support to selected national NGOs

The logical frameworks of the two phases are also quite similar: They aim at reducing the number of new infections and mitigate the effects of the epidemic, and they wish to enhance national institutional capacity. The UAC and the Partnership Committee are in focus in these aims. UAC, formed in 1992, is the overall responsible body for AIDS control while the Partnership Fund, set up in 2002, is intended to support the coordinating capacity of the UAC.

It appears from the formulation of the specific objectives that coordination is seen as an important objective. Production of evidence to improve effectiveness is also seen as important.

Civil society figures prominently in the Danish, USAID and Irish support as also reflected in the fact that the lion's share of the funds goes to civil society activities. In 2010 two new features appear: a wish to integrate Sexual and Reproductive Health and Rights (SRHR) and Most at Risk Populations (MARP) in the control efforts.

In the first phase three selected NGOs that were considered strategically important (and had previously obtained Danish support) were earmarked for support within the basket. The NGOs were Straight Talk Foundation, The AIDS Support Organisation, and Hospice Africa Uganda.

In the second phase an agreement was signed between the Embassy of Denmark and UNFPA on a project to be funded under the Danish programme support. The project comprises support to comprehensive condom programming and Reproductive Health-HIV integration through youth- friendly services and will be implemented by MoH, UNFPA, Reproductive Health Uganda, and four faith-based organisations. The four-year project budget is DKK 20 million.

In order to intensify support to Most-At-Risk-Populations in the second phase, an agreement was signed between the EDK and the MARPS Network. The agreement covers i.a. knowledge management on effective HIV prevention among MARPs, strengthening of member organisations, and advocacy for access to prevention services. The four-year project has a budget of DKK 8 million.

The Irish Support
Like Denmark, Ireland has been one of the earliest supporters of Uganda's national response to HIV/AIDS. The most recent support from Ireland is an integrated part of the Irish Aid Country Strategy Paper 2010-2014 (CSP). The country strategy has eight objectives:

- Objective 1: To strengthen the participation and influence of Civil Society in advancing human rights and accountability
- Objective 2: To increase the effectiveness and efficiency of government systems to promote equity and autonomy at local levels
- Objective 3: To increase access to quality justice services for the poor and vulnerable
- Objective 4: To improve equitable access to quality education especially for the poor and vulnerable
- Objective 5: To reduce the number of HIV infections and the burden of HIV particularly among the poor and vulnerable
- Objective 6: To reduce the incidence of Gender Based Violence (GBV) particularly amongst the vulnerable
- Objective 7: To build the assets and economic opportunity of the most vulnerable in Karamoja
- Objective 8: To strengthen the capacity of Ugandan institutions (public and private) to promote responsible and sustainable economic development

In addition, the country strategy specifies three expected outcomes:

- Outcome 1: Government is more responsive and accountable to the poor and vulnerable
- Outcome 2: Poor and vulnerable people have better health, higher levels of education achievement and a more secure and stable environment
- Outcome 3: Increased economic opportunity and empowerment for the poor and vulnerable

Objective 5 comprises Ireland's support to the response to HIV/AIDS. It is based on an overall wish to help Uganda consolidate the gains it has made in reducing HIV prevalence. Ireland is concerned at recent trends in the epidemic; for this reason, Irish Aid (with DFID and Danida) was designed to support the implementation of a harmonised HIV prevention programme whose main objective is to increase access to quality

prevention services for the most vulnerable. The harmonised approach will provide more leverage in promoting national leadership and better aid effectiveness through the application of key principles such as alignment, mutual accountability and managing for results. It will help to revitalise support for effective prevention, care and treatment, as well as social support to achieve universal access. The country strategy paper 2010-14 envisages further programming in the first year of implementation.

The CSP states that support will continue for the civil society fund to help scale up evidence-based prevention activities, and improve access to quality services provided by non-state actors. Irish Aid will ensure that there is a greater focus on 'hard to reach areas' and a more equitable allocation of resources around prevention. Support will also be provided for innovative prevention strategies that reach the most vulnerable populations.

