Annex F: Detailed Evaluation Findings across the NSP Thematic Areas

F.1 Advocacy and networking

F.1.1 Background to advocacy and networking in the Ugandan AIDS Response

In order to reach individuals at most risk and the general public, the NSP urges the use of all social, religious and economic, cultural, and health institutions for delivering HIV prevention advocacy. Civil society is considered instrumental in advocating for the various HIV & AIDS issues, including the rights of PLHIV. This has been championed by networks and coalitions such as Coalition for Health Promotion and Social Development, National Forum for PLHIV Networks in Uganda, the International Community of Women living with HIV & AIDS, and CSOs including Better Health Action Group Uganda and TASO.

Advocacy efforts under the Uganda AIDS response address (1) increased funding for the response by development partners and the GoU; (2) policy formulation and reviews; (3) increasing support to the decentralised response especially at the local government level; and (4) inclusion of CSOs at community level in the AIDS response. Specific targeted advocacy efforts concerned increased access to services by MARP through changing the national response priorities for MARP and the commitment to advocacy for universal coverage (scope & scale)[1].

Advocacy for sustainable funding to the response has yet to yield results given the high dependence on development partners that provide nearly 90% of the funding envelope for HIV & AIDS interventions in Uganda[2]. Any significant reduction of this support will inevitably negatively affect the implementation of the national response, in view of the low funding levels from GoU. The HIV & AIDS Partnership Mechanism Review Report[3] shows that while there has been active involvement in policy, plan and programme development at various levels, insufficient resource mobilisation especially for care and support and very low funding from GoU remain a key hindrance to progress.

Advocacy efforts to strengthen systems in the AIDS response has been undermined by dwindling political commitment compared to that of the previous two decades. The previous strong leadership, governance and coordination across government, combined with effective coordination of all stakeholders by UAC, which was the mainstay of a successful response is becoming watered down by changes in national priorities.

F.1.2 CSO Capacity for Advocacy

The CSF and Partnership Fund have not adequately addressed capacity building for advocacy activities in the AIDS response. The National Forum for PLHIV Networks in Uganda, an umbrella organisation for PLHIV networks and a Partnership Fund self-governing entity, with a primary role in advocacy has limited capacity to execute its capacity building mandate. Funding from the Partnership Fund supports its secretariat costs and coordination with the district networks, but not it's programming building capacity of district networks for advocacy. CSF grants might complement the core funding from the Partnership Fund, to enable programming

[1] UAC (2012) *National Strategic Plan for HIV & AIDS 2011/12 -2014/15 (Revised)*. Uganda AIDS Commission, Kampala.
[2] UAC (2012) *National AIDS Spending Assessment, Uganda 208/9 to 2009/10*. Uganda AIDS Commission, Kampala.
[3] Report (2013) *HIV/AIDS Partnership Mechanism Review*. Uganda AIDS Commission, Kampala.

activities – and the evaluators were told by one organisation that they have such complementary grants (see next paragraph). However, the evaluation was also told that National Forum for PLHIV Networks in Uganda is part of a consortium with Uganda Network of AIDS Service Organisations and Uganda Network on Law, Ethics and HIV/AIDS that has a CSF grant. But the CSF grant does not support the National Forum for PLHIV Networks in Uganda's mandate for advocacy. This lack of support is surprising as the National Forum has a 2010 advocacy strategy[4] in line with the NSP, for advocating and promoting a positive health, dignity and prevention approach that focuses on PLHIV and their needs for living a healthy life while reducing the risk of transmission of HIV to others.

The CSF has provided grants to the National Forum for PLHIV Networks in Uganda and Uganda Network of AIDS Service Organisations – Partnership Fund self-coordinating entities for coordination of the AIDS response in their respective constituencies. The rationale for supporting them through the Partnership Fund *and* CSF was the unique role they play under their mandate. However, these organisations are heavily dependent on the two sources of funding. If the Partnership Fund and CSF financial support ends, they are at risk of shutting up shop.

F.1.3 Advocacy for Involvement of Marginalised and Excluded MARP

Advocacy for participation and inclusion of marginalised individuals such as MSM, other LGBTI and sex workers faces an uphill task given the illegality of their behaviours and lack of tolerance by government and much of Ugandan society. This has driven marginalised individuals underground, yet they are highly vulnerable to HIV infection and commonly form a bridge for infection into the general population. CSF has not funded any CSO representing MSM, other LGBTI, or sex workers; rather it has an overall general focus on MARP with mainstream CSOs doing outreach to fishing communities (to a limited extent), boda-boda drivers, uniformed personnel and truck drivers.

The Midterm Review report of the NSP points to efforts made to improve the legal and policy environment for the national response albeit with some challenges. The long delay in the amendment of the UAC statute and the passing of policies such as the National HIV & AIDS Policy and School Health Policy have had a degree of negative impact on the multi-sectoral response. There is also concern that the provisions in the HIV/AIDS Prevention and Control Bill 2010 infringe international standards for human rights by inclusion of mandatory serotesting, disclosure of results without consent, criminalisation of attempted and intentional transmission, lack of gender sensitive counselling and lack of protection of vulnerable populations etcetera[5]. Although the modes of transmission study[6] identified MARP as commercial sex workers, uniformed services, fishing communities, truck drivers, MSM and injecting drug users, there are still no policies or guidelines for the implementation of interventions for these MARP, nor are there any dedicated MoH services for MSM, sex workers and injecting drug users. The modes of transmission report notes that while more responsive legislation is required by the revised NSP, more advocacy work will be required to have guidance widely translated and disseminated[7].

F.2 Prevention

---

[4] NAFOPHANU (2010). *NAFOPHANU Advocacy Strategy – 2010-2012*. National Forum for PLHIV Networks in Uganda, Kampala.

[5] 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 said national parliaments will then have to ratify the East African bill and synchronise it with local law.

[6] Report (2009) *Uganda - HIV Prevention Response and Modes of Transmission Analysis*. Uganda AIDS Commission, Kampala.

[7] Report (2009) *Uganda – HIV Prevention Response and Modes of Transmission Analysis*. Uganda AIDS Commission, Kampala.

F.2.1 The Context of Prevention

Prior to the NSP and the implementation period for the current evaluation, prevention strategies largely focused on individual behaviour change – initially in the 1990s messages supported a package of **A**bstain, **B**e faithful, and use **C**ondoms, with "zero grazing" a slogan popularised by the Head of State. From 2001, USAID supported the Presidential Initiative on AIDS Strategy for Communication to Youth in Ugandan schools[8] that promoted abstinence-only messages[9], followed by PEPFAR's emphasis on "AB/Y" or abstinence until marriage and marital fidelity for young people, with condoms only being promoted for high risk sexual encounters[10]. In 2004, the political climate favouring abstinence-only approaches in Uganda included numerous anti-condom statements by senior politicians; the First Lady championed abstinence-only through the National Youth Forum which she established and which received USAID funding, and UAC released a draft "Abstinence and Being Faithful (AB)" policy[11].

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"[12]. A strong focus on preventing new HIV infections is highly *relevant* to achieving an AIDS transition.

F.2.2 GoU Prevention Policy, Priorities and Plans 2007-2012

From 2007, the NSP[13] established priorities for prevention and outlined imperatives for strengthening systems for service delivery. However, there is no mention of MSM in the situational analysis of key drivers of the epidemic[14] 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." Priority areas for prevention to achieve the goal of 40% reduced incidence of HIV infection by 2012 (a target reduced in the revised NSP to 30% by 2015) included:

- Accelerating prevention of sexual transmission of HIV targeting the vulnerable and MARP
- Promotion and scale-up of PMTCT
- Ensuring blood transfusion safety, universal precautions and post-exposure prophylaxis
- Controlling sexually transmitted infections
- Developing appropriate policies and programmatic guidelines for implementation of new HIV preventive technologies proven to be effective.

The NSP prevention goal had five objectives with partly measurable outcomes. Objective 1 aimed at accelerating the prevention of sexual transmission of HIV through established as well as new and innovative strategies. This suggested an array of indistinct "strategic actions" given as[15]: promote ABC;

---

[8] Irish Aid also collaborated on this initiative see: Chapman, N. et al (20XX) *Evaluation of the Irish Aid (Uganda) Country Strategy Paper 2007-2009*. ITAD, Brighton, UK.
[9] *Human Rights Watch* (2005) Vol. 17, No. 4 (A).
[10] 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 Relief*. Office of the Global AIDS Coordinator Washington, DC.
[11] http://www.hrw.org/en/reports/2005/03/29/less-they-know-better (accessed 25 June 2013).
[12] http://www.who.int/hiv/pub/mtct/programmatic_update_tasp/en/ (accessed 29 June 2013).
[13] UAC (2007) *Moving Toward Universal Access: National HIV & AIDS Strategic Plan 2007/8-2011/12*. Uganda AIDS Commission, Kampala.
[14] UAC (2007) *Moving Toward Universal Access: National HIV & AIDS Strategic Plan 2007/8-2011/12*. Uganda AIDS Commission, Kampala, p. 12.
[15] UAC (2007) *Moving Toward Universal Access: National HIV & AIDS Strategic Plan 2007/8-2011/12*. Uganda AIDS Commission, Kampala, pp. 21-22.

develop and implement prevention interventions among key populations; focus on youth; empower service providers; target discordant couples; develop effective information education communication (IEC) interventions; promote abstinence among youth; focus prevention on key populations at higher risk addressing socio-economic and cultural factors; improve legislative and policy framework to support population at higher risk; utilise social, religious, health, economic and cultural institutions for HIV prevention messages; support prevention for women and children in conflict areas; increase preventive work in fishing communities through HIV counselling and testing.

Objective 2, a biomedical intervention, aimed to reduce HIV transmission from mother-to-child by 50% by 2012. Several of the strategic actions for PMTCT are specific to the MoH, and outside the scope of this evaluation as not funded by the joint door support. However, the structural barriers to uptake of PMTCT services and continued adherence to ART cannot be addressed by the MoH services alone as they need sustained support for change that might ideally be provided by CSO programmes. There are also key care services that should be linked to PMTCT. These include sexual and reproductive health with a focus on family, prevention, early diagnosis and treatment of sexually transmitted infection, and safer motherhood.

Objective 3, a biomedical strategy, aimed at maintaining 100% blood transfusion safety, for 100% adherence to universal precautions, and 100% access to post-exposure prophylaxis at ART centres by 2012. The strategic actions also focused on better screening of blood at health facilities, linking exposed individuals to counselling and testing, and improved selection of HIV-free blood donors.