Irish Aid will also support national and decentralised level coordination, as well as the strengthening of monitoring and evaluation systems. It will include an institutional review and strengthening of the Uganda AIDS Commission and the AIDS Partnership Committee through a Partnership Fund. Irish Aid will ensure that this fund is used to support research related issues, such as the national AIDS conferences. The Ministry of Local Government will also receive support to strengthen capacity at local government level in resource mobilisation as well as data collection and analysis for planning and delivery of HIV and AIDS services. These interventions will help to improve the capacity of local authorities in planning, coordination, and monitoring of all HIV and AIDS activities at district level.

The outcome will be improved quality in the delivery of services at local level.

The CSP further states that Irish Aid will support coordination of relevant research that will facilitate evidence-based planning, programming and implementation, targeting those bearing the heaviest burden. This will help to focus on the poor and vulnerable. Irish Aid will contribute to aid effectiveness by strengthening national coordination and leadership through the AIDS Partnership Fund, ensuring effective implementation of the 'Three Ones' concept[201].

Irish Aid will also assist the 11 UN agencies that have come together as the Joint UN Team on AIDS to deliver the single Joint UN Programme of Support to AIDS. This programme maximises the comparative advantage of each agency and fund to provide technical assistance for policy work, advocacy for political commitment, building an enabling environment and ensuring a more informed society. Greater attention will be directed at the lower levels through joint programming, in alignment with the HIV/AIDS National Strategic Plan. Irish Aid will continue to mainstream HIV in the education and governance sectors. It will also ensure that learning from the decentralised response informs national level policy and programming.

It is expected that improvements in service delivery and accountability by government and non-state actors will lead to a more equitable distribution of services and an increase in uptake by the poor and vulnerable. In addition, the capacity of the Uganda AIDS Commission, the AIDS Partnership Committee and local governments to plan and manage the multi-sectoral response will be enhanced.

201 One agreed AIDS action framework that provides the basis for coordinating the work of all partners. One national AIDS coordinating authority, with a broad-based multisectoral mandate. One agreed country-level monitoring and evaluation system.

USAID

The U.S. Agency for International Development (USAID) works to improve health and health systems in Uganda. USAID works with the government, private sector and people of Uganda to increase access to quality and availability of health services and encourage healthy behaviour. The goal is to develop a sustainable programme that results in improved health and nutrition in focus districts and targeted populations. In 2012, U.S. health assistance to Uganda will be about USD 430 million, reach seven million Ugandans, and focus on HIV/AIDS, malaria and TB prevention and treatment, maternal and child health, family planning, nutrition, treatment of neglected tropical diseases, and emerging pandemic threats. The United States is the largest single donor providing health aid to Uganda, investing money where it is most needed and where it will make the most difference.

HIV/AIDS

As a focus country for the U.S. President's Emergency Plan for AIDS Relief (PEPFAR), USAID works with partners to deliver prevention, treatment, care and support services to those infected with and affected by HIV/AIDS, including orphans and vulnerable children. A central element of the programme is to build local leadership response to HIV prevention, care and treatment programmes, bolster the multi-sectoral response, including improving workplace policies, and linking nutrition needs of people infected and affected by HIV/AIDS with food security programmes.

Disease Prevention

Uganda is also a focus country for the U.S. President's Malaria Initiative (PMI) that aims to reduce malaria by 70% through proven approaches, such as indoor residual spraying, insecticide-treated bed nets, prevention of malaria during pregnancy and appropriate diagnosis and treatment of the disease. USAID also provides critical support to the Ugandan Government's Tuberculosis programme and integrates TB programmes with other health and HIV/AIDS programmes. A majority of Uganda's diseases are caused by poor hygiene and sanitation, often attributed to the low 67% national coverage for reliable water source. USAID's water programme focuses on water, sanitation, and hygiene interventions and is integrated with the larger goals of improved nutrition.