Objective 4 aimed at control of sexually transmitted infections and increased appropriate uptake of services to 70% by 2012. Strategic actions included review of guidelines, strengthened capacity of health facilities for diagnosis and treatment, provision of commodities and social services for sexually transmitted infection management, integration of HIV counselling and testing, and *provision services for key populations at high risk*[16].

Objective 5 promoted the use of new biomedical HIV prevention technologies and approaches of proven effectiveness and included policies for safe male circumcision as part of a comprehensive prevention package.

The Minimum Package of HIV Prevention Services for Adults defined by the National HIV Prevention strategy

Core Components:

1. PMTCT
2. Male circumcision
3. HIV counselling and testing
4. Antiretroviral Therapy
5. Condom promotion

Complimentary Components:

6. BCC integrated into existing structures (religious institutions, work places, school, etc)
7. IEC Messages and social norms reinforced through mass media
8. STI screening and treatment
9. Blood Transfusion Safety and Infection Control
10. Supporting policy and advocacy

The National HIV Prevention Strategy for Uganda: 2011-15[17] drew on the Crane Survey[18] and 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

[16] Key populations at higher risk are defined 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."
[17] UAC (2011) *The National HIV Prevention Strategy for Uganda: 2011-15*. Uganda AIDS Commission, Kampala.
[18] 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.

operate motor-cycle taxis (8%). It noted that students in six universities with recent data had lower prevalence 1.2% (0.4-1.8%). The UAC National Prevention Committee also received a detailed report 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"[19]. The National Prevention Strategy also acknowledged "the importance of socio-cultural, gender, structural and other underlying factors in driving HIV epidemics in sub-Saharan Africa. These factors operate at distal level to influence the proximate risk factors for HIV infection, including influencing uptake of HIV prevention services and sexual behaviour"[20]. The draft prevention strategy flagged up that: "The Civil Society Fund, by June 2009, it had disbursed 51% of its HIV prevention resources (UGX 21,180,360,653) 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). These are not aligned to the Modes of Transmission."[21]

The National HIV Prevention Strategy affirmed "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, vertical infections, 20%, and blood borne infections probably less than one%, 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. In Uganda's generalised HIV epidemic, there are geographic hotspots typical of a concentrated epidemic and most-at-risk-population groups (MARP) with risk behaviours that make them more vulnerable to HIV infection than the general population."

However, the revised NSP[22] and the National HIV Prevention Strategy rest heavily on biomedical interventions and individual behaviour change promoted by IEC. There is a lesser focus on addressing structural issues. The Revised NSP endorses combination HIV prevention involving implementing multiple (biomedical, behavioural and structural) prevention interventions with known efficacy in a geographic area at a scale, quality, and intensity to impact the epidemic. It emphasises four components, to scale up biomedical interventions to achieve universal access targets, uphold behavioural interventions articulated in the National Prevention Strategy, address socio-cultural and economic drivers of the epidemic and re-invigorate the political leadership at all levels to enlist their commitment to HIV prevention. Yet the 2012 report to UNGASS states "(the) limited efforts towards a structured combination package and integration of services was a big challenge. IEC/BCC interventions lacked clear guidelines, policies, standards and were often not aligned to factors driving the epidemic while social cultural norms that influence behaviour were often neglected. In general, mainstreaming of HIV prevention in development programmes remained sub-optimal."[23]

F.2.3 Comprehensive Behaviour Change Approaches

Blankenship et al. identify three different levels in the design of structural interventions: 1) *Availability interventions* – where people are often restricted via laws, taxation, distribution of support or hindering

---

[19] 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.

[20] Identified with further detail in Report (2010) *Development of Uganda National HIV Prevention Strategy: Report of the Background Review of the Epidemiology, Drivers, coverage, Scope and Effectiveness of HIV Prevention Efforts: Draft Consultancy Report*. Uganda AIDS Commission, Kampala.

[21] 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.

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

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

mechanisms or criminalisation. 2) *Acceptability interventions* – where normative structures in public health problems are located and manipulated to affect public health. 3) *Accessibility interventions* – have a focus on the unequal distribution of resources and power and interventions that try to compensate for or re-balance defined inequalities in the social context[24]. These different levels work interchangeably, but it is important to note that single prevention strategies are often insufficient and a combination of strategies are needed, including biomedical, behaviour and structural intervention efforts[25]. By combining or using different strategies some synergistic effects can be achieved that can elevate the predicted health outcomes. Even though several structural interventions have proven to be successful in other public health concerns, there are obviously great challenges when it comes to HIV and sexuality. There might be other mechanisms and interests in maintaining specific behaviours such as for commercial sex workers, or limited/unequal power in relationships or ethical dilemmas when it comes to human right issues and planned interventions. Another key problem regarding people's sexuality is that it is viewed as private, often surrounded by secrecy and taboos, and thus not dealt with openly in the public sphere. Therefore, an understanding of people's social and sexual interaction in relation to the risk for transmission is important to curb the incidence.

To sustain 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, much as the care and support grantees had expressed 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. Many small CSOs that have few possibilities to continue their programmes and attract new funding for their prevention strategy face two different sustainability issues. The first is the overall investment of GoU and the other is programmatic, where the CSF grants are too short-term. Most CSOs reported to the evaluation worries about the next phase of funding and if they would able to continue their work. Often, grants were given on an 18 months funding basis that left little time after the start-up phase before the need to close out for the actual prevention activities. 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.

F.2.4 Biomedical Prevention

Prevention of Mother-to-Child Transmission of HIV

In Uganda where HIV prevalence increases during reproductive age, and, for example, students have a low HIV prevalence, provision of PMTCT services is highly relevant if Uganda it is to achieve a "generation free from AIDS"[26] that will be supported to grow up free from HIV infection, so that the HIV epidemic "ages out".

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.[27] In turn the objectives of the guidelines are with in line with the PMTCT scale up plan 2010-2015.

[24] Blankenship, K M, Bray, SJ & Merson, M. H. 2000. *Structural interventions in public health*. Aids, 14 Suppl. 1, p. 11-21.
[25] Horton, R & Das, P. 2008. *Putting prevention at the forefront of HIV/AIDS*. Lancet, 372, 421-2.
[26] The Mission of the Ministry of Health Sexually Transmitted Diseases & AIDS Control Programme.
[27] Guidelines (2011) *Integrated National Guidelines on ART, PMTCT, and IYCF*. Ministry of Health, Kampala.

The percentage of health facilities offering PMTCT services increased in 2011/12 to 36% from 32% in the previous year although PMTCT service coverage varies by level of health facility with 84% of hospitals, 95% of health centre-IVs, 93% of health centre-IIIs, and 12% of health centre-IIs offering PMTCT services in 2011/12. However, PMTCT service provision is still very low in health centre-IIs, which make up the majority (70%) of health facilities in Uganda[28]. Yet the 2012 country progress report to UNGASS stated that "PMTCT services were being provided in ***all*** hospitals, health centre-IVs and IIIs" for the same period[29]. Nonetheless, not all HIV positive pregnant mothers have access to PMTCT services, and the GoU admitted 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"[30]. Additional reported challenges to PMTCT service delivery include low male partner involvement although spouses could positively influence uptake of PMTCT and reproductive health services as well as positively influence adherence to ART and cotrimoxazole prophylaxis, optimum breast-feeding in the context of HIV, and provide psychosocial support to the mother.

MoH PMTCT specific objectives

To increase access and utilisation of:
(1) reproductive health/HIV and sexually transmitted infection prevention and treatment services to 80% of the women of reproductive age

(2) family planning services to 80% of all women living with HIV

(3) the recommended package for prevention of mother-to-child transmission of HIV to 80% of HIV-infected women and their infants

(4) family-centred HIV care and treatment to 80% of HIV-infected pregnant and lactating women and their children (if infected with HIV)

In Uganda pregnant women with CD4 less than or equal to 350 account for approximately 40% of all HIV infected pregnant women. They contribute to more than 75% of overall mother-to-child HIV transmission and more than 80% of mother-to-child transmission after delivery. Eight-five % of maternal deaths within two years of delivery are associated with disease progression, further justifying a more comprehensive approach.[31] In September 2012, Uganda opted for life- long ART for *every HIV positive pregnant mother, regardless of their CD4 count*[32], the "Option B+" strategy[33]. This policy has huge cost and other implications, particularly as it is currently estimated that of the PLHIV eligible for ART only 50% are accessing ART services[34],[35].

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

[28] Report (2012) *Annual Health Sector Performance Report FY 2011/12*. Ministry of Health, Kampala.
[29] Report (2012) *Global AIDS Response Progress Report: Country Progress Report*. Uganda AIDS Commission, Kampala.
[30] Report (2012) *Global AIDS Response Progress Report: Country Progress Report*. Uganda AIDS Commission, Kampala.
[31] http://www.idi-makerere.com/docs/ATICNewsletter.pdf (accessed 2 July 2013).
[32] http://www.keycorrespondents.org/2013/04/05/uganda-adopts-emtct-intervention-option-b/ (accessed 2 July 2013).
[33] Programmatic Update (2012*) Use of antiretroviral drugs for treating pregnant women and preventing HIV infection in infants*. World Health Organization, Geneva; http://www.who.int/hiv/pub/mtct/programmatic_update2012/en/
[34] Table 1 in PEPFAR (2012) *PEPFAR Blueprint: Creating an AIDS-free Generation*. Office of the Global AIDS Coordinator, Washington, DC.
[35] UNAIDS (2012) *Report on the Global AIDS epidemic*. Joint United Nations Programme on HIV/AIDS, Geneva estimates that the proportion eligible PLHIV on ART in Uganda is 40-59%, as did the UNAIDS (2011) Report.

a pregnant woman discloses to her partner that she is HIV positive[36]. Unequal power relations between a woman and her partner reduce her decision making ability and access to household resources. The pregnant women, her family and community perceptions on the quality and appropriateness of maternity services may also act as a barrier to uptake of PMTCT services. 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 treatment results in suppressed viral loads, it is also highly effective in preventing transmission to others. The HPTN 052 study showed that effective treatment of a person living with HIV reduced the risk of transmission to their discordant partners by 96%[37]. This means that ART has the highest efficacy so far seen for any "real-world" HIV-prevention intervention. (Condoms have 95-99% efficacy in ideal use, but in real-world settings 100% attempted use has an efficacy of no more than 85%[38].) Further, HIV is the strongest risk factor for developing tuberculosis – PLHIV have a 20 to 37 times higher risk of developing tuberculosis than those who do not. ART has a significant secondary prevention benefit for both HIV and tuberculosis[39]. Reducing secondary infection is particularly relevant to Uganda where 43%[40] of new infections occur in monogamous discordant relationships indicating an imperative for addressing HIV testing linked to provision of ART services for such couples, with additional support for the use of condoms at least until the positive partner's HIV infection is fully controlled as indicated by CD4 count if not viral load.

However, ART alone will not be able to stem the HIV epidemic in Uganda. The efficacy of ART is limited by PLHIV knowledge of their HIV serostatus. Even those who know they are HIV positive only became aware of their status and eligible for ART years after they were first infected. Primary infection is associated with a rapid increase in viral load, and newly infected persons transmit HIV to other sexual partners[41]. No HIV prevention intervention will be fully protective, and so there will always be need for multiple HIV prevention strategies as well as interventions that reduce HIV infectiousness & susceptibility[42].

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. However, CSOs have good potential for working closely with ART service providers to increase uptake of ART, improve adherence to ART, and thus reduce the infectiousness of PLHIV on treatment, and to encourage partner HIV counselling and testing. The evaluation visited Mukono District HIV Counselling and Testing Fair, organised by a CSF grantee that included provision of IEC materials, and HIV counselling

---

[36] 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.

[37] Cohen, MS et al (2011) *Prevention of HIV-1 Infection with Early Antiretroviral Therapy*. N Engl J Med; 365: 493-505.

[38] http://www.aidsmap.com/Condom-use-in-the-real-world/page/1746225/ (accessed 29 June 2013).

[39] Programmatic Update (2012*) Antiretroviral Treatment as Prevention (TasP) of HIV and TB*. World Health Organization, Geneva.

[40] UAC (2009) *Uganda HIV Prevention Response and Modes of Transmission Analysi*s. Uganda AIDS Commission, Kampala.

[41] Similarly, a woman who becomes newly infected during pregnancy and breast feeding can transmit infection to her infant, and injecting drug users can pass on HIV infection through shared injecting paraphernalia or sexually very soon after primary infection. This often occurs in the "window period" during which the newly infected person remains negative on serotesting.

[42] 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).

and testing. Peer educators and counsellors organised groups and individual counselling as per client request[43].

HIV Counselling and Testing

Counselling and testing is regarded as a prevention strategy with the assumption that knowing one's status is effective in enabling people to make risk reducing changes in their behaviour. An indicator of the proportion of people who probably know their current HIV status is the percentage of those that received an HIV test in the past 12 months and received their results. In 2006, an estimated 82% of women and 87% of men in age group 15-49 knew where to obtain an HIV test but only 24.8% of women and 20.7% of men had ever tested and received the results of their test. From 2010 to 2011, there was a rapid scaling up of HIV counselling and testing services to being available at all hospitals and health centre-IVs, 80% of health centre-IIIs and 22% of health centre-II facilities. However, only 5% facilities offer youth-friendly HIV counselling and testing services and these are mainly hospitals and health centre-IVs particularly around Kampala. As a result of these efforts, 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[44]. These figures are not clear cut as it is not known how many being tested are new to testing or if the figures include people returning for repeat tests. 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 there were no personal data given when they went for a test and no system for tracking a person's results over time. Thus the UAC numbers for persons tested can include a significant proportion of individuals that are tested repeatedly during 12 months affecting the effectiveness of HIV counselling and testing as a behaviour change strategy.

[43] Unfortunately the community expectations of receiving free treatment for several diseases could not be met. Such events, with the presence of local leaders, can be powerful for mobilising and motivating communities around HIV &AIDS issues. However the evaluation noted a need for improved quality of information distributed before and after the event.

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

Safe male circumcision

Research in Uganda and elsewhere[45] has demonstrated that medical male circumcision reduces the risk of *female-to-male* transmission by 60%[46]. This influenced the revised NSP and the HIV and AIDS Prevention Policy and the Ministry of Health issued a *Safe male circumcision policy* in 2010[47]. Provision in public health facilities is supposed to be 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. The evaluation was told in Mbarara that uptake is 8% in that district, one of the barriers being a male perception that circumcision is "Islamisation". Sexuality is not discussed in the MoH policy, but male (and female) beliefs about sexuality are likely to be a further barrier to demand. Even in Rakai uptake rates are far too low, only 28% of non-Muslim men were as yet circumcised, for the district to reach its target of 80% of men circumcised by 2016[48].

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 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. However, 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

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. The mean number of lifetime sexual partners among those who have ever had sex is seven for men. Among those with two or more partners, condom use at the last sexual intercourse is 15% for men; only 38[49]% of men reported using condoms at the most recent high-risk sex[50]. This, along with knowledge that 43% of new HIV infections are among stable married couples, prompted a campaign in early 2013 to encourage condom use amongst men having extramarital sex, although such messages stigmatise condom use. However, if condom promotion is to work, supplies need to be sustainable affordable and of good quality; in 2011 there was a country-wide condom shortage [51].

[45] Kenya and South Africa.
[46] http://clinicaltrials.gov/show/NCT00425984 (accessed 1 July 2013).
[47] MoH (2010) *Safe Male Circumcision Policy*. Ministry of Health, Kampala.
[48] Kong XR et al. *Male Circumcision Coverage by Risk Profiles: Rakai, Uganda*. 20th Conference on Retroviruses and Opportunistic Infections (CROI), Atlanta, abstract 1009, 2013. (Abstract on CROI website unavailable July 2013) cited by http://www.aidsmap.com/Slow-progress-in-expansion-of-voluntary-circumcision-coverage/page/2590358/ (Accessed 2 July 2013).
[49] 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).
[50] Ministry of Health (2012). *2011 Uganda AIDS Indicator Survey: Key Findings*. ICF International, Maryland.
[51] http://www.avert.org/aids-uganda.htm#contentTable1 (accessed June 2013).

CSF funded the availability of 14.5 million condoms through 3,500 outlets in 2012/13[52] although the targeting (to whom and how many) is not known. The evaluation did not see a prioritised distribution plan or list.

At two fish landing sites the evaluation visited on Lake Victoria, local fisher folk – who are identified as MARP within the NSP – had incomplete knowledge of condom use and only sporadic access to condoms, which they have to purchase, in one case far from the landing site. By Lake Edward, the fishing community visited by the evaluation had access to free USAID-provided condoms in two dispensers on the outside wall of the health centre in the centre of the community.

Youth benefitting from the UNFPA SRHR project supported by Danida and implemented through four church networks have access to male and female condoms, where the church involved agrees. The four-year project that aims at long-term knowledge attitudes and behaviour change: availability of male and female condoms is a cornerstone; another is provision of youth-friendly services and teaching life skills to youth through the local church networks. The project is being implemented as part of the new MoH condom strategy.

A post-shipment testing requirement was introduced following a scandal in 2004 in which government-subsidised "Engabu" condoms failed a "free from holes" and "smell" test[53]; this requirement has led to delays in condoms reaching the public, resulting in condom shortages. 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[54]. Uganda financial expenditure on condoms as recently as 2008/09 was only USD 2 million per annum[55].

"Condom use is erratic in Uganda, partly because they are not always available to users." "Condoms are not on the essential drugs list and therefore, for the public sector, condoms are (supplied) as per available resources from UNFPA and USAID or the GFATM. This support is given when the resources are available rather than when the country needs condoms."[56]

Two free condom dispensers on outside wall of Health Centre in a Fishing Village

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[57]. The 2012 Annual Health Sector Performance Report indicates that 78% of

[52] Evaluation Key Informant Interview with a CSO in Mukono District.
[53] *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).
[54] Irin Africa (2013) *Analysis: Condoms continue to confound Uganda* http://www.irinnews.org/report/97573/analysis-condoms-continue-to-confound-uganda
[55] Health systems 20/20 (2012) *Uganda Health Systems Assessment* 2011. Abt Associates, Bethesda, MD.
[56] Irin Africa (2013) *Analysis: Condoms continue to confound Uganda* http://www.irinnews.org/report/97573/analysis-condoms-continue-to-confound-uganda
[57] Report (2012) *Global AIDS Response Progress Report: Country Progress Report*. Uganda AIDS Commission, Kampala.

health facilities provide male condoms and 8% female condoms in 2011/12[58]. Nonetheless, the evaluation learned of current district wide condom shortages during the in Uganda field work[59].

F.2.5 Civil Society Fund Prevention Grants

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 CSF should facilitate achievement of the GoU goals to tackle the HIV epidemic, as CSO programmes are a crucial component of the national response. However, the DFID-funded review of CSF[60] 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. The setup and work of CSF is important to donors investing in the initiative, for basket funding and to coordinate their work in conjunction with other structures in society[61].

The CSF provides CSOs with grants in a competitive manner through solicitations for applications although earmarked funding grants were given through non-competitive process to strategic NNGOs. The solicitations direct the focus of the grants to be awarded to reflect objectives outlined in the NSP – 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, with most CSF grants awarded for combination prevention themes BCC programming, condom distribution, HIV counselling and testing, and PMTCT.

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 DFID-funded 2009 review identified that nearly half of the prevention grants at that time focused on abstinence and faithfulness[62]. By June 2009 it was reported as 51%[63]. MEEPP data for performance trends from 2010 to 2013 indicate that CSF grants are still reporting against sexual prevention (ABC/AB) but the grant financial data from the Financial Management Agent does not make this distinction. The Financial Management Agent records are for grants for "Reduction of New HIV Infections through enhanced Community Engagement in Combination HIV Sub grantees" in line with the revised NSP.