Maternal and Child Health

USAID focuses on improved health for children under the age of five, and women of reproductive age. Specifically, USAID/Uganda programmes include immunization, Vitamin A supplementation, improved antenatal care, safe delivery services, and fistula repair. USAID activities also help to address barriers for women to access health services through the promotion of gender equity. Under the U.S. President's Global Health Initiative (GHI), we have started to implement "Saving Mothers, Giving Life" programme in four districts. This programme aims to significantly reduce maternal mortality in focus districts by finding sustainable, scaleable solutions that reduce maternal deaths during labour, delivery, and the 24 hours following delivery. As a part of Uganda's "Feed the Future" Programme, USAID nutrition programmes seek to prevent under nutrition by focusing on evidence-based interventions during pregnancy and the first two years of life, or the "first 1,000 days." Nutrition programmes are also integrated with economic growth and agriculture programmes.

Family Planning and Reproductive Health

Uganda has one of the highest fertility rates in the world with 6.2 children per woman, and over 40% of women report an unmet need for family planning. In 2000, the popula-

tion was approximately 23 million. Now it is approximately 35 million. To address the challenges that come with a rapidly growing population, USAID works with a variety of stakeholders in the public and private sector to support voluntary family planning and reproductive health, including social marketing, vouchers, franchising, outreach camps, and workplace programmes. USAID also works closely with the Ugandan Ministry of Health to increase the availability, affordability, and quality of voluntary family planning services, including contraceptives within the public health systems.

2. Purpose of the Evaluation
For a number of years, especially in the early phases of the epidemic, Uganda attracted attention from the rest of the world because of its success in reducing HIV/AIDS prevalence. Since 2006, however, prevalence and incidence have stopped declining despite increased funding.

Ultimately, as stated by Uganda AIDS Commission, the aim of the AIDS response is to rid Uganda of the disease. This will take decades; in the shorter or medium term it will be important to bring the epidemic under control or, in other words, to achieve an AIDS transition[202] (i.e to ensure that the number of new cases does not surpass the number of deaths) so that the total number of people living with HIV/AIDS begins to fall and the disease can be treated liked other chronic diseases. The prospects for this will be an important outcome of the evaluation.

The purpose of the evaluation is to analyse the (recent) past practices of government, donors and civil society with a view to determining what has been successful and what has not – and why - so that future interventions can become more effective. The evaluation should be a learning evaluation which also provides documentation of results. The above implies analysing the 'theories of change' or, in other words, the logic of how change is to be brought about, including questions of which donor support mechanisms seem to work and the reasons for this. Furthermore, an assessment should be made of the supportive and constraining factors including any assumptions.

3. Scope of the Evaluation
The evaluation will assess the support from Irish Aid, USAID (to CSF and the PF) and Danida to the response to HIV/AIDS during the period 2007 to 2012 against the background of the general progress in Uganda's response to the epidemic and present data on results.

The scope of the evaluation is not to assess the national response as such; this would be a major undertaking which would fall under the purview of the Ugandan authorities. However, an evaluation of the donor support would not make sense in itself because the donor support, as the name implies, is intended to intensify and give strength to the national response; therefore, some description of the national response including its progress and its challenges is necessary.

A number of studies, reviews and evaluations have been undertaken within recent years. These provide a wealth of information that will make it possible for the evaluation to assess and describe the national response in order to paint the backdrop for the evaluation of the donor support. The following list, which may not be exhaustive, gives an impression of the most relevant literature:

202 See "Achieving an AIDS Transition – Preventing Infections to Sustain Treatment" by Mead Over, Center for Global Development, Washington 2011.