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 for two and a half years (2011-2013) is reported as 184,155 with 47% reported as fisher folk. *The indicators reported do not capture whether the prevention activities are iterative, quality BCC activities that might influence structural, social change as well as individual behaviour change.*

Efficiency is related to how effective the grant-funded prevention activities were and if this is reflected in set objectives and targets, and the unit costs of these initiatives. Clearly, biomedical interventions are

---

[58] Report (2012) *Annual Health Sector Performance Report FY 2011/12*. Ministry of Health, Kampala.
[59] Mbarara District.
[60] Janssen, PL & Mwijuka, B. (2009) *Review of The Civil Society Fund, Uganda*. DFID Health Resource Centre, London.
[61] Janssen, PL & Mwijuka, B. (2009) *Review of The Civil Society Fund, Uganda*. DFID Health Resource Centre, London.
[62] 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).
[63] UAC (2011) *The National HIV Prevention Strategy for Uganda: 2011-15*. Uganda AIDS Commission, Kampala.

more measurable and controlled via the monitoring of PMTCT and ART programmes. BCC and IEC are more difficult to assess if investments have been cost-effective or not. Organisations that receive support for prevention activities are predominantly focusing on peer education, HIV counselling and testing, or other programmes addressing individual behavioural by influencing individuals' knowledge, attitude and practice among defined populations. These populations are outlined in the NSP and are also included in the solicitations released by CSF. Messages communicated have a focus on **A**bstain until marriage and **B**e faithful in marriage. **C**ondoms have been promoted to a lesser extent and condom use has been hampered in Uganda repeatedly by supply chain and product quality issues. **A**bstain and **B**e faithful messages are often far from peoples' realities and are not evidence-based but rather driven by political ideology and religious values.

Risk and reality for many young women in Uganda

Uganda has one of the world's highest fertility rates at 6.14[64] and many pregnancies are in teenage girls. Child marriage is also commonly practiced; 46% of women 20-24 years old were married or entered into union before the age of 18 years[65] often to older men[66]. The median age at first sexual intercourse is 17 for women and 18 for men[67]. This means that many risky sexual acts are taking place and indicates that abstinence and be faithful messages do not address the reality of risky sex for women which *often occurs within marriage* in Uganda.

Behaviour change in populations

Important for reducing new infections, behaviour change requires large numbers of people adopting substantial risk reduction strategies as well as maintaining these changes over time. Achieving this likely requires societal change to support individual behaviour change, and interventions to catalyse social and individual behaviour change generally have to be sustained over a long enough period for the new behaviour to become the norm. Measuring the impact of individual BCC and IEC, identifying more efficient ways of doing it, or assessing if the intervention might have been conducted more efficiently is not possible. However, it is likely that the CSF behaviour change interventions focusing on **A**bstain and **B**e faithful were not effective or sustained enough to significantly reduce new infections.

Sexual and reproductive health services

The NSP required that sexual and reproductive health services should be part of preventive interventions to reduce the number of new HIV infections, particularly linked to PMTCT services. CSF grant recipients participating in this evaluation had a very narrow focus on reproductive health, omitting a sexuality component, with human rights issues systematically ignored. The organisations that stressed human rights were UNFPA and those representing at risk populations that were marginalised and did not receive much attention – such as the fishing communities – or representing persons whose behaviours are criminalised under Ugandan laws – such as sex workers and MSM. The exception was that people living with disability (PLWD) in Masaka were empowered, talked about human rights and demanded their rights.

Quality control for HIV prevention materials and messaging

---

[64] Index Mundi (2012). *Total fertility map Africa*: http://www.indexmundi.com/map/?v=31&r=af&l=en (accessed June 2013) although the GoU and UNFPA *Country Programme Action Plan 2010 – 2014* put this figure at 7%, while the *Health Sector Strategic Plan III 2010/11-2014/15* states 6.5. The *Uganda DHS 2012* report gives a figure of 6.2.

[65] UNFPA (2012). *Marrying Too Young - End Child Marriage*. United Nations Populations Fund, New York http://www.unfpa.org/webdav/site/global/shared/documents/publications/2012/MarryingTooYoung.pdf

[66] Hope, R (2007) *Addressing Cross-generational Sex: A Desk Review of Research and Programs*. Population Reference Bureau, Washington, DC.

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

Comprehensive knowledge of HIV & AIDS is an important cornerstone in the prevention of sexual transmission of HIV, although knowledge alone is not adequate to lead to behaviour change[68]. The Uganda response to HIV is not guided by a strategic and comprehensive preventive strategy (for individual behaviour change and societal change), and there is a general lack of quality control of what is communicated and what is reaching the populations in most need of prevention information. Many messages communicated to the general population or to MARP are mixed with misconceptions or contain scientifically incorrect information[69]. This not only occurs at grass roots level, but occurs at all levels of society including the CSF and UAC, up to governmental levels. Investments in BCC and IEC material to reduce new infections are going into a system that lacks quality control of messages delivered and there is an absence of support for a theoretical and structural design that could guide CSOs to develop and implement comprehensive communication strategies[70].

No grantees interviewed had received technical capacity building in prevention. Several CSOs interviewed had more 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 could not be implemented with CSF funding.

F.3 Treatment

F.3.1 Background

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[71]. Since 2005, availability of ART has increased dramatically with assistance from PEPFAR and a contribution from the GFATM. 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[72].

F.3.2 GoU Treatment Achievements and Challenges

The NSP treatment goal was: to increase equitable access to ART by those in need, from 105,000 to 240,000 by 2012[73]. This was updated in the revised NSP: to increase equitable access to ART by those in need from 50% to 80% by 2015. 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[74]. During the implementation of the revised NSP, the MoH committed to changing the threshold for eligibility for ART to a CD4 count of 350, and to *all* positive pregnant women, irrespective of their CD4 counts[75].

---

[68] Effort must also be given to addressing the structural determinants of behaviour.

[69] In Mbarara, the evaluation observed a community dialogue with community leaders in which it was stated that one can identify MSM as they are the young men who walk round with their trousers waist bands sagging down below their hips. None of the facilitators or community leaders challenged the statement which would have become accepted "fact" if the evaluation's cultural facilitator had not asked to clear up that and other misinformation that had been shared during the discussion.

[70] The evaluation was informed by TASO, Straight Talk and PACE staff that their respective organisations have central departments responsible for developing IEC material and testing messages.

[71] http://www.mrcuganda.org/research/hivaids-care-research-programme/ (accessed 28/06/213).

[72] 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.

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

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

[75] http://www.keycorrespondents.org/2013/04/05/uganda-adopts-emtct-intervention-option-b/ (accessed 2 July 2013).

This will greatly increase the numbers of PLHIV eligible for treatment and make attainment of the revised target more difficult and more costly.

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 longitudinal ART outcomes has also been recorded in terms of the facilities providing data that also increased from 186 in 2010 and 191 in 2011[76]. There are particular challenges to achieve good long-term adherence for children on ART[77].

To test the effectiveness of expanding ART services to rural health centres, bringing it closer to more PLHIV, Makerere University undertook a pilot study that demonstrated successful ART outcomes in the health centre/community-based cohort were equivalent to those in the hospital-based cohort after two years of treatment. In multivariate analysis patients in the health centre/community-based were more likely to have virologic suppression compared to hospital-based patients[78].

However, Uganda is likely to fall short of achieving its goal of ensuring that 80% of eligible people living with HIV receive ART by 2015, in part because of frequent drugs stock-outs at health facilities, inadequate numbers of functioning CD4 count machines and understaffing. Additionally, Uganda's HIV programmes have been hit hard by a funding crunch limiting its ability to operate HIV programmes. Of the 700 health facilities listed as offering ART, only 532 were doing so by end of March 2012[79].

F.3.3 CSO Provision of 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. Nonetheless, CSOs working in communities over long periods that have good rapport and the trust of their community, have great potential for working closely with ART service providers to increase uptake of ART and improve adherence to ART.

F.4 Care and Social Support

F.4.1 Context and Concept of Care and Support

Most care is provided in the home by family and community members, supplemented by support from local CSOs – including NNGOs, CSOs and FBOs – and the GoU health and welfare systems. Many patients are referred for CSO and GoU services after being diagnosed with HIV; others are referred by community volunteers, and again others through self- or family-referral. Prior to the availability of ART, many self- and family-referrals were very weak both physically and financially, when they sought care, having sold their assets to cope with loss of income and increasing expenses on care and treatment. Most PLHIV are diagnosed and started on treatment at a local health centre III or district hospital outpatient clinic, and followed up regularly at home. When needed, weekly home care visits are done. An increasing number of PLHIV are referred by community health volunteers after having tested positive in the community.

The model of care integral to the NSP is an adaptation of the "continuum of holistic care" model promoted by UNAIDS since 2000[80]. The needs of PLHIV and those affected by HIV vary over time as

[76] Report (2012) *Global AIDS Response Progress Report: Country Progress Report*. Uganda AIDS Commission, Kampala.
[77] Haberer JE, et al. (2012) *Multiple Measures Reveal Antiretroviral Adherence Successes and Challenges in HIV-Infected Ugandan Children*. PLoS ONE 7(5): e36737. doi:10.1371/journal.pone.0036737
[78] Kipp W, et al. (2012) *Antiretroviral Treatment for HIV in Rural Uganda: Two-Year Treatment Outcomes of a Prospective Health Centre/Community-Based and Hospital-Based Cohort*. PLoS ONE 7(7): e40902. doi:10.1371/journal.pone.0040902
[79] http://www.irinnews.org/report/97184/hiv-aids-uganda-still-behind-on-arv-target (accessed 2 June 2013).
[80] Best Practice Series (2000) *AIDS: Palliative Care: UNAIDS Technical Update*. Joint UN Programme on HIV/AIDS, Geneva.

their situation changes, ranging from the need to reduce their vulnerability to the need for bereavement support and meeting the needs of children affected by and orphaned by AIDS. To be most effective, providers must plan and link services in an integrated manner to respond to clients' *changing needs*. Further, care services must be linked to prevention, treatment and social support, maximising the relevance and synergy between the different components to attain the goal of the NSP. HIV counselling and testing is offered in the community by an increasing number of CSOs. The focus of care at health facilities is typically on the needs of the PLHIV and less on the family's needs with the exception of discordant couples, where prevention and protection of the both partners are part of care and support. This has without a doubt increased prevention. Some CSOs have adjusted counselling and testing service hours to increase availability to men who are only free after working hours.

Quality care as a standard is safe, timely, and comprehensive (addressing physical, emotional, social and spiritual needs of the client and his/her family) care, which continues for as long as needed. It integrates "prevention for positives" – that is prevention for the PLHIV from re-infection with HIV and prevention of infection of others with HIV – with family planning, nutrition support, screening for and diagnosis and treatment of tuberculosis and sexually transmitted infections, prevention and treatment of malaria, and other common illnesses as well as supportive counselling. It reflects a human rights and a value-based approach (respect, dignity, privacy and protection against stigma and discrimination), and integrates the sexual and reproductive health and rights of the PLHIV. The "model" for comprehensive, quality care services is promoted in the various MoH policies and guidelines and in the training programmes offered by organisations including TASO and Hospice Africa Uganda.

With effective prevention of re-infection with HIV; prevention, early diagnosis and treatment of opportunistic infections including tuberculosis; diagnosis and treatment of common illness; support for adherence to ART; and nutritional support, most PLHIV have few bouts of illness compared with before treatment was available. However, not all PLHIV are in ideal situations. Nationally the prevalence of tuberculosis co-infection continues at high levels[81] and malaria remains highly prevalent[82], but regular tuberculosis screening as part of chronic care increases detection and facilitates early treatment. 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[83].)

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 MSM and SWs and so these clients only go to MoH facilities when they have no alternative and are very ill. At all CSO programmes

[81] Tuberculosis is a major public health problem in Uganda with an annual incidence of 330 cases of all forms and 136 new smear positive cases per 100,000 people per year. In 2010 WHO Report ranked Uganda 16th among the 22 tuberculosis high burden countries. The situation is exacerbated by the dual tuberculosis and HIV epidemics. It is estimated that about 60% of the tuberculosis patients are co-infected with HIV, resulting in a fourfold increase in the notification numbers of tuberculosis cases. Tuberculosis is the number one killer of PLHIV. http://health.go.ug/mohweb/?page_id=155 (accessed 7 July 2013).

[82] WHO classifies most of Uganda as High transmission (≥1 case per 1000 population) in 2011 WHO recorded 31,100,000 episodes of Malaria – that is in 90% of the Ugandan population: http://www.who.int/malaria/publications/country-profiles/profile_uga_en.pdf (accessed 7 July 2013).

[83] Report (2013). *Annual Report 2011-2012*. Hospice Africa Uganda, Kampala.

visited, the evaluation was told that CSO staff are trained to be inclusive and non-discriminatory. 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.

F.4.2 GoU Care and Support Achievements and Challenges

The NSP 2007-12 goal for treatment and care was: to improve the quality of life of PLHIV by mitigating the health effects of HIV/AIDS by 2012[84] (updated to 2015 in the NSP 2011/12-14/15[85]). 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 complementary, and provide complementary support including nutrition to PLHIV. In the revised NSP[86], the objectives related to care are to: increase access to prevention and treatment of opportunistic infections including tuberculosis; integrate sexual and reproductive health (including HIV prevention) into all care & treatment; and support and expand the provision of home based and community based care and support. The NSP emphasises increasing access to ART and universal access to all services. Attaining "*universal access to care*" requires a keen awareness of the different and changing needs as well as of coordination with other community activities, services, and providers.

That 329,060 Ugandans[87] were currently receiving ART in financial year 2011/12 has changed *the predominant care services* needed from hospital and home based care for extremely sick or bedridden patients, to community and short-term health facility support services (such as provision of water purification equipment and tablets for clean drinking water, improved domestic sanitation, insecticide treated mosquito nets, use of cotrimoxazole for prevention of opportunistic infection and malaria, and periodic day care – supplemented by home visits and psychosocial support by volunteers.) 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. PLHIV often continue to work and support their families, except for during short periods of illness.

The GoU is currently financing about 8% of the health care budget and is not a contributor to the CSF. It is unrealistic to expect that Uganda will finance the current and over the medium term increasing need for care services. Beyond the international commitment to providing access to prevention, treatment and care as a human right, ART cannot be effective without care services and neither can social protection.

Care Policies for PLHIV and MARP

Access to care services and support as one of the four key components in the National AIDS Strategy, is prioritised in the NSP, and the MoH AIDS Control Plan. The National AIDS Spending Assessment shows that just over one half of all HIV expenditures were spent on treatment and care (UGX 564-597 billion) making it the largest category[88]. This is due mainly to the high unit cost of ART. NSP budget

---

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

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

[86] UAC (2011) *National HIV and AIDS Monitoring and Evaluation Plan 2011/12 to 2014/15*. Uganda AIDS Commission, Kampala, p. 25.

[87] GoU (2012) *Annual Health Sector Performance Report FY 2011-12*. Ministry of Health, Kampala, p. 28.

[88] UAC (2012) *National AIDS Spending Assessment, Uganda 208/9 to 2009/10*, Uganda AIDS Commission, Kampala, p. 56.

allocations for care services only are, however, very modest, reflecting the expectation that these services will be largely provided by CSOs.

The NSP and the revised NSP clearly aim for universal access to prevention, treatment, care and mitigation, and the National AIDS Policy (2011) and the HIV and AIDS Strategy are guided by the principles of human rights, non-discrimination and equality, meaning equal rights to and equal access to such services[89]. The essence of prevention, treatment, 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. The MARPs Network reports that HIV efforts have not adequately focused on the needs of different MARP and that current interventions do not match the magnitude of the problem[90],[91] 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."[92]

Coverage

Service data show a dramatic increase in patients receiving care over the past five years. The total number of PLHIV enrolled in care increased from 136,269 in 2010/11 to 152,484 (12,212 children and 140,272 adults) in 2011/12[93]. There are, however, still a large (unknown) number of unreached and undiagnosed PLHIV in need of and without access to home based care and other care services. Estimates put the number as high as 650,000.[94] However, a comprehensive database or mapping of PLHIV needing care and receiving care does not exist. The declared goal of the revised NSP is to offer universal access, but there is little likelihood that funds will be available to reach this goal, or that the health and social systems can cope with such a high number of clients. For the hard to reach populations, namely rural populations far from commercial centres, fisher folk, migrants, and truck drivers, there are some outreach programmes that reach locations where these populations live or work. Several partial mappings have identified "hot spots" where they congregate, but no comprehensive needs assessments or plans for service provision have been made. Lack of awareness raising and prevention BCC, inadequate infrastructure including health facilities providing HIV testing, ART and follow-up care, and more continuous support is a serious gap in the Uganda AIDS response, particularly for fishing communities around Lakes Victoria, Edward, Albert and George although several are known to have very high prevalence. Their needs for basic health services in general are not met. Asked why a population of more than three million fisher folk with an extremely high prevalence can be left ignored by GoU and civil society in general, the evaluation was told that "They are hard to reach", "They are not prioritised", "They are marginalised and ignored". This seems perplexing as the fishing community contributes significantly to the Ugandan economy.

The evaluation visited fishing communities on Lake Victoria and Lake Edward and met with leaders and others in the communities as well as Uganda Fisheries and Fish Conservation Association (UFFCA) a small organisation founded and managed by persons from fishing communities that addresses the interests of fishing communities. Without doubt, fishing community needs for HIV

[89] Although the evaluation found that this isn't so for sex workers, MSM and fishing communities.

[90] Report (2011) *MARPs Network Programme Document 2011-2014*. MARPs Network, Kampala.

[91] Report (2012) *Annual Performance Draft Report*. MARPs Network, Kampala.

[92] UAC (2009) *Uganda HIV Prevention Response and Modes of Transmission Analysi*s. Uganda AIDS Commission, Kampala.

[93] GoU (2012) *Annual Health Sector Performance Report FY 2011-12*. Ministry of Health, Kampala, p. 28.

[94] CSF Presentation at CSF Annual Review Meeting, May 21, 2013.

prevention, treatment, care and support are definitely not being met and Uganda currently lacks the political will to address fishing community needs. There is manifest discrepancy between GoU strategy as reflected in the NSP and provisions on the ground for fishing communities.

F.4.3 CSO Care and Support Achievements and Challenges

Improvement in Quality of Life of PLHIV

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. They included rapid recovery of physical strength (after starting on ART and receiving care), most patients going back to work and becoming strong enough to hold a job/continue studies/take on their roles in the community and family (including child care). With more physical strength and stamina, household production and income often increase again. Food consumption improves, and fewer children are undernourished. PLHIV regain hope and self-esteem, although stigma and discrimination are still major problems, not least for MARP.

Coverage

The numbers of CSOs involved in providing community-based and home-based care has increased through Danida direct funding, CSF grants, PEPFAR, and others. Access to care services and support is prioritised in the CSF Three-Year Strategic Plan 2009-2012 (strategic objective 3.2) and solicitations. "HIV care" is a prioritised area in the current CSF portfolio[95].

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, treatment and support. As of financial year 2012, CSF grantees were providing care and support, clinical and non-clinical services, to 78,383 adult and children PLHIV[96,97]. The Technical Management Agent aspired to increase access and utilisation of care and support services, albeit for only 18 month periods, in communities it targets in four ways: 1) through capacity building of CSOs, 2) through funding of CSO programmes and projects providing such services, 3) through strengthening financial management, and 4) reporting systems and policies to support HIV and orphan service delivery.

CSF grants have funded CSOs to conduct HIV counselling and testing; to supply PLHIV with cotrimoxazole prophylaxis; to provide clinical care and social services to adult and child PLHIV. Between April 2008 and March 2012, CSF-funded CSOs provided services to more than 300,000 orphans and vulnerable children who benefitted from improved access to education, social economic empowerment, food security, child protection, psycho-social support, care and support, and legal support. By April 2013, nearly 200,000 PLHIV had been reached with a minimum package of prevention interventions – including risk education counselling, disclosure, condoms, family planning, screening and treatment for sexually transmitted infections, and adherence support, referrals for ART, and PMTCT; and more than 100,000 PLHIV had been screened for tuberculosis[98]. In FY 2012[99], 89% of PLHIV served received psychological counselling, although far fewer received social support, because the grant funding for OVC from USAID had ended.

---

95 CSF (2013) *Annual Review Meeting Presentation: CSF Results Chain, 2013/2014*.

96 MEEPP data.

97 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.

98 MEEPP summary data for CSF over the periods stated, provided to the evaluation.

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

It is a serious concern that continuity of care services is not guaranteed beyond the 18 month funding period that CSF grants offered. The evaluation heard of CSOs that had either stopped or would stop providing care services once their CSF grant was over and the Technical Management Agent confirmed that some CSOs ceased to be after the period of their CSF grant. 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 others such as 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.