- Uganda AIDS Commission (2011): *Status of HIV Prevention Policies and Programmes in Uganda. Review Report.* UAC Kampala
- Uganda AIDS Commission (2012): *Global AIDS Response Progress Report. Country Progress Report.* UAC Kampala
- Uganda AIDS Commission (2012): *National AIDS Spending Assessment.* UAC Kampala
- Uganda AIDS Commission (2011): S*tatus of HIV Prevention Policies and Programmes in Uganda. Review Report.* UAC Kampala
- Uganda AIDS Commission (2012): *Global AIDS Response Progress Report. Country Progress Report*. UAC Kampala
- Uganda AIDS Commission (2012): *National AIDS Spending Assessment.* UAC Kampala
- Uganda AIDS Commission (2011): *Institutional Review. Volume I Review Report.* UAC Kampala
- The Civil Society Fund (2009): *Review of the Civil Society Fund Uganda.* P. Janssen and B. Mwijuka. DFID Resource Centre London
- The Civil Society Fund (2011): *Mid-term Review of Civil Society Fund Uganda.* EASE International Copenhagen
- Straight Talk Foundation (2007): *The Straight Talk Campaign in Uganda: Impact of Mass Media Initiatives. The Full report.* STF Kampala
- Uganda AIDS Commission (2009): *Uganda HIV Modes of Transmission and Prevention Response Analysis. Final Report*. UAC/UNAIDS Kampala
- Uganda AIDS Commission (2008): *Report of the Third Joint AIDS Review and Sixth AIDS Partnership Forum held at Imperial Royal Hotel October 13th -17th, 2008.* UAC Kampala
- Uganda AIDS Commission (2011): F*ourth Joint Annual AIDS Review Conference 2011. The National HIV&AIDS Strategic Plan 2007/8 -2011/12.* UAC Kampala
- Ministry of Health et al (2011): *Uganda AIDS Indicator Survey 2011. Preliminary Report.* MoH Kampala
- The draft National Strategic Plan for HIV&AIDS 2011/12-2014/15 (Revised) UAC, January 2011, has a chapter describing the experiences gained through the implementation of the first NSP.

The company which is awarded the contract will get all documentation collected in the preparatory process.

The scope of the evaluation is the total support packages from Denmark and Ireland as well as the support from USAID to the CSF and the PF. This means that the evaluation will cover the following:

- The support through the AIDS Partnership Fund and the Civil Society Fund. The evaluation should assess whether the chosen modality is relevant, efficient, effective, and sustainable, and whether the impact is satisfactory.

- The donors' ways of supporting the two funds including the extent of earmarked versus coresupport, the quality of the Support Documents (Danida's Programme Support Document and Irish Aid's Country Programme Paper), the validity of the Logical Framework, the logic of how change is to be brought about (intervention logic/theory of change), the mechanisms for ensuring that the objectives are attained including the use of technical assistance, and the assumptions and risks identified.

- The management of the support to the two funds. It will include lessons learned from the CSF's broader implementation experience and working with multiple donors, including, best practice/innovations and programme management experiences.

4. Evaluation Criteria and Evaluation Questions
The most important question is whether the Danish/Irish/USAID support has contributed to achieving the results that the National Strategy set out to achieve[203]. A relevant supplement to this assessment is whether Uganda has made progress towards the AIDS transition or, in other words, is the epidemic under control or is it still growing?

The key evaluation questions relate to the DAC criteria of Relevance, Efficiency, Effectiveness, Impact and Sustainability. The answers to the key questions should help establish whether the support has been helpful based on its own logic. Below is outlined what each DAC criterion implies in an AIDS context.

Relevance
In an AIDS context the term relevance means whether an intervention has addressed the needs of the users, i.e. the People living with HIV/AIDS (infected as well as affected), and whether it has contributed to the prevention of new cases. It should be established which difference it made and if possible provide data to corroborate this. Suggested key evaluation questions for discussion:

1. Has the policy dialogue regarding the 2007/12 and the new national AIDS strategy been relevant and effective, including whether the donors' areas of support conforms to the needs, priorities and policies of Uganda? To answer this, a document review shall be undertaken and donors and government alike should be asked questions based on the main elements of the NSP. Specifically, given the importance of the issue related to human rights and those drivers of the epidemic often seen as 'difficult', i.e., MARPs, it should be established whether the dialogue has resulted in the inclusion of the dialogue partners' points of view in the NSP.