Hospice Africa and TASO key staff gave examples of the difference improved access to and quality of care and supportive services has made to PLHIV, their families and communities. In general PLHIV start treatment earlier, before they become debilitated or lose all their financial resources. Because PLHIV are being followed with regular medical check-ups, health and other problems are discovered early on and more often prevented/treated in time. HIV tests, CD4 counts and supportive care can be provided in day care/home care with less need for hospitalisation. PLHIV live longer and are often able to work and take care of their families, and bring up their children through their crucial formative years. This leads to fewer children forced out from home to fend for themselves at an early age, and reduces pressure on girls to engage in transactional sex. Community based care also benefits the family and community in terms of more awareness, less stigmatisation, and increased knowledge and skills in prevention and care giving. Families and communities are less impoverished by HIV as fewer resources are needed to cope with the situation (care giving, medication, transport, support, food).

Quality of Care

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). Many examples of full recovery from a state of general weakness, the "Lazarus effect" of ART, were citied and used as proof of the possibilities of dramatic changes and the effectiveness of care and treatment.

In the "Centre of Excellency" model[100], which is how Hospice Africa, Uganda styles itself, the standard of palliative care is very high. Each patient gets a comprehensive assessment followed by a tailored care and support programme that caters to the needs of the individual PLHIV and his/her family. The PLHIV accesses care through day care services at the Hospice or at home. The Hospice is well staffed and outreach is through community volunteers. Prevention and social support is integrated in the care services. As the scope of the services is comprehensive and long-term, a relatively small number of PLHIV are served at any time. The number of PLHIV which had been steadily rising for the last decade began levelling off in 2011-2012. The total number of PLHIV were 3,371 in 2011-2012, representing an increase of 1.4% compared to yearly increases of 8-24% over the preceding six years. Of the 3,371 patients seen in 2011-12, 59% were female, 57% had cancer, 11% had cancer and HIV, and 28% were HIV positive only. These PLHIV received 20,524 contacts either as outpatients, at home, in outreach clinics, or in hospitals. Hospice Africa reached 826 patients in their homes which is the PLHIV preferred place for end of life 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.

[100] See details in Annex B Summary of Danida Support to three NNGOs.

PLHIV and staff interviewed[101] reported that factors that account for the exceptionally high quality of care at Hospice Africa include: 1) a multidisciplinary and broad health assessment and care plan that addresses all the PLHIV health related needs, not just HIV symptoms; 2) one stop comprehensive and continuous care provided in the Hospice or at home as needed, continuous availability of medication, counselling and care adapted to the PLHIV and the family's changing needs, varied social support for PLHIV and family, including for orphans and children affected by AIDS, 3) a high level of interpersonal relationship skills of staff, peer and group support, capacity building and involvement of PLHIV.

However, the PLHIV interviewed also mentioned a number of areas that affect the care negatively: 1) food and nutrition support has declined; 2) diminishing transport refunds limit attendance at training; 3) group therapy is slowly dying off as meetings are not facilitated as previously, and the morale of community volunteers has declined due to decline in facilitation; 4) community volunteers mobilise PLHIV, some of whom are not taken on as eligible, causing animosity in the communities; 5) charity walks that helped publicise the Hospice's work have stopped; 6) the Hospice no longer treats volunteers accompanying clients if they fall sick at the Hospice, and there is no particular space at the Hospice allocated to the community volunteers. Poverty continues to be widespread problem.

The PLHIV interviewed want more influence on how Hospice Africa functions: having only one representative on the Board is too few; they want to be consulted when proposals are being developed, and they suggest the institution of an official complaints procedure[102]. Other suggestions from clients for improvement include: Hospice Africa should collaborate with other institutions to ensure adherence to ART, and establish a more comprehensive laboratory service; a playroom for children be set up at the Hospice, scaling up of life skills training, orphan support and income generation support.

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.

Sexual and reproductive health (not SRHR) is supposed to be integrated into all CSF-funded activities in the form of distribution of condoms for FP, sexually transmitted infection screening and treatment, FP education, PMTCT and HIV messaging, and youth centres and youth friendly IEC materials and BCC services for in and out of school youth[103].

CSO Comparative Advantage

Being close to where people live and work, CSOs know the situation and needs of most families and can design low-cost care programmes that are relevant. This has led to many variations of community based care, new ways of training and supporting family care givers and volunteers, peer and buddy systems, work place support programmes, and projects that are capable of responding to the specific needs of different risk populations. CSOs, however, often need guidance and capacity building in developing project proposals and project management systems that are acceptable to donors. This is where a synergy between the larger NNGOs and the smaller CSOs is very important in fostering such comparative advantages in sustainable ways (see examples in the assessment of TASO and Hospice Africa, Uganda in Annex B: Summary of Danida Support to three NNGOs).

---

[101] Evaluation Key Informant Interview with key staff of Hospice Africa; evaluation semi-structured discussion with PLHIV and users of Hospice Africa's services.

[102] Evaluation semi-structured structured discussions with Hospice Africa, Uganda beneficiaries.

[103] CSF (2013) *Annual Review Meeting Presentation: CSF Results Chain, 2013/2014*.

CSOs have several ways of increasing sustainability of the funds invested in providing care and these could be strengthened: training and supporting family care givers, providing testing and follow-up in the communities, reducing needs for hospitalisation, employing low-cost models of care, organising self-help and mutual support networks, charging people who can afford it a nominal fee for care, combining prevention and care, building capacity in CBOs, integrating prevention of HIV, tuberculosis, malaria and other common diseases.

Care and Support of People Living with Disability

For PLWD, Masaka District Union of People with Disability (MADIPU) reports that TASO has begun to deploy PLWD as volunteer peer counsellors in each of its clinics[104].

MADIPU originally received technical assistance from the National Union of Disabled Persons of Uganda (NUDIPU) that had direct funding from Danida to undertake HIV awareness and prevention for PLWD. NUDIPU provided oversight and technical support to MADIPU, and the grant also paid for peer counsellor training by TASO. The PLWD who were trained as peer counsellors received TASO certificates and volunteer in MoH health centre-IIIs that provide ART services. MADIPU reports that TASO was so impressed by the PLWD peer counsellors that it recognised the need to have PLWD volunteers in all its own centres. MADIPU then received a CSF grant for HIV prevention for PLWD that funded a group of HIV positive PLWD to start peer support groups at community. The group became Masaka Disabled People Living with HIV/AIDS Association (MADIPHA), a separate CSO member association of MADIPU. MADIPHA uses community drama and other innovative communication techniques to engage people in the community on issues related to PLWD and HIV & AIDS. After the end of the CSF grant, MADIPHA is "limping but still working" and MADIPU was able to call in more than 20 members and two of the three CSF grant-funded staff (although the staff have had to be laid off at the end of the grant) at only 24 hours' notice to meet the evaluation. MADIPU is now meeting far less frequently than when it had CSF funding, but was able to photocopy the evaluation brief and share it with members before meeting the evaluation. A volunteer signer was available during the discussion with the evaluation to interpret for deaf members.

The evaluation also visited a self-help centre for disabled people Masaka Disabled Persons Association (MADIPA) – another member association of MADIPU. MADIPA has never received a CSF grant although it has applied three times. It offers shelter, care, social support and income generating activities to its members, who also offer a programme of HIV awareness and prevention talks by guest speakers such as the District HIV Focal person.

F.5 Human Rights

F.5.1 Donor Perspectives on Human Rights and the HIV Epidemic

Human Rights are of prime importance to Danida[105] and Irish Aid[106], as they are to Sida and other Scandinavian donors in Uganda[107]. 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 publication 2008 *HIV/AIDS, Human Rights, and Legal Services in Uganda*[108] 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

[104] Evaluation Key Informant Interview with MADIPU.

[105] Evaluation Key Informant Interview with Danida.
[106] Evaluation Key Informant Interview with Irish Aid.
[107] Evaluation Key Informant Interview with Sida.
[108] Mukasa, S & Gathumbi, A (2008) *HIV/AIDS, Human Rights, and Legal Services in Uganda: A Country Assessment*. Open Society Institute for East Africa, Nairobi.

especially true for marginalised populations who are most vulnerable to HIV-related human rights abuses: women (especially young women, widows, and women living in fishing communities); sex workers; orphans and vulnerable children; LGBTI individuals; and internally displaced persons.

F.5.2 Ugandan Perspectives on Human Rights and the HIV Epidemic

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. However, 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 serostatus sets in motion a string of human rights violations and calls for legal protection. Under the section on prevention, links with sexual and reproductive health are mentioned as an important part of PMTCT. However, human rights are not mentioned in this section and sexuality from a broader perspective is not discussed in the NSP. Uganda does not provide services for sex workers, MSM and injecting drug users, does not report on these services to WHO/UNAIDS, and 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. Thus, the NSP has a focus on reproductive health and on family planning but is not embracing a genuine human rights perspective.

Many people are not able to access health and HIV care as a result of structural and poverty related issues in general, but there are aspects of health and HIV care that clearly are neglected. Additionally, there are legal and policy issues that hamper initiatives to address the HIV epidemic and thus the national response. The term SRHR has been widely discussed and Uganda has signed on to both the Cairo International Conference on Population and Development and the 1995 Fourth World Conference on Women held in Beijing, that built on the World Health Organisation's holistic definition of health. However, sexual rights or sexual orientation was not mentioned explicitly at the Beijing Women's Conference, although the result and the process proved more useful than anticipated. A change in norms has been underway in international law since then, as evidenced by the growing body of documentation and commentary on these issues at the UN and in regional human rights forums. 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. In Uganda, sexual intercourse between consenting adults of the same sex is a crime. The proposals in the Anti-Homosexuality Bill aim to extend criminal sanctions even further. A number of provisions of the HIV/AIDS Prevention and Control Bill prohibit LGBTI 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 being constrained or shaped by structures in the social context. Yet the limited research on MSM in Uganda[109] 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. 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 different populations in the society.

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

F.5.3 Men-who-have-Sex-with-Men and other Sexual Minorities

Although UAC recognises that the effective implementation of HIV interventions requires a conducive policy and strategy environment[110], the activities of MSM are criminalised and they are virtually invisible in the NSP and HIV & AIDS Prevention Policy. This is an area where the general political and organisational debate in Uganda is rather working against changes needed to enable more effective prevention of new infections among specific vulnerable populations. It also highlights human right violations as both MSM and other individuals within the LGBTI population are vulnerable to abuse as they are not protected by law. Lack of HIV information and services for MSM and other LGBTI individuals is extremely problematic for AIDS control. Minimal services such as HIV sensitisation and awareness are provided by CSOs, with no specific services provided by government health facilities. Most CSOs told the evaluation that they treat and support all clients, irrespective of sexual orientation, but that they were unable provide specific services tailored only to individual at risk populations. If homosexuality is mentioned in sexual and reproductive health programmes, it is often treated as a pathology or deviance. Thus, prevention activities needed by MARP to address specific risk behaviours is lacking and services for care and treatment in the context of risk behaviours is non-existent.

UAC reported to UNGASS in 2012[242] "… 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 facilities."

Discrimination against sexual minorities is attitude-based and transmitted through verbal and non-verbal normative communication. Religious writings are an important source of repressive attitudes, since religions in Uganda condemn same-sex sexual relations. 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. As the Ugandan response to the HIV epidemic is largely driven by religious values, mixed with scientific facts, these MARP are excluded on all levels, in violation of their human rights. MSM interviewed by the evaluation reported that many sexual 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.

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.

[110] Report (2012) *Global AIDS Response Progress Report: Country Progress Report*. Uganda AIDS Commission, Kampala.
[111] Report (2012) *Global AIDS Response Progress Report: Country Progress Report*. Uganda AIDS Commission, Kampala.

Donors reported that their embassies are involved in quiet diplomacy in relation to the Anti-Homosexuality Bill, as overt action would be counterproductive. The evaluation met with three office bearers from Sexual Minorities Uganda (SMUG) who both confirmed the difficulties and widespread harassment experienced by MSM and others in the LGBTI community, and that quiet diplomacy is the best way forward. SMUG would like to receive direct funding to enable the work organising, educating – including on prevention of HIV infection – and legally supporting their community and area frustrated that funding generally goes to partners that are willing to collaborate. SMUG considers that funding organisations that do not specifically represent sexual minorities "dilutes" the voice of sexual minorities. At the same time, SMUG sees the utility of networks like the MARPs Network in terms of them advocating for the rights of different MARP. The SMUG office bearers are not short of personal professional development assistance, however, and have all received training outside of Uganda and attend relevant conferences that has given them a voice internationally, paid for by European private and public donors.

F.5.4 Sex 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 is available to sex workers. Sex workers reported to the evaluation that they suffer coercion and other violence including from the police. Some police demand sex workers' money or demand free sex, threatening sex workers with arrest if they do not comply with the demands. It is impossible for a sex worker to report rape by a client or the police, adding to sex workers vulnerability to violence.

In the Crane Study [112], only 15% of sexual partners of sex workers always used condoms, 19% had never used condoms. The most frequent reasons for not using a condom were not having one when it was needed, reported by 21% of the respondents, did not thinking of it, 15%, believed their partners were HIV uninfected 14%, did not like them, 10%, partners rejected, 9%. Another survey conducted by the MoH in 2009 noted that over 95% of sex workers were able to access condoms irrespective of their age groups but less than 80% actually used them, implying that they probably had a poor negotiation capacity[113]. Despite growing evidence about these at risk individuals and the relation to the general epidemic in Uganda, sex workers are not served by the public health services and are harassed by the police

The evaluation also met with representatives of a women's organisation representing street-based sex workers that is registered as a CSO, by not defining sex work as an interest or activity, which would prevent registration. Membership is restricted to women over the age of 18 years to avoid accusations of trafficking children, although CSO staff know of sex workers under 18 years old. This CSO, which has not received a CSF grant, confirmed the difficulties experienced by sex workers in terms of harassment by police – who do not harass their male clients, only the sex workers themselves – and pointed out that sex workers come in all ranks of society. Many street sex workers were said to be women supporting families; many hotel-based sex workers were said to be students, doing sex work more as a "hobby" than a necessity, wanting more cash for luxuries. The CSO was very critical of donor-funded programmes intended to reduce sex workers' financial dependence on sex work, through cottage crafts such as candle making. The criticism centred on donors' implementing partners' lack of understanding of sex workers' needs and economic situations – in Kampala sex workers do not need to

[112] Report (2010) *The Crane Survey Report: High Risk Group Surveys Conducted in 2008/9*. Kampala, Uganda. Makerere University, Kampala.
[113] Report (2012) *Global AIDS Response Progress Report: Country Progress Report*. Uganda AIDS Commission, Kampala.

receive candle making materials: if they wanted to make and sell candles, they could buy their own materials. But they do not want to make and sell candles as this is not lucrative enough. Economic empowerment for sex workers has to generate more than they earn from sex work. Yet the CSO also reported that for sex workers the use of a condom isn't simply a matter of negotiation skills: use of condoms reduces the payment from the client. From the CSO perspective, empowering sex workers to reduce their risk of HIV infection first requires legal protection and recognition of sex workers as valid human beings of equal worth to all others in society. Only then will sex workers' self-esteem be raised to a point where HIV prevention becomes of personal interest. The attitude of sex workers served by TASO Entebbe was different in that they saw alternative income generating activities as important ways out of sex work for them.[114]

F.5.5 Fishing Communities

As noted in *2.3 Structural Change, Changing Priorities and Assumptions*, the fishing community is the largest at risk population, including around three million persons in villages around Lakes Victoria, Kyoga, Albert, Edward and George. The evaluation met with UFFCA a development and advocacy CSO founded in 1993 by members of the fishing community and registered in 1994. It is a national collective of community-based fisheries-related organisations working for the concerns, needs, strategic interests and aspirations of lake-dependent communities, countrywide. UFFCA has not received a CSF grant.

With UFFCA, the evaluation visited fishing communities in Kampala, and Kasese. The evaluation also visited fishing communities in Entebbe and Buikwe. The community visited in Kampala had received some HIV information and services – particularly HIV counselling and testing – although follow up ART services were not close by. The counselling and testing seemed to be driven by the need to perform quotas of tests and many of the men had been repeatedly tested. Although the men in Kampala has some understanding of how HIV is transmitted and how to protect themselves from HIV, they admitted to risky behaviours – fuelled by alcohol – when they meet with "a pretty girl" at the evening social events at the landing site. They did not trust the quality of the testing available to them as, despite their risky behaviour, many of them tested negative. They had a very fatalistic attitude to the possibility of being infected.

In Kasese district, the evaluation visited a remote fishing village on Lake Edward that was beneficiary of a DFID/UK grant managed by UFFCA. The village, off the main tarmacked road, was within the Queen Elizabeth National Park and so had restrictions on its land use. It had a primary school, and a type II health facility but no officer-in-charge and virtually no drugs or consumables. Condoms were freely available from a very publically placed dispenser on the outside wall of the health facility. UFFCA had facilitated the formation of a local association to carry out development activities under its grant. Community members were not interested in attending health promotion sessions learning about HIV & AIDS, but they were interested in events that addressed their perceived needs and had pooled resources to build a durable village hall – the best quality building in the community. One interest had been in a savings and loan scheme – many of the men had disposable incomes, but no experience of saving and investing in the future. Savings and loans club meetings were the venue for health promotion and other education sessions. The local development association met with the evaluation and confirmed the fishing community lifestyle involved a lot of extramarital sex, and concurrent sex partners, fuelled by ready cash and alcohol. Gender-based violence was an issue, fertility high, and there was a problem with abandoned mothers and children, and grandmothers caring for multiple children. On Lake Edward, the communities' major health issue was lack of safe delivery facilities with a resulting high neonatal mortality and maternal mortality. There was no HIV counselling and testing, no PMTCT and no ART, although these matters ranked below lack of treatment for malaria and lack of tsetse fly traps in the community's list of concerns. Mostly the fishing community association members

[114] Evaluation semi-structured discussion with a group of sex workers.

were angry that they and their needs were ignored by GoU and local government even though their endeavours "feed Kampala" and are thus of economic importance. They believe that the government sets more store on the wildlife in the National Park than the fishing community – because the wildlife attracts conservation and tourist money into Uganda. This belief was fostered by the laws that protect wildlife – particularly hippopotamus, which are a problem to the fishing community.

In Buikwe, a different situation was noted. The community was isolated by a two hour drive along a bad side road off the main Mukono-Jinja road. The evaluation met with two women and 12 men (including a peer educator) "We do not know but we believe we are all infected" was said several times as well as "stop wasting our time". The participants were mostly friendly, but there was an atmosphere of agitation and frustration. The answers may have been influenced by visits by several NGOs who asked questions, but who never came back. HIV & AIDS messages have been passed on at sports events, but that is not what they need, they say. From time to time, health workers come conduct rapid HIV testing – which the community does not trust. The testing opportunity appears without warning and there is no continuity. If they want condoms they have to buy them, if they are HIV positive they have to travel 27 and 35 km on bad roads to get medical attention including staging, follow-up, and medication. A CSO which was listed as supposedly implementing HIV prevention activities in the community and funded by CSF had not been around. They all said they have to buy their own antiretroviral drugs (from as far away as Kampala) which they do when they have enough money. Treatment was often without CD4 counts and follow up medical monitoring visits. Also drug treatment for opportunistic infections is not free at the nearest clinic. Most people earn cash every day and sex work is rampant. People migrate to the landing site to earn money fishing from different parts of Uganda.

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.

F.6 Systems Strengthening, Human Resources, and Capacity Building

F.6.1 Systems Strengthening

The HIV & AIDS Partnership Fund was established to support leadership and coordination of the Uganda AIDS response at national and decentralised district local government levels effected through the UAC which has the overall mandate to coordinate the response. At national level, the coordination mechanism was expected to bring together bilateral and multilateral donor agencies through a harmonised funding mechanism where all HIV resources would be pooled in order minimise duplication and resource wastage under the principles of the "Three Ones" (one national strategic plan, one M&E plan and one coordinating entity – UAC). Self-coordinating entities were defined as "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. Self-coordinating entities have generic ToR but individual self-coordinating entities can develop these further to accommodate issues unique to their constituency. Membership of most self-coordinating entities can be easily established and readily accessed while for others especially those that attract individuals for example the self–coordinating entity of young people is still developing mechanisms of identifying and reaching all membership. Some self-coordinating entities have conducted mapping

exercises to establish their membership. The coordination activities of most self-coordinating entities are facilitated through the Partnership Fund"[115].

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 bilateral AIDS development partners; 9) research, academia and scientific institutions; 10) the youth representatives; 11) the media, arts and cultural institutions, and 12) Parliament. Through the Partnership Fund, it was expected that expertise and technical skills from members would be harnessed to complement and maximise the comparative advantages of the members and add value in delivering the NSP targets that are jointly owned.