203 The aim of the NSP is universal access to prevention, care and treatment, and social support. The NSP aims to reduce the incidence rate by 40%, treat 80% and expand social support to 54%, all by 2012.

Efficiency
Efficiency means whether an intervention has been effective when compared to the cost involved. This means that the evaluation should try to establish how much has been spent, and on what, in order to provide an assessment of whether it was worthwhile and the relative efficiency of various components. Suggested key evaluation questions for discussion:

2. For each of the components (for the Danish support: Two in Phase 1, three in Phase 2) and subcomponents (four in the first phase of Danish support, five in the second) establish the amounts spent and assess the degree of attainment of outputs and outcomes and comment on the relative efficiencies. This will also cover the efficiency of the CFS and the PF.

3. An assessment of efficiency also involves opportunity costs – are there unaddressed issues that would have produced better results for the same amounts (male circumcision, Prevention of Mother To Child Transmission (PMTCT), sexual minorities, prisons)? Would it have been reasonable to introduce more earmarked components despite the commitment to the Paris Declaration?

Effectiveness
Did the support achieve what it intended to achieve?

Sustainability
The big issue here is treatment costs. Treatment of AIDS with ARVs is life long, and the more people on treatment the more unsustainable the intervention becomes. The health economist Mead Over's new book on 'Achieving an AIDS Transition' refers.

The evaluation should look at Uganda's ability to foot the AIDS bill if the amount of external support cannot be sustained, as well as government commitment, political will, and institutional capacity including private sector and civil society.

A discussion of whether an intervention to curb an epidemic must be sustainable – i.e., is there a case for 'killing the thing' because if you succeed there will be no future costs? Is this likely?

5. Approach and Proposed Methodology
The evaluation shall be conducted according to OECD/DAC standards (DAC 2010) and the specific rules applying to evaluation of Danida-funded activities (see Danida Evaluation Guidelines January 2012). Due to the multiple-actor issue it will most likely be difficult to attribute outcomes to specific/individual donors, but where feasible the evaluation will do so.

It is proposed that the evaluation use a mix of quantitative and qualitative methods.

Quantitative methods:
The HIV/AIDS subsector is relatively well documented because of the solid funding and the evaluation should make maximum use of existing documentation. An element of triangulation could be introduced by primarily using data from the National Performance Measurement and Management Set-up[204], contrasting and supplementing these

204 See the National Performance Measurement and Management plan for the National Strategic Plan for HIV/AIDS in Uganda 2007/8 2011/12 elaborated by Uganda Aids Commission in 2007.

with 'independent' data from UNAIDS, WHO, and Measure DHS, and data from those donors that fund or undertake surveys such as USAID and others.

Qualitative methods:

- Document review. Given that many hundred documents on the development of the epidemic in Uganda exist, it is important to select the key documents.

- Interviews with key actors. Again, the number of organisations working with HIV/AIDS in Uganda is very large, and care should be taken to select the most important of these while making sure that different categories are represented (National NGOs including those based at district level, CBOs, FBOs, private sector organisations, International NGOs, UN organisations, donors, researchers, human rights organisations, and user groups.

- Semi-structured interviews.

Given the extensive amount of data on AIDS in Uganda it is suggested that the evaluation be based primarily on secondary data and interviews; the evaluation will, however, assess the very important issues related to the adequacy of the national data collection methods and the data collected, including possible limitations on data availability and their implications for evaluation of interventions. In this context the use of data for real-time monitoring and adjustment of the response should be assessed.

The proposed methodology shall be further developed by the Tenderers as part of technical proposals and by the incumbent evaluation team as part of the inception phase.

For the full text of the Terms of Reference, please refer to www.evaluation.dk

9. Evaluation Principles, Management and Support

The evaluation will be carried out by an independent Evaluation Team selected through an international tender.