The UAC has put in place the Zonal Coordination Offices for the purpose of 1) closer coordination of the clusters of districts/District AIDS Committees in a zone 2) supporting the District AIDS Committees, District/Regional Partnership Forums and AIDS reviews as may be convened. Thus, among other things, the Zonal Coordination Officer will enrich district activities, synthesis regional and cross cutting issues for onward transmission to UAC. Functionality and effectiveness of these structures are yet to be realised[116].

The evaluation was told in several districts that the district had received Partnership Fund support to coordination that had provided much needed transportation as well as funds for participation in District AIDS Committee meetings. A District Health Officer expressed frustration at the loss of the Partnership Fund support as a result of the "mismanagement in UAC," and AIDS Focal Persons were frustrated at no longer being able to get out and supervise activities, including community dialogues, at grass roots level. In one district, District AIDS Committee Meetings had been cut back from quarterly to twice annually and committees at lower levels were "committees in name only", as they no longer met.

F.6.2 Human Resources for the AIDS Response

The human resource is a most important element required to deliver HIV services. In government health facilities, which are mandated to provide health services, the MoH human resource capacity has remained limited even after efforts to recruit 59,000 doctors, nurses, midwifes in 2009/10. As in other countries in Sub Saharan Africa, many qualified health workers have been employed by PEPFAR implementing partners on higher salary scales than the public sector can afford, hampering MoH effort to recruit and retain staff. Efforts to strengthen the capacity of health workers through training and supportive supervision reached 86% in the 2009/10 compared to the Health Sector Strategic Plan[117] target of 100%[118]. This has not adequately addressed the capacity gaps in health service delivery, which is reflected in the difficulty in establishing effective referral mechanisms between CSOs in the community and health facilities. The skills required to provide some of the biomedical HIV preventive services, such as male circumcision, are limited to few health facilities, thus undermining access to services. To address staffing gaps, the MoH has adopted task shifting – including training of expert patients, use of community volunteers, and cadre substitution. In order to leverage human resources to deliver comprehensive services, some health facilities accept seconded CSO staff to help with non-medical activities including checking mothers' weights, checking immunisation cards, conducting health education and helping with infant feeding matters[119].

---

[115] http://www.aidsuganda.org/index.php/partnership (accessed 21 April 013).
[116] Report (2013) *HIV/AIDS Partnership Mechanism Review Report*. Uganda AIDS Commission, Kampala.
[117] MoH (2010) *Health Sector Strategic Plan III 2010/11-2014/15*. Ministry of Health, Kampala.
[118] MoH (2011) *Annual Health Sector Performance Report*. Ministry of Health, Kampala.
[119] USAID (2010) *The Capacity Module Application: Estimating the Human Resources to Scale-up ART In Uganda*. United States Agency for International Development, Kampala.

In 2010, the Health Policy Initiative used its Capacity Module[120] – a Microsoft Excel-based tool – with Ugandan data to estimate the existing capacity in Uganda for ART interventions[121]. The study showed that the human resource capacity for providing ART was at 359 in 2006 (baseline) and that it increased to 3,161 in 2011 with the largest increase in capacity among nurses:

Ugandan Human Resource Capacity for Providing ART

Year Cadre of health worker	2006 Baseline	2007	2008	2009	2010	2011
Physicians	67	184	257	380	507	671
Clinical Officers	66	163	242	351	475	627
Nurses	176	291	467	656	893	1,291
Laboratory Technicians	50	159	217	324	432	572
Total	**359**	**797**	**1,183**	**1,711**	**2,307**	**3,161**

The service provision assessment study of 2007 indicated that just under one-third of health care facilities in Uganda were providing HIV testing services while 61% were providing care and support services; 84% of hospitals and 52% of health centre-IVs were providing ART. The district league computed by the MoH in 2009/10 indicated that on average there was 78% of HIV service availability throughout the country[122].

The evaluation found that CSO human resource capacities are also limited especially for smaller, community-based organisations. Their limited budgets cannot attract and sustain skilled staff. CSF grants have paid for the hire of some grant management personnel – often including a programme manager, an M&E officer and a finance officer – who received training from CSF in Kampala. But grantees visited after the end of their CSF grant had had to lay off these staff, and so their institutional capacity was not increased by their CSF grant. Low CSO salary scales contribute to high staff turnover rates despite the tremendous work they are contributing to the AIDS response. CSF until of late had not specific technical capacity building interventions targeting the small service providers which has affected their capacity to deliver quality services. None of the CSOs visited during the evaluation reported that they had received technical training or capacity building although they in general were appreciative of the grant financial management and M&E support they had received.

F.6.3 Challenges/Weaknesses

Systems strengthening especially for M&E at UAC is still a challenge given the limited human resources available and the high dependence on donor funding with limited input by GoU. Management systems for the Partnership Fund remain a serious challenge and contributed to the UAC mismanagement of the Partnership Fund. Currently, Deloitte Uganda Ltd manages the Partnership Fund with about 25% of the fund going to administrative costs thus negatively impacting on other areas where the fund was supposed to facilitate[123].

[120] http://www.healthpolicyinitiative.com/Publications/Documents/1289_1_Uganda_CM_HR_FINAL_acc.pdf

[121] The Capacity Module estimates the human resources required to effectively reach a specified number of individuals with various interventions. It uses the target number of people reached by each intervention as the basis for identifying gaps in existing capacity to meet HIV and AIDS strategic goals.

[122] AMICAALL (2012) *Annual Report 2012*. AMICAALL, Kampala.

[123] Evaluation key informant interview UAC Director Planning, Monitoring and Evaluation.

The District Local Government HIV decentralised structures, the District AIDS Committees are largely non-functional due to lack of funds except in areas where earmarked funding is provided to implementing NGOs. One example is Irish Aid support to TASO and AMICAALL in Karamoja region, supporting the decentralised response[124].

F.6.4 Capacity Building

Donors have supported capacity building efforts as a means to an effective HIV response through a number of mechanisms. Through the Partnership Fund, capacity building efforts focused on the 12 self-coordinating entities, which were in turn expected to build capacity of their constituencies at district level. However, as the Partnership Fund was limited to supporting coordination of the national and district response, the Partnership Fund has been unable to support capacity building for community-based service providers of direct service delivery.

The CSF developed a capacity building plan for CSOs, to respond directly gaps identified by the CSF. One strategy was training through participatory regional thematic workshops to address knowledge and skills gaps for service providers. Another strategy was mentorship and coaching with on-the-job training and mentoring /technical support. Joint support supervision visits to CSOs was to be decentralised and individual CSOs' capacity building interventions mapped out by their mentor/coach. It was expected to enhance cross fertilisation of interventions to strengthen the capacity gaps of leadership, governance and organisational systems. CSF was to identify and train a local organisation to eventually take on the duties of the CSF. However, this has not yet materialised given the many transformations CSF has undergone.

CSOs report that the capacity building models adopted by CSF – Technical Service Organisations Model, Lead Agency Model, and Regional Technical Support Teams Model – have not had their desired effects on CSO capacity.

F.7 Resource Requirements and Mobilisation

Most of the resources for the Uganda AIDS have come from external donors. The National AIDS Spending Assessment report[125] funded by Irish Aid indicates that during 2008/09, 68% of the funding for HIV/AIDS was from donors and 80% of this is from the US government through the off-budget finding mechanism[126]. Funding from GoU is about 11% of the total resource envelope. Only 18% is spent on prevention, 20% on coordination and over 50% is on care and treatment[127]. (See figure below.) The skewed resource allocation to the components of the HIV response is likely to negatively influence incidence trends where prevention efforts are relegated to lower funding priority.

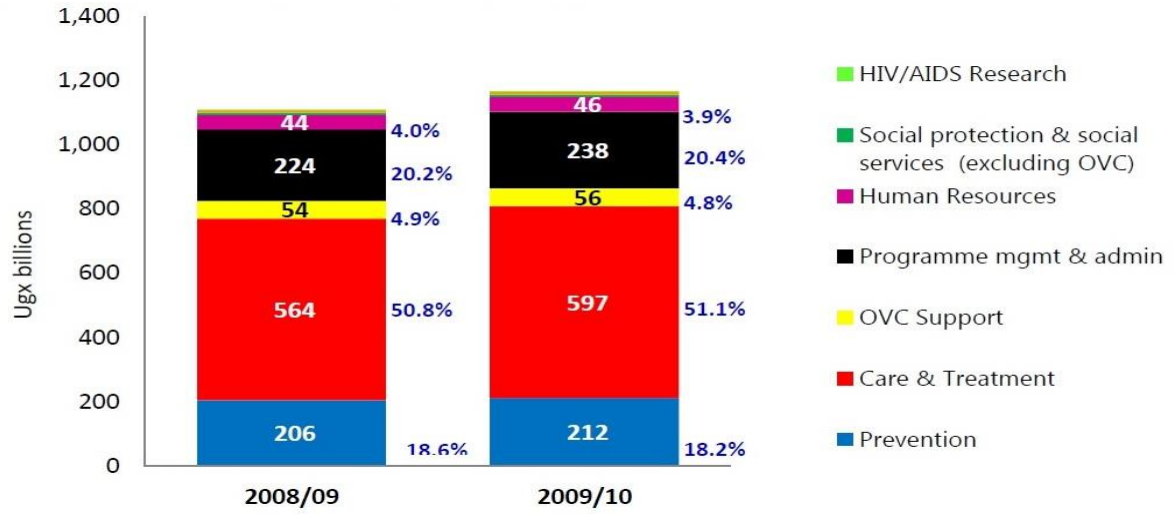
Resource mobilisation to fund the AIDS response has been further influence by donor fatigue and by high levels of corruption within government ministries as evidenced in the recent "Office of the Prime Minister" scandal[128] when direct aid was halted after evidence of fraud by the prime minister's office. If

---

[124] AMICAALL (2012) *Annual Report 2012*. AMICAALL, Kampala.
[125] UAC (2012) *National AIDS Spending Assessment, Uganda 208/9 to 2009/10*. Uganda AIDS Commission, Kampala, p. 56.
[126] 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.
[127] UAC (2012) *National AIDS Spending Assessment, Uganda 208/9 to 2009/10*. Uganda AIDS Commission, Kampala.
[128] 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

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.

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



Source: UAC (2012) National AIDS Spending Assessment, Uganda 208/9 to 2009/10, Uganda AIDS Commission, Kampala. Figure 12

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 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. 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.