Governance Structure

A Reference Group for the evaluation will be established, comprising stakeholder representatives and relevant technical expertise. The reference group will comprise representatives from the embassies of Denmark and Ireland, USAID, The Africa Office and the Technical Advisory Services of the Ministry of Foreign Affairs of Denmark, The Office of the Prime Minister of Uganda, representatives of UAC, CSF and civil society in Uganda[205]. The Reference Group will have an advisory role and will provide comments to the draft inception report and draft evaluation report. It will work as a virtual group (by means of e-mail and video-conferencing), but members of the reference group will also be invited to participate in relevant workshops during the evaluation process.

The evaluation will be managed by Danida EVAL. Management of the evaluation will be in accordance with Danida Evaluation Guidelines (2012) and the OECD/DAC evaluation standards.

205 Other development partners may join the group or be involved e.g. in stakeholder workshops during the evaluation process to facilitate learning and exchange of experience.

Stakeholders will be consulted at strategic points during the evaluation process, notably in connection with the discussion of the draft inception report and the draft evaluation report.

Duties of the evaluation team
The evaluation team will carry out the evaluation based on a contract between MFA and the incumbent company/institution. The evaluation team will:

- Prepare and carry out the evaluation according to the ToR and the approved Inception Report and Work Plan.

- Be responsible to EVAL for the findings, conclusions and recommendations of the evaluation.

- Report to EVAL regularly.

- Coordinate meetings and field visits, and other key events.

- The Team Leader is responsible for the team's reporting, proper quality assurance, and for the organisation of the work of the team. The Team Leader will participate in the Evaluation Reference Groups' meetings and other meetings as required.

For the full text of the Terms of Reference, please refer to www.evaluation.dk

Annex G Documents Consulted by the Evaluation

1. Adamchak, SE et al. (2007) *The Straight Talk Campaign in Uganda: Impact of Mass Media Initiatives.* Summary Report. Population Council, New York NY

2. AMICAALL (2012) *Annual Report 2012.* AMICAALL, Kampala

3. Anon (2011) *Development of Uganda's HIV Prevention Strategy 2011-15 and National HIV Prevention Action Plan 2011/12- 2012/13 Volume 1: Report of the Review of the Magnitude and Dynamics of the HIV Epidemic and Existing HIV Prevention Policies and Programmes in Uganda.* Report submitted to UAC, Kampala.

4. Anon (2011) *Mid-Term Review of Civil Society Fund Uganda.* EASE International, Copenhagen

5. ARROW Trial Team (2013) *Routine versus clinically driven laboratory monitoring and first-line antiretroviral therapy strategies in African children with HIV (ARROW): a 5-year open-label randomised factorial trial.* Lancet; 381: 1391-1403

6. Asiki, G et al. (2011) *HIV and syphilis prevalence and associated risk factors among fishing communities of Lake Victoria, Uganda.* Sex Transm Infect; 87:511-515 doi:10.1136/sti.2010.046805

7. Bass, E (2005) *Fighting to close the condom gap in Uganda* http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(05)71861-4/fulltext (Accessed 1 July 2012)

8. Beuving, JJ. (2010) *Playing Pool Along the Shores of Lake Victoria: Fishermen, Careers and Capital Accumulation in the Ugandan Nile Perch Business.* Africa; 80,Issue 02, pp. 224-248 DOI: http://dx.doi.org/10.3366/afr.2010.0203

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10. Blankenship, KM, Bray, SJ & Merson, M H (2000) *Structural interventions in public health*. AIDS, 14 Suppl 1, S11-2

11. Blue, R et al. (2011) *Evaluation of the Implementation of the Paris Declaration: United States Government Synthesis Report.* Social Impact, Arlington VA

12. Bunnell, R. et al. (2006) *Changes in sexual behavior and risk of HIV transmission after antiretroviral therapy and prevention interventions in rural Uganda.* AIDS, 20:85–9

13. Chapman, N. et al (20XX) *Evaluation of the Irish Aid (Uganda) Country Strategy Paper 2007-2009.* ITAD, Brighton, UK

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